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Appendix A: Defining a Veteran and Military Discharge

Appendix A
Defining "Veteran" and "Military Discharge"

(Adapted from the Wikipedia, the U.S. Code, conversations with King County Veterans Program staff, members of the King County Veterans Program Advisory Board and other sources)

A *military discharge* is given when a member of the armed forces is released from their obligation to serve. The U.S. Department of Defense technically refers to a military discharge as *separation*. There are two basic types of separations: ***administrative separations*** and ***punitive separations***. Punitive separations occur as part of punishment for a crime, while all other types of discharges are considered administrative.

Administrative Separation

Under most situations, a service member is granted an administrative separation. When the character of service can be determined, the overall quality of the individual's service, as well as the reason for separation, is reviewed. In instances where the member is being discharged due to no fault of his or her own and there is a history of honorable service and no severe instances of bad conduct, an honorable discharge is issued. Exceptions are sometimes granted to those who, despite a history of poor conduct, showed otherwise exemplary service that would justify an *honorable discharge*.

On the other hand, service members with a record of bad conduct are issued *general discharges*. General discharges are characterized in one of two ways: under honorable conditions, or other than honorable conditions. Other than honorable discharges are usually only issued in cases where an individual is being discharged as a result of a particular infraction that wouldn't otherwise warrant a punitive discharge (for example, drug use).

If the term of service was unusually short (typically, less than six months), the discharge is considered *uncharacterized*, as insufficient time has passed to determine the character of one's service. Typically, these are issued to those who are discharged early on, such as failing basic training or demonstrating an inability to adapt to military life after basic training.

It is important to note that, even when the discharge is under honorable conditions, a general discharge is still considered "less than honorable." This distinction is critical in the context of eligibility for veteran's benefits, where a "less than honorable" discharge can be a disqualifying factor. For example, burial benefits and the Montgomery G.I. Bill education program are both denied to veterans with a general discharge of either characterization. Benefits may be further reduced by the conditions of the general discharge, as well as the specific offenses leading to it.

Punitive Separation

Punitive separations occur after conviction of a crime by a court martial and then only if the Uniform Code of Military Justice (UCMJ) specifies discharge as part of the allowable punishment for that offense. A *bad conduct discharge* is the less severe type of punitive discharge. It may be handed down by a special or general court martial. A *dishonorable discharge*, on the other hand, may only be handed down by a General Court-Martial. A conviction at a General Court-Martial is often considered by civilians to be a felony conviction, although the UCMJ does not make such a distinction. A service member who is convicted at a Court-Martial is not necessarily given a punitive discharge. If the member is found guilty of any offense, then the court martial members (similar to a jury), or the military judge if the accused elects trial by judge alone, determine a sentence. Depending on the offense, this punishment can include a punitive discharge, confinement, forfeitures of pay, a fine, and for enlisted members, reduction in pay grade.

Commissioned Officers cannot be reduced in rank by a court-martial, nor can they be given a bad conduct discharge or a dishonorable discharge. If an officer is convicted by a General Court-Martial of an offense and qualifies for a punitive discharge, then the General Court-Martial can sentence the officer to a *Dismissal*. This is considered to be the same as a Dishonorable Discharge.

Discharge Papers: The DD214

Every service member who is discharged, or released from active duty, is issued a DD 214, a military discharge certificate.

A DD 214 specifies the time that the member served on active duty, lists any major awards or medals, and lists the characterization of discharge. This characterization will be honorable, general - under honorable conditions, general - under other than honorable conditions, entry level separation (or ELS), bad conduct, dishonorable, or dismissal.

Discharge from the Reserves

Most that join the military that are honorably discharged after less than eight years of service are issued a DD 214 and then usually transferred to the *individual ready reserve*. These members are subject to being recalled to active duty, but do not otherwise have any military duties and are distinguished from a *drilling* reservist. A reservist who is called up to active duty is given a DD 214 when they are deactivated and returned to the reserves.

Discharge from the National Guard

TITLE 32, Section 322, Chapter 3, of the U.S. Code pertaining to the National Guard states the following:

- An enlisted member of the National Guard shall be discharged when 1) He becomes 64 years of age; or 2) His federal recognition is withdrawn.
- An enlisted member who is discharged from the National Guard is entitled to a discharge certificate similar in form and classification to the corresponding certificate prescribed for members of the Regular Army or the Regular Air Force, as the case may be.
- In time of peace, an enlisted member of the National Guard may be discharged before his enlistment expires, under such regulations as may be prescribed by the Secretary of the Army or the Secretary of the Air Force, as the case may be.

Additional Note

Some individuals who served in the military may not consider themselves “veterans” if they received an other than honorable discharge or never served in the military during a time of war or never experienced combat situations. These individuals may still qualify for veteran’s benefits and related services. Therefore, it is advised that outreach workers and others making contact with veterans not ask the question, “Are you a veteran?” but instead ask “Did you ever serve in the United States Military?” The qualifier about the “U.S.” military is important because there are many immigrants and refugees in the U.S. who may have served in the armed forces of other nations, but will not qualify for veteran’s benefits or services here.

Appendix B:
Priority Investment Areas

1. Whom the Levy will Serve
2. Help Veterans and Their Families in Need
3. Improve Housing and Services by Creating Seamless Pathways
4. Develop and Expand the Capacity of Supportive Housing Networks
5. Allow for the Timely and Appropriate Sharing of Client Information
6. Increase Access to Quality PTSD Treatment
7. Increase Impact of Effective Recidivism-Reduction Programs
8. Add Employment Goals and Services to Existing Programs
9. Promote Healthy Development for At-Risk Children

Whom the Levy will Serve: An Overview of Priority Populations

Target Populations

Four distinct target populations have been identified as the priority populations for Levy investments, based on both the requirements of the Levy itself, and the input received from community stakeholders. These populations are:

> ***Veterans and their families*** in need who are struggling with or at risk for mental illness, health problems, post traumatic stress disorder, unstable housing or homelessness, and under-employment.
>
> ***Individuals and families who experience long-term homelessness*** and are frequent users of hospital emergency departments, have frequent encounters with law-enforcement, and repeated stays in jail or institutions.
>
> ***Parents who have been recently released from prison or*** *jail*, or are under court supervision, and who are striving to maintain their family or be re-united with their children.
>
> ***Families and children who are at risk*** for homelessness or involvement with the child welfare, behavioral health or justice systems because of life circumstances.

Demographic Issues and Highlights

In recognizing the goal of ensuring Levy fund decisions are data-driven, it is also essential to note that the region's current ability to provide complete and accurate data about many of the Levy target populations remains limited. Comprehensive data about many groups is still not available, or is collected in a format that makes it difficult to extract detailed information about the target populations to be served.

In many instances, data that might have been helpful to inform Levy allocation discussions either do not exist or were not accessible to the Levy Planning Team. For example:

- The Safe Harbors Homeless Management Information System (HMIS) is in its implementation stage and has set a goal to collect enough data to produce system-wide data analysis by July 2007.
- Comprehensive data about the number of veterans in King County providing specific information about their housing, treatment and supportive service needs was not available.
- Information about the total number of families at risk of homelessness, criminal justice system involvement or other destabilizing circumstances was not available.

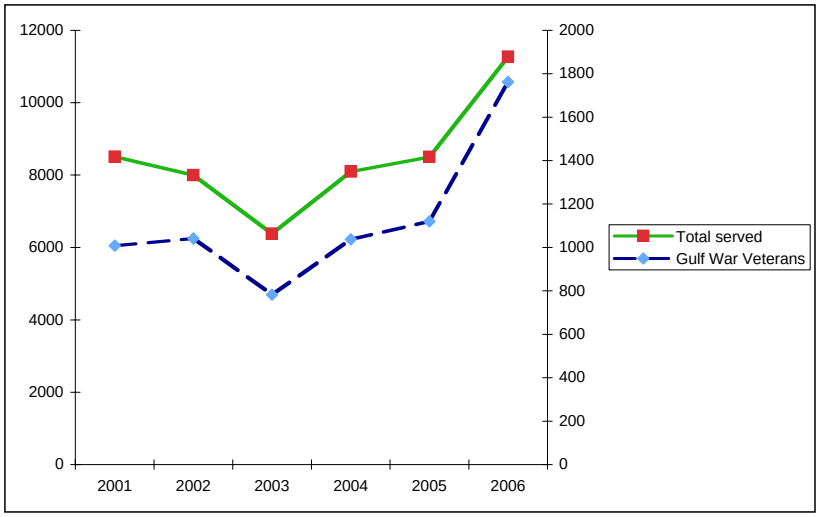
Within these limitations, the Levy Planning Team did collect a significant amount of information about the selected target populations and the nature of many of the services that are available to them. This information is included in this appendix. What follows here is basic information that illustrates who the people in the target populations are and what their needs are likely to be.

Veterans

In 2004, there were more than 147,000 civilian veterans living in King County[1] of which a third were 65 years or older and seven percent were women. As a group, they are similar to the non-veteran population except that they are less likely to be college educated and more likely to have a disability, but they enjoy a higher median income. The majority (40 percent) is Vietnam era veterans and 16 percent were considered Persian Gulf era veterans (which includes the current deployments.)

A better gauge of number and type of veterans in need is the King County Veterans' Program, which serves veterans who are encountering economic, social and/or mental health problems. They have experienced increasing client volumes in the last three years, with Gulf War veterans contributing sharply to that curve, as shown in Figure 1.

Figure 1
Total Veterans and Gulf War Veterans Served
King County Veterans Program[2]



Homeless Veterans

It is estimated that as many as 30 percent of homeless persons in King County has served in the military.[3] The King County Health Care for the Homeless program (HCH) is one of the few programs for the homeless, which inquires about veteran status. In 2005, HCH served 365 homeless veterans, 93 percent of whom were men and 94 percent of whom were single. The disproportional nature of homelessness in respect to race is clear with a comparison of King County's general veteran population and that of HCH.

[1] 2004 American Community Survey, U.S. Census Bureau
[2] 2006 is annualized based on the first six months experience.
[3] 2004 One Night Count of Homeless People in King County

Table 2
Race and Homeless Veterans

	General Veteran Population	HCH Veteran Population
White	86%	50%
African American	10%	28%
American Indian/Alaska Native	<1%	12%
Other	4%	10%

Homeless veterans served by HCH were most likely to be seen for substance abuse and/or mental illness, skin conditions and cardiovascular or respiratory problems. This correlates with estimates by the King County Veterans' Program that 45 percent of its clients have some type of mental illness and 70 percent have substance abuse problems.

More detailed information about veterans is contained elsewhere in Appendix B. However, much of the information that would be most useful for maximizing Levy investments in this area is not readily available. The collection of data through providers about veterans and their families will be important in the future to assure that Levy funds for veterans are being well used and having the desired benefits.

Long-Term Homelessness

There is no single data set or source that describes the group of individuals who are experiencing extended periods with no permanent housing. What we know is pieced together through a variety of different sources.

The Seattle/King County Coalition for the Homeless conducts an annual "One Night Count," which includes a street count in portions of Seattle, Eastside, Shoreline, Kent, White Center, and in 2005-2006, Federal Way. The 2004 One Night Count counted 2,216 surviving outside without any form of shelter; estimated that another 1,484 were living unsheltered in King County outside of Seattle; and counted 4,636 people living in shelters and transitional housing for a total estimated 8,336 people.[4] Of these, roughly 2,500 were estimated to be long-term homeless, as defined by the federal government.[5] In the most recent One Night Count of Homeless People in King County, conducted in January of 2006, a total of 1,946 unsheltered persons were counted on the streets, along with 2,463 in emergency shelters and 3,501 in transitional housing. An additional 1,500 persons were estimated to be unsheltered in parts of King County not included in the count, for a total of 9,410 people experiencing homelessness.[6]

[4] This count excludes people in the King County adult detention facilities, which had an average census of 2,601 in 2005, of whom at least 15-20% are homeless. King County Department of Adult and Juvenile Detention

[5] The Committee to End Homelessness in King County recognizes the difficulty in correlating the "One Night Count", which is a single point in time, with the number of people who experience homelessness over a period of time, such as a year. It uses a multiplier of 3.0 to estimate the number of people who experience homelessness in a year, implying that in 2004, an estimated 25,000 people experienced homelessness in King County.

[6] Data provided by the Seattle/King County Coalition for the Homeless

For the purposes of the Service Improvement Plan, the definition of long-term homeless includes individuals and families who have experienced repeated or continuous homelessness without meeting the federal Department of Housing and Urban Development (HUD) definition for chronic homelessness[7]. The 2004 "One Night Count" found 600 families living in shelters and transitional housing, including more than 1,100 children under the age of 18.

Health Care for the Homeless, which served 8,148 unduplicated individuals who were homeless in 2005, collects data which helps put a "face" on the homeless person:

- 55% of their clients were people of color, with the largest group being African-American (26%)
- 63% were single adults, but 10% were unattached youth and 23% were individuals in families
- 62% were living either on the street or in a shelter
- Only 35% had Medicaid coverage
- 29% had been homeless more than three times.

Homeless and Domestic Violence

Women and children frequently become homeless as a consequence of experiencing domestic violence. They are in great need of safe and permanent housing. In 2005, over 15,000 individual requests for shelter from victims of domestic violence and their children were turned away due to lack of space. While undoubtedly a duplicated count, as women will call multiple shelters for days in row looking for space, this statistic provides an indication of the level of need.[8]

High Utilizers

The impact of people who are homeless in other services is represented in their use of emergency services in 2005:

- Of the 300 people who were the most frequent outpatient users of the Harborview Medical Center Emergency Department, at least 40 percent were homeless[9].
- There were at least 1,574 emergency medical responses made to homeless shelters, transitional housing and homeless day service centers in Seattle and King County, according to the King County Emergency Medical Services.

Even in its brevity, the descriptive data for people experiencing long-term and/or repeated homelessness elucidates the critical need to provide increased, comprehensive and long-term services for people without homes.

Families with Criminal Justice Involvement

There is a growing awareness that families in which a parent is incarcerated present a critical opportunity for intervention and prevention of future encounters with the criminal justice system. Children with an incarcerated parent are five-six times more likely to be incarcerated than

[7] HUD Definition***:*** An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.
[8] "Issue Brief: Domestic Violence and Homelessness in King County", Linda Olsen, City of Seattle, Domestic Violence and Sexual Assault Prevention Division, Human Services Department, April 2006
[9] Harborview Medical Center

other children. Data and programs for children with an incarcerated parent, or a parent who is re-entering the community, are both sorely lacking.[10]

Many demographic studies of these families are dated and are therefore of limited help in understanding the specific current needs of these families. For example, one of the most recent national studies of state and federal inmates was published by the Bureau of Justice Statistics in 2000, but used 1997 data. It showed that 55% of male inmates in state prisons, and 65% of female inmates, had children under the age 18. Almost two-thirds of the women and 44% of these parents lived with their children at the time they were incarcerated. Nearly 90% of the children of male inmates lived with their mother, but only 28% of the children of female inmates lived with their father. Children of incarcerated mothers were most likely to live with a grandparent or other relative, but more than 20% were either with friends or in a foster home.

This study confirms the destructiveness of prison on families, leaving many children to be raised by a single parent, another relative, or a dependent of the child welfare system. This is, however, also a group for whom Levy investments may be able to interrupt an intergenerational pattern of incarceration and help reunite and/or strengthen families as parents are released from prison.

Young Children At Risk

The Levy specifically puts a priority on "reduce[ing] the risk of future criminal behavior or dependency problems, or both, by promoting healthy child development for children most at risk." The Levy Planning Team studied a group of children (in addition to those who have a parent with criminal justice involvement described above) who have one or more of the following characteristics:

- Mother is a low-income first-time parent
- Mother is a single low-income parent
- Mother suffers from maternal depression
- Family is isolated due to language and/or cultural barriers.

Low-Income Mothers

Children born into low or very low-income families are at risk for multiple social, school and health issues. These risks are increased when the mother is an adolescent or a single parent. The potential for a meaningful long-term intervention, however, is also greatest with the first pregnancy when the mother is going through the transition to parenthood.

Birth certificate records for 2004 showed that there were 2,640 first time mothers in King County whose birth costs were paid for by Medicaid.[11] Of these, 1,698 were young–age 24 or less. The majority, over 60 percent, live in the south region of King County.

[10] The State Legislature passed House Bill 1426 in 2005 calling for a collaborative interagency exploration by the Department of Corrections and DSHS of the needs of children whose parents are incarcerated. The final report and recommendations are due summer 2006.

[11] Medicaid coverage is used as a proxy for low income since actual income data is not available

Table 3
First Time Mothers ≤ 24 years – Birth Paid by Medicaid[12]

Region	Number	%
East	185	11%
North	45	3%
Seattle	324	19%
South	1083	64%
Unknown	61	4%
Total	1698	

The number of children born into low-income or very poor families each year in King County is evident from the 2004 American Communities Survey:

- An estimated 7,400 mothers with incomes below 200% of the federal poverty level gave birth in 2004, or 37 percent of all births.
- 77 percent (approximately 2,000) of mothers below 100% of poverty were single parents, and 39 percent (approximately 1,900) of those between 100–199% of poverty were single.

The children of these mothers will benefit from services and strategies that help both the parents and the child by helping improve the relationship between parent and child, improving the economic security of the family, and improving the health of the family.

Maternal Depression

Parental nurturing in the first months and years of life is critical in shaping the development of the infant brain. Maternal post-partum depression puts children at risk because these parents are unable to engage in responsive interactions with their infant and the physical structures of the infant's brain, therefore, do not develop normally. If normal interactions have not occurred in the first three years of life, the development of empathy and emotional control after that time is limited and the child is likely to be handicapped in learning and relationships. Children whose mothers suffer from maternal depression are also considered at risk because there is a significant correlation of maternal depression with child abuse and neglect and increased involvement with the child welfare system.

By some reports, the overall prevalence of maternal depression is under 20 percent, but among low-income women it is between 35 and 48 percent.[13] In the state of Washington, one study reports that more than half of mothers who have recently given birth report low to moderate postpartum depression, and women were much more likely to report severe postpartum depression if they were homeless, she or her husband/partner went to jail, someone close to her had a problem with drinking or drugs, she moved, she or her husband/partner lost their job, she had a lot of bills she couldn't pay or she was physically abused during pregnancy.[14] Domestic violence is also associated with maternal depression and there is an expectation that as more families of

[12] Washington Department of Health, Birth Certificates
[13] Literature review on maternal depression, prepared by Michelle Hetzel, Neglect Research Workgroup, University of Washington School of Social Work
[14] Pregnancy Risk Assessment Monitoring System, Centers for Disease Control

current war veterans are served in the community, the stresses of deployment in a war zone and family separations will result in an increase in both maternal depression and domestic violence. Clearly, maternal depression can be a significant piece of a cycle of social dysfunction in families with young children.

Immigrants

All of the populations selected for Levy investment include immigrants who have language and cultural barriers to accessing services. The immigrant population in King County is growing, with an estimated 77,000 new foreign-born residents between 2000 and 2004. More than half are from Asia, 15 percent from Europe and 20 percent from Mexico and Central or South America. It is also estimated that there are more than 48,000 foreign-born residents living below the federal poverty line, and an additional 27,600 with household incomes at 100-149% of poverty.[15]

Immigrants live throughout King County, as illustrated by the percent of persons who speak a language at home other than English. In 2004, 19 percent of people over the age of five in King County spoke a language other than English at home. Recent data by city is not available but the 2000 census gives a feel for the impact on various communities, as shown in Table 4.

Table 4
Percent of Population Who Speak a Language Other Than English at Home

City	% of Population
Tukwila	32%
Bellevue	27%
Redmond	23%
Seattle	20%
Kent	22%
Federal Way	21%
Shoreline	19%

Geographic Issues

Although in the past, it could have been argued that the City of Seattle presented the most significant levels of poverty and need for human services, demographic changes over the past decade in other areas of King County have challenged assumptions. Some of these changes are visible to the public through the emergence of visible homeless populations outside Seattle, especially in south and east King County.

Other changes are visible in the increase in the number of primary languages spoken by children in schools throughout the region that point to the need for culturally and linguistically competent services across the county.

Some of these changes and challenges are noticeable through a comparison of the county's geographic areas, as shown in Table 5 (next page).

[15] American Communities Survey, 2004 US Census

Table 5
Demographic Comparison of Different Areas of King County[16]

	Seattle	South	East	North
% of all King County residents who live in each area	34%	35%	24%	8%
% of residents who are persons of color	33%	28%	19%	18%
% of all King County persons of color who live in each area	41%	36%	17%	5%
% of residents who are children	16%	27%	25%	25%
% of all King County children who live in each area	24%	41%	26%	9%
% of residents who receive state assistance	7%	8%	2%	3%
% of all King County residents receiving state assistance who live in each area	38%	49%	8%	5%
% of all single parent homes in King County	29%	45%	19%	7%
% of all King County children on School Lunch Aid who live in each area	26%	57%	6%	10%

This table, developed by the South King Council of Human Services, shows that South King County has become more like the City of Seattle in aspects such as total population and ethnic diversity. In some aspects, such as the number of single parent homes and number of children on School Lunch Aid, the levels of need in South King County appear to have outstripped Seattle.

East and North King County areas reflect the same trend of having a diverse and young population. While they do not have the same rate of poverty as South King County and Seattle, these areas have their own particular challenges in meeting the needs of their poorer and more fragile residents. There is a critical shortage of housing, with median house prices above what a middle class family can afford. The number of people living in poverty is increasing and their needs, while perhaps invisible to the public, are clear to the organizations serving them. The number of calls to Eastside Domestic Violence Programs doubled between 2000 and 2003, and the number of Eastside residents receiving publicly funded mental health services almost doubled between 2002 and 2004.[17]

The challenge of the Service Improvement Plan is to provide investments that help people across the county, while focusing in the areas of the greatest need. Geography, therefore, is not a criterion for a strategy, but a guide to implementation.

[16] "A Matter of Need", South King Council of Human Services, 2005
[17] "Eastside Story: The Changing Face of Need in East King County", Eastside Human Services Forum, 2005

Priority Investment Area 1:
Veterans, Military Personnel and Their Families in Need

Help veterans and their families who are in need to benefit from increased access to services that more effectively meet their needs in both the veterans' service systems and other human services systems and that encourage development of new partnerships between veterans' service systems and other human services systems.

In many ways, a review of the scope of programs available to veterans creates the impression of service-rich opportunities. While written program descriptions add to that view, reality portrays a different picture. The real picture is of a fragmented system, restrictive eligibility criteria, limited benefits, and insufficient resources to meet the actual needs and demands from those who served our nation in times of conflict and in times of peace. While many programs have been developed for veterans and their family members, there are often wait lists that extend so far into the future that applicants become discouraged and lose hope of ever accessing the supports they need. These issues are further complicated by a lack of coordination and collaboration between veteran-focused and non-veteran-focused systems.

There is compelling data that shows how veterans are paying the price – increased homelessness, incarceration, mental health problems, substance abuse, and hospitalizations. Timely access, appropriate assessments, targeted treatment, and support services can turn these trends around and restore the hope lost to many veterans with unmet needs. The emotional, financial and social consequences for veterans are no different from others who are unable to access necessary human services, and yet veterans are "compartmentalized" by routing them to veteran-focused services, even though many of the resources needed by veterans are no different from those who never served in the military.

Summary of Populations Served

Demographics

In order to describe the population *served*, it must be understood that such portrayals are based on each service delivery system's eligibility criteria. In a general way, treatment, support services, and programs developed for and provided to veterans[18] have enrollment criteria that stipulate the veteran's discharge status and length of time in service, and may also address length of residency and whether the veteran served within active duty status or with a National Guard or Reserve unit. For most systems, there are additional "means tests" (usually tied to the veteran's income or assets) that must also be met. In some systems, the families of people who have served in the military may also receive services and typically, their eligibility is tied to that of their veteran family member.

The demographics of veteran populations are undergoing a transition. The population of World War II and Korean War veterans is decreasing as these individuals age – even many Vietnam veterans are now 60-65 years old. Until recently, eligible Vietnam veterans and their family members comprised the majority of "consumers" of services. While this group will continue to need support services, as more recently discharged veterans return to Washington State, there have been changes in both the ages of people served as well as the military action in which they were engaged.

For instance, recently, there has been an increased demand for services from veterans who served during the Middle Eastern conflicts (e.g. Gulf War, Iraq, Afghanistan) and these military personnel are significantly younger than Vietnam or other veterans. As an example, the King County Veterans' Program (KCVP) provided services to 1,120 veterans who served in Middle Eastern conflicts[19] during

[18] Please see Appendix A: Defining "Veteran" and "Military Discharge"

[19] A person that served during these periods of time is considered a veteran whether or not that person saw active duty in the Middle East.

2005, but from January through June 2006, 881 were served, suggesting the program will serve 50% more Middle Eastern conflict veterans in 2006 than in 2005. Among other implications, this means the population in need of services will be younger, as will their family members.

King County Veterans Programs
Gulf War Period Veterans[20] and Total Served

Year	Total served	Gulf War vets
2001	8,506	1,008 (11.8%)
2002	7,995	1,041 (13%)
2003	6,382	782[21] (12%)
2004	8,095	1,037 (13%)
2005	8,501	1,120 (13%)
2006 (through 06/30)	5,634	881 (15.6%)

Another population shift relates to the type of military personnel that are engaged in conflict. In previous times, "regular" military personnel (those who either joined or were conscripted) were the primary participants. However, the current Middle Eastern conflicts are largely being fought by members of the National Guard and Reserves. These are the service men and women who must often give up the most - as they are required to quickly leave their employment and family obligations behind when called to active duty.

National Data

Most people currently serving in the military will eventually become veterans, so it can be helpful to review a profile of current military personnel. The Department of Defense[22] divides military personnel into two categories: 1) Active Duty and 2) Reserve and Guard. In 2003, there were a total of 3.2 million individuals serving in both categories of military personnel.

Active Duty: In 2003, there were nearly 1.5 million Active Duty personnel (Army, Navy, Air Force, and Marines), which is a 30% decrease since 1990. Women comprise 15% of all active duty forces. There is a significant growth in the proportion of racial/ethnic minority (African American, Hispanic American, Native American, Alaskan Native, Asian American, Pacific Islander, or multi-racial) Active Duty personnel. In 1990, the percentage of racial/ ethnic minority officers was 9.1%, but in 2003, racial/ethnic minority officers comprised 20.5%. Enlisted racial/ethnic minority personnel increased from 28.2% in 1990 to 38.7% in 2003. Overall, 52.3% of Active Duty personnel are married and have 1,924,170 members of immediate families.

Reserve/Guard: The number of Reserve/Guard personnel also decreased by 24.2% from 1990 (1,165,336 in 1990 to 882,792 in 2003). Women comprise 17.3% of the Reserve/Guard force, which is an increase since 1990. The percentage of racial/ethnic minority personnel is 30.6%, nearly 5% less than Active Duty. Overall 51.4% of Reserve/Guard personnel are married and nearly one-third of these also have children.

State of Washington Veteran Data[23]

The state of Washington ranks seventh among all states for having the most Active Duty military personnel, with 54,164 residing inside its borders. The proportion of veterans residing in King County

[20] The Department of Veterans Affairs states that the Gulf War period began in August 1990 and will end on "a date to be set by law or Presidential Proclamation," which has not yet occurred. Therefore, all current military personnel are still serving in the Gulf War period.
[21] Staff say this figure is under-reported
[22] 2003 Demographics: Profile of the Military Community, the Office of the Deputy under Secretary of Defense.
[23] Prepared by the Dept. of Veterans Affairs using 2000 census data

should be relatively low, compared to counties with military bases and facilities within their boundaries. However, approximately 2,400 National Guard families live within King County. In the year 2000, the population of Washington was 4,336,465. Of these, 670,628 (or 15%) of the total population were veterans. At that time, only three states had a greater veteran population than Washington. King County census data comparing veterans to the general population is as follows.

Veteran Status - King County, Washington
2004 American Community Survey
(U.S. Census Bureau – American FactFinder)

	Veterans	Non-Veterans
Civilian Population 18 years and over	**147,296**	**1,211,199**
18 – 64 years	67.2%	89.4%
65 – 74	16.6%	5.5%
75 years and over	16.3%	5.0%
Race and Hispanic or Latino Origin		
White	83.4%	74.8%
Black or African American	6.9%	5.1%
American Indian and Alaska Native	1.7%	0.7%
Other (Asian, Native Hawaiian, other Pacific Islander)	4.0%	16.6%
Two or more races	3.1%	2.1%
Hispanic or Latino origin (any race)	2.5%	6.1%
White alone, not Hispanic or Latino	82.9%	71.5%
Period of Service		
Persian Gulf War Veterans	13.6 yrs	-
Vietnam Era Veterans	40 yrs	-
Korean War Veterans	11.1 yrs	-
World War II Veterans	13.2 yrs	-
Educational Attainment (Civilian Pop. 25–64 yrs)	**97,800**	**947,143**
High school graduate (incl. equivalency or higher)	95.5%	91.6%
Bachelor's degree or higher	28.8%	46.9%
Median Income in past 12 months (in 2004 inflation-adjusted dollars) for civilians 18 years and over with income	$40,209	$31,249
Civilian Population 18 to 64 years	**98,925**	**1,083,252**
Female	7.0%	53.6%
Labor force participation rate	78.9%	78.9%
Unemployment rate	6.3%	7.6%
Below poverty level in past 12 months	8.1%	10.1%
With any disability	13.7%	9.9%
Civilian Population 65 years and over	**48,371**	**127,947**
Female	4.6%	77.1%
Below poverty level in past 12 months	3.2%	9.3%
With any disability	36.1%	35.4%

Description of Overall Systems

There are numerous systems providing services to veterans and their families, ranging from the federal government to veteran-operated volunteer programs to non-veteran-focused systems.

Federally Operated Systems

History - The United States has the most comprehensive veterans' assistance system of any nation in the world. During the period of settlements in North American by Europeans, a benefit system originated in 1636 as the result of a war with the Pequot Indians. The Pilgrims passed a law, which stated that disabled soldiers would be supported by Plymouth Colony. From these early beginnings, the veterans' benefits system has expanded as the colonies grew and became an independent country, eventually including not only veterans, but their widows/widowers and children. The following summarizes the history of today's Veterans Administration programs.

- Civil War: Veterans' "homes" were established to provide domiciliary care.
- World War I: Programs for disability compensation, insurance for servicepersons and veterans, and vocational rehabilitation for the disabled were established by congress.
- 1930: Congress authorized the President to establish the Veterans Administration (VA).
- World War II: A host of new benefits reflecting the growth in the veteran population. The World War II GI Bill is said to have had more impact on the American way of life than any law since the Homestead Act.
- Further educational assistance acts were passed for the benefit of veterans of the Korean Conflict, the Vietnam Era, Persian Gulf War, and the All-Volunteer Force.
- In 1973, the Veterans Administration assumed responsibility for the National Cemetery System from the Department of the Army.
- The Department of Veterans Affairs (VA) was established as a Cabinet-level position on March 15, 1989.[24]

Active Duty Veterans

Nationally, the VA health care system has grown from 54 hospitals in 1930, to include 171 medical centers; approximately 350 outpatient, community, and outreach clinics; 126 nursing home care units; and 35 domiciliaries. The federal Veterans Administration (VA) estimates expenditures of $1.5 billion on behalf of veterans residing in Washington State during calendar year 2003.[25] VA health care facilities provide a broad spectrum of medical, surgical, and rehabilitative care. The following is a partial description of health-related benefits that may be available to eligible veterans[26] and their families:

- *VA Health Care:* The VA health care system is the nation's largest integrated health care system. Three categories of veterans are automatically eligible: 1) those with a service-connected disability of 50 percent or more; 2) pre-existing disabilities that were aggravated in the line of duty; and 3) veterans seeking care for a service-connected disability only. In addition, the VA assigns veterans to priority groups at the time of their enrollment in order to balance demand with resources. If there are changes in resources, the number of priority groups may reduce proportionately. If a veteran does not receive VA disability compensation

[24] This information was adapted from the United States Department of Veterans Affairs web site. Please see http://www.va.gov/about_va/vahistory.asp for further details.
[25] These expenditures are not limited to health and human services.
[26] Eligibility for most VA benefits is based upon discharge from active military service under other than dishonorable conditions. Dishonorable and bad conduct discharges issued by general courts-martial may bar VA benefits. Veterans in prison and parolees may lose their eligibility, and benefits are not provided to any veteran or dependent wanted for an outstanding felony warrant. In addition, some benefits require wartime service. In all cases, veterans must be able to produce certain documents in order to establish eligibility.

or pension payments, s/he must be able to prove s/he meets certain financial thresholds. In some cases, veterans are required to make a co-payment in order to receive health care. There are conditions under which veterans may be reimbursed for travel expenses incurred when accessing VA health care.

- *VA Medical Programs:* The VA maintains health registries to provide special health examinations (e.g. Gulf War Registry, Agent Orange Registry). Readjustment counseling is provided at Vet Centers located in all 50 states for veterans who served in active duty during specified conflicts. The types of counseling offered include: individual, group and family; post-traumatic stress disorder (PTSD); and assistance with readjustment issues. Bereavement counseling is available to all family members.
- *Mental Health Care:* Includes specialty services such as PTSD and substance abuse treatment.

The VA offers services to veterans returning to their communities that assist them with *employment* needs:

- *Work Restoration Programs:* Vocational assistance and therapeutic work opportunities are provided to help veterans live and work in their communities.
- *Incentive Therapy:* A pre-vocation program for seriously disabled veterans for whom employment is not considered viable in the foreseeable future.
- *Compensated Work Therapy:* A vocational program that includes vocational assessments, rehabilitation planning and work experience with the goal of job placement in the community.

The VA provides an array of programs and services specifically for *veterans with service-connected disabilities*. A partial list follows:

- *Disability Compensation:* A monetary benefit paid to veterans who are disabled by and injury or disease that was incurred or aggravated during active military service.
- *Vocational and Rehabilitation and Employment:* Evaluation of skills, help with resumes and work readiness, assistance in finding and keeping jobs, vocational counseling and planning, on-the-job training and work-experience programs
- *Training including college or technical programs*
- *Supportive rehabilitation services*

Some veterans may be eligible for *VA pensions*, including those with low incomes who are permanently and totally disabled, or are aged 65 and have 90 days or more of active military service, at least one day of which was during a period of war, *and* their discharge was under conditions other than dishonorable.

Under the Montgomery Act, commonly known as the GI Bill, veterans may have access to *education benefits* while on active duty or after separation if eligibility requirements are met *and* if the veteran is eligible under one of four categories. Other veterans may be eligible for the Veterans' Educational Assistance Program (VEAP), which requires monetary participation from the veteran.

Reserve or National Guard Veterans

Reservists who served on active duty establish veteran status and may be eligible for the full-range of VA benefits, depending on the length of active military service and a discharge or release from active duty under conditions other than dishonorable. In addition, reservists not activated may qualify for some VA benefits.

National Guard members can establish eligibility for VA benefits if activated for federal service during a period of war or domestic emergency and certain evidence is provided. Activation for other than federal service does not qualify guard members for all VA benefits.

If Reservists and National Guard members meet the conditions above, they are generally eligible to access the same set of benefits as active duty veterans. However, programs may also stipulate additional eligibility criteria.

Reservists and National Guard members have re-employment rights if they leave a civilian job to enter active duty after discharge or release from active duty if they:

- give advance notice to employers
- do not exceed five years cumulative absence from the civilian job
- submit timely applications for re-employment
- do not receive a dishonorable or other punitive discharge.

Since Reservists and National Guard members are the mainstay of the fighting force in the Middle East, dispersing information about these rights could be a critical factor towards reintegration of these women and men as they return from active duty.

Special Veteran Groups

The VA has identified "special groups of veterans". Membership in one or more of these groups (in addition to other eligibility criteria described elsewhere) impacts access to benefits that are tied to the characteristics of the group. Three of these groups are discussed in the following paragraphs.

1. *Women veterans* - can access gender-specific health services and counseling and treatment from VA health care professionals to help overcome psychological issues resulting from sexual trauma incurred while serving in the military. Female veterans are provided with appropriate services for any injury, illness or psychological condition resulting from sexual trauma. For the most part, standard eligibility criteria are largely waived.
2. *Homeless veterans* - can obtain comprehensive medical, psychological and rehabilitation treatment. Outreach efforts, such as community-based "stand downs", occur regularly. "Stand downs" are typically one to three day events providing services to homeless veterans (e.g. food, shelter, clothing, health screenings, VA and Social Security benefits counseling, referrals for housing, employment and substance abuse treatment). "Stand downs" are collaborative events, coordinated between local VA's, other government agencies, and community agencies that serve the homeless.
3. *Incarcerated veterans* - and others entitled to VA benefits may lose or have their benefits reduced if the beneficiary is convicted of a felony and imprisoned for more than 60 days.

Transition Assistance

A recent initiative that was developed in response to seriously injured service members returning from conflicts in the Middle East is the VA Seamless Transition Program. Veterans are assisted in filing claims and accessing services. Examples of transition assistance follow, some of which are sponsored by agencies other than the VA. The VA offers a number of programs to assist veterans to become employed or deal with employment issues when they return to civilian life. The following is a brief description of some of these programs.

- *Comprehensive three-day workshops* (at military installations): Employment and training information, job-search, assistance in accessing VA benefits and programs.
- *Disabled Transition Assistance Program*: Provides information of VA's Vocational Rehabilitation and Employment Program, as well as other programs for the disabled.

- *Pre-separation counseling*: Available at least 90 days prior to discharge. Information is provided on education, training, employment assistance, medical benefits and financial assistance.
- *The Veterans' Workforce Investment program*: Developed to assist recently separated veterans and those with service-connected disabilities, significant barriers to employment (as well as other qualifying criteria) to connect with the nearest state employment office for help through the Veterans' Workforce Investment Program.
- *State Employment Services:* Offers veterans information about employment, education and training, job counseling and job search workshops, and resume preparation assistance. The programs are provided at state Workforce Career or One-Stop Centers and have specialists to help disabled veterans find employment.
- *Unemployment compensation*: May be available to veterans who do not begin civilian employment immediately after leaving military service. These benefits are set by states and may vary by state.
- *Civil service employment:* Certain veterans, especially those who are disabled or who served in a hostile area, are entitled to preference for civil service jobs.
- *The Veterans' Employment Opportunities Act*: Allows eligible veterans to apply for jobs closed to those outside the federal government.
- *Veterans' Recruitment Appointments:* Allows federal agencies to appoint eligible veterans to jobs without competition.

Dependents and Survivors

The VA has developed programs tailored to the unique needs of dependents and survivors, including bereavement counseling to all family members of service members who die while on active duty. Low-income surviving spouses and unmarried children of deceased veterans with wartime service may be entitled to VA death pensions. Education and training opportunities are offered to eligible non-remarried spouses and children of qualifying veterans. VA medical care programs provides reimbursement for most medical expenses, including inpatient, outpatient, mental health, prescription medication, skilled nursing care, and durable medical equipment, again tied to eligibility requirements.

Local VA Services (State and King County)

In 2004, over 85,000 people in Washington State received health care from the VA. In federal fiscal year 2003, 12,095 inpatient admissions were provided in Washington State VA health care facilities, and 1,020,972 outpatient visits were provided, including community outpatient care.

The two-division VA Puget Sound Medical Center operates a community-based outpatient clinic in Bremerton and contracts for primary care with UW Physicians Network clinics in Shoreline, Federal Way and Woodinville. The combined total of patients seen in these clinics in 2004 was approximately 3,000. All outpatient clinics provide primary care, some provide mental health care, and specialty care is provided at the VA Medical Center.

The Veterans' Integrated Service Network (VISN) 20, which includes Alaska, Idaho, Oregon, and Washington, reports the highest percentage of homeless vets (50%) hospitalized for mental health reasons compared to the national average (28%). The network ranked fifth in the nation for the proportion of veterans with psychiatric disorders.

Benefits Provided by Other Federal Agencies

It's worth mentioning that there are other federal agencies that offer benefits to qualified veterans that may assist civilian transition and long-term stability, including the following:

- US Department of Agriculture provides loans for farms and homes.

- Housing and Urban Development (HUD) provides information to national veterans' organizations on all HUD sponsored housing and community development programs.
- Effective July 3, 2002 and by Executive Order, certain military personnel are granted preference in applications for United States citizenship.
- Small Business Administration has special programs to help veterans develop or own small businesses.
- Qualifying veterans and dependents eligible for the full array of Social Security benefits.
- Veterans who are 65 years old or older, and have qualifying disabilities, may be eligible for Supplemental Security Income, if other eligibility criteria are met.
- Certain veterans are eligible to live in one of two Armed Forces Retirement Homes (Washington, D.C. or Gulfport, Mississippi)
- Eligible veterans have unlimited exchange and commissary store privileges.

Washington State Department of Veterans Affairs (WDVA)

The WDVA is a full-service state agency that assists veterans, their family members and survivors. The department operates a statewide referral service and provides staff that is qualified benefits specialists who help veterans and family members to access benefits to which they may be entitled. Staff can represent veterans in cases adjudicated with the US Department of Veterans Affairs in Seattle, and can provide outreach to areas that are not near a Veterans Service Office. Programs offered under the auspices of WDVA are typically subject to rules and requirements laid out in several chapters of the Revised Code of Washington (RCW). These codes specify eligibility for state programs, which largely reflect federal VA requirements, particularly the requirement that veterans may not have a less than honorable discharge from any branch of the military.

Eligible veterans and guard members may be exempt from payment of certain fees at state universities, regional universities and Evergreen State College. In addition, private universities, colleges and trade schools are "encouraged"[27] to offer the same waivers and benefits as provided by public institutions to veterans of the Person Gulf War.

Homeless Veterans Action Plan

The "Homeless Veterans Action Plan" seeks solutions to veterans' homelessness and recognizes that *prevention* is fundamental to breaking the homeless cycle. The plan incorporates a coordinated approach among federal, state and local governments, involves the business community, and includes agencies and organizations that service the homeless. WDVA participates in the Committee to End Homelessness in King County in the establishment of benchmarks, measurements, and reports on progress.

It is estimated that the homeless veteran population in Washington State ranges from 4,000 – 6,800.[28] Nearly 3,000 homeless veterans in Washington State were provided support during FY 2005. King County has a total of 124 beds in 6 facilities that can provide short or long-term transitional housing to homeless vets.

A national profile of homeless veterans reveals that 33% of all adult homeless people are veterans. The typical profile of this homeless veteran suggests that most are:

- single, male, and with an average age of 56
- unemployed
- discharged under conditions other than dishonorable

[27] RCW 28B15.625
[28] US Department of Veterans Affairs and the National Coalition for Homeless Veterans.

- high school graduates
- no family supports
- lack transportation
- need medical and dental care

In addition:

- 50% served in the Vietnam War era
- 4% are women, some of whom have children
- 50% have problems with chemical addiction
- 45% suffer from mental illness
- 46% are Caucasian, 45% are African American, 5% Hispanic, 4% Native American[29]

Homeless Veterans Reintegration Project

WDVA developed the Homeless Veterans Reintegration Project that serves Seattle and the Puget Sound region. This is a successful program that helps homeless veterans become productive members of society. Case management provides veterans with a structured plan incorporating their need for food, transportation, residential stability, and employment support services. The project also provides outreach, assessments, and enrollment into services.

Post Traumatic Stress Disorder (PTSD)

Increase access to and quality of post-traumatic stress syndrome treatment for veterans and others in need is one of the Priority Investment Areas discussed in greater detail in "Appendix B: Priority Investment Areas, 1 - Increase Access to Quality PTSD Treatment. " Please see this appendix for a description of PTSD services available through the WDVA.

State Veterans Homes

WDVA manages three facilities throughout the state where eligible veterans who can no longer take care of themselves are provided with responsive medical and supportive care.

Veterans Estate Management Program

WDVA offers protective payee services for veterans and family members who are incapable of managing their own financial affairs. By assuming custody of finances, WDVA ensures basic needs (e.g. housing, food, clothing, medical care) are provided.

King County Veterans' Program (KCVP)

The KCVP operates with guidance and input from its Veterans' Advisory Board. Most members of this board represent such volunteer veterans' programs as Veterans of Foreign Wars, the Military Order of the Purple Heart, Vietnam Veterans of America, American Legion, and the Disabled American Veterans. The KCVP describes the characteristics of its clients as follows (not unduplicated):

- 45% have some form of mental illness
- 70% have substance abuse problems
- 56% are either African American or Hispanic
- 3% are women

The program is located in the Pioneer Square area of downtown Seattle, and it is from there that most of its programs operate and most of its services are provided. Programs include financial aid,

[29] Ibid.

employment services, mental health counseling, case management, and Section 8 housing. While many of the programs are provided by county staff, others are offered through contracts with providers (e.g., short and long-term transitional housing, Veterans' Incarcerated Program). County staff work closely with other veteran-focused programs (VA, WDVA) and participate in local and statewide planning efforts.

For the most part, veterans must meet RCW chapters 41 and 73 eligibility requirements to receive services. Dependents of veterans are only eligible if their veteran family member meets eligibility criteria, which include honorable discharge status, active duty, and residency requirements. In addition, veterans and their dependents often need to meet income and asset-based means tests to be eligible. National Guard members may also be eligible and have additional eligibility criteria.

An important element of the KCVP is financial assistance, often considered the cornerstone of the entire program. Through this program, eligible (needy and indigent) clients receive vouchers that can provide rental assistance, food, medical needs, transportation and utility assistance. Each client's allocation is based on his/her income and resources, and the current maximum annual allotment is $400 per client. While not a large amount, this type of help can be what is needed to temporarily stabilize families.

Veteran-Operated Volunteer Programs and Non-governmental Organizations

Programs offered by veterans for veterans are most typically staffed by volunteers, offer peer support as a primary focus, and provide referrals to services and programs that serve veterans. Many of these programs are developed to provide support to veterans of specific military conflicts (e.g. World War II, the Gulf War), or other specific veteran characteristics (e.g. veterans with service related disabilities). Some have a strong social networking component, enabling veterans to participate in activities with peers that have similar experiences. The importance of these groups should not be understated.

- *National Association for Black Veterans:* With a national membership of 250,000, 50 percent of all black veterans belong to this organization. The organization advocates for veteran rights (e.g., benefits, discharge upgrades), works to end homelessness, provides transitional and permanent housing, offers holistic day services (e.g., health, welfare, rehabilitation), and provides community service opportunities with an emphasis on youth.
- *American Legion:* This organization describes itself as "the nation's largest veterans organization" (membership figures not available). The organization provides legislative advocacy for veterans and offers temporary financial assistance designed to keep children of deceased/disabled veterans at home by providing help with such basic needs as shelter, food, utilities, and health expenses.
- *Vietnam Veterans of America*: With a current membership of more than 50,000, this organization promotes and supports issues that are important to Vietnam War veterans, including participation in the National Task Force for Homeless Veterans, healthcare for all veterans, issues of importance to women and minority veterans, scholarships, and assistance to veterans seeking benefits and assistance.
- *Disabled American Veterans:* A volunteer organization, DAV provides a continuum of supportive services to disabled vets, including transition services (e.g., assistance with discharge planning, transitional briefings, volunteer review of medical and service records, assistance with filing for benefits and claims); outreach (e.g., veteran informational seminars, mobile service vans); Homeless Veterans Initiative (help to homeless vets in transforming from life on the streets to productive, normal lives, supportive housing and services, with a total of $2.4 million expended since 1989); and grants to VA medical centers to expand access to mental illness and substance abuse treatments.

Non-veteran-focused systems

People who have served in the military and their families may also receive services and programs that are non-veteran focused, regardless of their eligibility for services related to their veteran status.

These services include, but are not limited to:

- financial assistance
- inpatient and outpatient primary health care
- emergency health services (e.g. ambulance transport, emergency room visits)
- crisis, inpatient, outpatient and residential behavioral health services (mental health and/or substance abuse and dependency)
- programs for the homeless (e.g., Homeless Outreach, Stabilization and Treatment Services or HOST, REACH, Healthcare for the Homeless)
- emergency, transitional, and long-term housing assistance
- employment services
- other “safety net” health and human services

County Veterans’ Coalition

In 1997, a County Veterans’ Coalition was formed. King, Pierce, Snohomish, and Thurston counties were the originating members, and over the years, other veteran serving systems have joined. The purpose for the organization is to share resource information, to develop an effective legislative lobbying coalition, and to collaboratively determine the service needs of returning veterans and their families. The formation of this coalition has resulted in a unique effort toward providing locally relevant assistance and services to needy veterans and their families through the collaborative effort of counties, veteran service organizations, state, and federal agencies. The original chapter has now expanded to other areas across the state with participation from every county in Washington State.

Major Funding Streams

Major funders of programs available to veterans residing in King County include:

- Federal government (Department of Veterans Affairs, Department of Labor, Housing and Urban Development, Health and Human Services, Social Security, Supplemental Security Income)
- State of Washington (Washington State Department of Veterans Affairs)
- King County permanent property tax levy dedicated millage – the county tax base can be no less than one 1/8 cent and not greater than 27 cents per thousand dollars of assessed property value
- Non-veteran-focused systems and programs
- Private philanthropic organizations (e.g., United Way)
- A multitude of veteran support organizations

Issues and Gaps

While there are numerous formal and informal systems that serve veterans, services tend to be fragmented, confusing, and difficult to access. The complexity of these systems cannot be under-estimated; in fact, there are examples of staff working within particular programs that are uncertain about eligibility criteria and the types of services/programs offered in their own organizations for which a veteran may qualify.

Although many veterans frequently access non-veteran-focused services, these providers do not always determine whether a person seeking assistance is a veteran. Even when such data is collected, it is often not used in a manner that assists veterans to access benefits and services to which the veteran may be entitled. Because such data is not routinely collected, it is not possible to know where (location and system) veterans are seeking services, the types of services they are requesting/receiving, if the issues for which they are requesting services are service-related, and whether appropriate services are provided.

In general, most veterans programs tend to be located in the city of Seattle and in the downtown region. Veterans who live in other parts of King County must either travel to Seattle or forgo services. For indigent or low-income veterans, the cost of traveling (public means or private autos) is a difficult challenge, as is the need for appropriate childcare when veterans are accessing services (some of which are court mandated).

The KCVP states that with the recent increase of military personnel serving in combat duty, there will be enhanced need for certain specialized services. The VA reports that 20-25% of veterans returning from Iraq and Afghanistan may need treatment for PTSD, mental illness and depression. The long-term manifestations of PTSD (e.g. alienation from family and friends, difficulties holding a job) suggest there will be many veterans at risk for loss of housing, employment, and family and social supports -- each of which can lead to additional adverse consequences as homelessness, further abuse of drugs/alcohol, exacerbated mental illnesses, declining health, and criminal behavior/incarceration.

Veterans with extensive injuries (e.g. loss of limbs, blindness, brain trauma) and their families will need support in rehabilitation, job placement, daily living skills, and family counseling. Since the current Middle Eastern conflicts are mainly fought with National Guard and Reserve personnel, expanded eligibility criteria will be needed so that these veterans can access needed services.

The KCVP also notes that veterans from earlier wars are aging – Vietnam veterans are typically in their 60's – and this means service needs must respond to the changes brought about in the aging process, including increased medical and mental health problems, and a greater need for supportive housing.

Consistent with any population in need of human and health services, by far the greatest need for veterans and their families is appropriate, affordable, and acceptable housing. The cost of housing in Seattle and King County has rapidly accelerated in the past several years, driving low-income people to outlying areas of the county away from where service sites are often located. Too often, affordable housing located close to services is in high risk/crime areas and is neither safe nor acceptable – especially to families with children.

As mentioned elsewhere, the Reserve and National Guard are the primary fighting force in the Middle Eastern conflicts. Since many of these troops may not meet current eligibility requirements, they and their family members could be ineligible for many services.

Potential strategies

- Identify resources for people who have served in the military, but don't meet federal, state, and county eligibility requirements for veterans' services.
- Review current resources and update as needed to meet needs of younger veterans and their families.
- Expand access to PTSD treatment and resources, especially in outlying areas.
- Encourage all potential veteran-serving systems (including "mainstream" providers) to begin collecting minimal data related to a person's veteran status. At a minimum, this information should be used to refer and link veterans to veteran-focused programs.

- Improve geographic access to veteran services. Most services are now offered at the VA Medical Center or at the Pioneer Square location for the King County Veterans' Program. People with low income are increasingly moving to other parts of the county, particularly South King County, in order to find affordable housing. However, this region has not kept up with burgeoning demands for expanded health and human services for veterans.
- Dispense user-friendly, comprehensive information that can be used by veterans, service providers and the community at large to learn about resources available to veterans (veteran-focused and non-veteran focused).
- Incorporate the housing needs of veterans into the overall planning for ending homelessness.
- Increase access to employment programs -- consider placing employment services at existing employment programs, such as the One Stop centers.
- Provide cross-system training about programs and services that may be appropriate for veterans and their families. Include veteran-focused and non-veteran-focused programs and staff.
- Identify outcomes in common for veterans and non-veterans alike, and develop data collection systems that assist planners and funders to holistically measure system and individual performance in such key areas as increased access to housing, employment, mental health and chemical dependency treatment.
- Fill gaps that occur when veterans lose their benefits after conviction on felony criminal charges.
- Reach out to the children of veterans who have experienced or witnessed traumatic events so that children have places to turn and don't experience secondary trauma within their families.
- Maximize the use of volunteer agencies and peer support, especially as system navigators. Many of these individuals provide these roles in informal ways already.

Current Programs Being Provided by the King County Veterans Program

Program	Serves	Focus/location	Provided by	Funding	Goals
KCVP	Veterans and dependents who meet RCW eligibility criteria	Most services provided at Pioneer Square location	County staff and contracted providers	County Millage	To provide tools for positive life changes to veterans and their families.
Financial assistance	Veterans and dependents in need of temporary assistance	KCVP office Vouchers can be used for rental assistance, emergency food, medical services, transportation & utility expenses Level of funding tied to income & family size; maximum annual award is $400 Annual expenditure = $400,000	County staff	Millage	Stabilize families in crisis; prevent loss of housing
Employment	Eligible veterans seeking employment	Resume assistance, job counseling & placement, career testing, skills assessment		Millage	Minimum of 185 veterans placed in jobs annually
Long-term transitional housing	Chronically homeless veterans	To receive services, veterans must be engaged in reintegration, education, or training programs and/or treatment	County staff & contracted providers	Millage	Approximately 50 vets placed per year
Short-term transitional housing	Work-ready veterans	To receive services, veterans must be homeless, waiting to get into treatment programs, or need housing for a short time.	County staff & contracted providers	Millage	Approximately 11,000 bed nights per year
Mental health counseling	Veterans with behavioral health issues	Treatment and services that address Post Traumatic Stress Disorder, addictions, and other mental health needs; assistance with filing for disability claims	County staff & contracted providers	Millage	719 veterans received MH services in 2005. Veterans received at least $300,000 in pensions and disability awards, as a result of assistance from staff.

Program	Serves	Focus/location	Provided by	Funding	Goals
Trauma services	Veterans and dependents dealing with PTSD & other trauma disorders	Counseling for spouses, significant others, and children who have grown up with a parent or partner who is suffering from PTSD	County staff & contracted providers; program provided in partnership with WDVA	Millage	In 2004: - 80% showed significant progress - 508 hours of family therapy provided - 2,251 hours of individual therapy
Veterans' Incarcerated Program	Incarcerated veterans (KCCF) are referred by KC judges	Chemical dependency treatment & support services; transitional housing.	Contract with WDVA	Millage	In 2004: - 169 enrolled - est. 6,712 jail days saved - $519,000 saved in jail costs - 17.7% recidivism rate

Evidence-Based Practices

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Any veteran with major depression	Early diagnosis and treatment of Major Depressive Disorder resulting in remission and full functional ability	Assessment and management of depression in primary care settings Management of depression in outpatient mental health settings Management of depression in inpatient psychiatric settings	U.S. Department of Veterans Affairs (http://www.oqp.med.va.gov/cpg/MDD/G/MDD_about.htm)
Any veteran with PTSD	- Implement routine screening in primary care - Standardize initial and follow-up assessments - Increased prevention – promote resilience - Increased detection of PTSD - Integrate/coordinate primary and mental health care - Implement routine screening for trauma and PTSD	Management of PTSD in primary care and mental health specialty, including recommendations for pharmacology and psychotherapy interventions	U.S. Department of Veterans Affairs (http://www.oqp.med.va.gov/cpg/PTSD/G/PTSD_about.htm)
Any veteran with a substance use disorder	- Promote evidence-based management of patients with substance use disorders - Identify the critical decision points in the management of patients with substance use disorders - Allow flexibility to local policies or procedures, such as those regarding referrals to or consultation with specialists - Improve local management of patients with substance use disorders and thereby improve patient outcomes	Five distinct modules that are designed to assist clinicians in primary care settings and specialized treatment settings with early detection of symptoms, assessment of treatment readiness, determination of the appropriate setting and intensity of treatment, and delivery of individualized interventions. The guideline also contains two appendices that provide screening and assessment instruments.	U.S. Department of Veterans Affairs (http://www.oqp.med.va.gov/cpg/SUD/G/SUD_about.htm)

Priority Investment Area 2:
Improve Housing and Services by Creating Seamless Pathways

Improve access to and success in housing and services by creating seamless, user-friendly pathways from local institutions, the courts, emergency medical and public safety services and the streets into coordinated and integrated services.

Overview

This section summarizes major existing practices and programs in outreach/engagement and in discharge planning that helps homeless people, and those leaving institutions, to improve their access to services and housing. The focus is on those who make the highest use of emergency medical and criminal justice systems. Please also see the Attachment B, Priority Investment Area 6: Increase Impact of Effective Recidivism-Reduction Programs.

Because so many different agencies and systems serve high users of the emergency medical and criminal justice systems, there is no single source of data that can be used to fully describe this group. A profile of the population is provided in this section by providing "snapshot" data from several sources. The information portrays a target population that is frequently characterized by substance abuse and/or mental health disorders that include a subset of veterans and that are disproportionately people of color, with the largest group being African Americans. While most are single adults, families are also included in some high utilizer analyses. A set of tables in this appendix describes the existing relevant programs in outreach/ engagement, in discharge planning, and in high utilizer case staffing, along with who they target and how they are funded (where known). Conveyed are some of the relationships across programs and agencies, and the ways in which specific funding streams have built the "system" such as it is today. This section concludes with a discussion of gaps, issues, and opportunities for moving King County toward the envisioned "seamless, user-friendly pathways" called for in the levy Ordinance.

Because many different pathways into services and housing currently exist, this summary may not include all relevant information on all programs. *In particular, it does not attempt to describe all shelters, day centers, and drop-in programs*. It is, instead, focused on street outreach/engagement programs and on discharge planning practices and programs. It should be recognized, of course, that several Seattle-based drop-in locations - such as Chief Seattle Club, Angeline's, Connections, DESC mental health drop-in, Street Outreach Services, and many other locations - have outreach and case management services linked to them in varying degrees, in many different partnership configurations.

This section does not provide detail on supportive housing resources and strategies. Information on efforts and programs to align housing resources toward serving the population in need of integrated services, please refer to the next section on supportive housing.

Summary of the Populations Served

High Utilizers of Harborview Medical Center

Harborview examined high users of the Emergency Department (ED) for 2005. High users were defined as the 300 most frequent ED users who then were admitted as an inpatient and the 300 most frequent ED users who were seen as outpatients only. Combining these two groups of high users results in 563 unique individuals who were high users of ED services in 2005.

At least 159 of the high utilizers of the emergency department were homeless in 2005.

Veteran Status

Of this group, 15% (or 84) were *veterans*, but veteran status may not always be disclosed. Of those veterans, 83 were male and 1 was female. 40% were Black, 1% Hispanic, 5% Native American, and

55% White. This group of 84 veterans accounted for *$1,441,599* in direct costs in 2005. Of the group, 23 of them (27%) were homeless veterans.

Homelessness

Of the 300 people who had the most frequent visits to Harborview Emergency Department in 2005 who were served as outpatients, 40% of them were confirmed as homeless (through address matching with homeless sites or no address). Of the top 300 ED utilizers whose visit resulted in an inpatient stay, 48 (or 16%) were homeless. In all, 159 of the 563 (28%) were confirmed as homeless. This group of 159 accounted for *$1,674,513* in direct costs in 2005 ($240,933 of this amount were costs associated with the 23 homeless veterans and so is also counted in the $1.4 million in veterans costs listed above). Of these homeless high utilizers, 42% were African American, 8% Hispanic, 6% Native American, 1% Asian/Pacific Islander, and 43% White. 115 were male (72%) and 44 (28%) were female.

Visits to Harborview Emergency Department by High Users – 2005[30]
(By Diagnosis Category)

Diagnosis Category	#	%	Diagnosis Category	#	%
Wound Care/Dressing Changes	1852	23%	Other Exams & Treatments	78	1%
Respiratory	619	8%	Viral & Bacterial Infections	77	1%
Injury	547	7%	Prescription Refill	72	1%
Musculoskeletal	503	6%	Substance Related/	71	1%
Skin Infections (includes cellulitis)	493	6%	Prescription Drug Poisoning		
General Medical Exam	386	5%	Nutrition & Metabolic	65	1%
Signs & Symptoms/ Other	383	5%	Immune	46	1%
Substance Related/ Alcohol Poisoning	364	5%	Signs & Symptoms/Headache	45	1%
Cardiovascular	345	4%	Liver Disorders	35	0%
Nervous System Disorders	215	3%	Ear Disorders	33	0%
Psychoses	212	3%	Disorders of the Eye	33	0%
Substance Related/ Alcohol Abuse	189	2%	Neurotic Disorder	32	0%
Gastrointestinal	181	2%	Substance Related/Overdose	24	0%
Depression	154	2%	Poisoning		
Skin Disorders	144	2%	Cancer	22	0%
Genitourinary	138	2%	Blood Disorder	22	0%
Substance Related/ Drug Abuse	124	2%	Poisoning	13	0%
Endocrine	106	1%	Anxiety	11	0%
Signs & Symptoms/ Abdominal Pain	97	1%	Pregnancy Related	9	0%
Dental	84	1%	Missing	3	> 0.1%
Medical/Surgical Complications	81	1%	Substance Related	3	> 0.1%
			Mental Disability	2	> 0.1%
			Total	**7913**	**100%**

Homeless Persons Using King County - Jail Health Services

Because jail inmates who are homeless may be reluctant to disclose their true housing status to jail authorities (due to the concern that homelessness may delay release dates), collecting accurate data about the extent of homelessness among incarcerated populations presents significant challenges. During a one-month period (December 2005), Jail Health

Among the high-need patients working with the Jail Health medical & chemical dependency social workers, about 28% are homeless.

[30] Source: Harborview Medical Center

Services conducted a special pilot to gather homeless status of all patients. They found that 798 (50%) of 1584 inmates seen by Jail Health Services at King County Correctional Facility (Seattle) and the Regional Justice Center (Kent) were homeless (they had no stable housing to go to upon release), using the broader definition of homeless used by the US Department of Health & Human Services. It should be noted that not all inmates use Jail Health, but those with the most complex health issues likely do.

Homeless Status	#	%
Street	340	43%
Shelter	32	4%
Transitional	54	7%
Other[31]	240	30%
Doubled Up	121	15%
At Risk[32]	11	1%
Total	**798**	**10%**

Race	#	%
Asian	24	3%
Black	272	34%
White	458	57%
Native Am	38	5%
Missing	6	1%
Total	798	100%

Gender: 74% were male, 26% were female

Jail Health analyzed a group of 100 among the 798 homeless people and found that on average, those 100 had 3.6 bookings each in 2005. Over the course of a year, Jail Health estimates they may be serving roughly 2,500 unduplicated homeless people at the downtown Seattle and Kent locations combined. The top 5 diagnoses of the homeless individuals seen in the pilot period are[33]:

1. Cellulitis/abscess, unspecified
2. Depressive Disorder, NOS
3. Alcohol withdrawal
4. Psychotic Disorder, NOS
5. Schizoaffective Disorder

Emergency Medical Services – 911 Responses to Homeless Service Sites

In 2005, there were at least 1,574 emergency medical system Basic Life Support responses to homeless shelters, transitional housing, and day centers in Seattle-King County (determined through address matching). The numbers below represent total responses - not unduplicated individuals. Of those served, 42% were females and 58% were males.

In 2005, at least 1,262 people (not unduplicated) were transported by ambulance from homeless shelters/day program sites in King County to hospitals.

[31] "Other" is high because it reflects the many people who lost some type of housing when they came to jail, and expect to have no housing on release.
[32] "At Risk" means the individual has stable housing to return to, but has been homeless in the past 12 months.
[33] Source: Public Health-Seattle & King County, Jail Health Services

Basic Life Support Responses to Homeless Shelters, Transitional Housing, and Day Centers[34]

Age	Number	Percent
0-17 yrs	37	2%
18-24 yrs	73	5%
25-44 yrs	523	33%
45-64 yrs	716	45%
65+ yrs	106	7%
Not Recorded	119	8%
Total	1,574	100%

Response by time of day	Number	Percent
Midnight to 6:00 am	266	17%
6:00 am – Noon	361	23%
Noon – 6:00 pm	448	28%
6:00 pm - Midnight	499	32%
Total	1,574	100%

Response by typecode:	Number	Percent	Response by typecode:	Number	Percent
Neurologic	245	16%	Not Recorded/Invalid	70	4%
Trauma	189	12%	Cardiovascular	70	4%
Respiratory	188	12%	Metabolic/Endocrine	35	2%
Abdominal/Genito-Urinary	169	11%	Obstetric/Gynecological	15	1%
Other Alarms	139	9%	Anaphylaxis/Allergy	3	0%
Psychiatric	88	6%	All Other Illnesses	276	18%
Alcohol/Drug	87	6%			
			Total	1574	100%

Of those who were transported to a hospital, 866 (69%) were taken to Harborview Medical Center and 31% were transported to other area hospitals. Most responses occurred in the downtown Seattle core.

Sobering Center High Utilizers

In 2003, King County Department of Community & Human Services completed a high utilizer cost study of two programs – the Dutch Shisler Sobering Support Center and the Crisis Triage Unit (CTU, no longer operating) – which primarily serve/d individuals who are homeless and have a chemical dependency problem and/or mental illness.

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) analyzed the 20 individuals with the most number of admissions to the two programs in 2003. No individuals were on both lists, so the total number was 40. They examined costs for jail, sobering, detoxification, CTU services, and medical costs from Harborview and Health Care for the Homeless.

[34] Source: King County Emergency Medical Services

High Utilizer Cost Study
The Sobering Center and the Crisis Triage Unit[35]

Population Profile	Sobering Center (N=20)	Crisis Triage Unit (N=20)
Homeless	14	10
Male/Female	20/0	15/5
Age range	34-61	19-59
Median age	46	39
Jail use in 2003	13	10
Enrolled in public mental health system	1	13
Drug/alcohol involvement	20 (100%)	14 (70%)
Total Cost	**$963,033**	**$1,116,534**
Total Cost per person	**$48,152**	**$55,827**

King County Regional Support Network High Utilizer Profile

High utilizers are defined as anyone with a tier benefit in the King County mental health plan (outpatient or long-term residential) who experienced three or more hospitalizations during the time period. For February 1, 2004 – January 31, 2005, 243 high utilizers were identified. The characteristics of these high utilizers are broken out as follows:[36]

- 85% were adults, 11% children, and 5% older adults.
- 55% were males and 45% were females
- 67% were Caucasian, 18% African American, 13% Asian/PI, 5% Hispanic, 13% Mixed, and 7% other/unknown
- 48% have co-occurring mental illness and chemical dependency
- Among the high utilizers, 17.3% were homeless.

High Utilizer Homeless Families. Health Care for the Homeless Database

An analysis of the Health Care for the Homeless (HCH) database identified 261 individuals in families who were high users of HCH services in 2005-2006 and had been showing up in the HCH system for at least one year. The typical HCH household profile is a single female head of household with 2.5 children. Of this group of 261:

- 54% are people of color; the largest group is African Americans – 87 of the 261 (33%).
- At the time of their first visit with a Health Care for the Homeless provider, 122 (47%) of the individuals were living in emergency shelters and 58 (22%) were in transitional housing. Others were in various other locations; only 5 were living on the street.
- 12% are refugees or immigrants.
- 10% are on SSI/SSDI
- 24% are children under age 18. (Does not represent total number of children who were in the care of parents who are high users but only those children who were seen by a HCH provider.)
- 110 (42%) had at least one chronic health condition; the majority were substance abuse or mental health related. Total exceeds 110 because some had more than one chronic condition.

[35] Source: King County Department of Community & Human Services
[36] Source: King County Department of Community & Human Services

High Users of Health Care for the Homeless Services
Chronic Health Conditions[37]

Chronic Health Condition	# with this disorder	Percent
Substance Abuse Related	52	24%
Depression	54	25%
Anxiety (including PTSD)	50	23%
Respiratory	18	8%
Other mental health conditions	11	5%
Musculoskeletal	7	3%
Psychoses	6	3%
Cardiovascular	5	2%
Nutrition	5	2%
Endocrine	4	2%
Sign/Symptom	2	1%
Gastrointestinal	1	0%
Total	215	100%

[37] Source: Public Health-Seattle & King County, Health Care for the Homeless

Major Components of Outreach, Engagement, & Referral of Homeless People

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
Emergency Services Patrol (ESP)	King County van transports inebriates from streets to/from the Sobering Center and selected other locations Location: Downtown Seattle and Capitol Hill. Operates 20 hours/day, 365 days/year (does not operate from 8 am – noon each day). Results in cost offset for expensive ambulance transports and emergency department admissions for incapacitated individuals.	Provided by staff of King County DCHS-MHCADS. The staff is based at the Sobering Center.	2006 Adopted budget: $1.3 million Federal: $403,085 State: $6,000 County: $570,748 City of Seattle: $430,070	Responds to calls dispatched via 911. 20 hours/day	In the first 6 months of 2006, there were 7,170 pick ups. Profile: - 41% White - 25% Native American - 21% Hispanic - 12% African American - 1% Asian - 92% male - 8% female
Dutch Shisler Sobering Support Center	A place for people to sleep off the effects of alcohol; provides medical screening, a cot, and soup. Location: 9th & Boren. Open 24/7, 365 days/year. Links clients to detox, treatment (voluntary & involuntary) and case management through REACH (see below) - where capacity allows.	King County DCHS contracts with Recovery Centers of King County (RCKC). RCKC also operates detox.	Total 2006 budget is about $878,948 per year Federal (HUD McKinney grant): $594,825 State: $284,123	Most brought here in ESP van; some walk-ins. Open 24/7, 365 days/year	Capacity to serve 60 at any given time. About 1,000 unduplicated served over the course of the year.
REACH	The **REACH** team currently has 15 FTEs working in four components: (1) case management for chronic public inebriates; (2) discharge planning/case management for homeless TB clients; (3) HEET case managers for homeless, chemically dependent, HIV-positive people with criminal justice system involvement; and (4) two case managers for King County Drug Court. (With the exception of the registered nurse on the main REACH team, who is a Pike Market Medical Clinic employee, all staff members are employees of Evergreen Treatment Services.)				

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
REACH Chronic Substance Abuse Case Management Team	Established at the same time as the Sobering Center opened, this team provides outreach, engagement, case management, and housing linkage/ongoing support for homeless adults with chronic substance abuse problems. The REACH team, provided by Evergreen Treatment Services, is based at the Sobering Center and focuses on high utilizers of sobering. 40% of their caseload is Native Americans. Controls about 30 Shelter Plus Care vouchers. Goals include: - 40% of clients will improve or maintain stable housing - 30% will engage in substance abuse treatment - 75% will access non-urgent health care. There are approximately 7.8 case managers; caseloads = 20:1	Public Health - Health Care for Homeless contracts with Evergreen Treatment Services (for case managers) and Pike Market Medical (for one full-time nurse) who together constitute the REACH team.	2006 cost: $502,487 $407,395 local funds (City of Seattle & King County) about $95,000 through Medicaid Administrative Match	Primarily takes referrals from Sobering and targets the highest utilizers. Also does outreach at Angeline's to women with chronic substance abuse problems. One staff also focuses on Native American outreach. Staff work M-F, 8-5 Has three vans; all in active use. They transport clients to various places (DSHS, housing, treatment, etc) Because ESP van does not operate from 8-12, REACH uses its vans to transport clients from Sobering to Detox.	Served about 136 – 140 (both new and continuing clients). Capacity to case manage about 30 new clients/year. In late 2005/early 2006, 40+ REACH clients moved into the 1811 Eastlake.

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
REACH – HEET Case managers	[See also section on HEET below] The REACH team provides 2 full-time intensive case managers to provide services to the homeless, HIV infected, chemically dependent & those involved in the CJ system and not currently engaged in the HIV care system. The goal is to get them engaged & housed. Practice is similar to the rest of REACH – they go out, find people, help link them to benefits, etc. As a complement, REACH applied for & received Ryan White funds (via King County process) for 1 FTE HIV outreach position who does referral/linkage for the same target population ($50,000)	The Downtown Emergency Service Center contracts with Evergreen Treatment Services for these positions, which are sited at the Lyon Building.	HOPWA grant	Sited at Lyon building Primarily, they take referrals from the HIV discharge planner/social worker in the King County Jail, plus other service providers.	
REACH – Drug Court	Two case management positions are located at King County Drug Court. Due to high volumes, this work is primarily office-based. Population is somewhat higher functioning than other REACH clients (e.g., people can generally get to treatment appointments on their own). Works on housing linkages, I & R, helping people get on entitlements, financial aid for school, etc.	King County drug court contracts with ETS-REACH for these 2 positions.		Referrals from Drug Court only	

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
REACH – TB Discharge Planner	Part-time case manager works with homeless TB patients to link them to benefits & housing. Funds also provide short-term housing assistance while working with the client to access long-term housing. Goal is that 60% of homeless TB patients will be in stable housing at the close of TB treatment.	Public Health - Health Care for the Homeless contracts with Evergreen Treatment Services REACH for 0.5 FTE. Also contracts with Plymouth Housing Group for 4 set-aside units.	Funded by City of Seattle HSD; part of Enhanced TB Services Cost of discharge planner & housing (PHG units plus motel vouchers) = about $60,000 annually	Position sited at the TB Control Program (at Harborview) Takes only homeless adults with TB in need of case management	Works with about 20-25 people over the course of a year
HEET – HIV Enhanced Engagement Team	Federally funded (HOPWA) Special Projects of National Significance program that provides intensive outreach-based case management to persons that are chronically homeless, as well as HIV-positive or living with AIDS. Goal is to help secure and maintain access into dedicated shelter and permanent supportive housing units. This program is focused on those who are hardest to house - many have criminal justice involvement.	Collaborative partnership of the Downtown Emergency Service Center (housing & grant admin), Evergreen Treatment Services (case management), The Compass Center (shelter), AIDS Housing of WA (system integration), and Northwest Resource Association (evaluation).	Funding primarily through a HOPWA Special Projects of National Significance grant	Referrals come from social work in the King County Jail, as well as from HIV/AIDS service providers, DSHS, and WA State Department of Corrections	Capacity for about 90 clients

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
HOST (Homeless Outreach, Stabilization & Transition) and **PATH** (Projects for Assistance in Transition from Homelessness) **Outlying Areas Project**	Outreach and engagement services, intensive case management, and transition to appropriate resources in the community for adults with serious chronic mental illness who are homeless and not enrolled in other mental health services	King County MHCADS contracts with the Downtown Emergency Service Center (DESC) (6 outreach workers; 5 case managers) and For outlying areas, with Seattle Mental Health (1.0 outreach FTE) - office is currently based in Tukwila.	About $1,044,999 per year (combination of MHCADS funds: $799,000 and federal PATH funds: $245,000 per year)	Takes referrals from service professionals & paraprofessionals. HOST does regular outreach at key homeless sites that have mentally ill guests.	In 2004, outreach to 430 individuals. 105 were served with intensive case management; 68 clients moved from homelessness to housing. DESC HOST team - outreach staff has caseloads of 30+ (working to transition clients); intensive case managers have caseloads of about 15 (working with 75 at any given time)
Mental Health Chaplaincy (Craig Rennebohm)	For the last 19 years, Craig Rennebohm has walked a regular route through downtown Seattle seeking those who are "most isolated and vulnerable." He also visits the inpatient MH unit at Harborview. Builds relationship, helps people link to shelter, housing, and care.	Private program		He walks a regular route; also gets referrals from churches	
NCI Team (Neighborhood Corrections Initiative)	A collaboration between WA State Department of Corrections & Seattle Police Department. Community Corrections Specialists (6) pair with SPD officers (8) to patrol streets - seeking those who may be violating terms of release. Links to treatment, housing, shelter, etc.	Department of Corrections and Seattle Police Department		Active outreach on the streets; has laptop in van to check if individuals are under DOC supervision	

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
Ambassadors – Downtown Seattle Association	Safety Ambassadors (on foot or bicycle) wake 40-80 homeless people in doorways starting at 7:30 each morning. They give out referrals, provide information to tourists, etc. Program is interested in linkages to other outreach/social service programs & transportation. Maintenance ambassadors: program that employs formerly homeless. Focus on particular areas of downtown to clean graffiti, alleys, etc.	This is a program of Downtown Seattle Association (DSA) Metropolitan Improvement District. 60 FTEs (30 maintenance workers; 30 safety workers)	Funded by a business improvement area tax	Regular routes and referrals from merchants	Tracks contracts by type; has had this database since 1999. Able to track changes in extent of panhandling, etc. by different sectors of downtown Seattle
DSHS Native American Outreach Workers	Two Native American outreach workers work with urban Indians and with the tribes. Many clients may be far from, or not involved with, tribal services. One staff focuses on single adults - especially high utilizers & chronically homeless - takes applications and updates cases. The other works primarily with families - primarily as an advocate and case manager for families in crisis	Based in the Belltown DSHS Community Service Office, but work countywide serving all CSOs and Native American people needing their help anywhere in the county.	Funded by DSHS. One of the positions is half funded by the Children's Services Administration (CPS/CWS/FRS)	Primarily CSOs, Sobering Center, Chief Seattle Club, and the Seattle Justice Center Court Resource Center (2nd Floor). Also spends time on the streets.	
Seattle Indian Health Board (SIHB) Native American Outreach	Outreach to homeless Native Americans with health issues; intensive case management with linkages to SIHB, treatment, housing, and other services. Coordinates with REACH. (Expected outcomes of this service are similar to those of the REACH team – improvements in housing, access to health care, and other domains.)	Funded by Public Health - Health Care for the Homeless under contract to SIHB	Federal Health Care for the Homeless grant funds - about $40,000 annually	Primarily SIHB & Chief Seattle Club	About 20 individuals at a given time

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
New Seattle projects linking law enforcement & human services **(1 of 3 pilots)**	*GOTS* – Get Off the Streets: To reduce nuisance street crime & disturbances. Current focus is at 20th & Madison. Teams outreach worker and police to provide referrals & linkages to housing, treatment, & other services. Individual and community/neighborhood outcomes.	City of Seattle contracts with lead organization - Seattle Neighborhood Group (SNG) - for program coordination Outreach worker via POCAAN	City of Seattle: $104,420 for June 2006-Dec 2006	Presence at 20th & Madison in Seattle	20 individuals
New Seattle projects linking law enforcement & human services **(1 of 3 pilots)**	*Rainier Beach*: Peer outreach workers and case manager will engage 10-20 young adults with drug, alcohol, mental illness, housing, employment, or CJ issues who are causing public safety or quality of life problems. Will do assessment and linkage to treatment, housing, education, job training and placement, and more. Will examine clients' arrest records, client progress towards goals, community comments, etc.	City of Seattle to contract with Street Outreach Services (SOS) as lead organization. Partners to include SPD, Rainier Beach Community Empowerment Coalition, Rainier Beach High School principal, public defense, and others.	City of Seattle: $140,000	Presence in and around Rainier Ave S. - between S. Graham & S. Henderson. Community members will help identify potential clients for program	10-20 individuals

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
New Seattle projects linking law enforcement & human services **(1 of 3 pilots)**	*Downtown Seattle Pilot*. Enhance existing West Precinct NCI by referring those stopped by NCI to Community Court case managers who will assess and refer to needed services, including treatment for drug/alcohol or mental illness and to long-term housing. Goal is to reduce low-level drug offenses and other minor crimes. Will measure reduction in failures by clients to comply with the conditions of supervision or failures to appear in court.	City of Seattle would contract with a provider(s) to be selected via RFI. Metropolitan Improvement District (MID) would assist with outreach. Seattle Mental Health would provide services under its contract with King County MHCADS.	City of Seattle: $120,000	NCI would do outreach in the course of its current operations and refer individuals to Community Court case managers for assessment and referral to appropriate services, including housing, alcohol/drug treatment, mental health services, etc.	10-15 people at one time
Health Care for the Homeless Shelter & Day Center-Based Services	Shelter and day center based services in selected shelters, including nursing and limited mental health/substance abuse screening and assistance with access to benefits/medical coverage.	Public Health contracts with 12 community clinics & mental health/substance abuse agencies.	Federal Health Care for the Homeless funds, Local funds, and Medicaid Match	Major sites include: – DESC – Compass Center – Angeline's – St. Martin de Porres – Sacred Heart – Seattle Emergency Housing – YWCA East & South Sites – Hopelink – South KC Multiservice Center – others	

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
South King County	*[From November 2, 2005 - Focus Group organized by Jason Johnson, City of Kent]* Increasing number of chronically homeless single adults are characterized by: – Many are jail discharges – Pet owners not willing to give away pet(s) – Some are anti-establishment/ government/system; many do not trust the VA – Women-many are domestic violence victims – Some characterized as the "drug trade" crowd – found in cars, woods, surfing, motels – Couples in 30s, many with COD, can't get into shelters, drug-involved – Many have unaddressed health issues – dental, wounds, nutrition, diabetes, STDs	Major funders and service agencies are: – DSHS-CSOs, – Seattle Mental Health, – Valley Cities, – Kent Food Bank, – New Connections, – Community Health Centers of King County, – Catholic Community Services, and – suburban cities No real "system" or clear engagement/ entry points exist for homeless adults in south King County.	Has one PATH worker funded by King County MHCADS to do outreach to mentally ill	"Word of mouth"; Day labor used by some; Church sponsored shelters Some stop by the CSO but hard to serve – cycle on & off Found in libraries, lobbies of CCS, CSOs, non-profits, government agencies, fast food Shower at St. James Episcopal (men, HOME clients)	

Major Services and Programs Assisting Those Leaving Institutions

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
Jail Health Services Discharge Planning At King County Correctional Facility (Seattle) and Regional Justice Center (Kent)	Does release planning for high-need inmates to facilitate success following release. The five current components include: (1) HIV Case management and release planning (2) Chemical dependency (including Jail-based Opioid Dependency Engagement & Treatment Program) release planning (1.0 FTE) (3) Medical Case Management & Release Planning (1.0 FTE) (4) Mental Health Case Management & Release Planning (2.0 FTE) (5) DSHS/ADATSA Application & Social Workers (3.5 FTE)	3 FTEs are Jail Health staff: HIV case manager, JODET, and medical case manager. 2.0 FTE mental health professionals are employees of Seattle Mental Health (part of Criminal Justice Initiative investments) 3.5 FTEs are Belltown DSHS office staff - funded by King County and out-stationed in the Jail	Varies by position Fund sources include: – Ryan White Title I grant funds (for HIV social worker), – King County CX (medical social worker), and – King County CX - Criminal Justice Initiative funds.	Inmates of King County Jail who meet the criteria	
Harborview Medical Center	Each inpatient unit has a nurse care coordinator charged with knowing the "big picture" and orchestrating discharge planning. Process essentially starts when admitted; HMC is able to project how long patient will need to stay. HMC financial counselors & DSHS staff on-site can complete applications. HMC makes substantial use of both the Medical Respite (an average of 36 homeless discharges per month go to Medical Respite) and Crisis Respite programs - discharging homeless people who meet the eligibility criteria into those set-aside beds, when open.	Provided by HMC staff. Also has out-stationed DSHS staff. HMC also makes efforts to link discharged homeless patients to those shelter sites where HMC-Health Care for the Homeless has staff sited. This helps with follow-up and coordination of care since the on-site nurses are HMC employees.	HMC	Patients of HMC	

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
Other Hospitals	Discharge planners from hospitals other than Harborview also report challenges finding places for homeless people (e.g., case managers at Valley Medical say there are few resources in South King County). It is also hard to find places that take people not fully independent in activities of daily living. Skilled nursing facilities are more reluctant to take homeless people needing recuperation due to discharge challenges faced once the patient no longer needs that level of care.	Varies by hospital			Most do not appear to have ready access to data on homeless, but many report increased levels of charity care for uninsured and problems with emergency department overcrowding.
Medical Respite Program Physical location with set-aside beds	22 set-aside beds for homeless people needing recuperation from an acute medical condition. Clients receive full psychosocial assessment, help with Medicaid eligibility, help linking to housing, etc. 17 beds for men at William Booth; 5 for women at YWCA Angeline's Program has 2 dedicated transitional housing placements per month with Compass Center Access to Recovery (SAMSHA grant managed by King County MHCADS) provides 1 case manager to work with chemically dependent clients post-respite 20 permanent housing set asides (shared with REACH) at Plymouth on Stewart. [Units filled summer 2006 – City of Seattle funded]	Public Health-Health Care for the Homeless contracts with Pioneer Square Clinic (Harborview), William Booth Center (for men's beds), and the YWCA (for women's beds).	About $900,000/year Combination of federal HUD McKinney funds & HHS Bureau of Primary Health Care	Can take referrals from any health care provider via the Harborview operator, but most referrals are directly from Harborview, especially inpatient Many patients end up leaving Respite stay because they cannot use alcohol/drugs while in the recuperation program	Served 420 people in 2005 Of those, 279 (66%) met the federal definition of chronically homeless On average, 4 people are referred per month who are not served due to lack of space; 5 per month on average decline the referral; and 17 per month are referred but do not meet the criteria About 20% served are veterans

Program	Focus / Location	Provided by	Funding	How Accessed	# Served
Crisis Respite Program (mental health) Physical location with set-aside beds	20 set-aside beds at Downtown Emergency Service Center (DESC) for people with serious mental illness needing engagement. Provides shelter, food, assessment, case management, care coordination, and medication monitoring 14-bed dorm for men; 6-bed dorm for women In addition to the mental health crisis that made them eligible, many also have chronic health problems and/or substance abuse disorders	King County DCHS-MHCADS contracts with DESC		Takes referrals from Harborview PES/ED, psych inpatient unit, mental health courts, KC Crisis & Commitment, and West Seattle Psych hospital	Average stay is about 14 days Unable to follow clients after their stay (unless enrolled in another DESC program)
Hospital Liaison Services	Liaisons work at local hospitals and Western State Hospital to assess individuals for enrollment eligibility for Regional Support Network (RSN) mental health services, and work with hospital discharge staff to arrange discharge plans, including housing.	Contracted by King County DCHS to Community Psychiatric Services	King County Regional Support Network - $300,000		

Existing "High Utilizer" Groups and Projects (individual case level)

Program	Purpose & Sponsorship
High Utilizer Group (HUG) (focuses on high utilizers of sobering, Harborview PES, chemical dependency involuntary treatment services, and REACH)	King County DCHS – MHCADS sponsors this case-level staffing of high utilizers of sobering services; PES; involuntary treatment, and REACH. Convened by Caroline Bacon, MHCADS employee who is the chemical dependency liaison at the Harborview PES (Psychiatric Emergency Services). Currently, this group is trying to increase the level of follow-up / tracking of previously identified clients. The entities described above identify the individuals and bring together the people and information needed to coordinate a care plan. Meetings are held every other week at Seattle Indian Health Board. Typical attendees include REACH, chemical dependency involuntary treatment specialists, detox staff, and others as needed. Position is funded in part by King County DCHS and in part by City of Seattle HSD.
High utilizers of Harborview Medical Center Emergency Department (ED)	HMC has a high ED utilizer case review program. Identifies high users having most impact on the ED; works with medical & other service providers to develop plan. Collaborates closely with Caroline Bacon because some clients are shared high utilizers. Not enough capacity in one FTE to address all the homeless high utilizers. The position is funded by Harborview.
DSHS "A" team	Group meets to identify and staff individual DSHS cases that cross systems. Convened by DSHS Home & Community Services. Participants include home & community services, inpatient units, Department of Corrections, MAA, Division on Developmental Disabilities, King County MHCADS, and Seattle Aging & Disability services. DSHS convenes and identifies cases for staffing.
Interagency Staffing Team	Multi-system planning group convened to develop unified care plans for children/youth that are served by multiple systems. May include mental health staff, DDD, JRA, KCJD, PD, parents & family members, community supports, and others.

Gaps, Issues, and Opportunities

Outreach/Engagement Key Issues

Outreach and engagement work takes place through active presence on the streets, in day centers or drop-in locations, in shelters, and in health care settings. Outreach & engagement to homeless persons initially began in Seattle-King County primarily through volunteer efforts of faith-based organizations and individuals. Over the years, more programs have emerged in response to specific, categorical funding opportunities at the federal and local levels, resulting in the rather disjointed services in operation today. Different provider agencies are funded by different revenue streams to provide targeted outreach to different populations. As various institutions and agencies have built—and continue to build—programs to address the most critical needs identified among the populations that they serve, the patchwork grows ever more complex. Non-profit agencies, which deliver the bulk of the services, have adjusted and expanded to respond to these various funding streams and their differing requirements. Taken as a whole, our collective of strong programs cannot yet be described as offering "seamless, user-friendly pathways into services and housing," and many opportunities exist to reorganize existing programs into a more unified approach that will better serve those homeless people with the most complex and chronic issues.

In other areas of King County, such as South and East King County, very few "pathways" into services and housing exist at all. DSHS community service offices are a key entry point, as are individual agencies and churches. The lack of infrastructure, coupled with rising street populations and great geographic distances, is a particularly serious challenge in south King County's efforts to address chronic homelessness.

The following observations have been raised by stakeholders during the planning for the levy as well as at prior discussions and meetings sponsored by the CEHKC:

- There appears to be inadequate funder-level coordination across jurisdictions and with private sector programs. At the front-line level, informal coordination among the programs can be quite strong, especially among programs who share a similar target population. Opportunities exist, as laid out in the 10-Year Plan to End Homelessness, to increase housing with an appropriate level of case management and supportive services – and establish a more coordinated entry approach into housing for those making high use of public systems.
- The existing "high utilizer" client-level case staffing groups that operate are viewed as a very positive approach to identifying and working with high utilizers. Some concerns exist that even among these groups there may be some duplication—that is, the same clients coming up in multiple high utilizer groups. Several stakeholders involved in the current high utilizer groups have indicated that their current work could benefit from an expanded and more formalized approach, including more structured approach of working with housing programs to "triage" and refer clients into available "housing first" and other supportive housing resources. Assistance is needed to support legal information-sharing and data analysis for high utilizers across systems, and data systems to track high utilizers need to be developed (building upon existing data systems if they can be modified to meet the need).
- An increasing number of high utilizer clients are cocaine and/or heroin-involved. Most existing programs appear tailored primarily for either alcohol abuse and/or serious mental illness, but data shows high numbers of illegal drug-related offenses connected with criminal justice system high utilizers, and health care system data on homeless people commonly includes high numbers of diagnoses that are frequently associated with illegal drug use. Little existing case management or peer support programs focused on this group.
- There is high level of interest among the funders of the Emergency Service Patrol, Sobering Center, and REACH to consider redesign of outreach/engagement services to create a more coordinated approach to street outreach work, and to explore increased partnerships with law enforcement and programs such as the Metropolitan Improvement District's Ambassadors.

Models such as those in Philadelphia and San Diego may have components that King County could build upon.

- Strong partnerships are in place with DSHS, particularly through the Belltown CSO, which has been highly responsive in outstationing staff and exploring ways to help assure that those who are potentially eligible for financial and medical assistance receive expedited assistance with application and recertification processes.

Discharge/Release Planning Key Issues

The following observations have been raised by stakeholders during the planning for the levy as well as at prior discussions and meetings sponsored by the Committee to End Homelessness in King County.

- Access to *day of release/discharge temporary housing* was the key issue raised by discharge and release planners. One wrote: "The main problem is that it is very difficult to get inmates into a transitional-to-permanent housing continuum on the day of release. Emergency housing (shelter, hotel) is usually the first step, along with referral to an outside case manager who can continue the process after release.
- Discharge planners find that the application process for housing is "long and involved." Housing resources change a great deal, so social workers need housing advocates who can work with clients.
- The current Medical Respite program has narrow criteria; it plays a key role but space is limited and there are many people with health issues who do not qualify, for example, discharge planners would like options for homeless people who are not continent, people with communicable conditions, those not fully independent in mobility, etc.
- Placement options for people leaving the two respite programs (medical and mental health) are extremely limited; both programs end up with many clients returning to homelessness due to lack of housing and case management, as well as significant numbers of clients who leave those programs before their stay is completed.
- People need to be released/discharged with an adequate supply of medications and supplies (supplies for homeless diabetics are a particular gap).
- There is no case management to hand people off to, especially those who lack Medicaid; it is difficult for people to complete or continue with the processes for housing applications, wait lists, and benefits once they leave the institution.

Existing Directions and System Recommendations

King County Level

Four of the six priorities of the Interagency Council of the Committee to End Homelessness are directly related to this area. There are strong opportunities to use levy resources to coordinate with CEHKC actions in these areas:

- *Discharge Planning*: Identify the role of the criminal justice system, health care system, and foster care system in the creation/prevention of homelessness. Forge/strengthen partnerships and create programs to ensure that people aren't discharged into homelessness. (Note: CEHKC has recently hired Chris Hurley to work on discharge planning priority.)
- *Coordinated Entry*: Restructure the system by which people access services/housing to be more streamlined, efficient and user-friendly with as much consolidation of information and application activity as feasible.
- *Landlord/Service Provider Partnership Project*: Create a framework for landlords and service providers in which landlords can relax current barriers to housing people exiting homelessness

in return for assurances of supportive services/response to tenant issues and similar protections.

- *Shelter to Housing Transition Plan*: Identify how and when to move our housing and homeless response away from a reliance on emergency shelter and transitional housing and towards a permanent/permanent supportive housing model.

State Level

The Homeless Housing Assistance Act, House Bill 2163, passed in the 2005 Washington State legislative session, requires the state and counties to develop and implement Ten-Year Plans to Reduce Homelessness and creates a funding stream to help implement those plans – a $10 per document recording fee for real estate documents. The receipts are allocated 60% to the counties (based on the amount generated in each county), with the balance of 40% allocated to CTED which in turn will distribute it to the counties based on an RFP Process. HB 2163 will generate approximately $3 million per year allocated to King County. The first year's allocation is currently the subject of an RFP in which 200 Section 8 vouchers are also being distributed.

It is anticipated that the State will begin in summer 2006 an award process for $5 million of state 2163 money plus $3 million in HOME dollars. The state has indicated intent to make awards to no more than three or four projects, with a distribution among rural, suburban and big city projects. The state is looking for "system changing" projects. *The Committee to End Homelessness in King County is exploring the possibility of a discharge planning related project for a state 2163 application, focused on those leaving the jails and Harborview.*

House Bill 1290: This bill, which passed during the Legislative Session in 2005, directs the State to work in partnership with the WA Association of Sheriffs & Police Chiefs, Department of Corrections, Regional Support Networks, and Social Security Administration. The goal is to conduct speedy medical eligibility determinations for people with a mental disorder who are incarcerated in a county or city jail. The goal is to assure eligible clients have benefits available to the client upon release.

Program for Assertive Community Treatment (PACT): This is an evidence-based treatment that provides intensive services for individuals who are high utilizers of psychiatric hospitals. Beginning in April 2007, King County MHCADS will receive over $2 million in funding from the state Mental Health Division to form PACT teams serving 200 mentally ill individuals who will be leaving Western State Hospital, local hospitals, jail, and/or are at risk for frequent hospitalizations. The $2 million will pay for services and King County will release an RFI/RFQ to identify lead agencies. Housing will be needed for at least 140 individuals, to be funded from other sources but coordinated with the services RFI/RFQ. .

Existing Coordination Groups that address issues related to this population include:

- **DAETN (Seattle) -** Downtown Access, Engagement, & Transition Network (Seattle) - convened by Downtown Emergency Service Center. Information sharing and system coordination. A longstanding networking and information sharing/systems issues group of those working with homeless adults in the downtown Seattle area.
- **Pre-Release Benefits Group (Seattle) -** convened monthly by Mark Alstead, Discharge Planning, Jail Health Services (Public Health). Includes social workers, case managers, entitlement workers (DSHS, SSA, VA), program managers, court staff, and others who work with or on behalf of persons involved with the criminal justice system. The primary purposes of these meetings are to: (1) increase understanding of legal, benefits, jail health, and corrections systems among participants in order to more effectively collaborate and coordinate with each other as well as enhance (and make more efficient and effective) service delivery for our mutual clients/patients; and (2) provide a forum for discussion and processing of unresolved benefits issues regarding incarcerated clients.

- **CHOW -** Community Health Outreach Workers meetings - convened monthly by Joe Tinsley, Public Health HIV/AIDS Program. These meetings are for outreach workers and other line staff who interact with low-income people who are at risk for or have substance use/abuse problems. The goal of the CHOW meeting is to provide trainings and discussions that will improve and support outreach workers in the community. Trainings include topics that focus on HIV/AIDS, harm reduction, referrals and services.
- **United Way Impact Council** on health, mental health, & chemical dependency. This Council has recently launched two committees as a follow up to a medical provider training. One group will be looking at how to provide more training and skill development on mental health/chemical dependency for community & public health clinics; the other will explore cross-system information sharing with DSHS/MAA specifically related to high utilizers and their medications to promote coordination.
- **South King County Forum on Homelessness** meets monthly at Kent City Hall (first Wednesdays at 9:00 a.m.); Jason Johnson with City of Kent currently facilitates. This group was formed following a focus group with south county homeless providers in which participants indicated they felt very disconnected from each other. The forum emerged as a result, and the group now brings together South King County stakeholders in homelessness (service providers, local government staff, homeless individuals, DSHS representatives from Kent and Federal Way, municipal corrections from Kent and Auburn, fire and patrol officers, Northwest Justice Center staff, and others). Its purpose is to:
    1) keep South King County homelessness service providers in touch with one-another
    2) share resources with/for SKC service providers
    3) receive updates and announcements of new or future projects
    4) coordinate our efforts in ending homelessness
    5) help bridge the disconnect between the homeless and the service providers.

Evidence-Based Practices

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Serial inebriates	Reduction in arrests / criminal justice involvement Reduction in hospital and EMS costs	**San Diego Serial Inebriate Program (SIP)**. SIP was designed as an alternative sentencing pilot program in 2000, using the principles behind the drug court model. A collaborative team of law enforcement, prosecutors, public defenders, the court, and non-profit alcohol abuse treatment providers offered individuals in custody for public drunkenness treatment instead of jail time. SIP incorporates community-based treatment and rehabilitation, psychological counseling, job readiness, housing, and other resources needed to help participants succeed in not returning to the streets or to substance use. Since its inception, SIP has produced quantifiable results for law enforcement that have improved the lives of homeless individuals while reducing public expense through police, hospital and emergency costs. 32% of clients entering the Serial Inebriate Program complete the program. A study by the San Diego Police Department' showed that individual arrests were down 12%, total arrests were down 33%, and arrests per person were down 25% for SIP clients. Emergency health care services also demonstrated cost savings. "Use of EMS, ED, and inpatient services declined by 50% for clients who chose treatment, resulting in an estimated decrease in total monthly average charges of $5,662 (EMS), $12,006 (ED), and $55,684 (inpatient)." *Annals of Emergency Medicine*, April 2006.	Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources Dunford, JV et al, *Annals of Emergency Medicine* 47(4):328-336, April 2006 Innovative Initiatives, U.S. Interagency Council on Homelessness http://www.ich.gov/innovations/index.html

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Homeless people on the streets	Reductions in street census of homeless population	**Philadelphia Outreach Coordination Center** – Project HOME. Project H.O.M.E. is a nonprofit founded by Sister Mary Scullion and Joan Dawson McConnon in 1989. The organization provides a full range of services for chronically homeless people with mental illness and/or substance abuse disorders, including street outreach, safe havens, permanent supportive housing and a range of services to supplement housing. One component is the Outreach Coordination Center, a project of the City of Philadelphia and Project Home. o Coordination, dispatch, and data tracking service for all 5 outreach teams in the City of Philadelphia o Assessment of training needs & provision of training for all outreach teams o 24 hour hotline (to call to report homeless persons needing engagement) o Direct linkages to shelter and housing placements for some	http://www.endhomelessness.org/best/projecthome.htm

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Homeless high utilizers of emergency department services	Typical outcomes: Increased housing stability Decrease in ED visits/costs Decrease in jail days Decreased ambulance service use Decreased hospital inpatient days	Several interventions and studies are currently underway focused on high utilizers of emergency medical services. In addition, studies on permanent supportive housing have reviewed the impact on the use of health services. Interventions are showing promising results. **Chicago Housing for Health Partnership** - 436 adults living with a chronic medical illness, who are homeless, and who were inpatient at three Chicago area hospitals. Half have been randomized into intervention group and the other half into control group (intervention: 216 / control: 220) The intervention group participants have been housed using "housing first" and "harm reduction" approaches within 30-90 days after discharge from the hospital. *Preliminary data: 50% reduction in nursing home days / 66% reduction in ER visits / some reduction in inpatient hospital days* **Santa Cruz Project Connect** Interdisciplinary intensive case management; focused on low-income individuals who had 5 or more ER visits in the previous 12 months to either of two county hospitals. 47% decrease in ambulance service use 30% decrease in jail days 54% reduction in ER visits 27%, 36% reduction in ER charges for each hospital, respectively 52%, 40% reduction in inpatient days, per hospital 14%, 39% avoid inpatient stays following enrollment, per hospital **Recently published study in Psychiatric Services** studied impact of supportive housing on 236 single adults who entered supportive housing in San Francisco. Concluded," providing permanent supportive housing to homeless people with psychiatric and substance use disorders reduced their use of costly hospital emergency department and inpatient services."	Arturo Valdivia Bendixen, Associate Director, AIDS Foundation of Chicago (Chicago Housing for Health Partnership) Impact of Permanent Supportive Housing on the Use of Acute Health Services by Homeless Adults. Martinez, TE, Burt MR. *Psychiatric Services* 57(7):992-00999, July 2006.

Priority Investment Area 3:
Develop and Expand the Capacity of Supportive Housing Networks

Reduce repeated involvement in the emergency medical and criminal justice systems and increase stability and self-sufficiency by developing and expanding the capacity of supportive housing networks that use housing first strategies and provide integrated support, treatment and employment services.

Overview

Permanent supportive housing is defined as housing where households can live for as long as they wish or need to and where the units are connected with supportive services to help households maintain their housing stability.

Summary of Populations Served

The target population for permanent supportive housing includes both individuals and families with complex needs who are unlikely to be able to maintain housing without services.

According to the 2006 Inventory of Homeless Units and Beds, Seattle-King County currently has a total of 2,158 units (2,584 beds) of permanent supportive housing for homeless people. Populations served include families and single adults and these numbers encompass households that have been chronically homeless.

The following table compares the data from the major providers of permanent supportive housing for single adults in King County currently being served:

	Shelter Plus Care (out of 664 adults)	Plymouth Housing Group[38] (out of 499 adults)	DESC[39] (out of 405 adults)	Archdiocesan Housing Authority[40] (out of 470 adults)
Asian	3.5 %	1.5 %	—	—
African American	19.1 %	24 %	22 %	23.2 %
Caucasian	61.0 %	50 %	56.5 %	68.3 %
Alaska Native or Native American	8.3 %	10 %	10.4 %	6.2 %
Hawaiian/Other Pacific Islander	7.7 %	< 1 %	—	—
Asian or Pacific Islander	—	—	3.2 %	2.3 %
Latino[41]	—	7 %	4.2 %	—
Hispanic	—	—	—	5.3 %
Other	—	3.5 %	—	—
Multi-racial	—	2.5 %	—	—
Unknown race	—	1.5 %	—	—
Multi-racial, other, or unknown	—	—	3.7 %	—
Did not report race	0.4 %	—	—	—
Veterans	7.0 %	—	19 %	—

[38] Includes data from Plymouth Place, Plymouth on Stewart, Pacific, Lewiston, Gatewood, Cal Anderson, St. Charles Rehabbed, and Scargo
[39] Downtown Emergency Service Center – includes data on Kerner-Scott, Lyon Building, the Morrison, Union Hotel, and 1811 Eastlake
[40] Includes data only from Frye Hotel and Josephinum
[41] "Latino" was listed as a racial category.

Description of Overall Systems

Supportive housing is a subset of a larger system of permanent housing for homeless people, as described in King County's current "*Inventory of Homeless Units and Beds"* from Spring 2006. Along with the rest of the region's low and moderate-income residents, formerly homeless people searching for affordable housing find it a very difficult task. Barriers include

- short supply of affordable housing
- low vacancy rates and reduced turnover
- little or no rental history
- prior evictions
- criminal records
- poor credit references
- discrimination
- need for housing-related support services in order to remain successful in permanent housing.

Public Housing

The lion's share of affordable housing for homeless people is made available through four local housing authorities – King County Housing Authority, Muckleshoot Housing Authority, Renton Housing Authority, and Seattle Housing Authority. This housing is project-based and requires Section 8 or Housing Choice vouchers. Historically, for the public housing waiting list, there have been a number of preferences, including homelessness, rent burden, sub-standard housing, and persons with disabilities, based on federal regulations. Currently, the King County and Seattle Housing Authorities have local preferences that prioritize homeless people for their housing programs.

Shelter Plus Care

Shelter Plus Care rental assistance, specifically for homeless people, is another major resource. The King County Shelter Plus Care program is a federally funded grant program for permanent supportive housing that provides long-term subsidies for homeless people with chronic disabilities living with mental illness, HIV/AIDS, and/or chemical addiction.

Non-Profit Owned/Operated Permanent Supportive Housing

Non-profit owned/operated permanent supportive housing is housing where households can live for as long as they wish or need to and where the units are connected with supportive services to help the households maintain their housing stability.

Non-Profit Owned/Operated Permanent Housing

A number of non-profit organizations have permanent housing units in some of their properties that are specifically designated for formerly homeless people.

Major Funding Streams

The construction and operation of permanent supportive housing depends on a complex mix of federal, state and local capital, operating and services funding. Each project has a different mix of these funds, depending on such factors as the population served and the site location.

Key Illustrative Programs

Projects exemplifying the best practice *"Housing First"* model are described in this section. Principles of Housing First include the following:

- immediate access (i.e., no “housing readiness” and no requirement for treatment or services prior to housing)
- independent units
- separation of housing and treatment (i.e., housing is not a reward for compliance)
- some sort of a standard leasing arrangement.

All three of the projects described below have established mechanisms to proactively seek out and house chronically homeless people who historically have been the hardest to house. All of these programs provide intensive supportive services to help residents maintain stability in housing.

Downtown Emergency Service Center’s (DESC) 1811 Project

DESC’s 1811 project provides supportive housing for 75 formerly homeless men and women living with chronic alcohol addiction. Available services include the following:

- State licensed mental health and chemical dependency treatment
- on-site health care services
- daily meals and weekly outings to food banks
- case management and payee services
- medication monitoring
- weekly community building activities.

A rigorous evaluation is being carried out with funding from the Robert Wood Johnson Foundation. The evaluation will examine the relationship between residing in permanent supportive housing in two salient domains: variables related to quality of life and the suppressed use of crisis services.

South King County Pilot Project

This is a new project jointly funded by the King County Housing Authority, the King County Department of Community and Human Services, and United Way of King County to fund units and services for 25 vulnerable homeless individuals in South King County. The project focuses on people who have been chronically homeless - that is, they have been homeless for one year or longer or have experienced four or more episodes of homelessness in the last three years. Many are disabled by mental illness, addiction and/or physical medical conditions. The project targets individuals who are Medicaid eligible and in the greatest need of services. This is a “housing first” program model and the provider, Seattle Mental Health, will provide outreach and engagement as well as on-site supportive services.

Set–Aside Units at Plymouth on Stewart

In 2006, the City of Seattle sponsored 20 "housing first" set-asides at the newly opened Plymouth on Stewart building. Funding enabled the non-profit housing agency, Plymouth Housing Group, to add enhanced case management and chemical dependency service staffing in order to accept and support tenants with complex health issues. In addition, funding for part-time, on-site nursing support was supported and is provided by Pike Market Medical Clinic. Entry into the units is through identification as a high medical user of Health Care for the Homeless Medical Respite or REACH case management programs. Clients must have been homeless for a year or more or experienced repeated homelessness (three or more times in four years); have one or more chronic health conditions (asthma, depression, diabetes, heart disease, hypertension, chemical dependency); and have incurred considerable cost in the health care system (threshold is defined in the range of $10,000 or more in the past 12 months or have spent 60 or more nights at the Sobering Center in the past 12 months).

An evaluation is being provided on an in-kind basis by a King County government evaluator who has evaluated similar projects. Outcomes under consideration include:

- Income support changes and length of stay
- health care and other service cost utilization (hospital ER, medical respite, mental health services, Detox, county jail, linkages to primary care) by visits and costs
- participant satisfaction.

The Landlord/Service Provider Partnership Project

This initiative is a priority of the Committee to End Homelessness in King County. It will create a framework for landlords and service providers in which landlords can relax current barriers to housing people exiting homelessness in return for assurances of supportive services, a quick response to tenant issues and similar protections. The goal of this program will be to increase access of formerly homeless people to market rate, privately owned rental housing.

The Public Funders Group

The Public Funders Group, which originated as part of the Taking Healthcare Home Initiative, has been operating for almost two years. This group of funders, originally focused on chronic homelessness, has expanded its scope to focus on supportive housing projects in the development pipeline, as well as housing-operating-service funding coordination, such as trying to coordinate application timing, forms, eligibility, etc. The first joint Notice of Funding Availability (NOFA) was released in July of 2006. This effort has enormous potential for improving coordination and focus of public funders and simplifying the application and contracting processes for providers.

Issues and Gaps

There are insufficient units for the number of households who need permanent supportive housing. The Ten-Year Plan to End Homelessness in King County makes the following estimates of the number of supportive housing units needed over ten years to end homelessness.

	Chronically Homeless Single Adults	Homeless Single Adults	Families	Youth	Total
Units with moderate services on site	700	2100	1500	0	4,300
Units with intensive services on site	1800	1100	200	250	3,350
TOTAL	2500	3200	1700	250	7,650

The Ten-Year Plan estimates that there will also be a need for approximately 2,600 units of subsidized independent apartments without services. According to the Inventory of Homeless Beds and Units dated Spring 2006, there are currently 169 units of permanent supportive housing for homeless people under development.

There is insufficient ongoing funding for services required to make supportive housing successful. There have been some successful attempts at accessing mainstream resources.

A number of populations who might benefit from supportive housing are very difficult to house for a variety of reasons. These populations include undocumented people and large families, as well as those with a history of serious felonies, especially sex offenders, violent offenders and arsonists.

There is a lack of permanent supportive housing options targeted to veterans. Many veterans are served in permanent supportive housing. Some, such as the Archdiocesan Housing Authority and Westlake, serve a very high percentage of veterans. However, at the same time, most veteran-specific funding for housing is targeted to transitional (time-limited) and not permanent housing.

Agencies lack capacity to develop supportive housing at the rate it is needed.

Evidence Based Practices

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Homeless individuals and families, including those with mental illness and co-occurring substance use disorders	Engagement into services and housing	Outreach and engagement • Meets immediate and basic needs for food, clothing, and shelter • Non-threatening, flexible approach to engage and connect people to needed services	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Sustained tenancy in housing over time, with reduced use of hospitals, jails and crisis service systems	Provision of housing with appropriate supports • Includes a range of options from Safe Havens to transitional and permanent supportive housing • Combines affordable, independent housing with flexible, supportive services	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Sustained treatment relationships over time that promote housing stability and reduced use of hospitals, jails and crisis service systems	Multi-Disciplinary Treatment Teams/Intensive Case Management • Provides or arranges for an individual's clinical, housing, and other rehabilitation needs • Features low caseloads (10-15:1) and 24-hour service availability	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Sustained treatment relationships over time that promote housing stability and reduced use of hospitals, jails and crisis service systems	Integrated treatment for co-occurring serious mental illness and substance use disorders • Features coordinated clinical treatment of both mental illnesses and substance use disorders • Reduces alcohol and drug use, homelessness, and the severity of mental health problems	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Movement towards recovery and stability over time that promotes housing stability	Motivational interventions and "stages of change model" approach to services • Helps prepare individuals for active treatment; incorporates relapse prevention strategies • Must be matched to an individual's stage of recovery	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Development of peer relationships and stable treatment to promote recovery and stability in preparation for a return to more independent community living	Modified Therapeutic Communities • Views the community as the therapeutic method for recovery from substance use • Have been successfully adapted for people who are homeless and people with co-occurring disorders	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Use of self-help programs and opportunities to promote recovery and stability in an environment that is understanding of the relationships between multiple disorders	Self-help programs • Often includes the 12-step method, with a focus on personal responsibility • May provide an important source of support for people who are homeless	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families, including those with mental illness and co-occurring substance use disorders	Use of peer supports to promote recovery and stability in an environment that is understanding of the relationships between multiple disorders	Consumer/peer involvement of recovering persons • Can serve as positive role models, help reduce stigma, and make good team members • Should be actively involved in the planning and delivery of services	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families, struggling with mental illness and co-occurring substance use disorders	Prevention of episodes of homelessness among persons with multiple disorders, including mental illness and addiction	Prevention services • Reduces risk factors and enhances protective factors • Includes supportive services in housing, discharge planning, and additional support during transition periods	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
OTHER ESSENTIAL SERVICES			
All homeless, formerly homeless and at-risk individuals and families	Access to care for medical problems that can lead to destabilization of housing and homelessness	Access to primary health care services • Includes outreach and case management to provide access to a range of comprehensive health services	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
All homeless, formerly homeless and at-risk individuals and families	All treatment and support service providers are educated about trauma and the delivery of appropriate services to survivors of trauma	Trauma-informed services • Ensures delivery of services in multiple settings that are sensitive to survivors of trauma and persons with PTSD	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
All homeless, formerly homeless and at-risk individuals and families	Access to needed mental health care for all persons, regardless of eligibility for long-term enrollment in the publicly-funded mental health system	Mental health and counseling services • Provides access to a full range of outpatient and inpatient services (e.g. counseling, hospitalization, self-help/peer support)	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
All homeless, formerly homeless and at-risk individuals and families	Treatment for substance use disorders is provided as needed and is available on demand	Alcohol and drug abuse services • Provides access to a full range of outpatient and inpatient services (e.g. counseling, detoxification, residential treatment, self-help/peer support)	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
OTHER ESSENTIAL SERVICES			
All homeless, formerly homeless and at-risk individuals and families	Training and support in basic living skills are available to individuals to increase housing stability and independence	Psychosocial rehabilitation • Helps individuals recover functioning and integrate or re-integrate into their communities	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
All homeless, formerly homeless and at-risk individuals and families	Individuals have access to the full array of benefits for which they may be eligible, including rental assistance	Income support and entitlement assistance • Outreach and case management to help people obtain, maintain, and manage their benefits	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
All homeless, formerly homeless and at-risk individuals and families	Employment training and services are accessible to and appropriate for individuals recovering from homelessness, mental illness, addictions, etc.	Employment, education and training • Requires assessment, case management, housing, supportive services, job training and placement, and follow-up	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk women, including those with small children	Services are available that promote housing stability and independence for women, including women with young children	Specialized services for women • Programs focus on women's specific needs (e.g. trauma, childcare, transportation, parenting, ongoing domestic violence, etc.)	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
OTHER ESSENTIAL SERVICES			
Homeless individuals and families with illnesses that create challenges in connecting to available housing, treatment and supportive services	Services are accessible and welcoming to the most challenging and/or reluctant individuals and families	Low-demand services • Helps engage individuals who initially are unwilling or unable to engage in more formal treatment	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families experiencing a crisis	Individuals in crisis have immediate access to services that can help to return the individual to stability without loss of housing	Crisis intervention and crisis care services • Responds quickly with services needed to avoid hospitalization and homelessness	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
All homeless, formerly homeless and at-risk individuals and families	Families receive information, education and advocacy to help them understand and address the full range of illnesses that may be present	Family self-help and advocacy • Helps families cope with family members' illnesses and addictions to prevent homelessness	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)
Homeless, formerly homeless and at-risk individuals and families from diverse cultural backgrounds	Services are culturally and linguistically accessible and appropriate	Culturally competent services • Accepts differences, recognizes strengths, and respects choices through culturally adapted services	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
OTHER ESSENTIAL SERVICES			
Homeless, formerly homeless and at-risk individuals and families with members who are involved with the criminal justice system	Individuals and families with criminal justice system involvement are diverted at the earliest possible point in time and/or are able to maintain their community-based housing during periods of incarceration	Criminal justice system linkages • Features including diversion, treatment while incarcerated, and re-entry services to help people re-enter or remain in the community	"Blueprint for Change" published by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, with assistance from the National Resource Center on Homelessness and Mental Illness and the Corporation for Supportive Housing (http://www.nrchmi.samhsa.gov/text_only/HTML%20Blueprint%20for%20Change%20Folder/Chapter%206.htm)

Priority Investment Area 4:
Allow for the Timely and Appropriate Sharing of Client Information

Allow for the timely and appropriate sharing of client information necessary to achieving maximum results with all of the access and service and housing improvement investments.

Overview

Many of the individuals and families in need of housing, health and human services have multiple, overlapping service needs. In many instances, no one agency or system is able to provide these individuals and families with the full array of assistance that is required. These individuals and families often must become involved in several different systems of care in order to access what is needed to promote stability and recovery. These different systems of care, in reflecting the existing "silos" of funding that support the full range of housing, health and human services, often maintain separate and discrete information systems. These information systems often do not have the capacity to communicate with one another.

A combination of the reality of existing state and federal laws governing information sharing, as well as perceptions of the requirements of these statutes and agency policies and procedures governing data collection, storage and sharing, often make it extremely difficult for different agencies and systems to communicate effectively and comprehensively about the clients they have in common. The laws most frequently cited inhibiting timely and appropriate sharing of client information include 42 CFR Part 2, HIPAA, and state RCWs governing the sharing of mental health and substance abuse treatment information. In addition, in some fields such as domestic violence services, maintaining the privacy of client information can become a matter of protecting the physical safety of a client and/or family.

Summary of Populations Served

The issue of client information sharing affects each one of the Levy's target populations in different ways. Of particular significance to the Levy is sharing information about people who have histories of:

- Long-term homelessness
- Criminal justice system involvement
- Mental illnesses
- Substance use disorders
- Domestic violence
- Other human services needs
- Service in the U.S. military

Creating appropriate, legal and secure venues for the sharing of information across systems is critical to the mobilization of effective and efficient services for virtually every client experiencing more than just one problem who is receiving some form of housing, health or human services in King County.

Major Components of Information Sharing

Information sharing must occur within a number of specific parameters. The sharing of information:

- must be legal under the principles established in numerous state and federal laws
- must protect the client's right to privacy of his/her personal treatment records and other information covered by confidentiality statutes
- must not jeopardize an individual's health and safety
- must be necessary for the improvement of the housing, health or human services being received.

Furthermore, the sharing of information:

- must be feasible, given the technological constraints that exist in each separate, free-standing database
- must be done in the most efficient and effective fashion, preferably in an electronic format
- must be done in a fashion that, when necessary or desirable, creates unique client identifiers that protect the privacy of individual participants.

At the same time, it is important to ensure that the failure to share information across systems does not prevent clients from accessing the services needed to promote stability or recovery. Statutes and practices related to information sharing were created to protect client privacy, ***not*** to prevent access to needed services. Barriers to information sharing that are not rooted in the law, are used as an excuse to prevent communication or are put in place for the convenience of provider staff while inhibiting effective service delivery should be considered unacceptable practices.

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Local Examples of Existing Opportunities for Timely and Appropriate Sharing of Information about "High Utilizer" Groups and Projects

(Individual case level)

Program	Purpose & Sponsorship
High Utilizer Group (HUG) (focuses on high utilizers of sobering, Harborview PES, chemical dependency involuntary treatment services, and REACH)	King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) sponsors this case-level staffing of high utilizers of sobering services; Psychiatric Emergency Services (PES); involuntary treatment, and REACH. Convened by Caroline Bacon, MHCADSD chemical dependency liaison at Harborview PES. Currently, this group is trying to increase the level of follow-up/tracking of previously identified clients. The entities described above identify the individuals and bring together the people and information needed to coordinate a care plan. Meetings are held every other week at Seattle Indian Health Board. Typical attendees include REACH, chemical dependency involuntary treatment specialists, detox staff, and others as needed. The position is funded in part by King County DCHS and in part by City of Seattle HSD.
High utilizers of Harborview Medical Center Emergency Department (ED)	HMC has a high ED utilizer case review program. This program Identifies high users having most impact on the ED and works with medical & other service providers to develop a plan. Some clients are shared high utilizers. There is not enough capacity in one FTE to address all the homeless high utilizers. The position is funded by Harborview.
DSHS "A" team	This group meets to identify and staff individual DSHS cases that cross systems. It is convened by DSHS Home & Community Services. Participants include Home & Community Services, inpatient units, Department of Corrections, MAA, Division on Developmental Disabilities (DDD), King County MHCADS, and Seattle Aging & Disability services. DSHS convenes and identifies cases for staffing.
Interagency Staffing Team	Multi-system planning group convened to develop unified care plans for children/youth that are served by multiple systems. May include mental health staff, public defense, DDD, education, juvenile justice, parents & family members, community supports, and others.
"Real-Time" Jail Notifications System	On a daily basis, the King County Department of Adult and Juvenile Detention provides to the King County MHCADSD a list of all individuals who have been booked into the King County Jail. The mental health system is then able to run this data against the database of everyone receiving services from the mental health system. Treatment providers are notified when their clients have been booked into the jail, and the jail is notified of the individual's case manager. In this fashion, rapid notification is provided to treatment providers about incarcerated clients, without violating confidentiality statutes regarding mental health treatment information. No information about the status of the client is sent back to the jail system.

Gaps, Issues, and Opportunities

There are numerous gaps and opportunities in the current system related to improvements in the sharing of client information, including the following:

- Safe Harbors Homeless Management Information System is in its implementation stage, with a goal of producing system-wide reports by July 2007.
- Creating an integrated outreach and engagement infrastructure that allows for the sharing of information by providers of outreach services related to who they are seeing on the streets, in shelters, etc., in order to maximize the efficiency of coordinated outreach efforts.
- Promoting a unified database of veterans and veterans receiving services that combines data available from federal, state and county-funded veterans programming.
- Expanding the capacity of the system to identify larger numbers of the highest users of emergency and crisis stabilization services.
- Current applications of HIPAA
- Creating a real-time database of available housing units that can be sorted by eligible population, location, duration of tenancy, etc.

Evidence Based Practices

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Homeless families, children and single adults	• Creation of an unduplicated count of homeless individuals seen in a given jurisdiction over a given period of time • Increase understanding of the needs of homeless people • Coordinate systems and funding to efficiently deliver housing and support services • Measure progress in ending homelessness	Homeless Management Information System (HMIS) that collects and unduplicates data for individuals seen in an identified set of programs in a specified geographic region	City of Spokane, Washington, HMIS. Operated by the City of Spokane Human Services Department since 1995 and recognized by HUD as an evidence-based model. Contact: City of Spokane Human Services Department, 808 W. Spokane Falls Blvd., Spokane, Washington 99201 Website: http://www.spokanehomeless.com/sub.aspx?id=369
Individuals with mental illness who are incarcerated in local jails	• Real-time, electronic identification of individuals known to the mental health system who are incarcerated in local jails, without violation of client confidentiality and at minimal ongoing cost • Promotion of rapid re-linkage to mental health services for incarcerated persons • Rapid and effective connection of treatment and criminal justice system staff to address client-specific needs	Maricopa County (Arizona) Data Link Project	National GAINS Center for Persons with Co-Occurring Disorders in the Justice System. Publication describing the Maricopa County Data Link Project can be downloaded from the following website: http://www.gainscenter.samhsa.gov/html/resources/publications.asp#services
Individuals with substance use disorders and other treatment needs	• Sharing of client-specific treatment information across systems and agencies without violation of federal confidentiality statutes protecting chemical dependency treatment records (42 CFR Part 2)	Qualified Service Organization Agreement (a formal document)	The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. See, for example: http://www.ncadi.samhsa.gov/govpubs/bkd163/15i.aspx

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Individuals under DOC Community Corrections Supervision and simultaneous court-ordered mental health or substance abuse treatment	Creation of effective, multi-disciplinary treatment teams comprised of Community Corrections Officers and treatment providers to ensure community safety in the context of compliance with identified treatment goals and activities	• ESSB 6358, a law passed in 2004 by the Washington State Legislature that mandates formal communication between the mental health, substance abuse and correctional systems for individuals under Community Corrections Supervision and simultaneous court-ordered mental health or substance abuse treatment • Section 20 of ESSB 6358, which mandates the development of a context and format for ongoing cross-systems communication • Three-system Release of Information Form covering corrections, mental health and substance abuse treatment providers that complies with 42 CFR Part 2, HIPAA and state confidentiality statutes.	Washington State Department of Corrections Washington State Department of Social and Health Services, Mental Health Division Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse Contact: Tom Saltrup, Washington State Department of Corrections, tesaltrup@DOC1.WA.GOV

Priority Investment Area 5:
Increase Access to Quality PTSD Treatment

Increase access to and quality of post-traumatic stress disorder treatment for veterans and others in need.

Overview

The United States Department of Veteran Affairs describes Post Traumatic Stress Disorder as follows:

> *Post Traumatic Stress Disorder, or PTSD, is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.*
>
> *PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting."*[42]
>
> *Prevalence studies suggest that an estimated 7.8 percent of Americans will experience PTSD at some point in their lives, with women (10.4%) twice as likely as men (5%) to develop it. About 3.6 % of U.S. adults aged 18 to 54 (5.2 million people) have PTSD during the course of a given year. Of those diagnosed with PTSD, 60.7% of men and 51.2% of women report experiencing at least one traumatic event. The traumatic events most often reported men with PTSD are rape, combat exposure, childhood neglect, and childhood physical abuse. The most traumatic events for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.* ***About 30 percent of the men and women who have spent time in war zones experience PTSD. An additional 20 to 25 percent have had partial PTSD at some point in their lives.***

People of all ages develop PTSD and PTSD creates multi-generational impacts. Significant evidence suggests that children of parents with PTSD can become afflicted through secondary processes; witnessing and living with the effects of PTSD can be enough to cause the disorder.

People diagnosed with PTSD often have additional medical or psychological problems and other significant stressors in their lives. A recent report concluded that PTSD is a highly prevalent lifetime disorder with symptoms that persist for years.[43] In addition, those diagnosed with PTSD often experience such co-existing disorders as substance abuse/dependency, other mental illnesses, and physical problems. Because the symptoms of the illness can lead to increased isolation and struggles with authority figures, un/under-employment and homelessness often accompany the disorder.

Although PTSD has come to be thought of as a "veteran's problem," veterans' exposure to the horrors of war is only one risk factor. Other factors known to cause trauma/PTSD disorders include natural disasters, serious automobile accidents, domestic violence and physical or sexual abuse.

[42] http://www.ncptsd.va.gov/facts/general/fs_what_is_ptsd.html
[43] National Co-morbidity Service Report

The PTSD Alliance[44] reports that those at risk for developing PTSD include the following:

- Anyone who has been victimized or has witnessed a violent act, or has been repeatedly exposed to life-threatening situations
- Survivors of domestic partner violence; rape or sexual assault; physical assault; or random acts of violence
- Survivors of unexpected events in everyday life (e.g., serious car accidents, natural disasters, industrial accidents)
- Children who are neglected or sexually, physically or verbally abused by adults (who were often abused themselves as children)
- Combat veterans or civilian victims of war
- People diagnosed with a life-threatening illness
- Professionals responding to victims in trauma situations (e.g., emergency medical responders, police, firefighters)
- People who learn of the sudden, unexpected death of a close friend or relative.

While any of those described above can be at risk for experiencing PTSD, available prevalence estimates are useful guidelines for clinicians and policy makers developing system-wide strategies.

Experience	Percentage of those with the experience who develop PTSD
Rape	49 %
Physical assault	32 %
Other sexual assault	24 %
Serious accident/injury	17 %
Shooting or stabbing	15 %
Unexpected death of loved one	14 %
Child's life threatening illness	10 %
Witness to a killing or serious injury	7 %
Witness natural disaster	4 %

Since high percentages of people who experience sexual and physical assault suffer from PTSD, it is useful to look at the frequency of such assaults in the general population.

- One in five boys is a victim of sexual assault.
- One in three girls will be sexually abused.
- Only one in ten child victims reports the abuse.
- Twenty-nine percent of rape victims are under 11 years old.
- For 60 percent of "sexually active" girls under age 14, their only sexual experience is a rape.
- Two-thirds of all prisoners convicted of rape were convicted for sexual assault against a child.
- Male survivors of child sexual abuse were twice as likely to be HIV positive.
- Seventy-five percent of women in treatment for drug and alcohol dependency report having been sexually abused.

[44] http://www.ptsdalliance.org/about_risk.html

- More than 70 percent of girls in the juvenile justice system or in shelters have histories of sexual abuse and assault.
- Rape victims have been found to be 8.7 times more likely to attempt suicide.
- In 61 percent of all rape cases, the victim is under 18 years of age.[45]

Summary of Populations Served

In 2005, the King County Veterans Program (KCVP) provided 719 veterans with mental health services, most of who were diagnosed with PTSD. In addition KCVP offers trauma counseling to spouses, significant other, and children who have grown-up with a parent or partner who is suffering from PTSD.

The King County Mental Health Plan served 2,232 individuals diagnosed with PTSD in calendar year 2005. Since data isn't collected, it is unknown how many of these might be veterans. Of these:

- average age was 32
- 1,751 (78%) lived in independent housing; 99 (9.5%) were homeless; 54 adults (2%) resided in a non-independent residential facility; and 205 (9%) children/youth were in foster care or lived in group care facilities
- 2,046 (92%) were unemployed[46] and 135 (6%) participated in some type of employment (full or part-time)
- 1,213 (54%) were Caucasian, 388 (17%) were African American, 143 (6%) were Asian/Pacific Islanders, 71 (3%) were Native Americans
- Average (mean) service hours were 36.2, while the median hours were 19.8
- Average length of time in service was three years, and the median was two years

Existing Systems of Treatment

The *United States Department of Veteran Affairs* sponsors the National Center for PTSD, and posts a plethora of information about symptoms, causes, therapeutic approaches (including best practice models), resources (treatment providers, websites), and benefit processes for service-related PTSD. With the extreme prevalence of PTSD among veterans, the VA has become a "center of excellence" in the identification and treatment of PTSD, and provides training and internships to mental health professionals.

The *Washington State Department of Veteran Affairs* (WDVA) has maintained a state-funded counseling program to assist veterans with war trauma related life issues. In 1991, Washington State became one of the first states to pass legislation creating support for outpatient treatment for war trauma, and extending these services to National Guard and Reserve members deployed during times of war.

WDVA maintains contracts with specialized providers and posts the names of counselors by county on their website. It also provides consultation to mental health centers and other professionals who provide counseling to veterans.

While the *King County Mental Health Plan* (the publicly funded mental health system) serves a large number of individuals with PTSD (2,232), there are no mandated "best practices" required of its provider network. However, the plan recently adopted "practice guidelines" for children/youth diagnosed with PTSD. During annual review processes in 2005, agency staff was asked about how

[45] Multiple sources, as quoted by the King County Sexual Assault Resource Center
[46] The clients in this data set were nearly all Medicaid recipients, meaning they are sufficiently impaired to qualify for Medicaid benefits.

these guidelines are being implemented. In coming years, implementation of these practice guidelines will continue to be incorporated into annual reviews.

The King County Department of Community and Human Services operates a *Veterans Program* through which eligible veterans and their family members can obtain counseling and treatment for PTSD and other trauma-related issues.

The network of service providers for *victims of domestic and/or sexual assault* is directly involved with individuals experiencing assault-related PTSD. Conservative estimates indicate that at least 50% of assault victims and their family members who seek treatment from these service providers may be diagnosed with PTSD.

Major Funding Streams

- Department of Veteran Affairs
- Washington State Division of Veterans Administration
- King County Department of Community and Human Services Veterans' Program
- Medicaid and state general monies fund paid to the King County Mental Health Plan
- Domestic violence and sexual assault service delivery system(s)

Issues and gaps

VA Medical Center

- *Wait lists.* There are often long wait lists for veterans wanting to access services.
- *Group modalities.* The VA relies heavily on group therapy, and for some veterans (e.g., male survivors of sexual assault), group modalities are not acceptable.

King County Veterans' Program

- *High demand.* There is a high demand for services, especially from homeless veterans that habituate the Pioneer Square area, and if this trend continues, wait lists will develop.
- *Demographic shifts in living locations and age of Veterans.*

  Given the shift in King County demographics, enhanced services for South King County veterans should be available.

  The over-arching treatment system will need to retool itself such that targeted services will be available to veterans (active duty, National Guard and reservists) who are younger than veterans from the Vietnam era. Guard and reserve members have the additional complications that arise from disrupted lives – employment, income, family life, etc.

King County Mental Health Plan

- *No specialty programs.* The publicly funded mental health system does not offer any specialty programs for treatment of PTSD, nor does it collect identifying data on veteran status.
- *Peer counselor support.* While the system increases it focus toward providing recovery-based services, it relies heavily on a case management model. However the use of peer counselors is expected to increase dramatically and this may be an area where people diagnosed with PTSD can receive support.
- *No summary data on PSTD-Qualified Staff.* As part of credentialing requirements, licensed mental health agencies are required to submit credentialing documentation to the MHP as a condition of doing business. Among the requirements from the staff qualifications section is the provision of a "count" of agency staff qualified to provide PTSD services (other diagnoses

are also addressed in this manner). The resulting information is not currently summarized at a system level, and the criteria for qualifications are not spelled out.

- *Identification processes.* In general, there is a need to improve processes in which people with PTSD are identified, particularly among those who are already at risk (e.g. homeless, criminal/juvenile justice involved, people who have experienced/witnessed domestic violence). Earlier identification and appropriate treatment might reduce further risk for adverse consequences associated with illness.

Summary of Available Services

The following table summarizes some of the PTSD services available in King County.

Program/Serves	Focus/location	Provided by	Funding	Goals / Outcomes
Department of Veteran Affairs				
Outpatient	Three types of clinics: 1) Clinical teams 2) Substance Use PTSD 3) Women's Stress Disorder Treatment Although each clinic has particular specialties, each provides evaluation, education, counseling, and psychotherapy	Multi-disciplinary professional teams	Department of Veteran Affairs	
Day Hospital	Programs provide two approaches to "therapeutic communities: 1) Day Treatment provide 1:1 case management, counseling, group therapy, education & activities 2) Residential units: 1:1 case management & counseling, group therapy, education, & activities for "lodgers"	Multi-disciplinary professional teams	Department of Veteran Affairs	Clients learn to live successfully with PTSD
Inpatient	Four types of service for veterans residing in hospital units: 1) specialized inpatient units: trauma-focused evaluation, education, and psychotherapy for 28-90 days 2) Evaluation and brief treatment unites: evaluation, education and psychotherapy 3) Residential Rehabilitation Programs: evaluation, education, counseling and case management 4) Substance Abuse Programs: combined evaluation, education, and counseling for SA/PTSD	Multi-disciplinary professional teams	Department of Veteran Affairs	

Program/Serves	Focus/location	Provided by	Funding	Goals / Outcomes
Washington State Department of Veterans Affairs (WSVA)				
1. Honorably discharged war era veterans & his/her family members 2. Nat'l Guard/military Reserve members deployed during war & peacekeeping mission, & their family members 3. must be able to demonstrate significant post-war adjustment issues 4. does not need to meet service connected disability criteria 5. services are free to qualified vets 6. priority to those most vulnerable & without other options for treatment	Community-based counseling services, including: • individual • couple • family • veteran groups Specialized counselors offer services to women veterans and spouses of veterans. If needed, veterans may be referred to specialized inpatient or outpatient treatment offered by the VA at Veteran Medical Centers or Veteran Centers within Washington.	Multi-disciplinary mental health professionals	WSVA	A primary goal is to provide services to those who may have difficulty accessing traditional vet treatment services.
King County Mental Health Plan (KC MHP)				
Primarily Medicaid recipients, with some non-Medicaid funded individuals as resources allow	All core and specialized services required of network providers	Mental Health practitioners and specialists, as required by RCW	Tier benefit rate. The amount paid to providers through tier benefits is a compilation of several factors	2,232 individuals served during CY 2005 Outcomes are uniformly applied across diagnostic groups, but are based on recovery – based expectations (e.g. housing, employment)

Program/Serves	Focus/location	Provided by	Funding	Goals / Outcomes
King County DCHS Veterans Program				
Veterans that meet RCW eligibility criteria and their eligible family members	Clients are provided with mental health counseling and/or trauma services. Through this program, clients are assisted in access benefits. Trauma	Mental Health Professionals (one KCVP staff; nine contracted professionals)	County millage	Provides over $300,000 in benefits secured by clients annually (e.g. disability claims) 719 veterans received MH counseling in 2005.
Harborview Mental Health Center				
Veterans and individuals enrolled in the King County Mental Health Plan	When there is sufficient demand, offers specialized groups for veterans, using Cognitive-Behavioral approaches. People with PTSD may also be referred for Dialectic Behavioral Therapy (DBT)	Mental Health Professionals; therapists with specialized training in modalities	Some paid by tier benefit rate but this is not the only source	Unknown how many individuals, veterans, or family members received treatment
King County Sexual Assault Resource Center				
Victims of sexual assault and their family members • 83% female • 17% male • 47% children • 23% teens				3,436 served in CY 2005 (unclear what % was diagnosed with PTSD, but prevalence data suggests at least 50%)

Program/Serves	Focus/location	Provided by	Funding	Goals / Outcomes
Harborview Medical Center, Sexual Assault and Traumatic Stress				
Victims of sexual assault and their family members	1. Traumatic Stress Counseling, including: • Immediate crisis counseling and support • Trauma specific treatment 2. Explanations of legal and medical systems 3. Information and support for family and friends 4. Assistance in applying for Crime Victims Compensation benefits	Trained social workers	Individuals, foundations, corporations City of Seattle King County Women's Program Washington State Office of Crime Victim Advocacy Women's Funding Alliance United Way of King County DSHS VOCA funds SAMSHA Harborview Classic Golf Tournament	To assist individuals to recover from the effects of sexual assault

Evidence-Based Practices

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Women experiencing PTSD, with co-occurring substance use disorders	Recovery from trauma and co-occurring disorders, including increased understanding of the nature of PTSD and its relationship to problematic behaviors in order to promote residential, social and vocational stability over time	Seeking Safety: A set of structured interventions for groups focused around 25 trauma-related topics, including trauma and substance abuse. Provides a particular focus on gender-specific services for women	Developed by Lisa Najavits et al. See: ***Seeking Safety: A Manual for PTSD and Substance Abuse*** (Guilford Press, 2002), and www.seekingsafety.org
Women experiencing PTSD, with co-occurring serious mental illness and substance use disorders	Recovery from trauma and the co-occurring of serious mental illness and substance use disorders, including increased understanding of the nature of PTSD and its relationship to problematic behaviors in order to promote residential, social and vocational stability over time	Trauma, Recovery and Empowerment (TREM): A set of 21-30 weekly sessions focused on trauma-related topics, including trauma, substance abuse and serious mental illness. Provides a particular focus on gender-specific services for women	Developed by Maxine Harris and Community Connections, Inc., - Washington, DC-based community mental health and substance abuse treatment center. Contact Community Connections or rfallot@communityconnectionsdc.org
Men experiencing PTSD, with co-occurring serious mental illness and substance use disorders	Recovery from trauma and the co-occurring of serious mental illness and substance use disorders, including increased understanding of the nature of PTSD and its relationship to problematic behaviors in order to promote residential, social and vocational stability over time	Men's Trauma, Recovery and Empowerment (M-TREM): A set of 21-30 weekly sessions focused on trauma-related topics, including trauma, substance abuse and serious mental illness. Provides a particular focus on gender-specific services for men.	Developed by Maxine Harris and Community Connections, Inc., - Washington, DC-based community mental health and substance abuse treatment center. Contact Community Connections or rfallot@communityconnectionsdc.org

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Women with infant children exiting prison settings who have experienced trauma, serious mental illness and co-occurring substance use disorders	Promotes successful re-entry from prison to the community and healthy attachment between infant children and their mothers for women who have experienced trauma and been separated from their infant children while incarcerated or given birth in prison	TAMAR's Women: A holistic and gender-specific approach to pregnant and post-partum women with co-occurring disorders. Services begin while the women are incarcerated and follow them into the community. Comprehensive services are provided, including housing, pre and post-natal care counseling, vocational assistance, mental health and substance abuse treatment, daily living skills, etc.	Developed and operated by the Maryland Community Criminal Justice Treatment Program (MCCJTP) of the Maryland Department of Mental Hygiene. Contact: Dr. Joan Gillece at: gillecej@dhmh.state.md.us
Veterans with PTSD	• Implement routine screening in primary care • Standardize initial and follow-up assessments • Increased prevention – promote resilience • Increased detection of PTSD • Integrate/coordinate primary and mental health care • Implement routine • screening for trauma and PTSD	Management of PTSD in primary care and mental health specialty, including recommendations for pharmacology and psychotherapy interventions	U.S. Department of Veterans Affairs (http://www.oqp.med.va.gov/cpg/PTSD/G/PTSD_about.htm)

Priority Investment Area 6:
Increase Impact of Effective Recidivism-Reduction Programs

Increase the impact of programs that have demonstrated effectiveness in reducing recidivism in the criminal justice system by adding housing and employment components or increasing capacity, or both.

Overview

There are many good reasons for working toward reduction of recidivism rates. Foremost among these is the threat to individual and public safety that criminal behavior creates. In addition, there are a host of other "costs" associated with high rates of recidivism.

- *Economic costs*: Lost victim's wages; cost of operating courts, prisons and jails places significant burden on taxpayers; lost productivity on the part of perpetrators; lost economic robustness for businesses impacted by criminal behavior (e.g., theft, arson).
- *Generational cycles*: Ample literature describes the generational nature of criminal acts and behaviors. Failure to address risk factors and provide appropriate interventions allows these cycles to continue at a huge cost to taxpayers. At-risk families need help to break the cycles.
- *Individual lives*: As a person embarks on a criminal career, the path ahead often leads to separation from family and other support systems, lack of competitive employment skills and/or work history, homelessness, drug addiction and/or mental illness.

Any one of these effects is sufficient reason to redirect and reinforce efforts toward initiatives that effectively and economically address recidivism.

King County has been highly innovative in the development of a number of initiatives designed to impact the recidivism rates of former inmates, and has received international attention for its efforts. Nevertheless, there much work remains. Current increases in federal and state attention to the problem of recidivism have brought new hope that additional funding may be made available for both existing and new recidivism-reduction efforts.

Summary of Populations Served

As mentioned in the main body of this report, the Veterans and Human Services Levy is focusing its efforts to the effective implementation of a limited number of initiatives. With that caveat in mind, this appendix specifically addresses adults (18+ years) in the context of criminal justice recidivism.

The population of interest can be clustered in three ways:

1) those being released from prison, jail, or other criminal justice program
2) those involved with court-ordered diversion programs
3) those with ongoing connections to community-based treatment and support programs.

The following provides a thumbnail sketch about the population included in each cluster. When possible, counts of individuals from each category and other demographic details are included to provide context for the magnitude of recidivism issues.

Population Cluster 1: Released from Jail, Prison or Other Criminal Justice Program

A. Inmates released from Federal Bureau of Prisons (FBP)

The federal prison in SeaTac is the only federal prison in King County. The census at this prison for the week of July 14, 2006 was 975.[47] It is unknown how many of these inmates may be released in King County. The American Civil Liberty Union reports that over 175,000 men and women comprise the FBP incarcerated population. The FBP places individuals in particular federal institutions related to a number of factors (e.g. the nature of the crime committed), and it is not possible to know how many of these inmates may return to King County upon release.

B. Inmates released from Department of Corrections (DOC) facilities

For state fiscal year 2005 (July 1, 2004 – June 30, 2005) 6,575 inmates were released to King County from a DOC facility. This represents approximately 1/3 of all DOC releases for the time period. Of these, 2,230 were "released from sentence" (meaning the inmate completed his/her prison sentence), and 4,345 were' released from violation" (meaning the inmate is released after serving time associated with a violation of his/her conditions of release).

Said another way, two-thirds of all DOC inmates discharged to King County by DOC had violated conditions and were re-incarcerated to serve out the remainder of their sentence. This finding has significant implications for recidivism reduction.

The racial makeup of inmates across all DOC facilities is: [48]

Race/Ethnicity	Percent of total DOC inmate population
Caucasian	71.6%
African American	19.7%
American Indian	4.2%
Asian	3.1%
Unknown/other	1.4%
Hispanic (counted separately)	9.7%

The current DOC inmate population of 17,905[49] has an average age of 36.4 years, and 93.4% of all inmates are US citizens. Length of sentence (usually tied to the severity of the crime) is one of the possible risk factors for recidivism. For the current DOC population, sentencing is as follows:

Length of Sentence	Percent of total DOC inmate population
Less than two years	23.7%
Two to five years	22.7%
Five to ten years	19.3%
Over ten years	31.3 %
Life without release	3.0%

DOC predicts that the population of offenders incarcerated by the state is expected to increase at a rate of about 300 offenders (two percent) per year. Concurrently, the number of offenders supervised in the community is also expected to increase. DOC has the third largest budget in state government, which has a ripple effect on the overall state budget, particularly in times of prison population growth and the associated costs. Between fiscal

[47] Bureau of Prisons, Weekly Population Report
[48] Department of Corrections: Populations Summaries, Confinement Statistics, as of June 30, 2006.
[49] Ibid.

years 1996 and 2006, the incarcerated offender population increased by 48 percent, or 5,863 offenders.

Between fiscal years 2006 and 2017, the incarcerated offender population is forecast to increase from about 18,000 to 24,000 (31%) based on the June 2006 forecast. The current and anticipated growth rate adds pressure to both state government and DOC budgets. For example, there is a bed capacity gap, which is being addressed by expanding the number of prison beds, and through contracting with local jurisdictions and prisons in other states to house Washington State offenders.

There is also a staffing shortage, which is partially linked to the growth of the prison population. While King County initiatives won't provide a complete solution to the challenges faced by DOC, if levy proceeds are effectively invested in strategies that have considerable impact, the savings will incur at both the county and state correctional facility levels.

If the growth of DOC proceeds as anticipated, the efforts toward reduction of recidivism will need to increase proportionally, as will the portion of the state budget dedicated to criminal justice and incarceration costs.

C. Former inmates under DOC community supervision[50]

There were 10,972 former inmates in King County who received community supervision, as of September 30, 2005. Of these, 2,206 were classified "Risk Management A" (RM-A, the classification with the greatest likelihood for re-offense). Statewide, women comprise 17.2 % of all former inmates receiving community supervision, while men comprise 82.3 %. However, women only account for 9% of RM-A's.

D. Inmates released from a King County Correctional Facility

There are two correctional facilities for adults: 1) the King County Correctional Facility (KCCF) in Seattle, and 2) the Regional Justice Center (RJC) in Kent. In calendar year 2005, there were a total of 50,627 bookings (not unduplicated) with an average length of stay of 18.7days. The average daily population for the combined facilities was approximately 2,600 inmates.

E. Participants in the King County Department of Adult and Juvenile Detention (DAJD) Community Corrections Division (CCD) Programs

In spring 2002, King County Executive Sims proposed the creation of a new Community Corrections Division (CCD) within DAJD. Goals for this initiative included reduced use of secure beds while maintaining public safety and changing offender behavior. The Executive's proposal included the development of programs that provide alternatives to secure detention, the centralization of current programs, and methods to increase offender accountability. [See "Description of overall systems" for additional program component detail.] The combined CCD programs served 4,390 participants in CY 2004.

In 2003, the racial composition of participants follows. (N = 2,112):[51]

Race/Ethnicity	Participants in CCD Programs
Caucasian	61%
African American	29%
Asian	7%
Native American	2%
Unknown	<1%

[50] The classification system used by DOC is based on composite scores related to the offenders risk for re-offense, supervision authority, and the conditions of the sentence (crime committed).
[51] 2004 data not available at the time this report was written.

Population Cluster 2: Court-Ordered Diversion Programs

King County and the City of Seattle have developed a number of "specialty courts" reflecting the growing recognition that incarcerating individuals whose criminal behaviors may be tied to unaddressed behavioral health issues is not a solution to the underlying problem, and has the effect of criminalizing illnesses. Local Specialty Court programs include:

A. *Seattle Municipal Mental Health Court:*

Established in 1999, the court seeks to: protect public safety; reduce jail use – including recidivism – of persons with mental illness; connect participants with mental health services; improve treatment success, access to housing, and linkages with critical supports.

Cases involving mentally ill defendants who choose to participate in the MHC are diverted from the regular court process whether at first appearance, pre-trial stage or probation review. The Department of Community and Human Services (DCHS) contracts with a local mental health agency to provide liaison services. These services include linkage between the court and the participant, and connecting participants to treatment (e.g. mental health, co-occurring disorders). To be eligible for MHC services, defendants must be mentally ill or developmentally disabled, or have co-occurring disorders. The program is available to defendants that have committed misdemeanant crimes, not felonies.

B. *South and East King County Municipal Courts:*

DCHS contracts with a mental health agency to provide liaison services to assist adult misdemeanant offenders with treatment services. The municipal courts that participate in this program are: Auburn, Enumclaw, Issaquah, Kent, Kirkland, and Renton. This is a relatively new program, so demographic information is not yet available.

C. *King County District Mental Health Court (KCDMHC):*

Implemented in February 1999, this project was created in order to better serve the community by addressing public safety, reducing criminalization of persons with mental illness, and promoting service integrations. The court offers misdemeanor defendants with mental illnesses a single point of contact with the court system. The defendant then works with a team including a judge, prosecutor, defender, treatment court liaison, and probation officers. Eligible candidates can determine whether they want to "opt in" or "opt out" of this particular court. If a defendant opts in, s/he must participate in court ordered treatment plans and successful participation may result in dismissed charges, early case closure or reduced sentencing.

D. *King County Superior Court – Drug Diversion Court Program (adult):*

The Drug Diversion Court (KCDDC) was implemented in August 1994, and is a pre-sentencing program that provides eligible defendants the opportunity to receive drug treatment in lieu of incarceration. Eligible defendants can elect to participate in the program (opt in) or proceed with traditional court proceedings (opt out). Defendants come under the court's supervision and are required to attend treatment sessions, undergo random urinalysis, and appear before the drug court judge on a regular basis. If a defendant meets all court requirements, his/her charges are dismissed.

For the period between August 1994 and May 2004 (Seattle & Kent sites):

- A total of 5,948 defendants were referred to the KCDDC.
- Of those 5,948 defendants, 3,071 "opted in" to the program.
- Of those who entered treatment, 350 were active and 622 had graduated.
- Sixty-six percent were unemployed and 25 percent had no permanent residence.

E. King County Superior Court – Family Treatment Court (KCFTC):

King County is one of a small but growing number of jurisdictions nationally that is implementing a court designed to address the needs of families involved in the legal system due to child abuse and neglect charges related to parental substance abuse. As of May 2006, 33 families and 53 children and adolescents were enrolled in the KCFTC.

Population Cluster 3: Community-based treatment and support programs

A. King County Criminal Justice Initiatives (CJI):

King County Council adopted the Adult Justice Operational Master Plan in November 2002, which paved the way for CJI development. The programs that comprise the CJI were developed for inmates who are high users of the jail and/or individuals who have substance use disorders and mental illnesses who are not otherwise eligible for service enrollment.[52]

Referrals for the period September 2003 – May 2006[53]	
King County Correctional Facility (KCCF)	1,635
Regional Justice Center (RJC)	1,394
King County Community Center for Alternative Programs (CCAP)[54]	1,046

B. Mentally Ill Offender Community Transition Program (MIOCTP):

This program began in July 1998 after a tragic incident in which a Seattle firefighter was murdered by a person with mental illness who had recently been released from incarceration from the King County Correctional Facility. This incident created an outcry from the community, and served to reveal numerous gaps in communication among institutions, a lack in continuity across systems, and holes in the service delivery system. This tragedy inspired the Washington State legislature to develop the MIOCTP project, which was piloted in King County. For the period September 1998 through July 2002, 64 individuals met eligibility criteria and were enrolled in the project. (The enabling legislation limited the project to serving no more than 25 clients at a time.) In many ways, this project provided foundation knowledge about effective strategies for transitioning inmates with behavioral health diagnoses from institutions to the community.

C. Dangerous Mentally Ill Offender (DMIO):

Building on the success of the MIOCTP program, the Washington State Legislature developed a statewide program that serves individuals with a serious mental disorder (mental illness and/or developmental disability), and who meet the statutory definition for "dangerousness"[55] – individuals that have committed first degree murder, or are Level III sex offenders, or have committed violent crimes, may be eligible for the program. Unlike MIOCTP, there is no cap on the number of individuals who can be served. In CY 2005, the DMIO program served 76 clients with pre- and post-release services, and 86 clients have been served since the program's inception.

[52] King County Criminal Justice Initiative: Interim Outcomes Report, July 2005.
[53] CJI Status Update – June 2006
[54] CCAP is a component of the Community Corrections program.
[55] Derived from composite information about the nature of the index crime, past history and other elements.

Issues and gaps

Disproportionality and over-representation: One major issue of concern is over-representation of African Americans in America's jails and prisons. The 2000 United States census found that African Americans comprised 43.7% of the population in all prisons and jails, compared to 12.3% of the total U.S. population. Washington State provides no exception to this problem. Although African Americans comprise only 3.2% of the state's total population, they comprise 18.2% of the combined prison/jail population (an incarcerated rate is nearly six times that of the general population). While it is beyond the scope of this levy to solve this long-standing, wide-ranging issue, we must diligently work to make inroads whenever we can.

Population descriptors: It is very difficult to obtain a clear understanding of the number of people released from jails or prisons to areas within King County. Federal, state, and local institutions each release a significant number of people each year, but there is no coordinated way to obtain demographic descriptions about who these people are. This information is critical to have when developing public policy and programs.

Increased incarceration rates: According to the latest statistics from the U.S. Department of Justice, more than two million men and women are now behind bars in the United States, which is a higher percentage of its people than any other country in the world. Violent crime is not responsible for the quadrupling of the incarcerated population in the United States since 1980. In fact, violent crime rates have been relatively constant or declining over the past two decades. The exploding prison is the result of public policy changes that have increased the use of prison sentences as well as the length of time served, e.g. through mandatory minimum sentencing, "three strikes" laws, and reductions in the availability of parole or early release. If this policy trend continues, efforts to reduce recidivism will be significantly challenged.

Lack of comprehensive discharge planning and resources: Judges, courts, jail, and community correction staff uniformly speak about the frustration that comes from not being able to release inmates with discharge plans that seamlessly route people to the supports they need to be maintained in the community. If inmates are not eligible or enrolled in special programs, there is very little likelihood they will independently seek out and access services. However, when inmates leave jail/prison without housing, income (e.g. employment, benefits), family or social support, or immediate access to treatment, it is an absolute formula for re-offense.

Mental Illness and Substance Abuse: It is estimated nationally that 80% of individuals who end up in jails or prisons are struggling with some level of substance use disorder. In many communities, 60% of individuals manifest some level of intoxication or drug use at the time they are booked into a local jail. In addition, incarcerated populations experience major mental illnesses at a rate of three times the incidence of mental illnesses in the general population. In addition, three-quarters of the incarcerated population of people with mental illnesses also experience co-occurring substance use disorders.

Housing: By far the biggest gap reported by all stakeholders is the lack of affordable, appropriate housing. Too often, former inmates are forced by lack of options into temporary housing (e.g. hotels, motels, shelters) or homelessness (living out of cars, under bridges, etc.) in areas where crime rates are the highest. Lacking income, rental history, or access to Section 8 vouchers, the only options seem to place inmates at risk for re-offense. In addition, the nature of crimes committed by former inmates can be a formidable barrier – crimes such as arson, murder, violent assault, and sexual assault can often rule out eligibility for many types of housing. Investing in strategies that increase the likelihood of accessing affordable, appropriate housing will be a key factor in addressing recidivism.

Employment: The issues that impact access to housing are largely the same issues that create challenges in procuring employment. In addition to the type of crimes committed, most inmates have poor employment histories and lack training, technical skills or sufficient education. The literature speaks of uncommonly high percentages of inmates with learning disabilities and illiteracy, both of

which create employment barriers – up to 47% of inmates in local jails have not completed high school or its equivalent, compared to 18% of the general population. Without legitimate means to income, the likelihood of recidivism increases.

Gaps in Services and program coordination:

- While there have been notable improvements in cross-system coordination over the past ten years, the various treatment systems still have work to do towards improving access to services. Establishing eligibility criteria, providing supporting documentation and being placed on wait lists soon becomes confusing and discouraging for former inmates, and others struggling with complex issues.
- Providing "system navigators" (described in the main body of this report) and consolidated service access points will create easier access, and a more user-friendly system.
- The transition/Reentry Initiative established through the KC 2006 budget was developed to provide case management/advocacy service to individuals leaving the jail and/or alternatives to incarceration programs. However, it was determined that approximately 50% offenders that leave the jail with benefit qualification and treatment appointments in place do not attend these scheduled appointments and end up committing another crime leading to further incarceration.
- The Community Center for Alternative Programs (operated by the Community Corrections Division) is a day reporting program for both pre-trial and sentenced offenders, and is based on a "one-stop shop" concept. A wide array of services is provided by an equally wide array of county and state staff, as well as community service providers. The King County District and Superior Courts have found the model to work well for individuals needing ambulatory treatment and also require structure, consistency and daily monitoring. When the program began in 2003, the target participation number was 75 offenders; however as the popularity of the program grew, the daily enrollment ballooned to 260. The program suffers from lack of a unified client-centered database that would assist in monitoring program performance measures, program placement/suitability, and risk assessments. Such tools exist and are employed by other jurisdictions.
- There is no system for children aging out of foster care who need assistance.

Summary of Current Recidivism-Reduction Programs

The programs described in the matrix below are examples of current programs operated and funded by a variety of systems that either have proven ability to reduce recidivism, or are beginning to show promising outcomes. While this list is incomplete, it attempts to provide a snapshot of a variety of programs and initiatives overseen by several significant systems.

Programs based in prisons and jails:

Program	Serves	Focus/Location	Provided By	Funding	Goals
Department of Corrections (DOC)					
Adult basic education	Adults incarcerated in DOC facilities	In prison Assists inmates with basic education needs that assist with community reintegration	Unknown	Unk. – assume DOC 6/30/06 attendance = 1,992	Acquisition of GED or high school diploma, basic skills & ESL
Vocational education	Adults incarcerated in DOC facilities	In prison Vocational training for offenders with no or poor work skill.	Unknown	Assume DOC 6/30/06 attendance = 1,446	Learn and apply skills used in workplaces
Correctional industries	Adults incarcerated in DOC facilities	In prison Paid work that enables offenders to acquire job skills while incarcerated	Unknown	Unknown 6/30/06 attendance = 1,523	Job skills that can be transferred to community employment
Substance abuse treatment programs	Adults incarcerated in DOC facilities	In prison State certified treatment for offenders that are chemically dependent	Contracted	Assume DOC 2,526 completed treatment in CY 2005	Sobriety and skills to remain sober
King County Correctional Facility					
Jail release planning	Incarcerated adults	Coordinated care for inmates while in custody; linkages with outside entities; application for client benefits	Social work, contracted MH staff, other treatment/ service providing entities	N/A	Effective release plans in place at discharge

Program	Serves	Focus/Location	Provided By	Funding	Goals
Pre-release benefits group	Incarcerated adults, stakeholders	Convened by JHS to provide procedural updates, changes in requirements, clarification of system issues	Jail, Harborview Medical Center, defense attorney social workers, DSHS, Fairfax, SPD, treatment providers, REACH, HOST – others as needed	N/A	Improved communication/ coordination
CD case management & release planning	Opioid dependent; alcohol dependent; other chemically dependent	In jail. Assessments, counseling & behavioral intervention; case management; treatment vouchers; discharge & release planning,	1.0 FTE CD certified social worker	CX (Criminal Justice Initiative funds	
HIV case management & release planning	Inmates with HIV/AIDS	In jail Assessment, counseling & behavioral intervention, case management, referral, discharge & release planning	0.7 FTE social worker, 0.3 FTE social worker	Ryan White Title 1; CX	
Medical case management & release planning	Medically complex inmates, including those with chemical dependency	Assessments, counseling & behavioral interventions, case management, referral, discharge & release planning,	1.0 social worker	CX	
Mental health case management & release planning	Inmates diagnosed with mental illness, or co-occurring mental illness/chemical dependency	Assessments, referral, discharge & release planning; beginning CD treatment	2.0 FTE mental health professionals (one at RJC, one at KCCF)	CX/CJI – contract with community treatment provider	
DSHS/ADATSA applications	Inmates in need of benefits	Application assistance	2.5 FTE application workers; 1.0 FTE DSHS social worker	CX/CJI	

Program	Serves	Focus/Location	Provided By	Funding	Goals
DAJD: Community Corrections Div (CCD) (not inclusive)					
CCD Overall	4,390 offenders served in 2004			CX budget for 2005 = $5.9 million+	
Community Center for Alternative Programs (CCAP)	Diverted offenders	Pioneer Square Treatment, educational programs, supports to reduce interaction with criminal justice systems		CJI/CX, DAJD 667 persons served	Reduced recidivism; improved skills in community living
Work & education release[56]	Detained offenders, pre- and post-trial	Work and education sites Alcohol and drug free program; offenders assisted with work, school, employment searches or treatment during day; return to secure building at night	Varies	Participants pay intake fee & room & board on sliding scale CX 10,709 hours of inmate labor; 11, 520 hours on community work crews	To assist offenders to remain clean and sober To enhance job skills & employment opportunities To provide education & training that leads to employment

[56] Both the work release and electronic home detention program (not described) generate revenue from inmate fees. Total for 2004 = $703,109.

Court diversion programs

Program	Serves	Focus/Location	Provided By	Funding	Goals
Seattle Municipal Mental Health Court	Misdemeanant offenders with mental illnesses	Court and community treatment sites To provide mentally ill offenders with treatment options in lieu of incarceration; court monitoring and oversight; access to priority beds for homeless participant	Judges, court monitors, contracted providers	City of Seattle, DCHS	Reduce recidivism and provide appropriate treatment and supports
Seattle Community Court	Homeless people Resource Center can be used by people involved in Seattle Municipal Court as well as other community members.	Seattle Justice Center Provides linkages to services and housing. Services include: drop-in child care center; DSHS benefits (e.g. food stamps, medical & financial assistance); Native American Outreach worker (one day/week); ADATSA assessments; substance abuse services; relapse prevention; alcohol/drug information; school; linkage to housing and employment resources; domestic violence treatment	Staff manager + eight volunteers One dedicated probation counselor who works out of Resource Center Belltown DSHS co-locates an eligibility worker that can take referrals from anywhere	City of Seattle	
King County District Mental Health Court	Misdemeanant offenders with mental illnesses	Court and community treatment sites	Judges, court monitors; contracted providers	Leveraged existing funds/staff and additional CX. Criminal Justice fund; Mental Health fund	Expedited case processing; improved access to treatment; reduced recidivism; increased public safety

Program	Serves	Focus/Location	Provided By	Funding	Goals
King County Superior Court – Drug Diversion Court Program (Seattle & RJC)	Pre-sentence defendants	Court & community treatment sites Court ordered treatment; random UA, appearances, chemical dependency assessments & treatment	Judges, court monitors, contracted providers		Reduce substance abuse & related criminal activity; enhance community safety; hold offenders accountable; integrate substance abuse treatment with criminal justice case processes Successful "graduation" = dismissed charges
King County Superior Court – Family Treatment Court	Families involved in the legal system due to child abuse and neglect charges related to parental substance abuse	Frequent court appearances, judicial monitory of family's treatment progress, support of non-adversarial team	Judges, court monitors, contracted providers	Two year federal grant (expires 12/06)	To ensure children have safe and permanent homes; ensure families of color have outcomes from dependency cases similar to families not of color; improve parents' ability to care for self, children; reduce cost to society of dependency cases involving substances

Community-based programs

Program	Serves	Focus/Location	Provided By	Funding	Goals
Community Justice Initiatives					
Community Justice Initiatives Overall Budget				FY2006: CX = $2.3 M State RSN via HB 1290:~ $1.2 million Total $3.5 million	
Co-Occurring Disorder integrated treatment	Adult offenders with co-occurring mental health & chemical dependency referred by KC Adult Drug Diversion Court, KC District MH Court or Seattle Municipal MH Court AND who agree opt in	12 months of integrated outpatient MH and CD treatment, case management, medication management & housing stabilization	Contracted providers	CX	Reduce booking, jail days, and recidivism
Methadone Voucher	Opiate-dependent adults	Up to 9 months of methadone treatment provided in jail and outpatient settings when released; assessment and medical exams; re-entry and employment counseling; HIV/AIDS counseling.	Contracted providers	CX	Reduced recidivism; expedited access to alternative treatment
Housing Voucher & Case management program	Adult offenders who are homeless, have a CD or co-occurring MH/CD problem referred by one of the specialty courts described above. Persons fleeing domestic violence also eligible.	Provides a 6 month treatment benefit; clients linked to array of housing options; assistance with applying for benefits; close connection with referral court	Contracted providers and housing network	CX	Stable housing, reduced recidivism, appropriate treatment

Program	Serves	Focus/Location	Provided By	Funding	Goals
Mentally Ill Offender Community Transition Program (MIOCTP) (legislative mandate)	Inmates that meet statutorily mandated criteria that are incarcerated in one of four DOC facilities; referrals reviewed by multi-disciplinary /multi-system team. Note: certain index crimes rule out eligibility. 86% have COD MH/CD	Through enhanced funding, participants receive approx. 3 months of pre-release planning & ongoing post-release intensive case management; treatment & support services. Up to $6000 p/yr can be spent on housing each participant	Contracted provider and their subcontractors; close partnership with DOC (institutions, risk managers, community correction officers)	Federal Block Grant	Reduced recidivism, reduced psychiatric symptoms, and increased community functioning
Dangerous Mentally Ill Offenders (DMIO) (legislative mandate)	Inmates from any DOC facility who meet statutorily mandated eligibility requirements; no crimes are rule outs	Through enhanced funding, participants are provided with 3 months pre-release planning and assessments; short-term community transition plan and long-term community tenure planning. Treatment is administered by provider or sub-contractors (e.g., sexual deviancy treatment), housing, CD treatment. Total time in program cannot exceed 60 months.	Contracted provider and their subcontractors; close partnership with DOC institutions, risk managers, community correction officers)	State MHD (state only and Medicaid match if client eligible)	Reduced recidivism, appropriate services and improved treatment outcomes, and reduced hospitalization

Evidence Based Practices

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Jail inmates with co-occurring disorders transitioning to the community	Reduce hospitalization, relapse to substance abuse, suicide, homelessness and re-arrest.	There are no outcome studies of transition planning for persons with co-occurring disorders or mental illness. However, based on multi-site studies of jail mental health programs a conceptual best practice model has been developed called APIC. This model has four steps: 1) *Assess the clinical and social needs and public safety risks of the inmate*. This includes clinical assessment, gathering information from courts, families, police etc, assessing cultural needs, engaging the inmate in their own assessment, and identifying means to pay for needed services. 2) *Plan for treatment and services*. This includes addressing the critical period immediately following release, learning from the inmate what has worked or not worked in the past, seeking family input, assuring housing, assuring continuation of medications, integrated treatment for the inmate's co-occurring disorders and linking the inmate to community medical providers. 3) *Identify community and correctional programs responsible for post-release services*. This includes naming in the transition plan specific community referrals, communicating to those providers, assuring that the supportive services and treatment match the inmates level of disability, motivation for change, and the availability of services, and assuring that the inmate has his/her benefit cards and photo ID on release. 4) *Coordinate the transition plan to ensure implementation and gaps in care.* This includes assuring the inmate has a case manager in the community at the time of release, and communicating that to all involved parties including the inmate. It also involves having a mechanism to locate released inmates who do not keep up the first follow-up appointment. The model should be supported by a joint committee of jail community behavioral health providers to set standards and monitor the process.	"*A Best Practice Approach to Community Re-Entry from Jails for Inmates with Co-occurring Disorders: The APIC Model,*" Fred Osher, Henry Steadman, Heather Barr, National Gains Center, September 2002

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Inmates at time of release	Reduce recidivism and increase success	Successful re-entry into the community is an increasing focus of many national and state organizations such as the National Governors Association, federal agencies, and departments of correction. Few programs have been rigorously studied but some conceptual best practices & principals have been identified: – Informal social controls such as family, peer and community have a more direct effect on offender behavior than formal controls – Behavior change is a lengthy effort and therefore the re-integration period is also – Interventions need to be matched to the offenders needs, risk to re-offend, and readiness to change – Services need to be comprehensive, integrated and flexible – There needs to be continuity of interventions, such as treatment from jail/prison to community – Behavioral contracts with offenders with clear communication of offender responsibility and expectations are useful. – There must be a system of sanctions and incentives, which hold the offender accountable to behavioral standards. – Support mechanisms such as family, AA, church are critical	"*From Prison Safety to Public Safety: Innovations in Offender Re-Entry",* Faye Taxman, Douglas Young et al., Bureau of Governmental Research, University of Maryland

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Released inmates in need of employment	Help former inmates maintain employment and avoid re-arrest.	*Center for Employment Opportunities (New York*) provides job readiness and placement services to men and women returning from prison to New York City and others under community supervision. They provide immediate, paid, short-term employment and serves as an "employment lab," preparing participants with the essential skills to rejoin the workforce and restart their lives. Within 2-3 months, 60% of training graduates are placed in permanent jobs and the program has demonstrated lower returns to prison. CEO experience has shown that there are parallels in relapse prevention and sustaining former inmates in jobs including: more than one job placement is likely to be needed before client is successful; intensive support is needed in the first 30 days when risk of failure is greatest; long-term support is needed to sustain successes and maintain motivation.	http://www.ceoworks.org "*Applying Lessons Learned from Relapse Prevention to Job Retention Strategies for Hard-to-Employ Ex-Offenders," Mindy Tarlow,* Offender Employment Report, December/January 2001
Ex-felons and addicts	Enable people to re-build their lives	*Delancey Street Foundation:* provides a structured educational, treatment living environment, which is run by residents. The average person entering Delancey Street has a long history of felony convictions and a lifetime history of substance abuse. They have an average of eight years of formal education; have a poor employment history and few marketable skills. Upon graduation from Delancey Street, they have earned not only a high school diploma, but are often on the way to attaining a college degree. Delancey Street graduates leave with marketable skills that they develop by working in several of the many business training schools that are completely run and managed by Delancey residents. These resident-run businesses are completely self-sustaining and provide the majority of the funding for the organization. Approximately 60% of the residents are successful in staying with the program and living self-sufficient and socially responsible lives afterwards.	http://www.nhtsa.dot.gov/people/injury/enforce/PromisingSentence/pages/PSP10.htm

Target Population	Purpose/desired outcomes	Practices/Models	Source/Citation
Inmates released from correctional institutions to work release	Help former inmates attain recovery, become employable and avoid re-arrest A University of Washington study found that participants in the Pioneer program had a lower recidivism rate (about six percent after two years) than other work-release programs. The study also found that Pioneer participants have higher earnings and work more hours than a comparison group that was used in the study.	*Pioneer Human Services:* is a combination of correctional services, substance abuse services, behavioral health services, drug and alcohol-free housing, and employment in one of Pioneer's multiple social enterprise businesses. Washington State Department of Corrections staff provides the training and counseling elements of the residential program, and Pioneer staff run the custodial and job training elements. The program has an integrated approach to helping its clients. Services such as housing, on the job training, life skills training, risk assessment, communication skills, and inpatient substance abuse are provided. In addition, clients also have access to Pioneer-operated businesses. When clients leave the work-release program, they have the opportunity to continue working with Pioneer.	http://www.reentrymediaoutreach.org/index.html http://www.pioneerhumanserv.com/index.html

Priority Investment Area 7:
Add Employment Goals and Services to Existing Programs

Increase self-sufficiency by adding employment goals and services to existing programs.

The employment system in King County is large and complex, with the greatest proportion of both funding and guidance coming from the federal government. The Washington State Employment Security Department is the largest and most comprehensive resource for people who are unemployed or seeking work. Local governments, primarily King County and the City of Seattle along with private foundations and community-based organizations also provide significant contributions to employment programs. A brief summary of the major components of the system and the populations served follows. Due to the complexity of this system, it is possible that some relevant information has not been included.

The WorkSource System

The Workforce Development Council (WDC) of Seattle King County is a 501c3 non-profit organization established after the passage of the federal Workforce Investment Act in 2000. The WDC oversees employment and training programs for adults, dislocated workers and youth throughout King County.

The Workforce Investment Act (WIA) is both a mandate for how workforce services will be provided and a funding source. WorkSource (One-Stop) Centers and services are mandated by the WIA. In King County, WorkSource has over twenty-five community partners with eight One-Stop locations.

Within each WorkSource Center, three levels of services are available: core, intensive and training services. Core services, including information, career counseling, job search assistance and self-service Internet access are available to anyone seeking employment and any employer needing assistance with personnel needs. Intensive and training services are those funded through WIA funds from the Department of Labor and are prioritized for those who are low income and have a barrier to employment, or are veterans, who receive top priority.

WorkSource Renton managed by King County is the largest one-stop center in Washington. More than 80,000 customers each year receive a range of education and pre-employment and job search training for dislocated workers, adults and at-risk youth. Another affiliate office is the downtown Seattle WorkSource center located within the YWCA's Opportunity Place, which has permanent supportive housing units, a women's shelter, a medical clinic, and staff from the Homeless Intervention Project (HIP), who are able to provide additional support to homeless clients.

Supported Employment for Persons with Disabilities

King County is a national leader in creating supported employment opportunities for people with developmental disabilities thanks to a strong network of dedicated employment provider agencies and employers across the region. Eight agencies within the community mental health system have contracts with the Department of Vocational Rehabilitation (DVR). In 2005, 11% of adults (18-64) served in the mental health system were employed. King County has established employment goals for each of its contracted agencies providing outpatient services. In 2006, each agency is expected to increase the percent of employed clients by 2% from the percent employed in 2005. King County also administers specialized programs working with individuals leaving state hospitals and correctional facilities with employment services.

Employment Programs Targeted to Homeless People

Employment programs targeted to homeless people do not constitute a "system" per se, but are described in the "Key Illustrative Programs" section of this document.

Major funding streams

A summary of the major funding sources for employment services in King County, as well as a description of how funding is distributed through the system, is summarized in the following charts and tables taken from the report titled ***"Developing Community Employment Pathways for Homeless Job Seekers in King County & Washington State - A Report of the Taking Health Care Home Initiative, June 2006."***

Chart 1
Schematic Diagram of the Flow of Dollars through the Workforce Training System in King County

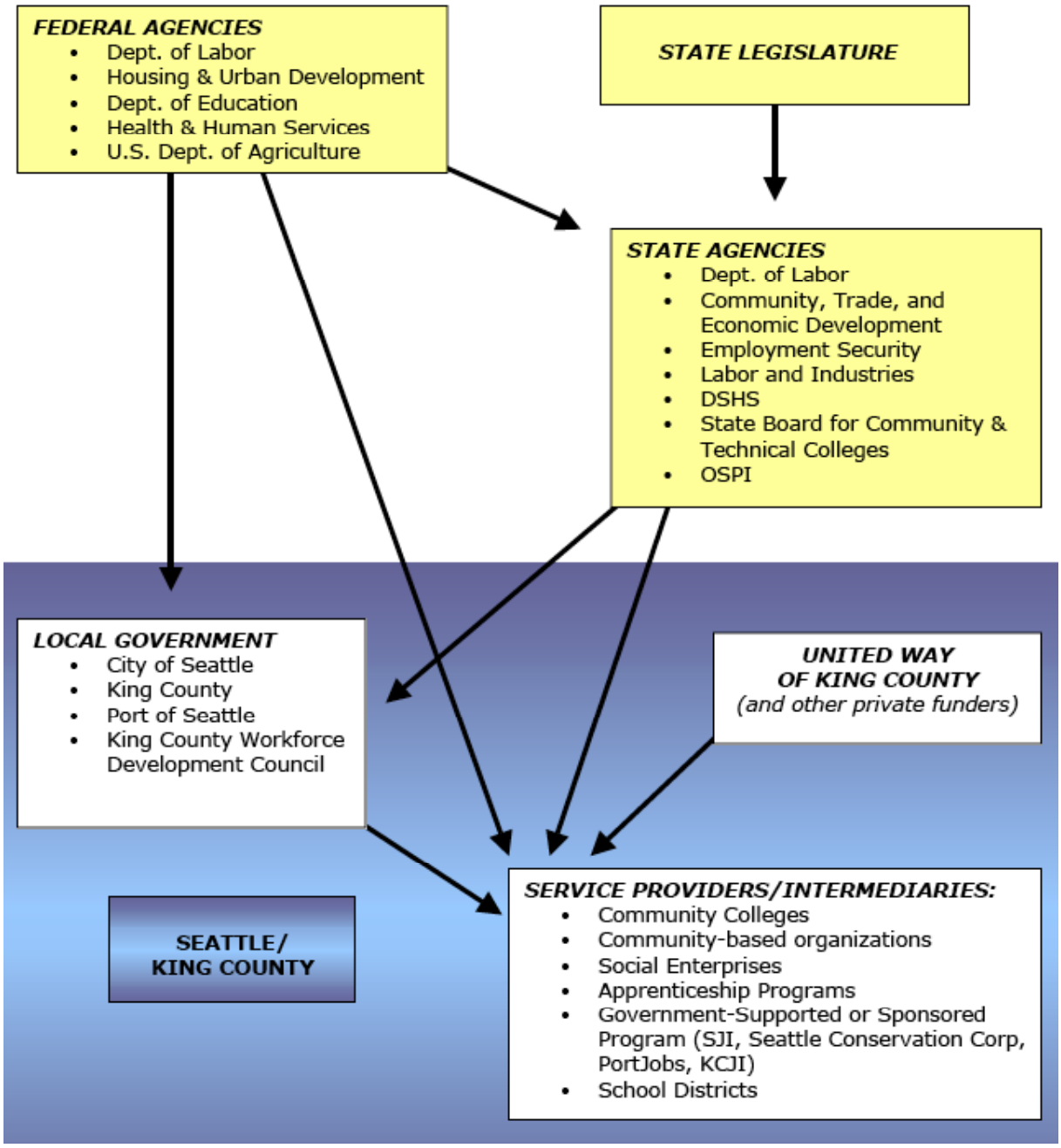

Table 1
Major Funders and Associated Programs within the
King County Workforce System (2005 expenditures)

Funder (2005 Expenditures)	Programs
King County ($25 million) (King County receives WDC funds for some of these programs)	• Workforce Investment Act (WIA) Adult Employment (WorkSource System) • WIA Dislocated Workers • King County Jobs Initiative • Community Center for Alternative Programs (CCAP) Employment Programs • Regional Support Network Employment Services Center (mental health) • Developmental Disabilities Supported Employment • King County Veterans' Incarcerated Project • Community Development Block Grant Employment Programs • Renton Technical College Custodial Industries Program • Youth Employment • Courts
City of Seattle ($8 million)	• Seattle Conservation Corp • Connections at the Morrison • Youth Employment • Senior Employment • Community Court • Homeless Intervention Project (federal dollars passed through to WDC) City-Funded Programs (or intermediaries): • Seattle Jobs Initiative • Casa Latina • Port Jobs • Worker Center
Port of Seattle ($500,000)	Port-funded programs: • PortJobs (also gets city, county, and grant funds) Total budget about $1 million • Airport Jobs (a program of PortJobs).
King County Workforce Development Council ($16.7 million) (WDC provides funds to King County for some programs)	Adult: • H1-B Health Care, Info. Tech. • Homeless Intervention Project (with funding from City of Seattle) • Inc. Worker – BioTech • Projects with Industry • Literacy Works • Adult Pre-Apprenticeships • New Emerging Apprenticeships • WIA Adults • WIA Dislocated Worker Services • Health Work Force Institute Senior: • Senior Community Service Youth: • Employment Foster Teen Advocate • WIA Youth Services • Drop Out Prevention • In-Demand Scholar • Nursing Pathways for Youth • Health Workforce

United Way of King County ($1.7 million) other private funders	• Numerous community-based organizations

Homelessness and Employment
Work opportunities are critical to helping individuals and families recovering from homelessness increase their housing stability and economic circumstances. Taking Health Care Home, in their July 2006 report on employment and homelessness, produced the following tables to describe the demographic dimensions of homeless job seekers and a typology for job seekers who are homeless that offer information essential to enhancing existing resources and services for this target population.

Table 2
Demographic Data on Homeless Job Seekers in Seattle/King County[57]

Category	*Data*
Total homeless adults in King County (2004 One Night Count Data)	7,994
Annualized figure (utilizing a multiplying factor of 3.0)	23,982
Percentages of those with no employment who have one or more disabilities/special needs that require additional treatment and/or supportive services in order to achieve stable employment:	
• Alcohol and Drug Abuse Issues (50%)	11,991
• Serious and Persistent Mental Illness (23%)	5,516
• Developmental Disabilities (1%)	240
• Physical Disability as primary problem (2%)	480
• HIV/AIDS (3%)	719
• Learning Disabilities (minimal estimate: at least 50%)	11,991
Geographic Distribution/Last Permanent Address	
• Seattle (56%)	13,430
• North King County (3%)	719
• East King County (8%)	1,919
• South King County (11%)	2,638
• Other Washington State (9%)	2,158
• Out of State (13%)	3,118

Some of the data contained in this table requires additional explanation:

- Not all of the adults who are homeless in King County are ready, able or interested in work. Some experience extensive disabilities and circumstances that make readiness for work a long-range goal. Nevertheless, the subcommittee determined it would be most accurate to include all adults who are homeless in the pool of individuals who might eventually be ready for and/or interested in some level of employment activities.
- A total of 22% of the individuals identified in the King County point-in-time count reported that they are already employed. Despite this statistic, these adults have been included in the table above. These individuals are, for the most part, not likely to be employed on an ongoing basis in regular work, and so are likely in need of assistance and support in moving towards more stable jobs situations. At the very least, despite the fact that they are employed, they are still homeless and will need assistance in finding and securing housing.

[57] A Report on Developing Community Employment Pathways for Homeless Job Seekers in King County & Washington State, The Taking Health Care Home Project, July 2006

- The data related to the prevalence of various disabilities listed in this table has been derived from a variety of sources at the local, state and national levels. Where feasible, we have used local estimates for the incidence of specific conditions. For example, although there is no reliable data related the number of people who are homeless who have learning disabilities, The Learning Center instructor at South Seattle Community College reports that, of those individuals referred to the Community College (which is already a somewhat skewed sample), at least 50% have a low IQ, ADD or Dyslexia. Although this is likely a low estimate for these types of disabilities among people who are homeless, this statistic has been utilized here. The prevalence of serious and persistent mental illness used here (23%) is derived from a study conducted by the U.S. Conference of Mayors, which included data from Seattle. The figures on the incidence of HIV/AIDS were developed in consultation with the King County Ryan White Program Manager.

Table 3
Job Seekers Who Are Homeless By Typology

Job Seeker Features (Typology)	Example of Individual and Family	Estimated Number of Job Seekers (Annual)
Group 1: High Amount of Employment Assistance and Case Management Anticipated Job Seekers lacking a vocational goal; limited or no work history; may be without PSH or may be a tenant of PSH; work inexperienced; not likely to pass Work Readiness Credential; needs case management to meet demands of living in supportive housing or shelter; self-care skills lacking	***Individual:*** Person with schizophrenia and co-occurring substance use disorder with history of long-term homelessness. Would like to be able to work 10-20 hours a week to earn extra income. ***Family:*** Mother with two young children who has left a 10-year marriage with a physically and emotionally abusive spouse. Experiencing severe PTSD, homelessness, a lack of job experience and limited skill managing economic resources. Has recently tested positive for HIV.	4,800
Group 2: Moderate Amount of Employment Assistance and Case Management Anticipated Job Seekers with ambition for employment; may have low basic skills and few workplace skills; uncertain or unsuccessful in locating a job; does not know how to present well for interview; could benefit from customized employment and/or supported employment; may lack child care needs	***Individual:*** Single male with history of poly-substance abuse and homelessness. Has completed 90 days of sobriety and is engaged in chemical dependency treatment under the auspices of the King County Drug Court. Actively seeking full-time work but has poor work history due to substance abuse and has been unable to locate permanent housing due to criminal history. ***Family:*** Young couple with an infant child. Couch surfing with family members. Neither has completed high school; Husband has problems with alcohol and has recently completed chemical dependency treatment. Wife has anger management issues secondary to childhood sexual abuse. He faces 6-month sentence for an old vehicular assault (DWI) charge; she has been expelled from Job Corps for behavior problems. Both are unemployed, but want to be working.	4,800
Group 3: Low Amount of Employment Assistance and Case Management Anticipated Job Seekers with a job goal or expressed interest; lacks occupational skills for preferred job; need moderate case management; lacks child care or has dependents; one time-limited benefits; may have language challenges; can negotiate with systems to get benefits with minimal assistance	***Individual:*** Hispanic warehouse worker with limited English language skills and recently laid off during a period of downsizing in his company. He has become depressed and is drinking heavily. He has been evicted from his housing and is experiencing his first episode of prolonged homelessness. His wife is seeking a divorce, custody of their children and regular child support. He is motivated to find work, but has been unsuccessful to date in his job search. ***Family:*** Recent "legal" immigrant family from East Africa: Husband, wife, Two children: 3 and 1-year old. Living with relatives on an interim basis, but need their own place due to space limitations. Limited English language skills. Husband would like to work driving a taxi, but has been unable to find work in this area. Wife would like part-time job, has a sister who can provide some child-care to free up her time. Motivated, but not connected to any services, entitlements or supports.	14,400

Individual job seekers in each of these three typologies may be seeking different types and levels of employment. The Supply Side Subcommittee identified a continuum of employment opportunities that would, ideally, be available to people who are homeless and have a variety of different skill levels and degrees of readiness for work. These are:

- ***Occasional part-time employment, at the (irregular) times that people are ready and want to work.*** Existing opportunities for this type of work includes Labor Ready (day labor), Casa Latina (which includes some ESL training) and the Millionaire Club (which includes some hygiene and meal services). Not many employers will hire individuals who only want to work "when they feel like it," but this is an important category or level of work for many individuals, especially those entering the work force for the first time, or for after a long delay related to absence or disability. At present, case management services from other systems are not linked to these services, but could be integrated with Labor Ready, Casa Latina and Millionaire Club in some fashion.
- ***Regular part-time work that is on a regular schedule at known locations and specific work activities.*** Part-time work of this nature offers a pathway into the established work force and can lead to full-time employment over time. This part-time work can be for temporary placement agencies, but are more likely to result from the efforts of employment program staff and others going into the field to recruit employers and negotiate the terms on a placement-by-placement basis. This work can include seasonal work at sports arenas and Seattle Center, janitorial/cleaning crew work, etc.
- ***Full-time employment.*** This type of work may be an immediate goal for the higher-functioning population of people who are homeless or a longer-term goal for some of the individuals who enter the work force initially through occasional or regular part-time work.

Existing Employment Programs Targeting People who are Homeless

The **WorkSource** system does not track the characteristics of individuals who use the self-directed services, so the extent to which they are being used by homeless people is unknown.

The **Homeless Intervention Project** (described below) served 350 individuals during the 2005-06 program year. Of this total, 124 were chronically homeless, 308 had substance abuse issues, 118 had mental illness, 86 were ex-offenders, and 64 were disabled.

The Millionaire Club provides the following demographic information about those who participate in their employment programs:

- 90% male
- 30-40% chronically homeless
- ethnicity is approximately 1/3 each African American, Caucasian and Hispanic
- approximately 15% are veterans
- a significant portion has disabilities and a high prevalence of addictions.

Key Illustrative Programs

Homeless Employment Programs

Homeless Intervention Project (HIP): A best practice supported employment program serving homeless individuals in King county. The project is a partnership between the Workforce Development Council with four community agencies: YWCA, FareStart, Seattle Conservation Corps (SCC) and Community Psychiatric Clinic (CPC). These agencies provide case management, direct support and employment training services for homeless adults. Outcomes for the 2005-06 program

year included 63% employed at exit, 84% retained employment three months after exit, 63% had upgraded housing by exit, and 78% had upgraded housing by three-month follow-up.

- CPC serves homeless adults with mental illness. Clients receive a 30 to 90 day paid work experience focusing on basic transferable work skills, as well as individualized job placement and retention services based on the supported employment model.
- FareStart prepares homeless adults for employment in the food industry through a rigorous 16 week, 35 hour per week program. Program design includes technical skills, job readiness and direct support services.
- SCC serves primarily single homeless adults with multiple barriers to employment, particularly ex-offenders and those overcoming substance abuse. Clients receive a year of paid work experience in a variety of public works projects, as well as housing stabilization services and comprehensive support services.
- YWCA's HIP program has two tracks: 1) Training-to-Employment, in which the enrolled participant receives training, paid for by the program, job placement, and three months of retention/wage progression case management; and 2) Direct Placement for individuals who are more work-ready. Enrolled participants are placed directly into employment and receive six months of retention and wage progression case management.

Metropolitan Improvement District Ambassador Program employs 60 ambassadors to patrol the streets of downtown Seattle, providing information to visitors, security escorts, and maintaining a clean urban environment. Many are homeless or formerly homeless. They also accept non-violent offenders referred by Community Court of Seattle Municipal Court.

Connections at the Morrison is a comprehensive daytime service and referral center operated by Downtown Emergency Service Center, providing specialized services for homeless men and women seeking employment and affordable housing. Connections case management staff conducts assessments to determine barriers to employment and housing and develop a plan to help the individual attain their goals. DESC is creating partnerships to expand other services on site, including regular visits from the Veterans Administration and expansion of employment through Seattle Job Initiative.

The Millionaire Club runs a dispatch center that works with businesses and individuals to match qualified workers to job sites. In most cases they work as a matching service, and workers are not covered. They can also act as an agency if needed and provides a variety of other support services.

Issues and Gaps for Job Seekers who are Homeless

The WDC One-Stop system is not easily accessible to homeless people, and others who have significant barriers and may require more assistance and support than that system is currently designed to provide.

Employment assistance for returning veterans is available on a limited basis, but there is no centralized, easy way to access programs.

Employment services for homeless people

There are a variety of employment programs for homeless people. Findings from the Taking Healthcare Home report, *"Developing Community Employment Pathways"* found that:

- Homeless Employment programs are an excellent resource to move people out of the homeless system toward greater integration into mainstream housing and employment. Some individuals may move towards employment instead of seeking disability benefits

- Many of the homeless employment programs serve individuals with significant drug and alcohol abuse issues. Many of these programs have limited resources available to support these individuals actively using, in early recovery or needing relapse prevention.
- A significant number of individuals have mental health needs but do not have the severity of symptoms to qualify for Medicaid; therefore, they do not have access to public mental health services.

Existing Employment Programs Assisting People in the Criminal Justice System

Community Centers for Alternatives Programs (CCAP): provides assessment, job readiness training and educational programs for adults participating in "court ordered" programs. Programs include numerous partnerships:

- South Seattle Community College (SSCC)/Workforce Development Life Skills-to-Work Program – A partnership between CCAP and SSCC that provides comprehensive re-entry, education and employment services to ex-offenders in Seattle/King County. The program includes referrals for transitional housing, transportation, education and other related support services.

- CCAP – Community Psychiatric Clinic is an intensive outpatient services at CCAP with chemical dependency counselors. The curriculum includes employment training for reentry population.

- Regional Support Network Employment Services Center provides engagement activities, assessments, job readiness training, referral to the state Division of Vocational Rehabilitation, job placements, and on-going job support services after employment.

Evidence-Based Practices: Employment Services for Homeless Job Seekers and Other At-Risk Populations

Target Population	Purpose/Desired Outcomes	Practices/Models	Source/Citation
Broad range of job seekers, including people who are homeless, veterans, etc.	Creation of accessible, user-friendly, One-Stop Career Centers that create a welcoming environment for all job seekers at a variety of skill levels and with a range of job interests and abilities	The Pima County Jackson Employment Center (JEC), Tucson, Arizona Services include assessment, employability workshops, skills training program, case management, transportation, day care, housing referrals, medical referrals, provision of work-related equipment and uniforms, job retention and aftercare strategies, etc.	***Taking Health Care Home: Developing Community Employment Pathways***, July 2006. Local contact: Steven Nelson, Jackson Employment Center, Tucson, AZ. Website: www.pima.gov/CED/CS/OneStop/JacksonEmpCent.html
Broad range of job seekers, including people who are homeless, veterans, etc.	Creation of accessible, user-friendly, One-Stop Career Centers that create a welcoming environment for all job seekers at a variety of skill levels and with a range of job interests and abilities	The JobNet One Stop Career Center "Enhanced Services" are available for higher-need clients, including case management, benefits counseling, individualized job referrals, post-placement support and system navigator services. Combines employment services with Shelter Plus Care housing opportunities.	***Taking Health Care Home: Developing Community Employment Pathways***, July 2006. Local contact: Dennis Rogers, Boston Private Industry Council, dennis.rogers@bostonpic.org, website: www.bostonpic.org
Broad range of unemployed and underemployed job seekers, including people who are homeless, veterans, etc.	Connection of unemployed and underemployed workers who are motivated with specific employers in the community	Primavera Works Case managers help with job search planning, referrals for housing, health needs, food and other services.	***Taking Health Care Home: Developing Community Employment Pathways***, July 2006. Local contact: Primavera Works, (520) 882-9668
Homeless job seekers	Provision of broad array of work-related services as part of the local Workforce Board programs offering One Stop Career Services for people who are homeless	Service of the Emergency Aid Resource Center for the Homeless (SEARCH, Inc.) Services include core Workforce Investment Act services, as well as a job bank, literacy program, GED program, culinary training program and workforce re-entry program.	***Taking Health Care Home: Developing Community Employment Pathways***, July 2006. Local contact: Kate Lyons, SEARCH, at: klyons@searchproject.org website: www.searchproject.org

Target Population	Purpose/Desired Outcomes	Practices/Models	Source/Citation
Individuals with serious mental illness and histories of homelessness who are seeking work	Provision of employment services of the Private Industry Council (PIC) and community-based organizations serving individuals with histories of long-term homelessness and a disabling condition	Project HomeWork: A partnership supported by the U.S. Departments of Labor and HUD, led by the Boston PIC and fifteen partners from state agencies, city departments and community-based organizations	***Taking Health Care Home: Developing Community Employment Pathways***, July 2006. Local contact: Dwaign Tyndal, Boston Private Industry Council, dwaign.tyndal@bostonpic.org. Website: www.bostonpic.org
Individuals with Developmental Disabilities who are in need of supports to work in community settings	Provision of employment services through private providers to develop jobs, place individuals with developmental disabilities into jobs, and maintain persons in employment over time.	King County Developmental Disabilities Division Supported Employment Program: A nationally recognized program funded by the KCDDD utilizing a network of community providers.	***Case Study of High Performing States: Washington State*** ***Institute for Community Inclusion*** Pushing the Integrated Employment Agenda: Case Study Research in Washington State *http://www.communityinclusion.org/article.php?article_id=173* *Local contact: Ray Jensen, Director, KCDDD* *Ray.Jensen@metrokc.gov.* *Website: www.metrokc.gov/dchs/ddd*
Job seekers who have past or present involvement in the criminal justice system	Pioneer Human Services serves people formerly incarcerated or substance abusers; combines correctional, substance abuse, mental health, housing and employment services to improve each client's quality of life.	PHS offers a strong employment component to its treatment services continuum, through contractual relationships with businesses like Nintendo, Boeing, and Microsoft, the Department of Corrections, and with local community colleges and state certification programs to help their clients get good jobs. A UW study found PHS clients had lower recidivism rates, higher earnings and work more hours than a comparison group.	***Outside the Walls: A National Snapshot of Community-Based Prisoner Reentry Programs*** ***Annie E. Casey Foundation*** http://www.aecf.org/publications/data/9_outside.pdf Local contact: Larry Fehr, Pioneer Human Services, 206-766-7023
Job seekers who have past or present involvement in the criminal justice system	Mentally Ill Offender/Dangerous MIO Programs help people coming out of prison find work opportunities to turn their lives around and live safely and successfully in the community.	Both programs work to create a continuum of care that provides mental health and substance abuse treatment services along with housing and employment services and supports. Partners include the State Division of Vocational Rehabilitation, community colleges and employment assistant agencies to serve as part of the treatment team.	***Outside the Walls: A National Snapshot of Community-Based Prisoner Reentry Programs*** ***Annie E. Casey Foundation*** http://www.aecf.org/publications/data/9_outside.pdf Local contact: Thomas Saltrup, DOC, 360-586-4371

Priority Investment Area 8:
Promote Healthy Development for At-Risk Children

Reduce the risk of future criminal behavior or dependency problems, or both, by promoting healthy child development for children most at risk.

Overview

The following summarizes some of the major programs and initiatives in King County that are focused on fostering the healthy mental, emotional, and social health of young children between the ages of birth to eight, who are growing up in families that can be considered "at risk" because one or more of the following conditions describe the family:

- mother is an adolescent
- only one parent lives in the home
- a parent suffers substance abuse and/or mental illness
- family is homeless or has unstable housing
- domestic violence exists in the household
- a parent is involved in the criminal justice system
- child is in foster care or under state supervision.

In general, these programs strive to:

- reduce parental stress
- increase parenting skills and understanding of child development
- foster the parent-child relationship
- reduce the social isolation of young mothers.

Some of the programs, such as home visiting, also work with parents to develop their own plans and link them to employment services and mental health or substance abuse treatment programs.

This review of current status seeks to highlight examples of child care programs that are grounded in their ethnic community or provide a unique combination of services.

This document does not offer a review of the well-established Head Start and Early Head Start programs, which are found across the county and are a critical component of the effort to raise healthy children. There are also a number of relatively new initiatives - spearheaded by the Governor's Office, the Gates Foundation, SOAR and others - that are working to boost early education and healthy child development through public and private partnerships and a variety of venues including child care and pre-school programs. These are also not reviewed here, but should be taken note of, as these efforts ultimately must dovetail with early intervention and prevention programs. Effective early education, which prepares children to be ready for and successful in school, is also dependent on stabilizing families and strong parent-child relationships.

Populations Served

The focus of this review, and the target of the investment strategies in the plan, is children from ages 0-5 and their parents (with a few programs targeting children up to age eight). Newly heightened awareness of the importance of the early years of a child's development on their future success suggests that the 0-5 population is the optimal target for intervention work.

We also know that prevention and early intervention strategies, in general, work best at moments when an individual or family is undergoing a transition. Therefore, first-time mothers are also a focus.

Left out of this review, but not forgotten, are children at other transition points, such as when children enter middle school. These programs and opportunities are important and should be supported through other efforts.

Key Issues

Cultural Competency

The local child and parent development programs profiled here serve a diverse population of mostly young, first-time parents. Immigrant and refugee families, as well as communities of color, make up a large percentage of families served. In an effort to be representative of the population they serve, programs seek to employ bilingual and bicultural staff. Truly client-centered programs encourage clients to work in partnership with staff and volunteers to set and achieve goals, which are meaningful to their success as parents, thereby ensuring program relevancy to all participants.

Access to programs

Most of the programs described below are provided at no cost or minimal cost to parents and children. Most families are referred to services through the health care system, schools, and public and private social service agencies.

Evaluation

Outcomes evaluation of prevention and early interventions can only be done over a period of many years. In aggregate, the use of these interventions and programs are expected to result in a reduction in the need for intensive services, a decrease in child abuse and neglect, and an increase in the number of children who succeed in school.

Gaps in Services and System Coordination

- Certain areas of King County - in particular Federal Way and Auburn - have populations of high-risk first-time parents that are not served or underserved due to lack of program availability.
- Key to the success of all home visiting programs is the role the home visitor plays as mentor and trusted advocate for the parents. The lack of credentialed bilingual and bicultural staff in certain programs poses a gap in cultural competency best practice and leaves certain groups underserved.
- Program models are limited in scope and capacity to meet the inter-connected needs of young families. At-risk families are deeply impacted by an array of systemic issues involving housing availability, education, and economic supports. Programs designed to focus on supporting healthy family functioning and development are stretched constantly to address these inter-related issues.
- Not all targeted high-risk first-time parents engage in services. Some of the most in-need parents are least likely to engage due to issues of homelessness, involvement with the criminal justice system, chemical dependency issues or immigration status.
- Better coordination with the DCHS Developmental Disabilities Division and other programs could lead to earlier identification of developmental delays and a greater integration of services for the child and family.

Examples of Services and Programs

It is not possible here to catalogue all the services and programs available to families of young children. The following describes the key programs and services in King County, which are targeted to families of very young children who are at risk for being unsuccessful in school and having contact with the child welfare or criminal justice systems.

Home Visiting Programs

Program	Serves	Focus/Location	Provided by	Funding	Goals
Healthy Start	Parents must be under 23 and pregnant or parenting their first child under six months of age at referral. They can be enrolled until the baby is three years old. Serves 220 families at any given time.	North and Eastside Healthy Start is a home-based support program where young parents learn parenting skills, how to plan for their own future and how to access community resources. Social events are offered to reduce social isolation. Program includes a volunteer parent-mentor component, and uses a "parents as teacher" evidence-based approach for teaching parenting skills.	Collaborative program of Friends of Youth and Children's Home Society of Washington	King County Family and Children Commission Children's Home Society Costs - $1285/year/family	– reduce incidence of domestic violence, child abuse, and neglect in the home – link children and pregnant mothers to a medical home – decrease parental stress – increase parenting skills
Nurse Family Partnership – Best Beginnings	Pregnant and parenting low-income first time mothers. Serves 269 families at any given time.	An evidence-based program designed by Dr. David Olds. Serves women in Seattle, Renton, Auburn and Kent. Participates in Washington State Consortium of Nurse Family Partnerships, which works to assure fidelity of program implementation, and provides technical and training resources.	Public Health–Seattle & King County	Medicaid & other federal funds, Cities of Seattle and Kent, and King County Children and Family Commission (KCCFC). Costs $6000 per family per year	– reduce incidence of domestic violence, child abuse, and neglect in the home – link children and pregnant mothers to a medical home – decreased percentage of low-birth weight babies – decreased smoking in mothers – increased rate of breast feeding – increase parenting skills

Program	Serves	Focus/Location	Provided by	Funding	Goals
Early Intervention Program	High risk pregnant and parenting low-income families. Serves up to 100 families at a given time.	Ensures high-risk mothers receive individualized support as a well as access to support groups, education groups, and information and referral. Project works to improve the system coordination by ensuring families use existing services and avoid duplication of services.	Highline Medical Group	Partnership of Public Health, Highline Medical Group, and Highline School District. Costs $1220 per family per year	– reduce incidence of domestic violence, child abuse, and neglect in the home – link children and pregnant mothers to a medical home – improve self-sufficiency skills - increase parenting skills
Next Generation	Homeless teen parents and Latino teen parents. Will serve 75 parents.	New program. Will include home visits, employment training, parent support and education, nutrition, well baby care, and will involve both the baby's fathers and the parents of the teen parent(s). Will serve Seattle and South King County.	Partnership of El Centro de la Raza, Children and Family Commission, Parents Trust, UW Policy Center, Children's Home Society, and Public Health-Seattle & King County	5 year federal grant.	

Parent and Provider Education and Skill Building

Program	Serves	Focus/Location	Provided by	Funding	Goals
Promoting First Relationships	Children 0-3 years, through the training of child care providers, case managers, counselors, etc. Have program for families transitioning from homelessness to stable housing in Pierce County and other statewide programs, including for infants in foster care.	An evidence-based program that trains service providers in the use of practical, effective strategies for promoting secure and healthy relationships between caregivers and young children (birth to 3 years). Features of the training program include: - Videotaping caregiver-child interactions to provide insight into real-life situations. – Giving positive feedback that builds caregiver competence with and commitment to their children. – Focusing on the deeper emotional needs underlying children's challenging behaviors.	Kindering Center and others. Training is available to childcare providers, but information about where it is being used in King County is not readily available.	Gates Foundation Annie E. Casey Foundation State DOH National Institutes for Mental Health (NIMH)	Secure and healthy relationships between infant/toddler and their parent or other caregiver.
The Incredible Years	Children 4-8 years, with behavioral problems, including unusual aggression.	An evidence-based program that includes three curricula - one for parents, one for teachers, and one for children – that can be used alone or in combination with each other.	University of Washington Parenting Clinic Selected Seattle area Head Start Programs and Seattle elementary schools	Multiple Federal Grants	To develop emotional and social competence in children and to prevent, reduce, and treat behavioral and emotional problems in young children.

Program	Serves	Focus/Location	Provided by	Funding	Goals
Parent-Child Interactive Therapy (PICT)	Children 2-8 with behavioral problems such as aggression and tantrums that are interfering with the child's success outside of the home and creating chaos in the home.	An evidence-based program, in which parents are taught specific skills to improve their interaction with their children. They then have the unique opportunity to practice and master these skills with their children in supervised sessions.	Encompass and Child Haven f(or parents) Children's Response Center (for children referred by the Court or DCFS) King County Sexual Assault Resource Center provides PICT training for persons working with families.		– improvement in the quality of the parent-child relationship – decrease in child behavior problems with an increase in pro-social behaviors – increase in parenting skills, including positive discipline – decrease in parental stress
Second Step	Curriculum extends from preschool to middle school. In this instance, it is for pre-schoolers of primarily Asian immigrant families.	A SAMSA model program, the curriculum focuses on increasing empathy, impulse control and problem solving, and anger management in the classroom. A parenting component is also available.	Denise Louie Education Center		

Examples of multi-faceted programs for children with special needs

Program	Serves	Focus/Location	Provided by	Funding	Goals
Daily Therapeutic Child Care	Abused and neglected and other at-risk children between the ages of one month and five years, who have been referred by Child Protective Services and Child Welfare services. Also children whose parent(s) are enrolled in outpatient programs for chemical dependency.	Provides individually focused care to provide predictable, nurturing, and developmentally supportive experiences. Includes monitoring of home environment and home visits, developmental and emotional/social status screening.	Childhaven	DSHS United Way of KC Grants/private donations	
CHERISH	Children ages 0 – 3 who are in foster care, and their care givers	Provides complete developmental and social/emotional assessment, a therapeutic home-visiting program, support group for foster parents and relative care-givers as well as individual counseling if needed, and the Stepping Stones preschool class for children age 18-30 months.	Kindering Center		
Birth to Three Developmental Center	Children from 0-3 with developmental disabilities in South King County and Pierce County	Offers developmental screening, evaluation and assessment, OT and PT, speech and language therapy, oral motor and feeding therapy, early education and play groups, and family education and support programs.	Network of service providers	Area school districts, King County Developmental Disabilities Division, United Way City of Federal Way, Pierce County Human Services, Insurance & Medicaid, grants and donations.	

Evidence-Based Practices

Target Population	Purpose/Desired Outcomes	Practices/Models	Source/Citation
Children, ages two to eight, at risk for and/or presenting with conduct problems (for example aggression, defiance, oppositional or impulsive behaviors.)	The program goals are twofold: 1) to develop comprehensive treatment programs for young children with early onset conduct problems and 2) the development of cost-effective, community-based, universal prevention programs that all families and teachers of young children can use to promote social competence and to prevent children from developing conduct problems in the first place. The programs have been shown to result in reduced parental depression and increased parent self-confidence; improvement in positive family communication and problem solving; reduced child conduct problems; and increased school readiness.	*The Incredible Years*: a comprehensive set of curricula for parents, teachers and children designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 4 to 8 years). They address multiple risk factors, which have been shown to be related to later development of delinquency, substance abuse and violence. These include child risk factors (e.g., language and learning delays, attention deficit disorder, conduct problems, lack of social skills), family and parenting risk factors (e.g., harsh and inconsistent discipline, poor monitoring, lack of parental support, poor relationship with teachers and schools) and school risk factors (e.g., teachers classroom management skills, academic difficulties, classroom aggression, playground bullying, peer rejection and deviant peer groups).	Developed by Carolyn Webster-Stratton, Profession Parenting Clinic, UW http://www.incredibleyears.com/ http://www.promisingpractices.net/program.asp?programid=134 Cited as a Model Program by SAMHSA, and Blueprint Program by Center for the Study and Prevention of Violence, University of Colorado
Children ages two to eight at risk for and/or presenting with conduct problems (for example aggression, defiance, oppositional or impulsive behaviors.)	Goals are to improve quality of the parent-child relationship, decrease child behavior problems and encourage "pro-social" behaviors, increase parenting skills using positive approaches, and decrease parent stress. It has been adapted also for work with physically abusive parents and shown to decrease re-reporting of abuse. It has also been shown that changes in child behavior after parent training are sustained over a period of time.	*Parent-Child Interactive Therapy (PICT):* Parents or other caregivers (such as foster parents, grandparents, etc.) are taught specific skills to improve their interaction with their children. They then have the unique opportunity to practice and master these skills with their children in supervised sessions. Program is 12-20 weeks and is mastery based rather than time limited.	National Child Traumatic Stress Network: http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/PCIT_fact_sheet_2-11-05.pdf Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3). Hood, K. K., & Eyberg, S. M. (2003). Outcomes of Parent-Child Interaction Therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32(3)*, 419-429.

Target Population	Purpose/Desired Outcomes	Practices/Models	Source/Citation
Preschool age children	Promote social and cognitive development in at-risk children. Children participating in initial program were evaluated at age 27 compared to a control group and program participants had higher rates of high school graduation, higher weekly earnings, higher percentages of home ownership, lower rates of receipt of welfare assistance as adults, fewer out of wedlock births and fewer arrests.	*High Scope/Perry Preschool Model:* Uses well trained teachers, small student to teacher ratios, and regular home visiting by teachers. Based on Piaget's theories, children are encouraged to initiate activities, explore and control their environment in order to learn and stimulate creativity.	http://www.highscope.org/Research/PerryProject/perrymain.htm Designated as a model program by SAMSHA.
Children birth to three	Support healthy social –emotional development, through secure, responsive and nurturing relationships with parents and care givers. We train service providers in the use of practical, effective strategies for promoting secure and healthy relationships between caregivers and young children (birth to 3 years).	*Promoting First Relationships*: Trains service providers including child care providers in practical strategies for promoting healthy parental and care giver relationships. Caregivers learn to recognize and respond to child's emotional needs. Program has been adapted for caregivers who are family, friends or neighbors, through funding from Annie E. Casey Foundation.	Developed through UW Department of Family and Child Nursing. http://www.son.washington.edu/centers/pfr/index.html
Children birth to three	Foster social and intellectual competence to prepare children for success in school. Counteract the impact of profound poverty on family. Long range outcomes have been shown to be higher scoring by children on Stanford-Binet Intelligence scale, less destructive behavior and over-activity.	*Houston Parent-Child Development program:* Serves low-income Mexican American families with children under 3. Provides an intensive range of supports including Parent as Teachers training, biweekly home visits, English language classes, well child checkups, and group support and classes for mothers, and pre-school. Parental participation time is roughly 500 hours over two years.	Designated an effective program by SAMHSA. http://www.modelprograms.samhsa.gov/template_cf.cfm?page=effective&pkProgramID=124&section=description

Target Population	Purpose/Desired Outcomes	Practices/Models	Source/Citation
First time, low-income, young expectant parents	1) to improve pregnancy outcomes by promoting health-related behaviors 2) to improve child health, development and safety by promoting competent care-giving; and 3) to enhance parent growth and development by promoting pregnancy planning, educational achievement, and employment. The program also has two secondary goals: to enhance families' material support by providing links with needed health and social services, and to promote supportive relationships among family and friends.	*Family Nurse Partnership*: Intensive and comprehensive home visitation by nurses during a woman's first pregnancy, with continued follow-up for two years after the birth. It has resulted in a range of outcomes including decreased maternal smoking, decreased use of public assistance, decreased child abuse and neglect, fewer emergency room visits, delay in second pregnancy, and fewer arrests of the children by age 15.	Developed by Dr. David Olds http://www.nursefamilypartnership.org/index.cfm?fuseaction=home Cited as a Model Program by SAMHSA, and Blueprint Program by Center for the Study and Prevention of Violence, University of Colorado
First time, expectant parents facing multiple challenges (e.g. elements that would add stressors to any home: single parent status, low income, substance abuse problems, victim of abuse or domestic violence, etc.	1) to promote positive parenting skills and parent-child interaction; 2) to prevent child abuse and neglect; 3) to ensure optimal prenatal care and child health and development; and 4) to increase parents' self-sufficiency. Outcomes have included: reducing child maltreatment; ensuring healthy child development; encouraging school readiness; promoting family self-sufficiency; and demonstrating positive parenting.	*Healthy Families America:* A national program based on Healthy Start and other proven practices such as the Nurturing Parent Program. Uses trained paraprofessionals who often come from the community being served in home visiting program and act as "Family Support Workers"	Specific programs, such as the Healthy Families, New York have been cited as proven or model programs. http://www.promisingpractices.net/program.asp?programid=147 http://www.healthyfamiliesamerica.org/home/index.shtml

Appendix C:
Stakeholder Input Summary and Presentation

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Stakeholder Input Summary and Presentation

INFRASTRUCTURE NEEDS

Coordination and Collaboration / Cultural Competency

- Invest in current coordination structures and strengthen them; develop strong partnership models; help organizations see the possibilities; build trust.
- Help small community-based organizations navigate the funding system.
- Help large organizations learn to be effective partners with smaller community based organizations - combining the data systems, fiscal accountability, evaluation capacity, human resources, etc. of the larger organizations with the cultural competency and innovation of the smaller organizations.
- Build connections and linkages to VA system and veteran's organizations.
- There is a need for a shared vision by leaders across the county for the continuum of care for chronically homeless adults and families.
- Use levy funds to pull together employment partners, possible co-location.
- Fund boundary spanners between networks, coalitions, and organizations.
- Create a lattice work/scaffolding on which services can be built.
- Build cultural competency across the service delivery systems.
- Levy funds must be able to measure and document levels of partnership that exist and that you want to create in local communities. We need to take levy resources and demonstrate how to do this in a few areas.
- Recognize that immigrant groups tend to be informal. Work with them to manage funds wisely.

Management / Governance

- Develop a regional governance structure for human services.
- Build capacity across the county so that services aren't concentrated in Seattle.
- Oversight Boards roles should include regional coordination and other concepts forwarded by the Healthy Families and Communities (HFC) Task Force.
- Recommendations of the HFC should be reflected in the Levy Service Improvement Plan.
- Structure that allows implementation at a local level, but coordinated.
- Get the right people from the right sectors on the levy oversight bodies. Avoid political appointees.
- Levy investments should focus and go deep, as well as attract $1 for every $1 spent.
- Use levy funds to leverage private philanthropy.
- Maintain sub-regional equity. Acknowledge that needs vary by subregion.
- There is an absence of leadership. Key funders and key policy managers need to sit down and create a vision that represents the political will to change. This applies to many areas, not just homelessness.

Service Delivery/Seamless Pathways

- Establish cultural navigators to provide support between systems.
- Provide wrap-around services.
- Create links between CJ, employment, business, and treatment.
- Develop single points of entry for services (link to CEHKC plan).
- Increase capacity of mental health services for residents of South King County.
- Coordinate outreach so that the extent of the problems and gaps in service are revealed.
- Break down silos and build incentives to move away from them. (e.g., create single point of entry or a consolidated access process – easy and straightforward access to help.)
- Get consultation on how best to expand outreach capacity and coordinated entry.
- Develop immediate back doors of housing and services when individuals leave jail or services.
- Break the cycle by getting people quickly qualified for GAU and SSI.
- Create expanded 24-hour outreach/case management.
- Need longer term supportive services to help people stay housed and employed.
- Focus on non-Medicaid populations who are falling through the cracks of the system (including meds) and build capacity with the mental health system.
- Invest in a common electronic medical record system across community clinics.
- Provide regional triage centers where assessments and immediate access to needed services is available.
- Build a model that is more proactive rather than reactive. The model should create allies at the front end, where outreach teams coordinate with and respond to the front door programs in an organized manner.
- Look at service delivery effectiveness in terms of using an array of small organizations vs. a few larger organizations with greater capacity to manage employment related services for higher need clients.
- Increase capacity across the human service delivery system to engage in the change work that the envisioned system requires.
- Integrate medical, substance abuse and mental health treatment so that clients don't need to figure this out.
- Increase access/expand transportation resources that allow individuals and families to connect with services.
- In less urban communities, integration of services means connecting with faith communities, schools and food banks.

Housing

- "Housing first" for chronically homeless; align with the Ten-Year Plan; issue a consolidated RFP for permanent housing.
- Develop strategies to reduce risks for landlords/housing providers, such as a respite model; provide rent subsidy and damage deposits through a revolving fund.
- Supportive housing with training/apprenticeship opportunities.
- Stabilize housing for families.
- Make sure that people are 'ready' for housing.
- Need safe place for people coming out of inpatient psychiatric unit.

- Interim housing for single parents.
- Replicate City of Seattle master leasing approach.

Non-Housing Capital

- Mobile health services for South King County homeless.
- Transportation in South King County to daycare, jobs, services - maybe via a system of vans.
- Mobile outreach van for homeless people in South King County.
- Basic technology infrastructure for Workforce Development Council (WDC) programs (technology replacement and maintenance).
- Help organizations expand their presence to other areas of the county (particularly north and south).
- Integrated Service Centers – two in north end are loosing space and could be co-located.
- Dental equipment/van or expanded capacity for Community Health Centers.
- Create the infrastructure that is needed to support seamless pathways.
- There is no funding to keep technology infrastructure going within WDC programs.

Planning

- Study more deeply who over-uses the emergency room and why, and what the overlap is to Healthcare for the Homeless (HCH). What is the potential role of primary care providers?
- Strategic planning across the different types of employment programs, to integrate services, articulate relationships, and establish a continuum of access based on need.
- Global community health plan mobilized by Harborview Medical Center (HMC).
- Support regional jail planning by the cities.
- Identify the model programs all over the county – replicate them and expand their capacity.

Training

- Build skills and expertise in existing organizations for cross-system coordination, prevention strategies, etc. Needs to be sustainable, as both staff and policies change.
- One way to enhance services across the systems is to build training programs for existing organizations.

Public Education

- Educate business community about need for and how to support people who have reached a milestone in their recovery that makes them ready to employ.
- Educate public that employment emphasis is an investment in people, not a social program.
- Use levy funds to stimulate community readiness and willingness to tackle homelessness.
- Change public focus on CJ system from incarceration to public safety and community well-being; demonstrate effectiveness of jail diversion programs, etc.
- Educate the public about the range of services being provided by levy funds – both veterans and others in need.

ONGOING STRATEGIES

Reducing Criminal Justice Costs

- Expand REACH and similar programs for increased case management, job readiness, etc.
- Create regional crisis triage centers that divert people to treatment and housing rather than jail.

- Create set-asides in housing so offenders are discharged to housing with connections and services beginning while incarcerated/or in specialty courts, e.g., community court, drug court, etc.
- Help offenders re-acclimate/start working with them before discharge.
- Get released offenders directly into drug treatment – no waiting.
- Need diversion programs and strong case management.
- Use Community Clinics as a resource to keep people connected to their other supports.
- Collaborate with law enforcement to redirect as many arrests as possible to therapeutic interventions and services.
- Address the needs of women with children, e.g., family reunification, housing, continuing alcohol or other drug abuse.
- Use levy funds to bolster mental health and drug court programs.
- In south King County, concentrate services in the 'hot spots' of juvenile justice encounters.
- Dealing with young people who are unemployed will have an impact on whether they get trapped in the criminal justice system.

Reducing Emergency Medical Costs

- Use community clinics as medical homes for chronically homeless – HMC clinic at Opportunity House may be a model for tying health care to housing.
- Fund behavioral health specialists for community clinics – they are trying to integrate behavioral health and primary care (would potentially affect CJ costs, early childhood prevention etc.)
- Have a mobile team of public health nurses, chemical dependency and mental health providers in transitional and permanent housing programs.
- Expand mental health services for people not covered by Medicaid.
- Expand the methadone program.
- Study interface of HCH, primary care and ER databases, not just for high-utilizers but to understand why people use the ER, and then develop strategies.
- Increase access to medical and dental coverage for uninsured adults.

Employment

- Move beyond the Work Source model - services are too limited, too focused on those who are employment ready, and not yet doing its part to help low-income or homeless people.
- Work with King County businesses to be part of the solution.
- Work with small businesses and provide incentives to train and hire individuals having difficulty finding and keeping jobs.
- Employers are crying out for workers – can we train homeless people for these jobs?
- Develop employment support models similar to Displaced Homemaker models.
- Teach English for the workplace. Refugees and immigrants are unable to function in entry level service jobs without this skill.
- Address issues of disabled vets within employment context; pilot best practice models for employment of disabled persons; create a partnership across employment and treatment systems.
- Look for ways to make expunging of criminal records easier (or create some sort of certificate) when the person has made a turn around.
- Immigrants need assistance with social security and documentation.
- See if one can partner with SEIU re: apprenticeship programs.

- Expand points of entry into employment and make the training tracks shorter with rewards like apprenticeships.
- Employment programs for homeless need to focus on building self-esteem and overcoming barriers.
- Deal with childcare and transportation as major barriers to maintaining employment.
- Lack of education (high school diploma or GED) is a huge barrier to employment. Add education components to employment programs for homeless and at-risk families.
- Fund dental services – serious dental disease can impact ability to get work.
- Job training opportunities posted at the community clinics and the Center for Career Alternatives.
- Provide intensive case management that addresses obstacles and develops work internships/apprenticeships.
- Integrate skills training with employment process, e.g., Automotive Training Program at Shoreline Community College that combines ESL with a two-quarter program that results in a living wage.
- Look to model program for employment of veterans in Tacoma.
- Engage the community colleges to align their systems with the community's skill demands.
- Need follow-up services to make sure people stabilize their employment.
- Deal with young people who have not graduated from high school or who have never had summer employment to help them find a reliable route into the workforce.

Veterans

- Integrate veterans and non-veterans systems.
- Create "One-Stop Shop" for veteran's services.
- Assist veterans to access services through the VA through effective discharge and case management.
- Look at creating a specialized veterans program at Work Source to link veterans to services.
- Create a Veterans' Affairs Office for South King County.
- Infuse staff with knowledge of both systems, or at least have VA outreach workers in shelters, etc.
- Look for ways to help veterans with 'bad paper' to reenter job and housing markets.
- Boost veteran support groups.
- Create housing opportunities where a veteran's PTSD will be tolerated.
- Hold the VA, including the Medical Center, accountable for the services they are supposed to be providing to veterans, particularly primary care.
- Expand veterans outreach outside of downtown Seattle, including mobile services.
- Services promote self-sufficiency.
- Provide transitional services for young adults returning from active duty.
- Advocate for all types of housing for veterans; wet, damp and dry.
- Do a pilot in King County to pool federal, state, county funding streams related to integrated services for veterans.
- Improve/enhance Web capabilities to provide more information and links to related services for vets.

Early Childhood Prevention

- Strengthen the primary relationship between parent and child.
- Need child care funding for homeless – it is being lost.
- Strengthen the skills and relationships between children and their formal and informal caregivers.

- Invest in Best Beginnings.
- Expand Head Start; partner with Early Head Start.
- Provide the fundamental components of early childhood development (early health, nutrition, attachment activities) for the most at risk kids, including abused, neglected and/or homeless kids.
- Deal with the kids inside homelessness.
- Parental support needs to be culturally appropriate if it is going to be trusted.
- Incorporate the Shoreline School District Early Development Indicators model to identify and evaluate how well the community is helping the child become ready for school.
- Build on existing models that are already underway, such as Bellevue Wrap Around, Redmond 'Neighborhood Schoolhouse', and Family Net; these projects are designed to demonstrate how to make the school the focal point for an entire neighborhood, build communities that involve families.
- Build the capacity of childcare programs to serve difficult children e.g. those with development delays, aggressive behaviors, emotionally disturbed.
- Target families where there are unmarried parents, such as those where one is in the military and deployed, teen parents or families where one parent is in prison.
- Balance prevention with urgent needs.

Other

- Use Levy to fund services not usually reimbursed, e.g., behavioral health, case management, advocacy, etc.
- Levy funds should leverage other dollars.
- Ensure that services touch all regions of King County.
- Focus on high impact services.
- Deal with the issues of people over 50 who have difficulty finding and keeping jobs or, when they are homeless, are likely to be higher users of emergency medical resources.
- Need information and training for families that relates to financial management; could involve employers in helping to build these skills.
- Pick one thing and do it well.
- Anticipate impact of baby boomers at risk of homelessness because they have no savings and no retirement.

King County

King County Veterans and Human Services Levy
Background Information on Stakeholder Input – May 2006

In November of 2005, the King County voters approved the creation of a King County regional human services levy to generate approximately $13.3 million per year for six years to implement human services for veterans, their families and other low-income residents of King County. On April 18, 2006, the Metropolitan King County Council approved an ordinance providing direction regarding the expenditures of this levy. Their directions include the creation of a Service Improvement Plan describing specific investments and strategies that are able to address the goals of the levy at the system, service and client levels for veteran and non-veteran populations in need. The goals are to:

- Reduce homelessness and emergency medical costs
- Reduce criminal justice system involvement
- Increase self-sufficiency by means of employment

The Service Improvement Plan will seek to address these goals by:

- Improving the coordination between, access to, and effectiveness of health, human services and housing programs for individuals and families in immediate need.
- Helping the community to identify and expand the most effective means of promoting healthy development for children most at-risk for dependency and criminal justice system involvement.

The overall purposes in addressing these goals are to:

- Provide a measure of safety, dignity and opportunity to those most in need and, thereby, to improve the overall quality of community life.
- Reduce the unsustainable growth of public safety, criminal justice and emergency medical costs affecting county, city and state budgets.

The levy identifies specific priority areas to guide the contents and scope of the Service Improvement Plan. These are:

1. Ensure access for veterans and their families to effective services and inter-system partnerships
2. Develop seamless, user-friendly pathways to coordinated and integrated services and housing
3. Expand capacity of supportive housing and “housing first” networks
4. Promote timely and appropriate sharing of client information
5. Provide increased access to and quality of Post-Traumatic Stress Disorder treatment
6. Expand impact of demonstrably effective recidivism-reduction programs by adding housing and employment components and/or increasing capacity
7. Add employment-related goals and services to existing programs
8. Promote healthy child development for children most at risk of future criminal behavior and/or dependency problems

As part of the process for creating the Service Improvement Plan, the Council instructed the King County Executive to gather information related to the above-stated goals from a broad range of community stakeholders throughout King County. A team of external consultants and County staff are now working to collect this input, prior to creating an initial draft of the Service Improvement Plan. We are actively seeking your participation in this process, and hope to learn about your perspectives on goal-related priorities that levy funds might be used to address.

In order to begin implementation of levy-funded activities as soon as possible, the County is working on a very tightly scheduled timeline to create the Service Improvement Plan. We will be back in contact with our stakeholder informants in early July to obtain feedback, (electronically), to the draft plan prior to submission by the Executive to the Council.

Thank you for your participation in this critically important planning process!

Stakeholder Input – May 2006

PowerPoint outline

King County Veterans and Human Services Levy

- Background
- Questions for Stakeholders

The Veterans and Human Services Levy

- Approved by King County voters in 11/05
- Provides $13.3 million per year for next 6 years.
- First year focused on capital improvements, information systems, training, equipment and one-time needs.
- After first year, $1M each year for capital improvements
- Funds split between veterans and their families, and other low-income populations in need.

Goals of Levy

- Reduce homelessness and emergency medical costs
- Reduce criminal justice system involvement
- Increase self-sufficiency by means of employment

Strategies to Achieve Goals

- Improve coordination between, access to, and effectiveness of health, human services and housing programs
- Help the community to identify and expand the most effective means of promoting healthy development for children most at-risk.

Overall Purposes

- Provide a measure of safety, dignity and opportunity to those most in need, thereby improving the quality of community life
- Reduce the unsustainable growth of public safety, criminal justice and emergency medical costs affecting county, city and state budgets

Process for Obtaining Stakeholder Input

- Reduce the unsustainable growth of public safety, criminal justice and emergency medical costs affecting county, city and state budgets
- Current activity: Creation of a Service Improvement Plan informed by stakeholder input
- County staff and consultants are meeting with a broad range of internal and external stakeholder groups and constituencies from mid-May to mid-June.
- Relevant existing plans and recommendations are being reviewed and studied
- Stakeholder feedback on the first draft Service Improvement Plan will be solicited in July of 2006, electronically, before the plan is finalized.

The Stakeholder Input

We Need:

- Ideas for the best use of one-time and ongoing levy funds to meet the goals, including:
- Combining existing resources or leveraging new resources to improve results
- Building new or expanding existing infrastructures to meet the levy's goals
- Developing new programs or systems, or strengthening those that already exist
- Promoting new partnerships between the veteran's system and other housing and human service systems

Core Question #1

What strategies do you recommend to reduce homelessness and emergency medical costs for:

- Veteran populations?
- Non-veteran populations?

Core Question #2
What strategies do you recommend to reduce criminal justice system involvement for:
- Veteran populations?
- Non-veteran populations?

Core question: #3
What strategies do you recommend to increase self-sufficiency by means of employment for:
- Veteran populations?
- Non-veteran populations?

Core question: #4
What strategies do you recommend to enhance or expand childhood interventions for those most at-risk for criminal behavior and/or dependency problems?

Next Steps
- Opportunities for additional stakeholder feedback will be made available for those not able to attend scheduled meetings
- Stakeholder feedback will be collected and reviewed for incorporation into the Service Improvement Plan
- The draft plan will be circulated electronically to stakeholders for review and comment (the week of 7/10.)

Thank you for your time and input!

King County Veteran/Human Services Property Tax Levy
Stakeholder Group Meetings

- Committee to End Homelessness in King County (CEHKC) Interagency Council
- CEHKC Consumer Advisory Council
- Community Health Council of Seattle/King County
- Community Corrections Leadership
- Downtown Seattle Association (DSA) and Metropolitan Improvement District
- United Way Leadership Team
- Minority Executive Director's Coalition (MEDC)
- King County Human Services Alliance
- Eastside Human Service Forum
- South King County Human Services Forum
- North Urban Human Services Alliance
- Health Care for the Homeless Planning Council
- Harborview Medical Center
- Homeless Veterans Stakeholder Ad Hoc Group
- Seattle–King County Coalition for the Homeless
- Seattle/King County Workforce Development Council
- King County Criminal Justice Council
- King County Department of Community and Human Services (DCHS) Management Team
- King County Mental Health, Chemical Abuse and Dependency Services Division
- King County Housing and Community Development
- King County HIV/AIDS Program
- King County Juvenile Justice Operational Master Plan Work Group
- King County Alcoholism and Substance Abuse Administrative Board
- King County Board for Developmental Disabilities
- King County Child and Family Commission stakeholders
- King County Mental Health Advisory Board
- King County Veteran's Program Advisory Board
- King County Veteran's Program staff
- Lake Forest Park Human Services Commission
- Low Income Housing Institute
- Project HOME's Outreach Coordinating Council
- King County Regional Law, Justice and Human Services Committee
- King County Regional Policy Committee staff group
- City of Seattle City Council
- City of Seattle Department of Human Services
- City of Seattle Office of Housing
- City of Seattle Office of Policy and Management
- Safe Harbors staff
- SOAR
- Salvation Army William Booth Center
- DAWN

Note: Many of these groups received multiple briefings. See *Appendix F: Acknowledgements* for a list of individuals who participated in the Service Improvement Plan effort.

Appendix D: Veterans and Human Services Levy Financial Allocation Plan

Appendix D - Table 1

Veterans & Human Services Levy Allocation Plan
Operating Funds Years 2-6 by Overarching Strategy
Includes Ongoing and One-Time Investments

In 2006 Dollars

	2006	2007	2008	2009	2010	2011	Total
Enhancing Access to Services for Veterans and their Families							
Increase access to services							
Expand geographic range of King County Veterans' Program	200,000	100,000	100,000	100,000	100,000	100,000	700,000
Increase the capacity of the KC Veterans' Program, including:							
Financial assistance	250,000	500,000	500,000	500,000	500,000	500,000	2,750,000
Contracted PTSD treatment for veterans & their families	242,500	485,000	485,000	485,000	485,000	485,000	2,667,500
Contracted Veterans Incarcerated Program	45,000	95,000	95,000	95,000	95,000	95,000	520,000
Employment, outreach and case mgt in S & E King County	370,080	920,000	920,000	920,000	920,000	920,000	4,970,080
Subtotal							**$11,607,580**
Increase access to information about services							
Provide dedicated phone resource for veterans		100,000	100,000	100,000	100,000	100,000	500,000
Provide training and information for community providers on VA services and linkages		40,000	40,000	40,000	40,000	40,000	200,000
Subtotal							**$700,000**
TOTAL							**$ 12,307,580**
							16.9%
Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment							
Initiatives to identify, engage and house long-term homeless people							
Develop coordinated entry into housing and expanded outreach and engagement		470,000	820,000	820,000	820,000	820,000	**$3,750,000**
Increase permanent housing with supportive services							
Veterans	4,762,500	300,000	300,000	300,000	300,000	300,000	6,262,500
Other persons in need	4,092,500	700,000	700,000	700,000	700,000	700,000	7,592,500
Subtotal							**$13,855,000**

Permanent housing – operations & supportive services							
Landlord Risk Reduction Fund:							
Veterans	500,000						500,000
Other persons in need	500,000						500,000
Investment in supportive services and operating costs for current and new permanent housing		1,250,000	1,250,000	1,250,000	1,250,000	1,250,000	6,250,000
Enhance the housing and supportive service program of the KCCJI for individuals with histories of long-term homelessness		500,000	500,000	500,000	500,000	500,000	2,500,000
Invest in permanent housing placement supports for single parents with children with criminal justice involvement exiting transitional housing			110,000	110,000	110,000	110,000	440,000
Subtotal							**$10,190,000**
Prevent homelessness from re-occurring							
Invest in housing stability program:							
Veterans		500,000	500,000	500,000	500,000	500,000	2,500,000
Other persons in need		500,000	500,000	500,000	500,000	500,000	2,500,000
Link comprehensive education and employment programs for the homeless and formerly homeless to housing and supportive services		700,000	850,000	1,000,000	1,000,000	1,000,000	4,550,000
Subtotal							**$9,550,000**
TOTAL							**$ 37,345,000**
							51.2%
Increasing Access to Behavioral Health Services							
Expand behavioral health services through primary care and other providers							
Enhance the integration of mental health/chemical dependency treatment services with primary care at Community Health and Public Health Clinics:							
Veterans		600,000	800,000	800,000	800,000	800,000	3,800,000
Other persons in need		500,000	500,000	500,000	500,000	500,000	2,500,000
Invest in training programs in trauma sensitive and PTSD treatment		75,000	75,000	75,000	75,000	75,000	375,000
Subtotal							**$6,675,000**

Train behavioral health providers to use evidence based practices						
Train behavioral health providers across multiple systems to use evidence based practices for Post Traumatic Stress Disorder	250,000	250,000	250,000	250,000	250,000	1,250,000
Expand and extend availability of in-home mental health services						
Invest in services to treat depression in chronically ill & disabled elderly vets, spouses, and other elderly						
Veterans	70,000	84,000	98,000	98,000	98,000	448,000
Others in need	70,000	84,000	98,000	98,000	98,000	448,000
Subtotal						**$2,146,000**
TOTAL						**$ 8,821,000**
						12.1%
Strengthening Families at Risk						
Support maternal-child attachment and maternal health						
Expand Nurse Family Partnership and add linkages to employment opportunities	400,000	400,000	400,000	400,000	400,000	2,000,000
Pilot new services for maternal depression through community health and public health clinics	500,000	500,000	500,000	500,000	500,000	2,500,000
Subtotal						**$4,500,000**
Support early childhood development and parenting						
Establish pool of funds to invest in early childhood intervention and prevention best practices (examples include but not limited to community-based home visiting; curricula such as Promoting First Relationships & Incredible Years; and improving access to services for immigrant families)	493,000	493,000	493,000	493,000	493,000	**$2,465,000**
Provide early intervention and supports for parents exiting the criminal justice system						
Provide service enhancements for single parents exiting the criminal justice system, living in transitional housing		280,000	280,000	280,000	280,000	1,120,000
Invest in education and employment programs for single parents exiting the criminal justice system		150,000	150,000	150,000	150,000	600,000
Provide treatment for parents involved with the King County Family Treatment Court for Child Dependency Cases. This critical program faces a one-year funding gap as new funding streams are put in place to secure stability over time.	200,000					200,000
Subtotal						**$1,920,000**
TOTAL						**$ 8,885,000**
						12.2%

Increasing Effectiveness of Resource Management & Evaluation							
Planning & Evaluation							
Design and implement comprehensive evaluation of Levy process and outcomes	200,000	350,000	350,000	350,000	350,000	350,000	1,950,000
Cross systems planning and start-up initiatives for a coherent system of care for youth 18-21 aging out of foster care, juvenile justice and other systems serving youth	250,000						250,000
Create a profile of offenders in King County with mental illnesses and co-occurring substance use disorders	120,000						120,000
Planning, training and service design efforts to be determined and carried out over life of the Levy			100,000	100,000	100,000	100,000	400,000
Subtotal							**$2,720,000**
Information Systems							
Facilitate the Homeless Management Information System (Safe Harbors) with one-time assistance to providers		350,000	275,000	200,000	150,000	150,000	1,125,000
Enhance DCHS information systems to support administration and evaluation of the Levy	350,000						350,000
Consultation and training related to protocols and policies for Release of Information and sharing of patient information		150,000					150,000
Subtotal							**$1,625,000**
Enhancement of collaboration between local governments and human service organizations							
Develop a common data set for assessment for adults, youth and families seeking a range of human services		200,000	100,000	80,000	60,000	40,000	480,000
Facilitation of ongoing partnerships		150,000	150,000	150,000	150,000	150,000	750,000
Subtotal							**$1,230,000**
TOTAL							**$ 5,575,000**
							7.6%
TOTAL OVERARCHING STRATEGIES (in 2006 Dollars)	**12,082,580**	**11,318,000**	**12,361,000**	**12,444,000**	**12,374,000**	**12,354,000**	**$ 72,933,580**
Levy Administration	257,513	665,000	665,000	665,000	665,000	665,000	3,582,513
One-time planning, development and start-up in 2006	302,315						302,315
GRAND TOTAL	**12,642,408**	**11,983,000**	**13,026,000**	**13,109,000**	**13,039,000**	**13,019,000**	**$ 76,818,408**

Appendix D - Table 2
Summary of Allocations for Veteran and Non-Veteran Populations

	2006	2007	2008	2009	2010	2011	Total
Veterans in need	$7,109,994	$6,042,000	$6,312,700	$6,343,400	$6,318,400	$6,308,400	$38,434,894
Non-veteran populations in need	$5,532,414	$5,941,000	$6,713,300	$6,765,600	$6,720,600	$6,710,600	$38,383,514
	$12,642,408	$11,983,000	$13,026,000	$13,109,000	$13,039,000	$13,019,000	$76,818,408
Percent Distribution							
Veterans	56%	50%	48%	48%	48%	48%	50%
Non-veteran	44%	50%	52%	52%	52%	52%	50%

Appendix D - Table 3
Allocation of 2006 Revenues for One Time Investments

FOR VETERANS AND THEIR FAMILIES	
For individuals and families experiencing or at risk for long-term homelessness	
New permanent housing units	4,762,500
Landlord Risk Reduction Insurance Fund	500,000
Subtotal	**5,262,500**
Enhanced access to Veterans Program services	
Expand geographic range for programs	**200,000**
TOTAL FOR VETERANS AND THEIR FAMILIES	**$5,462,500**
FOR NON-VETERAN PERSONS IN NEED	
For individuals and families experiencing or at risk for long-term homelessness	
New permanent housing units	4,092,500
Landlord Risk Reduction Insurance Fund	500,000
Subtotal	**4,592,500**
Services for high risk families	
Provide Treatment for parents involved with the King County Family Treatment Court for Child Dependency cases	**200,000**
TOTAL FOR NON-VETERANS	**$4,792,500**
SUPPORT FOR RESOURCE MANAGEMENT & EVALUATION - ALL POPULATIONS	
Cross systems planning and start-up projects for a system of care for youth 18-21 aging out of foster care, juvenile justice and other systems serving youth	**250,000**
Create a profile of offenders in King County with mental illnesses and co-occurring substance use disorders	**120,000**
Enhance DCHS information systems to support administration and evaluation of levy	**350,000**
TOTAL FOR RESOURCE MGMT & EVALUATION*	**$720,000**
TOTAL INVESTMENT**	**$10,975,000**

* This category of expenditures is split evenly between Veterans and Non-Veteran Persons in Need

** Does not include ongoing services that start in 2006

Appendix E:
Oversight Boards Roles & Responsibilities

Appendix E
Oversight Boards Roles and Responsibilities

King County Ordinance 15406 provides implementation guidance for the King County Veterans and Human Services Levy approved by King County voters in November 2005. Because levy proceeds will be equally divided between veterans, military personnel and their families, and non-veterans, two citizen advisory boards are needed to oversee the investments made with levy resources. The ordinance states that board members shall be residents of King County with a diverse, balanced representation of private and public sectors, veterans, community leaders, jurisdictions and human service representatives. Members may not be elected or officials of any unit of government. In addition, it has been suggested that board nominees should not be employed by, or hold any other interest in, any human service provider agency that may directly or indirectly benefit from proceeds from this levy, in order to avoid any appearance of conflict of interest.

The following describes the roles and responsibilities for each board.

Both Boards:

Terms of office for board members will be up to three years. In order to prevent the terms of all board members from expiring at the same time, each board will establish terms of appointment by lot. After the initial terms have expired, all appointments shall be for three years. If an appointment is terminated before completion of a full-term, either the council member who made the original appointment or the County Executive (if the board member is an Executive appointee) will select a replacement board member for the remainder of the term, subject to council confirmation. If the appointing entity and the board member agree, a member may be appointed for a second term (subject to confirmation) and serve for a total of six years.

An initial task for both boards shall be the development of a charter/statement of work, including a process for electing board chairs and vice-chairs. At a minimum, officers should include a chair and a vice-chair, who are responsible for conducting meetings and creating agendas. County staff will be assigned to both boards and will coordinate meetings, prepare draft meeting notes for board approval and provide information about levy investments.

Both boards will meet quarterly.

Veterans' Citizens Levy Oversight Board (VCLOB):

The primary responsibility for the VCLOB is the review of levy investment strategies made on behalf of King County veterans, military personnel in need, and their families. On an annual basis, the VCLOB shall prepare reports for the Metropolitan King County Council and the King County Executive that review the expenditure of levy proceeds and results of implementation and programming, in accordance with the adopted Service Improvement Plan. These reports are due on or before June 1 of each year, beginning in 2007. In addition, the VCLOB will make recommendations to the County Executive and County Council prior to November 2011 as to whether the levy should be renewed through a subsequent ballot measure or a different replacement proposition.

Regional Human Services Levy Oversight Board (RHSLOB)

The primary responsibility for the RHSLOB is the review of levy human service investment strategies made on behalf of at-risk King County residents. As recommended by the Healthy Families and Communities (HFC) Task Force, the RHSLOB shall also explore ways to increase flexibility and improve regional coordination of human services delivery and collaborative funding. On an annual basis, the RHSLOB shall prepare a report for the Metropolitan King County Council and the King County Executive that reviews the expenditure of levy proceeds and results of implementation and programming, in accordance with the adopted Service Improvement Plan. These reports are due on

or before June 1 of each year, beginning in 2007. In addition, the RHSLOB will make recommendations to the County Executive and County Council prior to November 2011 as to whether the levy should be renewed through a subsequent ballot measure or a different replacement proposition.

Joint Meetings of the Veterans' and Regional Human Services Levy Oversight Boards:

Some amount of overlap is expected in levy-supported services that assist both veterans and non-veterans and their families. As many of the programs funded with levy resources will be provided to veteran populations through the mainstream human services system, a significant overlap will exist between the work of the VCLOB and the RHSLOB. It will be important for the two boards to communicate with each other on an ongoing basis. Therefore, it is recommended that the VCLOB and RHSLOB coordinate their activities through occasionally scheduled joint meetings.

Appendix F: Acknowledgements

Appendix F
Acknowledgements

Acknowledgements to the consultants and to the Levy Planning Team, who worked so hard to gather, consolidate and synthesize input from the multitudes of group and individual stakeholders in veteran's and regional human services. Special thanks to David Wertheimer, Kelly Point Partners and to Ursula Roosen-Runge, Strategic Learning Resources, Inc.

The consultants and Planning Team acknowledge and thank the following individuals for their input and ideas during the planning process. The richness of their contributions greatly informed all stages of the planning effort. It should be noted that every effort was made to capture the names of all the individuals who provided input and attended the feedback sessions. Please accept our apologies if there are any oversights to this list or if names are misspelled.

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Tim Lockwood, Hopelink

Bonnie Lowes, Interested citizen

Don Luby, King County Board for Developmental Disabilities

Judy Mackenzie, Lake Forest Park Human Services Commission

Nicole Macri, Seattle/King County Coalition for the Homeless

Cathy Ann Mallman, Interested citizen

Judy Manchester, City of Kirkland Parks and Community Services Department

Cheryl Markham, King County Housing and Community Development

Carol Maurer, Public Health-Seattle & King County Children & Family Commission

Patricia McInturff, City of Seattle Human Services Department

Susan McLaughlin, King County Mental Health, Chemical Abuse & Dependency Services Division

Linda McVeigh, Country Doctor Community Health Centers

Debbie Meyers, Interested citizen

Katy Miller, King County Housing and Community Development

Lori Mitchell, Harborview Medical Center Finance

Liz Moehkre, Lake Forest Park Human Services Commission

Jack Moffitt, Pacific Associates

Don Moreland, Interested citizen

Jo Moore, King County Crisis and Commitment Services

Beth Mountsier, King County Regional Policy Committee

Andrew Murphy, Public Health-Seattle & King County Correctional Health and Rehab Services

Diane Narasaki, Asian Counseling and Referral Service

Shankar Narayan, Hate Free Zone Washington

Jeff Natter, Public Health-Seattle & King County Prevention Division

Marilyn Nault, Regional Law, Safety and Justice Committee

John Nesbitt, King County Board for Developmental Disabilities

Tema Nesoff, City of Lake Forest Park Human Services Department

Diep Nguyen, King County Mental Health, Chemical Abuse and Dependency Services Division

Helen Nilon, King County Mental Health Advisory Board

James Nobles, King County Mental Health Advisory Board

Keith Officer, Lake Forest Park Human Services Commission

David Okimoto, United Way of King County

Chris Oliver, Washington State Department of Veterans Affairs

Sandy Olson, Harborview Medical Center Pioneer Square Clinic

Alex O'Reilly, City of Bellevue Human Services Division

Jim Ott, Public-Health Seattle & King County Children & Family Commission

Eleanor Owen, King County Mental Health Advisory Board

Ann Oxrieder, Bellevue School District

Alan Painter, City of Seattle Human Services Department

Allan Panitch, King County Mental Health Advisory Board

Camron Parker, City of Bellevue

Linda Peterson, King County Housing and Community Development

Diane Pien, City of Seattle Human Services Department

Pam Piering, City of Seattle Human Services Department

Bette Pine, Public Health-Seattle & King County Correctional Health & Rehab Services

Marybeth Poch, Washington State Department of Social and Health Services Division of Developmental Disabilities - Region 5

Lisa Podell, Public Health-Seattle & King County Health Action Plan

Al Poole, City of Seattle Human Services Department

Adrienne Quinn, City of Seattle Office of Housing

Sue Rahr, Regional Law, Safety and Justice Committee and King County Sheriff

Linda Rasmussen, South King County YWCA

Tom Rasmussen, Seattle City Council

Traci Ratzliff, Seattle City Council staff

Grace Reamer, King County Council staff

Toni Rezab, Regional Law, Safety and Justice Committee

Jennifer Rigg, United Way of King County

Dana Ritter, King County Mental Health, Chemical Abuse and Dependency Services Division

Jean Robertson, King County Mental Health, Chemical Abuse and Dependency Services Division

Ebony Romano, Regional Law, Safety and Justice Committee

Mike Roskind, Regional Law, Safety and Justice Committee

Eva Ruiz, Community Member

Bill Rumpf, City of Seattle Office of Housing

Joe Russell, Regional Law, Safety and Justice Committee

Mary Jean Ryan, City of Seattle Office of Policy and Management

Rita Ryder, YWCA

Lois Schipper, Public Health-Seattle & King County Parent-Child Health Program

Kaye Schmidt, Public Health-Seattle & King County Correctional Health and Rehab Services

Sheryl Schwatz, UW Health Promotion Research Center

Sheila Sebron, Veterans' Advocate

Mark Secord, Puget Sound Neighborhood Health Center

Bill Sellars, Interested citizen

Kathy Sellars, Interested citizen

Ann Shahan, VA Puget Sound Health Care System

Joan Sharp, Washington Council for Prevention of Child Abuse and Neglect

Paul Sherfy, Regional Law, Safety and Justice Committee

Amnon Shoenfeld, King County Mental Health, Chemical Abuse & Dependency Services Division

Dave Sieminski, United Way of King County

Sierra Silbersdorff, King County Veterans' Program

Karen Sluiter, Lake Forest Park Human Services Commission

George Smith, City of Shoreline

John Smith, SMS

Yasmin Smith, King County Alcoholism and Substance Abuse Administrative Board

Jan Solomon, Juvenile Justice Operational Master Plan Work Group

Min Song, Workforce Development Council of Seattle – King County

Rose SooHoo, King County Mental Health, Chemical Abuse & Dependency Services Division

Scott Sotebeer, Regional Law, Safety and Justice Committee

Kathleen Southwick, Crisis Clinic

Kate Speltz, King County Housing and Community Development Homeless Housing Program

Karen Spoelman, King County Mental Health, Chemical Abuse & Dependency Services Division

Rick Stendera, Lake Forest Park Human Services Commission

Ron Sterling, King County Mental Health Advisory Board

Ed Sterner, Juvenile Justice Operational Master Plan Work Group

Doug Stevenson, King County Council staff

Mary Ellen Stone, King County Sexual Assault Resource Center

Jim Street, Juvenile Justice Operational Master Plan Work Group

Ray Takeuchi, Washington State Department of Social and Health Services, Division of Developmental Disabilities - Region 6

Hikari Tamura, Juvenile Justice Operational Master Plan Work Group

Margaret-Lee Thompson, Interested citizen

Kip Tokuda, City of Seattle Human Services Department

Sharon Toquinto, King County Mental Health, Chemical Abuse and Dependency Services Division

Jerry Towne, Washington State Department of Veterans Affairs

Thomas Trumpeter, Community Health Centers of King County

Peter Tsai, Center for Career Alternatives

Janice Tufte, Interfaith Task Force on Ending Homelessness (ITFH)

Harla Tumbleson, United Way of King County SOAR

Lisa Turner, Interested citizen

Page Ulrey, Juvenile Justice Operational Master Plan Work Group

Sandy Ulson, Harborview Medical Center

Pradeepta Upadhyay, Chaya

Dianne Utecht, City of Renton

Jim Vollendroff, King County Mental Health, Chemical Abuse & Dependency Services Division

Susan Waild, Juvenile Justice Operational Master Plan Work Group

Eugene Wan, King County Mental Health Advisory Board

Linda Weedman, YWCA

Jeff Welch, Interested citizen

Linda Wells, King County Aging Program

Elizabeth Westburg, YWCA

Jane White-Vulliet, King County Children and Family Commission

Gwendolyn Williams, King County Mental Health Advisory Board

Kathryn Williams, Home Street Bank

Richard Wilson, Interested citizen

Mark Wirschem, Juvenile Justice Operational Master Plan Work Group

John Wise, Mayor, City of Enumclaw

Linda Woodall, United Way of King County

Jan Wrathall, King County Developmental Disabilities Division

Wyman Yip, Juvenile Justice Operational Master Plan Work Group

Billie Young, City of Seattle Human Services Department

Nick Zajchowski, Regional Law, Safety and Justice Committee