Submitted at 9:39:12 PM, on Tuesday, June 03, 2008
Trish Blanchard, Sound Mental Health

Dear MIDD Oversight Committee Members:

Please accept this feedback to the Draft Implementation Plan.

Strong stakeholder participation in the design and implementation shows in the targeted, substantive plan. The plan ensures new services and/or increased capacity.
The MIDD significantly strengthens the criminal justice continuum of care and supports recovery and resilience of our communitys most vulnerable populations. The MIDD is transformative to King Countys mental health and substance abuse services, addressing much needed access to care and services.

There is much needed emphasis on increasing access to care for people with mental health issues who do not have Medicaid, both with the increase in Non-Medicaid funding strategy and the caseload reduction strategies.

Please clarify peer support services. It reads as consumer run; the major need is to support mental health agencies to develop peer and parent support specialist services.
The MIDD funds are needed to help agencies flexibly increase the number and type of peer support services.

Certain MIDD strategies encourage collaboration of the domestic violence and sexual assault services with mental health services. This is a much needed enhancement to the system. This is an opportunity to share expertise and collaborate to ensure mental health services for those who experience physical violence and/or sexual abuse.

When the implementation, oversight and evaluation plans are approved, funding for each of these initiatives will begin to be released. Please keep RFP/RFQ processes to a minimum. Build upon the strengths and effectiveness of the system and its providers with allocations or designated funds.

Thank you for the opportunity to give feedback.

Submitted at 7:25:41 PM, on Tuesday, June 03, 2008
Linda Brown, KC Alcohol and Chemical Dependency Board

All of the stategies that refer to treatment for chemical dependency should include language that makes it clear that substance abuse treatment for adults is also included in the funding. This language is important because adult treatment services paid for by State DASA funds are limited to chemical dependency treatment with no funding for substance abuse treatment services that provide earlier intervention and prevention treatment. MIDD funds do not have these limits and can and should be used for substance abuse treatment.

This language is not a issue for treatment programs for youth for both DASA and proposed MIDD programs cover substance abuse treatment for youth. It is, however, important to have adult substance abuse treatment clearly identified so that treatment is not limited to adults who are chemically dependent. I have talked with Jim Vollendroff and he supports the inclusion of treatment for adults who are substance abusers who are not yet chemically dependent.

I know this issue may be somewhat confusing but it is an important one to provide comprehensive treatment services that will include early intervention services for adults.

Submitted at 5:03:54 PM, on Tuesday, June 03, 2008
Ann McGettigan, Seattle Counseling Service for Sexual Minorities

Dear MIDD Oversight Committee Members:

As Executive Director of Seattle Counseling Service for Sexual Minorities, I am pleased to provide feedback to the Draft Implementation Plan. I appreciate the time and effort that has clearly been spent by committee members and staff in writing such a thoughtful and thorough implementation plan.

I am glad to see the emphasis on increasing access to care for people without Medicaid coverage, as at SCS, we have many community members who have been intermittently eligible for Medicaid. This has meant that many of our clients have not been covered for their services throughout the time they are engaged in therapy, and as a result the agency has lost thousand of dollars in funding. We have struggled to continue to care for many of our clients, without appropriate funding support. This change, the increase in Non-Medicaid funding alone, will make a huge difference in our agencys ability to continue to care for our clients.

I encourage the oversight committee to only let RFPs where absolutely necessary. When a network or specific agency is identified as the logical choice in a strategy, we believe this ensures the most efficient and effective method of moving funding out into the community in the most timely way possible. I am concerned about the amount of time and effort it would take to let RFPs for many of these strategies, and that funding would be unnecessarily delayed as a result.

I am very supportive of the domestic violence and sexual assault strategies, and in particular support the placement of a coordinating role in an agency working in the field of anti- violence. It presents an opportunity to bring systems of care into a more collaborative working relationship, which will enhance access to mental health care for many individuals who experience sexual and/or domestic violence. As someone who has worked in both the dv/sa and mental health fields, I feel strongly that this is a prime opportunity to increase access to care for all of our clients.

Finally, I believe this funding is essential to ensure that more of our community members have access to care, including the LGBT community, which SCS is mission-driven to serve. We look forward to participating in the changes ahead for King County as this funding will truly make the difference in peoples lives.

Sincerely,
Ann McGettigan

Submitted at 4:58:21 PM, on Tuesday, June 03, 2008
Jill SanJule, Advocate

comments: I would like to make an addition to my official remarks please: I did not speak to the issue of using monies to cover medications for individuals who are not covered under Medicaid or other means. As a staunch supporter of peer/mutual/self-help programs/strategies, I am also a person who believes that medication also plays a critical role for many. Because I have always been very resourceful, since the age of about 20, when I finally conceded I did need medication, even during times of extreme poverty (on miserable GAU benefits) I was able to get my very expensive anti-depressants filled(average monthly cost of approx. $400-$600). For me, there is nothing political about this issue--if a person believes that medications truly make a positive difference in their emotional and mental health, then it should be a "given" that they have both access to a correct "diagnosis" (even if this means from the ol' medical model DSM bible) and to the means to purchase any medications they have found to be helpful. From my own experience and that of many more of my peers, I can guarantee you the quickest way to send an individual into a immediate mental health

meltdown is to take them off of their psych medications cold turkey. I don't wish this on my worst enemy. Therefore, as one of the most vocal consumer advocates in the state of Washington, I definitely support using monies to cover medications for those individuals who voluntarily take medications and have no way to cover the costs. Thank you. 4:57pm June 3, Jill San Jule

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Submitted at 4:50:46 PM, on Tuesday, June 03, 2008
Marilyn Littlejohn, City of Seattle

The needs of those who struggle with mental illness and chemical dependency are vast. The plan reflects difficult decisions and the need to prioritize. Moving forward three things will be critical:

1-tracking outcomes and making appropriate mid-course corrections
2-establishing linkages betwen the various MIDD strategies so those served have greatest chance for recovery and stability
3-coordinating efforts, including evaluations, with funding partners to create program and spending efficiencies.

Seattle supports using $18M of unspent 2008 funds for the development of new housing units and/or rental assistance. Whatever housing is developed needs to be appropriately sized and coordinated with other MIDD strategies to support the recovery and stability of those assisted.

Seattle also supports establishing within the currently projected annual fund of $50M an ongoing Housing/Rental Assistance fund, perhaps as high as $10M/year. Many mentally ill individuals are homeless.

1B-Target Population-include a link to shelters, perhaps "Individuals being discharged to shelters from jails...."
1B-Partnership-list "City of Seattle"
1F-Enhance or expand capacity to better address the needs of families with children ages 14-30 with mental illness 7A-Target Population-change "youth who have been arrested" to "youth involved with the criminal justice system." This will leave open the door to assist youth who have been arrested, but also recognizes that the police, who have contact with many troubled youth,want a place to take some of them without arresting them. Also, like 10b, this strategy will work only if sufficient community-based services are available and partnerships are established. Some of these youth will need specialized services. E.g., young girls, 12-18 involved in prostitution will need safe housing, along with services.
10b-CDF will work only if sufficient community-based services and supportive housing exist for the individuals diverted and strong parnterships exist between the CDF and these CBOs. Otherwise, the individuals will probably not maintain stability. If these services and linkages are not assured, funding allocated for CDF might be better used for supportive housing (capital or services).
12a-Address how the plan will build capacity to support new jails coming on line in the region in 5 years.
16a-Problem statement-if known, include the number of mentally ill/chemically dependent currently being served who are homeless.

Submitted at 4:57:33 PM, on Tuesday, June 03, 2008
William (Brad) Webb, Recovery Services

I am a recovering drug addict/alcoholic, with over 22 years of sobriety who also has several psychiatric diagnoses. If an individual, such as myself were to enter the Non-Medicaid system today they would not qualify under the MIDD Action Plan as they would not be entering the system due to a current substance abuse issue -- even though they would more than meet the criteria for medical necessity.

They would not qualify as their income exceeds the medical FINANCIAL criteria of $657 per month. While I am in favor of those with substance abuse issues entering the system it should not be the detrament of those with mental health diagnoses. The same financial and need criteria should be required.

Submitted at 4:46:51 PM, on Tuesday, June 03, 2008
Jobyna Nickum, Enumclaw Senior Center

I would like to express my concerns that this plan does not seem to visably address the mental health/mental illness needs of older adults in King County. Many older adults face issues of drug dependency, substance abuse, depression, grief and loss issues (health,housing, family structure, spouse, etc...)and have a higher rate of suicide than any other segment of our population.

I would like to see more attention and focus on addressing the needs of our senior population in King County.

Is there someone on your Board who represents the needs of older adults?

There needs to be an awareness - at this level - that older adults are a growing segment of our population (and the numbers will only increase in the next 5-10 years), that older adults face mental health/illness issues and are deserving of funding, treatment and awarenss of this fact.

Could you please discuss what the decision-making process was in regards to older adults and assuring that their needs were addressed in your implementation plan?

Thank you.

Submitted at 4:39:45 PM, on Tuesday, June 03, 2008
Erica Horn, HERO House

I wish to begin by celebrating all of the hard work and hours of service that went into creating the MIDD Action Plan. I believe if implemented correctly, the outcomes for consumers with mental illness living in King County will experience great benefits.

Next, I would like to comment directly on the strategy of Improving Quality of Care, Strategy #2b: Employment Services for Individuals with Mental Illness and Chemical Dependency. While the strategy calls out that "This funding level provides for the addition of up to 23 vocational specialists within the contracted King County mental health and substance abuse treatment provider community," it fails to ensure that the funding related to the hiring of vocational specialists will be applied in a equitable manner to all agencies currently providing the required level of Supported Employment Services, such as clubhouses.

HERO House, an ICCD (International Center for Clubhouse Development) Certified model of psychiatric rehabilitation located in Bellevue, WA is a CRP (Community Rehabilitation Program) vendor with DVR and is contracted to provide all levels of supported employment services consistent with CRP requirements. In addition, HERO House continues to produce employment related outputs and outcomes that are consistent with the MIDD's strategies. In 2007, 74% of HERO Houses active enrolled membership was employed, attending school or volunteering in the community. Furthermore, we provide a higher level of on-going support services to our employed members than most CRPs as our services do not end with successful placement, but rather, they continue through the lifetime of the individual's membership. We also don't require any extensive pre-employment measures to be met by the individual before placement and therefore often successfully place individuals in employment that other programs have deemed unemployable.

However, since we are not affiliated with a clinical auspice agency we have been informed that we will not be eligible to access this new funding, which is desperately needed to stabilize and grow our employment program. Therefore, we respectfully request that a provision be made to allow King County designated ICCD Clubhouse programs to be considered as eligible providers through this RFP process. Thank You

Erica Horn. Executive Director, HERO House

Submitted at 4:12:01 PM, on Tuesday, June 03, 2008
Ann McGettigan, King County Mental Health Providers Association

Dear MIDD Oversight Committee Members:

As President of the King County Mental Health Providers Association, I am pleased to provide feedback to the Draft Implementation Plan. We appreciate the level of thoughtfulness and detail in the plan, as it ensures that the funding is utilized effectively and efficiently.

Overall, we support the draft implementation plan as written, with the following comments and requests for clarification.

We are very supportive of the emphasis on increasing access to care for people with mental health issues who do not have Medicaid, both with the increase in Non-Medicaid funding strategy and the caseload reduction strategies.

We appreciate the need to spend out a significant sum of money in 2008, within a very short period of time, after the implementation and oversight and evaluation plans are approved. We expect that in 2009 and beyond, the allocations for other strategies in the implementation plan will be fully funded and that housing will not continue to be a significant portion of the overall funding allocations.

We would appreciate some clarification in the language regarding peer support and parent partner family assistance programs. It is not clear in the description of the strategies that peer support programs may be an aspect of a mental health program. We would like to see this funding support mental health agencies increase the number of peer support services, and hope this would be an allowable expense in under this strategy.

We encourage the oversight committee to only let RFPs where absolutely necessary. When a network or specific agency is identified as the logical choice in a strategy, we believe this ensures the most efficient and effective method of moving funding out into the community in the most timely way possible.

We are supportive of the domestic violence and sexual assault strategies, and in particular support the placement of a coordinating role in an agency working in the field of anti- violence. It presents an opportunity to bring systems of care into a more collaborative working relationship, which will enhance access to mental health care for many individuals who experience sexual and/or domestic violence.

Finally, despite pressures on the King County budget overall, we are grateful that this funding has been approved and believe it is absolutely essential that it be protected in the future to ensure that our most vulnerable community members have access to care & recovery.

Submitted at 3:49:35 PM, on Tuesday, June 03, 2008
Merril Cousin, King County Coalition Against Domestic Violence

I support the domestic violence and sexual assault plans (13a, 13 b, and 14a).

The agencies identified in these plans as receiving funding were specified because they are the only agencies qualified to provide the services as intended. An RFP process should not be necessary for these strategies.

Plans 13 a and 14a jointly call for a Coordinator position to focus on cross training, enhancing linkages and consultation between domestic violence (DV), sexual assault (SA) chemical dependency (CD),and mental health (MH) providers, and identifying needed policy changes in DV/SA and MH/CD agencies to better serve people dealing with multiple issues. As written, the plan calls for housing the position at the King County Coalition Against Domestic Violence. This was agreed to by providers from both the DV and SA fields, with input from providers of MH and CD services who have collaborated with DV and SA providers in the past. It is felt that it is important that this position remain at a community based agency with connections and credibility with providers in all of these fields. Ideally, MHCADS will work with this position to institutionalize recommended training and policies in mental health and chemical dependency programs. Similarly, KCCADV would work with DV and SA providers to institutionalize recommended training and policies in their agencies.

In regards to strategy 16 a) Housing. I support the allocation of unallocated funds in 2008 to the housing strategies as called for in this plan. However, the issue of how much funding, if any, should be allocated to this strategy in following years should come back to the MIDD Oversight Committee for discussion and development of recommendations, especially given how little is know about how the King County general fund deficit will affect other strategies.

Thank you.

Thank you for the opportunity to offer my feedback on the MIDD Action Plan for King County.

While I reside in Pierce County and work in Thurston County, my husband and I both spent our sickest years on the streets of Seattle, unable to get the help we needed to move towards mental health and recovery. Seattle will always be our home—it is part of our make-up as it played such a huge role in defining the people we are today. I experienced homelessness, addictions, gang rape, self-mutilation, untreated serious mental illness and all the horrors that come with street living-- both Bruce and I came into contact with multiple systems on multiple occasions over the course of many, many years (Bruce was on the streets from age 14-22) and **not once** were we EVER offered any type of help. In fact, the state of affairs in King County were so bad that we ended up moving to Arizona, where we finally got access to help--more importantly the type of help that did not engender dependence but instead empowered us to take steps towards becoming productive members of our community —access to programs that gave us hope and the belief that we controlled our own destinies; access to programs that partnered with us to create new possibilities for our lives; access to programs that taught us new skills and allowed us to remember that despite having a diagnoses of serious mental illness and co-occurring substance abuse disorders, we had many talents and skills that were being wasted; access to support programs that helped us through the difficult periods; access to peer run programs that allowed us to see first-hand that recovery was not just possible, but probable with the right tools and supports; access to programs that are next to non-existent for adults in this plan. I have to say that there is not a whole lot of innovation with regards to adults in this plan--for the most part, it is a little more of " business as usual," --that is a sprinkling here and there of *more of the same* that hasn't shown to be real successful helping folks move towards independence, health, and overall wellness. There is one clear area of exception—this deals with **youth** and what I would classify as "prevention" efforts aimed at **youth and families**, which I applaud. The monies directed for youth peer mentoring is a wonderful example of where this plan *gets it right*.

Unfortunately, this is not the case when it comes to adult programs. This leads me to believe that there were many vocal family members invited to the table, in attendance, and clearly heard. This is to be commended. Unfortunately, this does not seem to be the case for adult consumers. I would like to follow up with those individuals who represented the personal experience of mental illness and recovery—if you could please email me their names and contact information I would greatly appreciate it.

This is such a great lost opportunity—to have a pot of money that does not have the same "medical model" restrictions that have hindered rehabilitation and recovery; to have such an amazing opportunity to implement innovation and the latest cutting edge mutual support programs that promote recovery; to have had the opportunity to put into place evidenced based trauma interventions (as we know that nearly 2/3 of both the prison and psychiatric hospital populations at any given time have experienced life-altering trauma and abuse)— that have been shown to greatly reduce the use of hospitals as revolving doors; to have the opportunity to put into place peer run warmlines (a program which ,by the way, continues to wait for funding despite putting forth a proposal based on 16 months of work done by a volunteer KC Warm Line Committee continues to wait for funding)–these are the things that keep people out of the hospital, out of the jails, and out of homelessness. Where are the strategies for community re-entry? Where are the bridge programs that assist individuals in making the transition from jail to the community? The programs that match folks up with a mentor to help guide them back to becoming a contributing member of their community? Where are the programs that teach new skills that move people away from dependence on social services? Where are the programs that employ all of the truly amazing certified peer counselors, whose lives themselves illustrate the possibilities of mental health and wellness? What a lost opportunity. King County received a recent transplant from the East Coast, an amazing African-American woman, trained by the well-known Howie the Harp Center as a Forensic Peer Specialist--where are the programs that employ such heroic individuals, the programs that address the NUMBER ONE need expressed by over 200 consumer/survivors(see below) related to the CJ system: **Peer support specialists should be available at every point of contact in the criminal justice system using GAINS Center 5-Point intercept model.** Where are the positions for the dozens of peers trained to run WRAP groups, an evidenced based program that has been shown to give individuals the tools they need to remain independent, out of the hospital, away from their demons (i.e. drugs/alcohol/addictions, etc.)? Where are the consumer run crisis respite centers that keep people out of crisis (i.e. homelessness, jail, hospital) for a fraction of the cost of the alternative (i.e. homelessness, jail, hospital)? Where is the funding for the recovery drop-in centers that for so many of us from other states speak of as being the place where our recovery was "jumpstarted"? Where is the funding for the development and teaching of psychoducation and wellness education that enabled many of us to learn how to live within the realms of our physical and emotional limitations? These are all completely missing from the plan. I am afraid that King County missed a huge opportunity to truly do something transformational. What a lost opportunity.

The rhetoric of recovery language must be followed by the implementation of programs that actually support healing, the learning of new skills and *new ways*, as well as the ongoing supports that continue to reinforce and maintain recovery and overall wellness. I'm afraid that this does not mean more case management. Case management is not a program or a service. In fact, it is not even an evidence based practice. Case managers do not keep people out of crisis, out of jail, or prevent homelessness. While they are somewhat effective in helping individuals access other services and assistance, this is a "systems navigator" role, should be renamed such; and can/has been done in other states by trained peers and family members for a whole lot less money and with much greater success.

At the end of the day, this plan serves for the most part, the same people who have for so many years, whether well intentioned or not, served as hindrances to recovery. **NOT ONE** program in this ENTIRE PLAN speaks to the heartfelt input that over 200 adult mental health consumers put forth as the most important program/service needed for recovery:**The implementation and expansion of**

peer-run mutual support and mentorship programs. (again, I will point out that the two programs that mention peers are for children/youth).

How can we make this more loud and clear? If King County is not sure what this looks like, I sincerely ask that it takes the time to seek out those of us who have expertise in this arena. I am more than happy (as I am certain others are as well) to offer up my time and expertise (obviously within the realms of what I can do voluntarily with my full time job) to help King County move towards real transformation—towards the implementation of programs that are truly going to assist individuals with mental health and substance abuse challenges. Thank you for the opportunity to share my insights and I certainly hope that I can be of assistance in changing the course of the plan in the near future.

Sincerely,
Jill M. SanJule
Peer Advocate

Submitted at 3:30:43 PM, on Tuesday, June 03, 2008
Alessandra Pollock, Seattle Municipal Court

SMC appreciates the plans focus on the whole county as well as the inclusion of all defendants in programs run from the King County jails.

SMC appreciates the plans Mental Health Court component that includes individuals who may be unable to opt-in because of their lack of legal competency.

SMC suggests continuing a strong link between re-entry case management for defendants, the crisis diversion center, and treatment and supportive housing services. Ensuring that defendants have adequate access to supportive housing and treatment is critical to reducing future utilization of emergency systems.

Submitted at 3:22:15 PM, on Tuesday, June 03, 2008
Nancy Dapper, Executive Director, Alzheimer's Association

With the aging of the baby boomers we will continue to see an increase in the number of older adults seeking services in King County. To adequately address the needs of this group, it is crucial that you add a representative from the aging community to your Advisory Board prior to finalizing the MIDD plan. Specific areas of concern are noted below. I can be reached at 206.363.5500 or nancy.dapper@alz.org. Please do not hesitate to contact me with any questions you may have.

Strategy Number 1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Older Adults

1) In its early stages Alzheimers disease often produces symptoms similar to those of depression. Given the high prevalence of Alzheimers disease among older adults, performing depression screenings in the absence of an Alzheimers screening could result in misdiagnosis. To best serve this demographic, screeners should perform a comprehensive assessment comparable to that used by Geriatric Crisis Services (referenced in Strategy No. 1h).

2) Subsection 1F states that screening and interventions will occur for 2,500 to 4,000 individuals annually, but does not state the considerations that will be used to determine which patients will receive these services. Clarification on this matter would be useful.

Submitted at 1:54:42 PM, on Tuesday, June 03, 2008
Helen Nilon, The Nilon Group

Most concerning is the lack of representation for individuals who have a serious and persistent mental health diagnosis. The plan does not speak of mental health and recovery it speaks to mental ILLNESS, which is contrary to the Countys current Recovery focus! (There does not appear to be consumer/peer voice meaning voices from those individuals who actually have a diagnosis of a mental illness.)

Sections on supported employment do not include clubhouses, which can be a vital asset in assisting individuals to either resume their education or employment. Clubhouses especially those who have ICCD accreditation should be included in the Countys efforts towards Supported Employment.

I am appalled at the differences related to access of care. The plan does enable individuals who are dually diagnosed to gain access to the system if their income is no higher than 80% of medium income (per the KC 2007 Annual Growth Report the figure for 2006 was $63,500 - 80% of medium would equal $50,800). This is not the problem. The problem is that the 40 to 50% of those with a psychiatric diagnosis can only enter the new non-Medicaid system if their income does not exceed the Medicaid financial limits or approximately $7,900 per year. This discrepancy is unacceptable. Individuals or families with this level of income in King County are unlikely to afford services even when they meet the medical necessity criteria.

The figures used, related to case management size are inaccurate. Figures for case management are much higher when one calculates the size of a typical case loads and does not use PACT, ECS and other non-typical case management programs.

The plans states Navigating complex service systems can be a frustrating, confusing and challenging experience for consumers (peer who) benefit from the unique mentoring, guidance and expertise offered by someone who has had similar experiences is quite true.

This section goes on to provide for 40 parent partner/youth peers which will be quite beneficial to those who receive services from this system of care. Nowhere in the document did I see a similar resource for adults that of obtaining an adequate number of Certified Peer Counselors/ Peer Support Specialists to serve peers of our system. Peers need to be added to the sections of the plan where adults (18 to 59) are served.

Please contact me if you have any questions.
Helen Nilon, AICP, CPC, PSS, MHRE

Submitted at 1:31:46 PM, on Tuesday, June 03, 2008
Barbara Langdon, EDVP

Thank you for your support of domestic violence and sexual assault vitims. They are often the forgotten victims of crime who have extensive mental health needs and concerns. We support your inclusion in this important document.

Submitted at 11:29:01 AM, on Tuesday, June 03, 2008
Debra Boyer, PhD, Boyer Research/University of Washington

Therapeutic Court Services goals do not address gender specific needs for females in the juvenile justice system adequately. The linkage to services is laudable but they do not exist. A specific

population of youth, which includes girls and some boys who are engaged in prostitution, may fall through the cracks, in spite of new money and services brought on line. I am completing a report that calls for the following interventions for an estimated 250 youth who are currently involved in prostitution in Seattle and King County this population meets the technical definition of trafficking. The population, ranging in age from 13 to 18, mostly girls, are heavy users of the criminal justice system and coerced by pimps and gangs. They are at extreme risk of harm, have histories of sexual abuse, chemical addition issues, suffer from extreme trauma disorders and PTSD, have few if any adults that they can safely interact with, are not able to go home. Working with this population requires specialized training something many of the local providers admit they do not have and desperately need. The report commissioned makes specific recommendations that can be addressed by the MIDD funds:

Safe housing up to 25 dedicated secure housing placements among local youth housing providers so that these youth can get off the street, away from their pimp/batterer and into supportive housing. Many prostituted youth are released from detention, back into the hands of pimps. They need specialized services and direct referrals from detention to these services. These programs should provide mental health and chemical dependency treatment.

Provide community-based case management for prostitution-involved youth released from juvenile facilities. The wrap around case management model is appropriate for this population.

Training for community providers to build and sustain knowledge and assessment skills across agencies where sexually exploited youth present or are contacted.

Expand counseling services for trauma and PTSD for young women of color who engage in prostitution, in their communities

Some of the MIDD action plans address portions of these recommendations, but none specifically address the unique needs of prostituted youth and the gender based needs of girls in the juvenile system. Assessment is not treatment, and youth need to be safe first, and in stable housing in order to effectively use community treatment. I would like to see this included.

Thanks for all your hard work on the MIDDS plan. As chair of the work group for the Eastside Human Services Forum, I am submitting the attached feedback from us. Please consider our comments.

Carrie S. Hite, Deputy Director◦ Parks & Community Services ◦ City of Kirkland, Washington

Eastside Human Services Forum
Feedback on MIDDS strategy plans
June 2, 2008

Strategy 1a-1—Increase Access to Community Mental Health

- We have a concern that this is going to be too hard to achieve in such a short time frame. Also, do we have the capacity in the community 75 additional FTE's?
- The outcome of not hiring 75 FTE's is that to accomplish this objective, caseloads will be very high. Our concern is that this is not achievable.
- Geographic location: not specified; will there be services available in East King County.
- How are you going to measure the outcomes?

Strategy 1a-2—Increase Access to Community Substance Abuse Treatment

- Who are the OST providers that have already been identified to provide these services? Are there any in East King County? We would want to ensure that there are service levels represented in East King County. And, if there are no current OST providers identified in East King County, that this objective identifies resources for geographical representation for services.
- The anticipated caseload seems a bit high.
- Only outputs listed, no outcomes.

Strategy 1d—Mental Health crisis next day appointments and stabilization services

- Who are the five existing Adult Crisis Service providers that have been identified? Do they represent all geographical areas of the County? And, if not, can resources be allocated to ensure consistent levels of services that match need throughout the County?
- We have a concern that this is too ambitious a timeline to create a new service model and train providers.
- How are you going to measure outcome?

Strategy 1f—Peer Support and Parent Partner Family Assistance

- We have a concern that the County is proposing provision of direct service, as opposed to housing this program in an already existing agency. Seems like an expensive and duplicative model.
- The caseload seems a bit high. The way this is designed it looks like 40 parttime staff are going to service 4000 clients per year. That equates to 100 caseloads on a parttime basis.
- The content is not clear. We can't tell if this was designed on a best practice, or where this model came from, will it be effective.

Strategy 1g—Prevention and Early Intervention Mental Health and Substance Abuse Services for Older Adults

- Not clear on some content, some jargon: i.e. define "safety net clinics"
- There is no reference to any outreach strategies to screen older adults who may not attend primary care clinics, which is where the services will be delivered. Many older adults, especially those from other cultures, may not use primary care clinics. This gap needs to be addressed in the service model. Senior or community centers would be a good place to begin.
- Some obstacles that we see include:
    a. Geographic location: not specified; will there be services available in East King County. If not, this will be a barrier to older adults living here.
    b. Capacity: The overview states that there is a "shortage in trained CD providers" so the timeline to add the 10.0 FTEs of staff in the first 2 quarters of the program seems unrealistic. Also, the outputs seem very high at up to 4,000 annually.
    c. After screening: The goal states that the strategy will provide screening and treatment. There is not enough detail on how the treatment will happen for people who are not Medicare or Medicaid-eligible. Screening is not useful if there is not adequate time/resources included for follow-up. Who will do the case management? This is unclear.
    d. Outcomes: How will the data be collected? Who will do it?

Strategy 1h—Expand the Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults

- Content is not clear if these services are already in place and this is just an effort to establish a program that is evidence based and increase the capacity. (I'd suggest changing the wording to evidence based program instead of evidence based team.) It states that Evergreen Community Health Care will provide the service; are they doing it now? Will the team members do ongoing case management? We have concerns that the client, once

assessed, will fall through the cracks without team follow-up. Agencies to whom they are referred are overwhelmed and under-funded so often follow-up does not happen.

- Follow-up strategy is missing. One of the stated goals is to build capacity in the community to provide prevention and treatment services. There is no mention of how this will be done as the funds are only for the crisis team. Again, after they do the assessment, referrals will go to agencies that may not have the funding or staff to respond.
- Some obstacles we see include:
    a. Program model: Is it based on an evidence based model? If yes, what are the outcomes and success rate? If not, why not?
    b. Capacity: If this is an additional team to add to existing ones at Evergreen Healthcare, it seems overly ambitious to serve an additional 3,400 clients each year as these are brand new staff.
    c. Geography: Is it countywide? It is good that an East KC organization, Evergreen, will be the provider.
    d. Timeline: To be ready to begin by Dec. 2008 seems unrealistic. Community outreach to police, etc. will take longer to coordinate.
    e. Outcomes: None stated, just outputs. What are the outcomes?
    f. Program is very needed but this model does not seem to go far enough.

Strategy 2b – Employment Services for Individuals with Mental Illness and Chemical Dependency

- The anticipated caseload seems a bit high given that this is a form of supported employment. The implementation timeline and six-month service period also seem a bit ambitious, depending on the severity of symptoms and level of treatment compliance in the participant cohort.
- The strategy identifies 23 vocational services staff. For the service components identified, it may be more realistic to build in more case management staff support for a more holistic approach. Is this built into the evidence-based program which this strategy follows?
- Existing service providers will be the likely recipients of the award(s). Will services be provided to the Eastside?
- The strategy could mention outreach and education to participants who may be concerned about how getting a job will affect eligibility for public resources.
- How will the strategy address creaming and serving only the highest functioning individuals? Will measures of retention and wage progression play a role?

Strategy 3a – Supportive Services for Housing Projects

- This refers apparently to on-site supportive services and transitional housing. Again, the caseload and staffing figures seem a bit ambitious, and perhaps the timeline as well.
- Some clarification as to the nature of the residence should be incorporated. What kind of eligibility restrictions are used to determine residents who will live at the site at which these services are provided? Will criminal history, treatment history, etc. impact who can live there?
- Are move-in costs and rental subsidies built-in to the $2,000,000 annual figure?
- As this seems to be a site-based, transitional housing project, how likely is it that the Eastside will be the location for this site?

Strategy 4a – Comprehensive CD Outpatient Services to Parents in Recovery

- This apparently will target individuals in outpatient treatment who are also parents. These clients will be provided parenting skills and support, running parallel to their participation in outpatient.
- During the current period, KC is supposed to gauge local readiness for this program, before releasing an RFQ and determining awards by the end of 2008 for launch in 2009.
- There is not much detail as to how they will determine local readiness for this. There is no funding marked out for this process.
- The timeline does provide some lead time, in that launch can be as late as 6/09.

- The strategy document references the DASA TA for KC, which understandably suggests that the existing provider network is likely to receive the award(s).
- This should naturally raise some questions of the volume of prospectively available services for Eastside parents, as most of the providers are based in Seattle, North KC and South KC. FOY and YES are exceptions.

Strategy 4b – Prevention Services to Children of Substance Abusers

- This will be an EBP (Celebrate Families!™) that focuses on building positive family interaction through modeling and participant education/support, targeting children with a substance abusing parent.
- Referral sources come from CBOs, schools, CD providers, etc.)
- Again, there is no funding for planning. The $400,000 annual figure suggests a limited number of awards, given the evidence-base nature of the program which will require training for fidelity. Furthermore, it is anticipated that the program will serve 400 annually.
- Launch is expected in April 2009.

Strategy 4c—School District Based Mental Health and Substance Abuse

- Although the service design model has not yet been completed, there needs to be some assurance that the 19 grant awards for these services will be distributed equitably throughout the county. All schools have students dealing with mental health challenges and at risk of abusing drugs and/or alcohol.
- What level of schools will be targeted? High school only?
- How will this strategy work in those schools that do not have existing school based health centers?
- What are the measures that will be used to determine if the specified outcomes have been reached?

Strategy 4d—School Based Suicide Prevention

- Although there is no integrated suicide prevention strategy countywide, this has been an area of focus for the East Community Network and they should be involved as a key partner.
- Given that the identified provider is based out of Seattle, what is the plan to ensure that services will be provided across the entire county?
- It is difficult to tell if the resources allocated here will be sufficient.
- What measure(s) will be used to determine increased awareness?

Strategy 6a—Wraparound Family, Professional and Natural Support Services for Emotionally Disturbed Youth

- We would like assurance that these services will be available throughout the county
- Will those providers already using the wraparound model be utilized first?
- All stated outcomes should have specific measures attached to them
- What are MIDD funded parent organizations?
- If the design and training plan will be done in Dec, 2008, why will it take until mid-March to release an RFP?
- If awards are made in May, why will it take until September for services to begin? $3 million is a lot of money for a year that includes only 4 months of actual service delivery.
- How will dollars planned for evaluation of this component be linked/integrated with dollars planned for an overall MIDD evaluation?

Strategy 7a—Reception Centers for Youth in Crisis

- Because this is really a plan to make a plan, it is difficult to make specific comments. One question is what entity will be responsible for implementation of a coordinated response system?
- Youth service providers should be added to the list of partners identified for the coordinated response planning process.

Strategy 7b— Expanded Crisis Outreach and Stabilization for Children and Youth

- Is the current model evidence based? Is that going to happen during the planning process as well as the needs assessment? Who gets the technical assistance?
- How are families included in the model? Will there be adequate family support built into the current and /or enhanced model?
- Some obstacles we see include:
    a. Geographic Distribution: How will the YMCA of Greater Seattle provide services to East King County? Do they currently have a presence on the Eastside? If more providers are added, one should be included that serves the Eastside.
    b. Staffing: The plan does not describe how many staff the YMCA has now for this program, so it is hard to conclude whether 300 more to be served is realistic, or if the $1 million is enough for the ongoing program.
    c. Outcomes: How and who will collect the data?

Strategy 11b—Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services provided to Individuals with Mental Illness and Chemical Dependency

- Strategy is appropriate, but needs geographic distribution throughout King County, specifically on the Eastside.
- Who will collect the data?
- Follow-up: Is there a case management component for follow up and funds for services?

Strategy 13a—Domestic Violence/Mental Health Services and System Coordination

- Not sure how estimate of number of clients was determined (175-200 per year).
- Refugee Women's Alliance will house a mental health professional serving refugee and immigrant DV survivors; as a Seattle-based agency, it's not clear how/if DV clients from Eastside would be served.
- Timeline may be ambitious since mental health professionals with DV expertise need to be put in place at community based agencies by January 2009 – do these MH professionals need to be hired or out-stationed from existing mental health agencies?

Strategy 13b—Domestic Violence Early Intervention/Prevention

- This strategy is geared to children exposed to DV but is limited to South King County through collaboration between DAWN, YWCA, and Sound Mental Health.
- Given that the identified provider is based in South King County, what is the plan to ensure that services will be expanded across the entire county at some point? There is need in East King County as well, e.g. Eastside Domestic Violence Program has ongoing support groups for children while their mothers are in their support groups. In 2005, a group was also started for teens affected by DV whose families are not necessarily receiving services from EDVP.

Strategy 14a—Sexual Assault Services

- Not clear how increased coordination between mental health agencies and CSAPs will be measured.
- Similar to Strategy 13a above, Refugee Women's Alliance will house a mental health professional serving refugee and immigrant victims of sexual assault; as a Seattle-based agency, it's not clear how/if DV clients from Eastside would be served.
- Timeline may be ambitious unless the staff to provide these expanded services are already in place.

Strategy 15a—Drug Court: Expansion and Enhancement of Recovery Support Services

- Timeline may be ambitious since spending authority won't be approved the County Council until September 2008.

Strategy 16a—New Housing Units and Rental Subsidies

- We recognize the need for housing and the use of MIDD funds in the start-up year, but first priority for future years should be for direct mental health/drug dependency services, especially in view of other funding sources available for housing
- Some current housing applications for this population are already struggling to secure service partnerships because service dollars are so limited. So--it doesn't make sense to build more supportive housing that is unable to provide the needed services--we need to do both together.

Submitted at 9:37:16 PM, on Monday, June 02, 2008
Faith Richie, Valley Cities Counseling and Consultation

The Mental Illness and Drug Dependency Action Plan is a thoughtful document that gives us hope about a significantly improved service delivery system for citizens with mental illness and/or chemical dependency service needs.

Given the Countys potential deficit in human services funding, it is really critical that this funding not be used to supplant existing services or resources. As we understand it, sales tax funds can be used to replace lost federal dollars, but not to supplant local resources. This no supplanting rule will assure that the sales tax resources are truly used to enhance and improve the existing system.

Strategy 1a: King County is dramatically under serving persons without Medicaid. This strategy will open up access to outpatient care, and help to divert clients out of expensive criminal justice or inpatient facilities. We strongly support the concept of care continuity. When persons are authorized for services and go on and off of Medicaid, it is best to continue the course of outpatient treatment, rather than disrupt care and end up serving the person in emergency rooms or inpatient services.

Strategy 1b: The same principles apply to outpatient chemical dependency services. This investment will assure cost effective treatment.

Strategy 1d: Currently Next Day Appointments (NDA) crisis services are well utilized, but provide only very immediate crisis services with no opportunity to stabilize the client. We strongly support this strategy to provide short term treatment and stabilization services beyond the current initial assessment.

Strategy 1e: This support for training and education of chemical dependency professionals (CDPs) is a critically needed investment in the workforce.

Strategy 1f: We recommend that you broaden the strategy to allow existing provider agencies to also participate, if they have the expertise and the capacity to recruit and train Parent Partners.

Strategy 2a: We strongly support this strategy but the estimates for how much the funding will reduce caseloads are overstated. It takes other clinical and support staff to provide services including Psychiatrists and ARNPS, reception and medical records staff, clinical supervisors, and indirect costs including malpractice insurance, facility costs, training, etc.

Strategy 16a: We support the intent to use start-up funds for capital for housing development for low income clients with mental illness and/or chemical dependency.

Submitted at 9:20:15 PM, on Monday, June 02, 2008
Joanne Donohue, Senior Services

Why is there no older adult representation on the Advisory Board? Given the demographics and the prevalence of depression and cognitive disorders that go along with aging, I would assume you would want a person with aging expertise on the advisory board.

Submitted at 4:25:22 PM, on Monday, June 02, 2008
Nancy Cole, NAMI Greater Seattle

First, I think the work that has gone into this Plan is outstanding. It is one of the best plans I have ever read and clearly outlines the strategies to achieve the goal. Great job!

My comment - I am a strong supporter of housing and employment services and would like to recommend that the funds that are used for housing take the following into consideration:

1. Most of the low income housing is in downtown Seattle and is in, my opinion, reaching the saturation point. I would like to see some of the housing developers explore other parts of the county to increase housing and expand to other neigborhoods. Downtown housing is also very expensive.

2. I would like to see more housing using the "sweat equity" model that NAMI GS has developed and has proven to be very successful. This model provides a prospective tenant with the opportunity to help remodel the home they will move into. It provides ownership and work skills with the outcome of safe affordable housing. One of the men who lived in the Hofmann House for men for the past 8 years, has started his own landscaping company and moved into his own home.

The other positive aspect of this housing is once it's paid for, the rents provide the necessary operating funds and it does not need subsidy and the criteria can be more flexible.

NAMI GS is not in a position to develop more housing but could help others develop this model and there are city funds to help support this type of housing.

Thank you. Nancy

Submitted at 1:47:10 PM, on Monday, June 02, 2008
Mary Stevens, Resident/Voter

I am very pleased that housing development is a component of this plan. In order for treatment to be successful, persons w/ mental illness first need a safe place they can call home. This is an excellent use of our tax dollars, and I applaud King County's understanding of the role of supportive housing in successfully treating persons with mental illness and substance abuse.

Submitted at 10:52:55 AM, on Monday, June 02, 2008
Leonard Haan, Consumer Advocate

Although the workgroup was facilitated and staffed by MHCADSD and included representatives from DCHS, King County Council, Superior Court, District Court, DCHS Community Services Division, Office of Management and Budget, Jail Health Services, Department of Adult and Juvenile Detention, Judicial Administration, Community Corrections, Office of the Prosecuting Attorney, and Office of the Public Defender, none of these representatives are recognized experts on recovery from either

mental illness or addiction. As a result, the Plan suffers greatly. In order to correct this enormous problem with the King County plan, it will become necessary to affirmatively seek input from such consumer experts so that the overall objective of the plan, i.e. "recovery" can be actualized. The most fundamental transformation of the system will be the enactment of a more "consumer driven" system. This requirement is sorely lacking from the Plan.

In order for King County to establish a more credible Plan it will be required to overcome the barriers it has to listening to consumer wisdom and expertise in recovery. This may require some stigma reduction within the governing body which initiated the Plan so that the requisite communication can be opened and implemented for a more meaningful Plan. As it stands, the King County Plan bucks at National Consensus surrounding recovery, i.e. that it be "self-directed" by consumers. Overcoming this barrier is the most fundamental step in achieving the "recovery" sought by the King County Recovery Ordinance. While the observations of the current participants are completely valid in terms of what is going on in the system, without the key component of "consumer voice" the Plan lacks credibility and appears to perpetuate the stigmas and discriminations which are at the heart of societal problems in dealing with mental illness and drug dependency.

Briefly, the Plan offers no apparent support or implementation of Consumer Run Organizations in their many varieties. This needs immediate correction for the Plan to maintain any credibility with the population which it is supported to support, i.e. King County Consumers. There are many ways to obtain and receive information from local consumers and until their names are listed as being fully participating members of the workgroup developing and implementing the Plan, King County will not have overcome the most fundamental hurdle which has been overcome by other states in the nation.

Submitted at 10:28:35 PM, on Sunday, June 01, 2008
Ron Jaeger, WADADS

There is a very impressive thorough progression from planning to implementation. Excellent job!

I'm anxiously awaiting the plan for outreach and engagement to individuals leaving hospitals, jails, or crisis facilities.

Heavy use of peers and advocates is encouraged in the community throughout the programs wherever possible to increase opportunities for changes at significant points of access to the system such as emergency room substance abuse. They are best able to emotionally reach those in need.

Glad to see the funding for parent and youth partners in 1f and caseload reduction plans in 2a.

Under strategy 2b, it would be good to provide some lifelong supported employment service to those few who will require such long-term support.

Under 5a, please dont forget the health needs of those juveniles who wind up in the adult system due to auto-declines and are cut off from family and community services and are often developmentally delayed and unable to fend for themselves.

As mentioned in 6a, Wraparound is known to be highly effective. The greatest benefit to society will result from a system that serves not exclusively Medicaid recipients but all at-risk children and youth at all income strata. It is a proven process that unfortunately appears to be unsupported by private insurance systems. I think it is important to make sure that access is not limited and is provided at multiple points in the health and justice systems.

A large contingent of parents in the community could be invited through existing parent organizations to participate in discussions regarding 7b to expand crisis outreach and stabilization. They represent a wealth of valuable experience.

Linkages developed in 10b could greatly reduce the number of juveniles who later enter the corrections system because they were not considered to be safe for a community hospital and were sent home without a follow-up plan.

I believe that the implementation plan meets the intended goals and requirements and expect that it will continue to be refined through the years. One of our largest challenges is probably still reaching the maximum number of needy individuals at the earliest possible intervention point in their lives when the most good can be done with the least effort.

Everyone who participated in the development of this plan is to be congratulated. This is a comprehensive plan and was well worth the wait.

Submitted at 8:20:35 PM, on Sunday, June 01, 2008
Helen Nilon, The Nilon Group

I request, as a citizen of King County -- not affiliated with a particular group (comment was submitted earlier where "affiliation" was listed as NAMI Eastside. I am not commenting here for NES) -- that the County extend by two weeks the comment period for this document. Many of us, who have been stakeholders, had not been informed of this comment period as of Thursday May 29, 2008.

Helen E. Nilon, AICP, CPC, PSS, CMHE

Submitted at 9:52:23 AM, on Sunday, June 01, 2008
Jill Zaremba, Plymouth Housing Board member

The Housing aspect of this plan is very important to its success. It is very difficult to have recovery without a safe place to live. I am very pleased to see Housing being funded with our tax dollars. Congratulations to King County for its leadership to ending homelessness for our neighbors with mental illness!!

Submitted at 7:31:52 AM, on Sunday, June 01, 2008
Helen Nilon, NAMI Eastside

Please extend the deadline for comments to this important plan. Two weeks is not ample time to evaluate this Implementation Plan!

Submitted at 7:30:01 AM, on Sunday, June 01, 2008
Donald Mitchell, Plymouth Housing Group

The Housing aspect of this plan is very important to its success. We know that recovery is impossible without a safe, secure place to live. I am very glad to see Housing being funded with our sales tax dollars. Congratulations to King County for its leadership in ending homelessness for our neighbors with mental illness.

Submitted at 6:22:07 AM, on Friday, May 30, 2008
Michael Miller, Chair, Seattle/King Couny Aging and Disability Services Advisory Council

The Advisory Council for Aging and Disability Services strongly supports your timely decision to invest a portion of the 1/10th of 1% sales tax option for mental health and drug dependency services for older adults in King County.

We appreciate the opportunity to comment on the Mental Illness and Drug Dependency Action Plan (MIDD). We acknowledge the intensive work that has occurred to develop the MIDD Plan and would like to make the following comments:

1. We support the opportunities outlined in the MIDD Plan to fund prevention and early intervention strategies with demonstrated outcomes to enable older adults with severe mental health and drug dependency problems to access acute medical care services more appropriately. We would advocate for culturally competent services that intervene early and meet people where they are rather than waiting for a crisis to identify people in need of services.

2. Of the total amount of revenue raised by this initiative, about 1.8% is earmarked for older adults (Strategies 1g and 1h). While this is a good start, we recommend a level of funding proportionate to the population of older adults. As noted in the Aging and Disability Services Area Plan (http://www.agingkingcounty.org/area_plan.htm), the population over 60 will grow from 15% in 2005 to 23% in 2025 in King County.

3. We support the funding for crisis intervention for older adults with the GRAT (Geriatric Regional Assessment Team) consisting of geriatric mental health specialists, social workers, an on-call occupational therapist and a psychiatrist. The team works collaboratively to provide in-home medical, psychosocial and functional assessments for people age 60 and older who meet the criteria for eligibility.

4. We hope you will also consider evidence-based strategies tailored to older adults in the community or at home such as PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) depression therapy model for people 55 years and older who have minor depression or dysthymia. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS provides eight 50-minute sessions with a trained social service worker in the client's home over 19 weeks (http://www.agingkingcounty.org/docs/PearlsJamaApril2004.pdf).

5. We recommend outreach strategies targeted to older adults and adults with disabilities to ensure their proportionate use of the MIDD Plan Community-Based Care Strategies (1a-3a).

6. The MIDD Plan appears to target people whose incomes are above the Medicaid eligibility level, but the delivery setting still appears to be clinic-based only and not home-based. We recommend multiple types of delivery settings including senior centers and meal sites. Older adults need interventions delivered in collaboration with caregivers and family and tailored to their needs to generate positive outcomes. By using proven behavioral health services models, offered in home or in settings older adults already access such as senior centers, meal sites, and supported housing buildings, a greater number of older adults will benefit from these services.

7. While the make-up of the Oversight Committee is not a part of this MIDD Plan, we continue to be concerned about the lack of designated committee spots for either older adults or persons with disabilities. We are concerned about how older adults and people with disabilities, a large and growing portion of the County population will have a voice in this service area.

Thank you again for the opportunity to comment on the MIDD Plan.

Submitted at 11:59:19 AM, on Thursday, May 29, 2008
Sandra melo, family member

Hello--
I've got a family member who 'falls through the cracks' in many ways. She has an untreated mental illness, which is severe and persistent. She attempted to get housing in the Seattle area about 3 years ago.

She was a frequent visitor at the Seattle Housing office (when it was still on 4th). She was clearly mentally ill, but was not assigned an advocate. It is very difficult for her to complete paperwork or maneuver the system on her own. She gave up on the idea of housing in Seattle, and was been in transitional housing in Spokane.

After more than a decade of living in shelters and on the streets --and now in transitional housing-- the family is trying to help her obtain section 8 housing closer to us, perhaps in Seattle or Lynnwood.

However, we are concerned that she will be overlooked yet again. She is not in a group targeted for services: She is not a mother, not a youth, not addicted to a drug, not an immigrant, not involved with the criminal justice system. How can she get section 8 housing?? This MIDD plan could exclude her.

Submitted at 6:39:28 PM, on Tuesday, May 27, 2008
Carolyn LADNIAK, citizen

I think this looks good. Let's get drug addicts and alcoholics out of the criminal side of things and get them the help they need.

Submitted at 4:19:32 PM, on Wednesday, May 28, 2008
Debbie Doane, Children's Response Center - Harborview

These comments concern the Sexual Assault Services strategy (14a):

1)The plan calls for a Coordinator position to focus on cross training, policy development, and enhancing linkages/referrals between DV, CD, SA and mental health. This represents an agreement between the sexual assault and domestic violence providers who recognized the need for enhanced community based coordination between the various systems. The position should be hired and housed at the King County Coalition Against Domestic Violence, a community based organization. The coordination is focused on the community programs involved in delivering the services and thus it makes the most sense to have the position be based in the community as well.

2) The SA strategy focuses on increasing treatment and services capacity for SA victims with the accredited Community Sexual Assault Programs (CSAPs)taking the lead in delivering these services. The plan recognizes that CSAPs provide a uniquely integrated system of SA services (albeit underfunded) with a particular gap in mental health treatment for SA victims having been identified. Since the CSAPs are already positioned to deliver mental health care to children, youth and adults impacted by sexual victimization and since there are limited SA funds available through this plan, it could best be handled as a contract amendment through the county for the 3 CSAPs and not as a RFP. The goal of the plan is to bridge an identified gap in delivering mental health services. An RFP process could potentially alter the provider pool and change the intended focus of the strategy.

3) The original intent of these funds was to provide for some predictable funding for human services. Housing is a real need related to issues of mental health and substance abuse. Identified sources of funding for housing in recent years has increased many times over what has been made available for human services. It appears that there will be some un-spent funds in the first year of this funding that could go to housing to support or leverage the funding of the many identified needs in that area. In future years, the priority needs to continue to be human services with any additional funds considering both human service needs as well as housing.

Thank you.

Submitted at 5:40:17 PM, on Tuesday, May 27, 2008
Tracey Wickersham, Employed by Seattle CVB / Plymouth Housing Group Board Member

I wish to voice my support for the housing aspect of this plan, which I feel is critically important to its success. We know that recovery is impossible without a safe, secure place to live. As a worker in downtown Seattle, I see people on the street every day with obvious signs of mental illness, and without a secure place to live, access to treatment and long term positive outcomes seem difficult if not impossible to achieve. I am pleased to see housing being funded with our sales tax dollars. Congratulations to King County for its leadership in ending homelessness for our neighbors with mental illness.

Thank you for the opportunity to comment.

Submitted at 6:05:20 PM, on Tuesday, May 27, 2008
Gretchen Reade, Seattle resident

Housing is a key component of this plan. Our neighbors who are homeless and contending mental illness or chemical addictions simply cannot recover until they have a safe, secure place to live. I am glad to see my tax dollars going toward a strategy that makes sense and will be a real solution. Many thanks to King County for its leadership.

Submitted at 1:55:48 PM, on Tuesday, May 27, 2008
Kerriann Suglia, citizen of seattle

The Housing aspect of this plan is very important to its success. We know that recovery is impossible without a safe, secure place to live. I am very glad to see Housing being funded with our sales tax dollars. Congratulations to King County for its leadership in ending homelessness for our neighbors with mental illness

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Submitted at 4:24:14 PM, on Tuesday, May 27, 2008
Leslie Christian, Portfolio 21 Investments, Plymouth Housing Group (Board Chair)

The Housing aspect of this plan is an essential component for its success. We know that recovery is impossible without a safe, secure place to live, and I am grateful that King County recognizes this and is willing to use tax revenues to address the issue of homelessness and mental illness.

Submitted at 1:06:58 PM, on Tuesday, May 27, 2008
Henry Berman, None

I am a physician who has specialized in Adolescent Medicine for almost 40 years. In the past few years I have focused on teens with behavioral problems, including depression and anxiety. I have seen a number of teens (and even a few pre-teens) who have tried to kill themselves and/or have told their parents that they are contemplating doing so. I had the tragic experience of having one such patient under my care go ahead with his plan.

Suicide is something we don't talk about in polite society--let alone adolescent suicide. We need much more public awareness of this problem, and a way to reach out to teens to make them aware of what resources are available to them if they feel life is hopeless, and also a way to teach their peers how to recognize depression and anxiety in their friends, and how to help them get the help they need.

I strongly support your draft plan, in particular strategy #4d.

Henry Berman, MD
Specialist in Adolescent Medicine
Children's Hospital & Regional Medical Center

Submitted at 12:42:00 PM, on Tuesday, May 27, 2008
Mike Staszak, SEIU member and therapist at CPC

I am concerned how you can guarantee that money allocated to individual agencies to reduce caseloads will actually be used for that?

There were numerous clear examples of agencies not following state guidelines for the wages and benefits increases for 2007-2009 budget years. And, the guidelines were written right in the state budget.

If an agnecy ignored state guidelines then how will we know they are following and accountable for this county sales tax to reduce caseloads?

I have one other concern, there is no policy or plan that I can find on any county, state, or even agency level for providing evidence based trauma treatment for adults. I work with all adults at my job and at the least 95% have chronic trauma histories and yet we have little to no resources to adequately address these complicated diagnoses.

If government at any level wants the recovery plan to work, then you HAVE to provide comprehensive and evidenced based chronic trauma treatment for the large number of adults on disability and unable to work.

I feel the Recovery model is ignoring one of it's biggest challenges. How can you really expect people to recover and return to work or productivity if they cannot get the help they really need??

People who have chronic trauma tend to avoid any interactions with people, which means they will not be able to do most jobs or just get around in the community.

Thank you for your time.

Submitted at 11:58:50 AM, on Tuesday, May 27, 2008
Edie Loyer Nelson, Human Service Levy Oversight Board

Please note the message from Marcy Krubbs who staffs the King County Human Services Oversight Board. She created a list of areas where the MIDD proposal overlaps the activities of the Human Services Levy. As long as the Dept. of Community and Human Services is implementing both plans, I believe any duplication of services will be avoided. I am pleased there is a section serving youth in the MIDD proposal as they were not well addressed by the Human Services Levy.

Submitted at 12:33:04 PM, on Tuesday, May 27, 2008
Mahinda Werake, Northwest Defenders Association

Thank you for the excellent work done. We hope that the plan would be implemented without delay so that it would benefit the mentally ill and drug addicted persons in the King County. However, getting these persons into treatment voluntarily (without the intervention of the court system) would be a challenge.

Submitted at 11:28:52 AM, on Tuesday, May 27, 2008
Sylvia Haven, World citizen and 46th District Democrat

With this approach to mental illness and drug dependency we are finally weaning ourselves from the Middle Ages practice of inhumanely punishing people for being sick. I applaud especially goal number 4:" Changes will be made in the criminal justice system to create more treatment options for the courts to support rehabilitation and recovery."

I leave it to the financial experts to manage the 2008 spending plan. I would be happy to pay more taxes for this program if you would only please stop using public money for stadiums and streetcars to nowhere.

It is the evaluation process that will determine the hoped for effectiveness of this program. It makes sense to do that part thoroughly.

Submitted at 10:45:23 AM, on Tuesday, May 27, 2008
Jerry Forell, Taxpayer/Kirkland

Another group of people that have to be taken care of by government? Our babysitter?

I know you mean well and I know it's hard to say no to these people but too much gov't babysitting instills in people a belief that they don't have to rely on themselves. There will always be a gov't program to bail me out of every bad decision I make.

The fear of self reliance guides better personal decision making.

Submitted at 8:50:35 AM, on Tuesday, May 27, 2008
Annette Dawson, Case Manager

The Housing aspect of this plan is very important to its success. We know that recovery is impossible without a safe, secure place to live. I am very glad to see Housing being funded with our sales tax dollars. Congratulations to King County for its leadership in ending homelessness for our neighbors with mental illness.

Submitted at 8:45:06 AM, on Tuesday, May 27, 2008
Chris Hollinger, Citizen

Housing is key to a person's recovery and identifying housing in this plan very important to its success. We know that recovery is impossible without a safe, secure place to live. It pleases me to see Housing being funded with my sales tax dollars. Congratulations to King County for its leadership in ending homelessness for our neighbors with mental illness.

Submitted at 8:08:00 AM, on Tuesday, May 27, 2008
Richard Liranzo, Plymouth Housing Group

As the real estate specialist for the federal Shelter Plus Care program in King County for over 13 years, I've seen by meeting these people on a continuing one-to-one basis where providing basic permanent shelter for mentally persons has been the most important factor in their treatment process. Elimination of their stress in locating and keeping a roof over their heads is the best beginning for their recovery.

Submitted at 8:06:11 AM, on Tuesday, May 27, 2008
Solana Booth, Indigenious Vision

The Housing aspect of this plan is very important to its success with Native American people or Urban Indians. I know that if we can dilude the mantal illnesses of the Urban Indians by housing them, then we can start meeting their needs to match our expectations of them. I am Native American, of the Tsimshian and Nooksak Nations. I am a Urban Indian who has been through the Seattle Streets, worked in the Social Services field, and understand their needs are not being met. However, I belivee that this is a start. I appreciate what Martin Luther King County is doing for Chief Seattle City, for our city of all the people in need!

We know that recovery is impossible without a safe, secure place to live. I am very glad to see Housing being funded with our sales tax dollars. Congratulations to King County for its leadership in ending homelessness for our neighbors with mental illness.

Submitted at 8:01:26 AM, on Tuesday, May 27, 2008
Solana Booth, Plymoyth Housing Group

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Sent: Friday, May 23, 2008 5:17 PM
Subject: sales tax comments

I am a 30 year Seattle resident who has lived in affordable housing, volunteered or worked in other housing or shelter agencies. This experience has shown me how support services (or the lack of) can make or break a housing program. It has become very clear to me that a support services component is necessary to a resident's successful re entry into the "housed" population. A roof is not enough.

I fully support using sales tax for these additional resouces and encourage you attach these support services on every housing project you fund that serves the homeless population.

Thank you
Laura Schaack

Submitted at 3:33:55 PM, on Thursday, May 22, 2008
TM Connor, King County voter and taxpayer

It was very exciting to note that housing was included in this plan - too often we have ignored the fact that safe housing is integral to real and lasting recovery--- At this point in the 'ending homelessness' implementation, capital funds to meet the goals are woefully inadequate, and this presents an obvious barrier to progress.

congratulations on your foresight, and plan well-researched.
