6/15/83

Lois North, Gary Grant,
INTRODUCED BY: Audrey Gruger
Ruby Chow
PROPOSED BY: 83-312

MOTION NO. 5771

A MOTION approving the 1983-85 Biennial Mental Health Plan and authorizing the King County Executive to transmit the Plan to the State of Washington, Department of Social and Health Services.

WHEREAS, Washington State and federal funds are provided to King County to support a program of community based services for the acutely mentally ill, chronically mentally ill, and seriously disturbed persons, and

WHEREAS, King County receipt of State and federal funds is contingent upon review and approval by the Department of Social and Health Services of a biennial plan of mental health services, and

WHEREAS, the King County Mental Health Board has recommended to the King County Council the 1983-85 Mental Health Program Plan which includes policies for the expenditure of the State and federal funds;

NOW THEREFORE, BE IT MOVED by the Council of King County:

A. The 1983-85 Biennial Mental Health Plan is hereby adopted by the King County Council.

B. The King County Executive is authorized to transmit the Plan to the State of Washington, Department of Social and Health Services.

PASSED This 5th day of July, 1983.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Chairman

ATTEST:

Clerk of the Council

MOTION NO. 5771

1983-85 Biennial Mental Health Plan

Submitted to Randy Revelle
King County Executive

Prepared by Staff of
Human Services Division
Adopted May 17, 1983 by
King County Mental Health Board
June 15, 1983

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Plan of Services

The 1983-85 King County Mental Health Plan responds to the mandates of the revised Community Mental Health Services Act for provision of a program of services to address the needs of the acutely mentally ill, the chronically mentally ill, and the seriously disturbed. The plan has been developed within the framework of the new King County mental health goals and objectives and the King County Mental Health Board's Long-Range Plan.

The 1983-85 Biennial Plan contains a combination of new and existing services that are intended to accomplish the following objectives:

- respond to the emergency/short-term-care needs of the acutely mentally ill;
- engage and keep the most severely mentally ill (the chronically mentally ill and seriously disturbed with a recent history or ongoing risk of institutionalization) in long-term-care;
- reduce the incidence of involuntary hospitalizations and jailings involving county program clients; and
- improve the ability of county program clients to live in the community in a manner which is personally satisfying and allows fulfillment of potential as contributing community members.

In order to accomplish the above, the 1983-85 Plan proposes a restructuring of the existing adult treatment program to incorporate essential community support services. The new Basic Community Support and Treatment Program combines traditional outpatient counseling, medications, day activities, housing, referral and advocacy for essential financial and social services, and help with solving problems of living which might otherwise build up to crisis proportions. The service mix for any individual client will depend upon need and will vary as the client's condition or social situation changes. This program also includes some capacity for serving walk-in clients in need of emergency services. The program will be provided by a number of contractors distributed throughout King County. Contractor selection through a request for proposal (RFP) process will assure that ethnic minority, elderly, developmentally disabled, hearing-impaired, and other special needs groups have access to appropriate services.

The second major change to the existing program of services is the addition of the new Regional Emergency/Short-Term-Care Program which will provide hospital prescreening, crisis intervention, and referral for persons experiencing acute

episodes of illness who are not enrolled in the long-term-care program. This program will also provide follow-up contacts and short-term treatment and support for persons discharged from inpatient units who are not immediately linked to the long-term-care system. Staff from this program will regularly visit designated hospitals to assess potential referrals and consult with hospital discharge planners. The Regional Emergency/Short-Term-Care Program is a key linkage point between the hospital system and the community services program. This program will be provided by no more than four contractors also selected through an RFP process.

A third change is the addition of a Client Tracking/Care Coordination Program. Counties are now required to maintain centralized tracking information on chronically mentally ill in community programs and coordinate services for persons discharged from inpatient care. A new county staff person will be employed to maintain the tracking information files and coordinate the referral system between hospitals and the Regional Emergency/Short-Term-Care and Basic Community Support and Treatment Programs.

A fourth change is the initiation of a small Demonstration Training and Supported Work Program for chronically mentally ill who are not yet able to qualify for support through the Department of Vocational Rehabilitation program. This program will expand opportunities for work-related activity outside day treatment settings. One contractor will be selected through an RFP process.

Existing programs which will be maintained are: 24-hour Crisis Line, Involuntary Treatment Services/Crisis Outreach, Downtown Emergency Shelter (case management), and Intensive Community Support Teams. The Semi-Independent Living Program will be maintained if separate residential funding is made available by the state.

The Children's Services Program, including outpatient counseling, medications, and day treatment services, will be maintained as is through the middle of 1984. The Children's Coordinator will be participating in the Human Resources Coalition planning effort on children and youth during the first biennial year. Program changes needed to better integrate mental health and other services for children and youth will be made for July 1984. The existing special residential treatment program, the Violently Disturbed Child Project, will be maintained through the biennium.

Changes in County Administration

The plan proposes the addition of a new Mental Health Administrator as the lead position in the Mental Health Section of the Human Services Division. The addition of this position will partially restore county mental health staff to the level which existed prior to temporary state funding reductions in 1981 and will provide increased program leadership necessary to implement the biennial and long-range plans and meet the intent of the revised law. The administrator will supervise the overall planning of the mental health system in King County including its voluntary and involuntary aspects as well as the management of all programs except Involuntary Treatment Services (ITS), which due to the size of

its county staff, will remain an operationally separate unit. The existing Mental Health Coordinator position will report to the administrator and will continue to provide staff support to the Mental Health Board in its planning and allocation role.

Separate funding is also being requested from the state for a Residential Coordinator to help develop new residential treatment options included in the Governor's Budget Request. Proper development of new residential treatment programs is critical to reducing the "revolving door" syndrome in involuntary treatment and at the King County Jail.

Biennial Revenue Projections

King County is required to develop a budget for two levels of state-appropriated funding--a "No Change" Budget and the Governor's Request Level Budget. The former budget actually represents a loss of $73,204 in ongoing revenue per budget year due to new state funding policies. The Governor's Request Level Budget yields increases of $509,542 and $796,617 for 1983-84 and 1984-85, respectively.

King County has expressed opposition to the funding formula currently used to distribute funds to counties. This formula considers only projections of seriously disturbed despite the fact that new state mental health legislation gives chronically mentally ill higher priority. By the state's own calculations, King County has 32 percent of Washington State's chronic population and 25 percent of the seriously disturbed. King County contends that an adequate funding formula must take both populations into consideration.

The state has significant sums of unobligated federal block grant funds for allocation to the counties, and it is likely that new residential care funds will become available. For this reason, King County has developed a third "Adequate" Level Budget which includes justification for increased levels of resources.

In preparing budgets it is assumed that the General Assistance-Unemployable (GAU) mental health program funds will be consolidated into the grant coming to counties. It is also assumed that the Involuntary Treatment Administration funds currently supporting contract services will still be available.

Funding Strategies

The 1983-85 King County Mental Health Plan includes a three-month period (July 1 - September 30, 1983) during which existing contracts will be extended. This contract extension period allows time to develop a final budget based on the actual state award not anticipated now until July or later as well as time to complete contractor selection and contract negotiations for the major new programs to be implemented during the biennium. In order to extend all contracted services during the three-month period, King County requires additional revenues to replace federal mental health block grant funds which were made available on a one-time-only basis during the 1983-85 biennium to support a

portion of adult treatment services and a Semi-Independent Living Program. Permission is being sought to use $111,262 in unexpended block grant funds previously allocated to King County for the Intensive Community Support Teams Program to maintain adult treatment services and Semi-Independent Living services during the contract extension period.

The funding strategy adopted by the Mental Health Board for the Governor's Request Level Budget funds all programs identified in the 1983-85 Plan of Services. It maintains existing programs at current levels and funds Regional Emergency/Short-Term-Care, Training and Supported Work, Geriatric Assessment, and Client Tracking/Care Coordination at the minimum needed for a viable program without reducing the defined scope of any program. The new Mental Health Administrator position is also funded. The Basic Community Support and Treatment Program receives all funds remaining after the other program and administrative costs have been allocated.

At the Governor's Request Level of funding, the Basic Community Support and Treatment Program will serve fewer persons than were served in 1982 by the Adult Treatment Program. This situation occurs for two reasons: 1) staff maintain severely mentally ill persons in the community and 2) fewer persons will drop out of the program prematurely, leading to lower client turnover. Preliminary information from providers suggests the annual caseload reduction may be one-third or more as a result of the new scope of services. Reductions in non-county-administered funds supporting services for priority clients and cost-of-living adjustments will further influence these figures.

The "Adequate" Budget, which builds on the Governor's Request Level Budget, adds funding to support caseload maintenance for the Basic Community Support and Treatment Program. It also adds funds for cost-of-living adjustments and maintenance of the Semi-Independent Living Program. The need to fund the Involuntary Treatment Program adequately is also identified.

A final "No Change" Budget has been developed. Funding policies adopted by the Mental Health Board eliminate the Training and Supported Work and the Geriatric Assessment Team programs. The Regional Emergency/Short-Term-Care Program is reduced, with visits to hospitals and voluntary patients in the community occurring less frequently. The Basic Community Support and Treatment Program is unacceptably reduced.

BACKGROUND

In 1982 the Washington State Legislature passed the revised Community Mental Health Services Act. This new legislation specified that public mental health funds were to pay for services for a limited target population composed of the acutely mentally ill, the chronically mentally ill, and the seriously disturbed. The legislation also added support services to the array of required outpatient services and made residential care an optional service to be provided by the county program. Under the new legislation, counties are also required to maintain centralized tracking information on the chronically mentally ill and to provide community support services which assure follow-up of discharged hospital patients. These additions were designed to provide a more responsive and better coordinated system of mental health care for state priority clients.

King County responded to the new legislation with a thorough review of its existing system. The major problem identified in King County, as in other parts of the country, is the failure to adequately maintain certain subpopulations of the mentally ill in the community. A major indication of this problem is a large number of involuntary detentions--2,244 detentions for 1982. This level of activity contributes to high acute psychiatric inpatient care as well as higher legal costs. More significantly, it represents a high degree of individual and family distress and an increased burden on the community.

The Mental Health Board, in conjunction with citizens and providers, sought to address this problem through identification of needed system change and enhancements. The Board adopted a long-range system development plan which proposed major changes in the existing county program structure to assure a more effective response to the severely mentally ill requiring crisis intervention, post-hospital follow-up, treatment and support services. These changes are intended to accomplish the following objectives:

- respond to the emergency/short-term-care needs of the acutely mentally ill;
- engage and keep the most severely mentally ill (the chronically mentally ill and seriously disturbed with a recent history or ongoing risk of institutionalization) in long-term-care;
- reduce the incidence of involuntary hospitalizations and jailings involving county program clients; and
- improve the ability of county program clients to live in the community in a manner which is personally satisfying and allows fulfillment of potential as contributing community members

During the time the Mental Health Board was developing its Long-Range Plan, the Executive Task Force on Mental Health was meeting to advise the Executive on mental health goals and objectives for King County. The Task Force reviewed the

Mental Health Board's Long-Range Plan and incorporated major elements of the plan into a more general set of mental health goals and objectives for King County. The goals and objectives are intended to provide a broad policy framework for county action in the area of mental health. The goals and objectives cover mental health promotion and mental illness prevention as well as programs for those experiencing mental illness. A complete version of the Goals and Objectives is found in Attachment A.

The 1983-85 Biennial Mental Health Plan has been developed within a framework of the Community Mental Health Services Act, the Board's Long-Range-Plan, and the King County Mental Health Goals and Objectives relating to the state priority target population. The 1983-85 Plan has been completed for submission to the State Department of Social and Health Services, following Executive and Council approval, in fulfillment of requirements for receipt of state funds to support the King County Mental Health Program.

PROPOSED 1983-85 PROGRAM PLAN

The Board's Long-Range Plan identified and defined a number of critical programs needed by seriously mentally ill adults, children, and elderly. Some of these programs are new components to the system; others are significantly modified existing programs, and some are current components needing to be maintained as they are. The 1983-85 Plan includes these high priority programs.

In order to show how the service plan for 1983-85 is part of an overall long-term strategy it is expressed in terms of action steps related to the goals and objectives which emanated from the Long-Range Plan and the Executive Task Force.

More detailed descriptions of each planned program are found in Attachment B.

GOAL - Develop and implement an integrated voluntary and involuntary emergency/acute-care system to meet the emergency short-term-care needs of the acutely mentally ill in King County.

Objective

Develop and implement cost-effective, short-term outpatient and residential care options and assure admissions and transfers between acute and long-term-care when needed.

Action Steps

- Implement a new Regional Emergency/Short-Term-Care Program. This program will provide assessment of the need for hospitalization, crisis intervention when this is an appropriate alternative to inpatient care, and referral for needed inpatient care. This program will also provide follow-up services for all priority persons discharged from inpatient units or the jail who have not been linked to a long-term-care

program. Follow-up services include outreach, short-term support and treatment, medications and referral to a long-term-care program. Regional Emergency/Short-Term-Care services will be provided by contractors located in four regions of the county: north, central, south and east. Contractors will be selected through a competitive proposal process. Program development will consider the needs of non-English-speaking and handicapped persons for accessible and appropriate services.

- Include within the new Basic Community Support and Treatment Program described under the next goal, a walk-in emergency services component. This component will respond to the needs of the acutely mentally ill who may come to local agencies requesting services.

Objective

Maintain critical components of the existing emergency/acute-care system.

Action Steps

- Continue the existing 24-hour Crisis Line Program. This program provides one-number telephone assessment, crisis intervention and linkage to acute-care resources, including the Crisis Outreach and Involuntary Treatment Program. It will be continued with the existing contractor.

- Continue the existing Centralized Crisis Outreach, Involuntary Treatment Services Program. This county program provides 24-hour-per-day, 7-day-per-week outreach services to persons requiring emergency assessment, crisis intervention, or referral to appropriate outpatient or inpatient care. Detentions are used only in situations where persons meet strict legal criteria and no other option exists for linking them to needed emergency care. Coordination of the setting of the court dates and documentation of legal cases are also program functions. This work will continue to be done by the Involuntary Treatment Services Section of the King County Human Services Division.

- Continue the existing Emergency Shelter Case Management Program. This program includes two case managers located at the emergency shelter in the Morrison Hotel. These case managers serve mentally ill persons coming to the shelter who are in need of housing, financial assistance, or referral for mental health treatment. This program will be continued with the existing contractor.

Objective

Coordinate services for King County residents being referred from the acute-care system to the long-term-care system.

Action Step

- Implement the new Client Tracking/Care Coordination Program. This program fulfills state requirements for maintenance of centralized tracking information on chronically mentally ill persons and for coordination of services for persons moving between inpatient care and the community mental health program. The program includes one full-time county employee, the Client Tracking/Care Coordinator and support for that position. This coordinator will identify and attempt to resolve major referral problems and will work with the new Regional Emergency/Short-Term-Care Program to develop hospital follow-up procedures, including outreach, for the mentally ill who are not linked to the long-term community care system at discharge.

Objective

Provide sufficient mental health care beds in King County to handle short-term voluntary and involuntary needs in an appropriate and affordable manner.

Action Step

- Assist the state to develop one or more involuntary treatment options in non-hospital settings with appropriate medical care.

GOAL - Develop an improved range of outpatient and residential options, for longer-term stabilization, maintenance and rehabilitation of chronically and seriously mentally ill residents of King County.

Objective

Improve the current basic outpatient program to: (1) ensure that mental health services are provided first for those most in need; (2) require assistance with basic living needs and medication monitoring; (3) locate responsibility for primary care and coordination of all necessary services for client support in the community with the mental health care provider; (4) provide greater choice of mental health services for clients; and (5) allow providers greater flexibility in providing appropriate types, levels, and mix of care for clients.

Action Steps

- Implement the Basic Community Support and Treatment Program. This is the primary long-term-care program for priority clients replacing the previous basic program of outpatient and day treatment services. Services include assistance with basic living needs and development of support systems, medications, day activities or day treatment, outpatient therapy, and care coordination and consultation with other service providers. Provider agencies will have primary care respon-

sibility for their clients and will be expected to make outreach visits to keep clients at risk of hospitalization in treatment. This program is intended to provide a more appropriate range of care, which will better maintain seriously disabled persons in the community with a minimum of episodes of hospitalization. It is also intended to develop a personal support network for clients so that the need for intervention by professional staff will diminish.

Some emergency services will also be provided for non-enrolled persons who walk in and need immediate attention.

A variety of local and specialized contractors will be sought. Contractor selection will be by competitive proposals. The needs of minority, handicapped and elderly priority mentally ill will be addressed through the development of criteria for contractor selection which will assure access to appropriate services for these special needs populations.

Objective

Evaluate and expand to other parts of the county, if appropriate, the demonstration program (Intensive Community Support Team) that provides 24-hour-per-day outreach assistance to a small caseload of the most seriously and chronically mentally ill.

Action Step

- Continue the Intensive Community Support Team Program. This pilot program, supported by special federal block grant funds, provides a combination of treatment and support services with 24-hour emergency availability of program staff for multiply-hospitalized clients. It is a higher level of care than the Basic Community Support and Treatment Program and is intended for unstable or highly disabled persons who need more frequent contact with and assistance from case management staff. This program will be continued with existing providers serving the central and south regions of the county.

Objective

Promote development and implementation of a range of residential care options, including such new options as semi-independent living programs for people able to live on their own with some assistance, and residential treatment for those needing more intensive care. Administer these state-funded residential programs directly if the state provides the county with adequate resources.

Action Steps

- Seek residential care or block grant funds from the Mental Health Division to maintain and enhance the existing Semi-Independent Living Program. This residential program provides placement and ongoing

assistance to groups of clients living together in apartments and private homes. Staff of four provider agencies help to resolve interpersonal problems involving the living group and consult with landlords and others when necessary to maintain clients in these settings. Pending sufficient funding and a review of the program, the current providers will be maintained. Additional providers may be sought if funding levels increase.

- Seek funds from the Mental Health Division to hire a county residential services coordinator to assist the state with the implementation of new residential care and treatment initiatives within the county and prepare a proposal for assumption of residential care administration.

Objective

Encourage development of work training and subsidized work projects in the private sector, as well as in sheltered employment environments, to provide the mentally ill with financial support, self-esteem, and independence.

Action Step

- Implement a demonstration Training and Supported Work in Non-Treatment Settings Project, which replaces the limited and dispersed Vocational Resources Coordination Program. This demonstration program provides vocational training and supported work for persons who are not yet eligible for services through the Department of Vocational Rehabilitation programs under present criteria. These persons can benefit from training and work in natural or sheltered work settings. A contractor for this regional program will be selected through a competitive bid process. Some vocational coordination will continue to be provided as part of the Basic Community Support and Treatment Program.

GOAL - Assure reasonable access to a range of mental health services and appropriate care for priority clients regardless of race, color, creed, religion, national origin, sex, age, marital status, sexual preference, language, income, or the presence of any sensory, mental or physical handicap.

Objective

In conjunction with other primary care systems, enhance mental health treatment and consultation services for the elderly, children and youth, and disabled populations.

Action Steps

- Continue the existing Children's Outpatient and Day Treatment Program. Within the program, outpatient therapy and day treatment are offered to seriously disabled children by a number of community mental health agencies around the county. No major changes in this program are an-

ticipated until mid-1984 unless necessitated by a performance problem. In 1984 the program may be changed to better fit within a larger King County plan for children's services.

- Continue the existing Violently Disturbed Child project. This is a residential treatment program funded by the state on a special project basis to seriously disturbed youth whose behavior problems require much staff time and structure. It is jointly administered by the Bureau of Children's Services and the County. Five youth at a time can be served in the home-like setting. This program will be continued with the existing contractor.

- Begin joint funding of the Geriatric Assessment Team Program with the Seattle-King County Division on Aging (SKDOA). This program will provide the critical link between the mental health and aging systems, helping to determine in difficult cases what combinaton of services from the two systems is appropriate. A nurse, social worker and a psychiatrist, all with specialized knowledge of geriatric problems, assess health and mental health problems of elderly who are unable or unwilling to seek assistance, and make referrals to appropriate care. In keeping with the Board's long-range-plan to develop a coordinated elderly program in conjunction with SKDOA, support for one new staff person for the team plus additional psychiatric time will be provided beginning in 1984. A joint request for proposal will be issued by the city and county to determine the contractor for this expanded program. Additional funds may be sought from the state to develop a second team.

- Assure that provision is made in the array of agency programs funded under the Basic Community Support and Treatment Program for the special needs of the elderly and the developmentally disabled and handicapped.

Objective

Enhance the range of appropriate services available to cultural and ethnic minority residents.

Action Steps

- Assure that provision is made in the array of agency programs funded under the Basic Community Support and Treatment Program for enhancement of appropriate services for cultural and ethnic minority residents. In the past, some specialized providers were funded simply for outpatient and minimal social services. They were unable to offer a full range of services for disabled clients.

- Make provision for non-English-speaking and hearing-impaired to use the Regional Emergency Services Program.

GOAL - Wherever feasible and appropriate, divert the mentally ill from the King County Jail to appropriate mental health services in the community.

Objective

Assure that community mental health services give priority to chronically and seriously mentally ill persons referred from the King County Jail.

Action Step

- Implement the new Basic Community Support and Treatment program; identify referrals from the King County Jail as a high priority.

In addition to program goals, there is one goal which relates to county administration activity.

GOAL - Exercise King County's leadership role and responsibilities as defined in the new Community Mental Health Services Act by designing and implementing a complete and adequate system of care for the chronically and seriously mentally ill.

Objective

Develop and begin implementation of a long-range-plan which includes: (1) King County's mental health goals and objectives; (2) descriptions of the necessary components of the mental health system; (3) definitions of the respective roles and responsibilities of the mental health system and other primary care systems such as aging and child welfare; and (4) the full range of voluntary short- and long-term-care including residential components and the mental health services in the jail.

Action Step

- Add a new mental health administrator position to supervise implementation of the long-range and biennial plans. Planning and implementation of a comprehensive mental health system requires restoration and redirection of county administration capacity. This position will be responsible for integrating planning for the components of the voluntary and involuntary mental health program and portions of the residential care system.

  The Mental Health Program administrator will supervise all other staff in the Mental Health Section including the existing Mental Health Board Coordinator, and the new Tracking and Residential Care Coordinator positions.

  The addition of the Mental Health Administrator position and portions of two clerical support positions will partially restore the Mental Health Section staff component that existed prior to cuts in 1981.

Objective

Assure effective public participation in mental health planning process by continuing the active role of the King County Mental Health Board.

Action Step

- Maintain the Board's role in plan development, allocations, and review of programs and its necessary staffing support.

STATE ALLOCATION PROJECTIONS AND FUNDING STRATEGY

King County has been instructed by the Mental Health Division to develop a mental health program budget based on two levels of state appropriated funding: a "No Change" Budget and the Governor's Request Level Budget. Table I shows these ongoing revenue figures in comparison with 1982 ongoing levels.

TABLE I

ONGOING STATE PROGRAM REVENUES

1982	"No Change" Budget 1983-84	"No Change" Budget 1984-85	Governor's Request 1983-84	Governor's Request 1984-85
$4,172,055	$4,098,851	$4,098,851	$4,681,597	$4,968,668

It should be noted that the "No Change" Budget actually represents a loss of ongoing state revenue of some $73,204 per budget year. This is the result of a new state funding formula which distributes funds between counties based on the estimated prevalence of serious disturbance due to mental illness. Previously, funds above a base amount were distributed on a straight per capita basis. According to state estimates King County has 25.8 percent of the seriously disturbed population. This percentage is considerably less than King County's proportion of total state population which is 30.7 percent. The prevalence estimate is based upon the use of socio-economic indicators related to poverty and unemployment. King County has relatively higher per capita income and lower unemployment than the rest of the state.

While this method of estimating the size of the allowable target population may have some validity, it does not recognize the intent of the law to focus on the most needy and seriously ill within this population. The law specifically gives priority to the acutely and chronically mentally ill. The state estimates that King County has 32 percent of the chronically mentally ill population.

King County has taken the position with the Legislature and the Department of Social and Health Services that the funding formula should give equal weight to the prevalence of the chronically mentally ill and the seriously disturbed. Furthermore, once the required state and county tracking systems are in place, it will be possible to have an actual, unduplicated count of the chronically mentally ill in each county rather than an estimate.

If the formula gave equal weight to the chronically mentally ill, King County would receive a decrease of $31,902 per fiscal year rather than a decrease of $73,204 per fiscal year under the "No Change" Budget and the increase under the Governor's Request Level Budget would rise from $509,542 to $620,810 in the first year and from $796,613 to $942,347 for the second year.

Ongoing state revenues support just a portion of the current county program. Federal Mental Health Block Grant funds have also been provided by the state to supplement ongoing funds for basic treatment and to fund the Intensive Community

Support Teams and the Semi-Independent Living Program. The state has informed King County that the current block grant support for basic treatment services and the Semi-Independent Living Program will not be continued as such although significant amounts of federal block grant as well as new state residential funds will be generally available at the state level.

The impact of the loss of these current grant funds is shown in Table II. A loss of this amount would almost cancel out the increases projected for ongoing state funds at the Governor's Request Level.

TABLE II

BLOCK GRANT FUNDS

	Amount Needed to Continue at Current Level for 1983-85	Amount Expected	
Semi-Independent Living	$ 324,044	$ 0	
GAU Distress	785,764	0	
Harborview Distress	150,000	128,250*	
Intensive Community Teams	1,800,000	1,800,000*	
	$3,059,808	$1,928,250	($1,109,808)

*These are estimates. No official figures have been received by the county.

Because it is likely that the legislative budget will be at least as high as the Governor's Request Level and that the state will have significant amounts of unobligated federal block grant funds and new state residential care funding, a third budget is included with the plan. This budget is called the "Adequate" Level Budget. It details the additional funds necessary to maintain current caseload levels while instituting the new program components inherent in the plan. It is intended to form the basis for a request for additional state funds to better meet the needs of the existing caseloads of acutely and chronically mentally ill persons in King County.

In developing all of the proposed budgets the following assumptions are made:

- The General Assistance Unemployable (GAU) Mental Health Program will remain part of the consolidated state grant coming to counties.
- The ITA funds supporting contracted services will remain available, even if they are later converted to grant-in-aid.
- Estimated county millage for the biennium will amount to $895,442, an increase of $154,334 over 1982 levels.

In addition to these assumptions, budget development for the new biennium was influenced by the need to extend existing contracts for a three-month period in order to complete conversion of the system to the new program of services. Board policies relating to contract extensions are shown below.

Three-Month Contract Extension Policy

1. Existing contracts will be extended for a three-month period, subject to the availability of funding with the exception of the Children's Diagnostic program, which will be eliminated due to underutilization.*
2. If GAU is included in the county grant, providers with existing GAU contracts will be allocated one-fourth their 1982 lids. Reimbursement provisions will recognize that services to clients on the GAU Public Assistance Program bring no federal match funds.
3. Permission from the Mental Health Division will be sought to use unexpended federal block grant funds allocated to King County for the Intensive Community Support Team program to fully maintain GAU Distress and partially maintain the Semi-Independent Living Program. An additional $27,463 in ongoing funds will be allocated to fully support the Semi-Independent Living Program if there is assurance of continuing source of funds for the rest of the biennium.
4. Providers will be informed that only services for priority clients will be reimbursed. Services will be provided in accordance with new state standards.

GOVERNOR'S REQUEST LEVEL BUDGET

During preparation of the Biennial Mental Health Needs Assessment, the Board established priorities for implementation of its Long-Range Plan in the 1983-85 biennium. Programs prioritized during this process were incorporated into the proposed plan of services for the 1983-85 biennium.

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*Only $6,635.46 was billed in 1982 out of a possible $14,000. The individual contract amounts are too small to warrant keeping.

Program allocations was a separate process. The Board needed to prioritize among the various programs in its proposed plan of services for the 1983-85 biennium. The program funding strategies adopted by the Board are shown below.

1. The budget development process will begin with establishment of a baseline program budget. This budget will be developed through identifying how existing contract dollars are distributed across the new county program categories. Changes in funding will be made incrementally to this baseline budget.

2. Because of an existing limited funding base, services to children will be held safe from major funding reductions.

3. Shifts of funding from one adult program to another will be made, if needed, to meet state standards in these priority areas: case tracking and service coordination, hospital follow-up services, and emergency and short-term-care.

4. In order to promote a balanced system of care, the Demonstration Program of Training and Supported Work will be implemented.

5. In recognition of the critical need for specialized assessment of elderly persons, the county will assume partial responsibility, along with the Seattle-King County Division on Aging, for the Geriatric Assessment Team.

6. Within the Basic Community Support and Treatment Program, access to a full range of appropriate services by eligible minority and handicapped persons will be improved.

7. Add administrative staff to meet county goals for better coordination of the full range of mental health program components.

8. Add cost-of-living increases for "fragile" programs that are part of emergency services system.

This funding strategy recognizes that the requirements in the new law for case tracking and service coordination, hospital follow-up services, and emergency and short-term-care must be addressed, even at the expense of other priority programs. However, because the 1983-85 biennial needs assessment identified children as the most underserved of the special needs priority populations, the Board determined that the existing funding level for children's services would be held safe.

The Training and Supported Work Program and the Geriatric Assessment Team Program were approved for funding, but only after the minimum funding requirements for viable programs were established. The programs were funded at minimum levels. The policy relating to access for minority and handicapped persons

reflects a board commitment to assure that the Basic Community Support and Treatment Program is available to those who need it regardless of language, culture, or handicap. The policy on the addition of administrative staff relates to the new mental health manager position which has been approved by the Board. Finally, the contingency for cost-of-living to "fragile" programs in the emergency services system reflects the need to make some provision for funding adjustments, if needed to maintain critical service capacity.

These funding strategies were applied to the revenues anticipated with the Governor's Request Level Budget. Table 3 shows the resulting 1983-85 biennial budget by source of funds.

It is important to note that ITA program funds are making a significant contribution to the Regional Emergency/Short-Term-Care Program and the 24-hour Crisis Line. These funds are currently in the Community Mental Health Program through Involuntary Treatment Emergency Services and 24-hour telephone services contracts. The Mental Health Division has indicated that it intends to convert ITA funds supporting voluntary services into voluntary program dollars at some future time. If these funds were not available, deficits would need to be picked up out of formula funds or millage. This would adversely affect other programs.

Table 4 compares the actual 1982 program allocations and the proposed allocations for the first biennial year. According to these figures, the major emergency services programs and long-term-care programs maintain or increase funding levels.

This picture, however, does not accurately reflect the impact of other system changes. In the case of long-term-care Basic Community Support and Treatment Program, the program concept emphasizes provider agency responsibility for assisting clients to adequately maintain themselves in the community. Outreach, supportive contacts, and linkage to needed social services are activities which will assist in better community maintenance of highly disabled chronically mentally ill. More staff time will be spent on individualized services to clients with a resulting loss of caseload capacity. There will also be less client turnover due to dropouts. Based on provider information and review, the Human Services Division estimates that implementation of the new Basic Community Support and Treatment Program will result in a 43 percent reduction in the annual caseload. (See Attachment II, Basic Community Support and Treatment Program Implementation.)

In order to maintain the 1982 annual caseload of 9,031 priority adults, significant resources above those allocated to the Basic Community Support and Treatment Program are needed. Estimates of resources needed have been developed and are included in projections for the "Adequate Budget" discussed in the next section.

Table 3

1983-85 KING COUNTY MENTAL HEALTH PROGRAM-GOVERNOR'S REQUEST LEVEL BUDGET

	Formula Funds & County Millage	Federal Block Grants Expected	Federal Block Grant Carryover And Other Special Projects	ITA
Client Tracking/Care Coordination	$ 97,715.75			
Emergency				
Regional Emergency/Short-Term-Care	485,091.50			$ 324,90
24-Hour Crisis Line	168,512.00			80,42
Involuntary Treatment Services/Crisis Outreach[1]				3,715,14
Downtown Emergency Shelter	78,052.00			
Adult Long-Term-Care				
Basic Community Support and Treatment	7,702,344.09	128,250.00	98,221.00	
Intensive Community Support Teams		1,800,000.00		
Training and Supported Work	110,315.00			
Semi-Independent Living	27,463.50		13,042.00	
Children's Programs				
Outpatient and Day Treatment	911,938.00			
Violently Disturbed Child Project			214,100.00	
Geriatric Assessment Team	60,000.00			
Contingency Fund	5,000.00			
County Administration				
Existing	774,667.76			
New	124,607.40			
TOTAL	$10,545,707.00	$1,928,250.00	$ 325,363.00	$4,120,48

[1]Also included are legal costs, transportation, translation services and 3 months of ITS follow-up service.
[2]This amount, minus the Federal Block Grant carryover ($111,263), equals $16,808,537.00
[3]The amount needed to support this program for 12 months is $162,022. The amount needed to support the program until resident monies can be obtained (3 months) is $40,505.50. This allocation is contingent upon the availability of other revenue sources program in the new biennium.

COMPARISON OF GOVERNOR'S REQUEST LEVEL BUDGET TO CURRENT PROGRAM BUDGET

Table 4

COMPARISON OF GOVERNOR'S REQUEST LEVEL BUDGET TO CURRENT PROGRAM BUDGET

	1982 Actual Allocations [12 Months]	1983-84 Allocations at Governor's Request Level [12 Months]	P
Client Tracking/Care Coordination	$ Ø	$ 47,467.00	
Emergency			
Regional Emergency/Short-Term-Care	Ø	337,500.00	
24-Hour Crisis Line	124,470.00	124,470.00	
Involuntary Treatment Services/Crisis Outreach	1,867,160.00	1,820,885.50	
Downtown Emergency Shelter	39,026.00	39,026.00	
Adult Long-Term-Care			
Basic Community Support and Treatment	3,902.813.00	3,914,449.93	
Intensive Community Support Teams	900,000.00	900,000.00	
Training and Supported Work	91,257.00	60,315.00	
Semi-Independent Living	30,251.00	40,505.00	
Children's Programs			
Outpatient and Day Treatment	455,969.00	455,969.00	
Violently Disturbed Child Project	107,050.00	107,050.00	
Geriatric Assessment Team	Ø	20,000.00	
Contingency Fund	78,121.00	5,000.00	
County Administration			
Existing	352,418.00	368,756.83	
New	Ø	51,919.74	
TOTAL BUDGETED EXPENDITURES	$7,948,535.00	$8,293,314.00	

[1] $139,246.50 shifted to RE/STC Program

[2] $40,505 is amount to operate program for 3 months until Residential Budget can pay. The 1982 amount ($30,251) represents less than 3 months operation. This allocation is contingent upon the availability of other revenue sources to continue the program in the new biennium.

[3] Transferred to BCSTP.

Revenues:
Formula Funds/Millage
Federal Block Grants
ITA
Other Special Project
Federal Block Grant Carryover
TOTAL

"ADEQUATE" BUDGET LEVEL

The King County Mental Health Board is committed to reorganizing its program to provide more coordinated and responsive services for the chronically mentally ill. In order to provide the range and type of services needed to effectively maintain clients in the community, there will need to be an increase in resources or fewer clients will be served. It is estimated that the Basic Community Support and Treatment Program requires $2,614,815 more in county-administered dollars for the biennium in order to maintain its 1982 caseload level of 9,031 priority clients.

The Board has reviewed this situation as well as other problems created by potential funding deficits and has approved the following funding strategy for development of an "Adequate" Level Budget. This funding strategy is shown below.

Program Funding Strategy for "Adequate" Level Budget

- Begin with the Governor's Request Level Program Allocations.
- Fund the Basic Community Support and Treatment Program to a level intended to maintain annual caseload capacity.
- Provide cost-of-living for all services not covered in Governor's calculations.
- Maintain the Semi-Independent Living Program with Residential Services funds and/or block grant throughout the biennium.

Table 5 shows the "Adequate" Level Budget. It includes the funds needed to support the current priority client caseload in the Basic Community Support and Treatment Program. It also identifies $283,538 in semi-independent living reesidential program dollars which are being requested for caseload maintenance. In addition, cost-of-living adjustments needed by programs are shown.

This chart documents major resource gaps faced by the county. In order for the county program to be able to meet its responsibilities under the new law, a more adequate level of resources must be provided.

Table 5

1983-85 KING COUNTY MENTAL HEALTH PROGRAM-ADEQUATE LEVEL BUDGET

Program budget with revenues in excess of the Governor's Budget that adds resources needed to provide the necessary mix of su services to the current priority caseload and to allocate cost-of-living increases.

	Total Expected Revenues [From Attachment 4]	Funds Needed to Support Current Adult Priority Caseload	Cost-of-Li Adjustment 1983-19
Client Tracking/Care Coordination	$ 97,715.75	Ø	
Emergency			
Regional Emergency/Short-Term-Care	810,000.00	Ø	
24-Hour Crisis Line	248,940.00	Ø	$ 13,36
Involuntary Treatment Services/Crisis Outreach	3,715,143.50	Unknown[1]	
Downtown Emergency Shelter	78,052.00	Ø	4,19
Adult Long-Term-Care			
Basic Community Support and Treatment	7,928,815.09	$2,614,815.00	566,08
Intensive Community Support Teams	1,800,000.00	Ø	96,66
Training and Supported Work	110,315.00	Ø	
Semi-Independent Living	40,505.50[3]	283,538.50[2]	17,39
Children's Programs			
Outpatient and Day Treatment	911,938.00	Ø	49,15
Violently Disturbed Child Project	214,100.00	Ø	11,49
Geriatric Assessment Team	60,000.00	Ø	2,00
Contingency Fund	5,000.00	Ø	
County Administration			
Existing	774,667.76	Ø	
New	124,607.40	Ø	
TOTAL	$16,919.800.00	$2,898,353.50	$ 760,35

[1]This amount is known to be inadequate. The Offices of Finance and Budget are currently determining how large an addition is needed to cover ITA legal costs.

[2]This amount should come from Residential Programs funds as Semi-Independent Living is a residential program.

[3]This allocation is contingent upon the availability of other revenue sources to continue the program in the new biennium.

"NO CHANGE" BUDGET

In order to comply with state plan requirements, the county must develop a program budget at the reduced level of resources represented by the "No Change" Budget. Although this budget is viewed as unacceptable, a budget strategy was developed and approved by the Board.

Program Funding Strategy for "No Change" Budget Level

- These programs will be maintained at the 1982 levels: 24-hour Crisis Line, Downtown Emergency Shelter, Children's Outpatient and Day Treatment.
- The Tracking/Care Coordinator Program will be funded at a minimum level for a viable program to meet requirements of the new law.
- Training and Supported Work and Geriatric Assessment will not be funded.
- The Regional Emergency Services/Short-Term-Care Program will be reduced to one centralized provider with on-site hospital liaison functions and most outreach capacity dropped. The emphasis will be on emergency modification and crisis intervention.
- Add county administrative staff to meet county goals for better coordination of all components of the mental health program.
- The Basic Community Support and Treatment Program will be funded as adequately as possible with funds available after the above policies are implemented.

This funding strategy eliminates Training and Supported Work and the Geriatric Team Program and reduces support in the Basic Community Support and Treatment Program and the REgional Emergency/Short-Term-Care Program.

Table 6 shows the 1983-85 biennial budget when this funding strategy is applied to available resources. Table 7 compares 1983-84 allocations at the "No Change" Budget level with 1982 actual allocations. According to this table, the Regional Emergency/Short-Term-Care Program has an increase in funding over 1982 of $176,746.50. Compared to the Governor's Request Level of funding, however, it is actually reduced by $160,754. This reduction will result in major losses in program capacity, particularly involving outreach to voluntary clients. The Basic Community Support Program loses $334,067, resulting in further significant caseload reductions.

Table 6

1983-85 KING COUNTY MENTAL HEALTH PROGRAM-"NO CHANGE" BUDGET

	Formula Funds & County Millage	Federal Block Grants Expected	Federal Block Grant Carryover And Other Special Projects	I
Client Tracking/Care Coordination	$ 97,715.75	Ø	Ø	
Emergency				
Regional Emergency/Short-Term-Care	87,500.00	Ø	Ø	$ 324
24-Hour Crisis Line	168,512.00	Ø	Ø	80
Involuntary Treatment Services/Crisis Outreach[1]	Ø	Ø	Ø	3,715
Downtown Emergency Shelter	78,052.00	Ø	Ø	
Adult Long-Term-Care				
Basic Community Support and Treatment	6,794,872.59	128,250.00	98,221.00	
Intensive Community Support Teams	Ø	1,800,000.00	Ø	
Training and Supported Work	22,815.00	Ø	Ø	
Semi-Independent Living	27,463.50	Ø	13,042.00	
Children's Programs				
Outpatient and Day Treatment	911,938.00	Ø	Ø	
Violently Disturbed Child Project	Ø	Ø	214,100.00	
Geriatric Assessment Team	Ø	Ø	Ø	
Contingency Fund	5,000.00	Ø	Ø	
County Administration				
Existing	774,667.76	Ø	Ø	
New	124,607.40	Ø	Ø	
TOTAL	$ 9,093,144.00	$1,928,250.00	$ 325,363.00	$4,120,

[1]Also included as legal costs, transportation, translation services, and 3 months of ITS follow-up service.
[2]This amount, minus the Federal Block Grant carryover ($111,263), equals $ 15,355,974.
[3]The amount needed to support this program for 12 months is $162,022. The amount needed to support the program until resi
or Block Grant monies can be obtained (3 months) is $40,505.50. This allocation is contingent upon the availability of ot
revenue sources to continue the program in the new biennium.
[4]This amount continues the current Vocational Resources Coordinator Program for the first 3 months of the 83-85 biennium.

TABLE 7

COMPARISON OF "NO CHANGE" BUDGET TO CURRENT PROGRAM BUDGET

	1982 Actual Allocations [12 Months]	1983-84 Allocations at "no change" level [12 Months]	Change Program
Client Tracking/Care Coordination	$ Ø	$ 47,467.00	$ +4
Emergency			
Regional Emergency/Short-Term-Care	Ø	176,746.50	+17
24-Hour Crisis Line	124,470.00	124,470.00	No
Involuntary Treatment Services/Crisis Outreach	1,867,160.00	1,820,885.50	No
Downtown Emergency Shelter	39,026.00	39,026.00	No
Adult Long-Term-Care			
Basic Community Support and Treatment	3,902,813.00	3,568,745.43	(334
Intensive Community Support Teams	900,000.00	900,000.00	No
Training and Supported Work	91,257.00	22,815.00	(68
Semi-Independent Living	30,251.00	40,505.00	No
Children's Programs			
Outpatient and Day Treatment	455,969.00	455,969.00	No
Violently Disturbed Child Project	107,050.00	107,050.00	No
Geriatric Assessment Team	Ø	Ø	No
Contingency Fund	78,121.00	5,000.00	(7
County Administration			
Existing	352,418.00	368,756.83	+1
New	Ø	51,919.74	+5
TOTAL BUDGETED EXPENDITURES	$7,948,535.00	$7,729,356.00	$ (21

[1] $139,246.50 shifted to RE/STC Program

[2] $40,505 is amount to operate program for 3 months until Residential Budget can pay. The 1982 amount ($30,251) represents less than 3 months operation. This allocation is contingent upon the availability of other revenue sources to continue the program in the new biennium.

[3] Transferred to BCSTP.

TOTAL BUDGETED REVENUES:		
	$4,546,572.00	Formula Funds & Mi
	964,125.00	Federal Block Gran
	2,000,346.00	ITA
	107,050.00	Other Special Proj
	111,263.00	Federal Block Gran
	$7,729,356.00	

ATTACHMENT A

6/15/83

INTRODUCED BY Grant Gruger, North, Chow, Laing

PROPOSED NO. 83-313

MOTION NO._____

A MOTION adopting mental health goals and objectives for King County.

WHEREAS, on March 29, 1967, the Washington State Legislature enacted the Community Mental Health Services Act which gives counties the authority to establish a local mental health program, earmarks property taxes to support mental health programs, and assigns planning, coordination, and service responsibilities to county mental health administrative boards, and

WHEREAS, on September 12, 1969, the King County Council enacted ordinance 00141 establishing the King County Mental Health Board and the King County Mental Health Program pursuant to State law, and

WHEREAS, on January 1, 1974, the Washington State Legislature enacted the Involuntary Treatment Act requiring counties to administer involuntary treatment services, and

WHEREAS, on September 30, 1980, the United States Congress enacted the Mental Health Systems Act providing federal funding support for community mental health services through the states, rather than directly to service delivery agencies, and

WHEREAS, on August 13, 1981, Congress enacted the omnibus Budget Reconciliation Act of 1981 consolidating community mental health funding into a block grant to the states, and

WHEREAS, on March 8, 1982, the Washington State Legislature enacted the revised Community Mental Health Services Act which designates counties as the local mental health planning authority; directs mental health programming in priority order to the acutely/chronically mentally ill and seriously disturbed; requires recognition of the special needs of minorities, children, the elderly, low income, and disabled persons; requires counties to develop and administer a range of community based services for the chronically mentally ill; gives counties the option to administer residential and inpatient services; and requires counties to develop a client tracking and coordination system, and

WHEREAS, on June 16, 1982, the King County Executive formed a twenty member Executive Task Force on Mental Health to assist him in identifying priority problems in the mental health system and developing strategies for

effectively addressing them, and

WHEREAS, on December 14, 1982, the King County Mental Health Board adopted the King County Mental Health Long Range System Development Plan, and

WHEREAS, the growing needs and problems of the mentally ill in King County have been demonstrated by the increased demand for involuntary treatment services; an increased incidence of police intervention with the mentally ill; a higher number of mentally ill on the streets and in the King County Jail; and insufficient community mental health services, and

WHEREAS, mental illness is diverse and complex, requiring a wide range of medical and psychiatric assistance, as well as strong social support systems to help people who have experienced mental illness be integrated back into the community, and

WHEREAS, the Washington State Governor and Legislature bear the primary responsibility for ensuring adequate financial resources are available to support a complete and appropriate system of care for the acutely/chronically mentally ill and the seriously disturbed, and

WHEREAS, existing mental health goals and objectives are inadequate to guide systematic planning, coordination, and delivery of mental health services in King County;

NOW, THEREFORE, BE IT MOVED by the King County Council:

The following are the official mental health goals and objectives for King County:

GOAL I -- Help the mentally ill residing in King County improve their quality of life by achieving the goals and objectives adopted in this motion.

GOAL II -- Exercise King County's leadership role and responsibilities as defined in the revised Community Mental Health Services Act by designing, implementing, monitoring, and evaluating a comprehensive system of care for the acutely/chronically mentally ill and the seriously disturbed.

Objectives:

A. Develop and update periodically a long-range mental health plan which includes:

1. King County's mental health goals and objectives;

2. descriptions of the necessary components of the mental health

system;

3. definitions of the respective roles and responsibilities of the mental health system and other primary care systems such as aging and child welfare;

4. the full range of voluntary and involuntary short/long-term care, including residential treatment and mental health services in the King County Jail.

B. Institute client tracking and care coordination to assure that those persons most in need of mental health care are properly tracked and monitored as they move through the mental health system within King County and between King County and Western State Hospital.

C. Assure effective public participation in the mental health planning process by continuing the active role of the King County Mental Health Board.

D. Obtain adequate financial support for mental health programs from the Washington State Governor and Legislature.

E. King County's Current Expense Fund resources may be used only to support administrative costs of the County's Mental Health Section in order to:

1. ensure efficient and effective community mental health programs; and

2. maximize the availability of grant funds for the delivery of mental health services in King County.

F. Assume responsibility for administering State-funded mental health residential care in King County when adequate resources are provided by the State.

G. Work with the University of Washington and the Harborview Medical Center to maximize the potential of these two institutions to improve mental health care in King County.

H. Monitor and evaluate the full range of voluntary and involuntary short/long-term mental health services to ensure they meet the needs of the acutely/chronically mentally ill and the seriously disturbed.

GOAL III -- Develop and implement an integrated voluntary and involuntary emergency/acute care system to meet the emergency, short-term care needs of the acutely mentally ill in King County.

Objectives:

A. Design the integrated system to assure immediate client screening, assessment, and appropriate care and referral services.

B. Pursue adequate resources to maintain a County-wide crisis line, crisis outreach and commitment investigation, and legal services necessary to fulfill Involuntary Treatment Act requirements and assure immediate access to care for voluntary and involuntary patients.

C. Provide sufficient and adequately staffed beds in King County to handle short-term voluntary and involuntary care needs in an appropriate and affordable manner by:

1. Assisting the State to develop one or more involuntary treatment options in psychiatric hospitals and non-hospital facilities with appropriate medical care;

2. Encouraging Harborview Medical Center to provide sufficient involuntary beds at a reasonable cost for persons with medical complications or with the most intensive care needs;

3. Encouraging the State to allow indigent voluntary and involuntary patients to use non-hospital options with appropriate medical care.

4. Only use Western State Hospital:

a. for longer term inpatient treatment;

b. as a backup to the King County inpatient mental health system during times of extraordinary demand.

D. Develop and implement cost-effective, short-term outpatient and residential care options and assure admissions and transfers between acute and long-term care when needed by:

1. Continuing walk-in, short-term outpatient services in a variety of community facilities;

2. Developing a regional capacity for short term care for persons referred from crisis outreach and inpatient units;

3. Increasing appropriate emergency shelter capacity.

E. Work with hospitals and community mental health agencies to develop walk-in emergency room screening and assessment services that are accessible throughout King County 24 hours a day, seven days a week.

GOAL IV -- Develop an improved range of outpatient and residential options for

longer-term stabilization, maintenance, and rehabilitation of chronically mentally ill and seriously disturbed residents of King County.

Objectives:

A. Improve the basic outpatient program (called Basic Community Support and Treatment) to:

1. ensure that mental health services are provided first for those most in need;

2. require assistance with basic living needs and medication monitoring;

3. locate responsibility for primary care and coordination of all necessary services for client support in the community with the mental health care provider;

4. provide greater choice of mental health services for clients;

5. allow mental health providers greater flexibility in determining appropriate types, level, and mix of care for clients.

B. Evaluate and expand to other parts of King County, if appropriate, the demonstration program (Intensive Community Support Team) that provides 24-hour a day outreach assistance to a small caseload of the most severely mentally ill.

C. Promote the development and implementation of a range of residential care options, including such new options as semi-independent living programs for people able to live on their own with some assistance, as well as residential treatment for those needing more intensive care. Administer these State-funded residential programs directly when the State provides the County with adequate resources.

D. Encourage the development of appropriate employment, work-training programs, and subsidized work projects in the private sector, as well as in sheltered employment environments, to help provide the mentally ill with financial support, self-esteem, and independence. Work with King County departments and agencies, other public agencies, and the business community to identify and create these opportunities.

E. Enhance the human support systems of the mentally ill by developing respite care capabilities to give families of the mentally ill relief from

their constant role of primary care providers.

F. Support initiatives for foster care programs for the mentally ill.

G. Assure that an appropriate portion of public resources directed to housing assistance is made available to the mentally ill.

H. Obtain State and federal capital and operating funds for housing for the mentally ill.

GOAL V -- Whenever feasible and appropriate, divert the mentally ill from the King County Jail to appropriate mental health facilities and services in the community.

Objectives:

A. Work with the King County Superior and District Court Judges, the King County Prosecuting Attorney, and other criminal justice officials to divert the mentally ill from the criminal justice system.

B. Assure that community mental health services give priority to chronically mentally ill and seriously disturbed persons referred from the King County Jail.

C. For those mentally ill who are placed in the Jail, provide appropriate mental health care in a safe, secure, and humane setting.

D. Train public safety and corrections personnel to be sensitive to the special needs and appropriate treatment of the mentally ill.

GOAL VI -- Assure reasonable access to a range of mental health services and appropriate care for priority clients regardless of race, color, creed, religion, national origin, sex, age, marital status, sexual preference, language, income, or the presence of any sensory, mental, or physical handicap.

Objectives:

A. In conjunction with other primary care systems, enhance mental health treatment and consultation services for the elderly, children and youth, and disabled populations.

B. Pursue adequate funds to support a wide range of mental health programs which provide special services for ethnic minorities and other populations with special needs.

C. Assure that the mental health needs of these special client populations are appropriately addressed in the County's overall planning and eva-

luation process.

GOAL VII -- Reduce the public stigma surrounding mental illness and increase public support for appropriate mental health care by promoting public awareness, understanding, and concern about the mentally ill in King County.

Objectives:

A. Work with television, radio, and newspaper personnel to promote accurate, informed, sensitive, and complete coverage of mental illness.

B. Promote volunteer services for the mentally ill throughout King County.

C. Work with educational institutions to promote relevant mental health research, a greater understanding of mental illness, and leadership in men tal health training.

D. Appoint and confirm King County Mental Health Board members who are committed to improving mental health care and promoting public understanding of mental illness.

GOAL VIII -- Encourage mental health promotion and mental illness prevention programs.

Objectives:

A. Encourage and assist employers, labor unions, and community groups in developing and providing mental health education and promotion.

B. Encourage community education programs on early recognition of mental illness.

C. Encourage the integration of mental health issues with general health promotion.

PASSED this _____ day of _____, 19___.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____
Chairman

ATTEST:

_____
Clerk of the Council

ATTACHMENT B

DETAILED PROGRAM DESCRIPTIONS AND IMPLEMENTATION PLANS

TABLE OF CONTENTS

PROGRAM: Client Tracking/Care Coordination

Allocation
Governor's Budget Level

STATE REQUIREMENTS:
Counties are responsible for assuring that clients leaving inpatient settings are referred to community care, to monitor the continuity of care and, at least annually, to assess th of referral patterns and procedures. Counties are required to maintain centralized tracking infor mentally ill persons.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:

"Develop an integrated voluntary and involuntary emergency/acute-care system to meet the emergency short-term-care needs of the seriously and chronically mentally ill in King County. This integrated system should assure immediate client screening, assessment, and appropriate care and referral services."*

"Initiate client tracking/coordination at the county level.**

*King County Executive Goals and Objectives.

**Long-Range-Plan

1983-85 PLAN:

The Tracking/coordination program will fulfill King County's obligation under state law for maintenance of centralized client tracking information and coordination between state hospitals and the community service system. A tracking coordinator and clerical support will be added to the Division of Human Services. The functions of the tracking coordinator will be as follows:

1. Enhance and build a referral network for chronically mentally ill King County residents.
2. Coordinate the implementation and operation of the Regional Emergency/Short-Term-Care (RE/STC) program.
3. Assign "missing" clients to the RE/STC program for follow-up.
4. Compile periodic reports regarding continuity of care, service utilization, and resource needs.
5. Estimate the prevalence of chronically mentally ill persons in King County.
6. Collect and maintain all tracking information regarding the King County Mental Health Program.

IMPLEMENTATION S

This program wil
July 1, 1983.

The tracking coo
sion of Mental H
tracking system
tracking data.
system has made
data collection
cost) from the c

The benefits of
health system wi

1. Previously "l
referred to t
up may be lir
2. The referral
discharge wil
and efficient
3. There will be
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utilization t
King County r
4. There will be
numbers of ch
cannot get ir
resources, ap
own choice.

CLIENT TRACKING/CARE COORDINATION

The tracking/coordination program will fulfill King County's obligation under state law for maintenance of centralized client tracking information and coordination between state hospitals and the community service system for chronically mentally ill adults. This program will be the cornerstone of the client care coordination program which is planned for implementation in a future biennium. The tracking/coordination program will be staffed in the 1983-1985 biennium by one professional level coordinator.

PROGRAM ACTIVITIES

The functions to be performed by the tracking coordinator (TC) are as follows:

1. The TC will work to enhance and build a referral network for chronically mentally ill persons in King County. To accomplish this, the TC will develop relationships with hospital and jail discharge planning staff, residential care providers, long-term-care providers, hospital emergency room staff, and Involuntary Treatment Services staff. The ultimate goal of the referral networks is to ensure that when clients are transferred or referred, they are sent to the provider most appropriate to their individual needs at that time. The TC will also work to establish systems of referral or transfer that minimize the risk of "losing" the client during the transfer.

2. The TC will coordinate the Regional Emergency/Short-Term-Care Program (RE/STC) It will be necessary for the TC to coordinate this program because a) the RE/STC program will not work unless it operates consistently from provider to provider and establishes workable and efficient referral relationships with acute and long-term-care providers, and b) the RE/STC program will be a valuable resource regarding referral and resource problems.

3. The TC will assign clients identified on tracking exception reports to the RE/STC program for follow-up. The TC will receive exception reports from the state tracking system which will identify clients who have "dropped out" while in transit between two providers. (For example, between an inpatient and outpatient provider). The TC will refer these "lost" clients to the nearest RE/STC program for follow-up. The RE/STC will attempt to locate the client and report the disposition of the case to the TC.

4. The TC will compile periodic status reports. These status reports will evaluate the community mental health program in King County on such subjects as continuity of care, service utilization, and resource needs. These reports will contain recommendations for improvement.

5. The TC will compile periodic estimates of the size of the chronically mentally ill population in King County.

6. The TC will be responsible for the maintenance of all King County tracking information.

INFORMATION SUPPORT

The TC will be supported by information obtained from the state computerized tracking system, the state Community Mental Health Information System, the RE/STC program and staff of Involuntary Treatment Services.

The major source of numerical information regarding referrals and clients movement will be the Division of Mental Health's (DSHS) computerized tracking system. This system will provide the TC with the following types of reports.

- Exception Report - This report identifies individual clients who have failed to follow-up on the referral they were given by an inpatient facility.
- Individual Client Report - This report will indicate, in order, all providers each client has received service from and what the first and last dates of service for each provider were.

The tracking coordinator will also be responsible for establishing systems for collection of data that are not included in the state's computerized system. Clients discharged from the mental health unit of the King County Jail, for example, will not be initially included in the computerized system unless they have been hospitalized.

IMPLEMENTATION STRATEGY

This program will be implemented as soon after July 1, 1983, as is possible. This will allow the TC some lead time to work with the regional providers prior to the actual implementation of the RE/STC program.

PROJECTED COSTS

FY 83-84

Salaries: 1 Tracking Coordinator (Range 53)	$29,388.64	
1/4 OA-III (Range 24)	3,517.25	
	32,905.89	
Benefits (20%)	6,581.17	
Overhead [Supplies, mileage, postage, etc.]	7,480.82	
Office Equipment [1 Desk]	500.00	
		$47,467.88

FY 84-85

Salaries: 1 Tracking Coordinator	31,510.75	
1/4 OA-III	3,693.11	
	35,203.86	
Benefits (20%)	7,040.77	
Overhead	8,003.24	
		50,247.87

TOTAL 83-85 Biennium Program Costs $97,715.75

PROGRAM: Regional Emergency and Short-Term-Care

Allocation
Governor's Budget Level

STATE REQUIREMENTS:
Acutely mentally ill persons are the highest priority. The county program shall provide discharge planning and hospital follow-up for persons leaving state psychiatric hospitals facilities. The county program shall provide screening for patients being considered for voluntary psychiatric hospitals.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION S
"Develop an integrated voluntary and involuntary emergency/acute care system to meet the emergency short-term-care needs of the seriously and chronically mentally ill in King County."* "Modify/enhance existing outpatient emergency service to assure that the community mental health system has the capacity to respond to walk-in emergencies and to provide follow-up emergency care to persons referred from inpatient facilities, emergency rooms, and involuntary treatment outreach workers."* "The emergency services system must provide more short-term-care in addition to crisis intervention."**	The regional program will be an intermediate program between acute care (hospital inpatient, emergency room, crisis outreach/commitment investigation) and long-term-treatment and support resources. The program will serve both voluntary and involuntary clients in the following manner: - Provide follow-up services for all persons discharged from hospital or jail who have not been linked to a long-term-care program. - Provisions for specialized follow-up service will be made for persons who do not speak English or who are deaf. - Follow-up services will consist of short-term support and treatment (including medication evaluation and prescription). - Provide pre-screening for voluntary admission to state hospitals. - Assist clients in gaining entry to needed residential and long-term-treatment and support placements.	The regional pro program which w of hospital/jai care services. primary means by tal health progr requirement of services to all psychiatric inp This program wi tract to provid of King County; east. Provide persons referre as a diversion services. The will be chosen If there are no allocating fund reduce the fund care programs.

*King County Executive Goals and Objectives.

**Long-Range-Plan

REGIONAL EMERGENCY AND SHORT-TERM-CARE

- Description of Implementation -

A. Service Regions and Provider Locations

There will be four regions; north, central, south and east. The specific boundaries of the regions will be developed by a working group made up of the five providers who have stated an interest in contracting for this program. Two factors regarding the development of regional boundaries and provider location are as follows.

1. There must be at least one contractor per region and the contractor shall be located (have an office) in the region which it serves.

2. Regional boundaries will take into account main routes of public transportation, geography, and the need to scale the south region into a manageable size.

B. Relationships with Other Acute Care Components

1. Local hospitals and the mental health unit in the King County Jail. Each region will provide on-site liaison service to the hospital(s), and the King County Jail, located within each of their own regions. The purpose of on-site liaison is to meet with referred clients prior to their release to describe the short-term-care/follow-up service and make follow-up appointments with the appropriate regional programs. In performing this service, regional liaison staff will occasionally act as brokers for the other regional programs.

2. Western State Hospital. One regional program will have the responsibility of providing on-site liaison service at Western State Hospital. This liaison will act as a broker for all of the regional programs when necessary.

3. Involuntary Treatment Services. The county designated mental health professional (CDMHP) will have three types of interaction with the regional program.

   a) referrals will be made for "monitoring" follow-up on selected non-detained cases;

   b) referrals will be made for "treatment" follow-up on selected non-detained cases; and

   c) the ITS office will send IT-12's to the regional programs for all persons detained.

4. Crisis Clinic. The arranged appointment process will operate according to current practice but appointments will only be available in the four regional programs.

5. Basic Community Support and Treatment Program (BCSTP). The regional program will refer and assist in the enrollment of short-term-care clients to the BCSTP when appropriate and whenever possible. This process will be supporte by an incentive within the BCSTP admission criteria and/or payment method.

REGIONAL EMERGENCY AND SHORT-TERM-CARE
Description of Implementation - continued

C. Provider Selection

The specific providers of this program will be chosen through a Request for Proposal (RFP) bidding process. The criteria used for provider selection will include the following:

1. Medication evaluation and prescription ability
   - hours of coverage
   - type of staff providing service (M.D., R.N., etc.)
2. Experience of the organization in providing emergency mental health and hospital liaison or follow-up service.
3. Where the provider is located in relationship to main routes of transportation and hospitals that will be served via liaison.
4. The cost per hour of coverage, clients served, or staff assigned.
5. Working agreements the provider has currently established with economic assistance offices and residential programs.
6. Ability to provide services to non-English-speaking or deaf persons.

D. Allocation Strategy

The following factors will be considered in the allocation of the regional program budget to each regional provider.

1. The number and size of the inpatient and jail units that each regional program will provide liaison service to.
2. The projected demand of priority clients which will be referred back to each region for short-term care/hospital follow-up.
3. The size of the area served and the dispersion of the population.
4. Allocations may be made to providers other than the basic regional providers to ensure access to follow-up care for non-English-speaking or deaf persons.

May 3, 1983

REGIONAL EMERGENCY/SHORT-TERM CARE

- Background for Program Allocation -

I. DEMAND

	North Zone	Central Zone	South Zone	East Zone	TOTAL
a. Estimated monthly demand obtained from MH Planning Questionnaire.	36 17%	100 49%	53 26%	17 8%	206 100%
b. Average monthly 72-hour detentions shown for comparison [3 sample months, 1982]	34 20%	78 45%	48 28%	13 7%	173 100%

	Western State	Fairfax	Harbor-view SC	King Co. Jail	TOTAL
c. Estimates from selected hospital and jail of numbers of persons per month they would refer to RE/STC program. [These estimates are considered by these organizations to be conservative.]	20	6	8	15	49

II. ALLOCATION

a. Dollars per case

The Involuntary Treatment Services next-day follow-up program was used as a basis for projecting needed resources per case. This program was chosen as it comes the closest, of any currently funded program, to meeting the RE/STC requirements.

1982 Expenditure per case	$155.70
1982 K.C. C.O.L.	x 1.0808
	$168.28
1983 K.C. C.O.L.	x 1.028
	$172.99

For purposes of the RE/STC program allocation a rate of $175.00 per case will be used.

b. Allocation formula

(206 x 12) = 2,472	+	(8 x 12) = 96	x	$175.00
Estimated annual demand for current King County contractors		One-half of the estimated assumed jail demand		Needed resources per case

= $449,400
12 month allocation

= $450,000

Notes regarding allocation formula:

1. The estimates from W.S.H., Fairfax, and Harborview 5-Center were not added to the demand projected by current Division contractors as the degree of duplication among estimates was unclear. This appears safe as the average monthly demand projected by current contractors is greater than the average monthly ITA detentions.

2. A portion of the K.C. Jail [mental health unit] estimate was considered in the formula since jail staff believe that most of these persons do not now come to the attention of mental health providers.

c. Biennial Allocation

83-84	The program will operate for 9 months beginning 10/1/83	$450,000 x .75 = $337,500
84-85	The program will operate for a full 12 months (5% cost of living is added)	$450,000 x 1.05 = $472,500
TOTAL BIENNIAL ALLOCATION		$810,000

d. Comparison with costs for Crisis Intervention Team program which provided emergency services 24 hours per day/7 days per week, was divided into four zones and ended 12/31/79.

1979 CIT cost	$439,521.00
1979 CIT program in 1983 dollars	$555,422.00

PROGRAM: 24-HOUR CRISIS LINE

STATE REQUIREMENTS:
Acutely mentally ill are the highest priority. The county shall provide emergency services 24 hours per day.

Allocation
Governor
Budget Level

Note: inclu

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION S
"Develop an integrated voluntary and involuntary emergency/acute care system to meet the emergency short-term-care needs of the seriously and chronically mentally ill in King County." * "Pursue adequate resources to maintain the county-wide crisis line..." * *King County Executive Goals and Objectives	The emergency telephone service (crisis line) will continue to operate as the single entry point for citizens in need of voluntary or involuntary emergency mental health service. The goal of this program is to "alleviate psychiatric crises and emergencies for individuals by providing timely assessment, intervention, and linkage to appropriate services." To accomplish this goal, this program has a system of direct referral mechanisms to both Involuntary Treatment Services and the Regional Emergency and Short-Term-Care Program.	There is no new program as it is has since 1980.

PROGRAM: Centralized Crisis Outreach, ITA Program

STATE REQUIREMENTS: RCW 71.05: County-designated mental health professionals (CDMHPs) are to investigate referrals of people who may have mental disorders and present a likelihood of serious harm to themselves or others or are gravely disabled. They may involuntarily detain such people if there is sufficient evidence and voluntary resources are not an option. These CDMHP services must be available 24 hours a day, 365 days a year. RCW 71.24: Acutely mentally ill are the highest priority for service. The county program shall provide emergency services 24 hours per d

* Allocatio *Governor* *Budget Lev*
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KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:

"Pursue adequate resources to maintain crisis outreach and commitment investigation and legal services necessary to fulfill ITA requirements."

"Work cooperatively with the state to develop several levels of affordable and appropriate community mental health inpatient care for involuntary patients."

"Develop an integrated voluntary and involuntary emergency/acute care system to meet the emergency short-term care needs of the seriously and chronically mentally ill in King County."

Crisis outreach services to remain centralized and provided by county-designated mental health professionals (CDMHPs) who are county employees.

1983-85 PLAN:

- To provide crisis outreach services 24 hours a day, 7 days a week to intervene in emergencies or crises involving the seriously mentally ill or those at risk of deteriorating without crisis intervention.
- To provide services 24 hours a day, 7 days a week to investigate all cases referred; to coordinate setting court dates and the decision-making process of the legal/medical system as long as the case is legally active.
- To encourage as much use of voluntary treatment, hospitalization or outpatient treatment as possible.
- To refer to the local community mental health center for ITA follow-up and treatment at the agency, including less restrictive alternative treatment whenever possible.
- To document a legal case when hospitalization is ordered.
- To be certain that all mandates of RCW 71.05 are met in terms of timely notice, court hearings, and the requirements of due process.
- To educate the community about RCW 71.05 and about the use of other treatment resources including crisis outreach services.
- To work with the Department of Social and Health Services to establish adequate inpatient treatment facilities within King County.

IMPLEMENTATION

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PROGRAM: Downtown Emergency Shelter/Case Management

STATE REQUIREMENTS:
Acutely mentally ill are the highest priority.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION
"Pursue additional emergency shelter capacity.* "Develop an integrated voluntary and involuntary emergency/acute care system to meet the emergency short-term-care needs of the seriously and chronically mentally ill in King County."* "There is a significant need for emergency residential care. Examples of emergency residential care to be developed and/or expanded on a regional basis are emergency shelter and short-term residential treatment."**	The primary goal of this program is to enhance the capacity of the Downtown Emergency Service Center to accommodate and assist seriously mentally ill persons.	No change fro

*King County Executive Goals and Objectives.

**Long-Range-Plan.

PROGRAM: Basic Community Support and Treatment

Allocatio
Governor's
Budget
Level

STATE REQUIREMENTS:

The county program shall provide the following non-emergency services: Outpatient Services, Day Treatment, Consultation & Education, and Community Support Services. Clients who are minority or handicapped shall be assured of access to these services.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:

"Develop a more adequate range of outpatient and residential options, for longer-term stabilization, maintenance and rehabilitation of chronically and seriously mentally ill residents of King County."*

"Modify/enhance the current basic outpatient program (to be called Basic Community Support and Treatment) to: 1) ensure that services are provided first to those most in need; 2) require assistance with basic living needs and medication monitoring; 3) locate responsibility for primary care and coordination of all necessary services for client support in the community with the mental health care provider; 4) provide greater choice of services for clients; and 5) allow providers greater flexibility in determining appropriate types, level, and mix of care for clients."*

"Assure access to a range of mental health services and appropriate care for priority clients regardless of age, sexual preference, language, culture, income, or special handicap."*

*Long-Range-Plan

1983-85 PLAN:

Basic Community Support and Treatment program will be the major long-term care resource for priority clients. This program incorporates the following services:

-Outpatient therapy, including day activities
-Day treatment (an optional service)
-Community support services (including medication management
-Consultation and education services

Basic Community Support & Treatment provider agencies will develop and modify client service plans to respond to client needs, incorporate whatever combination and intensity of services is required to meet client objectives for stabilization maintenance, or rehabilitation.

Basic Community Support & Treatment providers will have primary care responsibility for their clients. In situations where continued contact with the treatment system is viewed as essential to avoid excessive hospitalization or other institutionalization, providers will be expected to make outreach visits if clients are unable or unwilling to come to the mental health agency for care. In addition, for those clients who are unable to meet survival needs without assistance, the Basic Community Support & Treatment program will provide such assistance either directly or through referral to appropriate social services.

Within the constraints of available resources, including transportation, clients will be given a choice of providers.

There will be a number of local and specialized providers of Basic Community Support & Treatment Services. Provider selection will consider the needs of minority and handicapped mentally ill for access to the mental health system.

IMPLEMENTATION

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BASIC COMMUNITY SUPPORT AND TREATMENT

- Description of Implementation -

System Design

This service will be contracted to a number of providers. A geographic distribution of providers will be sought, with each emergency services region having at least one local Basic Community Support and Treatment program.

In addition to geographic coverage, there will be coverage of special needs populations including the handicapped, ethnic minorities, and elderly. Specialized providers for these groups will be identified where appropriate.

Some providers may also place emphasis on treating certain types of mental illness, and will be viewed as special resources. Long term development of the system is designed to foster a variety of service approaches to meet varying client needs.

Relationships

Western State Hospital - Each Basic Community Support and Treatment program provider will receive referrals directly from the hospital. If the caseload is closed, the client will be referred to another BCS&T provider or to the Regional Emergency Service program for interim service.

Local Inpatient Units - Referrals will be received directly. If the caseload is closed, the client will be referred to another BCS&T provider or to the local Regional Emergency Services program for interin service.

Regional Emergency Services Program - This program will refer clients for long term care, and will provide hospital liaison services for local inpatient units and Western State Hospital.

County Tracking Program - The County Tracking Coordinator will monitor the flow of clients into and out of the program and will work with providers to resolve problems in the referral system and county caseload standards.

Implementation Plan for Program Refinement

The new program description contains a number of concepts which require operational definitions which are applicable on a countywide basis. These operational definitions will be developed through a process which includes meetings with representatives of various parts of the mental health system. Some of these concepts will be developed prior to the request for proposal process so they can be incorporated in proposed development and review.

- There will be a general system-wide operational definition of the following priority category:

  Those eligible persons who have a recent history of or are at greatest risk for use of acute psychiatric inpatient resources and the mental health facility in the King County Jail.

- There will be further definition and prioritization within the category "all other eligible persons" with emphasis on the needs of special populations, including persons at risk for institutionalization in nursing homes or other more restrictive residential settings.

BASIC COMMUNITY SUPPORT AND TREATMENT
Description of Implementation - continued

- There will be established an operational definition of clients for whom "continued contact with the treatment system is needed to minimize dependence on public safety and acute care resource."

  This will be used in reviewing compliance with county program standards. There may also be established circumstances under which community support services other than client monitoring are denied, based on documented clinical considerations.

- There will be general countywide definitions of levels of care within the program, which take into consideration client characteristics and objectives relating to stabilization, maintenance and rehabilitation. These will be used to establish countywide caseload standards which will be used in further development of allocation policies.

Provider Selection/Allocations Strategy

Contractors will be selected through a request for proposal process which will consider such factors as the following:

- Geographic distribution of need
- Coverage for special needs populations, including Asians, Native Americans, Blacks, Hispanics, sexual minorities, developmentally disabled, the totally deaf, elderly, and physically disabled.
- Reasonableness of cost.
- Overall contribution to the system of care in the county.

Allocations policies will assume that all priority clients regardless of provider, will have access to an appropriate range of services.

Expected Impact

Clients served will receive a more appropriate range of services, which is expected to result in improved stabilization in the community.

Stabilizing and maintaining more dysfunctional clients on the long-term caseload will result in fewer clients being served because fewer new intakes can be taken. This will require more strict prioritization of clients.

Requirements for expanded community support services, including outreach visits, will take staff time formerly devoted to center-based treatment services and will further reduce caseload capacity. Although there will be variations according to individual providers, the average annual caseload reduction is expected to be about one-third at the Governor's budget request level of funding. Additional resources to maintain the existing caseload are being requested from the Division of Mental Health, which has Federal Mental Health Block Grant funds available for distribution to counties.

BASIC COMMUNITY SUPPORT AND TREATMENT
Description of Implementation - continued

Detail on Caseload Estimates

It has been estimated by some providers that implementation of the Basic Community Support and Treatment program will require a caseload ratio of 25 clients per full time equivalent (FTE) staff person. It has also been estimated that there will be a turnover rate of 1/3 during the course of a year. This results is in an averageeyearly caseload of 33 clients FTE to staff person.

In order to more adequately serve the existing yearly caseload of 9031 chronically mentally ill and seriously disturbed, 273 FTEs are required. This number exceeds total staff availability in the public community mental health program, as reflected in the King County biennial needs assessment by 56. A further increase in this service deficit must be made because 20% of the outpatient services provided go to non-seriously disturbed. (These services are supported through United Way, private fees and other revenue sources.) This adjustment results in a deficit of 82 FTE positions in order to support the existing caseload. It does not account for mentally ill persons who have failed to enter the system.

According to these figures, a 43% increase in staff resources is required to simply maintain the yearly caseload. This suggests that implementation of the Basic Community Support and Treatment program with only the existing level of resources will result in a significant reduction in the number of clients served in a year.

The preliminary estimated impact of various levels of long-term-care funding is shown below:

Budget Level	Amount	Annual Caseload
Adequate Level	$5,271.815	9031
Governor's Request Level	$3,914,450	6706

These figures assume that other non-county administered revenue sources supporting priority client services continue to be available. This is not necessarily the case. In addition, the impact of cost of living increases to provider staff has not been factored in, so further reductions in the annual caseload are to be expected.

PROGRAM: Intensive Community Support Teams

Allocation:
Governor
Budget Level

STATE REQUIREMENTS:

This is a demonstration program funded by the state. In incorporates the required services of community support, including medications, provided by teams of clinicians with limited caseloads.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION ST
This program is identified as one component of the long-term care system. It serves multiply hospitalized persons needing frequent contacts with staff, and 24-hour emergency services availability. "The Intensive Community Support Teams will operate as they do currently and will continue accepting clients under the current admission criteria." * *Long Range Plan	This program continues on a demonstration basis in the central and south zones of the county. Evaluation efforts will continue.	Stable funding f expansion will b evaluation resul

PROGRAM: Demonstration Training and Supported Work Program

Allocation
Governor
Budget Leve

STATE REQUIREMENTS:
Day treatment programs shall provide or arrange for vocational habilitation or rehabilitation, and sheltered work, training, or education.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION S
Develop a range of vocational programming and obtain support from other appropriate entities such as the Dept. of Vocational of Rehabilitation (DVR).* *Long Range Plan	There will be a new demonstration program which provides vocational training and supported work for chronically and seriously mentally ill persons who are not eligible for support through the DVR program. Training and supported work will occur in natural or sheltered work settings. The program is expected to demonstrate that some seriously disabled mentally ill can effectively function in work training and sheltered employment settings, prior to their meeting current eligibility requirements for the DVR program. Ultimately joint Mental Health-DVR funding for this program will be sought.	There will be or serve as a resou agencies. This to a provider se for Proposal pro

DEMONSTRATION TRAINING AND SUPPORTED WORK PROGRAM

- Description of Implementation -

I. System Design:

A. Service Region

- o This demonstration program would be available on a regional basis.

B. Relations with other programs

- o Basic Community Support and Treatment: Clients will also be enrolled in the BCST Program at one of the regional agencies.

II. Contract/Funding Provisions:

There will be an RFP for one regional program at $50,000.

PROGRAM: Children's Services /Outpatient and Day Treatment

Allocation
Governor
Budget Leve

STATE REQUIREMENTS:

The County shall assure that the special needs of children are met within state priorities.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION S
In conjunction with other primary care systems, enhance mental health treatment and consultation services for children and youth.* Long Range Plan	Maintain the existing program of outpatient and day treatment services through mid-1984. During that period, work on a coordinated system of mental health and social services for King County children and youth will be completed. Needed modifications in the mental health program will be made for the second half of 1984.	We will maintai ices through mi for seriously d which have been services progra general policy Specialized Dia under-utilizati services for no New program spe veloped during with implementa second half of be put out for changes in the At the 1982 lev expected that t in services due adjustments.

PROGRAM: Violently Disturbed Child Project

Allocation:
Governor
Budget Level

STATE REQUIREMENTS:

This is a residential treatment program initiated in 1980 with special project funding. It is not a required service under the Community Mental Health Act. Funds to support this program are being continued.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION STR
The long range plan for children and youth calls for residential treatment to be administered by the Department of Social and Health Services. The agency will also provide service coordination for children and youth.	This program will continue with joint administration from the county and Bureau of Children's services on an interim basis, since it remains a special project which does not fit standard residential care categories. The Project Steering Committee, which includes representatives from the county, will continue an active role in program development.	A modified progra collaberatively w Services and the will be used. Th address needed pr

PROGRAM: Geriatric Assessment Team Program

Allocation:
Governor
Budget Level

STATE REQUIREMENTS:

The county shall assure the special needs of elderly are met within state priorities.

KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION STR
The Long Range Plan for elderly prioritizes the development of a multi-level geriatric assessment program, jointly funded through the mental health and aging systems.	King County will partially support the Geriatric Assessment Team program which is currently funded through the Seattle/King County Division on Aging. This new funding will allow the addition of one staff person and more psychiatric time.	King County will w County Division on Request for Propos program. The expa implemented in 198 The funding identi minimum needed to tion to service de to allow developme be sought from the which has identifi priority for use o block grant funds.

PROGRAM: Semi-Independent Living

STATE REQUIREMENTS:
The Community Mental Health Act makes residential care an optional service to be administered by the county.

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KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:	1983-85 PLAN:	IMPLEMENTATION
To provide an appropriate range of residential services for priority clients.*	There are currently four semi-independent living program providers funded by the county. The program providers are giving assistance to groups of clients living together in apartments, private homes, or other non-institutional settings. Additional services include client placement and house resource development.	Permission to Block Grant f program will of Mental Hea will be added the existing months of the $283,539 in r grant funding tion of these three months

*Long-Range-Plan.

SEMI-INDEPENDENT LIVING BEDS

- Program Description -

In order to meet the critical need for more adequate living arrangements for chronically and severely mentally ill persons in the least restrictive and least costly manner possible, it is recommended that at least 120 new cluster living beds be developed by the end of June, 1985. These beds will be in homes or apartments, shared by two to six mentally ill persons. Basic Community Support and Treatment providers will be given funds to obtain and maintain housing units and screen, place and support clients in these units. Most units will be obtained from the private market or through community groups such as churches. The provider will act as intermediary and may lease and sublet to the residents, or may simply assist the residents and the actual landlord with a direct relationship. Some units will be built or purchased via Ref. 37 or special HUD loans.

Shared living makes housing more affordable for disabled, low income persons, and provides the opportunity for residents to help one another. It is expected that a wide range of seriously and chronically mentally ill persons will benefit from this type of program. Some persons will only need help to obtain the housing and little else. Others will need the full range of community support and treatment services. Service providers will use these funds primarily for the development and maintenance of shared living arrangement units. Funding for treatment, training in basic living skills, and more intensive support services will come from the basic program.

Priority for the use of these new beds should be given to persons leaving congregate care-Mental Health facilities, especially during the process of conversion to residential treatment, and to existing Community Support and Treatment clients who are in jeopardy due to inadequate or inappropriate living arrangements.

Implementation Strategy

Already developed are 106 semi-independent living beds in King County by four community mental health providers. These providers are now receiving some support from the county out of federal block grant funds for community support. These beds need to be maintained, and at least 120 new beds developed, including 80 to provide movement from CCF-MH facilities, which are proposed to be reduced by 80, and 40 for other existing priority community mental health clients at risk because of poor living arrangements.

Beds would be phased in at the rate of about 30 every 6 months through the biennium.

Impact on Other Parts of the System

A. Service Level: 120 persons housed by end of biennium.

SEMI-INDEPENDENT LIVING BEDS
Program Description - continued

B. Cost for 1983-85:

Bed months	1,900
Cost per bed month x	$ 150
Total Cost	$380,000

1,900 bed months is based on 30 new beds being implemented each 6 months. The cost per bed month is based on the $5 per day per bed costs used in the DSHS budget request.

C. Impact on Other Parts of the System:

Reduces the need for more expensive and difficult-to-develop residential facilities.

PROGRAM: County Administration

STATE REQUIREMENTS:
The County authority shall submit biennial needs assessments and mental health service plans, contract with licensed service providers, monitor and perform biennial fiscal audits of contracts, maintain patient tracking information and coordinate services for county residents sent to the state hospital. The county has the option of administering residential care.

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KING COUNTY LONG-RANGE GOALS, OBJECTIVES AND PLANS:

Integrate the voluntary and involuntary mental health programs, residential care and inpatient care into an effective system of mental health care.

In conjunction with other primary care systems, enhance mental health treatment for the elderly.

In conjunction with other primary care systems, enhance mental health treatment for the developmentally disabled.

In conjunction with other primary care systems, enhance mental health treatment for children and youth.

Promote the development and expansion of a range of residential care options, including semi-independent living programs and residential treatment.

1983-85 PLAN:

There will be a new mental health program position which will coordinate planning for the voluntary and involuntary system, supervise mental health Board coordination, the client tracking program and residential care planning and development.

Division staff will work collaboratively with the Seattle-King County Division on Aging (SKDOA) to develop a jointly funded program for Geriatric Assessment. In addition, staff will work with geriatric mental health specialists and members of the SKDOA outreach workers to identify the types of clients who will be the casemanagement responsibility of each system.

The developmentally disabled are one of the special needs populations to be considered in plan and contract development for the Basic Community Support & Treatment program.

Provide staff support for the Human Resources Coalition effort to develop a coordinated system of services for children and youth, and make needed changes in the mental health program to better fit within the larger framework of children's services.

The County is requesting state funding for support of a residential coordinator. A proposal for this position was included in the County Needs Assessment. This position will work with the state, potential providers, licensing and zoning authorities and county staff and board to develop some or all of the residential proposals and to develop the necessary internal Division and County mechanisms to contract and monitor these services.

IMPLEMENTATION

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COUNTY ADMINISTRATION

- Description of New Positions and Functions to be Supported by Community Mental Health Funds -

There will be one full-time professional position and portions of two clerical positions added to the mental health budget in the 1983-1985 biennium. The professional position and one of the clerical positions will begin work on 10/1/83. The remaining clerical position will begin work in the second year of the biennium.

The professional position, a Mental Health Program Administrator, will be added to supervise the development and management of the county Mental Health (MH) Program in accordance with the long-range goals and objectives developed by the Executive's Mental Health Task Force and the first biennial plan under the new Community Mental Health Services Act. The person in this position will directly supervise all other persons in the Mental Health Section including the new tracking/care coordinator, the new residential coordinator, the existing Mental Health Board coordinator and the existing half-time children's coordinator. The administrator will also be responsible for integrating involuntary treatment services into the overall mental health plans, and coordinating involuntary and voluntary services. The Mental Health Administrator will not, however, directly supervise the line operations of the Involuntary Treatment Section. Funding for this position will come from state MH funds and/or county dedicated millage. The new law limits the use of state funds for county administration to 2% plus one position.

Portions of the two clerical positions will be added as support to the Mental Health Administrator and the monitoring and fiscal management functions necessary to administer the Mental Health Program.

These staff additions generally restore the Mental Health staff component that existed prior to the cuts in 1981. Following is a comparison of the proportion of total county-administered program funds that have been allocated to county administration (not including ITA funds) for four years.

	1980 Actual	1981 Actual	1982 Actual	1983-84 Proposed
Total county-administered program funds	$3,653,382	$3,571,134	$4,315,028	$6,181,705
Support for county administration	$296,449	$327,373	$352,418	$413,670
	8.1%	9.1%	8.1%	6.7%

PROJECTED COSTS

FY 83-84

Salaries:	1 Mental Health Program Administrator (R. 63) [full-time, 100% MH, 9 months]	$ 26,191.00	
	1 Office Assistant III [full-time, 50% MH, 9 months]	5,275.88	
	1 Office Technician II [not added in 83-84 Fiscal Year]	-0-	
		$ 31,466.88	
Benefits (@ 20%)		6,293.38	
Overhead [Office Equipment, Supplies, etc.]		7,153.68	
SUB TOTAL NEW		$ 13,447.06	$44,913.94

COUNTY ADMINISTRATION
Description of New Positions and Functions - continued

May 10, 1983

SUB-TOTAL EXISTING POSITIONS/COSTS			$368,756.83
GRAND TOTAL FY 83-84			$413,670.77

FY 84-85

Salaries:	1 Mental Health Program Administrator [full-time, 100% MH, 12 months]	$34,921.00	
	1 Office Assistant III [full-time, 50% MH, 12 months]	7,386.23	
	1 Office Technician [half-time, 50% MH, 12 months]	4,252.24	
		46,559.47	
Benefits (@20%)		9,311.89	
Overhead		10,584.83	
		19,896.72	
SUB TOTAL NEW POSITIONS/COSTS			$ 66,456.19
SUB TOTAL EXISTING POSITIONS/COSTS			$405,910.93
GRAND TOTAL FY 84-85			$472,367.12

GRAND TOTAL 83-85 BIENNIUM $886,037.89

COUNTY ADMINISTRATION

- Description of Residential Coordinator Position to be Supported by Residential Program Funds -

In order to assure development of a significant number of new residential care and treatment options within the 1983-85 biennium and in order to prepare King County for assuming administration of residential facility funding in the 1985-87 biennium, it is proposed that King County hire a Mental Health Residential Program Coordinator by October 1, 1983. This coordinator will be responsible for working with the state program and licensing authorities, current and potential providers, local licensing and zoning authorities and county staff and board to develop some or all of the options outlined in the other residential program proposals. The coordinator will also make sure that new residential services are consistent with the county long range plan, update and further develop the residential program portion of county plans and prepare the specific proposal for county administration of all residential programs in the 1985-87 biennium. Included in the proposal for county administration will be plans for the development of quality of care standards and a system for compliance monitoring.

Implementation Strategy

Assuming significant funding for residential enhancement, the coordinator should be hired within three months after the beginning of the new biennium. This amount of time allows for the award of funds, county authorization of the position and completion of the hiring process.

If there are no significant enhancements funded, a half-time coordinator should be hired for the second year of the biennium to develop the proposal for county administration of residential programs.

Impact

Cost for 1983-85

$ 26,802	1983 Annual Salary (1 Social Service Program Coordinator)
4,980	Benefits
$ 31,782	Staff costs
2,359	O & M Costs
$ 34,141	12 months total cost
$ 59,747	21 months total cost of 1983-85

Neither the county nor the state currently has sufficient administrative resources to assure that funding for improvements in residential programs would in fact have positive results. The consequence of proceeding without this type of support could be quite negative. Therefore, King County should not assume the administration of residential programs in the 85-87 biennium without the addition, in the 83-85 biennium, of the Residential Program Coordinator.