King County
Criminal Justice Initiative

Interim Progress Report
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EXECUTIVE SUMMARY

King County Council adopted the Adult Justice Operational Master Plan (the Plan) in November, 2002, which paved the way for the Criminal Justice Initiative (CJI). The Plan recommended that a portion of the expected savings from the closure of the North Rehabilitation Facility and Cedar Hills Addiction Treatment facility be used for alternatives to 24-hour secure detention in King County correctional facilities. The primary objectives of developing jail alternatives were to reduce both the jail population and recidivism. A particular emphasis was placed on developing services for inmates who are high users of the jail and/or individuals who have substance use disorders and mental illnesses who are not otherwise eligible for service enrollment.

The Department of Community and Human Services initiated a cross-departmental CJI planning group in March, 2003 to determine which programs would be developed and delivered. The group was supported by a National Institute of Corrections Technical Assistance Grant. With the assistance of consulting facilitators and a review of relevant literature, the group settled on developing ten CJI programs -- five service programs to provide housing, mental health and chemical dependency treatment services, and five process improvements to train stakeholders and assist inmates to connect to treatment services and publicly-funded benefits. Specifically, the CJI planning group determined that the following programs would be developed:

- Co-occurring disorder (COD) integrated treatment
- Housing vouchers
- Mental health treatment vouchers
- Methadone vouchers
- Outpatient chemical dependency treatment at the Community Center for Alternative Programs
- Criminal justice (CJ) liaisons
- Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) application worker
- Department of Social and Health Services (DSHS) application worker
- Cross-system training
- Enhanced screening and assessment in jail
- Drug court evaluation - pending under Drug Court administration

I. Purpose of report

The purpose of this report is to describe the first six months of CJI operations. The report includes a description of the characteristics of individuals served by CJI programs, a limited range of early outcomes, and a variety of process evaluation issues including engagement rates, service utilization, length of treatment, dispositions at treatment completion, and participant and stakeholder satisfaction.

Recidivism data are not reported here as the programs have not been operational for a long enough period for participants to have had a full year in the community, the minimum period suggested by researchers and the Washington State Institute for Public Policy (WSIPP). Recidivism data should be available for most programs by April, 2005. Results are presented below by program. These results can be best used for quality improvement purposes to refine and strengthen programs and overall operations of the CJI.

II. Interim findings

A. Co-Occurring Disorder (COD) treatment

The COD treatment program began August, 2003 and is designed as a 12-month benefit. Adult offender clients with co-occurring mental health and chemical dependency problems are eligible for the program if they are referred from the King County Adult Drug Diversion Court, the King County District Mental Health Court or the Seattle Municipal Mental Health Court ("specialty courts").

During the first six months of operation, 61 people were served. There was a slightly higher proportion of females and a similar proportion of ethnic minorities compared to the jail population. Nearly two-thirds of participants were homeless and all had serious functioning impairments related to their substance use and/or mental illnesses.

Participant satisfaction was generally high, though few respondents were satisfied with the process of getting housing, and only modest satisfaction was reported for service availability. Staff and stakeholder satisfaction was also generally high, however satisfaction with housing resources was low, and suggestions were made to improve inter-system communication and collaboration. The comprehensiveness of the services and immediate access are seen as prominent strengths of the program. Program staff used many interventions which have shown empirical evidence of effectiveness -- also known as evidence-based practices. However, use of treatment to enhance motivation for behavior change, one such evidence-based practice, was low. Outcome data reported by case managers showed little change in housing or community functioning, but some reduction in substance use. Participant-reported outcomes included reduced substance use and improved coping skills, symptoms, and housing.

B. Mental health voucher

The mental health voucher program began October, 2003 and was designed as a 6-month benefit. The program was originally targeted for individuals with mental illnesses who were referred from the King County District Mental Health Court (DMHC). Within two months of initiating the program, the DMHC received a similar federal grant. At that time, the program transitioned from DMHC referrals to non-specialty courts (District or Superior) referrals via screening from the CJ liaisons.

During the first six months of operation, 10 people were served. The low number of people served was largely due to few referrals being made during the transition to non-specialty courts. Of those served, there were slightly lower proportions of women and ethnic minorities than the jail population. All had seriously impaired community functioning associated with their mental illnesses.

While staff reported that providing access to mental health treatment for this population was a major strength, they were dissatisfied with the program's resources, short benefit length, and their own training opportunities for working with the challenging CJ population. Stakeholders were generally more satisfied, but reported that referral criteria should be clarified and that housing and intersystem communication could be improved. Outcome data reported by case managers showed little change in mental health symptoms or community functioning. Also, few participants convert to other funding for mental health treatment, a central goal of the program.

C. Methadone voucher

The methadone program began July, 2003 and was designed as a 9-month benefit. During its first six months, services were provided to individuals participating in the King County Needle Exchange Program. Once staff were hired and trained to perform the screening, assessment, and referral functions in the King County Jail, services were restricted to client being released from King County jails.

During the first six months of operation, 107 people were served. The program served a higher proportion of females and ethnic minorities compared to the overall jail population. Nearly all participants reported using heroin, and over two-thirds report using cocaine as well. Over a third of the participants were homeless when they entered the program.

Client and staff satisfaction was high and some reported the program to be life-changing. Staff and stakeholders also reported high satisfaction, but felt the program should be longer and that intersystem communication and collaboration could be strengthened. Staff used many evidence-based practices, however use of motivational treatment was relatively low. A high proportion of participants reported

positive program impacts including reduced substance use and improved coping skills, family relationships, housing, and physical health.

Four-fifths, (81%) of participants reduced their primary substance use (almost all heroin), and nearly half had no heroin use after 9-months of treatment, or discharge, whichever came first. Nearly half had reductions in cocaine and other secondary substance use. There was also a significant reduction in the amount of money participants spent on illicit drugs.

D. Housing Voucher

The housing voucher program began May, 2003 and was designed as a 6-month benefit. Adult offender-clients who are homeless and have a chemical dependency problem or co-occurring mental illness and chemical dependency are eligible for the program if they are referred from one of the specialty courts.

During the first six months of operation, 93 people were served. There was a similar proportion of women and a higher proportion of ethnic minorities in the housing voucher program compared to the jail population.

About half (52%) of the participants exited services within three months and very few of these individuals obtained permanent housing. However, of those who stayed more than 90 days, 69% obtained permanent housing. Most of those who obtained permanent housing required an extension of the 6-month benefit. Overall, 36% of the participants obtained permanent housing.

Clients reported high global satisfaction but low satisfaction with the process and length of time it took to obtain permanent housing. Of the 48 respondents interviewed, 44% reported that they did not receive assistance obtaining permanent housing. Many also reported that the transitional housing was run down and in unsafe and high drug use areas, and that they didn't like the rules in the transitional housing sites. Staff and stakeholders reported high global satisfaction, but lower satisfaction with amount and types of housing resources. Both groups felt the benefit period is too short. Participant-reported outcomes included reduced substance use and improved coping skills, housing, and productivity.

E. Intensive outpatient (IOP) chemical dependency treatment at the Community Center for Alternative Programs (CCAP)

The CCAP IOP treatment program began April, 2004 and was designed as a 90-day benefit. Adult offender-clients who are court ordered for at least 30 service days by King County District or Superior courts and who are chemically dependent are eligible for the program.

During the first six months of the program, 30 people were served. The program served a higher proportion of females and ethnic minorities than in the overall jail population.

We will be able to complete the evaluation of the first six months of the CCAP IOP in January 2005 when all participants will have had an opportunity to participate for 90 days. At this time, 21 people had the opportunity to participate for 90 days, and of those, about half left within 60 days. Most withdrew from service or were lost to clinician contact. Five of the 21 participants completed treatment.

F. Criminal Justice (CJ) liaisons

The CJ liaisons began their work September, 2003. Two liaisons are stationed at King County adult jail sites (one liaison at each site), and one liaison is stationed at CCAP. Adult offender-clients within King County jails who have mental health and/or chemical dependency problems and who are expected to be released are eligible for the treatment and social service linkage services provided by the jail-based liaisons. Offenders in CCAP for less than 30 days and who are not chemically dependent are eligible to see the CCAP liaison.

During the first six months, 493 people were seen by the three liaisons. There was a slightly higher proportion of females served than in the jail population.

Referrals to the CJ liaisons were typically from inmates themselves or Jail Health Services. Referrals from CJ liaisons were most often to the ADATSA or DSHS application workers, courts, or community mental health agencies.

Staff and stakeholders were generally satisfied with the program, though staff were dissatisfied with training opportunities. Lack of role clarity and isolation of the liaisons was also mentioned by stakeholders, consistent with reports from staff of difficulties with intersystem communication and collaboration.

G. Cross-system training

Cross-system training occurred for King County human service and corrections staff in May and June, 2004. Nine trainings were provided to a total of 257 participants. The four trainings provided to human service audiences focused on the corrections and legal systems. The five trainings provided to corrections audiences focused on how CJI programs operate. Evaluations were provided by 64% of training attendees. Results showed that participants felt they increased their knowledge, and nearly all reported that they would recommend the training to others.

H. ADATSA application worker

An ADATSA application worker was assigned full-time to the CJI in January, 2004. Offender-clients are eligible for ADATSA application assistance if they are within 45 days of release from a King County jail, are indigent, and have a chemical dependency problem.

During the first six months of operation, 247 referrals were made to the ADATSA application worker. A slightly higher proportion of females and a similar proportion of ethnic minorities were referred compared to the jail population.

About half of referrals to the ADATSA application worker were not processed as they were not within 45 days of release, a criterion for service eligibility. About a third of the referrals received a completed screening.

I. DSHS application worker

The DSHS application worker began May, 2004. The first six months of operations have not been completed at this time, though 140 have been processed within the first three months.

J. Enhanced Screening & Assessment in the Jail

An improved screening and assessment process in the jail was initiated to provide more complete and accurate offender risk, mental health, and chemical dependency information for in-custody first appearance defendants. Parts 1 and 2 of the screening process were implemented in March 2004 and targeted at facilitating the judicial decision to release or detain within the first 48-72 hours. The third part of the protocol will target information at arraignment to expedite placement decisions by the court within the first 14 days. This process is currently being addressed by an Intake Services Small Working Group, and its implementation is anticipated soon.

III. Recommendations

The recommendations for quality improvement listed below are suggested by the data collected to date. Later reports that include recidivism outcome data will provide more useful information for determining the overall effectiveness of the programs. In the final report, recommendations will also be developed with input from key stakeholders involved in implementation of the CJ Initiative.

It should be noted that some changes to the CJI have already been made or will be implemented soon. Specifically, the mental health voucher period will be increased to nine months starting in 2005, training and supervision of the CJ liaisons has been enhanced, and workgroups have begun examining ways to increase housing options for CJI program participants.

Recommendations

1. Provide additional training regarding evidence-based practices, such as motivation enhancement therapy (MET) for the COD and methadone programs, particularly if program outcomes are not strong when such outcomes have been fully evaluated.

2. Consider providing additional training and clarification of expectations to staff for the mental health voucher program to promote positive outcomes given the relatively short benefit period. Training should include a focus on using the voucher period to convert participants to other funding mechanisms. As noted above, the voucher benefit period will be increased to nine months beginning in 2005. Evaluation the impact of this change should be considered.

3. Provide additional training and role clarification for the CJ liaisons and staff groups with whom they interact. Some training has already been conducted, as noted.

4. Develop a process to help determine reasons for the relatively high early drop-out rate in the housing voucher program and how more participants could obtain housing during the six-month benefit period.

5. Develop strategies for CJI programs to work with housing systems and funders to determine how the supply of safe, appropriate and well-maintained housing for CJI participants can be increased.

6. Explore reasons for the relatively high early drop-out rate in the CCAP IOP program

7. Provide additional information and training to ADATSA referral sources regarding eligibility for ADATSA application assistance

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INTRODUCTION

King County adopted the Adult Justice Operational Master Plan (the Plan) in November 2002 which paved the way for the current Criminal Justice Initiative (CJI). The Plan recommended that a portion of the expected savings from closure of the North Rehabilitation Facility and Cedar Hills Addiction Treatment facility be used for alternatives to secure detention in King County correctional facilities. The primary objective for the use of these funds is to both reduce the jail population and recidivism. The Plan stresses that secure detention should be reserved for those who are a public safety or flight risk or who have failed in community alternatives to secure detention. A particular emphasis was placed on developing alternatives to secure detention and services for inmates who are high users of the jail and/or individuals who have substance use disorders and mental illnesses and are not otherwise eligible for service enrollment. Jail alternatives developed through the CJI are intended to preserve public safety, provide an appropriate level of sanctioning for criminal offenses, be cost effective and acceptable to the courts, reduce risk of re-offense and actual recidivism, and not lead to net-widening (i.e., providing alternatives to people who otherwise would not have been incarcerated).

The rationale for focusing on individuals with substance use and mental illnesses stems from their disproportionately high jail usage. For example, among those with drug or alcohol-related charges, inmates with co-occurring psychiatric disorders (COD) have nearly double the average length of stay in King County jails. Further, people with CODs represent 60% of District Mental Health Court (DMHC) cases and 41% of Drug Diversion Court cases. About one-third of specialty drug and mental health court clients are also homeless. Among those with ten or more jail bookings in a year, all were homeless. A presumption of the CJI planning process was that at least a subset of these individuals could be safely and more appropriately served with community-based interventions.

CJI Planning

The Department of Community and Human Services initiated a cross-departmental CJI planning group in March, 2003 to determine which programs would be developed and delivered. The group was supported by a National Institute of Corrections Technical Assistance Grant.

The group consisted of representatives from the county's mental health and chemical dependency services administration (MHCADSD), jail and corrections leadership, staff from the Jail Health Service, and specialty courts. With the assistance of consulting facilitators, the group reviewed relevant research and best practice information, including information from model programs in Multnomah County in Oregon and Broward County in Florida. Findings from these reviews are briefly summarized in a logic model presented in Appendix A. In addition, the group discussed gaps in the current service system. This discussion revealed weak coordination between the specialty courts and their respective treatment systems, complex bureaucratic systems for inmates to obtain entitlements and treatment, inmate homelessness following release from jail, limited case management for individuals released pre-trial, little expertise in the provision of evidence-based care for this population, and little coordination of community care for people released from jail.

Based on information reviewed, the group reached consensus to develop ten CJI programs -- five client service programs to provide housing, mental health and chemical dependency services, and five process improvements to train stakeholders and assist inmates to connect to treatment services and publicly-

funded benefits. A decision was made that overall program management would be provided by (MHCADSD).

Specifically, the group decided that the following programs would be developed:

- Co-occurring disorder (COD) integrated treatment
- Housing vouchers
- Mental health treatment vouchers
- Methadone vouchers
- Outpatient chemical dependency treatment at the Community Center for Alternative Programs
- Criminal justice (CJ) liaisons
- Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) application worker
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The logic model (Appendix A) depicts the assumptions made by the group based on information reviewed, inputs for each program, and central activities and functions of the programs. The model also shows expected outcomes and system impacts. This information was derived from a set of 24 interviews with key stakeholders in the CJI process. External and unanticipated factors that could impact the effectiveness of the programs are also listed, and were developed based on discussions with MHCADSD administration.

Program Evaluation Questions

Outcome evaluation questions were developed based on stakeholder interviews as discussed above. The table below shows outcome evaluation questions for each of the five CJI service programs.

Table 1. Outcome evaluation questions by CJI service program

Outcome evaluation questions	Mental Health Vouchers	Housing Vouchers	Methadone Vouchers	COD tier	CCAP Intensive Outpatient CD treatment[2]
1. Reduced jail bookings and jail days	X	X	X	X	X
2. Convictions[1]	X	X	X	X	X
3. Reduced substance use			X	X	X
4. Reduced mental health symptoms	X			X	
5. Increased housing stability		X		X	
6. Improved community functioning	X		X	X	
7. Participant-reported impacts	X	X	X	X	X
8. Reduced jail average daily population (ADP)[1]					

[1]Reduced convictions on new charges as well as reduced jail ADP for individuals with mental health and chemical dependency issues will be examined as these data become available.

[2]Outcomes for the CCAP Intensive Outpatient Chemical Dependency Treatment program will be evaluated when the first 6 -month cohort of participants have been discharged from the program

The table below shows evaluation questions related to CJI service program processes as well the five CJI process improvements.

Table 2. Process Evaluation Questions

CJI Service Programs
1. What proportion of individuals offered CJI programs engage in treatment?*
2. What is the volume of services used by participants?*
3. How long do participants stay in treatment?*
4. What are client dispositions at treatment completion?*
5. Are services satisfactory to participants?
6. Are treatment programs using evidence-based practices?
7. Are programs satisfactory to stakeholders
CJ Liaisons/Linkage improvements
1. Are CJ liaisons integrated?
2. Are linkages to treatment consistently made?
3. Has the number of linkages to treatment increased?
Cross-system training
1. Has training reached all relevant groups?
2. Have training participants gained knowledge regarding treatment and CJ systems?
ADATSA and DSHS application workers[1]
1. Are more ADATSA and DSHS applications completed pre-release?
In-jail Assessment[1]
1. Is assessment process sound and feasible?
2. Is assessment process identifying all MH/CD cases?
3. Are more people with MH/CD issues identified for courts?
4. Do courts have more information re: MH/CD issues?
5. Are referrals to district MHC increased?

*Not evaluated for the housing voucher program

[1]Evaluation questions related to the ADATSA and DSHS application workers and the in-jail assessment will be examined in subsequent reports.

Program Evaluation Design and Methods

This interim evaluation report examines progress of the CJI programs during the first six months of operation. When possible, pre-program measures are compared with measures taken at the end of the program benefit period or at program discharge. Subsequent reports will include the second six-month cohort, and, when feasible, comparisons of participant outcomes with outcomes of samples (comparison groups) taken historically before the CJI programs were implemented, and concurrently with CJI program implementation.

A large number of data collection strategies were used in this evaluation. Participant and staff telephone interviews and stakeholder surveys were developed. Participant interviews were conducted as close to participants' program discharge point as was feasible. Staff interviews and stakeholder surveys were conducted when a given program had been operational for six months.

Data from the MHCADSD information system (IS) and the DSHS TARGET data system for chemical dependency treatment were also used for the evaluation. Subsequent reports will also utilize data from the King County jail system and conviction records organized by the Washington State Institute for

Public Policy (WSIPP). To supplement electronic records, outcome instruments were developed for the mental health voucher program, the COD treatment program, and the methadone voucher program. Data collection templates for electronic submission were also designed for the housing voucher program, CJ liaisons, and the DSHS and ADATSA application workers.

Additional information regarding the evaluation design, data collection, and instruments is available upon request.

Purpose of Report

The purpose of this report is to describe the first six months of CJI operations. The report includes a description of the characteristics of individuals served by CJI programs, a limited range of early outcomes, and a variety of process evaluation issues including engagement rates, service utilization, length of treatment, dispositions at treatment completion, and participant and stakeholder satisfaction.

Recidivism data are not reported here as the programs have not been operational for a long enough period for participants to have had a full year in the community, the minimum period suggested by researchers and the Washington State Institute for Public Policy (WSIPP). Recidivism data should be available for most programs by April, 2005. Results are presented below by program. These results can be best used for quality improvement purposes to refine and strengthen programs and overall operations of the CJI.

INTERIM FINDINGS

CO-OCCURRING DISORDER (COD) TREATMENT PROGRAM

I. Program Description

Program overview: The COD treatment program began August, 2003. Services are provided by Community Psychiatric Clinic and Seattle Mental Health. The program provides up to 12 months of integrated outpatient mental health and chemical dependency treatment, case management, and housing stabilization. The services are located in the same agency and treat both disorders equally. Caseloads are small (limited to 35 per agency or 70 combined, with a requirement of small staff to client ratios) and coordination is maintained with the court of referral.

Target population: Adult inmates with co-occurring mental health and chemical dependency problems who are referred from and agree to participate in ("opt in") the King County Drug Diversion Court, King County District Mental Health Court or Seattle Municipal Mental Health Court ("specialty courts"). Participants must also have had one additional prior incarceration.

II. Interim Results: First six months - Aug. 1, 2003 thru Jan. 31, 2004

A. Characteristics of persons served (n=61)

Characteristics of individuals served during the first six months of the COD program are presented below. Data during 2003 show that the daily population in the King County jail includes 12% women and 41% ethnic minorities. Thus, the COD program served a higher proportion of females and a similar proportion of ethnic minorities compared to the jail population. Diagnoses listed show that those served had major mental illnesses as well as substance use disorders characterized primarily by use of alcohol and cocaine. Functioning was seriously impaired by these problems. A subsample of 11 participants were reached for interviews, and of them, over 80% reported having prior mental health or chemical dependency treatment. Nearly two-thirds were homeless.

Table 3. COD program characteristics of persons served

Demographics	N	%
Gender- #/% female	20	33%
Ethnicity		
Caucasian	34	56%
African-American	18	30%
Native American	3	5%
Asian-Pacific Islander	3	5%
mixed or "other"	3	5%
Hispanic (duplicated)	6	10%
Age	Average 37 yrs	SD=10

Characteristics cont'd		
Mental illness diagnoses		
Depression	20	33%
Schizophrenia spectrum	18	30%
Bipolar	14	23%
Other	9	15%
Substance use (data for n=14)[1] May list more than one substance		
Alcohol	9	64%
Cocaine	8	57%
Marijuana	6	43%
Opiates	1	7%
Homelessness (or unstable/temporary housing)		
Case manager reported in the King County Mental Health Plan Information System (IS) (n=61)	37	61%
Client-reported (n=11)	9	82%
Community functioning		
Global Assessment of Functioning (GAF)	Average=43.4 serious impairment	SD=8
Problem Severity Summary[2]	Average=2.2 slight-marked impairment	SD=.6
Employment	1 employed	2%
Prior treatment	Self-report	
Mental health treatment (n=11)	9	81%
Chemical dependency treatment (n=11)	9	81%

[1]Substance use information was collected starting January, 2004 -- referrals from the first five months (i.e., Aug-Dec, 2003) of the six-month cohort are not represented
[2]Without socio-legal and symptom items, average =2.2 (SD=.7)

B. Process Evaluation

The process evaluation of the COD program consists of data regarding engagement rates, service utilization, length of treatment, disposition at treatment completion, participant satisfaction, use of evidence-based practices, and stakeholder satisfaction.

1. Engagement rate: Of 70 individuals referred to the program, 61 began treatment (87%)

2. Service utilization

   Outpatient mental health service data was drawn from the MHCADSD IS for services authorized under the COD program between service start and exit dates for each participant. Days that participants were in jail or inpatient units have not been removed from this analysis. Unbilled "searching" activities are also not included in service hours. Based on these data, average hours of service per week are shown in the table below.

Table 4. COD program average service hours per week

Ave service hours/week	N	%
<1 hour	32	52%
1 to <2 hours	19	31%
2 to <3 hours	4	7%
3 to <4 hours	2	3%
4 to <5 hours	2	3%
5+ hours	2	3%
	61	100%

During the first six months of the COD program, about half of the participants received an average of at least one hour of service per week. Given the difficulty of engaging this population in service, this seems reasonable as an average, understanding that averages mask periods of greater service intensity that might be expected in such a program.

3. Length of treatment

The COD program was designed as a 12-month benefit. Only after January 2005, will we be able to evaluate how many people who entered the program during the first six months (August 2003-January 2004) actually complete the full 12 months of service. However, to provide some information regarding length of treatment, we used July 31, 2004 as an arbitrary end date, which provides an evaluation period of at least six months for all participants entering the program during its first six months of operation.

As of July 31, 2004, the average length of treatment for the 61 people who entered treatment during the first six months was 230.4 days (SD=72.4; range 28-347 days). Four-fifths (82%) of participants completed at least six months of treatment as shown in the table below.

Table 5. COD program length of treatment

Length of treatment	N	%
0-90 days	2	3%
91-180 days	9	15%
181-270 days	26	43%
271-365 days	24	39%
Total	61	100%

4. Dispositions at treatment completion

Of the 61 people who entered treatment during the evaluation period, 15 were discharged as of July 31, 2004. All of these individuals would be considered to have left "prematurely" as the program is designed to last 12 months. The average length of treatment for these 15 people was 144.1 days (SD=60; range 74-246 days). Dispositions for these individuals are listed below.

Table 6. COD program disposition at discharge

Disposition at discharge from treatment (n=15)	N	%
Dropped from specialty court*	3	20%
Long-term incarceration	3	20%
Transferred to other programs/funding	3	20%
Lost to contact	2	13%
Refused further treatment	2	13%
Died	1	7%
Moved	1	7%

*As of January 2005, individuals referred to the COD program will be able to complete treatment even if they are dropped from court jurisdiction

5. Participant satisfaction

The evaluation of participant satisfaction for the COD program includes results from client and staff interviews.

Client interviews were completed for 11 of the 61 participants. Remaining individuals were unable to be reached (n=45) or refused to be interviewed (n=5). Interviews included satisfaction rating scales and open-ended questions about program strengths and weaknesses.

Client interviews (n=11 unless otherwise specified)

Table 7. COD program client global satisfaction

Items rated on 5-point scales - % of top two ratings	N	%
Counselor skills - "good" or "excellent"	9	82%
Current treatment "better" than previous treatment (n=9)	7	78%
Program satisfaction - "somewhat" or "very" satisfied	8	73%
Time to get housing - "somewhat" or "very" satisfied (n=10)	7	70%
Quality of therapy - "good" or "excellent" (n=10)	7	70%
Quality of program - "good" or "excellent"	7	64%
Process of getting housing - "somewhat" or "very" satisfied (n=10)	2	20%

Table 8. COD program client satisfaction with program components

% "Agree" or "Strongly agree" with statements below:	N	%
General Satisfaction		
If I had other choices, I'd still get service from the program	9	82%
I'd recommend the program (n=10)	8	80%
I liked the services I received	8	73%
Perception of Access		
Staff were willing to see me when I needed it (n=10)	9	90%
The location was convenient	9	82%
Staff returned my calls within 24 hrs (n=9)	7	78%
Services were available at good times	7	64%
I was able to get all the services I needed	7	64%
I was able to see a psychiatrist when I wanted	7	64%

Table 8 (cont'd) COD program client satisfaction with program components

Appropriateness and Quality of Services		
I felt free to complain	10	91%
Staff encouraged me to take responsibility for how I live life	10	91%
Staff believe I can grow, change, and recover	9	82%
Staff were sensitive to my cultural background	9	82%
I obtained information to take charge of my illness (n=10)	9	80%
Staff told me side effects to watch for	8	73%
I was given information about my rights	6	55%
Participation in Treatment Goals		
I felt comfortable asking medication questions	11	100%
Staff are kind and non-judgmental	10	91%
I, not staff, decided my treatment goals (n=10)	7	70%
Getting into the program was easy	7	64%
Staff understand what recovery is like	7	64%

Rating scale questions show generally high client satisfaction with the program with some notable exceptions. Few respondents were satisfied with the process of getting housing, though higher satisfaction was shown for the time it takes to get housing. Only modest satisfaction levels were shown for questions about access to and availability of services when needed, receiving information about rights, and having staff understand what recovery is like.

Open-ended questions regarding program strengths and weaknesses are shown below. Obtaining housing and learning how to manage mental health symptoms and substance use were the most frequently reported strengths. Group process issues, inadequate housing and staffing issues are reported weaknesses of the program.

Table 9. COD program client-reported strengths and weaknesses

Positive effects/strengths (10 of 11 people listed items)	N	%	Negative effects/weaknesses (4 of 11 people listed items)	N	%
Learned coping, MH and CD symptoms	5	45%	Cross talk; too long talk in group	3	27%
Housing; clean and sober housing	4	36%	Not enough housing; poor housing	3	27%
1:1 with case manager	2	18%	Understaffed; staff unavailable	3	27%
Staff good; can help with MH and CD	2	18%	Staff turnover	2	18%
Back on track w/my life	2	18%	More depressed	1	9%
Help with education	1	9%	Gave me unneeded meds	1	9%
Listening	1	9%	No 1:1; group membership changed	1	9%
Learn how to cooperate with services	1	9%	Too much "down time"	1	9%
Lots of services if want to change	1	9%	Agency shouldn't force you to go	1	9%
Useful feedback in group	1	9%			

Four staff interviews representing both COD providers were completed. The interviews included both satisfaction rating scales and open-ended questions regarding strengths and weaknesses.

Staff interviews (n=4)

Table 10. COD program staff global satisfaction

Items rated on 5-point scales - % "somewhat" or "very" satisfied	N*	%
Overall satisfaction	4	100%
Satisfaction with program resources	4	100%
Satisfaction with program length	4	100%
Satisfaction with training and training opportunities	4	100%
Satisfaction with therapy resources	4	100%
Satisfaction with referrals	3	75%
Satisfaction with housing	1	25%
Item rated on 4 -point scale - % "good" or "excellent"		
Overall quality	2	50%

*Here and elsewhere in this report, percentages for small Ns (<10) are considered highly unstable and should be interpreted with caution.

Rating scale questions show high satisfaction, with the exception of housing resources and overall quality. These findings may warrant further discussion with staff for more detail.

COD staff member interviews (below) suggested that providing access to treatment for individuals who otherwise would not receive treatment was a program strength. Two people listed intersystem collaboration and communication as a strength, but one listed it as a weakness. Staffing issues showed the same split.

Table 11. COD program staff-reported strengths and weaknesses

Strengths/best things of program	N	%	Weaknesses/worst things	N	%
Access to treatment services	4	100%	Difficult population	3	75%
Provision of COD	2	50%	Staffing	1	25%
Staffing	2	50%	Interagency communication/sharing	1	25%
Collaboration/communication	2	50%	Lack of housing	1	25%
Client-centered treatment	2	50%	Lack of leverage and ct. follow-through	1	25%
Being part of innovative program	2	50%	Referral issues	1	25%
Workload	1		Data requirements	1	25%
Financial assistance to clients	1	25%			
Watching clients improve	1	25%			
Paying for housing	1	25%			

6. Evidence-based practices

Evidence-based practices are interventions which have shown empirical evidence of effectiveness. Interventions were selected for evaluation based on their inclusion in the Co-Occurring Disorders: Integrated Dual Disorders Treatment Evidence-based Practice resource kit (Substance Abuse and Mental Health Services Administration, 2003) or based on discussion with national experts in the field. Use of evidence-based practices was evaluated through the staff and client interviews described above.

Table 12. COD program staff-reported evidence-based practices for COD program

Percent of clients receiving evidence-based practices (n=4)	None/ almost none	About 1/4 of clients	About 1/2 of clients	About 3/4 of clients	All/ nearly all clients	Don't know
Individual counseling					1 (100%)	
Relapse prevention			1 (25%)	2 (50%)	1 (25%)	
Therapy at least 1/week				2 (50%)	2 (50%)	
Motivational Enhancement Therapy (MET)			1 (25%)	2 (50%)		1 (25%)
Cognitive Behavioral Therapy (CBT)			3 (75%)		1 (25%)	

Staff reported that individual counseling, relapse prevention, and having therapy at least once per week were employed with at least 75% of program participants. Cognitive-behavioral therapy (CBT) was used less often. Motivational enhancement therapy (MET; Miller & Rollnick, 2002) is considered by some to be the treatment of choice for substance use disorders, and one staff member had never heard of this type of intervention.

Table 13. COD program client-reported evidence-based practices

Client self-report (n=11)	N	%
Have CD and MH treatment at same location	8	73%
Receive group therapy at least once/week	8	73%
Receive individual therapy at least once/week	7	64%

Clients reported good integration of mental health and chemical dependency treatment.

7. Stakeholder satisfaction

Stakeholders from MHCADSD administration, agency administration, and specialty courts were surveyed regarding their views about the COD program. Shown below, stakeholders showed moderate levels of overall satisfaction.

Table 14. COD program stakeholder satisfaction

Stakeholder satisfaction	N	%
Overall quality - "good" or "excellent" (n=19)	14	74%
Referrals - "fairly" or "very" easy to make referrals (n=11)	7	64%
Overall satisfaction - "somewhat" or "very" satisfied (n=19)	12	63%

Shown below, stakeholders suggested that the comprehensiveness of the program, its ability to address both mental health and chemical dependency, and the immediacy of services were major strengths. Intersystem communication and collaboration was reported as a strength but also a weakness. Although staff were satisfied with the program length, many stakeholders felt that the benefit period was too short. Needing more clarity regarding referral criteria was also reported. Care quality was mentioned as a weakness, consistent with ratings of quality reported in interviews with staff. More information is needed to fully understand care quality issues.

Table 15. COD program stakeholder-reported strengths and weaknesses

Strengths (n=18)	N	%	Weaknesses (n=18)	N	%
Comprehensiveness	7	39%	Benefit period too short	9	50%
Communication/collaboration	6	33%	Referral issues	6	33%
Addresses both MH & CD	5	28%	Lack of communication/collaboration	6	33%
Immediacy of services	5	28%	Lack of suitable housing	5	28%
Small caseload	2	11%	Poor quality care	4	22%
Easily accessible	1	6%	Staff issues/insufficient staff	3	17%
Housing options	1	6%	Inability to follow-up	1	6%
Strengths of staff	1	6%	Lack of structure for clients	1	6%
			Lack of resources for clients	1	6%
			Data challenges	1	6%

C. <u>Outcome evaluation</u>: Six month outcomes for first 6-month cohort (n=61)

Interim six-month outcomes were examined for individuals who entered the COD program during its first six months of operation. It should be again stressed that the program is designed as a 12-month benefit. Interim outcomes were examined to provide information for program quality improvement purposes.

Table 16. COD program six-month outcomes for individuals in treatment at 6 months

Outcome indicator	Measure	N=49	Results
Reduced jail bookings/days	Jail days/bookings	---	Not available at this time
Reduced substance use	Case manager report	N=14*	7 reduced to <=1 day/week 3 partial reduction 2 no change 1 increased use 1 unknown
Reduced MH symptoms	Problem Severity Scale	N=49	No change
Improved housing stability	Residential arrangement	N=49	46 no change 1 gained housing 1 lost housing 1 changed from supported to independent
Improved community functioning	Problem Severity scale	N=49	No change
	Employment	N=49	No change

*Substance use information was collected starting January, 2004 -- referrals from the first five months (i.e., Aug-Dec, 2003) of the six-month cohort are not represented

As shown in the table above, participants showed evidence of some reduction in substance use within six months, though little change in housing or mental health symptoms. It will be interesting to examine in later analyses whether it is a typical pattern for participants to experience change in substance use prior obtaining increased stability in mental health symptoms and housing. It seems reasonable that these latter indicators may not show change in this population in only a six month period.

In contrast, as the table below shows, participants interviewed (n=11) reported considerable positive impacts of the COD program, even within a six-month period. Most prominently, participants reported reduced substance use, improved housing, reduction in symptoms, and better overall coping.

Table 17. COD program client-reported program impacts

Participant-reported impacts (n=11 unless otherwise specified) % "Agree" or "Strongly Agree" with statements below:	N	%
Not using drugs as much (n=10)	8	80%
Housing situation has improved (n=10)	8	80%
Deal more effectively with problems	8	73%
Symptoms not bothering as much	8	73%
Better able to control life	7	64%
Not craving drugs as much	7	64%
Do more productive things (n=10)	6	60%
Physical health has improved (n=10)	6	60%
Better able to deal with crisis	6	56%
Getting along better w/family (n=10)	4	40%
Do better in social situations	4	36%
Do better in school and/or work (n=9)	5	56%

D. Summary of interim results

During the first six months of operation, 61 people were served. There was a slightly higher proportion of females and a similar proportion of ethnic minorities compared to the jail population. Nearly two-thirds of participants were homeless and all had serious functioning impairments related to their substance use and/or mental illnesses.

Participant satisfaction was generally high, though few respondents were satisfied with the process of getting housing, and only modest satisfaction was reported for service availability. Staff and stakeholder satisfaction was also generally high, however satisfaction with housing resources was low, and suggestions were made to improve inter-system communication and collaboration. The comprehensiveness of the services and immediate access are seen as prominent strengths of the program. Program staff used many interventions which have shown empirical evidence of effectiveness -- also known as evidence-based practices. However, use of treatment to enhance motivation for behavior change, one such evidence-based practice, was low. Outcome data reported by case managers showed little change in housing or community functioning, but some reduction in substance use. Participant-reported outcomes included reduced substance use and improved coping skills, symptoms, and housing.

MENTAL HEALTH VOUCHER

I. Program Description

Program overview: The mental health voucher program began October, 2003. The program provides up to 6 months of treatment. Mental health services provided during the first three months of the benefit period require more intensive staff involvement including client engagement, treatment planning, housing case management, placement, and stabilization, and linkage with support services. Initial vouchers were redeemed at one of seven community mental health agencies in King County as selected by the voucher recipient: Community Psychiatric Clinic, Consejo Counseling and Referral Services, Downtown Emergency Service Center, Highline-West Seattle Mental Health Center, Seattle Mental Health, and Therapeutic Health Services.

Target Population: The program was originally targeted for King County District Mental Health Court (DMHC) clients with major mental illnesses who were not receiving Medicaid benefits, but who were presumptively Medicaid eligible and low users of the King County Jail. Within the first two months of the program, the DMHC received a federal grant to provide services comparable to the mental health voucher program. As such, the program transitioned from the DMHC to non-specialty courts, specifically targeting adult offender-clients with major mental illnesses who are involved with any King County non-specialty court (District or Superior), regardless of incarceration history. Voucher recipients can now be Medicaid eligible or non-Medicaid. Screening for mental health voucher eligibility is conducted by the Criminal Justice Liaisons.

II. Interim Results: First six months - October 1, 2003 thru March 31, 2004

A. Characteristics of persons served (n=10)

Characteristics of individuals served during the first six months of the Mental Health Voucher program are shown below. Only ten individuals were served during this period, though the number of referrals has increased considerably in subsequent months. Only one woman was served and there is a slightly lower proportion of minorities than the overall jail population. Most participants had a major mental illness. More than half had co-occurring substance use currently or in remission. Functioning was seriously impaired by these problems. Homelessness was less prevalent in this program than in the COD program.

Table. 18 Mental health voucher program characteristics of persons served

Demographics	N	%
Gender - #/% female	1	10%
Ethnicity		
Caucasian	7	70%
African-American	2	20%
Native American	1	10%
Age	Average=39	SD=11
Mental illness diagnoses		
Depression	4	40%
Schizophrenia spectrum	1	10%
Bipolar	1	10%
Other	4	40%

Table 18 (cont'd)		
Substance use (from IS)		
Current	4	40%
Suspected or in remission	2	20%
No substance use	4	40%
Homelessness (or unstable/temporary)		
Case manager reported in IS	2	20%
Community functioning		
Global Assessment of Functioning (GAF)	Average=42 serious impairment	SD=8
Problem Severity Summary*	Average=2.4 Slight-marked impairment	SD=.5
Employment	1 employed	10%

*without socio-legal and symptom items, average =2.3 (SD=.5)

B. Process evaluation

The process evaluation of the mental health voucher program consists of data regarding engagement rates, service utilization, length of treatment, disposition at treatment completion, participant satisfaction, use of evidence-based practices, and stakeholder satisfaction.

1. Engagement rate

   Of the 32 individuals referred to the program during the first six months of operation, 17 began treatment (53%). Five immediately converted to Medicaid and two began treatment after the evaluation period, thus 10 are considered to have entered the program during the first six months.

2. Service utilization

   We examined service information for mental health voucher participants through September 30, 2004. Outpatient mental health service data was drawn from the MHCADSD IS for services authorized under the Mental Health Voucher program between service start and exit dates for each participant. Days that participants were in jail or inpatient units have not been removed from this analysis. Unbilled "searching" activities are also not included in service hours. Based on these data, the 10 participants received between 1 and 25 total hours of services over the six-month benefit period. All had an average of less than 1 hour of service per week.

3. Length of treatment

   The Mental Health Voucher program was designed as a six-month benefit. As of September 30, 2004, all individuals who entered during the first six months of the program (Oct, 2003 thru March, 2004) had the opportunity to participate for a full six months. All of the 10 mental health voucher participants had indeed been discharged as of this date. One individual was discharged after 57 days, the remaining participants completed the full six months of the voucher.

4. Dispositions at treatment completion

Dispositions off the 10 people discharged as of September 30, 2004 are shown below. Two of the ten participants transferred to other funding for mental health services. However, no additional mental health services have been reported to the MHCADSD information system, following the initial benefit, for these two individuals or any of the other program participants.

Table 19. Mental health voucher program disposition at discharge

Disposition at discharge from treatment (n=10)	N	%
Benefit ended	5	50%
Transferred to other funding	2	20%
Jailed near end of benefit	1	10%
Lost to contact	1	10%
Move out of area	1	10%

5. Participant Satisfaction

Participant satisfaction is based on staff interviews from the seven participating agencies. We were unable to reach any of the ten clients who had participated in the program.

Staff interviews (n=11)

Table 20. Mental health voucher program staff global satisfaction

Items rated on 5-point scales - % "somewhat" or "very" satisfied	N	%
Satisfaction with referrals	10	91%
Overall satisfaction	5	45%
Satisfaction with program resources	5	45%
Satisfaction with program length	4	36%
Satisfaction with training and training opportunities	4	36%
Item rated on 4 -point scale - % "good" or "excellent"		
Overall quality	10	91%

Staff responses to rating scale questions showed relatively weak satisfaction, particularly in terms of resources provided to the program, length of the benefit, and staff training.

Table 21. Mental health voucher program staff-reported strengths and weaknesses

Strengths/best things of program	N	%	Weaknesses/worst things	N	%
Access to treatment services	10	91%	Difficult clients, client barriers	6	55%
Watching clients improve	3	27%	Program not long enough	3	27%
Being part of something innovative	1	9%	Interagency communication/sharing	3	27%
Financial help	1	9%	Data requirements	3	27%
Multiple services	1	9%	No access to medications	1	9%
Other	3	27%	Referral issues	1	9%
			Lack of leverage; client follow-through	1	9%

As shown above, staff reported that the major strength of the program was providing access to treatment to individuals who otherwise would not receive services. Staff reported that the population is difficult to serve, that the program is not long enough, and that there are weaknesses in intersystem communication and information sharing.

6. Evidence-based practices

Evidence-based practices per se were not evaluated as there is little consensus in the research literature as to the specific components of mental health treatment that lead to effectiveness for a broad unselected population of clients. Instead, interventions were selected for evaluation based on those outlined in agency contracts for the program. These interventions are consistent with the best practice Community Support model of community mental health treatment (Stroul, 1989). Use of these interventions was evaluated through the same staff interviews.

Table 22. Mental health voucher program staff-reported evidence-based practices

Percentage of clients receiving evidence-based practices (n=11)	None/ almost none	About 1/4 of clients	About 1/2 of clients	About 3/4 of clients	All/ nearly all clients
Psychotropic medications	1 (9%)				10 (91%)
Housing assistance			1 (9%)		10 (91%)
Help with DSHS/SSI			1 (9%)	1 (9%)	9 (82%)
Individual counseling	1 (9%)	1 (9%)	2 (18%)		7 (63%)
Substance use treatment	1 (9%)	1 (9%)	3 (27%)		6 (54%)
Group therapy	2 (18%)		4 (36%)		5 (45%)
Employment assistance	3 (27%)		3 (27%)	1 (9%)	4 (36%)

Staff reported that medications, housing assistance, and help obtaining financial benefits were provided to nearly all clients. The proportion receiving substance abuse treatment was comparable to the proportion of clients having substance use disorders. Few received employment assistance; however, employment may be seen as a longer-term goal subsequent to obtaining stability with mental health symptoms and housing.

7. Stakeholder satisfaction

Stakeholders from MHCADSD administration, agency administration and the criminal justice liaisons were surveyed regarding their views about the Mental Health Voucher program.

Table 23. Mental health voucher program stakeholder satisfaction

Stakeholder satisfaction	N	%
Overall quality - "good" or "excellent" (n=15)	14	93%
Referrals - "fairly" or "very" easy (n=9)	7	78%
Overall satisfaction - "somewhat" or "very" satisfied (n=16)	12	75%

As shown above, stakeholders showed strong overall satisfaction with the program.

Shown below, stakeholders reported that access to treatment not otherwise available was a major strength. Clarity regarding referral criteria, intersystem communication and collaboration, lack of suitable housing and medications were reported as weaknesses. Inability to follow-up or leverage clients into treatment (as with the COD program) was also mentioned.

Table 24. Mental health voucher program stakeholder strengths and weaknesses

Strengths (n=14)	N	%	Weaknesses (n=14)	N	%
Access to treatment not otherwise available	7	50%	Referral issues	7	50%
Easily accessible	3	21%	Lack of communication/collaboration	4	29%
Strengths of staff	2	14%	Lack of suitable housing	3	21%
Immediacy of services	2	14%	Lack of medication coverage	2	14%
Communication/collaboration	1	7%	Inability to follow-up	2	14%
Other	2	14%	Benefit period too short	1	7%
			Staff issues/insufficient staff	1	7%
			Lack of resources for clients	1	7%
			Other	1	7%

C. <u>Outcome evaluation:</u> Six month (final) outcomes for first 6 month cohort (n=10)

Outcomes at the end of the six-month benefit period were examined for individuals who entered the program during the first six months of operation.

Table 25. Mental health voucher outcomes for individuals discharged from treatment

Outcome indicator (n=10)	Measure	Results
Reduced jail bookings/days	Jail days/bookings	Not available at this time
Reduced MH symptoms	Problem Severity Scale	No change
Improved community functioning	Problem Severity Scale Employment	No change 1 - lost employment
Participant-reported impacts	Client interview	No clients interviewed

Little change is shown in symptom reduction or improved community functioning. It will be important to obtain participant-reported impacts during the next evaluation period.

D. <u>Summary of interim results</u>

During the first six months of operation, 10 people were served. The low number of people served was largely due to few referrals being made during the transition to non-specialty courts. Of those served, there were slightly lower proportions of women and ethnic minorities than the jail population. All had seriously impaired community functioning associated with their mental illnesses.

While staff reported that providing access to mental health treatment for this population was a major strength, they were dissatisfied with the program's resources, short benefit length, and their

own training opportunities for working with the challenging CJ population. Stakeholders were generally more satisfied, but reported that referral criteria should be clarified and that housing and intersystem communication could be improved. Outcome data reported by case managers showed little change in mental health symptoms or community functioning. Also, few participants convert to other funding for mental health treatment, a central goal of the program.

METHADONE VOUCHER

I. Program Description

Program overview: The methadone voucher program began July, 2003. The program provides up to nine consecutive months of methadone treatment services that may be extended on a case-by-case basis. The service entails a daily dose of methadone that is provided by either of two community treatment agencies: Evergreen Treatment Services and Therapeutic Health Services (THS). Additional services provided by these two agencies include sobriety maintenance, psychosocial assessment and medical exams, re-entry and re-employment counseling, and HIV/AIDS counseling. THS currently provides courtesy dosing, which is methadone dosing for opiate dependent inmates who were already in methadone treatment at the time of arrest. Later this year, Jail Health Services will assume courtesy dosing of this population. In 2005, Jail Health Services will begin inducting opiate dependent inmates into treatment. Methadone therapy, is considered "one of the longest-established most thoroughly evaluated forms of drug treatment" (Office of the National Drug Control Policy, 2000), demonstrating significant reductions in crime (drug offenses, property crimes, overall arrests) and utilization of medical resources (medical and psychiatric hospitalizations, ER visits) and increases in employment as a result of methadone treatment (e.g., Office of the National Drug Control Policy, 2000; Washington State Department of Social and Health Services, 2002).

Target Population: To facilitate program startup and reduce existing waiting lists for treatment, initial methadone vouchers were provided to adult opiate-dependent clients accessing services provided by the King County Public Health Department's Needle Exchange Program. Previous investigations have shown that 93% of a sample of consecutive admissions to the Needle Exchange program had a history of incarceration, with 44% having incarcerations within the previous year. Beginning in April 2004, methadone vouchers issued through the CJI have been exclusively provided to opiate dependent offender-clients about to be released from the King County Jail.

II. Interim Results: First six months - July 1, 2003 thru December 31, 2003 all Needle Exchange

A. Characteristics of persons served: (n=106)

Characteristics of individuals served during the first six months of the methadone voucher program are shown below.

Table. 26. Methadone voucher program characteristics of persons served

Demographics (n=106)	N	%
Gender- #/% female	36	34%
Ethnicity (n=106)		
Caucasian	58	55%
African-American	35	33%
Native American	6	6%
Asian-Pacific Islander	3	3%
mixed or "other" or unknown	4	4%
Hispanic (duplicated)	2	2%
Age	44.4	9.2

Table 26 (cont'd)

Substances used (n=103) (may report more than one)		
Heroin	101	98%
Cocaine	67	65%
Alcohol	28	27%
Marijuana	6	6%
Other (non-tobacco)	9	9%
Homelessness		
DSHS Div. of Alcohol and Substance Abuse (DASA) (n=102)	38	37%
Client self-report (n=21)	11	51%
Community functioning (n=94)		
Employment	10	11%
Prior treatment (self-report n=20)		
Chemical dependency treatment	19	95%

The methadone program served a higher proportion of females and ethnic minorities compared to the overall jail population. As expected, participants reported using heroin, though over two-thirds also reported using cocaine, and nearly a third also used alcohol. Over a third of the participants were homeless when they entered the program; few were employed. Nearly all of the participants who were interviewed (n=20), reported that they had received chemical dependency treatment in the past.

B. Process evaluation

The process evaluation of the methadone voucher program consists of data regarding engagement rates, service utilization, length of treatment, disposition at treatment completion, participant satisfaction, use of evidence-based practices, and stakeholder satisfaction.

1. Engagement rates

   Of the 148 people referred to the program, 106 (72%) began treatment.

2. Service utilization

   Service utilization data has not been analyzed for this report.

3. Length of treatment

   A key to the success of opiate substitution treatment is retention in treatment. There is no clear expectation for when treatment is completed. In some cases methadone treatment is most appropriately provided indefinitely, in the same way that medication is provided for chronic medical conditions such as diabetes or hypertension.

   That said, the methadone voucher program was designed as a 9-month benefit. As of September 30, 2004, all individuals who entered during the first six months of the program (July, 2003 through December, 2003) had the opportunity to participate for a full nine months.

The average length of treatment was 260 days (SD=135 days). As the table below shows, 53 participants (50%) have remained in treatment for more than nine months. However, 24 of the 53 participants in treatment for more than nine months have converted to funding sources other than the voucher program (see also "Outcome evaluation" section for additional information about funding conversions).

Table 27. Methadone voucher program length of treatment

Length of treatment	N	%
0-90 days	12	11%
91-180 days	23	22%
181-270 days	18	17%
271-365 days	20	19%
More than 365 days	33	31%
Total	106	100%

4. Dispositions at treatment completion

Of the 106 individuals who entered the methadone voucher program during the evaluation period, 64 had been discharged as of September 30, 2004. Dispositions at discharge from treatment are listed below.

Table 28. Methadone voucher program disposition at discharge

Disposition at discharge from treatment (n=64)	N	%
Rule violation	33	52%
Withdrew or lost to contact	23	36%
Transferred to other facility	6	9%
Incarcerated	1	2%
Deceased	1	2%

5. Participant satisfaction

The evaluation of participant satisfaction for the methadone voucher program includes results from client and staff interviews.

Client interviews were completed for 24 of the 106 participants. Remaining individuals were unable to be reached (n=78) or refused to be interviewed (n=4). Interviews included satisfaction rating scales and open-ended questions about program strengths and weaknesses.

Client interviews (n=24 unless otherwise specified)

Table 29. Methadone voucher program client global satisfaction

Items rated on 5-point scales - % of top two ratings	N	%
Quality of program - "good" or "excellent" (n=23)	21	91%
Program satisfaction - "somewhat" or "very" satisfied (n=23)	21	91%
Current treatment "better" than previous treatment (n=21)	15	71%
Counselor skills - "good" or "excellent"	16	67%

Table 30. Methadone voucher program client satisfaction with program components

% "Agree" or "Strongly agree" with statements below:	N	%
General Satisfaction		
I'd recommend the program	21	88%
I liked the services I received	19	79%
If I had other choices, I'd still get services from the program	18	75%
Perception of Access		
Staff were willing to see me when I needed it	22	92%
Services were available at good times	19	79%
I was able to get all the services I needed	18	75%
The location was convenient	15	63%
Appropriateness and Quality of Services		
I was given information about my rights	20	83%
Staff encouraged me to take responsibility for how I live life	20	83%
Staff believe I can grow, change and recover	19	79%
Staff told me side effects to watch for	18	75%
Staff were sensitive to my cultural background (n=22)	16	73%
I felt free to complain	17	71%
Participation in Treatment Goals		
I felt comfortable asking medication questions	20	83%
I, not staff, decided my treatment goals	20	83%
Staff are kind and non-judgmental (n=23)	15	65%
Staff understand what recovery is like	15	63%
Getting into the program was easy	7	29%

Client responses to rating scale questions showed generally high satisfaction with some exceptions. Few respondents reported that it was easy to get into the program. Only modest satisfaction levels were shown for questions about service convenience, counselor skill, staff being kind and non-judgmental, and staff understanding what recovery is like.

Open-ended questions regarding program strengths and weaknesses are shown below.

Table 31. Methadone voucher program client-reported strengths and weaknesses

Positive effects/strengths (all 24 people listed items)	N	%	Negative effects/weaknesses (21 of 24 people listed items)	N	%
Good/great staff; caring, keep you Going; treat you as a person, director	11	46%	More understanding; empathy; counselors who were addicts	4	17%
Staying clean and sober	9	38%	Hard to get in; waitlists	3	13%
Got life back; life changing; hope	8	33%	Weight gain, sweating, bad teeth	3	13%
Got into treatment -otherwise not	3	13%	Jail doesn't dose	1	4%
More insight; learning; awareness	3	13%	Need more control over dosing; doses "to go"	2	8%
Housing; place to live	3	13%	Shouldn't punish by taking away meds	1	4%
Having group; AA/NA; 1:1	3	13%	Coming for daily dosing	1	4%
Accepting responsibility	2	8%	Staff don't listen to what clients say	1	4%
Convenient (in/out quick; open early)	2	8%	Double standard - people with mental illness get to have more dirty UAs	1	4%
Non-judgmental; non-punitive	2	8%	Should be able to have more dirty UAs	1	4%
Able to function, look for job, keep job	2	8%	Need better schedule - add p.m.	1	4%
Keep me out of prison	1	4%	Lack of confidentiality	1	4%
Other	5	21%	AA mtgs should be kept positive	1	4%
			Methadone and housing should be set up when leave prison	1	4%
			Other	4	17%

Clients reported that the greatest strength of the program was the staff, which somewhat contradicts the relatively weaker satisfaction ratings of staff attributes, such as staff being kind and non-judgmental and understanding what recovery is like (see Table 30). Many clients also report that they are able to stay clean and sober and that the program has been life changing. Housing, having groups, and learning to accept responsibility were also discussed. Convenience and staff being non-judgmental are also listed, which again somewhat differ from satisfaction ratings and also the most frequently-listed weakness that counselors need more understanding and empathy. Clients again mention difficulties getting into the program and long waiting lists.

Staff surveys were completed with 13 staff members. The interviews included both satisfaction rating scales and open-ended questions regarding strengths and weaknesses.

Staff surveys (n=13 unless otherwise specified)

Table 32. Methadone voucher program staff global satisfaction

Items rated on 5-point scales - % "somewhat" or "very" satisfied	N	%
Overall satisfaction (n=12)	8	75%
Training and training opportunities	8	62%
Item rated on 4 -point scale - % "good" or "excellent"		
Overall quality (n=12)	10	83%

Staff responses to rating scale questions showed strong general satisfaction with the program, though somewhat weaker satisfaction with training opportunities.

Table 33. Methadone voucher program staff-reported strengths and weaknesses

Strengths/best things about program	N	%	Weaknesses/worst things	N	%
Access to treatment	6	46%	Program not long enough	8	62%
Financial assistance	5	38%	Difficult clients; client barriers	5	38%
Watching clients improve	5	38%	Interagency communication/sharing	4	31%
Existing service components	4	31%	Quantity vs. quality issues	2	15%
Staffing	2	15%	Lack of access to mental health treatment	2	15%
Chance to improve clients' life	1	8%	Referral issues	2	15%
Collaboration and communication	1	8%	Staffing	1	8%
Client-centered treatment	1	8%	Waitlists	1	8%
Other	5	38%	Lack of housing	1	8%
			Other	3	23%

Staff reported that providing access to treatment to those who would not otherwise obtain treatment was a major strength, along with providing financial assistance and watching clients improve. Staff felt that the program benefit period (9 months) was too short, that caseloads were challenging, and that intersystem communication and information sharing needed improvement.

6. Evidence-based practices

As described earlier, evidence-based practices are interventions which have shown empirical evidence of effectiveness. Interventions were selected for evaluation based on review of relevant research and discussions with national experts in the field. Use of evidence-based practices was evaluated through the staff and client interviews described above.

Table 34. Methadone voucher program staff-reported evidence-based practices

Percentage of clients receiving evidence-based practices (n=13)	None/ almost none	About 1/4 of clients	About 1/2 of clients	About 3/4 of clients	All/ nearly all clients	Don't know	Clients report receiving (n=22)
Individual counseling					13 (100%)		22 (100%)
MET	1 (8%)	1 (8%)	3 (23%)	2 (15%)	3 (23%)	3 (23%)	7 (32%)[1]
Relapse prevention		1 (8%)	1 (8%)	2 (15%)	7 (54%)	2 (15%)	16 (73%
Therapy ≥1/week			2 (15%)	5 (38%)	4 (31%)	2 (15%)	14 (64%)
CBT			2 (15%)	2 (15%)	5 (38%)	4 (31%)	2 (9%)[2]
Family therapy	6 (46%)		2 (15%)		1 (8%)	4 (31%)	8 (36%)
Therapy ≥ 90 days					12 (92%)	1 (8%)	22 (100%)

[1] 7 Don't know
[2] 8 Don't know

Based on data from staff who were knowledgeable about the specific practices discussed, individual counseling, relapse prevention, cognitive behavioral therapy (CBT), and having therapy at least once per week and for at least 90 days were all provided to at least 3/4 of program participants. Family therapy was provided less often. As discussed for the COD program, motivational treatment (e.g., MET) is often considered to be the treatment of choice for substance use disorders. It is therefore troubling that some staff did not know whether clients were receiving this type of intervention.

Client reports of treatment received were generally consistent with staff reports. Again, some clients were not sure whether they were receiving MET or CBT, though it is possible that counselors do not provide the names of the interventions to their clients.

Ancillary services were provided to clients less frequently than core evidence-based practices, thought HIV/AIDS counseling and health/medical treatment and referrals are provided to about half of participants.

Table 35. Methadone voucher program staff and client reported ancillary services

Provision of ancillary services	Staff report N=13	%	Client report N =21	%
HIV/AIDS counseling	7	54%	14	66%
Health/medical	7	54%	7	33%
Employment assistance	6	46%	3	14%
Educational assistance	4	31%	1	5%
Financial assistance	4	31%	6	29%
Legal assistance	4	31%	2	10%

Client knowledge of their methadone dose and having control over raising and lowering it are also important evidence-based practices. Nearly all clients reported that they indeed knew their dose and could raise and lower it.

Table 36. Methadone voucher program client-reported evidence-based practices

Client report (n=22)	N	%
Know what methadone dosage is	21	96%
Report control over raising/lowering dosage	21	96%

7. Stakeholder satisfaction

Stakeholders from MHCADSD administration and Jail Health Services were surveyed regarding their views about the methadone voucher program.

Table 37. Methadone voucher program stakeholder satisfaction

Stakeholder satisfaction (n=3)	N	%
Overall satisfaction - "somewhat" or "very" satisfied	3	100%
Referrals - "fairly" or "very" easy	3	100%
Overall quality - "good" or "excellent"	3	100%

Table 38. Methadone voucher program stakeholder-report strengths and weaknesses

Strengths (n=3)	N	%	Weaknesses (n=3)	N	%
Immediacy of services	1	33%	Lack of communication/collaboration	3	100%
Easily accessible	1	33%	Lack of suitable housing	1	33%
Other	1	33%	Referral issues	1	33%

The three stakeholders surveyed showed very high satisfaction with the program. Cross-system communication was the only weakness mentioned by more than one respondent.

C. <u>Outcome evaluation</u>: Outcomes for first 6-month cohort (all from Needle Exchange)

Outcomes were examined for individuals who entered the methadone voucher program during its first six months of operation. Outcomes were measured at 9 months, or discharge if discharge occurred prior 9 months in the program.

Table 39. Methadone voucher program outcomes for individuals at discharge (or 9 months)

Outcome indicator	Measure	N*	Results
Reduced jail bookings/days	Jail days/bookings	---	Not available at this time
Reduced substance use	Primary substance (n=93 at admission - 90 heroin; 17 unknown use at discharge)	76	37 (49%) reduced to "no use" 24 (32%) partial reduction 14 (18%) no change 1 (1%) increased use
	Secondary substance (n=69 at admission; 11 unknown use at discharge)	58	11 (19%) reduced to "no use" 16 (28%) partial reduction 25 (43%) no change 6 (10%) increased use
	Heroin (n=91 at admission; 16 unknown use at discharge)	75	36 (48 %) reduced to "no use" 24 (32%) partial reduction 14 (19%) no change 1 (1%) increased use
	Cocaine (n=54 at admission; 11 unknown use at discharge	43	6 (14%) reduced to "no use" 15 (35%) partial reduction 15 (34%) no change 7 (16%) increased use
	Change in drug expenses	54	Reduction from $892 to $377 average per person per month [t=3.8; df=53; p<.001]
Outcome indicators cont'd	Measure	N	Results
Drug problem days		53	19 (39%) reduced 33 (62%) no change 1 (2%) increased
Alcohol problem days		53	1 (2%) reduced 50 (94%) no change 2 (4%) increased
Improved community functioning	DASA - TARGET Employment activity	96	7 gained employment; 3 lost employment

*Ns vary as data was not available for all participants for all variables at both admission and discharge

Shown above, over three-quarters (79%) of participants reduced their primary substance use (almost all heroin), and nearly half had no heroin use after 9-months of treatment, or discharge, whichever came first. Nearly half had reductions in cocaine use and other secondary substance use. There was also a significant reduction from admission to 9-months (or discharge, if first) in the amount of money participants spent on illicit drugs.

Table 40. Methadone voucher program client-reported program impacts

Participant-reported impacts (n=23 unless otherwise specified) % "Agree" of "Strongly Agree" with statements below	N	%
Not using drugs as much	23	100%
Deal more effectively w/problems	22	96%
Better able to control life	22	96%
Do more productive things	22	96%
Getting along better w/family (n=21)	20	95%
Do better in school and/or work (n=20)	18	90%
Better able to deal with crisis	20	87%
Not craving drugs as much	20	87%
Do better in social situations	19	83%
Housing situation has improved (n=20)	15	75%
Physical health has improved	17	74%
I have gotten a job (n=19)	8	42%

Participants who were reached for interviews consistently reported a wide range of positive outcomes (shown above), including reduced substance use, and improved coping, family relationships, housing, and physical health. One quote exemplifies how many of the participants felt about the methadone voucher program, "When I started, I was homeless, 180 lbs, doing narcotics now I'm felony free - it's saving my life."

Funding Conversions

An important outcome of the methadone voucher program is conversion to a funding source that will enable treatment to continue past the voucher benefit period. We are particularly interested in Medicaid funding as it provides the most stable long-term funding option.

Out of 106 participants during the first six months of the program, 26 were admitted with Medicaid, therefore 80 were non-Medicaid. Of those, 25 (31% of 80) converted to Medicaid while in treatment. Most converted within six months, as shown in the table below.

Table 41. Methadone voucher program funding conversions

Time to funding conversion	N	%
0-90 days	7	28%
91-180 days	10	40%
181-270 days	6	24%
271-365 days	0	0%
More than 365 days	2	8%
Total	25	100%

D. Summary of interim results

During the first six months of operation, 107 people were served. The program served a higher proportion of females and ethnic minorities compared to the overall jail population. Nearly all participants reported using heroin, and over two-thirds report using cocaine as well. Over a third of the participants were homeless when they entered the program.

Client and staff satisfaction was high and some reported the program to be life-changing. Staff and stakeholders also reported high satisfaction, but felt the program should be longer and that intersystem communication and collaboration could be strengthened. Staff used many evidence-based practices; however use of motivational treatment was relatively low. A high proportion of participants reported positive program impacts including reduced substance use and improved coping skills, family relationships, housing, and physical health.

Four-fifths, (81%) of participants reduced their primary substance use (almost all heroin), and nearly half had no heroin use after 9-months of treatment, or discharge, whichever came first. Nearly half had reductions in cocaine and other secondary substance use. There was also a significant reduction in the amount of money participants spent on illicit drugs.

HOUSING VOUCHER

I. Program description

Program overview: The housing voucher program began in May, 2003. The program provides up to six consecutive months of housing services that covers case management services, rent and utilities subsidies, and security deposits. Clients are linked to an array of housing options including respite, clean and sober, abstinence-encouraged, and "client choice". Seattle Mental Health functions as the housing broker and assigns a housing case manager to each voucher recipient. Case management services include permanent housing search, advocacy, and assistance in obtaining publicly funded benefits. Coordination is maintained with the court of referral and the housing provider.

Target population: Individuals eligible for the program are King County jail inmates who are homeless and who have substance abuse or chemical dependency problems or co-occurring mental health and substance abuse/chemical dependency problems. Homelessness is defined as being on the street, in a shelter or transitional setting for homeless individuals, being evicted within a week, being discharged from an institution where the individual has been for more than 30 days and has no housing, or having no housing and fleeing domestic violence. To be eligible for the program, individuals must also be referred from King County Drug Diversion Court, King County District Mental Health Court, or Seattle Municipal Mental Health Court ("specialty courts").

II. Interim results: First six months - May 1, 2003 thru October 31, 2003

A. Characteristics of persons served (n=93)

Characteristics of individuals served during the first six months of the housing voucher program are presented below. There was similar proportion of women and a higher proportion of ethnic minorities in the housing voucher program compared to the jail population. Based on self-report, only 79% of interviewed participants believed they were homeless at the time they received a housing voucher, despite using a broad definition of homelessness that included sleeping at friends' homes and other unstable transitional living arrangements.

Table 42. Housing voucher program characteristics of persons served

Demographics	N	%
Gender - #/% female	26	28%
Ethnicity (n=74 with DASA data)		
Caucasian	31	42%
African-American	34	46%
Native American	4	5%
Asian-Pacific Islander	3	4%
Mixed or "other" or unknown	2	3%
Hispanic (duplicated)	8	11%
Age	Average 39 yrs	SD=9 yrs
Homelessness		
Self-report (n=48)	38 Average=29 months 8% ≥3 episodes in last 3 yrs	79% SD=41 months

B. Process Evaluation

The process evaluation of the housing voucher program consists of data regarding engagement into the program, service utilization, length of service, disposition at program completion, participant satisfaction, use of evidence-based practices and stakeholder satisfaction.

1. Engagement rates:

   Ninety-three individuals engaged in the program; the number of referrals is unknown. Of those engaged in the program, half (51%) were referred from the King County Drug Court, while remaining participants were split between the King County District Mental Health Court (20%) and the Seattle Municipal Mental Health Court (29%).

2. Service utilization:

   Thirty-two (34%) of the 93 housing voucher participants received some mental health services during the period of their voucher, according to data available through the MHCADSD IS. Removing one outlier, total mental health service hours for participants who received any service during their voucher period was .5 - 222 hours. As the table below shows, most individuals who received services received an average of less than 1 hour/week, though a few received substantially more.

Table 43. Housing voucher program average service hours per week

Ave service hours/week	N	%
No hours listed	61	66%
<1 hour	13	14%
1 to <2 hours	6	6%
2 to <3 hours	0	0%
3 to <4 hours	4	4%
4 to <5 hours	1	1%
5+ hours	8	8%
Total	93	100%

3. Length of treatment

   As of July 31, 2004, all 93 participants in the first six-month cohort had had the opportunity to have the full six-month period in the housing voucher program. Length of treatment as of July 31, 2004 for the first six months of housing voucher participants is shown below.

Table 44. Housing voucher program length of treatment

Treatment length	Full 6-month cohort		Those who obtained permanent housing	
0-90 days	48	52%	3	9%
91-180 days	18	19%	8	24%
181-270 days	24	26%	20	58%
271+	3	3%	3	9%
Total	93	100%	34	100%

The average length of service for participants in the first six months of the housing voucher program was 103.6 days (SD=78.2). Nearly a third (29%) of participants received extensions to stay in the program longer than the six months originally allowed by the program. Most (67%) of those who obtained housing required such an extension.

4. Dispositions at treatment completion

All of the 93 participants who entered the housing voucher program during the first six months had been discharged as of July 31, 2004.

Table 45. Housing voucher program dispositions at discharge

Disposition at discharge from voucher program (n=93)	N	%
Obtained permanent/long-term housing	34	36%
Lost to contact	12	13%
Discharged from program due to dirty urinalysis	10	11%
Discharged from program due to rule violations	8	9%
Discharged from program due to bench warrant	7	8%
In inpatient treatment	6	6%
Discharged from program due to behavioral problems	5	5%
In custody	5	5%
Other (2 left courts; 1 moved; 1 turned down housing)	4	4%
End of voucher	1	1%
Unknown	1	1%
Total	93	100%

Over a third of participants during the first six months of the program were able to obtain permanent housing. These results seem reasonable given the very challenging population served and the difficulties their backgrounds present to obtaining housing. An additional third of participants were discharged from the program for various forms of rule violations (e.g., rules, UAs, bench warrants, behavioral problems).

5. Participant satisfaction

The evaluation of participant satisfaction with the housing voucher program included results from client and staff interviews.

Client interviews were completed for 48 of the 93 participants, a high response rate given the difficulty in tracking the population under evaluation. Remaining individuals were unable to be reached (n=39) or refused to be interviewed (n=6). Interviews included satisfaction rating scales and open-ended questions about strengths and weaknesses of the program

Client interviews (n=48 unless otherwise specified)

Rating scale questions showed mixed levels of satisfaction with general satisfaction high but notable dissatisfaction related to the process and amount of time it takes to obtain housing.

Table 46. Housing voucher program client global satisfaction

Items rated on 5-point scales - % of top two ratings	N	%
Program satisfaction - "somewhat" or "very" satisfied	40	83%
Quality of program - "good" or "excellent"	35	73%
Process of getting housing - "somewhat" or "very" satisfied	23	48%
Time to get housing - "somewhat" or "very" satisfied	17	35%

Table 47. Housing voucher program client perception of initial placement

(n=46) How do you feel about…	"Mostly satisfied", "Pleased" or "Delighted" (top 3 of 7-point scale) N	%
Safety where live	35	76%
Overall satisfaction	33	72%
Privacy	32	70%
Rules	31	68%
Freedom	29	63%
Neighborhood safety	27	58%

Shown above, once a placement is made, participants reported moderate levels of satisfaction, with weaker ratings for freedom and neighborhood safety. One question, asked for instrument validity, revealed that twenty-one (44%) respondents reported that they did not get assistance obtaining permanent housing. Below, rating scale questions show generally high satisfaction with the exception of ability to get all the services needed and staff being sensitive to the client's cultural background.

Table 48. Housing voucher program client satisfaction with program components

% "Agree" or "Strongly Agree" with statements below:	N	%
General Satisfaction		
If I had other choices, I'd still get service from this program (n=47)	38	81%
I liked the services I received	38	79%
I'd recommend the program	36	75%
Perception of Access		
Services were available at good times (n=46)	42	91%
Staff were willing to see me when I needed it (n=46)	39	85%
Staff returned my calls within 24 hrs (n=40)	33	83%
The location was convenient	38	79%
I was able to get all the services I needed (n=47)	31	66%
Appropriateness and Quality of Services		
Staff encouraged me to take responsibility for how I live life	42	88%
Staff believe I can grow, change and recover(n=47)	39	83%
I was given information about my rights	37	77%
I felt free to complain	35	73%
Staff were sensitive to my cultural background (n=47)	37	57%
Participation in Treatment Goals		
Staff are kind and non-judgmental	40	83%
Getting into the program was easy	35	73%

Open-ended questions regarding program strengths and weaknesses are shown below. Obtaining housing and having someone to listen and help were frequently-reported strengths. A number of participants also reported recovery-related outcomes including becoming clean and sober, learning responsibility and gaining self-sufficiency. The most prominent weakness reported was the location and physical condition of the housing provided, followed by restrictive rules (particularly regarding visitors) and difficulties with other tenants, long wait times for housing, and a recognition that the participants' own background made finding housing challenging.

Table 49. Housing voucher program client-reported strengths and weaknesses

Positive effects/strengths (40 of 46 people listed items)	N	%	Negative effects/weaknesses (12 of 46 listed items)	N	%
Have housing/off streets	11	24%	Run down housing, bad location	12	26%
Someone to help, listen, case manager is great	6	13%	Rules, can't have visitors, kids	7	15%
Stability (first time in many years)	4	9%	Wild tenants, mental health patients, tenant conflicts, drug dealing	6	13%
Help me be clean and sober	4	9%	Long wait	6	13%
Help me learn responsibility, get to appts, pay bills, child support	4	9%	My anger, criminal history get in the way of getting housing	5	11%
Good program; thanks, appreciate it	3	7%	Need someone to talk to; someone who cares; more contact	4	9%
Resources for work, education, meds, laundry, health care	3	7%	Not having so long to wait	3	7%
Help me be better person, self-worth, self-sufficient	3	7%	Counselor didn't turn in applications	2	4%
Getting sleep	2	4%	Discarded my things when away	2	4%
Give me hope to build better life	2	4%	Need longer program to get housing	2	4%
Improved relationships with kids	2	4%	Need to do more room checks, random UAs	1	2%
Saw what I could end up as	2	4%	A lot of anger toward one staff	1	2%
Agree w/what they are trying to say; put in plug for the judge	1	2%	Should have something lined up when you get out of jail	1	2%
Not using CTU	1	2%	Could have on-site AA, NA mtgs	1	2%
Sociable, meet cool guys	1	2%	Before you terminate someone - find out what their problem is	1	2%
Transition from jail to housing – no Effort	1	2%	More concentrated effort to help people with long-term housing	1	2%
Determination not to be homeless	1	2%	Felt racism	1	2%
			Need a trained counselor - we solved problems on our own	1	2%
			Weren't set up in Renton for housing	1	2%

Staff interviews were completed with the program's two staff. The interviews included satisfaction rating scales and open-ended questions regarding strengths and weaknesses.

Staff interviews (n=2)

Table 50. Housing voucher program staff global satisfaction

Items rated on 5-point scales - % "somewhat" or "very" satisfied	N	%
Referrals	2	100%
Overall satisfaction (n=2)	1	50%
Housing resources and types	1	50%
Item rated on 4 -point scale - % "good" or "excellent"		
Overall quality (n=2)	2	100%

While it is difficult to make strong conclusions based on reports from two people, weaker satisfaction with housing resources is consistent with client responses (see Tables 46 and 47) and stakeholder-reported program weaknesses (see Table 53).

Table 51. Housing voucher program staff-reported strengths and weaknesses

Strengths/best things about program	N	%	Weaknesses/worst things	N	%
Client has chance to improve life	2	100%	Program not long enough	2	100%
Provides financial assistance	1	50%	Lack of housing	2	100%
Provides multiple services	1	50%	Staffing issues	1	50%
Hooking clients up with services	1	50%	Interagency communication/sharing	1	50%
Be part of something innovative	1	50%	Lack of community treatment resources	1	50%

Above, staff reported that a strength of the housing voucher program was that it gave participants a chance to change and improve their lives, though they noted that the program should be longer and, again, that housing resources were too limited.

6. Evidence-based practices

The evidence base for housing programs is an evolving area of inquiry. No specific indicators are available. However, offering a range of housing options and offering housing first, prior to encouraging individuals to participate in treatment, are discussed as emerging best practices.

The housing voucher program offers a range of housing -- including housing that requires participants to remain clean and sober, housing in which abstinence is encouraged, and client "choice" housing, in which there is a greater recognition that some individuals will continue to use illicit drugs. The housing voucher program attempts to engage participants in housing while simultaneously encouraging treatment engagement, rather than providing housing first, as emerging best practices suggest. This is done as participants need to show adequate engagement in treatment to remain in the specialty courts; which are the referral sources and monitoring arms for the program.

7. Stakeholder satisfaction

Stakeholders from MHCADSD administration, agency administration and specialty drug and mental health courts were surveyed regarding their views about the housing voucher program.

Table 52. Housing voucher program stakeholder satisfaction

Stakeholder satisfaction	N	%
Overall satisfaction - "somewhat" or "very" satisfied (n=21)	21	100%
Referrals - "fairly" or "very" easy (n=15)	15	100%
Overall quality - "somewhat" or "very" (n=21)	19	90%

Table 53. Housing voucher program stakeholder-reported strengths and weaknesses

Strengths (n=27)	N	%	Weaknesses (n=27)	N	%
Strengths of staff	6	22%	Lack of suitable housing	9	33%
Housing options	6	22%	Benefit period too short	5	19%
Easily accessible	6	22%	Lack of communication/collaboration	3	11%
Immediacy of services	3	11%	Lack of resources for clients	3	11%
Addresses both mental health and substance use	2	7%	Staff isolation, lack of supervision	2	7%
Communication/collaboration	2	7%	Referral issues	2	7%
Access to treatment	2	7%	Resources for methadone clients	2	7%
Comprehensiveness	1	4%	Staff issues/insufficient staff	1	4%
Other	1	4%			

Stakeholders showed very high satisfaction with the program. Staff and accessibility of the program were notable strengths. Housing options were reported as a strength and as a weakness. Some stakeholders also felt the benefit period was too short.

C. Outcome evaluation

Outcomes at the end of the benefit period (six-months or longer in some cases) were examined for the 93 individuals who entered the program during the first six months of operation and were discharged.

Table 54. Housing voucher program outcomes for individuals discharged

Outcome indicator	Measure	Results (n=90)
Reduced jail bookings/days	Jail days/bookings	Not available at this time
Increased housing stability	#/% housed at discharge	36%

Above, consistent with data presented earlier, over a third of participants during the first six months of the program were able to obtain permanent housing.

Shown below, all outcomes were reported improved by over half of respondents, and improvement was reported by the most participants with respect to housing and reduced substance use.

Table 55. Housing voucher program client-reported program impacts

Participant-reported impacts (n=48 unless otherwise specified) % "Agree" or "Strongly Agree" with statements below:	N	%
Not using drugs as much (n=43)	31	72%
Housing situation has improved (n=47)	33	70%
Do more productive things (n=47)	33	70%
Better able to control life (n=47)	31	66%
Not craving drugs as much (n=44)	29	66%
Deal more effectively w/problems	30	63%
Better able to deal with crisis (n=47)	28	60%
Getting along better w/family (n=43)	27	61%
Physical health has improved	28	58%
Symptoms not bothering as much (n=45)	25	56%
Do better in school and/or work (n=40)	22	55%
Do better in social situations (n=46)	25	54%

D. Summary of interim results

During the first six months of operation, 93 people were served. There was a similar proportion of women and a higher proportion of ethnic minorities in the housing voucher program compared to the jail population.

About half (52%) of the participants exited services within three months and very few of these individuals obtained permanent housing. However, of those who stayed more than 90 days, 69% obtained permanent housing. Most of those who obtained permanent housing required an extension of the 6-month benefit. Overall, 36% of the participants obtained permanent housing.

Clients reported high global satisfaction but low satisfaction with the process and length of time it took to obtain permanent housing. Of the 48 respondents interviewed, 44% reported that they did not receive assistance obtaining permanent housing. Many also reported that the transitional housing was run down and in unsafe and high drug use areas, and that they didn't like the rules in the transitional housing sites. Staff and stakeholders reported high global satisfaction, but lower satisfaction with amount and types of housing resources. Both groups felt the benefit period is too short. Participant-reported outcomes included reduced substance use and improved coping skills, housing, and productivity.

INTENSIVE OUTPATIENT (IOP) CHEMICAL DEPENDENCY TREATMENT AT THE COMMUNITY CENTER FOR ALTERNATIVE PROGRAMS (CCAP)

I. Program description

Program overview: The CCAP IOP treatment program began April, 2004. The program provides state-certified intensive outpatient treatment for up to 3 months. A minimum of nine hours per week of individual and group treatment is provided as well as assistance with obtaining publicly-funded benefits. Referral to a community provider is to occur at least 14 days prior to each participant's discharge from CCAP, and a linkage/discharge plan is developed with the aftercare provider agency. Strong coordination with Community Corrections and ancillary/support services is provided through this program. Services are provided by Community Psychiatric Clinic, with staff housed within the CCAP facility.

Target Population: Adult offender-clients who are court ordered to CCAP for 30 service days or longer by King County District Court or King County Superior Court and who are chemically dependent are eligible for the CCAP IOP treatment program.

II. Interim Results: First six months - April 1, 2004 thru September 30, 2004

Not all individuals entering the program during its first six months have reached 90 days in the program, thus a full evaluation of the first six months of the program is not provided in this report. However, some descriptive information about individuals served thus far is provided below.

A. Characteristics of persons served (n=30)

Characteristics of individuals served during the first six months of the CCAP IOP are shown below. The program served a higher proportion of females and ethnic minorities compared to the overall jail population.

Table 56. CCAP IOP program characteristics of persons served

Demographics	N	%
Gender- #/% female	6	20%
Ethnicity (n=22 data available)		
Caucasian	5	23%
African-American	12	55%
Native American	0	0%
Asian-Pacific Islander	2	9%
mixed or "other"	3	14%
Hispanic (duplicated)	2	9%
Age	Average=31.2 yrs	SD=10.1

B. Process Evaluation

When the process evaluation is completed it will include engagement rates, service utilization, length of treatment, disposition at treatment completion, participant satisfaction, use of evidence-based practices, and stakeholder satisfaction. Data available in these areas are presented below.

1. Engagement rate: 30 people have begun treatment in the program

2. Service utilization: Service utilization will be evaluated after January 2005.

3. Length of treatment

   The CCAP IOP was designed as a 90-day benefit. Only after January 2005, will we be able to evaluate how many people who entered the program during the first six months (April, 2004 thru September, 2004) will complete the 90-day benefit. However, to provide some information regarding length of treatment, September 30, 2004 was used as an arbitrary end date. Length of treatment was then calculated for the 21 individuals who had had the opportunity to have 90 days of treatment. For these 21 people, the average length of treatment was 70.1 days (SD=47.1).

   Table 57. CCAP IOP program length of treatment

Length of treatment (N=21)	N	%
0-30 days	5	23%
31-60 days	7	33%
61-90 days	1	5%
91+	8	38%
Total	21	100%

4. Dispositions at treatment completion

   Of the 30 people who have entered the program during the first six months, 25 have been discharged as of September 30, 2004. Dispositions at discharge are listed below.

   Table 58. CCAP IOP program dispositions at discharge

Disposition at discharge from treatment (n=25)	N	%
Withdrew or lost to contact	10	40%
Completed treatment	5	20%
Incarcerated	5	20%
Transferred to other facility	4	16%
Rule violation	1	4%

   As noted above, the evaluation of the first six months of the CCAP IOP is not complete; stakeholder satisfaction, use of evidence-based practices and outcomes are not available.

D. Summary of interim results

During the first six months of the program, 30 people were served. The program served a higher proportion of females and ethnic minorities than in the overall jail population. We will be able to complete the evaluation of the first six months of the CCAP IOP in January 2005 when all participants will have had an opportunity to participate for 90 days. At this time, 21 people had the opportunity to participate for 90 days, and of those, about half left within 60 days. Most withdrew from service or were lost to clinician contact. Five of the 21 participants completed treatment.

CRIMINAL JUSTICE (CJ) LIASIONS

I. Program description

Program overview: The three CJ liaisons began work September, 2003. One liaison is based at the King County Correctional Facility (KCCF) and another is at the Regional Justice Center (RJC). They are responsible for serving non-opiate dependent inmate-clients with chemical dependency and/or mental health problems, screening and referring appropriate inmate-clients to the specialty courts for Co-Occurring Disorder (COD) and housing voucher programs, and directly issuing mental health vouchers to eligible clients prior to release from custody. They provide assistance to offender-clients regarding discharge planning, obtaining benefits, and providing linkage to treatment and/or other community-based services. A third liaison is sited at CCAP. This staff person is responsible for engaging out-of-custody individuals in on-site and post-discharge services, and facilitating a coping skills group for CCAP participants with mental health issues. All of the CJ liaisons provide mental health assessments and diagnostic evaluation, and screen and refer presumptively eligible clients to appropriate staff to assist with applications for publicly funded benefits. They each provide discharge planning for treatment, case management, and support services in the community. The liaisons are provided via a contract with Seattle Mental Health.

Target Population: Adult offender-clients within the King County Jail who have a mental health and/or chemical dependency (non-opiate) problem, and who will not be transferred to the state Department of Corrections or have an out-of-county hold, may be referred to a CJ liaison stationed at each jail venue. Offenders court ordered to the King County Community Center for Alternative Programs (CCAP) for less than 30 services days, or who are not chemically dependent, may be referred to the CJ liaison stationed at CCAP.

II. Interim Results: First six months - September 1, 2003 thru February 28, 2004

A. Characteristics of persons served (n=493)

Characteristics of individuals served during the first six months of operation of the CJ liaisons are presented in the table below. A slightly higher proportion of females were served than in the jail population as a whole. Most individuals served by jail-based liaisons have mental health and/or chemical dependency problems, while the CCAP-based liaison saw more individuals who had exclusively financial and employment issues.

Table 59. CJ liaisons characteristics of persons served

	KCCF		RJC		CCAP	
Total referrals seen	221		179		93	
Demographics						
Gender - #/% female	102	46%	44	25%	37	40%
Age*	Avg. 34.4	SD=9	Avg. 36.2	SD=10	Avg. 38.3	SD=10
Ethnicity	Unavailable at		this time			
Presenting Problems						
MH problem	156	71%	104	58%	19	20%
CD problem	149	67%	161	90%	17	18%
Homeless	82	37%	65	36%	14	15%
$ or job issues	Not recorded		Not recorded		73	78%

*7 missing DOB

B. Process Evaluation

The process evaluation of the CJ liaison service included data regarding the degree to which the liaison function is integrated within the system in which they work, whether linkages to treatment are made consistently and whether their work has changed the volume of those linkages. Participant and stakeholder satisfaction was also assessed.

1. CJ liaison integration

One way to assess the degree to which liaisons are integrated within the systems in which they work, is to examine their referral sources. If all expected referral sources are represented, we could conclude that the liaisons are sufficiently known and are functioning adequately in the views of referrants.

Table 60. CJ liaisons referral sources

Liaison referral sources*	KCCF (N=221)		RJC (N=179)	
Self	100	45%	104	58%
Jail Health Services	87	39%	23	12%
MH roster	0	0%	16	9%
Defender Associations	12	7%	2	2%
Courts/judges	6	3%	9	5%
Other liaison	0	0%	11	6%
RJC/DAJD jail staff	1	0%	7	4%
PO	1	0%	3	2%
CM at MH agency	3	1%	1	1%
Other/unknown	7	4%	3	2%
Total	221	100%	179	100%

*CCAP liaison not included - all referrals are from courts

The primary referral sources for the jail-based liaisons are inmate self-referrals and Jail Health Services. The judicial system provides fewer referrals.

We also asked all three liaisons whether they felt their position was integrated within the relevant systems. On a five point satisfaction scale ("very dissatisfied" to "very satisfied"), one liaison responded, "neutral", one "somewhat satisfied", and one "very satisfied".

2. Treatment linkages completed

CJ liaisons provide a wide range of referrals for clients they see. These referrals "out" are listed below. We are not able to determine whether individuals referred successfully connect with the referral agency.

Table 61. CJ liaisons referrals out

Liaison referrals out	KCCF (n=221)		RJC (n=179)		CCAP (n=93)	
ADATSA	53	24%[1]	18	10%	Not reported separate from DSHS	
DSHS benefits	28	13%	68[2]	38%	40	43%
Specialty court referred[3]	55	25%	34	19%	0	0%
-accepted	12	5%	0	0%	0	0%
Corrections or court staff (attorney, probation officer, social worker in facility; judge, DOC, Jail Health Service, liaison)	30	14%	17	9%	1	1%
MH agencies (includes vouchers)	31	15%	30	17%	10	11%
Courtesy call to case manager	24	11%	--	--	6	6%
Housing/YWCA housing	24	11%	3	2%	11	12%
Justice Resource Center	14	6%	3	2%	0	0%
Employment resources	0	0%	0	0%	27	29%
CD agency/AA or NA support groups/Needle Exchange	4	2%	3	2%	15	16%
Mom's plus (housing/substance abuse services)	5	2%	0	%	0	0%
Medical/dental/Veteran's Admin.	2	1%	0	0%	5	5%
Other	5	2%	1		8	8%

[1]Percentages do not add to 100% as liaisons may make more than one referral per client and some clients receive no referrals

[2]For Junior - DSHS referral is for substance use treatment benefits - in addition to other benefits that the client may be eligible for

[3]Drug Court referrals involve talking w/attorney or referring client to talk to attorney. Reasons Mental Health Courts won't accept (and why clients aren't referred to courts): criminal history, no significant MH problems/primary chemical dependency, out of jurisdiction charges, post-sentence, client refuses treatment, going to prison, DOC holds

3. Change in the number of linkages to treatment

CJ liaison work might be expected to result in an overall increase in referrals from King County correctional facilities and specialty courts to community mental health agencies. We examined this question within the MHCADSD IS. There were 225 reported referrals from these sources to the two agencies most highly involved with the CJI (Seattle Mental Health and Community Psychiatric Clinic) during the six months prior to beginning the CJI, and 217 during the subsequent six months. Unfortunately, because referral source is not a required data element, the data are very unreliable, and as such conclusions regarding the impact of the CJ liaisons based on these data should not be drawn.

4. Participant satisfaction

Participant satisfaction was evaluated only through staff interviews due to the infeasibility of contacting clients for whom no post-release contact information is available.

Staff interviews were completed with each of the three CJ liaisons. Interviews included both satisfaction ratings and open-ended questions regarding strengths and weaknesses of the service.

Staff interviews (n=3)

Table 62. CJ liaison staff global satisfaction

Items rated on 5-point scales - % "somewhat" or "very" satisfied	N	%
Overall satisfaction	3	100%
Clarity of job functions	3	100%
Availability of MH treatment resources	3	100%
Clarity of referral relationships	2	66%
Availability of CD treatment resources	2	66%
Availability of help for clients to obtain benefits	2	66%
Training opportunities	1	33%
Item rated on 4 -point scale - % "good" or "excellent"		
Overall quality	3	100%

Rating scale questions showed moderate levels of satisfaction overall with the exception of dissatisfaction with training opportunities. Integration and referral relationships were rated relatively weaker than general satisfaction levels. Availability of chemical dependency treatment and help with obtaining publicly-funded benefits were also rated relatively weaker, however the ADATSA and DSHS worker positions had not begun at the point of this evaluation.

Table 63. CJ liaison staff-reported strengths and weaknesses

Strengths/best things of program	N	%	Weaknesses/worst things	N	%
Watching clients improve	3	100%	Interagency communication/sharing	2	67%
Allows access to treatment	3	100%	Difficult client backgrounds	2	67%
Collaboration and communication	2	67%	Lack of leverage and follow-through	1	33%
Work autonomy	2	67%			
Provide hope	1	33%			

Shown above, CJ liaisons reported that providing access to needed treatment and watching clients improve are strengths of the service. Intersystem collaboration was viewed as a strength and weakness.

5. Stakeholder satisfaction

Stakeholders from MHCADSD administration, agency administration, Jail Health Service, and specialty courts were surveyed regarding their views of the CJ liaisons.

As shown below, stakeholders show very high satisfaction with the CJ liaisons, particularly with the individual qualities of the liaisons themselves. The only weaknesses mentioned are a lack of role clarity and isolation of the liaisons, which could speak to the issue of integration of the service within the work setting.

Table 64. CJ liaison stakeholder satisfaction

Stakeholder satisfaction (n=8)	N	%
Referrals - "fairly" or "very" easy (n=2)	2	100%
Overall quality - "good" or "excellent"	8	100%
Overall satisfaction - "somewhat" or "very" satisfied	7	88%

Table 65. CJ liaison stakeholder-reported strengths and weaknesses

Strengths (n=8)	N	%	Weaknesses (n=8)	N	%
Strengths of staff	5	63%	Lack of role clarity	2	25%
Service gap -opportunity to get treatment they otherwise wouldn't	1	13%	Staff isolation, lack of supervision	2	25%
Other	2	25%	Inability to follow-up	1	13%
			Data challenges	1	13%

D. Summary of interim results

During the first six months, 493 people were seen by the three liaisons. There was a slightly higher proportion of females served than in the jail population.

Referrals to the CJ liaisons were typically from inmates themselves or Jail Health Services. Referrals from CJ liaisons were most often to the ADATSA or DSHS application workers, courts, or community mental health agencies.

Staff and stakeholders were generally satisfied with the program, though staff were dissatisfied with training opportunities. Lack of role clarity and isolation of the liaisons was also mentioned by stakeholders, consistent with reports from staff of difficulties with intersystem communication and collaboration.

CROSS-SYSTEM TRAINING

I. Program Description

Program overview: A contracted trainer was hired in March 2004 to develop training for staff in King County human service and corrections setting. Nine trainings reached 257 participants between May and June, 2004. The four trainings provided to human service audiences focused on the corrections and legal systems. The five trainings provided to corrections staff focused on how CJI programs operate.

Target population: Trainings were anticipated to reach mental health treatment providers, chemical dependency treatment providers, Jail Health Services, King County Superior Court judges, CJ liaisons, District Court judges and probation officers, public defenders, selected prosecutors, King County Jail senior management, and housing managers associated with housing voucher program.

II. Interim Results

Nine trainings were provided with 257 people in attendance. Evaluations, developed by the trainer, were provided to all participants and 165 were returned at the end of the training sessions (64% response rate).

Results are shown below and suggest first that the trainings were differentiated by content -- participants at the CJI training most prominently learned about CJI program; participants at the legal system training learned about legal court processes. Most participants felt they increased their knowledge and nearly all would recommend the training to others.

Table 66. Cross system training participant-reported information learned

Information learned that will influence your work (coded from 4 similar questions)	How CJ Treatment Works (n=80)		Adversarial Legal System (n=85)	
How CJ programs fit together, for better advocacy, referrals, options for clients, info to clients	76	95%	28	33%
Legal processes for specialty courts, sentencing	NA	NA	51	60%
Tools for client advocacy	12	15%	27	32%
Perspective on legal system	NA	NA	34	40%
More perspective on client experience	5	6%	18	21%
Relationship of specialty courts to other courts	NA	NA	13	15%
Issues with competency to stand trial	NA	NA	10	12%
Information to share with public, families of offenders	4	5%	5	6%
Information that we can provide to inmates	7	9%	NA	NA
Rationale/perspective on CJI, program funding	7	9%	NA	NA
Data on CJI process	5	6%	NA	NA
Improved efficiency	NA	NA	5	6%
Information on intake processes	NA	NA	4	5%
Little/nothing	14	18%	8	9%
Increased in knowledge - top 2 ratings on 4-pt scale	55	69%	55	65%
Recommend training to others	74	92%	79	93%

In other narrative comments, attendees suggested that more trainings be provided and trainings to other groups (e.g., human services, attorneys, courts staff (n=13), that trainings should be targeted more closely to the audience (n=8), and that more training time is needed (n=3).

ADATSA APPLICATION WORKER

I. Program description

Program overview: An Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) application worker provided by the King County Assessment Center was assigned full-time to the CJI in January, 2004. This position screens offender-clients referred from the DSHS application worker for financial eligibility and assists offender-clients in applying for publicly funded chemical dependency treatment. The position is intended to increase the volume of offender-clients who are efficiently and effectively linked to needed chemical dependency treatment upon release.

Target Population: Eligible individuals are adult offender-clients within King County jails who have chemical dependency problems, are indigent, within 45 days of release from custody and not being transferred to the State Department of Corrections or have an out-of-county hold.

II. Interim Results: First six months - data available from February 1, 2004 thru July 31, 2004

A. Characteristics of referrals to ADATSA application worker (n=247)

Characteristics of individuals referred to the ADATSA application worker during the first six months of the position are shown below. There was a slightly higher proportion of females and a similar proportion of ethnic minorities were referred compared to the jail population.

Table 67. ADATSA application worker characteristics of persons referred

Demographics	N	%
Gender - #/% female	94	38%
Age*	Average=36	SD=9
Ethnicity		
Caucasian	78	32%
African-American	49	20%
Native American	15	6%
Asian-Pacific Islander	0	0%
Other	2	1%
Unknown	103	42%
Hispanic (duplicated)	3	1%

*Data unavailable for 85 people

B. Process Evaluation

At this time we are not able to evaluate whether ADATSA evaluations for inmates have increased subsequent to hiring the ADATSA application worker. However, below we report on the ADATSA worker's referral sources, productivity, and the result of service contacts.

1. Referral sources

The data below show that most of the referrals for the ADATSA application worker were from inmate self-referrals. CJ liaison and Jail Health Services comprised nearly all remaining referrals. Once the DSHS application worker position was hired (May 2004 - see below), referrals should predominantly come from the DSHS worker.

Table 68. ADATSA application worker referral sources

ADATSA referral sources	N	%
Self	134	54%
CJ liaison	45	18%
Jail Health Services	36	15%
Courts/judges	9	3%
PO	6	2%
RJC/DAJD jail staff	4	2%
Kent CSO	2	1%
Community agencies	2	1%
Other/unk	9	3%
Total	247	100%

1. Dispositions at completion of contact

As can be seen from the data below, nearly half of referrals to the ADATSA application worker were not processed because they were not within the 45 day period prior to release, a criterion for service eligibility. As a result, only a third of referrals received completed ADATSA screenings. Additional information should be provided to referral sources to clarify that inmates are not eligible to receive ADATSA application assistance until they are within 45 days of release.

Table 69. ADATSA application worker dispositions of referrals

Dispositions of referrals	N	%
Not within 45 days of release (cannot process)	118	48%
ADATSA screening completed -determined eligible	87 (80)	35%
Released before screening completed	26	11%
Other programs/benefits	8	3%
Refused	4	2%
No show	3	1%
Other/unknown	1	0%
Total	247	100%

C. <u>Summary of interim results</u>

During the first six months of operation, 247 referrals were made to the ADATSA application worker. A slightly higher proportion of females and a similar proportion of ethnic minorities were referred compared to the jail population.

About half of referrals to the ADATSA application worker were not processed as they were not within 45 days of release, a criterion for service eligibility. About a third of the referrals received a completed screening.

DSHS APPLICATION WORKER

I. Program description

Program overview: A financial services specialist, provided via contract with the Washington State Department of Social and Health Services (DSHS), began work May, 2004. She is assigned to the CJI to assist potentially eligible offender-clients in applying for publicly funded benefits. She is located at the Seattle Justice Center half-time to assist KCCF and at CCAP halftime. RJC inmates are assisted by the existing Kent CSO. The DSHS financial services specialist assists offender-clients referred from the ADATSA case monitor or a CJ Liaison in applying for Title XIX-Medicaid or other publicly-funded benefits. Additionally, the Social Security Administration's (SSA) Seattle office has agreed to send a claims representative to KCCF and the RJC to assist inmates with reinstatement of disability benefits and new applications processing. The DSHS application worker position is intended to increase the volume of offender-clients who are efficiently and effectively linked to needed benefits upon release.

Target Population: Eligible individuals are adult offender-clients within King County jails who have mental health and/or chemical dependency problems, are indigent, within 45 days of release from custody, and not being transferred to the State Department of Corrections or have an out-of-county hold.

II. Interim Results

The DSHS application worker began in May, 2004. As such, the first six months of work have not been completed. Evaluation findings will be presented in subsequent reports. We can report, however, that the DSHS application worker received 140 referrals during her first 3 months on the job.

ENHANCED SCREENING AND ASSESSMENT IN THE JAIL

I. Program description

Program overview: A new intake services model for the jail was initially proposed by King County Superior Court to standardize and provide up-to-date and more accurate offender information for in-custody first appearance defendants. Simultaneously, MHCADSD proposed an improved screening and assessment process in the jail for in-custody inmates with possible mental illness and/or chemical dependency treatment needs. These proposals were merged with the DAJD Personal Recognizance Section into a single program, called Intake Services, to be managed by the King County Community Corrections Division. Intake Services interviewing is separated into three parts. Parts 1 and 2, conducted by personal recognizance screeners, are targeted at facilitating the judicial decision to release or detain within the first 48 to 72 hours. Screeners establish the inmates' ties to the community, review Failure to Appear (FTA)/compliance history, identify substance abuse and/or mental health issues and assess victim and community safety concerns. Information in the screening document is also used for decisions regarding bail, assignment of counsel and evaluations for program recommendations. The revisions designed by Intake Services are intended to provide increased information to courts on which to base decisions regarding release-detain and placement in community-based jail alternatives and support services.

Target Population: Adult misdemeanor and felony defendants scheduled for the King County District Court and King County Superior Court First Appearance Calendars, charged felony in-custody defendants, and those defendants under consideration for Community Corrections programming.

II. Interim Results

Revisions to parts 1 and 2 were implemented in March, 2004. The third part of the protocol will target information at arraignment to expedite placement decisions by the court within the first 14 days. This process is currently being addressed by an Intake Services Small Working Group, and its implementation is anticipated soon.

CJI SERVICE PROGRAM COMPARISONS

Comparisons between programs are an important part of the CJI evaluation. At this time, we are able to examine comparisons among program with respect to participant-reported satisfaction and outcomes.

I. Participant Satisfaction

Client interviews were obtained for three CJI programs and results of participant satisfaction rating scales are shown below.

Table 70. CJI program comparison of participant satisfaction with program components

#/% responding "Agree" or "Strongly Agree" with statements below:	Housing Voucher N=40-47	COD N=9-11	Methadone N=20-24
General Satisfaction			
I liked the services I received	80%	73%	79%
If I had other choices, I'd still get service from this program	81%	81%	75%
I'd recommend the program	75%	80%	88%
Perception of Access			
The location was convenient	79%	82%	63%
Staff were willing to see me when I needed it	85%	90%	92%
Staff returned my calls within 24 hrs	83%	78%	NA
Services were available at good times	91%	64%	79%
I was able to get all the services I needed	66%	64%	75%
I was able to see a psychiatric when I wanted	NA	64%	NA
Appropriateness and Quality of Services			
Staff believe I can grow, change and recover	83%	82%	79%
I felt free to complain	73%	91%	71%
Staff told me side effects to watch for	NA	73%	75%
Staff were sensitive to my cultural background	57%	82%	73%
I obtained information to take charge of my illness	NA	80%	NA
I was given information about my rights	77%	55%	83%
Staff encouraged me to take responsibility for how I live life	88%	91%	83%
Participation in Treatment Goals			
I felt comfortable asking medication questions	NA	100%	83%
I, not staff, decided my treatment goals	NA	70%	83%
Getting into the program was easy	73%	64%	29%
Staff are kind and non-judgmental	83%	91%	65%
Staff understand what recovery is like	NA	64%	63%

Table 71. CJI program comparison of participant global satisfaction

Items rated on 5-point scales - % "somewhat" or "very" satisfied	Housing Voucher N=47	COD N=11	Methadone N=23
Overall satisfaction	85%	73%	91%
Process of getting housing	49%	20%	NA
Time to get housing	36%	70%	NA
Item rated on 4 -point scale -% "good" or "excellent"			
Overall quality	74%	64%	91%

Participants showed generally high general satisfaction across the three CJI programs in which participant satisfaction data was available. The location of methadone treatment and access to the program was rated less highly than for other programs. COD participants less often felt that they received information about their rights. The process and time it takes to obtain housing showed poor satisfaction in both programs in which this question was relevant (COD and housing voucher). Across all programs, availability of services and staff understanding recovery was rated less highly than global satisfaction ratings.

II. Participant-reported impacts

Table 72. CJI program comparison of participant-reported program impacts

Participant-reported impacts % "Agree" or "Strongly Agree" with statements below:	Housing Voucher N=47	COD N=11	Methadone N=23
As a direct result of services…			
Deal more effectively w/problems	62%	73%	96%
Better able to control life	66%	64%	96%
Better able to deal with crisis	60%	56%	87%
Getting along better w/family	61%	40%	95%
Do better in social situations	54%	64%	83%
Do better in school and/or work	55%	56%	90%
Symptoms not bothering as much	56%	73%	NA
Housing situation has improved	70%	80%	75%
I have gotten a job	NA	NA	42%
Do more productive things	70%	60%	96%
Physical health has improved	58%	60%	74%
Not craving drugs as much	66%	64%	87%
Not using drugs as much	72%	80%	100%

Participants reported a wide range of positive impacts from these three CJI programs. More participants in the methadone program reported positive impacts than participants in other programs overall. Housing voucher and COD impact rates were similar with a few exceptions. Fewer COD participants reported improved family relationships; fewer housing voucher participants reported improved symptoms.

RECOMMENDATIONS

The recommendations for quality improvement listed below are suggested by the data collected to date. Later reports that include recidivism outcome data will provide more useful information for determining the overall effectiveness of the programs. In the final report, recommendations will also be developed with input from key stakeholders involved in implementation of the CJ Initiative.

It should be noted that some changes to the CJI have already been made or will be implemented soon. Specifically, the mental health voucher period will be increased to nine months starting in 2005, training and supervision of the CJ liaisons has been enhanced, and workgroups have begun examining ways to increase housing options for CJI program participants.

Recommendations

1. Provide additional training regarding evidence-based practices, such as motivation enhancement therapy (MET) for the COD and methadone programs, particularly if program outcomes are not strong when such outcomes have been fully evaluated.

2. Consider providing additional training and clarification of expectations to staff for the mental health voucher program to promote positive outcomes given the relatively short benefit period. Training should include a focus on using the voucher period to convert participants to other funding mechanisms. As noted above, the voucher benefit period will be increased to nine months beginning in 2005. Evaluation the impact of this change should be considered.

3. Provide additional training and role clarification for the CJ liaisons and staff groups with whom they interact. Some training has already been conducted, as noted.

4. Develop a process to help determine reasons for the relatively high early drop-out rate in the housing voucher program and how more participants could obtain housing during the six-month benefit period.

5. Develop strategies for CJI programs to work with housing systems and funders to determine how the supply of safe, appropriate and well-maintained housing for CJI participants can be increased.

6. Explore reasons for the relatively high early drop-out rate in the CCAP IOP program

7. Provide additional information and training to ADATSA referral sources regarding eligibility for ADATSA application assistance

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Appendix A - CJI Logic Model

Assumptions	Inputs	Activities	External and unanticipated factors	Outcomes	Impacts
AJOMP mandate to: • reserve secure detention only for those who are a public safety or flight risk or who require secure detention as a graduated sanction • develop alternatives to use of secure detention for adult offenders • provide treatment options for persons significantly impaired by chemical dependency and/or mental illness and involved in the criminal justice (CJ) system Rationale for focus on individuals with mental illnesses and chemical dependency and homelessness: • Among inmates with drug or alcohol-related charges, inmates with co-occurring psychiatric disorders (COD) had nearly double the average length of stay in King County jails. • People with CODs represent 60% of District Mental Health Court (DMHC) cases and 41% of Drug Diversion Court cases. • DMHC and Drug Diversion Court note over 1/3 of clients are homeless. Service gaps: • The King County Criminal Justice Continuum of Care Work Group identified gaps in human services to clients involved in the criminal justice system in assessment, treatment, case management, and coordination • Factors in Multnomah (OR) and Broward (FL) counties effective in their programs for criminal justice-involved populations with mental illnesses and chemical dependency.	Housing Voucher • Contract with housing and case management provider • Referrals from specialty drug and mental health courts Methadone Voucher • Contracts with two methadone agencies • Referrals from Needle Exchange, Jail Health Services Mental health voucher • Contracts with six mental health agencies • Referrals by CJ Liaisons non-specialty court clients with major mental illnesses COD program • Contracts with 2 COD treatment agencies • Referrals from specialty drug and mental health courts CJ Liaisons • Contract with one agency to provide staff at both jails and CCAP	Housing Voucher Intake, 6-months of housing, case management to obtain permanent housing, and assistance with entitlements. Methadone Voucher Intake, 9-months of methadone treatment, counseling, supportive services Mental health voucher Intake, 6-month mental health treatment (except medications), intensive first 3-months, supportive services COD program Intake prior to client release from jail, 12-months of integrated mental health and chemical dependency treatment, housing, case management, help with entitlements, employment CJ Liaisons Assessment, discharge planning, referrals to services and mental health vouchers; support to engage CCAP clients	Housing Voucher • Criminal history, lack of rent history, behaviors, substance use, greatly limited housing options • Delays initial housing placements led to purchase of dedicated beds. • Difficulty keeping staffing levels Methadone • Confusion regarding relationship of TXIX funding to voucher • Few TXIX slots • Methadone maintenance is best provide long-term, so termination after 9 mos. may impede recovery Mental health voucher • Due to receipt of a similar grant by the DMHC, in November of 2003 the referrals for mental health vouchers shifted from the DMHC to non-specialty courts via the CJ liaisons, reducing court leverage on the clients to engage in treatment COD program • Lack of clarity re: clients who opt in, then out of specialty courts • Some housing was inadequately provided at low-rent hotels • Staff and director turnover at one agency at initiation of program CJ Liaisons • Lack of role clarity in relationship to Jail Health Service and drug and mental health court liaisons • Jail Health Service restructuring and changing roles	Do participants show reductions in criminal activity, use of jail, substance use and mental health symptoms? Do homeless participants gain housing stability? Do participants increase productive community functioning and employment? Do participants self-report positive impacts of the programs? Are processes for linking to treatment and entitlements improved? Do courts have improved information regarding risk, mental illness and substance use for placement decisions? Are relevant staff knowledgeable regarding CJ program and legal processes?	Reduced jail average daily population, reduced cost for King County Department of Adult and Juvenile Detention. Strengthening of coordination and cooperation between service providers, specialty and non-specialty courts, and Jail Health Services regarding the CJI client population Improved capacity of community agencies to provide integrated chemical dependency and mental health services as well as housing King County contributes to best practices for innovative programs.

Assumptions	Inputs	Activities	External and unanticipated factors	Outcomes	Impacts
Known features of effective programs for non-violent misdemeanants[1-7]: • integrated housing, mental health, and chemical dependency services, • involving key stakeholders from these agencies early in the planning process, • "boundary spanners" between criminal justice, mental health and chemical dependency treatment fields, • screening that happens as early as possible in an individual's contact with the CJ system, • dedicated case managers who understand both the CJ and mental health and chemical dependency treatment systems, • cross-agency collaboration and training across the CJ, mental health and chemical dependency disciplines and • designated case management for pre-release planning that includes reinstatement of government benefits. • sustained case management and housing resulted in positive outcomes for women in YWCA Women out of Corrections program • methadone significantly reduces illicit opiate drug use and crime, and enhances social productivity.	DSHS and ADATSA application workers • Agreements with DSHS and KC Assessment Center for two FTEs Intensive Outpatient CD Treatment at CCAP • Contract with community CD treatment agency for treatment at CCAP • Referrals for individuals court-ordered to CCAP for at least 30 days Cross-systems training • Training consultant • Training by staff from the King County Office of the Public Defender, Prosecutor's Office, and CJI Project Manager In-jail assessment • .5 FTE to develop in-jail assessment to support decisions for placement in jail alternatives Project Management and Evaluation • Project Manager • .5 Program Evaluator • .5 Research Assistant	DSHS and ADATSA Application workers Assistance with applications for benefits (e.g., Medicaid, SSI Intensive Outpatient CD Treatment at CCAP Intake, 90-days of outpatient chemical dependency treatment at CCAP; 9 hours/week of group CD treatment, discharge planning Cross-system training Cross-systems training to service providers, overview of CJI, court processes. Nine trainings, 3 videotapes recorded for dissemination In-jail assessment Now combined with Intake Services Workgroup Project Management and Evaluation Contract management, program evaluation, stakeholder facilitation and coordination	DSHS and ADATSA Application workers • Late hiring of ADATSA and DSHS application workers Cross-system training Difficulty executing contract for consultant trainer Challenges to identify all appropriate audiences In-jail assessment New HIPAA compliance issues affected ability of Jail Health Service to make provide information to courts and CJ liaisons Project Management and Evaluation Resignation of Jim Harms, a Program Analyst for DAJD, has increased the data collection burden on the jail.	Has King County jail's average daily population of individuals with mental illnesses or chemical dependency been reduced?	

[1]Borum, R. (1999). *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness Preliminary Report.* Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida..
[2] Barr, H. (1999). Prisons and Jail: Hospitals of Last Resort: The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illness in New York. http://www.soros.org/crime/MIReport.htm
[3] Moreno, K. & Sobel, L. (2000). California's Mentally Ill Offender Crime Reduction Grant: Reducing Recidivism by Improving Care
[4] Bazelon Center for Mental Health Law. (2004). Finding the Key to Successful Transition from Jail to the Community: An Explanation of Federal Medicaid and Disability Program Rules
[5] National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System. (2001). Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders. Fact Sheet Series: Delmar, NY: The National GAINS Center.
[6]Vanzo, P. (2003) Preliminary Assessment: YWCA WOC Case Management Project, February 1, 2002 through January 31, 2003.
[7] National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997.* November 17-19, 1997 15(6).