SAFE AND HEALTHY SPOKANE

TASK FORCE RECOMMENDATIONS

June 2026

Acknowledgements

This report is the result of the collective effort of hundreds of individuals and organizations whose expertise, lived experience, and unwavering commitment to building a safer, healthier Spokane County made this work possible.

Safe and Healthy Spokane Task Force

The Task Force was composed of dedicated representatives from across the community, spanning sectors including emergency response and health, government, justice, and corrections:

Community Representatives

Alicia Barbieri, Goodale and Barbieri

Ana Trusty, Mujeres in Action

Angel Tomeo Sam, Yoyot Sp'q'n'i

Chud Wendle, Hutton Settlement

Dr. Dean Martz, Waters Meet Foundation

Dr. Melissa Mace, NAACP Spokane

Erin Carden, Lutheran Community Services Northwest

Jack Heath, Washington Trust Bank

Jermal Joe, Community Advocate

Kitara Johnson, Gabriel's Challenge

Pam Parr, Spokane Housing Authority

Roshelle Cleland, Washington State Coalition Against Sexual and Domestic Violence

Sky Pagaling, Camas Foundation/ Kalispel Tribe of Indians

Stacey Cowles, Cowles Company

Stanley Harewood, Justice Not Jails

Toni Lodge, The NATIVE Project

Virla Spencer, The Way to Justice

Emergency Response and Health Representatives

Alex Jackson, MultiCare

Jan Downing, Frontier Behavioral Health

John Browne, CHAS Health

Matt Albright, Providence

Dr. Francisco Velazquez, Spokane Regional Health District

Justin Lundgren, Spokane County Sheriff's Office

Justin Johnson, Spokane County - Behavioral Health

Matthew Cowles, Spokane Police Department

Matthew Vinci, Spokane County Fire District 9

Government, Justice and Correctional Representatives

Erik Lamb, City of Spokane Valley

Maggie Yates, City of Spokane

Karl Otterstrom, Spokane Transit Authority

Dr. Adam Swinyard, Spokane Public Schools

Mike Sparber, Spokane County Regional Law and Justice Department

Chris Bowles, 492 Corrections Officers Labor Union

Jim Murphy, Spokane County Superior Court (Retired)

Judge Tony Hazel, Spokane County Superior Court

Judge Jeffrey Smith, Spokane County District Court

Judge Kristin O'Sullivan, Spokane Municipal Court

Misty Griffith, Spokane County District Court

Katie McNulty, Spokane County Prosecutor

Colin Charbonneau, Spokane County Public Defender

Justin Bingham, City of Spokane Prosecutor

Nick Antush, City of Spokane Public Defender

Advisory Committee

Informing the development of this report's recommendations was an Advisory Committee, comprising over 100 community members whose expertise and insights proved invaluable. This broader body was chaired by the following Committee Leads.

Advisory Committee Leads

Angel Tomeo Sam, Yoyot Sp’q’n’i

Jan Downing, Frontier Behavioral Health

Justin Johnson, Spokane County

Dr. Melissa Mace, NAACP Spokane

Judge Tony Hazel, Superior Court

Mike Sparber, Spokane County

Erik Lamb, City of Spokane Valley

Maggie Yates, City of Spokane

Matt Albright, Providence

Chud Wendle, Hutton Settlement

John Browne, CHAS

Virla Spencer, The Way to Justice

Project Leadership

The project was initiated and funded by five private sector partners to form the Safe and Healthy Spokane Task Force.

Latisha Hill, Avista Foundation

Lance Beck, Greater Spokane Valley Chamber of Commerce

Alisha Benson, Greater Spokane, Inc.

Emilie Cameron, Downtown Spokane Partnership

Zeke Smith, Waters Meet Foundation

Planning Team

The Planning Team (the Conveners and leaders from local jurisdictions), informed strategy, and provided input and alignment.

Spokane County:

- Commissioner Mary Brooks
- Commissioner Chris Jordan
- Sheriff John Nowels

City of Spokane Valley:

- Mayor Laura Padden
- Councilmember Pam Haley
- City Manager John Hohman

City of Spokane:

- Council President Betsy Wilkerson
- Council Member Michael Cathcart
- Mayor Lisa Brown
- Police Chief Kevin Hall

Consultants

This work was also supported by a team of consultants who provided project management, facilitation, technical expertise, communications strategy, and public engagement throughout the process.

Christine Varela and Michelle Hege, *DH*

Judge Steven Leifman, Patti Tobias, and Rick Schermer, *The Leifman Group*

Kate Welty, Kate Joncas, Sou Garner, Alex Dupey, and Jacqueline Robinette, *MIG*

We are grateful to CHAS Health and their excellent staff, who hosted our meetings at their beautiful Iron Bridge Health Center.

We would also like to acknowledge the spectacular Stacia Rasmussen from Greater Spokane Inc. who provided superior and cheerful support.

TABLE OF CONTENTS

Acknowledgements i

I. EXECUTIVE SUMMARY 1

II. INTRODUCTION 4

III. THE SAFE AND HEALTHY SPOKANE TASK FORCE AND THE PROCESS 7

IV. COMMUNITY ENGAGEMENT 15

V. NATIONAL TRENDS AND AN OVERVIEW OF SPOKANE'S EFFORTS 18

VI. RECOMMENDATIONS 27

VII. CONCLUSION: IMPLEMENTATION AND ACCOUNTABILITY 64

VIII. APPENDICES 65

I. EXECUTIVE SUMMARY

Spokane County is caught in a cycle that is costing lives and draining public resources. People with untreated mental illness and substance use disorders cycle repeatedly through the jail, the emergency room, and the street – never receiving the coordinated care that could break the pattern. First responders are overwhelmed. Families are shattered. Taxpayers fund the same crises again and again, with no end in sight. The community is struggling. People deserve timely, compassionate care with predictability, safety, and systems that prevent crisis from unfolding in the first place.

This is not a problem unique to Spokane. Across the country, jails have become the de facto behavioral health system for communities that never built the treatment capacity, housing, and crisis response infrastructure their residents need. But Spokane has reached a different kind of moment: the evidence is clear, the community is ready, and the path forward must be more than another study. The region now has a community-built roadmap for change. It's time to act on it.

In 2025, a coalition of community and civic leaders formed the Safe and Healthy Spokane Task Force – a broad, cross-sector body representing law enforcement, behavioral health, the courts, healthcare, providers, business, labor, Tribal partners, and people with lived experience in these systems. Over the following months, the Task Force conducted a rigorous assessment of Spokane's systems, engaged over 100 community members, reviewed national best practices, and developed the recommendations in this report. This is what Spokane's community, working together, believes it will take to build a system that is safer, healthier, and more just.

About the Process

Over the past three years, a coalition comprised of stakeholders from the private, nonprofit, philanthropic, and public sectors have worked collaboratively to assess the region's most pressing public health and safety challenges. These partners did extensive research on other similar efforts and sponsored a community-wide process to develop recommendations on how Spokane could improve community safety and the outcomes in our justice and behavioral health systems. We are thankful for the commitment of partnering organizations who provided the resources for technical expertise, public engagement and facilitation consultants to form the Safe and Healthy Spokane Task Force. A community-led initiative committed to developing actionable strategies that enhance public safety, support behavioral health, and strengthen system coordination across Spokane County, the Task Force has contributed time, leadership, and resources to an inclusive planning effort. The process involved over 100 community members and dozens of outreach meetings and has produced a thoughtful framework for moving forward. The Task Force consisted of a diverse array of experts, leaders, and individuals with lived experience. Their work reflects a commitment to identifying and implementing comprehensive, systemic, and data-driven strategies to improve outcomes for all who live and work in Spokane County.

There is a strong foundation of studies and projects underway to build on. This report identifies initiatives that can be implemented immediately and that will make a difference to the

community. It also provides a clear roadmap to planning for the longer-term efforts that will make Spokane a leader in effective management and alignment of the behavioral health and justice systems.

This report is based upon the efforts of countless others and the Task Force would like to acknowledge coordinated and aligned investments that have informed this report. Such efforts include coordinated partner investments to tackle the drug crisis using Opioid Settlement funds, the successful growth of the regional Crisis Stabilization Center, breaking ground on the PATH crisis relief and sobering center, and the deployment of behavioral health professionals with first responders in the field, all best practices.

The Task Force's recommendations prioritize actionable, cost-effective strategies to make Spokane safer and healthier. Its recommendations are designed to expand behavioral health interventions, reduce recidivism, modernize facilities, and strengthen system coordination – so that individuals with serious mental illness and substance use disorders have access to care that is comprehensive, effective, humane, equitable, and data-driven. The recommendations focus on expanding behavioral health interventions, reducing recidivism, improving and modernizing facilities, and improving system effectiveness and community safety.

We are pleased to provide the recommendations that resulted from this community process. We believe in the ability of the people of Spokane County to make the changes that will achieve our vision of the safe and healthy community that everyone in our region deserves. We look forward to the progress we will achieve together.

Recommendations

A summary of the Task Force recommendations is shown below. To develop these recommendations, the Task Force focused on four interrelated elements of the public health, safety, and justice system:

A. **Foundation:** Develop a sustainable approach to accountability and continued coordination.
B. **Cross-System Coordination:** Align public safety, behavioral health, and housing systems to function as a unified response to complex needs.
C. **New or Scaled Program, Service, or Process:** Expand capacity at the highest-impact pressure points in the continuum of care.
D. **Facilities:** Develop and modernize physical infrastructure to support an integrated system.

Foundation Develop a sustainable approach to accountability and coordination for a system of care.	
A.1	Establish a Cross-Sector Implementation Accountability and Coordination Council
Cross-System Coordination Align public safety, behavioral health, and housing systems to function as a unified response to complex needs.	

B.1	Create and Leverage a Robust Data and Accountability System
B.2	Formalize Partnerships to Support Upstream Prevention
B.3	Integrate Peers at Each Step in the System
B.4	Formalize Procedures across the System that Support Integrated Care Planning and Process: “Warm Handoffs”
New or Scaled Program, Service, or Process Expand capacity at the highest-impact pressure points in the continuum of care.	
C.1	Scale Alternative Crisis Response Models
C.2	Establish Coordinated Intake and Assessment with Shared Standards Across Entry Points
C.3	Strengthen Pre-trial Diversion, Ensuring both Support and Accountability
C.4	Focus Interventions on the High Utilizers of the Criminal Justice and Health Systems
C.5	Expand Culturally Responsive Supports and Services for Targeted Prevention Populations
C.6	Establish a Youth and Young Adult Prevention and Response System
C.7	Make Strategic Workforce Investment across the Justice and Behavioral Health System
Facilities Develop and modernize physical infrastructure to support an integrated system.	
D.1	Invest in Modern, Integrated Justice Facilities and the Coordinated Network of Community-Based Facilities That Advance Public Safety and Community Health
D.2	Strengthen Housing Options

II. INTRODUCTION

A community is only as safe as it is healthy, and only as healthy as it is safe. Spokane is living proof.

Many of the same people cycle through our jails, emergency rooms, and streets. Until that cycle is broken, neither they nor the community around them can be safe or well. When individuals with untreated mental illness and substance use disorders cannot access care, neighborhoods become less safe, families lose parents, partners, and children to cycles they cannot break alone, first responders are overwhelmed, and taxpayer dollars are consumed by systems responding to crises that were never resolved. Spokane has arrived at a moment where the evidence is clear: lasting public safety depends on community health, and a healthy community depends on a justice system built for the complexity of today's challenges.

This cycle is not unique to Spokane. In 2025, the Washington State Behavioral Health and Habilitation Administration Office of Forensic Mental Health Services updated their "Best Practices for Behavioral Health Services in Jail Settings" guidebook. It includes a clear summary of the national challenges for incarceration and behavioral health that are reflected in Spokane County:

> *"More than 70% of people in U.S. jails and prisons have at least one diagnosed mental illness or substance use disorder or both, and up to a third of incarcerated people have a serious mental illness (National Center for State Courts, 2022). In Washington State, 58% of adult Medicaid enrollees booked into jails in 2013 had a mental health treatment need, 61% had a substance-use disorder treatment need, and 41% experienced co-occurring treatment needs. People with co-occurring mental health and substance use disorders (SUD) experience greater difficulties under correctional supervision, may stay incarcerated longer, have increased difficulty managing in correctional settings, and recidivate more quickly post release. According to a 2020 study, people who are incarcerated and have a substance use disorder are at higher risk of recidivism than those without a substance use disorder, independent of whether they have a mental health condition. Furthermore, suicide remains the leading cause of death in jails, accounting for 49 deaths per 100,000 people in 2019."*

Across the country, the failure to build connected, coordinated systems of care has produced a predictable and costly result: a fragmented, crisis-driven approach that serves no one well. It is not the fault of any single agency. It is the consequence of systems that were never designed to work together and have not been reformed to meet today's realities. Jails and emergency rooms have become de facto behavioral health providers, holding people whose untreated mental illness or addiction drives their repeated contact with the system, and whose return to the community without treatment all but guarantees the next crisis. Breaking that cycle requires using each part of the system for what it is built to do: jail space reserved for those who pose a genuine risk to public safety, and treatment, housing, and crisis response available for those whose needs are clinical. Right now, Spokane has neither.

The cost is significant. Emergency departments absorb psychiatric crises with no capacity for follow-through. Individuals without stable housing cycle back through the same doors, again and again. Housing someone in jail costs far more per day than community-based treatment or supportive housing, and a small subset of high utilizers drives a disproportionate share of costs across jail, emergency, and crisis systems simultaneously. The argument for reform is not just moral; it is fiscal.

Coordination is the organizing principle behind the work that follows. The pieces of Spokane's response (prevention, crisis response, diversion, treatment, stabilization, reentry, and corrections) exist. What is missing is the connective tissue between them and a shared accountability for outcomes. A more coordinated approach reduces repeat crises, improves outcomes, strengthens accountability, and makes public resources go farther. That principle runs through every recommendation in this report.

Spokane's correctional facilities reflect the broader problem. The 1986 Downtown Jail and the 1952 Geiger Corrections Facility were not designed to serve a population where more than a third have serious mental illness, nearly 40 percent are on psychotropic medication, and co-occurring substance use disorders are the norm rather than the exception. Like many jails in Washington State, both facilities face overcrowding, staffing shortages, broken water pipes, poor ventilation, and outdated designs that create risks for incarcerated people and staff alike, and that undermine rehabilitative programming. A 2023 study by the Washington State Institute for Public Policy rated the physical condition of the Downtown Jail from bad to terrible, with only its security and electrical systems rising to "okay." These are not simply aging buildings; they are facilities that actively work against reducing recidivism and improving public safety. But correctional facilities are only half the problem. Modernizing correctional infrastructure and building out the community-based facilities that surround the justice system (treatment capacity, crisis stabilization, reentry housing, diversion receiving sites) must be planned and funded together.

The failed 2023 ballot measure to fund a new jail and services in Spokane County was not a verdict against change. It was a signal that the community needed a more honest, more complete, and more genuinely community-built roadmap. For some, the measure's defeat created a false choice: invest in jail facilities or invest in services. The Task Force rejects that framing. The evidence is unambiguous that both are necessary, and that neither works without the other. Modern, appropriately scaled correctional facilities paired with robust diversion, treatment, housing, and crisis response capacity: that is what a reformed approach looks like.

In the months following the 2023 measure's defeat, a diverse group of private, nonprofit, and public community leaders began a different kind of conversation. They set out to find common ground, not on every issue, but on steps Spokane could take together right now. They formed a community coalition, studied Spokane's existing systems and prior work, and traveled to Whatcom County to learn how leaders there had built a coalition of their own and passed a funding measure for justice and crisis facilities. What they heard in Spokane was consistent: people with mental health and substance use needs were not receiving coordinated care and were cycling between homelessness and jail at high human and public cost; the jail itself was overcrowded, understaffed, and ill-equipped for the behavioral complexity of its population,

creating unsafe conditions for incarcerated people and staff; and the broader justice and treatment infrastructure was overburdened in ways that compounded every other challenge. These were not three separate problems. They were one interlocking problem and addressing it would require working across systems that had long operated in parallel.

Out of that recognition, the Safe and Healthy Spokane Task Force was formed. It brought together a deliberately broad coalition: community members from law enforcement and the courts, behavioral health providers, housing advocates, business and labor leaders, Tribal and other Indigenous leaders, and people with lived experience of the system. The Task Force was not another study or gap analysis. It was a community-driven effort to build a roadmap: grounded in data, shaped by those closest to the challenges, and designed to move Spokane from endlessly managing crises toward preventing them.

The recommendations that follow reflect hard conversations, genuine tradeoffs, and a shared commitment to a community that is safer, healthier, and a better steward of the public's trust and resources. They address the full continuum: prevention and crisis response, diversion and courts, reentry and community corrections, facilities, and the cross-system coordination and governance needed to sustain change over time. Some can move forward now, through policy changes, operational improvements, and stronger coordination among existing agencies. Others will require sustained planning, regional alignment, flexible facilities and infrastructure, and long-term investment. All of them depend on a clear governance and accountability structure that ensures progress is monitored, reported, and sustained over time, independent of any single ballot measure or election cycle.

Spokane has done the analysis before. What is different this time is that the community has done the work together. The people most affected by systemic failures, and those most responsible for addressing them, built this roadmap side by side. What follows is the result.

Note: Throughout this report, "Spokane" refers to the broader Spokane County region, not the City of Spokane alone, unless specifically stated. This includes the region's cities, towns, unincorporated areas, and the systems that serve them across jurisdictional boundaries. Differences in jurisdictional responsibility and accountability are identified and made visible where relevant. The intent is to foster a shared commitment to change across the entire Spokane region – because the challenges addressed in this report do not stop at jurisdictional lines.

III. THE SAFE AND HEALTHY SPOKANE TASK FORCE AND THE PROCESS

a. Overview

The Task Force did not begin with a shared view of the problem. Members came from different sectors, lived experiences, and starting assumptions about what the Spokane region most needed. What emerged through the work was a shared conviction: that public safety and community health rise and fall together, and that lasting progress depends on how the parts of the system work as a whole. Evidence and expert analysis informed priorities. Advisory Committees turned findings into actionable workstreams. Community engagement was woven through each stage, so public input shaped recommendations in real time rather than at the end. And facility planning was developed in the context of broader system investments – diversion, crisis response, housing, workforce, and data – rather than as an isolated capital project. The result is a set of recommendations structured in the way a coordinated system has to function: in concert, not in isolation.

Formation, Purpose, and Guiding Framework

The Safe and Healthy Spokane Task Force was convened in 2025 by a coalition of private, nonprofit, philanthropic, and public partners to confront the single interlocking challenge described above: the convergence of unmet behavioral health needs, public safety strain, and overburdened facilities and services. Because the members began without a shared view of the problem, the Task Force established a clear framework to anchor decision-making, rely on data-informed methods, prioritize transparency and cross-system collaboration, pursue trauma-informed and culturally responsive approaches, and center the dignity and lived experience of those most affected by these systems. These principles were the operational rules of engagement that allowed a diverse group to move from differing perspectives to shared recommendations.

Throughout their many months of collaboration, Task Force members were guided by the following shared Vision Statement and a commitment to guiding values that helped the group navigate its work.

Vision Statement

In Spokane County, individuals with serious mental illness and substance use disorders will have access to a comprehensive, effective, humane, equitable, and data-driven system of care–one that improves public safety, strengthens behavioral health, and ensures coordinated services.

Guiding Values:

- Dignity and humanity -- Values/Ethics

- Data informed decisions -- Process/Method
- Trauma informed, healing centered and historically accountable -- Framework/Lens
- Culturally established norms -- Framework/Lens
- Sustainable, evidence based, laws reflect vision -- Outcomes
- Meaningful engagement with lived experience -- Inclusion/Voice
- Transparency and accountability -- Governance/Trust
- Collaboration and shared learning -- Partnership/Growth
- Root cause prevention and responsive intervention -- Strategy/Action

Task Force members represented diverse perspectives across the following groups and expertise areas:

- Advocacy
- Business
- Courts
- First responders
- Government
- Healthcare and public health
- Housing
- Judges and the justice system
- Labor
- Law enforcement
- Marginalized communities
- Nonprofit organizations
- People with lived experience in the system
- Philanthropy
- Victim advocacy and support groups

b. Phased Process and Timeline

The process unfolded in overlapping phases rather than discrete steps, allowing continuous refinement based on new data and stakeholder feedback:

- **Asset assessment and expert analysis**: The Leifman Group conducted a comprehensive Asset Assessment to map Spokane's systems, identify strengths and gaps, and recommend priority focus areas. The assessment provided shared evidence base and a phased roadmap (near-, mid-, and long-term options) that grounded subsequent work.
- **Convening and learning:** Task Force members participated in briefings, site visits, and expert presentations (including national models) to test assumptions and consider alternative approaches to facility and system design.
- **Advisory Committee work**: Four Advisory Committees (Prevention and Crisis Response; Jails and Courts; Reentry, Discharge and Community Corrections; Facilities, Infrastructure and Treatment Continuum) met in three structured sessions: assessment, recommendation development, and refinement, in order to translate findings into practical strategies and measurable outcomes.
- **Topic-specific workgroups and expert input:** Throughout the process, the Task Force, Conveners, and consulting team convened and consulted with a series of ad hoc workgroups, subject matter experts, practitioners, and individual stakeholders to explore specific issues in greater depth. These flexible, topic-driven engagements allowed for real-time problem solving, detailed policy and practice analysis, and validation of emerging ideas.
- **Ongoing community engagement:** Outreach, interviews, and listening sessions were conducted before, during, and after committee work so the ideas produced by technical teams and committees were vetted, challenged, and refined by community members, providers, people with lived experience, first responders, labor, and elected officials.
- **Synthesis and recommendation:** Committee outputs, community feedback, and Task Force deliberations were iteratively synthesized into the recommendations contained in this report, with attention to accountability metrics, equity goals, and cost-effectiveness.

Integration of Committees, Engagement, and Task Force Meetings

Integration was an explicit design feature: Task Force meetings brought together best practice research and expertise, as well as Advisory Committee feedback and community engagement findings so the full body could evaluate tradeoffs, prioritize options, and direct follow-up work. For example, after the Asset Assessment convening, Advisory Committees conducted targeted listening sessions (e.g., with first responders, people with lived experience, and corrections staff); those findings were presented back to the full Task Force.

This iterative loop: analysis, committee drafting, community vetting, and Task Force synthesis, repeated across topic areas, producing recommendations that balanced technical feasibility with community priorities.

Advisory Committee Structure and Workflow

The Task Force benefited from the work of its four Advisory Subcommittees, which were set up in alignment with the Asset Assessment report and national best practices research. The four Advisory Subcommittees focused on the following distinct, but interrelated topic areas:

A. Prevention, Crisis Response and Pre-Arrest Deflection

B. Custody Strategies and Courts

C. Re-entry, Discharge and Community Corrections

D. Facilities, Infrastructure and System Coordination

Over 120 community volunteers and Task Force members participated, meeting three times over several months to:

- Articulate a clear understanding of current challenges, opportunities, and existing opportunities within their area of focus.
- Develop practical recommendations, including both actions that can be implemented without new resources, as well as longer-term investments to bolster facilities and services, and advocate for policy changes that will enable systems improvements.
- Define desired outcomes supported by measurable indicators of success and addressing equity goals.

Community Engagement

Community engagement was multi-pronged (public meetings, targeted interviews, listening sessions, partner presentations, digital outreach, and stakeholder briefings) and explicitly designed to shape committee outputs rather than merely inform them. Engagement priorities included elevating lived experience, soliciting input from frontline workers (corrections, EMS, behavioral health clinicians), hearing from marginalized communities and Tribal partners, and testing tradeoffs with labor and fiscal stakeholders. Practical examples of influence:

- Community feedback prioritized on-site crisis stabilization capacity and warm-handoff procedures, prompting the Facilities Committee to elevate non-refusal stabilization beds and 24/7 clinical staffing as core design criteria.
- Labor and corrections input led to clearer workforce and training strategies embedded in facility planning, and to recommendations for transitional staffing investments tied to service scale-up.
- Lived-experience testimony shaped reentry and housing priorities, increasing emphasis on pre-release planning, peer navigation, and tenancy supports in the final recommendations.

Transparency, Accountability, and Public Reporting

Transparency was maintained through publicly posted meeting agendas and recordings, a project website with materials and updates, and regular public briefings. The Task Force committed to measurable indicators of success for each major recommendation (e.g., diversion rates, recidivism, housing placements, crisis center utilization, staffing targets) and to periodic public reporting so progress can be tracked and course corrected.

Decision-making principles and how choices were made

Decisions were guided by the Asset Assessment evidence, best practices (including SAMHSA and Sequential Intercept frameworks), fiscal and operational feasibility, and community priorities. The Task Force prioritized strategies that: (1) reduce unnecessary justice involvement; (2) expand accessible crisis and treatment capacity; (3) ensure continuity of care across transitions; and (4) align facility design with therapeutic and safety objectives. Importantly, facility recommendations were conditioned on parallel investment in diversion, housing, workforce, and data systems—reflecting the Task Force's view that modernization is necessary but insufficient alone.

Outcomes of the Process

The iterative process produced a set of recommendations that are evidence-based, community-informed, and operationally grounded. Committees delivered targeted strategies across prevention, crisis response, post-arrest diversion, reentry, and facilities. The Task Force synthesized these into a coordinated roadmap that emphasizes short-term actions to build momentum and longer-term investments that require capital and sustained cross-system collaboration.

c. Safe and Healthy Spokane Asset Assessment Report

The first step in the Task Force process was to conduct an Asset Assessment by the Leifman Group, led by Judge Steven Leifman, a national expert on mental health and the justice system. They assessed Spokane's systems and convened a multi-day work session to share the results and engage community members in solutions.

The Asset Assessment Report highlights both the complexity of the challenges and the strength of Spokane's existing systems. The asset assessment focuses on the need for a balanced, coordinated approach that strengthens the full continuum of response. The report focuses on how robust diversion, treatment, stabilization, and housing options alongside a modernized, safe correctional facility can produce meaningful and sustained impact.

The report outlines a phased roadmap for action, including near-term steps that can be implemented using existing resources, mid-term strategies to strengthen capacity and coordination, longer term investments needed to support practical implementation and sustained progress over time.

The Asset Assessment report (the full report is in the Appendix) provided a shared, evidence-based understanding of how Spokane's behavioral health and justice systems currently function—where targeted, coordinated action can produce meaningful change. This report provided a strong foundation for reducing incarceration, improving public safety, and strengthening community health. This prioritized report builds on that foundation and builds community trust by organizing recommendations that reflect:

1. Best practices for reducing incarceration and recidivism
2. Strength of evidence, proven effectiveness and clear accountability measures
3. Cost-effectiveness and fiscal sustainability
4. Achieving coordinated, cross-system response

The key findings were:

- Crisis response systems remain overburdened. Limited stabilization capacity, fragmented 911/988 coordination, and insufficient mobile crisis coverage result in avoidable emergency room utilization and unnecessary jail bookings.
- Courts and justice partners are committed to reform, yet lack the tools—such as standardized screening, real-time data sharing, and treatment capacity—to fully implement diversion models at scale.
- Reentry services are inconsistent and under-resourced. Individuals leaving jail, hospital settings, or state facilities frequently return to homelessness or unstable environments without coordinated supports.
- Housing is the fulcrum of the system. Nearly every stakeholder identified housing scarcity—particularly supportive and transitional housing—as the single most significant barrier to stability and recovery.
- Workforce shortages cut across behavioral health, crisis response, reentry, and treatment. Providers struggle to recruit and retain clinicians, peers, case managers, and specialty staff.
- Data systems are fragmented and incompatible. Stakeholders expressed a strong desire for shared data, dashboards, and transparency to guide decision-making and measure outcomes.

The assessment report also identified key opportunities across prevention, crisis response, diversion, treatment, housing, and long-term recovery:

- Creating a fully integrated crisis response continuum, including improved 911/988 call routing, expanded mobile crisis response, standardized warm handoffs, and planning for a non-refusal Crisis Receiving Center.

- Developing countywide post-arrest diversion systems, supported by validated screening tools, universal data-sharing, coordinated case processing, expanded court-aligned treatment options.
- Strengthening reentry transition services, including medication continuity, peer support, scheduled appointments, transitional housing, partnerships, and employment pathways.
- Building a more robust treatment continuum, including detoxification, residential, outpatient, co-occurring, and youth/young adult services.
- Creating a sustainable supportive housing pipeline, paired with tenancy supports, incentives, and integrated behavioral health services.
- Implementing data-sharing agreements, dashboards, and analytic tools to improve coordination, identify high utilizers, and track system outcomes.
- Expanding workforce pipelines, improving retention strategies, and strengthening cross-system training.

The recommendations in the Report provided a strong foundation for the work of the Task Force and the Advisory Committees.

d. Prior Plans and Efforts

Source Material - Asset Assessment

The Task Force did not begin its work in a vacuum. Spokane has a long history of studying these challenges, and several thoughtful plans and reports have laid important groundwork. The Task Force reviewed and built upon this body of work—drawing on what succeeded, learning from what stalled, and carrying forward the strongest ideas. Its role was not to start over, but to help carry prior efforts into a coordinated push for action. The following documents informed the Task Force's analysis and recommendations:

- A Blueprint for Reform - Spokane Criminal Justice System
- Asset Assessment Convening (2025)
- BH-ASO Overview (2024)
- Bennett Consulting Report
- Best Practices for Behavioral Health Services in Jail Settings
- City of Spokane SIM
- Corrections Community Newsletter
- CSD Annual Report (2024)
- CSD Programs Project (2024)

- Faith-Based Committee of Spokane Proposal Booklet
- Gabriel's Challenge No Wrong Door Summit Report
- Geiger Community Corrections Offender Programs (2024)
- GSI "The Pulse" Polling Reports
- Jail Modernization Task Force Final Report (2025)
- Pioneer Human Services Spokane Regional Stabilization Center Reporting Metrics (2024)
- SCDS Community Corrections Newsletter
- Spokane Community Health Needs Assessment (2024-25)
- Spokane County and City Budget Overview and Local Sales Tax (2024)
- Spokane County and City of Spokane Fiscal Conditions and Local Option Taxes
- Spokane County Corrections Needs Assessment Master Plan - Draft
- Spokane County Crisis Relief and Sobering Center Project
- Spokane County Detentions Programs Summary (2024)
- Spokane County SIM
- Spokane County Sobering, Triage and Transition (STaT) Program
- Spokane County-Spokane City Fire Co-Response Project
- Spokane County Voter Sentiment on Public Safety, Homelessness, Housing, Education, and Economic Development
- Spokane Regional Service Area Crisis System Overview Training
- Spokane Superior Court Calendaring and Court Efficiency Study
- SRHD Substance Use Disorder Resources; Fentanyl Roundtable; Spokane Public Health and Safety Meeting Dialogues
- SRLJC Jail Discussion
- Stabilization Center Metrics
- Substance Use Disorder Community Resources Assessment
- Whatcom County Justice Project

IV. COMMUNITY ENGAGEMENT

From the outset, the Task Force recognized that recommendations developed only by technical experts and institutional stakeholders would lack the legitimacy, nuance, and public trust needed for successful implementation. The goal was not simply to inform the community about the Task Force's work, but to ensure that the people most affected by Spokane's public safety and behavioral health systems had a meaningful opportunity to shape the recommendations that emerged.

Engagement was designed to reach across the full spectrum of Spokane County's community — from frontline service providers and corrections staff to individuals with lived experience in the justice system, from business and civic leaders to Tribal partners and marginalized communities that have historically been underrepresented in policy processes. The Task Force set out to seek input from:

- 492 Corrections Officers Labor Union Executive Board
- Bar Association
- Boards Task Force members serve on
- Building Owners and Managers Association
- Business community
- City of Spokane Community Assembly
- City of Spokane Valley email newsletter
- Council District 2 representatives
- County Medical Society
- Council of Governments
- County Sheriff comm staff
- District Court
- Downtown Spokane Partnership
- Dr. Velazquez's Facebook Livestream
- Emergency Department directors
- Experience Matters
- Fentanyl Roundtable
- Frontier Behavioral Health Executive Board
- Greater Spokane Inc.

- Greater Spokane Valley Chamber of Commerce
- Homeless advocacy organizations
- Housing Coalition
- ILA board
- Justice reform advocacy groups
- Law schools
- Leadership Spokane
- Low-Income Housing Consortium
- Mental health diversion coordinators
- Municipal Court
- NAACP conference committee
- Peer Spokane
- Recovery Café
- Rotary Club 21
- School families
- Special education community
- Spokane Justice Council
- Task Force Members' staff/leadership
- State agency contacts
- Superior Court
- Survivors councils
- Systems-impacted families
- Therapeutic/treatment court meetings
- Treatment court managers
- Tribal community organizations
- Union representatives
- Victims and survivors

To reach these audiences meaningfully, the Task Force employed engagement strategies that combined broad public awareness efforts with targeted outreach. A dedicated project website

and earned media kept the broader public informed and provided channels for ongoing feedback. Task Force and Advisory Committee members served as active messengers within their own networks, extending the reach of the process into communities and sectors the consulting team could not access alone. A suite of materials, including flyers, communications toolkits, and feedback forms, was developed to support these efforts and ensure consistent messaging.

More structured engagement activities, including a series of webinars, peer-organized focus groups, interviews, and listening sessions were deployed throughout the process to gather substantive input at key decision points.

Engagement was sequenced to align with the Task Force's phased process — input gathered early helped frame the Asset Assessment findings and establish priorities, while later engagement tested emerging recommendations against community experience and surfaced implementation considerations that technical analysis alone would have missed.

The themes and priorities that emerged from this engagement are woven throughout the recommendations in this report. Community voices consistently reinforced the urgency of addressing housing instability, expanding crisis response capacity, and ensuring that people leaving jail have real pathways to stability and recovery. They also challenged the Task Force to hold equity and lived experience as a standard against which recommendations should be measured.

V. NATIONAL TRENDS AND AN OVERVIEW OF SPOKANE'S EFFORTS

Across the United States, research shows a persistent pattern where individuals with untreated or undertreated behavioral health conditions repeatedly cycle between jails, hospital emergency rooms (ER), and homelessness. In many communities, jails have effectively become de facto behavioral health institutions, as they increasingly house individuals with untreated mental health and substance use disorders in the absence of adequate community-based treatment and crisis services. National estimates commonly find:

- Roughly 40 to 50% of people incarcerated in jails report mental health conditions.
- A substantial portion meet criteria for serious mental illness or serious psychological distress.
- Substance use disorders are even more prevalent, often co-occurring with mental illness.

Jails and emergency rooms are essential for acute crisis response, but they are not designed to provide the continuous, coordinated, and person-centered care required to effectively treat behavioral health conditions. In addition, relying on jails and health care systems is costly in these scenarios.

Trends

The trends described below are universal and experienced by jurisdictions of all sizes, from large urban centers to small, rural areas.

High system utilizers. A small subset of individuals account for a large share of systems use—jail bookings, ER visits, and crisis calls. Data from Federal evaluations, state research, and well-documented local models show that diversion systems are most effective in achieving outcomes and cutting costs when they prioritize high utilizers.

Relationship between incarceration and homelessness. People leaving jail are at high risk of becoming homeless shortly after release and people experiencing homelessness are at higher risk of arrest and incarceration.

Emergency rooms that function as default crisis responders. ERs are frequently used for psychiatric crises and substance use withdrawal, but people are discharged without a stabilization plan.

Jails that function as mental health crisis systems. National studies show a rising use of psychotropic Medications for Opioid Use Disorder in jails. As a result, jails are increasingly tasked with medication stabilization, crisis management, and short-term psychiatric containment. Jails are not designed to play this role.

System fragmentation. The fragmentation of the system perpetuates the problem with individuals repeatedly falling through the gaps. Structural issues include: inadequate housing options, insufficient community-based mental health treatment capacity, limited crisis alternatives to jail and the ER, fragmented funding streams, and little to no cross-system data sharing.

Recognition of incarceration's harmful effects on mental health. Research shows incarceration can worsen psychiatric symptoms, increase depression, PTSD and anxiety, and destabilize housing and employment upon release.

Expansion of diversion and crisis alternatives. Many communities are implementing co-responder models (e.g., police and behavioral health clinicians/peer partners), crisis stabilization centers, mobile crisis teams, jail diversion programs, and "high utilizer" care coordination programs. Despite these efforts, in many cases scale is uneven, coverage gaps remain significant, and housing availability limits effectiveness.

Beyond the human toll, system fragmentation carries a significant fiscal cost. Housing someone in jail for untreated behavioral health needs costs far more per day than community-based treatment or supportive housing. Emergency department visits for psychiatric crises that go unresolved generate repeated costs with no stabilizing outcome. High utilizers — a small subset of individuals — account for a disproportionate share of jail bookings, ER visits, and crisis calls, driving costs across multiple systems simultaneously. While Spokane-specific cost modeling is ongoing, national data consistently shows that coordinated diversion and treatment systems produce meaningful cost savings compared to crisis-driven cycling — savings that can be reinvested in the very services that reduce demand on jails and ERs. The argument for reform is not just moral; it is fiscal.

Best Practices

While a number of organizations and communities offer best practices for addressing the cycle of people with behavioral health needs moving between jail, emergency departments, and homelessness, the Substance Abuse and Mental Health Services Administration (SAMHSA) is the most influential resource. Below are SAMHSA's best practices for addressing the cycle of people with behavioral health conditions moving between jail, emergency departments, and homelessness.

1. **Prioritize diversion to treatment over incarceration.** Implement diversion at pre-arrest and pretrial using models such as Crisis Intervention Teams (CIT), co-response, and specialty courts.
2. **Use standardized screening, assessment, and identification.** Conduct universal screening and assessment at law enforcement contact, booking, and court intake. Use results to guide diversion and treatment placement so that people are matched to the appropriate level of care.

3. **Expand community-based behavioral health treatment.** Provide outpatient mental health care, substance use treatment (including MOUD), and peer support services. Ensure services are accessible, culturally responsive, and low barrier.
4. **Build strong crisis response systems outside ERs and jails.** Develop mobile crisis teams, crisis stabilization services, 24/7 crisis response systems. Integrate crisis lines (e.g., 988) with local response.
5. **Invest in housing as a core component of recovery.** SAMHSA explicitly identifies housing as essential to recovery and system stabilization. Expand recovery housing and supportive housing. Pair housing with behavioral health services and recovery supports.
6. **Ensure continuity of care during and after incarceration.** A major SAMHSA priority is preventing gaps in care at release. Begin discharge planning before release. Ensure medication continuity, health insurance activation (e.g., Medicaid), and scheduled appointments. Provide case management and peer navigation.
7. **Use case management and care coordination.** Assign care coordinators or case managers and develop individualized service plans. Coordinate across: justice, health care, behavioral health, and housing.
8. **Strengthen cross-system collaboration and data sharing.** SAMHSA emphasizes that no single system can solve the issue alone. Create a seamless system of care rather than siloed services. Formalize partnerships across law enforcement, courts, behavioral health providers, and housing agencies. Use shared data and integrated systems.
9. **Address reentry barriers (housing, employment, benefits).** Ensure access to housing, employment supports, transportation, public benefits. Remove barriers that increase risk of relapse and re-incarceration.
10. **Emphasize recovery-oriented, person-centered care.** Across all guidance, SAMHSA stresses that systems should support recovery through person-centered approaches, trauma-informed care, and recovery as a long-term process.

In addition to these best practices, Justice Center models have emerged across the Country. A justice center model offers a more effective and efficient approach by aligning criminal justice, behavioral health, and housing systems around coordinated intervention, reducing repeated system contact, improving public safety outcomes, and making better use of limited public resources. While expanding treatment and prevention, jail facilities will remain necessary for individuals who pose an immediate risk to public safety or whose actions require accountability under the law. Understanding this intersection, below are promising practices related to facility development and operations.1

[1] Justice Systems Partners, 2020; National Council for Mental Wellbeing, 2021; Balfour & Zeller, 2023; Kubiak et al., 2019

Facility Planning and Development

Effective facility planning requires building the data foundation, stakeholder alignment, and resource strategy that will determine whether a new or modernized facility can deliver better outcomes than the one it replaces. Communities that have successfully developed justice center models consistently point to the following planning elements as essential:

1. Gather data to determine if this alternate pathway is feasible and impactful. Data should help stakeholders understand the people we hope to serve and to help build consensus. Common data elements include:
    - Daily jail population
    - Proportion of people in jail who have a serious mental health need and/or substance use disorder (SUD)
    - Proportion of people in jail with low-level misdemeanors and felonies
    - Proportion of people in jail with low-level misdemeanors and felonies that have a serious mental health need and/or SUD
    - Number of jail bookings (12-month period), disaggregated by charge type
    - Average length of stay for this population
    - Court filing (charge and class) and disposition
    - Homeless management information system (HMIS) data re: housing status and needs
2. Map diversion alternatives, crisis system and all services to identify resources, gaps and opportunities.
3. Build a cross-sector modeling team: Approach continuum gaps strategically and through a phased approach. Most successful approaches have been built over time and engage in annual capacity reviews. This model embraces a continuity of care that builds trauma informed systems and facilities (vertical and horizontal flow).
4. Ensure law enforcement and prosecutor stakeholder involvement and voice & implement law enforcement friendly policies.
5. Establish a data governance structure:
    - Data use agreements and MOU’s must be in place.
    - Advanced, integrated technology to help manage individuals across systems/needs/crisis. Can track customer experience and performance. User friendly, portable EHR system.
6. Identify and secure resources across private partnership, state, and local funding. Utilize Medicaid funding if available/allowed.

Facility/Systems Operations

How a facility operates day-to-day is as important as how it is designed. The following operational practices are drawn from successful justice center models and reflect the principle that effective systems must be accessible, coordinated, and oriented toward moving people to the right level of care as quickly as possible:

1. Establish system and facilities that can easily accept individuals via “no wrong door” operations.
2. Use of mobile response teams.
3. Universal screening – use validated, standardized tools for screening and assessment.
4. Services should be robust and diverse and include data sharing agreements in order to minimize duplication of information collection.
5. Integrate peers across diversion and re-entry- they are the common denominator across all services/supports.
6. Daily staffing sessions (rapid exit team) between clinical team, jail and criminal justice stakeholders to identify individuals that can be moved to a lower level of care.

Spokane’s Experience

The City and County of Spokane are experiencing the same trends described above and have a long history of addressing the issue. The data below reflects the current scale of that challenge and emphasizes why incremental responses have not been sufficient. Spokane's jail population is large, behaviorally complex, and cycling through a system that lacks the treatment capacity, housing infrastructure, and coordination needed to produce desired outcomes. These statistics are the baseline against which the impact of the Task Force's recommendations should be measured:

A Snapshot of the Issue

Jail

- Average daily jail population: 700-800 individuals (WA State Dept. of Social Health Services)
- 58% of Medicaid enrollees booked into jail have mental health treatment needs, 61% have substance use disorder treatment needs, and 41% have indicators of co-occurring behavioral health disorders. (WA State Dept. of Social Health Services)
- Average book and release rate in 2025: 14% (Detention Services Dashboard)
- Average appearance rate for those in Supported Release Program from 2021-2026:92.5% (Office of Pretrial Services)

- In 2019, approximately half of the jail population was incarcerated on misdemeanor charges (Vera Institute of Justice)
- Average length of stay, pre-trial: 17 days (JFA Institute, 2019)

Behavioral Health

- Mental health was the leading cause of hospitalizations in 2021 (Spokane Co. Community Health Needs Assessment)
- Detox/withdrawal management capacity is limited relative to need
- Severe workforce shortage for outpatient and psychiatric care for adults and youth (American Psychiatric Association)
- Small and highly utilized inpatient bed base for youth
- Fragmented outpatient access for youth
- SUD youth capacity is constrained and rationed

Supportive Housing

- Critical supportive housing gap: 1,000+ units

History

1990s to 2000s

Spokane grew increasingly concerned about crime, substance use, and mental health crises. People with untreated behavioral health conditions were frequently encountering police, jails, and ERs with limited coordinated behavioral health diversion capacity.

Spokane Police Department developed early community policing and specialized units (including gang and crisis response approaches). Behavioral health crises largely handled through ERs, jail bookings, and inpatient psychiatric care.

At this point, there was no structured diversion system for frequent utilizers and separation between behavioral health, housing, and justice systems.

Early 2010s

There was a growing awareness in Spokane that a small group of individuals were repeatedly cycling through jail, ERs and homelessness services. Early regional efforts identified "high utilizers" of healthcare and crisis systems. Initial collaboration began between hospitals, behavioral health providers, and public systems. Data was beginning to demonstrate that system fragmentation was driving repeated crises.

In 2013, Spokane County Commissioners and the Mayor of Spokane chartered a three-person commission to make practical recommendations for improvements to the criminal justice system. In December of 2013, the commission's final report titled "A Blueprint for Reform" was published. In 2014, the Spokane Regional Law and Justice Council (SRLJC) was established to implement the Blueprint recommendations. Implementation of the Blueprint has been partial, with progress in governance coordination, pretrial services, and some diversion and crisis response initiatives, but the core recommendation of shifting away from jail reliance toward a fully integrated behavioral health and justice system has not been fully realized.

Mid to late 2010s

A major milestone during this time period was the expansion of the co-responder model. Spokane introduced formal co-responder teams, pairing law enforcement (SPD, Sheriff, Fire) and behavioral health clinicians. Police were no longer the sole responders to mental health crises, and the first structured efforts were made to divert people from jail and ERs. Early findings showed that most contacts did not result in arrest or hospitalization and there was a significant reduction in patrol burden and crisis escalation.

Late 2010s to early 2020s

Spokane expanded diversion and the infrastructure to support stabilization. The scale of the co-response team model was expanded and formalized. The focus was on de-escalation and linkage to services. Regional stabilization options were developed, resulting in the Spokane Regional Stabilization Center. Voluntary diversion began to move eligible individuals into treatment instead of incarceration.

In 2019, the County Commissioners created a community consulting task force to advise them on how best to decrease the need for future jail beds. The Justice Task Force was larger than the existing Spokane Regional Law and Justice Council and included a diverse representation of stakeholders. A majority of the final recommendations had complete consensus, and the balance had an overwhelming super majority of support. Subsequently, the report was not published or implemented.

Early 2020s

The Sequential Intercept Model (SIM) Assessment was completed and a Spokane Behavioral Health and Justice Summit was held to drive local priorities.

During this time, partners began identifying high utilizers and implemented care coordination pilot programs. The focus on housing as a stabilization intervention also increased during this time.

2020 to 2022

During this period, the co-responder system was formalized and evaluation began to show reduced system pressure. Specific milestones included:

- Expansion of Behavioral Health Unit and co-response teams Countywide
- Data showed large share of crisis contacts were diverted from jail or hospital systems
- Increased formal reporting of outcomes and reductions in patrol workload

2022–2024

Due to expanded behavioral health funding, there was growth in crisis stabilization beds, sobering services, and mobile crisis response capacity. System leaders recognized that crisis response alone was insufficient and housing and behavioral health integration would be required for long-term reduction in cycling.

In 2023, a statewide jail study by the Washington State Institute for Public Policy 2023 found that Washington jails, including Spokane County facilities, were experiencing increasing behavioral health needs, aging infrastructure, staffing and capacity constraints, and high pretrial turnover, reinforcing that jails were functioning primarily as short-term holding facilities rather than treatment environments capable of addressing the underlying drivers of system cycling. In November 2023, a ballot measure to fund a new jail and services in Spokane County failed.

2024–2026

The 2025 Washington State Jail Modernization Task Force Report Spokane concluded that jail modernization is necessary but not sufficient for Spokane. System outcomes will depend on parallel investment in diversion, housing stability, and behavioral health capacity. Furthermore, the report says workforce shortages will remain a limiting factor even with capital investment. An effective strategy requires alignment of jail planning with diversion, housing, and behavioral health system expansion.

Urgency Remains

The Leifman Group Asset Assessment and multiple other Spokane-specific system evaluations consistently indicate that, despite meaningful investments in crisis response and diversion capacity, many of the core issues fueling cross-system cycling remain unresolved. Those issues include:

- Poor system integration and coordination
- An inadequate detention facility
- Constrained behavioral health treatment capacity and prevention services
- Minimal data sharing
- Insufficient supportive housing capacity and housing instability

Taken together, these findings tell a consistent story: Spokane has made genuine investments in crisis response, and those investments have produced real results at the front end of the system. But incremental additions to a fragmented system are not the same as reforming it. The

structural drivers — inadequate facilities, siloed services, housing scarcity, insufficient treatment capacity, and absent data infrastructure — have not been addressed in a coordinated way. The Task Force was convened to do precisely that: to move Spokane from a posture of managing crises to one of preventing them, and from patching a broken system to rebuilding it around outcomes that matter.

VI. RECOMMENDATIONS

These recommendations reflect the ideas, expertise and commitment of a broad cross-section of community members, developed over nine months of discussion, learning and collaboration. These recommendations are a starting point for changing a complex behavioral health and justice system with many participants, responsibilities and points of entry. During this process, community members were able to define the problem, learn from successful approaches in other communities and identify strategies for action in Spokane. Several small groups of committed volunteers, including those with expertise in data and prevention, have already begun to develop priorities and implementation strategies. The recommendations are organized under the following strategic directions and framework:

Foundation: Develop a sustainable approach to accountability and coordination for a system of care.

A1: Establish a Cross-Sector Implementation Accountability and Coordination Council

Cross-System Coordination: Align public safety, behavioral health, and housing systems to function as a unified response to complex needs.

B1: Create and Leverage a Robust Data and Accountability System

B2: Formalize Partnerships to Support Upstream Prevention

B3: Integrate Peers at Each Step in the System

B4: Formalize Procedures across the System that Support Integrated Care Planning and Process: “Warm Handoffs”

New or Scaled Program, Service, or Process: Expand capacity at the highest-impact pressure points in the continuum of care.

C1: Scale Alternative Crisis Response Models

C2: Establish Coordinated Intake and Assessment with Shared Standards Across Entry Points

C3: Strengthen Pre-trial Diversion, Ensuring both Support and Accountability

C4: Focus Interventions on the High Utilizers of the Criminal Justice and Health Systems

C5: Expand Culturally Responsive Supports and Services for Targeted Prevention Populations

C6: Establish a Youth and Young Adult Prevention and Response System

C7: Make Strategic Workforce Investment across the Justice and Behavioral Health System

Facilities: Develop and modernize physical infrastructure to support an integrated system.

D1: Invest in Modern, Integrated Justice Facilities and the Coordinated Network of Community-Based Facilities That Advance Public Safety and Community Health

D2: Strengthen Housing Options

A1. ESTABLISH A CROSS-SECTOR IMPLEMENTATION ACCOUNTABILITY AND COORDINATION COUNCIL

Why This Recommendation is Important

The recommendations in this report span agencies, sectors, jurisdictions, funding streams, and systems of accountability. They cut across law enforcement, the courts, the jail, hospitals, behavioral health providers, community-based organizations, Tribal partners, and the public, private, philanthropic, and lived-experience partners who shaped this work. No single entity owns all of this work, and no single entity can deliver it alone.

Regional collaboration, accountability, and continued coordination are essential to this work, not supplemental to it. They are the foundation that underpins everything else in this report. Without a formal structure to drive this work across systems and across time, every other recommendation here is at risk of the fate of prior efforts: partial adoption, uneven implementation, stalled decision-making, and the loss of public trust that follows when the public sees ambitious plans produce limited results. The community cannot afford that outcome again. Goodwill brought these partners to the table and produced this report. Collaboration and accountability are what will be required to implement it.

This work cannot live inside a single government entity, and it cannot rise and fall with any single election cycle. The recommendations span too many systems for any one jurisdiction to carry alone, and the work of implementing them will outlast the terms of the leaders in office today. A structure controlled by a single agency cannot credibly hold that agency or its peers accountable. A structure tied to the political priorities of the moment cannot sustain the long-term focus that this work requires. A successful structure must sit across systems rather than inside one of them, and it must be designed to outlast the political cycles in which any one set of leaders serves. It must also bring together two kinds of members who are too often kept apart: people with the subject and systems expertise to understand what these recommendations require – including lived experience and subject matter expertise – and people with the power and authority to make decisions, align resources, and effect change. Expertise without authority produces analysis that goes nowhere. Authority without expertise produces decisions that miss what matters. Both are needed, working together, for this foundation to hold.

Recommendations

Establish a cross-sector coordinating council to provide collaboration, accountability, and coordination for the recommendations in this report. This council should sit outside of any single government entity and convene the partners necessary to advance this work as a coordinated whole. The council should bring together the public, private, nonprofit, philanthropic, Tribal, victims' rights and lived-experience partners that the work requires, and it should be designed around three functions:

Cross-system coordination and collaboration

Many of these recommendations require coordination across agency and system boundaries. While formal governance and decision-making authority rests with the appropriate jurisdictions and public entities, successful implementation will require structured collaboration with the cross-sector partners that have shaped these recommendations. A clear collaboration and coordination structure is needed to define roles, support shared problem-solving, align implementation efforts, and ensure that partners remain meaningfully involved as the recommendations move forward. This effort requires cross-jurisdictional commitment and dedicated staffing and operating support.

Accountability for completion

The community needs a named accountability pathway, independent of any single ballot measure or election cycle, which monitors progress against these recommendations, reports publicly on a defined cadence, and has the standing to escalate when implementation stalls. Without this, the recommendations risk the same fate as prior efforts.

Continued cross-sector coordination

The work of this Task Force has demonstrated what cross-sector coordination can produce when public, private, nonprofit, philanthropic, Tribal, victims' rights and lived-experience partners come together around a shared challenge. The wins this work produces are the collective impact from regularly being at the same table: community outcomes that exist because partners aligned across systems to produce them. That kind of convening, planning, and coordination must continue beyond the publication of this report.

Composition is as important as form. The council should include:

- People with the subject and systems expertise needed to ensure decisions remain grounded in the realities of the systems these recommendations are intended to change. This includes both lived experience and subject matter expertise across justice, victims' services, behavioral health, healthcare, housing, and community-based services.
- People with the power and authority to make decisions, align resources, and effect change based on the recommendations and opportunities that come out of this work, so that what the structure surfaces is acted on rather than only observed.

Immediate Steps:

- Convene the Planning Team and Advisory Group leads to develop an initial proposed collaboration, accountability, and coordination structure that can then be vetted and refined by the public, private, nonprofit, philanthropic, Tribal, victims' rights and lived-experience partners. Goal is design (3-6 months), stand up (6-12 months) and ongoing full operation.
- Define the roles, decision rights, and relationships between this structure and the formal governance and decision-making authority that rests with the appropriate jurisdictions and public entities.
- Establish intergovernmental agreements (IGAs) among participating jurisdictions and public entities to formalize their commitment to this structure and to cross-system collaboration, including the data-sharing agreements required for coordinated implementation and accountability.
- Ensure composition includes both lived experience and subject matter expertise alongside members with the authority to make decisions, align resources, and effect change.
- Establish a public reporting cadence on progress against the recommendations in this report, with the standing to escalate when implementation stalls.
- Identify the staffing, operating support, and resources needed for this structure to function durably beyond the life of the Task Force.
- Design this structure to operate independently of any single jurisdictional organization, so that accountability and coordination persist over the time horizon implementation requires.

Desired Outcomes

- A durable, cross-sector coordinating council is in place before significant implementation begins.
- Public reporting on progress against the recommendations occurs on a defined cadence.
- Cross-sector partners – public, private, nonprofit, philanthropic, Tribal, victims' rights and lived-experience – remain meaningfully involved in implementation and able to surface coordination issues that span agency boundaries.
- Implementation of the recommendations in this report does not stall, fragment, or lose momentum across leadership and election cycles.
- The council has the standing to escalate when implementation stalls and the credibility to convene the partners needed to resolve barriers.

B1. Create and Leverage a Robust Data and Accountability System

Why This Recommendation is Important

Spokane cannot fix what it cannot see. The continuum of care system in Spokane is not operating effectively, and the community has no shared way to measure how badly, where, or for whom. Too many people in crisis on the streets. The jail is overcrowded and staff are struggling with people suffering from mental illness and substance use disorder. Needed services are sometimes underused and sometimes forced to turn people away.

Spokane's current siloed data systems force agencies to duplicate work, delay intervention, and miss opportunities to coordinate care. The result is a fragmented and more expensive system, in which taxpayers fund repeated crisis response without clear visibility into outcomes or return on investment. Every system touches the same people, but no system can see the full picture. And every system bills the public separately for what is, in practice, the same unresolved problem.

Most of what we know about how Spokane's systems work is anecdotal or drawn from individual programs in isolation. Without coordinated data, the community cannot see the scale of need, the effectiveness of current services, or where investments are paying off. That is a problem of accountability as much as operations: when impact cannot be measured, well-functioning programs cannot make the case for the resources they need. And any request for additional public revenue will meet, reasonably, with skepticism from a community that cannot see what its current investment is producing.

Recommendations

The first step for all the recommendations in the report is collecting and organizing the data on how the current system is working, where the gaps and needs are, and how to measure success. Many of the recommendations have data associated with them; that data may be dispersed among agencies and simply needs to be identified and consolidated. Spokane has some notable strengths in this area. The jail has a robust and transparent website showing key trends and metrics. A volunteer team within the Safe and Healthy Spokane Task Force, drawing on multiple systems, has already begun developing a coordinated data framework. Their goal is to establish a best practice cross-system data sharing structure that enables timely, secure, and privacy-compliant exchange of information across justice, behavioral health, healthcare, housing, and community-based service providers to improve coordination and outcomes for high-need individuals.

Build an integrated data and accountability system that connects the agencies and providers across Spokane's continuum of care, enables real-time coordination for individuals with the highest needs, and gives the community visible measures of how systems are performing. This replaces a status quo in which agencies operate in informational silos and the public cannot see what its investments are producing. It treats data and outcome measurement not as a back-office function, but as core infrastructure for a coordinated system.

The result is a system that can see itself: that knows where high utilizers are entering, what services they are receiving, where handoffs are succeeding or failing, and what the public is getting in return for its investment. It eliminates duplicated assessments. It surfaces cost drivers across agencies that no single agency can see alone. And it gives taxpayers, elected officials, and service providers a shared, public picture of whether Spokane's systems are getting better or not.

Developing and solving one process at a time will be the initial practical approach, because incremental, consistent and achievable progress is more valuable than ambitious but stalled efforts.

Immediate Steps

- Research centralized or interoperable data platforms that allow authorized partners to identify high utilizers, coordinate care plans, and support warm handoffs in real time.
- Complete the data mapping process for justice systems currently underway, identifying data fields (who has them, who gets what data, needed permissions).
- Develop standardized data-sharing agreements and data governance for information-related processes including strong safeguards for privacy and equity, while enabling aggregated analytics to inform planning and resource allocation.
- Require metrics and outcome reporting for all programs in the system and in all funding allocations.

For Future Planning

- Implement a universal Release of Information tool.
- Implement a system wide data platform.
- Build toward a broader, integrated public dashboard that combines corrections facility, behavioral health, crisis response, courts, and other system data, building on the strong example of the existing corrections facility dashboard so the public, providers, and decision-makers can see system performance as a whole.

Desired Outcomes

- Develop a system of data-driven decision-making that improves efficiency and effectiveness while decreasing the instance of people being placed in over-burdened and inadequate interventions.
- Reduce duplication of data entry and assessments.
- Reduce administrative burdens, freeing up more time for services.
- Increase coordination and effectiveness of case management services for people in the system.

- Increase the number of agencies participating in common data systems.
- Identify high utilizers and successful prevention strategies.
- Provide dependable, transparent data dashboards to providers, users and the public.

B2. Formalize Partnerships to Support Upstream Prevention

Why This Recommendation is Important

Early prevention in the justice and behavioral health systems can change the trajectory of a life. It can prevent decades of cycling through the justice, health and behavioral health systems. It can save a community millions in avoidable costs. And it can spare families the heartbreak of watching a loved one cycle through systems that intervened only after the damage was done.

Spokane's current systems often wait until release, discharge, or crisis escalation before services begin, which weakens continuity of care and increases the likelihood of repeated system involvement. Upstream prevention strategies reverse that sequence. It starts with youth and first-time system contacts to provide mental health and substance use services before people enter the justice system, and it continues all along the continuum of care. Many people who encounter the justice system or crisis services have complex behavioral health, substance use, or social needs, and waiting until after release, discharge, or crisis escalation makes successful connection far less likely and individuals are more likely to fall through the cracks, experience repeated crises, or reenter the justice system.

Research consistently demonstrates that unresolved trauma and adverse childhood experiences (ACEs) are among the strongest predictors of later behavioral health disorders, substance use disorders, homelessness, and justice-system involvement. Exposure to violence, abuse, neglect, chronic instability, and untreated childhood trauma can alter neurological development, impair emotional regulation, and significantly increase the likelihood of self-medication through substance use and later involvement with crisis, healthcare, and criminal justice systems. Effective upstream prevention therefore requires trauma-informed, early-intervention strategies that identify and respond to trauma before individuals enter crisis pathways. Spokane should prioritize trauma-informed screening, early identification, resilience-building, family supports, and school-based interventions as core components of its prevention strategy.

Recommendations

Formalize proactive prevention partnerships to engage adults and youth with behavioral health, substance use, or social support needs before they leave the corrections facility, juvenile detention, hospitals, or other systems of care. This shifts the starting point of engagement from release to arrival, so that the work of connection begins the moment someone enters the system, not the moment they leave it. The work includes deploying trained case managers, peer support specialists, or behavioral health professionals to meet individuals on-site, assess needs, and begin connecting them to services prior to release or discharge.

Engaging earlier builds trust, improves participation in treatment and diversion programs, strengthens continuity of care through warm handoffs, and reduces reliance on emergency services and incarceration. For taxpayers, that means fewer repeated crises, fewer avoidable admissions, and public investments that actually produce results.

The first step is to convene criminal justice system (adult and juvenile), school districts, service agencies, and those with lived experience to assess opportunities and needs, identify appropriate assessment tools and formalize protocols, partnerships, procedures and measures of accountability. Some of these actions can begin immediately with existing partnerships; others will require new investment in staffing and facilities design.

Immediate Steps

- Convene representatives of organizations including Tribal Nations, people of color, LGBTQ+, communities, faith-based institutions and the criminal justice system (adult and juvenile), school districts, service agencies, as formal partners in upstream prevention and ongoing support.
- Identify appropriate prevention and assessment tools with a track record of success and formalize protocols, partnerships, procedures and measures of accountability.
- Research and implement best practice, culturally responsive assessment tools for people at risk.
- Identify access requirements, staffing constraints, and labor considerations to implement prevention services for adult and juvenile corrections.

For Future Planning

- Support families alongside system-impacted individuals including policies that support family connection during incarceration, including communication access, as a protective factor for both youth and caregivers.
- Embed the opportunity for prevention strategies and processes in the design and operations of any new correction facilities.

Desired Outcomes

- The number of at-risk people identified, connected to preventive care and redirected from the justice system increases.
- All adults and youth in correctional settings are assessed and the process of connecting them to services begins prior to release.
- All incarcerated people have effective access to family and services support.

B3. Integrate Peers at Each Step in the System

Why This Recommendation is Important

Right now, people moving through Spokane's justice and behavioral health systems are too often navigating those systems alone. They face decisions about treatment, court, housing, and recovery without a guide who has been through it themselves and can translate the experience. The result is missed appointments, missed eligibility, and missed chances to break the cycle.

The evidence for peer support is strong. Mental Health America and the National Institutes of Health report that peer support improves mental health outcomes, decreases hospitalizations and inpatient days, increases appropriate outpatient use, and reduces overall service costs. Peer support will also be critical to the successful implementation of warm handoffs.

Peer support works because it does what professional support, on its own, often cannot. It reduces isolation and stigma through shared lived experience and connections to grassroots, cultural helping systems, mentors and healers. It builds trust where institutions have eroded it. It demystifies systems for people who have been navigating them alone. And it empowers individuals to make informed decisions about their own care and recovery.

Peers—individuals who have personally experienced behavioral health challenges, substance use recovery, or system involvement—can bridge gaps between people and services at every stage, from crisis response to reentry. Specially trained peers are well positioned to help demystify criminal proceedings and provide effective support to individuals who are facing criminal charges, where the system is complex and trust in institutions is often low. Utilizing peers is not a new idea. Jurisdictions around Washington State and across the country, including in Spokane, are increasingly incorporating this model into various service sectors because the evidence is clear: people are more likely to engage, follow through, and stabilize when paired with someone who has walked the same path.

Recommendations

Support the existing peer system with training and work towards building a network of Certified Peer Support Specialists. The goal is that individuals with lived experience in behavioral health, substance use, or system involvement will be integrated into providing “warm handoffs” in crisis response, law enforcement contact, pre-trial diversion, courts, hospitals, recovery services, shelters and treatment, the corrections facility, reentry, and community-based services. This embeds lived experience as a core part of how Spokane delivers care and connection, rather than treating it as a supplemental service. It moves peer support from the margins of the system to the structure of it, builds support and important relationships for people in the system.

Immediate Steps

- Convene organizations providing peer support to identify the system points where peers will make the biggest difference
- Expand peers in all phases of the system (including pretrial, public defense, victim advocacy, probation, health system providers).

- Assign peers when checking in with public defense and when leaving jail, linking peers to individuals at first appearance or booking and through all stages of court obligations.
- Invest in peer-led community spaces like recovery centers, day spaces, culturally grounded spaces, peer-led hubs - low cost / high impact.
- Support and/or fund efforts for education and work force development to create a larger pool of certified peer specialists, supporting peers who wish to become Certified Peer Support Specialists and/or to train for professional behavioral health jobs.

For Future Planning

- Generate list of peers and organizations online for people and organizations to find, and so it can be updated (include community workers, substance, etc.).
- Develop a system that provides training and accountability for a broad peer support network and certified peer support options, particularly in the therapeutic courts. Use the national Peer Recovery Support Specialist guidelines, which establish standards for individuals with lived experience in mental health or substance use recovery to provide mentoring, supervision, advocacy, and support. Key guidelines focus on certification (training, experience), ethical standards, sufficient pay and specialized supervision.
- Assign a peer to each individual as they navigate their journey from beginning to end of the justice and behavioral health systems to ensure warm handoff happens at every service/institution transition.
- Plan for a group of mutually funded peers that can be available to work alongside an in-custody case worker and County probation tasked with managing the individual cases. Plans for the new facility should include non-restricted spaces for these meetings to occur.

Desired Outcomes

The Peer Recovery Support Specialist guidelines suggest that a robust peer support system metrics framework should combine individual recovery progress, peer support quality, and system performance indicators, using validated tools, consistent measurement, and a recovery-oriented lens to guide improvement and accountability. Examples of recommended metrics include:

- Time without substance use
- Program completion success
- Work and education progress
- Service utilization rates
- Agency performance indicators

B4. Formalize Procedures across the System that Support Integrated Care Planning and Process: “Warm Handoffs”

Why This Recommendation is Important

Across the country and in Spokane, people with complex needs routinely fall through the gaps between crisis response, treatment, housing, and reentry services. Each transition between providers is a moment when the system either holds someone or potentially loses them. When these transitions are successful, practitioners in the field call them a “warm handoff.” Whether leaving a corrections facility for the community, moving from the emergency department to follow-up services, or stepping down from crisis stabilization to residential treatment, every handoff is a chance for connection or a point of failure. Right now, the system in Spokane is losing far too many.

The justice and behavioral health continuum of care is made up of dozens of siloed programs, providers, and institutions, each with their own regulations and funding requirements. For people in crisis or coming out of a corrections facility, often dealing with mental health needs, substance use, housing instability, and mistrust of institutions, the current system asks the impossible: navigate dozens of providers, comply with conflicting rules, and follow through on referrals while in the hardest moment of your life.

When people miss appointments, cannot access services they are eligible for, cannot reconcile conflicting expectations across providers, they are at risk of ending up back in the corrections facility, the emergency department and on the street, only to start the cycle all over again. Every failed handoff has a cost: to the individual, to first responders, to emergency rooms, and to corrections facility beds filled with people whose needs are clinical. Taxpayers pay for the same person to enter the same system again and again, never receiving the connected care that would have stopped the cycle the first time.

Spokane has an opportunity to build a stronger and more balanced continuum of care if prevention, family stabilization, youth investment, peer-led supports, culturally responsive organizations, and neighborhood-based community services are expressly linked and treated as core infrastructure and protected accordingly through funding, governance, and measurable accountability.

Recommendations

Behavioral health, deflection, diversion, and crisis response programs formalize warm handoffs as a standard procedure. This replaces the current default of passive referral, where a person is often handed a phone number or an appointment slip and left to follow through alone, with shared responsibility for successful connection. When an individual is referred from one intercept or service to another, the individual is formally introduced to the next provider and stays connected until the handoff is complete. Embedding warm handoffs will improve engagement, reduce gaps in care, strengthen accountability, and increase the effectiveness of

Spokane's prevention, deflection, diversion, and crisis response systems, particularly for populations with complex behavioral health and social needs.

A successful warm handoff strategy for a person transitioning between institutions and services will contain a plan, a navigator, and a destination. Key intersections where a robust warm handoff will make the most difference for a person's stabilization and success include leaving a corrections facility and courts, the hospital and emergency room, the crisis stabilization center and residential treatment centers.

Immediate Steps

- Re-establish and support the behavioral health roundtable, monthly meetings for awareness and coordination.
- Convene partner agencies (pretrial, Jail, Courts, Prosecutors, Nonprofits, Spokane Transit Authority, Housing providers and those with lived experience) to begin communications and identify key transition points, assess needs, develop protocols and formal agreements to maintain accountability to a standard procedure.
- Develop universal release forms and procedures where correction facility release times and post crisis stabilization reliably coordinate with a "warm handoff."
- Review Case Manager/Care Coordinator and the Health Care Team processes, implementation of standardized protocols and development of a coordinated case management model.
- Implement Medicaid waivers to provide mental health and substance use disorder medications access from intake to release.
- Mandate reintegration programming (work release, work crew, CBT) so it is protected from budget cuts.
- Ensure housing placement is confirmed with formal Behavioral health provider relationships in place.
- Fund on-demand transportation from the receiving site to services.

For Future Planning

- Assign a navigator to each individual from beginning to end of their justice and behavioral health systems journey.
- Fund agencies to put in place the staff and processes to ensure solid transitions between institutions and services.
- Establish 24/7 permission processes for facilities drop-offs (in addition to PATH).

Desired Outcomes

- First-appointment attendance, leading to significantly reduced gaps in service.
- Attendance at the first appointment post release increases the gap between release and service engagement is reduced.
- The number of people completing their recovery plans and achieving stability increases.
- Recidivism and cycling back into institutions among people released from institutions and services decreases - Reduction in crisis system use.

C1. Scale Alternative Crisis Response Models

Why This Recommendation is Important

Not every crisis is a crime. When people experiencing a mental health or substance use crisis pose no safety risk to others, sending an alternative response is more effective, more humane, and less expensive than sending a police response. This is a national best practice.

Spokane has built important alternative crisis response capacity in recent years. The existing system provides trauma-informed care, reduces unnecessary arrests and hospitalizations, and frees up law enforcement to focus on calls that genuinely require a law enforcement response. But the system remains uneven, fragmented across the region, and overly dependent on high-cost responses when lower-acuity, community-based intervention could be more effective. Call volume to 988 continues to increase. Coverage gaps mean that the response a person receives still depends heavily on where they live and what time of day they call. Depending on the call and the location, the first responder may be law enforcement, fire, EMS, or a behavioral health responder, and which of these arrives first varies meaningfully across the city, the suburbs, and unincorporated parts of the county. A coordinated alternative response system has to start from that reality, ensuring that every type of first responder – not law enforcement alone – is connected to the right behavioral health resources and handoff pathways for the populations they encounter. Recovery, healing, stabilization, and prevention are most sustainable when rooted in community belonging, culture, and reciprocity.

Fragmentation is expensive. When a behavioral health crisis is met with a law enforcement response and an emergency room visit instead of a trained crisis responder and a stabilization bed, the public pays for the higher-cost response without getting the better outcome. This also occurs when a person with a dual diagnosis of mental illness and substance use disorder is turned away because the provider is equipped to treat only one issue. The same person often returns to the same crisis days or weeks later, generating another set of costs across another set of systems. Closing those gaps is not just better care. It is also a more effective use of public resources.

Recommendations

Spokane should continue expanding evidence-based pre-arrest deflection models that connect individuals experiencing behavioral health crises to treatment and stabilization rather than arrest

whenever safely appropriate. These strategies include Crisis Intervention Team (CIT) policing, co-responder programs, mobile crisis teams, non-law-enforcement crisis response models, peer-led crisis supports, coordinated 911/988 response systems, and law-enforcement-friendly diversion receiving sites that allow rapid clinical handoff in lieu of jail booking.

Scale Spokane's alternative crisis response system to provide consistent, region-wide coverage, with the staffing, infrastructure, and coordination needed to meet rising demand. Strengthening community-based crisis response improves both public safety and community health: it helps people get the right response earlier, reduces unnecessary arrests and hospitalizations, and preserves emergency resources, including law enforcement and emergency rooms, for the situations that truly require them. The result is a system in which the call you make in your worst moment reaches the right responder, regardless of where you live or when the crisis happens. These actions can make Spokane's alternative crisis response system more effective, equitable, and sustainable.

Any integrated behavioral health facility strategy should also evaluate inclusion of a non-refusal crisis receiving center that allows rapid law enforcement and first responder drop-off. These facilities significantly reduce officer wait times, decrease unnecessary jail bookings and emergency room utilization, and provide immediate clinical assessment and stabilization for individuals experiencing behavioral health crises.

Immediate Steps

- Investigate the effective mechanism of the Allegheny County alternative emergency response TEAMS program and other best practices to strengthen 911/988 coordination and establish clear protocols for when law enforcement vs alternative response is deployed.
- Use Medicaid waivers to provide continuation of medications for mental health and substance use disorder from intake to reentry.
- Evaluate establishing a non-refusal crisis receiving center that allows rapid law enforcement and first responder drop-off.
- Identify and offer services to a person's support system in every crisis contact including children, youth, and adults.
- Include efforts that limit harm exposure in system response.
- Ensure broad community awareness of available crisis response options.

For Future Planning

- Expand crisis responders/non-police crisis teams including Children Youth Family Mobile Crisis Team, Mobile Rapid Response Crisis Team, Mobile Community Assertive Treatment, Behavioral Health Units (responds to people in immediate crisis) and Homeless Outreach (provides on-going case management and warm hand-off to

community resource) and Designated Crisis Responders, inclusive of peers and clinicians.

- Staff first responders with licensed clinicians.
- Create a “what works” data loop: Identify top performing programs and use this to standardize metrics of “success,” providing clear and transparent data about outcomes and introducing accountability measures into deflection protocols.
- Expand county/west plains/airway heights co-responders with the Fire Department.
- Consider other resources such as peer respite in addition to a 23’59” unit including expanding peer-run respite options in home-like settings.
- Ensure no wrong door for people with dual diagnoses of mental health and substance use disorder.
- Fund and activate a network of Community Resource Centers.

Desired Outcomes

- Recidivism for people in the program declines
- Number of people who stabilize and are no longer homeless
- Neighborhoods impacted by drug markets and crime report feeling safer
- ER and crisis utilization reduction declines

C2. Establish Coordinated Intake and Assessment with Shared Standards Across Entry Points

Why This Recommendation is Important

People enter Spokane's justice and behavioral health systems through many doors: through law enforcement, through the courts, through corrections facility bookings, through hospital and school encounters. The assessment they receive at each of those doors sets the trajectory of what follows. Done well, intake informs and provides guidance throughout the cycle. The right assessment leads to the right service at the right time, and a person leaves the system more stable than they entered it. Done poorly, intake feeds the cycle. The wrong assessment, or no assessment, may send a person into repeated crises, repeated contact, and a system that grows more expensive with every return.

Spokane's current intake process is siloed and fragmented across law enforcement, courts, the jail, and hospitals, leading to inconsistent screening, duplicated assessments, delayed service matching, and missed opportunities to intervene earlier and more effectively. A coordinated system uses standardized, best practice assessment tools and processes across every entry point, allowing for quick identification of behavioral health needs, risk levels, and eligibility for

diversion or treatment programs, whether someone enters through arrest, the courts, a hospital encounter, a community provider, or self-referral.

Recommendations

Establish a coordinated intake and assessment system that ensures consistent and timely identification of risks, needs, and service eligibility regardless of how a person enters. These recommendations reform the current patchwork approach by aligning standards, tools, data, and handoffs across all entry points, including law enforcement, courts, the corrections facility, hospitals, behavioral health providers, community-based organizations, while recognizing that an expanded and better-equipped intake function is particularly critical for individuals being arrested or detained. This system uses standardized, trauma-informed screening tools; coordinates across law enforcement, courts, corrections facilities, hospitals, behavioral health providers, community-based organizations; and facilitates warm handoffs to treatment, diversion programs, or supportive services. The data generated by this process feeds the broader accountability system, giving Spokane a comprehensive picture of who is entering the system, why, and what happens next. This ensures that all referrals are handled consistently, equitably, and in a way that prioritizes safety and compliance.

Spokane should incorporate validated screening tools into coordinated intake, screening, diversion, supervision, and treatment planning. Validated screening tools should assess criminogenic risk, behavioral health needs, substance use disorders, trauma exposure, and responsivity factors at jail intake and other key intercepts. Using validated tools improves decision-making by helping systems identify who can safely be diverted, what level of supervision is appropriate, and what treatment and support services are most likely to reduce recidivism and improve outcomes. Low-risk individuals should generally be diverted away from deeper justice-system involvement, while higher-risk individuals should receive more intensive supervision and treatment interventions tailored to their specific needs.

Immediate Steps

- Create universal screening and assessment procedures, based on point of contact/entry (e.g. jail booking, pretrial screening, probation, treatment court, re-entry).
- Explore use of the Medicaid Waiver program the first 90 days of incarceration to fund services.
- Re-implement a validated pretrial risk assessment tool in Superior and District Court.

For Future Planning

- Build stronger intake capacity, both facilities and staffing, at the law enforcement and corrections entry point, which serves the highest-acuity population and is the most consequential for downstream outcomes.

- Establish multiple coordinated entry pathways – including self-referral, community-based referral, and clinical referral – that connect to the same standardized assessment, data, and handoff infrastructure as law enforcement and court-based intake.
- Align prosecutors and public defenders, County, and City policies on intake, booking, deflection and diversion.
- Implement a Universal, validated risk/need and behavioral health screening tool. Identifying tested, validated tools and practices. The tool needs to be guided by input and oversight by Law Enforcement, Superior, District and Municipal Court, Probation, Pretrial, Fire Departments, and other contracting cities.
- Include an on-site magistrate to improve efficiency and timeliness of actions.

Desired Outcomes

- Reduced time between arrest to referral to initial service connection or engagement with a diversion program or therapeutic Court
- High rate of completion/compliance of required program
- Client satisfaction
- Reduction in crisis system utilization

C3. Strengthen Pre-trial Diversion, Ensuring both Support and Accountability

Why This Recommendation is Important

Booking is the most expensive front door in the system. When someone is arrested for a low-level offense and the underlying issue is untreated mental illness, addiction, or homelessness, the corrections facility is being asked to do work it was not built to do. In many cases, the current system defaults to the criminal justice system, because the alternatives have not been built to scale. National data consistently shows that people with serious mental illnesses are vastly overrepresented in the criminal justice system, often cycling repeatedly through expensive and ineffective crisis responses that do little to improve public safety or individual outcomes.

Many individuals entering the corrections system are not there because they are dangerous as defined by the statutes. They are there because they lack access to mental health care, substance use treatment, or stable housing. Without effective diversion at the front end, those same individuals cycle through corrections, emergency departments, and crisis services, driving up public costs while failing to address underlying issues. The U.S. Surgeon General estimates that for every dollar spent in treatment, approximately $7 - 12 dollars can be saved in other social costs.

Pre-trial diversion offers a more effective alternative by redirecting eligible individuals into treatment and support services before their cases move deeper into the justice system. Well-designed diversion programs can reduce recidivism and connect people to care earlier. They also help reduce corrections facility overcrowding and preserve resources for higher-risk individuals who require secure custody.

Recommendations

Effective post-arrest diversion systems require rapid behavioral health screening at booking, coordinated clinical and judicial review, dedicated diversion staffing, peer navigation, and immediate linkage to treatment and housing supports. Diversion pathways should include misdemeanor and felony options, treatment court models, competency diversion alternatives, and structured reentry planning designed to reduce repeated cycling through jail, emergency departments, and homelessness systems.

Expand and strengthen pre-trial diversion programs to redirect individuals with low-level offenses—particularly those with behavioral health and substance use needs—away from the justice system and into appropriate community-based services. This recommendation is not only about expanding diversion capacity. It is also about reforming front-end justice processes that currently rely too heavily on booking and detention for people whose underlying needs are better addressed through treatment, stabilization, supervision, and support. Concretely, that means rebuilding the front end of the justice process around a first-appearance model in which every individual receives universal screening — behavioral health, substance use, housing stability, risk, and need — that determines the appropriate path forward, whether that is diversion, treatment, supervised release, or detention. Universal screening at first appearance replaces today's default of detention-by-omission with an evidence-based decision about what each person actually needs. This includes increasing eligibility, standardizing screening and referral processes at the earliest possible point (e.g., law enforcement contact, booking, or first appearance), and investing in diversion infrastructure such as case management, treatment capacity, and supportive services.

A stronger diversion system and set of diversion programming hold people accountable in ways that are clear, consistent, and proportionate, while ensuring that the corrections facility is reserved for the cases where it is genuinely the right response, not as the default for unmet behavioral health and social needs. Accountability is not the absence of assignment to a corrections facility, it is the presence of structure: clear expectations, swift and certain consequences for non-compliance, supported participation, and sustained engagement until the underlying issues are actually addressed. Participation in diversion is voluntary, but compliance is not. Once an individual opts into a diversion pathway, expectations are clear, responses are consistent, outcomes are measured, and participants are supported with the resources they need to succeed.

Operationally, this means investing in best-practice screening and risk assessment at the point of arrest and booking, so that decisions about who is eligible for diversion are made quickly and consistently. It means clear pathways for referrals to secure facilities or program-based settings depending on individual needs and risk. And it means strong oversight to ensure that diversion

remains a credible alternative, one that the public, the courts, and law enforcement can trust to deliver the outcomes it promises.

The County should also ensure strong coordination across courts, prosecutors, defense, and service providers, with an emphasis on culturally responsive approaches and the use of prevention and warm handoffs to support engagement.

Immediate Steps

- Change eligibility criteria and prosecutorial practices to expand eligibility for diversion for more individuals after charges are filed, enhancing pre-filing and post-booking diversion pathways.
- Use Medicaid waivers to provide continuation of medication for mental health and drug addiction from intake to reentry.
- Implement a jail population review team to continually assess incarcerated people's efficient and appropriate progress through the system.
- Upload materials onto tablets provided to individuals after booking that provide easy to understand, clear explanations about options.
- Ensure robust criminal justice system participation in program design (e.g., law enforcement, prosecutors, defenders, judiciary, victim rights and victim services advocates) and support regular convening meetings.
- Transition from direct filing to prosecution review with flags for diversion.
- Support Victim and Witness Services to ensure victims' rights, voices, and needs are formally represented in diversion design, charging and release decisions, program oversight, and outcome measurement and to provide a single, coordinated point of access for victims navigating the justice and behavioral health systems.
- Review and potentially expand criteria for existing diversion programs balanced with accountability for progress.
- Activate the Intake Center on county campus.
- Increase pretrial services to include a mental health/behavioral health partner to eliminate unneeded jail time.

For Future Planning

- Reform the corrections booking process to provide and require a more thorough assessment, establishing clear eligibility criteria (e.g., behavioral health, non-violent) based on best practices.

- Increase the number of case navigators and peers to align program options with individual needs and creating a hub (e.g., air traffic controller) that provides consistent information and resources for navigators.
- Increase staffing capacity: judges, attorneys, and staff, including case managers, diversion program coordinators, and behavioral health professionals and the systems that connect them.
- Create dedicated officers to enforce pre-trial release conditions (mirroring juvenile probation on the adult side).

Desired Outcomes

- Immediate access to treatment beds
- Families are connected during the process
- Recidivism for people in the program declines
- Percent of participants who complete treatment requirements increases
- Use of crisis services and emergency care
- Corrections facility capacity issues are mitigated, corrections facility usage declines, cost savings accrue
- Strong re-entry plans where outcomes are able to be measured

C4. Focus Interventions on the High Utilizers of the Criminal Justice and Health Systems

Why This Recommendation is Important

A small group of people drives an outsized share of public cost. Research across U.S. jurisdictions consistently finds that approximately 5 -10% of people involved in justice, health, and homelessness systems account for as much as 40-60% of system utilization and costs. The same individuals appear in corrections facility intake, the emergency room, and the shelter system, sometimes in the same week. They are the most visible expression of what fragmentation actually looks like, and the most expensive.

High utilization is often a symptom of system fragmentation. The same individuals repeatedly encounter disconnected services, short-term crisis responses, and gaps in housing, treatment, and follow-up that leave the underlying drivers unresolved. Each crisis is treated as a discrete event, when in fact each is a return visit. The result is a pattern that costs the public enormously, and that no single system can solve by itself.

Applying this pattern to Spokane suggests a relatively small population—potentially on the order of a few hundred individuals—who are high utilizers of multiple systems. These individuals are

more likely to cycle repeatedly through the corrections facility, generate frequent emergency room visits, and experience chronic homelessness, often simultaneously. Focusing intervention on this group could make a significant, immediate difference in corrections facility and court capacity, in emergency department volume, and in the visible crisis in the Spokane's streets and neighborhoods.

Recommendations

Establish a cross-system, coordinated intervention strategy focused on the small group of individuals who account for the largest share of public cost across justice, health, and homelessness systems. Identify the high users of the justice and health system in Spokane and coordinate resources to stabilize them in services. Communicate that initial costs for service consumption could be higher, but if successful this strategy will lower long term resource needs. Actions could include:

Spokane should explore the use of advanced technology and predictive analytic tools to support cross-system case management, identify high utilizers earlier, improve care coordination, and reduce fragmentation across behavioral health, healthcare, homelessness, and justice systems. Modern interoperable platforms can help providers and justice partners identify individuals with repeated crisis-system involvement, coordinate interventions in real time, support warm handoffs, and better allocate scarce public resources. Any implementation should include strong privacy protections, governance safeguards, and public accountability.

Immediate Steps

- Convene an inclusive group of stakeholders to evaluate current efforts and scale the program based on models and best practices.
- Expand the Hot Spotters/High Utilizer Program, which identifies people who frequently cycle through emergency, health, and justice systems and provides intensive, coordinated support to stabilize them.
- Prioritize using peer navigators prior to and at time of release from a corrections facility for high utilizers.

For Future Planning

- Invest in resources to set up and manage data and outcome systems.
- Create one place in the court system (a central docket for City and County cases) where high-need individuals have all their cases reviewed and managed together, instead of separately across different courts.

Desired Outcomes

- Reduced ER visits (pre/post)
- Reduced corrections facility bookings (pre/post)

- Increased Housing stability rate
- Reduction in total system cost per participant
- Participant engagement/retention completion of services increases

C5. Expand Culturally Responsive Supports and Services for Targeted Prevention Populations

Why This Recommendation is Important

Culturally responsive behavioral health services work. Studies published through the National Institutes of Health show that culturally responsive substance use disorder and mental health services lead to better patient outcomes, higher engagement, and stronger therapeutic alliances and can be up to four times more effective for minority groups compared to unadopted interventions.

Spokane's mainstream systems do not consistently meet people in culturally and linguistically appropriate ways, which contributes to lower engagement, poorer outcomes, and greater reliance on crisis-driven responses later. Disparities and gaps in behavioral health access and outcomes are driven in part by cultural and structural barriers, lack of culturally adapted interventions, and lack of awareness of services among institutions and providers. Everyone pays the cost of that gap: by individuals who never receive care that fits their needs, by families who watch a loved one cycle through systems that were not built for them, and by a public that pays again and again for the same crises that earlier engagement could have prevented.

Recommendations

Expand culturally responsive, community-based support and services for populations disproportionately impacted by behavioral health challenges and barriers to care. Engage Spokane organizations run by Tribal Nations, people of color, the LGBTQ+ communities with strong records of success. This includes investing in culturally specific providers and programs that are linguistically appropriate, trauma-informed, and grounded in the lived experiences of Indigenous communities, communities of color, and immigrant and refugee populations.

Pairing these efforts with targeted prevention strategies and approaches like upstream prevention and warm handoffs recommended elsewhere in this report compounds the impact. People are more likely to engage with services that meet them where they are. Disparities in access and outcomes narrow. And reliance on costly crisis systems such as emergency departments and corrections declines. The result is a system that is both more equitable and effective with public resources.

The first step would be to convene community organizations who represent impacted populations alongside service providers and people with lived experience to inventory assets, assess needs, opportunities and the robustness of data.

Immediate Steps

- Develop a program to increase awareness among providers in the behavioral health and justice system about existing culturally responsive resources in the system.
- Support the development of services and programs led by those closest to the impacts of the behavioral health and criminal justice systems in impacted communities.

For Future Planning

- Strengthen the County behavioral health and justice system workforce by increasing the number of bilingual and bicultural providers.
- Embed culturally responsive practices across mainstream services.
- Require that data systems disaggregate outcome data on behavioral health and justice system outcomes to assess impacts on culturally and demographically diverse communities.

Desired Outcomes

- Culturally appropriate services and workforce match the need
- The proportion of Indigenous, people of color and LGBTQ+ people in the corrections facility more accurately reflects local demographic proportions.
- Recidivism for people in the program declines
- Percent of participants who complete treatment requirements increase
- Clinical and recovery outcomes increase
- Use of crisis services and emergency care declines
- Disparities in access and outcomes declines
- Trust in providers and public systems by Indigenous people, people of color and LGBTQ people increases.

C6. Establish a Youth and Young Adult Prevention and Response System

Why This Recommendation is Important

By the time a young person reaches a crisis, the conditions that produced it have usually been visible for years, in schools, in homes, in healthcare encounters, in patterns that adults around them noticed but no system was organized to act on. Spokane County has strong systems in place to respond to crisis. However, data across all sectors—public health, education, behavioral health, and community safety—demonstrates that the conditions leading to these crises begin

much earlier and that what Spokane lacks is a coordinated way to act on what it sees long before the crisis arrives.

Many youth and young adults entering crisis systems have extensive histories of trauma exposure, including family instability, violence, abuse, neglect, and chronic adversity. Trauma significantly increases the risk of depression, anxiety, substance use disorders, school disengagement, homelessness, and later justice-system involvement. Effective youth prevention systems therefore must be trauma-informed at every level, incorporating trauma screening, family-centered interventions, resilience-building, and culturally responsive supports that interrupt the trajectory from early adversity to later crisis involvement.

A coordinated youth prevention system improves long-term community safety by addressing health, behavioral health, and family needs earlier, before they escalate into crisis or justice involvement. It is among the most direct ways Spokane can reduce future crises while reducing future costs, by ensuring that fewer crises develop in the first place. To change long-term outcomes, Spokane must invest at the earliest point of intervention before crisis occurs.

Data from the Spokane Regional Health District and Washington State Department of Health show:

- Increasing overdose trends, particularly driven by synthetic opioids such as fentanyl
- Significant impact among young adults ages 18–35

These findings confirm that overdose is not an isolated event, but the result of a trajectory of escalating risk and missed opportunities for earlier intervention.

Spokane County data from County Health Insights, the Healthy Youth Survey, and the DSHS Risk and Protection Profile demonstrate that protective factors such as strong adult relationships and school connectedness are not consistently present across all communities and children face a multitude of risk factors and exposure to violence.

Risk factors begin early in life, escalate through adolescence, and result in crisis outcomes in early adulthood—yet system investments are concentrated at the point of crisis rather than prevention. While Spokane has strong community-based organizations and crisis response systems, there is no coordinated, county-wide strategy that:

- Identifies risk early
- Strengthens protective factors
- Intervenes before youth enter crisis pathways

By investing in upstream prevention, Spokane can shift from reacting to crises to preventing them—reducing long-term system demand and improving outcomes for youth, families, and the broader community.

The current service landscape is fragmented across schools, healthcare providers, behavioral health programs, non-profits, juvenile justice, and homelessness services, resulting in

inconsistent access, delayed intervention, and frequent escalation to crisis-driven systems such as emergency departments, inpatient psychiatric care, and the justice system. This fragmentation is particularly acute for transition-age youth (approximately ages 16-25), who often fall between child-serving and adult systems of care. Every gap in this fragmented landscape carries forward. A young person who falls between child and adult services is often the same person who, years later, becomes a high utilizer of emergency rooms, the criminal justice system, and crisis response, at far greater public expense than early intervention would have required.

By shifting from a fragmented, crisis-driven approach to a coordinated prevention and response system, Spokane County can intervene earlier in the trajectory of need, improve long-term outcomes for youth and young adults, and reduce downstream reliance on high-cost emergency and justice system interventions.

Recommendations

Establish a coordinated, county-wide youth and young adult prevention and response system that begins with the populations most at risk and expands over time. Anchored in schools and delivered in partnership with community-based organizations, this system shifts Spokane's investment in young people from crisis response to crisis prevention. It identifies risk early, strengthens protective factors, and intervenes before young people enter the pathways that lead to emergency rooms, courtrooms, and detention cells. The Advisory Committee has developed a detailed plan for how this system would operate.

The Framework is a Tiered prevention model. Its core strategy is to implement a school-centered, community-partnered prevention model that ensures early identification, intervention, and connection to supports for youth in highest-need areas.

Immediate Steps

Tier 1: Universal Prevention (All Students) Delivered within schools in partnership with community-based organizations

For Future Planning

Tier 2: Targeted Early Intervention for students identified at risk

Tier 3: Coordinated referral pathways

Core Principle: Schools serve as the earliest and most consistent access point for prevention, while community-based organizations provide critical support and service delivery.

Key Program Components

- Early Identification Systems
- Integrated School Based Supports, Including Prevention Specialists
- Mental Health Literacy and Skill Building

- Basic Needs Stabilization
- Strengthening Protective Factors, Including Mentorship Programs
- Workforce and Future Pathways

The recommendations also include a plan for targeted start with geographic expansion. Expected outcomes are listed below.

Desired Outcomes

Short-Term

- Increased student connection to supports
- Improved attendance and engagement
- Increased identification of at-risk youth

Intermediate

- Reduction in behavioral health crises
- Reduced emergency system utilization

Long-Term

- Reduced substance use initiation
- Reduced overdose rates among young adults
- Reduced homelessness and system involvement
- Increased graduation and long-term success
- Improved family stability

C7. Make Strategic Workforce Investment Across the Justice and Behavioral Health System

Why This Recommendation is Important

Spokane is asking today's behavioral health, justice, community-based service providers, and corrections workforce to do work the current model was never built for. The complexity of today's behavioral health, crisis response, detention, diversion, and reentry needs has outpaced the staffing, training, and compensation structures designed in a different era. The result is delayed care, restricted access, unsafe working conditions, burnout, and reduced system effectiveness, for the people receiving services and the people delivering them.

The behavioral health workforce shows the strain most visibly. The CDC reports that the lack of mental health staff causes critical care delays, with over 90% of behavioral health workers reporting burnout, resulting in higher turnover rates (44% in 2022). Patients face long waitlists, reduced access to care, and the gap is increasingly absorbed by emergency departments: the most expensive and least therapeutic setting for behavioral health intervention.

Corrections officers carry one of the heaviest tolls. Their average life expectancy is approximately 59 years, 16 years younger than the national average. Their suicide rate is 39 percent higher. The December 2025 Washington State Jail Modernization Task Force report emphasized the challenging work environment for corrections officers -- the physical and emotional stress, pay and safety issues that make staff recruitment and retention difficult. Research consistently shows that working in corrections facilities also negatively impacts the mental health of officers.

The court and law enforcement systems face their own staffing crisis. The shortage of defenders, prosecutors, court staff, police officers and sheriffs causes severe, systemic bottlenecks, resulting in extended pretrial corrections facility stays, violated constitutional rights to counsel, and massive case backlogs. The downstream effects are exactly what no one wants: cases dismissed because they cannot be prosecuted, coerced plea deals, diminished public safety, and reduced public trust in the justice system.

In addition to shortages, the workforce's composition also matters. As behavioral health, justice, community health service providers and corrections have professionalized, the pipelines into these careers have not always reached the communities most affected by the systems they serve. People in crisis are best served by workers who understand their language, culture, and lived experience, and building that capacity strengthens trust, engagement in care, and outcomes, particularly for communities that have historically been underserved by these systems. A workforce that reflects all of Spokane is a workforce better equipped to do the work. Getting there means investing intentionally in recruitment, training, and pathways into these careers from communities currently underrepresented in them.

These patterns are visible across the country, and in Spokane. The behavioral health workforce shortage strains every part of the continuum the previous recommendations propose to build. The corrections workforce crisis is inseparable from the facilities questions this report addresses. The legal system shortages reach every diversion and accountability pathway this report describes. All these factors impact the continuum of care in Spokane and need to be addressed. Other recommendations in this report will provide savings, but additional, stable long-term funds will still be needed.

Recommendations

Strategic investments in compensation, retention, capacity, and the pipeline are required for system improvements elsewhere in this report to succeed. Recruitment alone is not enough; competitive wages, benefits, and working conditions are essential to retain the staff Spokane recruits and hires. Turnover is itself a cost to continuity of care, to institutional knowledge, and to the public investment already made in training each worker who leaves. Without a stable, well-

trained, and representative workforce, every other recommendation in this report — diversion, crisis response, treatment, reentry, modernized facilities — has nothing to operate on.

The Task Force recommends a coordinated, long-term workforce strategy developed in partnership with the institutions that train, recruit, and represent Spokane's workforce: Spokane Community Colleges and area universities, the regional workforce development council, Greater Spokane Incorporated, the area's minority business chambers, labor partners, Tribal partners, and behavioral health and justice system employers. This is not a one-agency effort. It is a regional planning effort that brings together the partners who can build the pipeline the system needs over the next decade and beyond.

The strategy should also include specific policy advocacy at the state legislature, where many of the funding, licensure, and credentialing decisions that shape this workforce are made.

Immediate Steps

- Develop a behavioral health and justice system workforce and community needs assessment update (for existing and future needs) in order to identify right people, right skill set and answer: “Where are we and where are the gaps?”. Determine whether data is present and what resources are already in place (e.g., Spokane Workforce Council, GSI, Launch NW, Education Orgs.).
- Develop a program to help peers train for professional behavioral health jobs.
- Establish partnerships with colleges and universities to aid in building needed. This would aid in research (data), content specialists, peer supports, supervision (degrees & licensing hours - this option increases their time with the program), and community partnerships.

For Future Planning

- Research and implement a competitive, appropriate pay scales and benefits packages sufficient to retain qualified staff, not only to recruit them.
- Develop a state legislative advocacy agenda to remove barriers to hiring and retaining justice and behavioral health staff.
- Convene Spokane Community Colleges, area universities, the regional workforce development council, Greater Spokane Incorporated, minority business chambers, labor partners, Tribal partners, and system employers in a coordinated workforce planning process with shared accountability for outcomes.
- Build intentional, merit-based pathways into these careers from communities currently underrepresented in the workforce, including paid training, apprenticeships, scholarship programs, and partnerships with K-12 and community-based organizations.
- Embed culturally responsive training as a core complement to professional training and licensure.

- Pursue state-level policy advocacy on funding, licensure, credentialing, and scope-of-practice issues that shape the workforce pipeline.

Desired Outcomes

- Increased availability of behavioral health and substance use disorder services.
- Reduced wait times for assessment, treatment, and crisis follow-up care.
- Improved access to care in high-demand areas (crisis, detox, psychiatry, outpatient)
- Reduced burnout and turnover among providers and frontline staff.
- Increased treatment capacity across the continuum of care.
- Reduced reliance on emergency departments, corrections facilities, and crisis systems due to capacity constraints.
- Reduced corrections facility demand as a result of reduced waits for court time.

D1. Invest in Modern, Integrated Justice Facilities and the Coordinated Network of Community-Based Facilities That Advance Public Safety and Community Health

Why This Recommendation is Important

Spokane needs to invest in appropriately sized justice facilities to meet its public safety responsibilities, while simultaneously it need to invest in community-based and public infrastructure – treatment, crisis stabilization, reentry housing, diversion receiving sites – that together make an integrated public safety and behavioral health system possible. Neither investment succeeds without the other and neither approach works in isolation. A 2021 University of Chicago study found that correctional facilities are unlikely to reduce reoffending unless they are transformed into institutions designed to change behavior, based on evidence of what works to support rehabilitation. A modernized justice facility without the community infrastructure to divert, treat, and receive people back into the community will not deliver the outcomes the public expects. A network of community facilities without a justice facility capable of safely and humanely holding people who must be incarcerated leaves a critical gap in the system.

Diversion, treatment, and community-based alternatives will resolve many situations more effectively than incarceration. But for serious and violent offenses, and where public safety requires it, incarceration will remain necessary. The question is not whether Spokane needs justice facilities, but whether the ones it has can do the job today's system requires – and whether the community-based facilities exist alongside them to make the system work as a whole.

Why Modern Justice Facilities Are Essential

Spokane's correctional facilities were not built for the work they are now being asked to do. They were not designed for the level of behavioral health, medical, reentry, family connection, programming, and workforce support that today's reality requires. They are not meeting the needs of incarcerated people, staff, service providers, or the broader community. And they cannot support the reforms outlined in this report or enable the community to achieve the results it aspires to.

Like facilities statewide, the Downtown Jail and Geiger Corrections Facilities face the kinds of problems that compound rather than resolve over time. Aging electrical, heating, cooling, and technology systems are increasingly expensive to maintain. They are not designed to support best practice programs like family visits and mental health services, cannot accommodate the proposed changes to intake and assessment. The current corrections system is not built to support best practice treatment options and lacks secure spaces needed for behavioral health stabilization or substance use treatment. Despite efforts, the existing facilities will not be able to be the high-quality workplaces where corrections officers can be safe, supported, or effective at the work the rest of this report asks of them.

Nearly everyone who enters a corrections facility eventually leaves it. Whether they return depends significantly on what happens during their time in custody, and on the support available when they leave. Modern justice facilities provide the accountability, supervision, and evidence-based programming proven to reduce reoffending, including treatment for the mental health and substance use conditions that often underlie criminal behavior, and the education, job training, and reentry preparation that help people build stable lives after release.

Why Community and Public Facilities are Essential

For the integrated system, the Task Force is recommending to function, the community-based facilities that surround the justice system must exist at the scale and quality the work requires. Community members report a shortfall of more than twenty beds for inpatient psychiatric treatment while detox and withdrawal management capacity is limited relative to need, even with the welcome addition of the soon to be open PATH facility. The small and highly utilized inpatient beds and substance use disorder treatment opportunities for youth are constrained and rationed.

Residential substance use treatment is constrained, and the few inpatient and substance Use Disorder options for youth are rationed against far greater need. Crisis stabilization, sobering, and 23-hour observation capacity falls short of what law enforcement and first responders need to divert from the corrections facility or the emergency department. Transitional and reentry housing is in short supply, breaking the warm handoffs from custody that reentry depends on. Culturally responsive providers remain too few.

Beyond capacity, the justice and behavioral health systems need facilities purpose-built for the populations they serve; spaces that support mental health and substance use stabilization and recovery, which offer culturally responsive options, and that function as safe and secure diversion receiving sites where law enforcement can hand off in real time. Without these, diversion exists only on paper.

Why These Investments Must Move Together

These are not two investments. They are two halves of one investment. Without community treatment capacity, the jail becomes the default response to mental health and addiction crises – and corrections officers end up doing work they were never meant to do. Modern, safe correctional facilities are an essential part of the public safety continuum and without them, law enforcement, prosecutors, and the courts lose the secure custody option that serious and violent offenses require. Diversion fails without receiving sites. Reentry fails without housing. Work done in custody recedes without services outside to continue it. Funded separately, neither investment delivers what the public is paying for. Funded together, they can.

Recommendations

This recommendation calls for facilities investments made together: right-sized justice facilities, and the community-based facilities required for an integrated system. Each is necessary. Neither is sufficient alone.

Public trust requires more than a new building and more than any single facility. To earn the support that previous proposals have not, the facilities plan must demonstrate not only what new infrastructure is needed across the justice system and community-based network, but how current practices, funding alignment, staffing models, and accountability systems will come alongside it. New facilities must be matched with funding for sufficient staff support and the programs that operate within them. And where coordination across agencies could reduce duplication, the plan must commit to it. The case for new investment is strongest when it is paired with a credible commitment to using existing investment better.

An integrated facilities plan that reflects the region's commitment to public safety, diversion, treatment, reentry, accountability, and more effective use of public resources across the continuum does not mean that Spokane is not starting from scratch on facilities. Many of the elements an integrated system requires – corrections facility capacity, the soon-to-open P.A.T.H. facility, inpatient beds, a crisis stabilization footprint, scattered community providers – already exist. They are not, however, coordinated with one another, and as a result they do not yet operate as a fully functioning system. These recommendations take what exists, identify what is missing, and connect them into something that works as a whole.

Spokane must address both modern, right-sized justice facilities and the build-out of the community-based facilities – treatment, crisis stabilization, reentry, diversion receiving sites – that an integrated system requires. Any decisions on criminal correction facilities and programming should distinguish between public, secure and custodial jail facilities. Each serve different needs and when used appropriately the community avoids unnecessary costs. The plan should approach these facilities as an ecosystem and in many cases as a co-located campus, asking deliberately where each function is best located for access and effectiveness so that related services can operate as a connected system rather than as scattered, disconnected sites. Justice facilities must be flexible by design, not as an afterthought to support both safety and health, enabling therapeutic programming, family connection, behavioral health services, staff safety, rehabilitation and smoother transitions back to the community as well as being able

to adapt as populations and policies that change over time. Community-based facilities must be built and funded at the scale needed to make diversion, treatment, and reentry real rather than aspirational.

Facilities decisions must be informed and use current best-practice research methods and go beyond future population modeling alone. They must examine the actual needs of the people incarcerated today — behavioral health acuity, substance use status, medical needs, housing status, length of stay, community risk, and partner with the courts to understand the populations moving through the system upstream. The bed types, support spaces, and program areas that need to be built or upgraded should be determined by that analysis. The evaluation of facility needs cannot be disconnected from the planning and design; it is a precondition for it. The recommendation is about the physical infrastructure that lets every other recommendation in this report succeed: the centralized intake from C2, the diversion strategies from C3, the prevention and warm handoffs from B4 and B2, the workforce conditions from C7, the data and accountability systems from B1. A facilities plan that does not advance these reforms is not the facilities plan this Task Force recommends.

The following criteria should be part of any facilities investment evaluation. The proposal brought to the public for funding facilities should be evaluated against the following principles that the Task Force expects to be addressed clearly:

1. Be evidence-based, adequate-sized and reflect strong regional collaboration
   - Capacity needs, both justice and community-based, must be established using fair, transparent analysis of population trends, behavioral health needs, legal obligations, and diversion commitments, avoiding both overbuilding and undercapacity.
   - Proposals need to be clearly based on data and evidence and designed to implement national best practices and the recommendations of recent studies by the State of Washington on jails, mental health and drug addiction needs.
   - Facilities should be based on effective agreements between political jurisdictions and institutional partners, adaptable to changing population needs and policy reforms, be built to last, easy to maintain, technologically modern.
2. Be seamlessly integrated and operating as one system
   - Correction facilities investments must be seamlessly integrated with, and clearly aligned to community-based facilities investments, and vice versa. The two are components of a single system that should be designed, located, sequenced, and operated together Proposals that fund one without the other do not meet this standard.
   - Capital plans should address corrections facility modernization, treatment capacity, reentry, housing and diversion infrastructure as a coordinated whole, and must explicitly demonstrate how the facilities support the reforms recommended elsewhere in this

report – centralized intake, diversion, prevention and warm handoffs, workforce conditions, and data and accountability systems.

3. Be paired with investments in alternatives to incarceration and operating funding
   - Capital investments in correction facilities must be accompanied by enforceable investments in diversion, treatment, housing, youth prevention and community-based facilities and by the operating funding required for the staff and programs that make any facilities, justice or community-based, function. Capital alone does not deliver outcomes.
   - Operating funding is required for the staff and programs, including investments in competitive salaries, adequate staff, and staff development to make the facilities, justice or community-based, functional.
4. Be designed for safety, dignity, and effectiveness
   - Facilities - whether jail, courts, community based or behavioral health - must:
     - Be safe for individuals, staff, families, and visitors
     - Provide medical care, education, vocational training, trauma informed processes and outdoor access
     - Support family and community visitation
     - Include confidential behavioral health treatment spaces
     - Designed to be participant centered, with fostering safe reintegration and reduced recidivism of participants as a top priority
   - Corrections facilities need to balance compassion with accountability to promote safety, health, rehabilitation, and recovery.
   - Like services should be appropriately grouped – clinically, operationally, and physically – so that related programs can share staff, referral pathways, security models, and infrastructure, and so that handoffs between them happen as part of normal operations rather than as exceptions. Grouping like services well is what allows each facility to function as part of a system rather than as a stand-alone building.
   - Proposals must identify measurable outcomes – recidivism, treatment completion, time-to-treatment, staff retention, diversion rates – that will be reported publicly on a defined cadence, so the public can judge whether the investment is delivering what was promised.
5. Be accessible, strategically located and future ready
   - Facilities must adequately serve all areas and jurisdictions in the county, including cities and tribal nations. Include community-based options that are well-located, accessible, culturally appropriate and adequately supported.

- Location criteria should support rapid diversion to services and easy accessibility, including public transportation, legal, reentry, and health resources. and be situated near adjacent land for future development where needed.
- Facilities should be adaptable to changing population needs and policy reforms – built to last, easy to maintain, and technologically modern.

6. Be feasible, flexible and fiscally responsible

- Proposals must document current facilities, programming, and staffing inefficiencies and commit to specific reforms. Before developing new facilities, assess current facilities, staffing and services, and explore reusing, expanding, and enhancing existing facilities and services before or alongside new investment. The case for new investment is strongest when it is paired with a credible commitment to using existing investment better.
- Capital investments must be accompanied by predictable, secure and durable investments in diversion, treatment, housing, and youth prevention.
- Projects must be realistic to fund and build, with clear operating cost projections and funding, and long-term sustainability plans including future growth needs for both justice and community-based facilities.

Immediate Steps

- Conduct a facilities needs study that explicitly evaluates how existing and proposed justice and community-based facilities support the reforms recommended elsewhere in this report and addresses corrections facility modernization, community-based treatment and crisis capacity, and diversion infrastructure as a coordinated whole, rather than as separate capital projects.
- Develop a regional facilities plan informed by the needs assessment, community input, and these recommendations.
- Enact a funding mechanism, such as a public safety sales tax, that adequately supports this integrated facilities plan and leverages existing and potential funding opportunities.

For Future Planning

- Invest in the inpatient psychiatric, detox, residential substance use treatment, crisis stabilization, sobering, and reentry housing capacity identified as gaps, with specific attention to youth capacity and culturally responsive providers.
- Establish secure diversion receiving sites that allow law enforcement and first responders to divert in real time.

- Build courtrooms inside justice and intake facilities, with an on-site magistrate available every day, so that first appearances, screening, release decisions, and case management happen in the same physical setting as booking, assessment, and supports, eliminating transport delays, reducing detention time for low-risk individuals, and tightening the loop between intake, screening, and judicial decision-making.
- Launch a public education effort that explain how facilities, services, and reforms work together as a system, including facilities tours and clear materials about how investments will be measured.

Desired Outcomes

- Adequate funding secured
- Needed behavioral health capacity created (beds/slots)
- Reduced corrections facility overcrowding rate
- Improved utilization and staffing levels
- Reduced wait time for behavioral health services
- Increase in proportion of justice-involved individuals connected to care
- Cost per person / system cost trend

D2. Strengthen Housing Options

Why This Recommendation is Important

You cannot stabilize a life without somewhere to live. Every recommendation in this report, diversion, treatment, reentry, crisis response, prevention, depends on a foundation that none of those systems can provide on their own. Housing is not a separate downstream issue. It is core public safety and public health infrastructure

Permanent supportive housing is one of the most effective and cost-effective interventions for individuals with serious mental illnesses, co-occurring substance use disorders, and repeated justice-system involvement. Supportive housing combines stable, affordable housing with wraparound behavioral health, case management, peer support, and recovery services. Research consistently demonstrates that supportive housing reduces homelessness, emergency room utilization, hospitalization, incarceration, and overall public-system costs while significantly improving long-term stability and recovery outcomes. Spokane should prioritize supportive housing expansion as a core behavioral health and public safety strategy, not simply a housing strategy.

The scale of Spokane's housing shortage compounds the problem.

Eastern Washington University's Institute for Public Policy & Economic Analysis showed that about 42,000 renters in Spokane County are burdened by their cost of housing. Some 54% of renters pay more than 30% of their income on their home. Of those, some 26% pay more than half of their income to stay in their homes. The Spokane Housing Authority is building more than 300 new affordable units, an important step that nonetheless underscores how much further the region must go.

For people exiting the justice, health, and behavioral health systems, this scarcity is acute. They are competing for limited inventory while carrying barriers that landlords often weigh heavily: criminal records, gaps in employment, lack of rental history, and the stigma still attached to mental illness and addiction. The result is that people who have successfully completed treatment, served their time, or stabilized through a crisis can return to homelessness, which sends them back through the same systems they were trying to leave.

Recommendations

Treat housing as core public safety and public health infrastructure, not as a separate downstream issue. Spokane should expand the diversity of housing options that the populations served by this report depend on, including expanding long-term housing solutions for people in recovery, removing barriers for people with Section 8 vouchers, exploring set asides by affordable housing providers, scattered site housing and landlord support programs in the private market. Housing built in isolation from these populations will not solve the problem this recommendation addresses, and reforms to the broader system will fall short without housing built to receive the people those reforms are intended to help.

Immediate Steps

- Identify current housing options and conduct gap analysis to prioritize advocacy and action.
- Facilitate regular coordination between City and County Housing Departments and housing and peer navigators.

For Future Planning

- Develop additional scattered site housing options across the County.
- Include incentives and funding for housing options in facilities funding packages.
- Explore programs that provide services and support to landlords in the private market to encourage them to house people in diversion programs.
- Consider using Medicaid Waivers 1115 for housing support.

Desired Outcomes

- Reduce the time from referral to housing placement

- Increased housing placement rate
- Increased retention in housing
- Increased number of housing units added (by type)
- Reduced waitlist size / wait time
- Equity in placement outcomes
- Reduction in crisis system use (corrections facility/ER/shelter returns)

VII. CONCLUSION: IMPLEMENTATION AND ACCOUNTABILITY

The recommendations in this report were built by Spokane's community, not handed down from outside experts or shaped by a single agency's priorities, but developed through months of honest conversation among people who came to this work from different directions and reached common ground. In a community that has studied these challenges for decades without a shared roadmap, this is the necessary first step.

What follows now is harder: turning a roadmap into a reality. The recommendations span agencies, jurisdictions, funding streams, and systems with their own cultures and timelines. No single entity owns this work. No election cycle is long enough to see it through. That is precisely why the Task Force's first recommendation — establishing a durable, cross-sector coordinating council — is foundational to everything else. Without a named accountability structure, independent of any single institution or political moment, the rest of this report is at risk of the fate that prior efforts have met: partial adoption, fading momentum, and public trust that erodes when ambitious plans produce limited results.

Spokane has been here before. The difference this time is that the community built this roadmap together and the people closest to the problem sat alongside the people with the power to address it. That shared ownership is the strongest foundation this work has ever had.

The problems this report addresses are pressing. The human cost of inaction is real and measurable, in lives disrupted, families broken, and public resources consumed by crises that were never resolved. The fiscal case for reform is equally clear. But more than cost, this is a question of what kind of community Spokane intends to be.

A community that is safe. A community that is healthy. A community that invests in people — before, during, and after the hardest moments of their lives.

Next Steps

In the coming months, City and County elected officials will consider the work of the Task Force, consult with experts in service design and delivery and facility planning, consider financing mechanisms, and prioritize action for implementation.

The Task Force recommends that a cross-sector coordinating council be established to provide collaboration, accountability, and coordination for the recommendations in this report. The Task Force proposes to convene the Planning Team and Task Force Advisory Group leads to develop an initial proposed collaboration, accountability, and coordination structure that can then be vetted and refined by the public, private, nonprofit, philanthropic, Tribal, victims' rights and lived-experience partners.

VIII. APPENDICES