King County

Metropolitan King County Council

Regional Policy Committee

Staff Report

Agenda Item No.:	8	**Name:**	Kelli Carroll
Briefing No.:	2009-B0201	**Date:**	September 9, 2009
Invited:	Beth Goldberg, Office of Management and Budget Amnon Shoenfeld, Mental Health, Chemical Abuse and Dependency Services Division, Department of Community and Human Services		

SUBJECT
A briefing on Mental Illness and Drug Dependency (MIDD) prioritization and supplantation.

PURPOSE
Members of the Regional Policy Committee requested a briefing on MIDD prioritization at the July committee meeting. In the intervening time, the Executive released his proposed plan for supplanting MIDD revenue in 2010. This briefing provides the committee with information on the MIDD prioritization process and recommendations, as well as the Executive's proposed MIDD supplantation approach.

SUMMARY
A subcommittee of the MIDD Oversight Committee developed a tool with which it would use to prioritize the 37 MIDD strategies. The results of the subcommittee's ranking were approved by, the MIDD Oversight Committee at its June 25, 2009 meeting. The ranking placed each of the 37 strategies into one of three tiers (high, medium, low) (attachment 1). The MIDD prioritization was provided to the Council and the Executive on July 13 along with a letter requesting that the Executive and Council take the recommended prioritization rankings under consideration when making supplantation proposals and decisions.

On August 25th, the Executive released his proposed plan for supplanting MIDD revenue in 2010 (attachments 2 and 3). For 2010, the Executive proposes to supplant $12.7 million of MIDD revenue to existing mental health, chemical dependency, and therapeutic court programs by reducing or delaying $8.8 million of MIDD programs. The Executive made 2010 MIDD strategy reduction and delay recommendations on a strategy by strategy basis. A discussion of the recommended reductions and delays as compared to the MIDD prioritization recommendations occurs in a subsequent section of this staff report.

BACKGROUND
Prioritization: In response to the reduction in the MIDD revenue due to the downward economy and anticipated legislative action that would allow MIDD revenue to be used to fund existing mental health, chemical dependency and therapeutic court services MIDD Oversight Committee created the MIDD Oversight Committee Prioritization Sub-Committee in early 2009.

The 15-member subcommittee and representatives from the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) worked together for six months to create a process, tool and criteria for rating the strategies. The results of the prioritization rankings were to be shared with the Executive and the Council in order to assist with 2010 MIDD budget and policy decisions. The three step prioritization process summarized in Table 1 below was approved by the MIDD Oversight Committee at its April 23rd meeting.

The tool that the subcommittee developed rated each strategy based on the five adopted MIDD policy goals, the MIDD principles and values, cost offsets and cost effectiveness. MHCADSD staff tested the tool and reported back to the subcommittee on the results. After reviewing the initial test results, the process and the instrument were modified. One significant change included inviting strategy leads/experts from within and outside MHCADSD to provide input on their specific strategies through completing the prioritization rating tool. The information provided by the strategy leads was then used by the MHCADSD team to complete the rating process. The final results of the prioritization ranking are shown in attachment 1.

Table 1.

Three-Step Process for Prioritization
1. First Set of Rating Criteria. Staff from the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Management Team applied the first set of rating criteria to place MIDD strategies into three groups: high priority, medium priority, and lower priority (approximately 12-13 strategies in each group, based on the spread of scores). This step included incorporating information from the strategy leads.
2. Overarching Criteria. MHCADSD Management Team applied overarching criteria to determine if group placement created an imbalance within the service areas/ target populations (some strategies were adjusted within priority groups in order to regain balance).
3. Final Set of Rating Criteria. At this point, strategies placed in the lowest priority group were further scored using the final set of rating criteria to determine a rank order for strategies recommended for delay suspension of the program due to reduction in MIDD spending. This step also included incorporating the information from the strategy leads.

Supplantation: In 2005, the Washington state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services. The initial statue providing for this tax (RCW 82.14.460) did not permit the revenues to be used to supplant other existing funding. The statute was revised in 2008 to allow for its use for housing that is part of a coordinated chemical dependency or mental health treatment program.

During the 2009 Legislative session, Washington State Legislators approved a change to the state statue, modifying the non supplantation language of the law. The modification allows MIDD revenue to replace (supplant) funds for **existing** mental health, chemical dependency, and therapeutic court services and programs, not only new or expanded programs. Beginning in 2010, up to 50 percent of the MIDD tax collected can be used to supplant other lost funds. There is a ten percent reduction to the amount of funds used each year, ending at 10 percent in year 2014.

The Office of Management and Budget (OMB) is currently projecting a $56 million general fund deficit for 2010. The Executive's letter of August 24, 2009 (attachment 2) indicates that a deficit of $60 million or larger is expected in 2011. It is expected that most if not all of the general fund will be eliminated from human services, including mental health, chemical dependency, and therapeutic court services and programs in 2010. Consequently, utilizing MIDD revenue is a key component to maintaining core mental health, chemical dependency, and therapeutic court services and programs and to balance the general fund budget.

On August 25th the Executive released one half of the proposed 2010 MIDD supplantation plan—what MIDD strategies will be reduced or delayed as a result of using MIDD funds to backfill general fund. The other half of the equation—what mental health, substance abuse, and therapeutic court programs will receive supplanted MIDD funds in lieu of general fund (and what amount) will be provided when the 2010 proposed budget is released later in September. A discussion of supplantaiton recommendations occurs in a subsequent section of this staff report.

ANALYSIS

Prioritization: The MIDD prioritization process provided a clearly articulated, inclusive, transparent, and rational approach to ranking the 37 MIDD strategies. As with any ranking endeavor, some MIDD Oversight Committee members and community stakeholders voiced disagreement with individual strategy scores.

The issue of the balance between youth, adult, and older adult strategies among the prioritization rankings was raised at the MIDD Oversight Committee and with the subcommittee. In particular, there was concern that the youth/adult continuum of services was not balanced across the three tiers (high, medium and low), with a disproportionate number of adult programs falling into the top two tiers (high and medium), while youth programs are overrepresented in the lowest tier. The memo from the subcommittee (attachment 5) states that it is "...the result of youth programs being less developed than adult programs; for example, no model yet exists for strategy 7a, "Reception Centers for Youth in Crisis," and this caused that strategy to lose points relative to strategies for which there are models and programs already up and running". The need to invest in youth was articulated again at the August 27 MIDD Oversight Committee meeting.

Supplantation: In 2010, the Exec proposes to supplant close to 30 percent, or about $12.7 million, of MIDD revenue to existing mental health, chemical dependency, and therapeutic court programs currently supported by general fund. Supplanting at 30% in 2010 allows the level of MIDD funding to MIDD strategies to remain level in 2010 and 2011 depending on the growth or decline in revenue to the fund and availability of fund balance. Unless there are revenue increases, the sustainability of 30 percent supplantation into 2012 is questionable.

It is important to recognize that $12.7 million in supplantation of MIDD revenue does not equate to $12.7 million proposed cuts to 2010 MIDD strategies. The Executive is proposing to reduce or delay nearly **$8.7 million** worth of MIDD strategies. The balance of the $12.7 million for supplantation comes from the MIDD's fund balance. MIDD fund balance is comprised of unspent revenues and under spending on 2009 strategies (see table 2 below).

Table 2.

2010 Proposed MIDD Supplantation	
$8.7	2010 Strategy Reductions/Delays
$4.0	MIDD Fund Balance
$12.7	**Total Proposed 2010 Supplantation Amount**

In 2009, the MIDD fund will under spend its adopted budget by $20 million. As a result of the under spending six strategies are delayed, most notably, two new strategies approved in 2008 and funded 2009 will not be implemented by the Executive: 17a: Crisis Intervention Team/Mental Health Partnership Pilot and 17b: Safe Housing and Treatment for Children in Prostitution. Strategy 11b, the expansion of Mental Health Court to all jurisdictions in King County is also delayed. The under spent funds become part of the fund balance for the MIDD fund.

It is expected that the supplanted MIDD funds will support core programs mental health, chemical dependency, and therapeutic court programs upon which many MIDD strategies are built. The Executive's letter (attachment 2) cites King County's Adult Drug Court as an example: one of the MIDD strategies enhances Drug Court; if the County doesn't utilize supplantation flexibility to preserve Adult Drug Court, Adult Drug Court would have to be eliminated entirely.

Attachment 2 outlines the Executive's approach to supplantation:

- Making small cuts to a number of strategies
- Delaying strategies that have not been implemented (except for the Crisis Diversion Strategy)
- Recommendations from staff based on analysis of service impact and full time employee impact
- Consideration of cost effectiveness and cost offsets along with the interrelatedness of programs
- Not reducing certain programs deemed critical to the success of MIDD plan as a whole

Attachment 4 compares the MIDD prioritization list with the Executive's supplantation proposal. Highlights include:

- Five of the 12 top tier strategies are fully funded in the proposed supplantation plan
- One strategy, 16a New Housing Units and Rental Subsidies is expanded in 2010 by $2 million
- The lowest tiered strategies sustained the deepest reductions and delays

The County Council will receive the Executive's 2010 proposed budget on September 27th. At that time, the other half of the supplantation equation---what existing programs are recommended to receive MIDD funds. The Council will consider both "sides" of the MIDD supplantation question as it deliberates throughout the fall on the 2010 budget.

ATTACHMENTS

1. Prioritization Ratings
2. MIDD Supplantation Letter from Executive Dated August 24,2009
3. Proposed MIDD 2010 MIDD Supplantation Detail
4. Prioritization and Supplantation Comparison
5. June 25, 2009 Memo from Subcommittee

strategy	short strategy description	MH, CD or both	Target pop	Community or Diversion	Total average score	Rank	annual ongoing funding	priority group funding total	priority group summary
16a	New Housing units and rental subsidies	both	adults	Community	73	1	0*		
10b	Adult Crisis Diversion Center, Respite, Mobile Svc	both	adults	Diversion	71.5	2	$ 6,100,000		7 adult
3a	Supportive Services for Housing Projects	both	adults	Community	71.5	2	$ 2,000,000		3 youth
1e	CD Professionals Training	CD	adults	Community	70	4	$ 615,625	$ 28,858,625	2 both
12b	Hospital Re-Entry Respite Beds	MH	adults	Diversion	69.5	5	$ 565,000		
1a(1)	MH treatment	MH	both	Community	69	6	$ 8,520,000		8 community
1f	Parent Partners Family Assistance	both	both	Community	68	7	$ 450,000		4 diversion
4c	School District Based MH & SA Services	both	youth	Community	68	7	$ 1,235,000		
6a	Wraparound Svc Emotionally Disturbed Youth	both	youth	Community	68	7	$ 4,692,000		3 MH
2a	MH Caseload Reduction	MH	adults	Community	67.5	10	$ 4,000,000		1CD
12a	Jail Re-Entry Program Capacity Increase	both	adults	Diversion	66	11	$ 320,000		8 MH & CD
5a	Juvenile Justice Youth Assessments	both	youth	Diversion	66	11	$ 361,000		
1a(2)	CD treatment	CD	both	Community	65.5	13	$ 2,623,225		
1d	MH Crisis Next Day Appointments	MH	adults	Community	65.5	13	$ 250,000		11 adult
2b	Employment Services MH & CD	both	adults	Community	65.5	13	$ 2,100,000		2 youth
12c	Harborview PES link to Community Based Svc	both	adults	Diversion	65	16	$ 200,000	$ 11,227,977	1 both
15a	Drug Court: Expansion of Recovery Support Services	CD	adults	Diversion	65	16	$ 358,000		1 older adult
1b	Outreach & Engagement - Hospitals, Jails, Crisis	both	adults	Diversion	64	18	$ 550,000		
13b	Domestic Violence Prevention	both	adults	Community	62.5	19	$ 200,000		
1g	Older Adults Prevention & Intervention MH & SA	both	older adults	Community	62.5	19	$ 500,000		8 community
4a	Parents In Recovery SA Outpatient Services	CD	youth	Community	62.5	19	$ 500,000		7 diversion
12d	Behavior Modification for CCAP Clients	program	adults	Community	62	22	$ 75,000		
10a	Crisis Intervention Training - First Responders	both	adults	Diversion	61.5	23	$ 1,500,000		3 MH
1c	SA Emergency Room Early Intervention	CD	adults	Diversion	61.5	23	$ 796,500		4CD
11a	Increase Jail Liaison Capacity	both	adults	Diversion	61	25	$ 80,000		8 MH & CD
11b	MH Court Expansion	MH	adults	Diversion	61	25	$ 1,295,252		
4d	School Based Suicide Prevention	MH	youth	Community	60	27	$ 200,000		
1h	Older Adults Crisis & Service Linkage	both	older adults	Community	59.5	28	$ 350,000		
14a	Sexual Assault, MH and CD Services	both	adults	Community	58.5	29	$ 500,000		6 youth
8a	Expand Family Treatment Court & Parent Support	CD	youth	Diversion	58.5	29	$ 468,407	$ 4,113,807	3 adult
4b	Prevention Services - Children of SA	CD	youth	Community	58	31	$ 400,000		1 older adult
9a	Expand Juvenile Drug Court Treatment	CD	youth	Diversion	57.5	32	$ 588,000		
7b	Expand Youth Crisis Services	MH	youth	Community	55	33	$ 1,000,000		6 community
13a	Domestic Violence and Mental Health Services	both	adults	Community	54.5	34	$ 310,000		4 diversion
17b	Safe Housing and MH & CD Treatment for Children in Prostitution Pilot (24 months)	both	youth	Community	54.5	34	0*		2 MH
7a	Reception Centers for Youth in Crisis	both	youth	Diversion	48	36	$ 497,400		3CD
17a	Crisis Intervention team/Mental Health Partnership (24 months)	MH	adults	Diversion	47	37	0*		5 MH & CD
							$ 44,200,409	$ 44,200,409	
			*one time pilot project funding from 2009, no ongoing funding associated with these strategies						

Attachment 1

Attachment 2

King County

Kurt Triplett
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August 24, 2009

Sue Rahr
King County Sheriff
Mental Illness and Drug Dependency (MIDD) Oversight Committee Co-chair
Room W-150
COURTHOUSE

Shirley Havenga, Chief Executive Officer, Community Psychiatric Clinic
Mental Illness and Drug Dependency (MIDD) Oversight Committee Co-chair
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Dear Sheriff Rahr, Ms. Havenga, and all members of the MIDD Oversight Committee:

Thank you for inviting me to meet with you at the MIDD Oversight Committee meeting on Thursday, August 27, 2009. I look forward to our discussion.

I know that you have received regular updates at your meetings from Beth Goldberg, Office of Management and Budget Deputy Director, regarding both the county budget crisis and the decline in revenues from the MIDD sales tax. Also at your meetings, you've had several discussions regarding the potential supplantation of a portion of MIDD revenues, as allowed under 2SSB 5433 passed by the State Legislature during the 2009 Legislative Session.

Last week, I submitted an ordinance to the Metropolitan King County Council making amendments related to the MIDD sales tax that will bring the King County Code into alignment with new state law and enable the county to supplant MIDD revenues. The 2009 legislation allows counties to use up to 50 percent of their one-tenth of one percent sales tax revenues in 2010 to fund current mental health and chemical dependency services and therapeutic courts. The amount that can be supplanted is reduced to 40 percent in 2011, 30 percent in 2012, and so on until 2015, when supplanting is no longer allowed.

I am proposing to use no more than 30 percent of our MIDD revenues in 2010, 2011 and 2012 to ensure continuation of mental health and chemical dependency services and mental health and drug courts currently funded out of the county's severely distressed General Fund. **I have enclosed my proposed spending plan that shows projected expenditures in 2009 and revised budgets for MIDD strategies in 2010.**

I want to share with you how and why I made the decision to exercise the supplanting option, and why I choose to limit the supplantation amount to 30 percent. I want to be clear that I would prefer not to supplant *any* of the MIDD funds. The MIDD was created to help us expand and enhance our current systems and services, as a means of reducing incarcerations and the painful cycling through our justice and emergency medical systems by people in need of treatment services but who have been previously unable to receive them. It is a wonderful plan, and I commend all of you for the work you have done to help guide its development and implementation.

King County's On-Going Structural Deficit

In order to understand why we find ourselves in the position of needing to rely on previous MIDD dollars to support existing mental health and chemical dependency programs funded through the General Fund, it is essential that I describe what has led to King County's fiscal crisis. Since the early part of this decade, King County – as well as all counties across the State of Washington – has faced an underlying structural deficit in the General Fund caused by restrictions imposed by the state in the types of revenue tools available to counties. Unlike cities that are authorized to impose property taxes, sales taxes, the B&O tax, and the utility tax, counties are only allowed to charge the property tax and sales tax. These restrictions are further exacerbated by the fact that property taxes are limited in their growth to 1 percent per year plus new construction. The limited commercial and retail tax base in unincorporated King County results in sales tax making up a relatively small portion of General Fund revenues, as compared to the property tax. The growth rate in this revenue foundation is not sufficient to sustain funding for existing programs. As a result, King County faced deficits totaling $137 million between 2002 and 2005. While a relatively healthy economy during the period of 2006 – 2008 provided the county with a brief respite from deficits, the combination of the worst economic downturn since the Great Depression, as well as the on-going structural deficit challenges, resulted in a $93 million deficit for 2009 and an anticipated deficit of $56.4 million for 2010. For 2011, a deficit of at least $60 million – perhaps larger – is anticipated.

To address the underlying structural nature of the General Fund deficits, King County, as well as all other counties in the State of Washington, went to the State Legislature earlier this year to ask for additional tools to address the fundamental flaws in the funding structure available to support county services. Among other things, King County sought the ability to impose a utility tax – similar to the tax afforded to cities in the State of Washington – to support local services we are required to provide to the citizens of urban unincorporated King County. It costs King County approximately $21 million more in expenditures to provide services to these areas than they generate in revenues. In other words, taxes collected to support regional services are being used to subsidize city-level services for the urban unincorporated areas of King County. King County came extremely close to gaining the authority to impose a utility tax – thanks in large part to the advocacy of the human services community – our efforts came up a few votes short in the Senate.

While we were not successful in obtaining the utility tax, we had some small victories in getting the State Legislature to ease supplantation restrictions – on a temporary basis for a few other

taxing options available to counties. The State Legislature eased supplantation restrictions on both the criminal justice sales tax and the MIDD. The supplantation option was the only tool the Legislature gave us to deal with the revenue problem facing every county in the state. When these options were approved, I made a commitment to utilize these tools in an effort to address our on-going funding crisis in the General Fund.

Putting Supplantation to Use

Earlier this year, I proposed to the King County Council a one-tenth of one percent increase in the criminal sales tax – using our newly afforded supplantation flexibility to shore up funding for existing criminal justice, health and human services programs. Unfortunately, the council decided to not give the voters of King County the opportunity to vote on this proposal, nor a companion property tax proposal from Councilmember Patterson that I supported. Without a new revenue source, General Fund support for human services programs in my 2010 proposed budget will be virtually eliminated.

I am similarly seeking County Council support to supplant up to 30 percent of MIDD revenues to support critical mental illness and drug dependency programs that are currently supported by the General Fund. Without this tool, funding for programs such as drug court and mental health court are in jeopardy in the face of the General Fund's $56 million deficit. If we don't use the flexibility that the Legislature gave us, we are faced with the elimination of a substantial number of county-funded programs that together make up an essential part of our continuum of services to care for and divert individuals who enter our criminal justice system. Many of these programs are the foundation upon which a number of our MIDD strategies are built. For example, one of the MIDD strategies seeks to enhance drug court services, but if we do not utilize MIDD supplantation funds, we won't be able to afford to have a drug court at all. The decision I faced, therefore, was not whether to propose supplanting some MIDD funds, but rather to determine how much.

First of all, I believe it is critical to maintain the integrity of the MIDD Plan, which was designed to provide a full continuum of treatment, housing and case management services as a means to reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems. Supplanting more than 30 percent of the MIDD funds threatens the integrity of that plan, which counts on interconnected programs to be most effective. In order to successfully divert an individual, we must have not only the diversion programs, but also housing and housing services and community-based services. We can't do all these things if we supplant 50 percent of the funding.

Second, there are clear legislative restrictions on what programs are eligible to receive supplanted sales tax revenues. They must be therapeutic court programs, mental health programs, or chemical dependency programs. We can't, for example, fund Metro Transit or Wastewater Treatment or the Sheriff's canine unit with these revenues. I looked at all the various county-funded programs in an effort to determine which were eligible for MIDD funding, and needed in order to maintain the continuum of diversion and treatment services. These programs total about $13 million, which is close to 30 percent supplantation.

Third, we need to look ahead. The county budget picture for 2011 is not looking any better. If we supplant at the 50 percent level, we would need to cut down to 40 percent supplantation in 2011, which means cutting programs we just preserved. By limiting ourselves to 30 percent in the first year, we eliminate the need to cut programs in 2011 or 2012.

I regret that our current budget situation makes it absolutely necessary to utilize the MIDD funds to preserve current services, but this is what we must do. I have enclosed a spending plan for the MIDD that shows the projected expenditures in 2009 and revised budgets for strategies in 2010. With just a few exceptions, the budgets for individual strategies in 2011 will be the same as in 2010. As you will see, most of the 37 strategies have received cuts and for those programs not yet implemented, most have been delayed.

I understand how painful it is to have to reduce or delay these programs, especially at a time when many more people are in need of services. Therefore, I want to briefly share with you the rationale I followed in deciding on the attached spending plan.

I thank the MIDD Oversight Committee for the work you did in developing a prioritization process and establishing a prioritized list of MIDD programs for my consideration, and that of the King County Council, in developing our budgets. I understand that committee members agreed on the process, including the criteria used in developing the prioritization list, but that some members and community stakeholders were not in agreement on the actual ratings that came out of the process.

In deciding how to achieve the savings I needed given both the reduction of MIDD revenues and the issue of supplantation, I considered many of the criteria used in the MIDD prioritization process. My plan calls for a delay in programs not yet implemented, with the exception of the crisis diversion strategy, which is an essential element of our central policy goal of criminal justice diversion. I also considered cost effectiveness and cost offsets, whether programs were essential for other programs to succeed, and other criteria.

Rather than use the rating criteria to eliminate programs entirely, my goal was to make small reductions to a number of programs, to achieve the savings needed and to keep programs operating effectively. Staff reviewed each strategy individually and the recommended reductions were based on an analysis of the impact of reducing service capacity, delaying implementation and/or reducing full time employees.

At the same time, there are some programs I did not cut at all – those that I felt were essential to the success of the MIDD plan as a whole, or areas where the funding could not be reduced and still provide services that would meet the strategy goals. I do not, for example, recommend a cut to strategies 1a-1, *Increase access to community mental health treatment* and 1a-2, *Increase access to community substance abuse treatment*, because MIDD non-Medicaid funding is critical to our efforts to maintain access for community-based treatment services. Diversion programs simply don't work if there is no community treatment.

While it might seem that these strategies already receive a significant amount of MIDD money, it is important to note that state funding for non-Medicaid mental health services has just been cut by close to $4 million per year for the next two years, and state funding for chemical dependency treatment has been reduced by close to $2 million per year. Although the original intent of strategies 1a-1 and 1a-2 was to increase access to services, given the state's cuts, these funds will be needed just to maintain services. Workload reduction for mental health was not cut because $4 million in MIDD funds leverages another $5 million in Medicaid funds. As the state will be reducing Medicaid funding to King County by close to $4 million in the coming year, these funds are critical.

These are very difficult times for all of us who value human services and who want to help people with mental illness and chemical dependency problems recover and restore their lives. It is never easy to cut programs that are valuable to the community and to people in need. We are fortunate to have a funding tool that will at least temper how deep we are forced to cut.

I am hopeful that we will continue to work together for the benefit of those who most need our help and support as the 2010 budget progresses. I also hope that you will join me in working to achieve sustainable funding solutions for the future.

I look forward to discussing my plan with you on August 27.

Sincerely,

Kurt Triplett
King County Executive

Enclosure

cc: MIDD Oversight Committee Members
Beth Goldberg, Deputy Director, Office of Management and Budget
Terry Mark, Deputy Director, Department of Community and Human Services (DCHS)
Amnon Shoenfeld, Division Director, Mental Health, Chemical Abuse and Dependency Services Division, DCHS

Attachment 3

	MIDD Spending Plan					
	August 25, 2009					
	Strategy Number and Description	**2009 Est Spending**	**Ongoing Allocation**	**2010 Proposed**	**$ Impact (2010 compared to Ongoing Allocation)**	**Impact**
1a-1	Increase access to community mental health treatment	$ 8,520,000	$ 8,520,000	$ 8,520,000		
1a-2	Increase access to community substance abuse treatment	$ 2,623,225	$ 2,623,225	$ 2,623,225		
1b	Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities	$ 500,000	$ 550,000	$ 495,000	$ (55,000)	cut 10%
1c	Emergency room substance abuse early intervention program	$ 566,000	$ 796,500	$ 717,000	$ (79,500)	cut 10%
1d	Mental health crisis next day appointments and stabilization services	$ 250,000	$ 250,000	$ 225,000	$ (25,000)	cut 10%
1e	Chemical dependency professional education and training	$ 615,625	$ 615,625	$ 555,000	$ (60,625)	cut 10%
1f	Peer support and parent partner family assistance	$ 75,000	$ 450,000	$ 375,000	$ (75,000)	cut 17%
1g	Prevention and early intervention mental health and substance abuse services for older adults	$ 450,000	$ 500,000	$ 450,000	$ (50,000)	cut 10%
1h	Expand availability of crisis intervention and linkage to on-going services for older adults	$ 350,000	$ 350,000	$ 315,000	$ (35,000)	cut 10%
2a	Caseload reduction for mental health	$ 3,500,000	$ 4,000,000	$ 4,000,000	$ -	
2b	Employment services for individuals with mental illness and chemical dependency	$ 500,000	$ 2,100,000	$ 1,000,000	$ (1,100,000)	cut 52%
3a	Supportive services for housing projects	$ 2,000,000	$ 2,000,000	$ 2,000,000	$ -	
4a	Services to parents participating in substance abuse outpatient treatment programs	$ -	$ 500,000		$ (500,000)	delay
4b	Prevention services to children of substance abusers	$ -	$ 400,000		$ (400,000)	delay
4c	School based mental health and substance abuse services	$ -	$ 1,235,000	$ 1,000,000	$ (235,000)	cut 19%
4d	School based suicide prevention	$ 200,000	$ 200,000	$ 200,000	$ -	
5a	Increase capacity for social and psychological assessments for juvenile justice youth	$ 129,307	$ 361,000	$ 290,700	$ (70,300)	cut 20%
6a	Wraparound family, professional and natural support services for emotionally disturbed youth	$ 2,000,000	$ 4,692,000	$ 3,200,000	$ (1,492,000)	32% in 2010 4% in 2011
7a	Reception centers for youth in crisis	$ -	$ 497,400		$ (497,400)	delayed
7b	Expanded crisis outreach and stabilization services for children and youth	$ -	$ 1,000,000	$ 500,000	$ (500,000)	cut 50%
8a	Expand family treatment court services and support to parents	$ 380,207	$ 468,407	$ 394,000	$ (74,407)	cut 16%
9a	Expand juvenile drug court treatment	$ 444,573	$ 588,000	$ 423,000	$ (165,000)	cut 28%
10a	Crisis intervention training program	$ 150,000	$ 1,500,000	$ 948,000	$ (552,000)	cut 37%
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	$ -	$ 6,100,000	$ 6,100,000	$ -	
11a	Increase capacity for jail liaison program	$ 80,000	$ 80,000	$ 80,000	$ -	
11b	Increase services available for new or existing mental health court programs	$ 500,000	$ 1,295,252		$ (1,295,252)	delayed
12a	Increase jail re-entry program capacity	$ 320,000	$ 320,000	$ 320,000	$ -	
12b	Hospital re-entry respite beds	$ 290,000	$ 565,000	$ 508,500	$ (56,500)	cut 10%
12c	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community-based services	$ 120,000	$ 200,000	$ 120,000	$ (80,000)	cut 40%
12d	Behavior modification classes for CCAP	$ 75,000	$ 75,000	$ 75,000	$ -	
13a	Domestic violence and mental health services	$ 310,000	$ 310,000	$ 250,000	$ (60,000)	cut 19%
13b	Domestic violence prevention	$ 280,000	$ 280,000	$ 224,000	$ (56,000)	cut 20%
14a	Sexual assault and mental health and chemical dependency services	$ 500,000	$ 500,000	$ 400,000	$ (100,000)	cut 20%
15a	Drug Court: Expansion of Recovery Support Services	$ 325,000	$ 358,000	$ 210,000	$ (148,000)	cut 41%
16a	New housing units and rental subsidies	$ 1,656,000		$ 2,000,000		
	New Strategies					
17a	Crisis Intervention Team/Mental Health Partnership Pilot					delay
17b	Safe Housing and Treatment for Children in Prostitution Pilot					delay
	Data Systems (and administration in 2008)		$ 500,000	$ -	$ (500,000)	cut 100%
	Contingency Funds		$ 500,000	$ -	$ (500,000)	cut 100%
	Administration and *All* Central Rates	$ 2,044,866	$ 2,544,866	$ 2,545,000		
Spending Plan Total w/o supplanted programs		**$ 29,754,803**	**$ 47,825,275**	**$ 41,063,425**		

MIDD Prioritization Ratings Compared to Executive's Supplantation 2010 Proposal

Strategy	Description	Target Pop	Prioritization Total average	Prioritization Rank	Ongoing funding	2010 Proposed Funding	Diff Ongoing/2010 Prop	2010 % Decrease from Ongoing
16a	New Housing units and rental subsidies	adults	73	1	$ -	$ 2,000,000	$ 2,000,000	na
10b	Adult Crisis Diversion Center, Respite, Mobile Svc	adults	71.5	2	$ 6,100,000	$ 6,100,000	$ -	0%
3a	Supportive Services for Housing Projects	adults	71.5	2	$ 2,000,000	$ 2,000,000	$ -	0%
1e	CD Professionals Training	adults	70	4	$ 615,625	$ 555,000	$ (60,625)	10%
12b	Hospital Re-Entry Respite Beds	adults	69.5	5	$ 565,000	$ 508,500	$ (56,500)	10%
1a(1)	MH treatment	both	69	6	$ 8,520,000	$ 8,520,000	$ -	0%
1f	Parent Partners Family Assistance	both	68	7	$ 450,000	$ 375,000	$ (75,000)	17%
4c	School District Based MH & SA Services	youth	68	7	$ 1,235,000	$ 1,000,000	$ (235,000)	19%
6a	Wraparound Svc Emotionally Disturbed Youth	youth	68	7	$ 4,692,000	$ 3,200,000	$ (1,492,000)	32%
2a	MH Caseload Reduction	adults	67.5	10	$ 4,000,000	$ 4,000,000	$ -	0%
12a	Jail Re-Entry Program Capacity Increase	adults	66	11	$ 320,000	$ 320,000	$ -	0%
5a	Juvenile Justice Youth Assessments	youth	66	11	$ 361,000	$ 290,700	$ (70,300)	20%
1a(2)	CD treatment	both	65.5	13	$ 2,623,225	$ 2,623,225	$ -	0%
1d	MH Crisis Next Day Appointments	adults	65.5	13	$ 250,000	$ 225,000	$ (25,000)	10%
2b	Employment Services MH & CD	adults	65.5	13	$ 2,100,000	$ 1,000,000	$ (1,100,000)	52%
12c	Harborview PES link to Community Based Svc	adults	65	16	$ 200,000	$ 120,000	$ (80,000)	40%
15a	Drug Court: Expansion of Recovery Support Services	adults	65	16	$ 358,000	$ 210,000	$ (148,000)	41%
1b	Outreach & Engagement - Hospitals, Jails, Crisis	adults	64	18	$ 550,000	$ 495,000	$ (55,000)	10%
13b	Domestic Violence Prevention	adults	62.5	19	$ 280,000	$ 224,000	$ (56,000)	20%
1g	Older Adults Prevention & Intervention MH & SA	older adults	62.5	19	$ 500,000	$ 450,000	$ (50,000)	10%
4a	Parents In Recovery SA Outpatient Services	youth	62.5	19	$ 500,000	$ 500,000	$ -	100%
12d	Behavior Modification for CCAP Clients	adults	62	22	$ 75,000	$ 75,000	$ -	0%
10a	Crisis Intervention Training - First Responders	adults	61.5	23	$ 1,500,000	$ 948,000	$ (552,000)	37%
1c	SA Emergency Room Early Intervention	adults	61.5	23	$ 796,500	$ 717,000	$ (79,500)	10%
11a	Increase Jail Liaison Capacity	adults	61	25	$ 80,000	$ 80,000	$ -	0%
11b	MH Court Expansion	adults	61	25	$ 1,295,252	$ -	$ (1,295,252)	100%
4d	School Based Suicide Prevention	youth	60	27	$ 200,000	$ 200,000	$ -	0%
1h	Older Adults Crisis & Service Linkage	older adults	59.5	28	$ 350,000	$ 315,000	$ (35,000)	10%
14a	Sexual Assault, MH and CD Services	adults	58.5	29	$ 500,000	$ 400,000	$ (100,000)	20%
8a	Expand Family Treatment Court & Parent Support	youth	58.5	29	$ 468,407	$ 394,000	$ (74,407)	16%
4b	Prevention Services - Children of SA	youth	58	31	$ 400,000	$ -	$ (400,000)	100%
9a	Expand Juvenile Drug Court Treatment	youth	57.5	32	$ 588,000	$ 423,000	$ (165,000)	28%
7b	Expand Youth Crisis Services	youth	55	33	$ 1,000,000	$ 500,000	$ (500,000)	50%
13a	Domestic Violence and Mental Health Services	adults	54.5	34	$ 310,000	$ 250,000	$ (60,000)	19%
17b	Safe Housing and MH & CD Treatment for Children in Prostitution Pilot (24 months)	youth	54.5	34	$ -		$ -	100%
7a	Reception Centers for Youth in Crisis	youth	48	36	$ 497,400	$ -	$ (497,400)	100%
17a	Crisis Intervention team/Mental Health Partnership (24 months)	adults	47	37	$ -		$ -	100%

1) 17a and 17b were to be fully funded in 2009; Exec recommends eliminating the funding in 2009. 2) $1.0 million in admin/contingency funds are proposed to be reduced in 2010 that do not appear on this list.

Attachment 4

Attachment 5

MEMO
TO: MIDD Oversight Committee
FROM: MIDD Oversight Committee Prioritization Sub-Committee
RE: MIDD Strategy Prioritization
DATE: June 25, 2009

Attached you will find the Mental Illness Drug Dependency (MIDD) prioritization tool and the results of the application of the prioritization tool to the MIDD strategies. The prioritization process and ranking tool which reflects 6 months of work by the subcommittee and staff from DCHS/MHCADSD were endorsed by the Oversight Committee in the April meeting. The attached rankings reflect the application of the endorsed process and ranking instrument. The prioritization process provides a clearly articulated, transparent, and rational approach to the very difficult task of setting priorities at a time when resources are seriously compromised. We recognize that while there may not be absolute agreement with every score, we ask that the Oversight Committee review of strategy rankings focus on transparency and the integrity to the prioritization process as it was endorsed by the Oversight Committee.

Background
In response to the reduction in the MIDD funding due to the downward economy and anticipated legislative action that would allow MIDD revenue to be used to fund existing mental health, chemical dependency and therapeutic court services facing critical funding cuts (supplantation), the MIDD Oversight Committee proactively created the MIDD Oversight Committee Prioritization Sub-Committee.

The charge of the Prioritization Sub-Committee was to develop a process for the prioritization of MIDD strategies to assist with budget and policy decisions made by the Executive and the Council. The subcommittee met seven times between January and June 2009. Members of the Sub-Committee included Linda Brown, Kelli Carroll, Steve Chupik designee for Mario Paredes, Steve Daschle designee for Mike Heinisch, Elisa Elliott designee for Sheriff Susan Rahr, Roycee Hasuko, Shirley Havenga, Mike Heinisch, Bruce Knutson, Barbara Miner, Mario Paredes, Marilyn Littlejohn, Mary Taylor (designee for Barbara Miner), Dwight Thompson, Cindy West and Mark Wirschem. Linda Brown and Dwight Thompson co-chaired the subcommittee.

Prioritization Process
The process used to prioritize the strategies is outlined below.

Three-Step Process for Prioritization
1. First Set of Rating Criteria. Staff from the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Management Team will apply the first set of rating criteria to place MIDD strategies into three groups: high priority, medium priority, and lower priority (approximately 12-13 strategies in each group, depending on the spread of scores). This includes incorporating the information from the strategy leads.
2. Overarching Criteria. MHCADSD Management Team will then apply overarching criteria to determine if group placement has created an imbalance within the service areas/ target populations, and, if so, may move some strategies within priority groups in order to regain

needed balance.

3. Final Set of Rating Criteria. At this point, strategies placed in the lowest priority group will be further scored using the final set of rating criteria to determine a rank order for strategies that may be recommended for delay in implementation or suspension of the program should a reduction in MIDD spending become necessary for budgetary reasons. This includes incorporating the information from the strategy leads.

The Rating Tool

A rating tool was developed by the subcommittee with assistance from staff of the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). The tool was created in order to rate each strategy based on the 5 policy goals, MIDD principles and values, cost offsets and cost effectiveness. At the request of the subcommittee, members of the MHCADSD management team tested the tool and reported back to the sub-committee on the results.

After reviewing the initial test results, the Sub-Committee modified the process and the instrument. A major change included inviting strategy leads/experts from within and outside MHCADSD to provide input on their specific strategies through completing the prioritization rating tool. The information provided by the strategy leads was then used by the MHCADSD team to complete the rating process.

The overall effect of the inclusion of strategy leads/experts in the rating process was to narrow the range of scores. The difference between being in the top tier (where strategies scored between 66 and 73 points) and being in the bottom or third tier (where strategies scored between 47 and 59.5 points) is now 6.5 point. To better understand the range of scores the Sub-Committee asked staff to do additional analysis to identify the factors that were most important in determining differences among strategy scores. The following three factors were identified as most important:
(1) the degree to which a strategy is necessary for other strategies/programs to be effective,
(2) cost offsets and cost effectiveness, and
(3) the stage of implementation.

It is of some concern that the youth/adult continuum of services is not completely balanced across the three tiers (high, medium and low): a disproportion of adults programs fall into the top two tiers (high and medium), while youth programs are overrepresented in the lowest tier. This is the result of youth programs being less developed than adult programs; for example, no model yet exists for strategy 7a, "Reception Centers for Youth in Crisis," and this caused that strategy to lose points relative to strategies for which there are models and programs already up and running. Strategies for programs that are evidence based and that bring in additional resources received points that the other strategies did not.

Conclusion

In conclusion, while there may be disagreements about individual strategy scores, the prioritization process provides a clearly articulated, transparent, and rational way to approach the very difficult task of setting priorities at a time when resources are seriously compromised. We

ask that the Oversight Committee review of strategy rankings focus on transparency and the integrity to the prioritization process as it was endorsed by the Oversight Committee.

Next Steps

The Prioritization Sub-Committee recommends that the Oversight Committee approve the prioritization process and rankings that will then to forwarded to the Executive and Council by the OC co-chairs as a recommended tool for their use in making MIDD policy and funding decisions.