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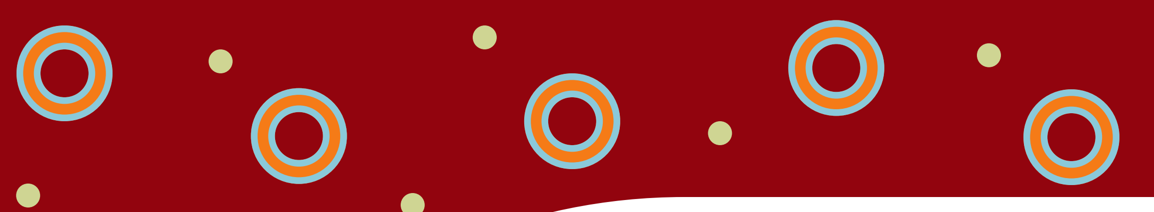

Mental Illness and Drug Dependency

Implementation and Evaluation Summary for Year Three
October 1, 2010—September 30, 2011

Fourth Annual Report

Mental Illness and Drug Dependency Oversight Committee

February 2012

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Fourth Annual Report

October 1, 2010—September 30, 2011

Report design by Lisa Kimmerly
Cover photo by Sergeant Don Gulla, King County Sheriff's Office

For further information on the current status of MIDD activities, please see the MIDD Web site at:

www.kingcounty.gov/healthservices/MHSA/MIDDPlan

Alternate formats available
Call 206-263-8663
or TTY Relay 711

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Introduction

The Implementation and Evaluation Summary for Year Three of the Mental Illness and Drug Dependency (MIDD) Plan covers the time period from October 1, 2010 through September 30, 2011. This is the fourth annual MIDD report, as required by Ordinances 15949, 16261 and 16262, and includes the following:

a) A summary of semi-annual report data

b) Updated performance measure targets for the following year of the programs

c) Recommendations on program and/or process changes to funded programs based on the measurement and evaluation data

d) Recommended revisions to the evaluation plan and processes

e) Recommended performance measures and performance measurement targets for each mental illness and drug dependency strategy, as well as any new strategies that are established.

Background

On November 13, 2007, the Metropolitan King County Council voted to enact a one-tenth of one percent sales tax to fund the strategies and programs outlined in King County's MIDD Action Plan. The MIDD vision is to prevent and reduce chronic homelessness and unnecessary involvement with criminal justice and emergency medical systems while promoting recovery for persons with mental illness or chemical dependency.

Exploring the possibility of a sales tax option within King County began with passage of Council Motion 12320, which yielded a three-part MIDD Action Plan, completed in June 2007. The King County Council accepted the action plan via Motion 12598 in October 2007, and authorized the sales tax levy collection via Ordinance 15949, approved on November 13, 2007.

Ordinance 15949 called for the development of three separate plans – an Oversight Plan, an Implementation Plan and an Evaluation Plan – all of which were completed prior to release of MIDD funds. On April 28, 2008, the King County Council passed Ordinance 16077 approving the Oversight Plan and establishing the MIDD Oversight Committee, which first convened in June 2008.

The MIDD implementation and evaluation plans were approved by the King County Council via Ordinances 16261 and 16262 on October 6, 2008, and implementation of strategies began on October 16, 2008. Work to develop those plans and implement strategies was completed by the MIDD Oversight Committee, staff from the County's Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and the Office of Performance, Strategy and Budget (PSB).

King County continues to implement a full continuum of prevention, treatment, housing support, and therapeutic court services to the extent possible given the ongoing economic recession. This fourth annual report covers the third year of MIDD programming from October 2010 through September 2011 and provides updates on all strategies, including relevant output measures, outcomes analyses for those who began services prior to September 30, 2010, client success stories, and features on specific strategies and providers making a difference in the lives of the people they serve.

MIDD Policy Goals*

1. Reduce the number of mentally ill and chemically dependent people using costly interventions, such as jail, emergency rooms, and hospitals.
2. Reduce the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.
3. Reduce the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
4. Divert mentally ill and chemically dependent youth and adults from initial or further justice system involvement.
5. Link with and further the work of other Council directed efforts, including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.

* *Edited from Ordinance 15949*

Oversight Committee Membership Roster

Barbara Linde, Presiding Judge, King County District Court (Co-Chair)
Representing: District Court
Mike Heinisch, Executive Director, Kent Youth and Family Services (Co-Chair)
Representing: Provider of youth mental health and chemical dependency services in King County

Claudia Balducci, Director, King County Department of Adult and Juvenile Detention
Representing: Adult and Juvenile Detention
Rhonda Berry, Assistant County Executive
Representing: County Executive
David Black, Residential Counselor, Community Psychiatric Clinic
Representing: Labor, representing a *bona fide* labor organization
Bill Block, Project Director, Committee to End Homelessness in King County
Representing: Committee to End Homelessness
Linda Brown, Board Member, King County Alcoholism and Substance Abuse Administrative Board
Representing: King County Alcoholism and Substance Abuse Administrative Board
John Chelminiak, Councilmember, City of Bellevue
Representing: City of Bellevue
Catherine Cornwall, Senior Policy Analyst
Representing: City of Seattle
Merril Cousin, Executive Director, King County Coalition Against Domestic Violence
Representing: Domestic violence prevention services
Nancy Dow-Witherbee, Member, King County Mental Health Advisory Board
Representing: Mental Health Advisory Board
Bob Ferguson, Councilmember, Metropolitan King County Council
Representing: King County Council
David Fleming, Director and Health Officer, Public Health–Seattle & King County
Representing: Public Health
Shirley Havenga, Chief Executive Officer, Community Psychiatric Clinic
Representing: Provider of mental health and chemical dependency services in King County
David Hocraffer, Director, King County Office of the Public Defender
Representing: Public Defense
Darcy Jaffe, Assistant Administrator, Patient Care Services
Representing: Harborview Medical Center

Norman Johnson, Executive Director, Therapeutic Health Services
Representing: Provider of culturally specific chemical dependency services in King County
Bruce Knutson, Director, Juvenile Court, King County Superior Court
Representing: King County Systems Integration Initiative
Christine Lindquist, National Alliance on Mental Illness (NAMI) member
Representing: NAMI in King County
Jackie MacLean, Director, King County Department of Community and Human Services (DCHS)
Representing: King County DCHS
Donald Madsen, Director, Associated Counsel for the Accused
Representing: Public defense agency in King County
Linda Madsen, Healthcare Consultant for Community Health Council of Seattle and King County
Representing: Council of Community Clinics
Richard McDermott, Presiding Judge, King County Superior Court
Representing: Superior Court
Ann McGettigan, Executive Director, Seattle Counseling Service
Representing: Provider of culturally specific mental health services in King County
Barbara Miner, Director, King County Department of Judicial Administration
Representing: Judicial Administration
Sue Rahr, Sheriff, King County Sheriff's Office
Representing: Sheriff's Office
Dan Satterberg, King County Prosecuting Attorney
Representing: Prosecuting Attorney's Office
Mary Ellen Stone, Director, King County Sexual Assault Resource Center
Representing: Provider of sexual assault victim services in King County
Dwight Thompson, Mayor Pro Tem City of Lake Forest Park
Representing: Suburban Cities Association
Chelene Whiteaker, Director, Advocacy and Policy, Washington State Hospital Association
Representing: Washington State Hospital Association/King County Hospitals

Oversight Committee Staff:
Andrea LaFazia-Geraghty, Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)
Bryan Baird, MHCADSD

As of 9/30/2011

Dear Friend:

We are pleased to report on the Mental Illness and Drug Dependency (MIDD) Plan Implementation and Evaluation Summary for Year Three (October 1, 2010–September 30, 2011). The MIDD-funded programs are making a difference in the lives of people throughout King County.

Thirty-four of the 37 strategies were operational during MIDD's third year, with only three strategies remaining on hold due to budget constraints. During the 2011 calendar year, $30.5 million of the $42.8 million budgeted was spent implementing MIDD strategies, with the remaining being spent on MIDD supplantation and fund balance.

Among the year's highlights:

- Approximately 30,704 unique individuals were touched by the MIDD.
- Of the MIDD clients served, approximately 1,020 had served in the U.S. military.
- Strategy 12b (Hospital Re-Entry Respite Beds) request for proposals was released and awarded.
- MIDD clients served were from throughout King County, including greater Seattle, south, east, and north King County.
- Twenty-six of the 29 strategies with performance measurement data met at least 85 percent of their annual target for one or more key targets.

As MIDD-funded programs reach more people who are retained in services over time, the ability to examine outcomes at the individual strategy level increases. Presented for the first time in this report are strategy-specific outcomes for those strategies that have served sufficient numbers of clients to make strategy-level outcome analysis possible.

Since MIDD funds are sales tax driven, the region's economy definitely affects the MIDD's services and programs. In looking forward, it is our hope that the economic picture will brighten so that we may implement all of the MIDD strategies. We are proud that even though the economy has slowed, we have taken up the challenge to provide the very best services to people with mental illness and chemical dependency throughout King County.

In 2010, King County approved the King County Strategic Plan. Two of the goals of the Plan are to "support safe communities and accessible justice systems for all" and to "promote opportunities for all communities and individuals to realize their full potential". The MIDD aligns with the strategic plan by providing a full array of mental health, chemical dependency and therapeutic court services that help reduce or prevent involvement in the criminal justice, crisis mental health and emergency medical systems, and promotes stability for individuals, across all ages, currently involved in those systems.

As you read this 2010-2011 report, you will learn a great deal about the many services the sales tax revenue provides to improve and stabilize the lives of people with mental illness and chemical dependency. We look forward to continuing our oversight role, monitoring programs firsthand, and reviewing evaluation reports to ensure the MIDD-funded programs achieve their intended results. Thank you very much for your continued support and investment in the MIDD.

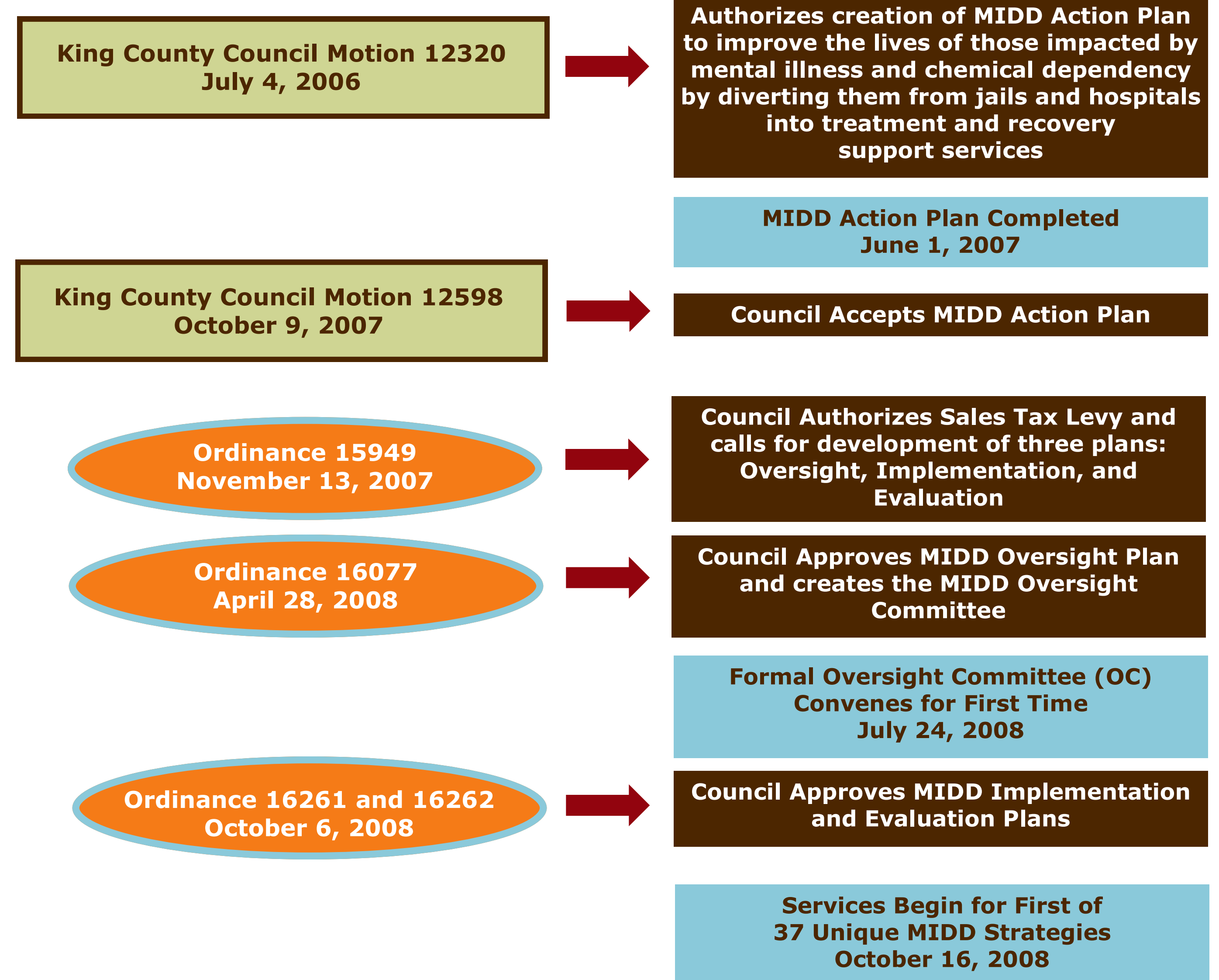
Judge Barbara Linde
Presiding Judge, King County District Court
Co-Chair

Mike Heinisch
Executive Director, Kent Youth and Family Services
Co-Chair

Acknowledgments

Thank you to the citizens of King County, the elected officials of King County, the MIDD Oversight Committee and Co-Chairs, and the many dedicated providers of MIDD-related services throughout King County. A special thank you to those willing to share their personal experiences and photos in this report.

Milestones in Adoption of MIDD Legislation



This Implementation and Evaluation Summary for Year Three provides information on:

* MIDD Oversight Committee third year activities
* Current performance measurement statistics and target percentages for each strategy, presented by MIDD service category
* Progress toward implementing all MIDD strategies
* Service delivery highlights for relevant strategies
* Demographics of unduplicated recipients of MIDD services
* Analyses of relevant outcomes for various MIDD strategies
* Recommendations for future strategy revisions
* Expenditures and budget information by strategy

NOTE: MIDD Year Three for the MIDD evaluation is based on the year October 1, 2010-September 30, 2011.

Glossary of Common Acronyms

CD	Chemical Dependency	MH	Mental Health	OST	Opiate Substitution Treatment
CDP	Chemical Dependency Professional	MHP	Mental Health Professional	PTSD	Post Traumatic Stress Disorder
DMHP	Designated Mental Health Professional	MOA	Memorandum of Agreement	RFP	Request for Proposals
FTE	Full-Time Equivalent	OC	Oversight Committee	SA	Substance Abuse

MIDD Strategies by Service Categories

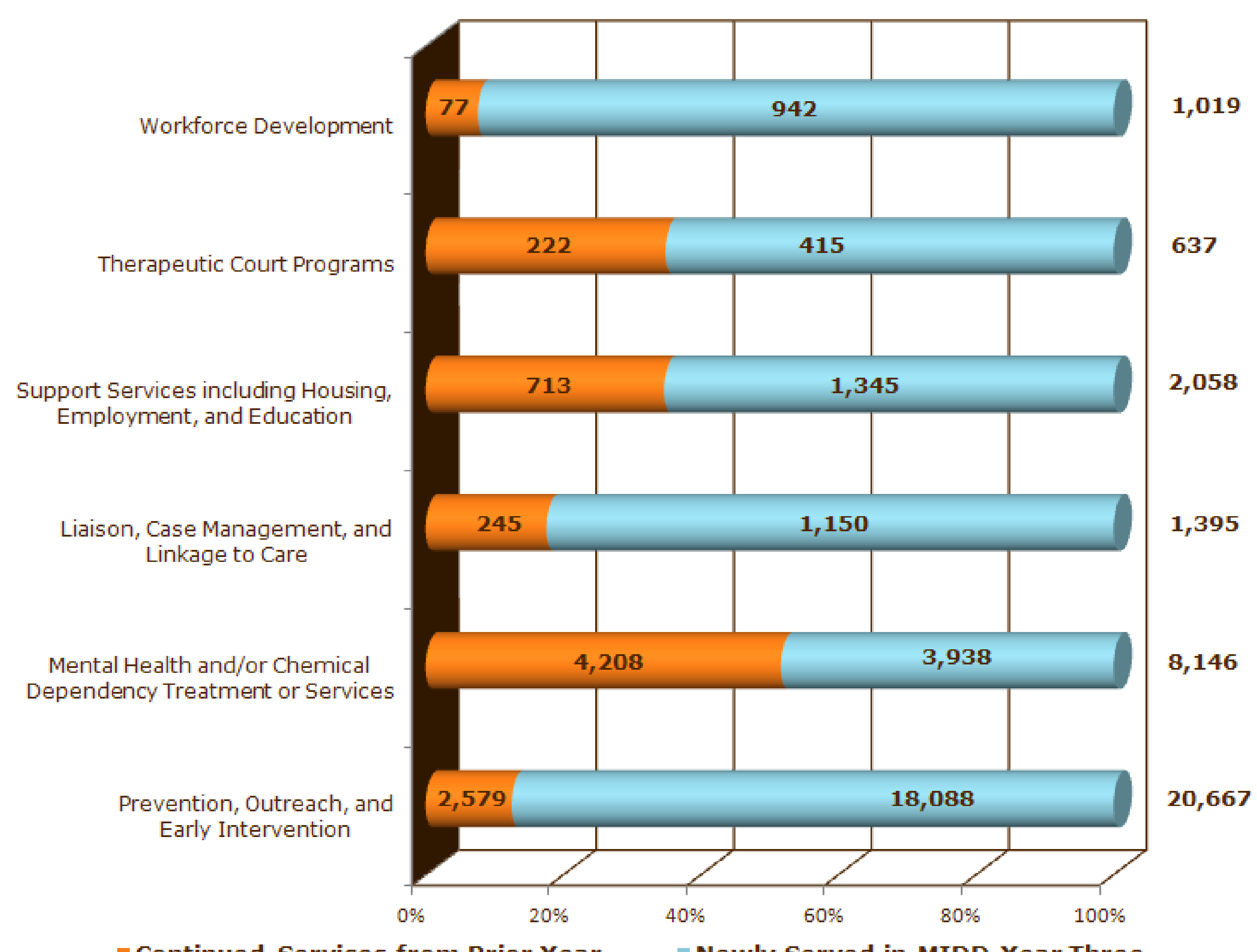
Strategy Number	Strategy Description	Strategy "Nickname"	MIDD Service Categories: Community Based Care	Programs to Help Youth	Jail and Hospital Diversion
1a-1	Increase Access to Community Mental Health Treatment	MH Treatment	✓		
1a-2	Increase Access to Community Substance Abuse Treatment	CD Treatment	✓		
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	Outreach & Engagement	✓		
1c	Emergency Room Substance Abuse Early Intervention Program	SA Emergency Room Intervention	✓		
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	MH Crisis Next Day Appts	✓		
1e	Chemical Dependency Professional Education and Training	CD Professionals Training	✓		
1f	Parent Partner and Youth Peer Support Assistance Program	Parent Partners Family Assistance	✓		
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	Older Adults Prevention MH & SA	✓		
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	Older Adults Crisis & Service Linkage	✓		
2a	Workload Reduction for Mental Health	MH Workload Reduction	✓		
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	Employment Services MH & CD	✓		
3a	Supportive Services for Housing Projects	Supportive Housing	✓		
4a	Services for Parents in Substance Abuse Outpatient Treatment	Parents in Recovery SA Services		✓	
4b	Prevention Services to Children of Substance Abusers	Prevention - Children of SA		✓	
4c	Collaborative School-Based Mental Health and Substance Abuse Services	School-Based MH & SA Services		✓	
4d	School-Based Suicide Prevention	Suicide Prevention Training		✓	
5a	Expand Assessments for Youth in the Juvenile Justice System	Juvenile Justice Youth Assessments		✓	
6a	Wraparound Services for Emotionally Disturbed Youth	Wraparound		✓	
7a	Reception Centers for Youth in Crisis	Youth Reception Centers		✓	
7b	Expansion of Children's Crisis Outreach Response Service System	Expand Youth Crisis Services		✓	
8a	Expand Family Treatment Court Services and Support to Parents	Family Treatment Court Expansion		✓	
9a	Expand Juvenile Drug Court Treatment	Juvenile Drug Court Expansion		✓	
10a	Crisis Intervention Team Training for First Responders	Crisis Intervention Team Training			✓
10b	Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	Adult Crisis Diversion			✓
11a	Increase Jail Liaison Capacity	Increase Jail Liaison Capacity			✓
11b	Increase Services for New or Existing Mental Health Court Programs	MH Court Expansion			✓
12a	Jail Re-Entry Program Capacity Increase	Jail Re-Entry Capacity Increase			✓
	Education Classes at Community Center for Alternative Programs	CCAP Education Classes			✓
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds			✓
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	PES Link to Community Services			✓
12d	Behavior Modification Classes for CCAP Clients	Behavior Modification for CCAP			✓
13a	Domestic Violence and Mental Health Services	Domestic Violence & MH Services	✓		
13b	Domestic Violence Prevention	Domestic Violence Prevention		✓	
14a	Sexual Assault, Mental Health, and Chemical Dependency Services	Sexual Assault, MH & CD Services	✓		
15a	Drug Court: Expansion of Recovery Support Services	Adult Drug Court Expansion			✓
16a	New Housing Units and Rental Subsidies	New Housing and Rental Subsidies			✓
17a	Crisis Intervention Team/Mental Health Partnership Pilot	Crisis Intervention/MH Partnership			✓
17b	Safe Housing and Treatment for Children in Prostitution Pilot	Safe Housing - Child Prostitution		✓	

NOTE: Shaded strategies denote "core" services. Please see Page 7 for description of core services.

Executive Summary

- $30.5 million of the $42.8 million budgeted were spent implementing MIDD strategies during the 2011 calendar year.
- Only three of the 37 original MIDD strategies remain on hold due to budget constraints. All others have moved forward with planning or serving their intended clientele.
- Twenty-six of the 29 strategies with performance measurement data met at least 85 percent of their annual target for one or more key targets.
- A request for proposals (RFP) was released and awarded for the operator of Strategy 12b (Hospital Re-Entry Respite Beds) in partnership with multiple funding agencies.
- At least 30,704 individuals (19,785 adults and 10,919 youth/children) received one or more MIDD-funded services in the third year.
- MIDD clients were from greater Seattle (32%), south King County (35%), east (17%), north (8%), and other (<9%).
- At least 1,020 MIDD clients reported that they had served in the U.S. military.
- Jail utilization varies widely by MIDD strategy participation, but average reductions in use over time were documented for *all* strategies eligible for a second post period analysis.
- Average days in community inpatient psychiatric hospitals dropped from 14.81 days (Pre Period) to 6.63 (Second Post Period) for the outcome-eligible sample.
- Reductions in depression and anxiety over time were found for many individuals served by Strategy 1a-1 (Mental Health Treatment).
- The MIDD Oversight Committee (OC) adopted a new framework for strategy prioritization.

Total Number of Individuals Served by Type of Service



Oversight Committee Meetings and Actions

Throughout MIDD Year Three, the OC met six times to monitor MIDD implementation and progress. Members of the committee cumulatively contributed over 175 hours of service during these meetings. A prioritization subcommittee also met several times in 2011, contributing a minimum of 300 additional work group hours. During OC meetings, the membership received updates and engaged in discussions on the following topics:

- State budget cuts and possible impacts of supplantation legislation passed by the Washington State Legislature allowing 50 percent of 2011 MIDD revenues to supplant lost funding for therapeutic courts and mental health/chemical dependency programs
- Strategy 10b (Crisis Diversion Services), including Downtown Emergency Service Center's intent to house the new facility in Seattle's Jackson Place neighborhood, the City of Seattle's approval for use of the site and improvements to existing facilities, Washington State's licensing requirements, informational community meetings held, and status updates on a lawsuit filed by concerned neighbors
- Services offered through Strategy 15a (Adult Drug Court Expansion)
- A 2011 budget proviso requiring submission of a report on Strategy 8a (Family Treatment Court) to the King County Council about the program and its blended funding, costs, and beneficiaries
- Continuing efforts to modify and implement Strategy 1f (Parent Partners Family Assistance), which will now create a family-run, non-profit agency to coordinate family and peer support services
- A mandate to review MIDD OC membership, per Ordinance 16077, evaluating the structure, membership, and responsibilities of the OC and reporting back to Council in June 2011
- Strategy 8a (Family Treatment Court) evaluation results presented by the University of Washington
- Expansion of the Regional Mental Health Court under Strategy 11b to create a one-year pilot providing a track for veterans suffering from post-traumatic stress disorder and/or traumatic brain injury who come into contact with the criminal justice system.

Adoption of the MIDD Strategy Prioritization Framework

Thirteen OC members participated in at least eight OC prioritization subcommittee workgroup sessions, meeting with County staff to develop a framework for prioritizing MIDD strategy funding. Formation of the subcommittee was prompted in part by reduced sales tax revenues, concerns about state budget cuts to mental health and substance abuse funding, and the potential for increased use of MIDD revenues for supplantation in response to these cuts.

With actual 2010 revenues well below original projections ($41 million rather than the originally forecasted $58 million), the OC Co-Chairs requested that a prioritization subcommittee work with County staff on strategy prioritization recommendations. The committee reviewed the prioritization process used in 2009, and decided that rather than rank-ordering strategies using a scoring system, to instead identify a set of core services and principles for the King County Council to use, should prioritization become necessary. Core services were defined as basic assessment, prevention, intervention and treatment services; without which people would be at greater risk for going to hospitals or jail/juvenile detention. Expansion strategies and those with other primary funding sources were not considered core. On August 25, 2011, the OC voted by consensus to adopt the new MIDD strategy prioritization framework which includes the following five criteria the OC recommends the King County Executive and Council use to determine the implementation of future budget reductions:

1) Maintain a balance of core services at levels necessary for the core services to be effective (NOTE: Core excludes most expansions and programs with other primary funding)
2) Preserve a continuum of services across age groups, intervention points, and types of services
3) Seek individual strategy level efficiencies
4) Ensure that equity and social justice priorities are maintained without disproportionate impacts on disadvantaged communities/geographical areas
5) Look at program effectiveness, based on achievement of performance measurement targets and on available outcomes.

Community-Based Care Strategies

Most strategies in this category seek to increase access to community mental health (MH) and substance abuse (SA) treatment for uninsured children, adults, and older adults. Other goals of strategies in the community-based care category include improving quality of care through decreased MH work loads, individualizing employment services, and providing intensive support services within housing programs.

Program Utilization and Performance Measurement Targets for Community-Based Care Strategies

Performance targets, such as the number of individuals to be served each year, numbers of service units to be provided, or other relevant measures are outlined in the MIDD Evaluation Plan matrices. Based on information drawn from the original MIDD Implementation Plan, these one-page per strategy documents allow for simplified tracking of modifications to evaluation measures as revisions are submitted for Council approval through the MIDD reporting process. The table below shows current targets from the evaluation matrices for each strategy aligned with community-based care, adjustments to targets (where indicated), achievement of goals set for MIDD Year Three, and success ratings.

Strategy Number	Strategy "Nickname"	Year 3 Targets	Continued Services from Prior Year(s)	New in Year 3	Year 3 Totals [1]	Percent of Year 3 Target	Target Success Rating
1a-1	MH Treatment	2,400 clients/yr	2,174	916	3,090	129%	↑
1a-2	CD Treatment	50,000 adult OP units 4,000 youth OP units 70,000 OST units	N/A	26,978 adult OP units 5,749 youth OP units 72,677 OST units	See "New in Year 3"	54% [2] 144% 104%	↓ ↑ ↑
1b	Outreach & Engagement	675 clients/yr	817	876	1,693	250% [3]	↑
1c	SA Emergency Room Intervention	6,400 screens/yr with 8 FTE [4] 4,340 brief interventions/yr **Adjust for 3/2011 start of 1 FTE**	N/A	4,649 screens 5,475 brief interventions (with 7.5 FTE)	See "New in Year 3"	77% (Adjusted) 135% (Adjusted)	→ ↑
1d	MH Crisis Next Day Appts	750 clients/yr with enhanced services **Adjust to 413 for ~60% reduction in funding/capacity on 1/1/2011**	94	381	475	115% (Adjusted)	↑
1e	CD Professionals Training	125 trainees/yr	77	267	344	275%	↑
1f	Parent Partners Family Assistance [5]	4,000 clients/yr	N/A	N/A	N/A	N/A	N/A
1g	Older Adults Prevention MH & SA	2,500 clients/yr (7.4 FTE) **Adjust to 2,196 clients/yr (6.5 FTE)**	1,164	1,829	2,993	136% (Adjusted)	↑
1h	Older Adults Crisis & Service Linkage	340 clients/yr (4.6 FTE) **Adjust to 258 clients/yr (3.5 FTE)**	30	394	424	165% (Adjusted)	↑
2a	MH Workload Reduction	16 agencies participating	N/A	N/A	N/A	N/A	N/A
2b	Employment Services MH & CD	920 clients/yr (23 FTE) **Adjust to 700 clients/yr (17.5 FTE)**	418	375	793	113% (Adjusted)	↑
3a	Supportive Housing	400 clients/yr [6] (Note: Awarded capacity is now 518) **Adjust to 445 reporting in MIDD Yr 3**	189	317	506	114% (Adjusted)	↑
13a	Domestic Violence & MH Services	700-800 clients/yr **Adjust to 560-640 clients per year** [7]	145	372	517	92% (Adjusted)	↑
14a	Sexual Assault, MH & CD Services	170 clients/yr [3,4]	105	196	301	177%	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.

[2] Other fund sources for these services were available during MIDD Year Three.

[3] Blended funds allow more clients to be served than the portion attributable to MIDD only on which the performance measurement targets are based.

[4] Revised targets accepted by Council in motion of acceptance on May 9, 2011.

[5] This strategy was not implemented or data were not ready or available for analysis within the reporting period.

[6] Working targets from Proposed MIDD Evaluation Plan Matrix Revisions transmitted to Council on 10/1/2010.

[7] Strategy is operating at 80 percent of original funding plan.

Key to Target Success Rating Symbols	
↑	Percentage of annual target is higher than 85%
→	Percentage of annual target is 65% to 85%
↓	Percentage of annual target is less than 65%

1a-1 Increase Access to Community Mental Health Treatment

Over 3,000 King County residents were able to start or continue outpatient MH treatment services with MIDD funding between October 1, 2010 and September 30, 2011. Approximately one-third of the individuals served were newly funded in MIDD's third year, while the other two-thirds carried over from prior years.

The maximum and average number of service visits per person are shown below. Clients typically had just over three service visits per month throughout the year, each lasting about 45 minutes. In some cases, clients were seen by their MH providers up to two times per day.

Service Statistics for Outpatient MH

Maximum		Average	
Visits	Service Hours	Visits	Service Hours
694	691	29	22

Clients receive individualized treatment through a network of outpatient service providers licensed as community MH agencies. A detailed listing of provider agencies appears in Exhibit 1 on Page 41.

Symptom reduction outcome information for an eligible sample of Strategy 1a-1 participants is available on Page 36 of this report.

1a-2 Increase Access to Community Substance Abuse Treatment

Substance abuse outpatient (OP) service units include hours for assessments, individual counseling, group counseling, and case management. For youth, these service units include urinalysis testing as well. For opiate substitution therapy (OST), service units are dose days when individuals receive medications.

The MIDD helped 2,635 people in OP treatment and 714 in OST treatment during MIDD Year Three. The number of units purchased and total payments for the evaluation time frame (October 2010 to September 2011) are shown below. Note that amounts here differ from fiscal reporting, as MIDD funds are allocated on a calendar year cycle. Also, these amounts tend to vary from year to year due to the availability of state funds for SA treatment transferred on their fiscal year cycle.

	MIDD Year Three	
	Units Paid	Payments
Youth OP Treatment	5,794	$ 262,751
Adult OP Treatment	26,978	$ 826,833
Adult OST Treatment	72,677	$1,023,715

1b Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities

Using a trauma-informed approach, 1,693 people experiencing chronic homelessness and/or debilitating addictions to drugs and alcohol were engaged through Strategy 1b during the current reporting period. While the program goal is to serve 675 clients per year, MIDD dollars leverage federal matching funds to help nearly three times as many people.

Key aspects for the successful engagement of individuals with multiple needs include:

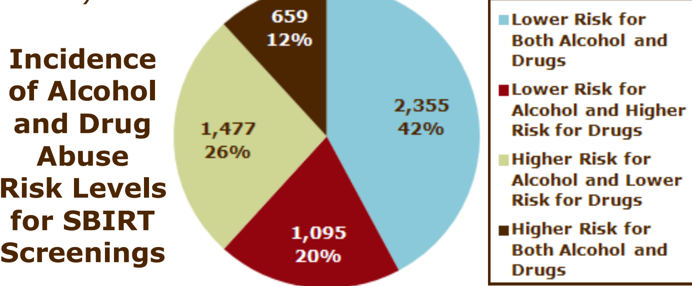
- Understanding how past trauma contributes to on-going vulnerabilities in survivors who may need treatment services
- Using harm reduction, or the moderation of risky behaviors rather than complete abstinence, to meet potential clients "where they are"
- Overcoming resistance and preparing people for change using motivational interviewing techniques such as asking their permission, reflective listening after open-ended questions, and affirming their strengths and successes.

1c Emergency Room Substance Abuse Early Intervention Program

Strategy 1c funds Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs in four area hospitals: Harborview Medical Center, Highline Medical Center, Valley Medical Center, and St. Francis Hospital. These programs seek to engage persons at risk for substance use disorders who are admitted to emergency departments for a number of different reasons, including accidents, acute intoxication, and suicidal ideation.

In the past year, 5,589 SBIRT service encounters had valid screening scores for both alcohol and drug abuse risk. In 58 percent of all cases, persons were screened at higher risk for alcohol abuse, substance abuse, or both (see pie chart below).

Incidence of Alcohol and Drug Abuse Risk Levels for SBIRT Screenings



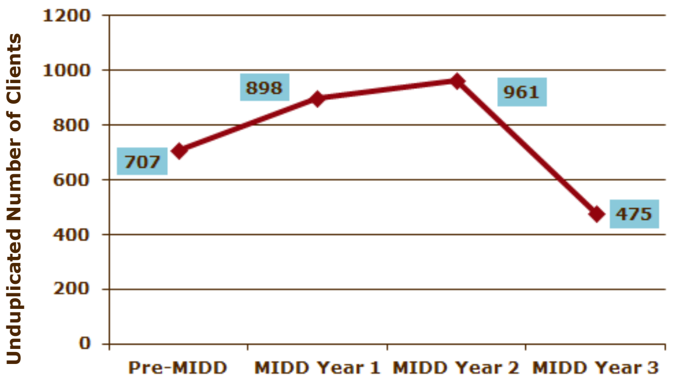
Since January 2009, SBIRT has served 9,337 unique patients in over 15,000 service encounters at area hospitals. The average length for completed encounters was 43 minutes, but varied according to level of risk as identified in screening.

1d Mental Health Crisis Next Day Appointments and Stabilization Services

Timely follow-up after a MH crisis can help clients avoid the need for psychiatric hospitalization. The MIDD enhanced established crisis stabilization services by funding psychiatric medication evaluations performed by specially-credentialed staff. During 2009 and 2010, the number of patients receiving medication management services increased by 36 percent over levels measured prior to MIDD start up. Medical service episodes increased by 51 percent, and medical service hours by 45 percent, during this time period.

In January 2011, a major reduction in state MH funding resulted in a 57 percent decrease in the core capacity to deliver next day appointments. These cuts then led to in a drop in enhanced services to pre-MIDD levels as shown below.

Clients with Crisis Medication Management



1e Chemical Dependency Professional Education and Training

Thirty-one agencies received reimbursement support for costs associated with professional certification of 344 chemical dependency professionals (CDPs) and/or CDP trainees during MIDD's third year. Other workforce development activities funded under Strategy 1e during this time were: 1) Partnering with the University of Washington School of Social Work to create more CDP learning opportunities, and 2) Contracting with The Northwest Frontier Addiction Technology Transfer Center to provide technical assistance and both introductory and advanced trainings on Motivational Interviewing and Clinical Supervision to 108 unduplicated participants.

Comments from trainees indicated they found the following aspects of these trainings most useful:

- "Real plays" versus role plays
- Learning how to "roll with resistance"
- Gaining skills to "work through negativity"
- Breaking problems down to "smaller scale."

1f Parent Partner and Youth Peer Support Assistance Program

In September 2011, following OC review of revisions to this strategy, MHCADSD began intensive work with a contracted consultant to move forward on its implementation. Strategic Learning Resources was chosen to conduct an updated needs assessment, create and implement the necessary foundational infrastructure, recruit staff, constitute a board, locate office space, and otherwise establish a Family Support Organization (FSO). The newly developed organization will be a non-profit agency run by families in support of one another.

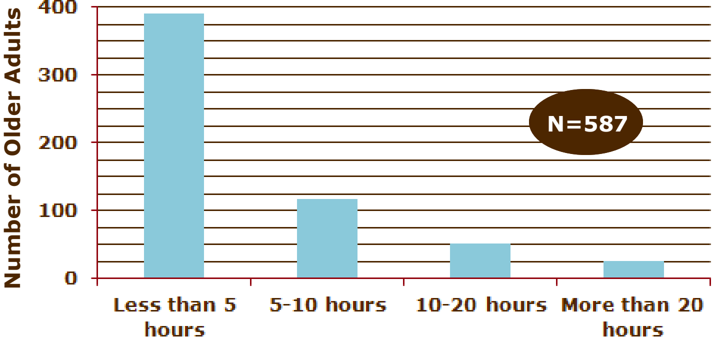
As reported in the MIDD Year Three Progress Report, the Parent Support Specialist who is funded by Strategy 1f continues to facilitate the King County Parent Partner Network and offers training and technical assistance to a variety of family-serving organizations, including those associated with Strategy 6a (Wraparound Services for Emotionally Disturbed Youth).

1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+

On the cutting edge of health care reform, Strategy 1g reaches out to older adults in their primary care settings to screen for symptoms of mental illness and/or substance misuse. When screening results are above a clinical threshold for concern, rapid brief intervention services are made immediately available on site.

An outcomes analysis for individuals with measures of depression and/or anxiety at two separate points in time showed a reduction in symptoms for over two-thirds of those participating in relatively brief (see below) MH treatment. Those with the most severe symptoms at initial assessment were found to have the greatest reductions in symptom severity. Successful outcomes were realized, on average, in as few as ten visits or within approximately seven service hours.

Service Hours for Year Three Treatment Exits



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

The Geriatric Regional Assessment Team (GRAT) responds to crisis referrals for older adults within 24-hours of receiving a call. Clinicians specializing in geriatric mental health conduct in-home assessments, linking individuals with essential resources throughout King County, often diverting them from evictions and hospitalizations.

In the year before the MIDD, the GRAT averaged 19 referrals to their program per month, or 227 in a one-year period. This average rose to 39 per month in the year immediately following MIDD expansion, an increase of over 100 percent. The average number of referrals staffed in GRAT's third year of expanded capacity was 42 per month, down slightly from 46 in the MIDD's second year.

The table below shows the most common linkages to other services upon discharge from GRAT during this reporting period. Future data will track diversions from hospitals and homelessness.

Referrals at Discharge (Multiple Possible)	Number
Medical	233
Self/Family/Friend/Neighbor/Guardian	201
Adult Protective Services	114
Community MH Center	71
Inpatient/Care Facility	59
Division of Aging	52

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

During MIDD Year Three, all nine agencies now providing evidence-based supported employment (SE) services underwent fidelity reviews conducted by specially-trained interdisciplinary teams. Each review lasted a minimum of two full days, including interviews with agency administrators, clinicians, employment specialists, and both currently employed and job-seeking SE clients. Field observations of job development activities and client chart reviews were another part of this process. Adherence to the evidence-based model of SE developed at Dartmouth College was rated for 25 different program components, and written feedback was provided to all agencies for quality improvement and program development purposes. Programs with the highest fidelity scores are believed to produce the best outcomes in the long run, although not enough data are available to conduct those analyses yet.

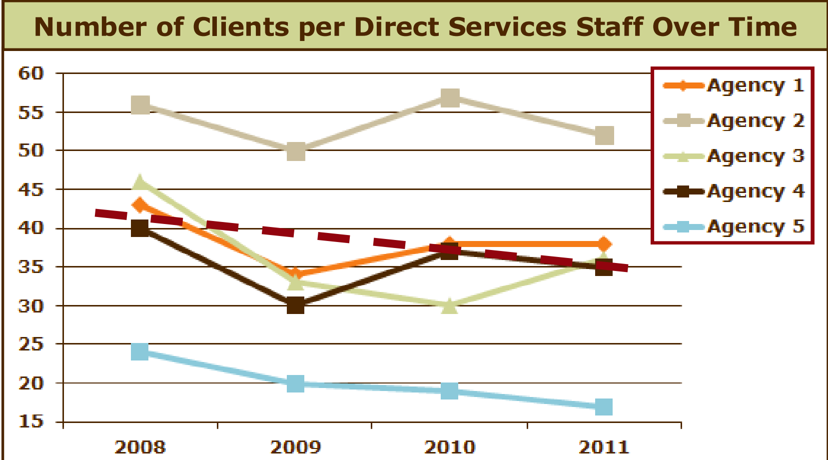
Please see Page 36 for current Strategy 2b outcomes information. Potential future evaluation may examine the ancillary benefits of SE participation by comparing individuals who do not gain competitive wage jobs with those who do.

2a Workload Reduction for Mental Health

The workload reduction initiative allocates funds to 16 mental health agencies for the purpose of providing adequate staffing to meet the demand for mental health services. Each agency created its own plan for reducing case manager workloads and funds have been spent in accordance with those approved plans. As of September 2010, 132 new direct service staff positions were reportedly filled systemwide that could be attributed to Strategy 2a. This number rose to 145 in March 2011, despite state budget cuts which led seven agencies to eliminate more than 75 total staff positions.

Assessing the impact of MIDD-attributed staffing increases on client-to-staff ratios was the focus of analyses recently conducted. Five agencies, chosen for the high reliability of data they submitted, were used in the illustration at right to show both individual agency trends (colored lines) in the number of clients per direct services staff member, as well as the average trend (red dashed line) across all sampled agencies over the past four years.

Depending on the agency, client-to-staff ratios ranged from 57:1 on the high end to 17:1 on the low end. Most, however, fell in the middle range of about 40:1. Overall, the highs and lows balanced out such that average caseload size was reduced from 42 down to 35 clients per direct services staff member; this represents a 17 percent reduction in client-to-staff ratios, which aligns with the case study done in 2009.



3a Supportive Services for Housing Projects

Housing support services are customized to help people live independently in stable housing despite mental illness and/or substance use disorders. Each year, Strategy 3a funding is pooled with other available funds and awarded to agencies through a competitive process in the form of grants lasting for five-year periods. This means that grants awarded in MIDD's first year will be not be due for renewal until MIDD's sixth year, enabling the capacity for housing units that offer MIDD supportive services to continue increasing.

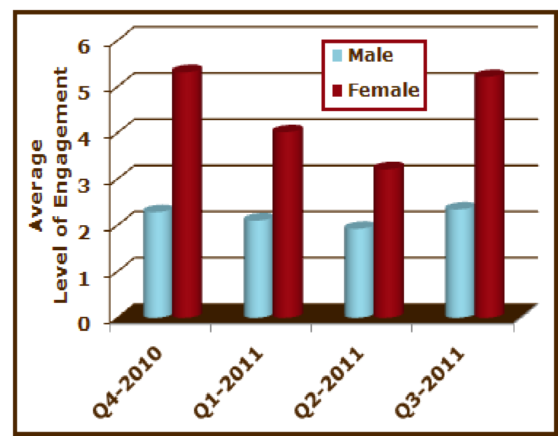
In January 2011, grants were awarded to each of the following provider agencies, bringing the total awarded capacity to 518 units, 445 of which began reporting data prior to October 2011:

Provider Agency	Project	Capacity
Transitional Resources	Avalon Place	16
Downtown Emergency Service Center	Kerner Scott House	13
Harborview	Housing First Vouchers	18
Evergreen Treatment Services	REACH Vouchers	20
Sound Mental Health	Gossett Place	53
TOTAL NEW SUPPORT UNITS		**120**

Turnover in supported housing units open for at least a year has been quite low throughout the current reporting period, at only 69 of 398 units, or 17 percent. Considering that many who leave these housing services do so because less support becomes necessary over time, it is an encouraging sign that offering support personnel can improve housing retention rates.

The extent to which individuals choose to engage in supportive programming can vary over time and by gender as shown below, where zero is "not engaged" and six is "extremely engaged". When additional information is available, engagement level will be examined in relationship to outcomes.

Level of Engagement by Gender at Wintonia*



***Wintonia was the first Strategy 3a project, which opened in April 2009.**

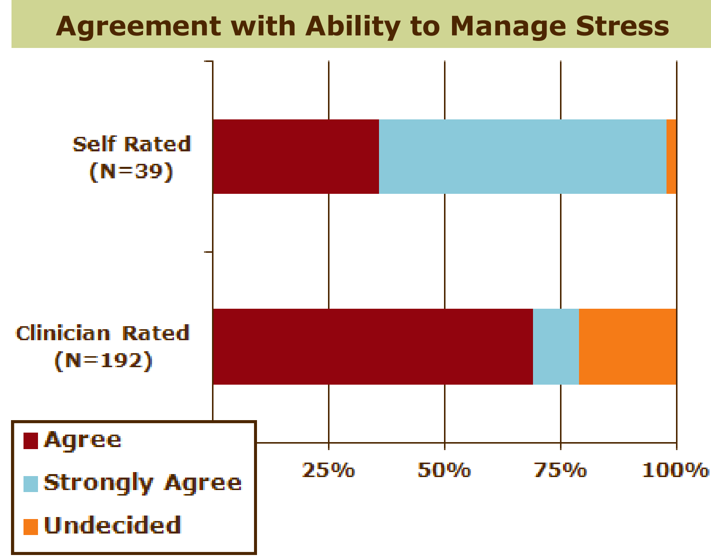
13a Domestic Violence and Mental Health Services

Strategy 13a enhances services at domestic violence (DV) advocacy agencies by offering MH and CD screening, counseling, and consultation. In MIDD's third full year, screenings were offered to 1,198 individuals served by Domestic Abuse Women's Network (DAWN), Eastside Domestic Violence Program, New Beginnings, and Refugee Women's Alliance (ReWA). Across all programs, 801 people (about 67 per month) were found to have significant MH or CD concerns. Of the 676 who were referred to agency MH professionals, 517 (76%) received at least one group, individual or case management service.

Evaluation efforts also track time spent in consultation between the MIDD-funded licensed therapists and DV advocates/others about MH or CD issues. Over a three-year period, across all four agencies, average hours per month spent in internal (within-agency) consultations have decreased as the advocates working with survivors have become more knowledgeable about the MH needs of their clientele.

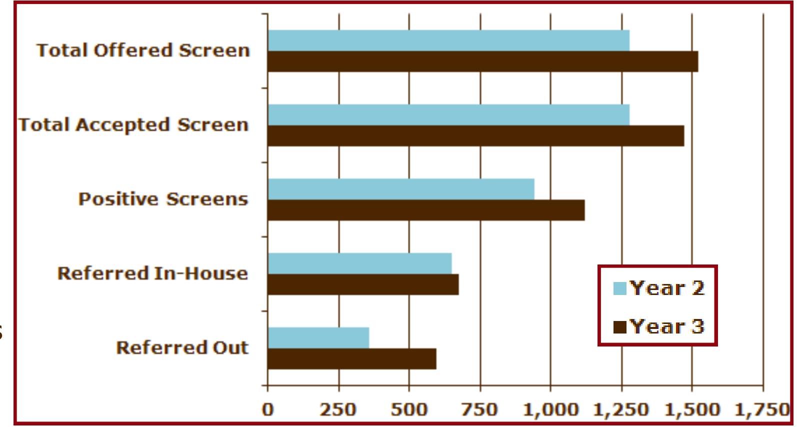
Clients who are seen by therapists in three separate months become eligible for outcomes measurement. The survey instrument used to measure outcomes can be completed by clinicians and/or clients. For the first outcomes-eligible sample, 62 percent of individuals agreed strongly when rating their level of agreement with a statement about their ability to better manage stress in their lives, as a result of having the additional support of a therapist. See graph below.

Agreement with Ability to Manage Stress



In surveys received throughout MIDD's third year, not a single person disagreed with statements about the positive role of their Strategy 13a therapists in regard to helping them with stress management, decision making, and self-care.

14a Sexual Assault and Mental Health Services



Four sexual assault survivor agencies in King County blended their MIDD funds with other revenues to offer specialized trauma-focused therapy services to more clients. They also implemented universal screening for MH and CD issues. While screenings increased between the second and third MIDD years, as shown at right, the overall percentage of positive screens remained level at about 75 percent. For both years, the percentage of people who screened positive that were referred to MH professionals within the agencies stayed above 60 percent. In MIDD Year Three, there was an increase in the number of people referred out to external MH and CD services. The "referred out" category in the graph above also includes sexual assault-specific referrals between the four agencies. Multiple referrals (both internal and external) were possible, depending on the needs and resources of the individuals screened.

Integrating Systems: Sexual Assault, Domestic Violence, Mental Health, and Chemical Dependency

Alicia Glenwell was always interested in helping others. She began volunteering for a crisis line shortly after college and developed a passion for the work. She moved into paid positions that eventually lead to directing community programs. Alicia now serves as the Systems Coordinator for Strategies 13a and 14a. As the Systems Coordinator, Alicia provides ongoing coordination, cross training, policy development, and consultation between mental health and chemical dependency treatment providers, and agencies providing domestic violence and sexual assault services throughout King County.

Different human services disciplines have historically had a variety of philosophies and practices. Programs often operated in silos and even sometimes gave conflicting messages to people. Coordination and collaboration efforts are happening and a lot of progress has been made, but more work is needed to fully integrate care. The Systems Coordinator facilitates this growing systems change.

Alicia enjoys the broad scope of her job. She supports existing bridges by increasing communication among individuals and agencies. She simplifies the logistics of referrals across organizations and cultivates reciprocal consultations among providers. Her multi-disciplinary trainings (see 2011 sampling at right) build relationships and increase the understanding that philosophies are now more similar than people realize. In this reporting period, at least 170 were trained.

Additionally, Alicia has the opportunity to impact change at the policy level. For example, she developed a set of best practice guidelines that mental health agencies can use in creating or enhancing policies and procedures for responding to disclosures of domestic violence. Along with continuing to facilitate cross-disciplinary connections, Alicia will be offering technical assistance to agencies in applying the guidelines to their specific programs in the next year. Her efforts assist the evolution of systems change—change that will ultimately increase both resiliency and coping skills among domestic violence and sexual assault survivors.

Number of Professionals Trained by Discipline

Topic	Date	Training Length	Discipline		
			CD	DV	MH
Essential Strategies for Working With Survivors of Domestic Violence	1/24/2011 Morning	1.5	5	0	0
Essential Strategies for Working With Survivors of Domestic Violence	1/24/2011 Afternoon	1.5	6	0	0
Systems of Oppression and DV	2/11/11	3	4	0	5
Mental Health First Aid for DV Program Managers	5/9/11	4	0	3	0
Essential Strategies for Working With Survivors of Domestic Violence	6/8/11	1	7	0	0
King County Domestic Violence and Sexual Assault Services: Understand, Navigate and Connect	6/23/11	3	22	0	19
Connecting Disciplines	8/25/11	2	15	14	12
Meeting on the Bridge: Working Together to Support Survivors of Domestic Violence	8/26/11	1.5	8	6	5
Overview of Orders for Protection	9/13/11	2	0	0	19
King County Domestic Violence and Sexual Assault Services: Understand, Navigate and Connect	9/15/11	3	9	0	11
	Totals	22.5	76	23	71

Strategies with Programs to Help Youth

The youth category has strategies designed to expand prevention and early intervention programs, to expand assessments for youth involved with the juvenile justice system, and to provide comprehensive team-based interventions through Wraparound. In addition to helping more youth in crisis, funding is available to maintain and expand both Family Treatment Court and Juvenile Drug Court.

Program Utilization and Performance Measurement Targets for Strategies with Programs for Youth

As indicated on Page 8, performance targets are outlined for each strategy in the MIDD Evaluation Plan matrices. During MIDD Year Three, matrix modifications for several youth strategies were proposed to better reflect program outputs, to clarify information, or to address program changes. For example, new targets were proposed for Strategy 5a (Juvenile Justice Youth Assessments) and when Strategy 8a (Family Treatment Court) reached capacity, their performance measures needed revision. Matrix changes proposed in the MIDD Year Three Progress Report will be formally adopted upon Council acceptance of the Recommendations for Plan Revisions as outlined on Page 37 of this report.

Strategy Number	Strategy "Nickname"	Year 3 Targets	Continued Services from Prior Year(s)	New in Year 3	Year 3 Totals [1]	Percent of Year 3 Target	Target Success Rating
4a	Parents in Recovery SA Services [2]	400 parents/yr	N/A	N/A	N/A	N/A	N/A
4b	Prevention - Children of SA [2]	400 children/yr	N/A	N/A	N/A	N/A	N/A
4c	School-Based MH & SA Services	2,268 youth/yr (19 programs) [3] **Adjust to 1,550 youth/yr (13 programs)**	N/A	at least 1,896	1,896	122% (Adjusted)	↑
4d	Suicide Prevention Training	1,500 adults/yr 3,250 youth/yr	N/A	1,065 adults 7,873 youth	See "New in Year 3"	71% 242% [4]	→ ↑
5a	Juvenile Justice Youth Assessments	Coordinate 500 assessments/yr [5] Provide 200 psychological services/yr Conduct 140 MH assessments Conduct 165 CD assessments **Adjust for 1/2011 start for two FTE**	N/A	580 coordinations 98 psychological services 143 MH assessments 234 CD assessments	See "New in Year 3"	116% 49% (Unadjusted) 136% [4] 189% [4] (Adjusted)	↑ ↓ ↑ ↑
6a	Wraparound	920 youth/yr [6] **Adjust to 374 youth/yr** (10 fewer facilitators in first half of 2011 and removing non-enrolled youth in families served from target)	219 enrolled youth	195 enrolled youth	414 enrolled youth	111% (Adjusted)	↑
7a	Youth Reception Centers [2]	TBD	N/A	N/A	N/A	N/A	N/A
7b	Expand Youth Crisis Services [2]	To be measured in MIDD Year Four	N/A	N/A	N/A	N/A	N/A
8a	Family Treatment Court Expansion	No more than 90 children per year [7]	N/A	N/A	83	92%	↑
9a	Juvenile Drug Court Expansion	36 **new** youth/yr (up to 5.5 FTE)	55	26	81	72% (New only)	→
13b	Domestic Violence Prevention	85 families/yr	81	53	134 families	158%	↑

1 Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
2 This strategy was not implemented or data were not ready or available for analysis within the reporting period.
3 Working targets from Proposed MIDD Evaluation Plan Matrix Revisions transmitted to Council on October 1, 2010.
4 Blended funds allow more clients to be served than the portion attributable to MIDD only on which the performance measurement targets are based.
5 New targets proposed on July 1, 2011. Program provided 49 psychological services in Q4-2011 (on pace to reach 100% of target in MIDD Year Four).
6 Original target included non-enrolled youth and/or other young members of families served. Proposed revision to 450 enrolled youth/yr.
7 Program has now reached capacity so service cap is being monitored.

Key to Target Success Rating Symbols	
↑	Percentage of annual target is higher than 85%
→	Percentage of annual target is 65% to 85%
↓	Percentage of annual target is less than 65%

4a Services for Parents in Substance Abuse Outpatient Treatment (On Hold)

Strategy 4a, which remains on hold, is based on concepts developed through research done by the Social Development Research Group in the School of Social Work at the University of Washington in Seattle. This program, known as "Families Facing the Future", is designed to help parents in substance use disorder recovery become more effective parents in order to reduce the risk that their children will abuse drugs or alcohol in the future. When funding is made available, about 400 parents per year are expected to participate.

4b Prevention Services to Children of Substance Abusers (On Hold)

This strategy, which remains on hold for budgetary reasons, will attempt to break the cycle of addiction using proactive, family-based approaches. When funded, 16 two-hour long sessions will be delivered to 400 area youth and children whose parents are participating in chemical dependency treatment or are in recovery.

4c Collaborative School-Based Mental Health and Substance Abuse Services

In the first full year of implementation, Strategy 4c served more than 1,896 individuals through 10 providers delivering 13 different programs at schools throughout King County. Depending upon the school district and area, targeted students were those attending either middle school or junior high. Both MH and SA services focused on indicated prevention, early intervention, screening, brief intervention, and referral to treatment. All services aligned with school-wide policies and offered alternatives to traditional disciplinary responses. Please see Page 16 for examples of successes achieved in collaboration with area schools.

Another aspect of Strategy 4c involves delivery of two specific suicide prevention curricula. The table at right shows the number of people trained by region.

Suicide Prevention Trainings for Strategy 4c

	SafeTalk *Suicide Alertness and Awareness Trainings*		Applied Suicide Intervention Skills Trainings(ASIST)	
	Number of Trainings	Number Trained	Number of Trainings	Number Trained
South	2	30	3	59
East	2	31	2	38
North	3	60	-	-
Seattle	5	80	3	65
TOTAL	**12**	**201**	**8**	**162**

Strategy 4c Provider Anne Lung of Neighborcare Health Receives 2011 Community Mental Health and Chemical Dependency Exemplary Service Award for Direct Service

Each year the MHCADS Division of King County's Department of Community and Human Services honors individuals and providers who are nominated by community members and selected by a panel of judges. In a letter of support for the 2011 recipient, Anne Lung, Seattle World School's principal wrote, "In her first year, Ms. Lung quickly identified scores of students with significant mental and emotional health issues. To support the students and address their diverse needs, she developed multiple support groups and worked tirelessly to develop empathy and leadership skills amongst the participants. The impact of her work…was evidenced in the decline of student discipline issues this academic year. Several of her support groups became positive change agents by conducting an Anti-Smoking Campaign and creating a Student Welcoming Committee…"

In her acceptance speech, Ms. Lung humbly gave the credit for her work to her students (featured on the cover of this MIDD Fourth Annual Report) by saying to them, "You each have a beautiful success story behind you. But if you have had no desire to change, I cannot have the honor to be here today." She also pointed out that in working with students "who do not have the language, transportation, insurance and culture to open up and get help...prevention work comes in all forms and shapes." She shares both tears and laughter with her students as they grow together.

Photo by Don Gulla

Success Stories from the 4c "Hallways"

1

A 14 year old female was suicidal, but her mother thought she just wanted attention. After months of work with her 4c provider, she was diagnosed with major depressive disorder by a psychiatrist and is doing much better on medication.

2

N, a 14 year old male, came to the 4c provider after experiencing physical abuse in his home. Unbeknownst to anyone at school, he had bi-polar disorder and was engaging in dangerous behaviors. Working with N's family, school staff, police, and Child Protective Services, he was admitted to an inpatient facility for needed help.

3

A student caught smoking marijuana on campus was suspended from school. Upon returning, she joined a 4c intervention group and graduated from the group with four months of clean time.

4

A parent of three middle school-aged children, recently divorced and new to the area, was having trouble adjusting. A 4c interventionist helped her process the changes she was going through, while helping her with parenting skills, boundary setting, and local resources to keep her family going strong.

5

After participating in a Concerned Others group at Kenmore Junior High School, one student said "I didn't realize that there were so many other people who had to deal with this...I don't feel so alone."

6

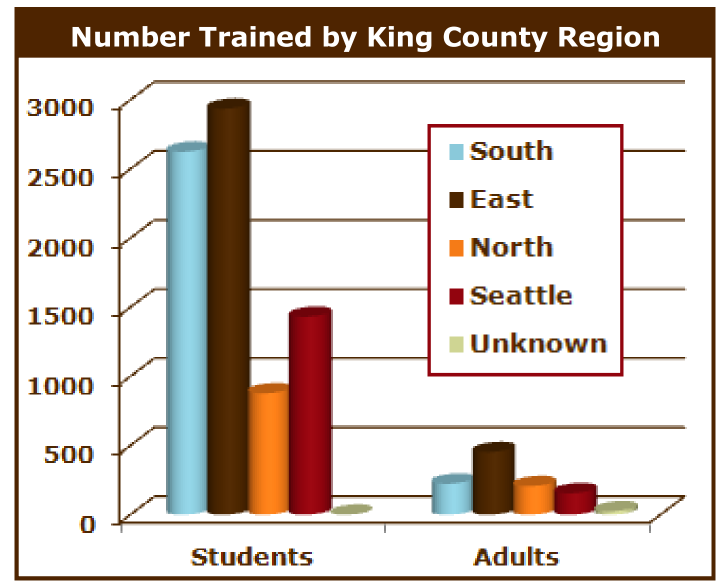
At Hamilton International Middle School in Seattle, a 4c counselor worked with a 7th grader who had been bullied for years by another student. Using the framework and tools gained in an ASIST training, she was able to assess this boy's level of suicidality and helped him craft a safety plan. Over time, he became noticeably less sad and anxious as he developed positive coping mechanisms to deal with stressors in his life.

7

When a middle school student came out at school as being gay, he experienced teasing, isolation and loneliness. Through a 4c counselor, he was connected to several community resources and was helped to apply for a scholarship to attend Camp Ten Trees, a camp for lesbian, gay, bisexual, and transgender (LGBT) youth. His counselor also collaborated with others to address bullying prevention and LGBT awareness. By co-facilitating a confidential group for LGBT students, this 4c provider helped the student connect with other youth working through similar issues. At the end of the year, he expressed an increase in confidence and a feeling of trust in school staff.

4d School-Based Suicide Prevention

The Teen Link program run by the Crisis Clinic was able to reach nearly 8,000 students during the year by combining MIDD funds with other revenues to deliver 313 youth-level sessions. These trainings give teens a safe outlet to talk openly about suicide, self-harm, peer pressure, violence, gender roles, self-image, parental expectations, and even the economy. They are also designed to teach youth skills in helping their friends through life's ups and downs. The number of youth and adults receiving suicide prevention training during MIDD Year Three are shown below:

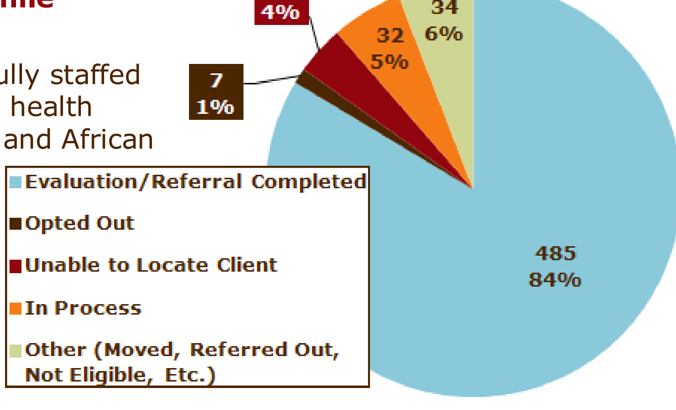


The Youth Suicide Prevention Project (YSPP), trained 1,065 adults in 32 different adult-level sessions during MIDD's third year, including a presentation delivered at the statewide Parent Teacher Association Conference. The YSPP and Crisis Clinic staff also met together quarterly to collaborate and ensure that gaps were filled when certain areas or schools were not being served by either agency.

Efforts to evaluate crisis response plans for the 19 school districts in King County continued to encounter substantial barriers. Although YSPP staff had initially reviewed 17 policies for intervening with students at risk for suicide, few school districts were open to receiving technical assistance to improve their written procedures. Auburn, Bellevue, and Highline are examples of school districts that have shown an interest in adopting more comprehensive crisis plans, in some cases hiring outside consultants. To date, no plans have been rated "exceptional" as defined by having an integrated policy that encompasses prevention, intervention, and post suicide incident concerns.

5a Expand Assessments for Youth in the Juvenile Justice System

The Juvenile Justice Assessment Team (JJAT) became fully staffed in December 2010 when they added a children's mental health liaison and a CDP with experience helping young Latino and African American offenders. Although the new staff did not begin serving clients until early 2011, their contribution enabled the JJAT to complete 143 MH assessments and 234 CD assessments before the end of September 2011. While targets proposed in July 2011 would allow for up to 200 psychological services to be delivered each year, only 98 were needed during MIDD Year Three. These and other encounters combined for 580 "coordination" events for 362 unduplicated youth. Exit data for each encounter are shown above.



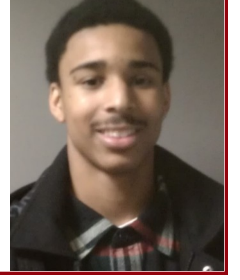
Team Work - JJAT Style!

In order to provide appropriate linkages and treatment, the JJAT has increased the availability of screening and assessment to determine if juvenile justice and child welfare system-involved youth have substance abuse and/or mental health issues. The team provides many services: triage, consultation, substance abuse screening, MH status exams, MH assessments, psychological evaluations and psychiatric consultations. The JJAT is a public/private partnership that includes King County Juvenile Court, Seattle Children's Home, Therapeutic Health Services, and Washington Asian Pacific Islander Families Against Substance Abuse (WAPIFASA). The team consists of diverse professionals from the court, mental health, and substance abuse worlds who find new ways of engaging youth. Their cross-disciplinary, balanced approach enables them to reveal opportunities and resources that may have been missed otherwise. They use their collective expertise to translate best practice findings from research into community-based practice. For example, they now screen for childhood trauma to connect youth to evidence-based programs such as Trauma Focused Cognitive Behavioral Therapy. A clinical psychology intern from Antioch University Seattle's doctorate in psychology program will be joining the team under the supervision of JJAT's psychologist, bringing fresh research information and expanding assessment capacity. In May 2011, MIDD funds allowed JJAT to move into its new location in the Central District. The new setting has helped develop a sense of trust with youth and families. Cultural competence and trust are cornerstones of JJAT. By being physically outside the traditional court and treatment systems the team can explore and use creative, unconventional therapeutic recommendations tailored to each youth. The team harnesses the strengths of the youth and local community-based organizations to re-connect youth with their families, schools, and communities.

JJAT and Juvenile Drug Court Provide Opportunities for Youth to Turn Their Lives Around

One youth recently helped by JJAT was C. His father was diagnosed with cancer when C was in the fifth grade. After being sick for a long time, his dad overcame the cancer and "came back harder and stronger." Despite his recovery, however, the cancer returned. C witnessed his father having a seizure before going into a coma and dying shortly thereafter.

C's father had come from a challenging background and kept his son off the streets. He helped C make good choices, but C began "hanging in the streets" after his dad passed away. He skipped school, smoked marijuana, and ended up in Juvenile Detention. He refused to believe he had a problem despite returning to detention again and again. One day C realized he was seeing the "same cell, same walls" and his eyes began to open. He still wasn't ready to change, though, or just didn't know how to do things differently. After a more serious charge, C was assessed by JJAT, started CD treatment, and was referred to Juvenile Drug Court (JDC). It wasn't easy! He had to "dig deep to the root of the problem." Gaining tools to stay focused and on track, C will soon graduate successfully from JDC and recently got a job that will help him accomplish his goals. C felt like his voice wasn't heard, so now he wants to be a lawyer to make sure that doesn't happen to other youth.



6a Wraparound Services for Emotionally Disturbed Youth

Wraparound is a coordinated system of support, customizing care for youth with severe mental illnesses. The wraparound process is available to youth throughout King County who are involved with multiple service systems. At this time, five MH treatment agencies have wraparound teams. When fully staffed, each team will have one coach, six facilitators, and two parent partners.

Wraparound plans typically join formal services and interventions with community services, interpersonal support, and assistance provided by friends, family, and others in a family's social network. Teams convene frequently to measure components of each plan against relevant indicators of success.

The Strategy 6a evaluation matrix was published in the MIDD Year Three Progress Report clarifying that non-enrolled youth in families served were to be counted toward meeting the performance measurement target of 920 youth per year when programs are fully staffed. As siblings cannot be individually identified, the target requires further revision to include enrolled youth only.

In March 2011, a new tool was developed to track living arrangements, school performance, substance use and other progress indicators every six months. At baseline, combined data from all five providers (see table below) show the diversity of living arrangements for wraparound youth.

Living Arrangement	Number	Percentage
Adoptive Home	5	5.95%
Biological Father	4	4.76%
Biological Mother	27	32.14%
Detention	1	1.19%
ER/Shelter	1	1.19%
Foster Care	5	5.95%
Friend Home	2	2.38%
Group Home	1	1.19%
Homeless	1	1.19%
Independent	3	3.57%
Psychiatric Hospital	1	1.19%
Relative	6	7.14%
Residential Treatment Center	2	2.38%
Split Parenting	1	1.19%
Two Parents	22	26.19%
Other	2	2.38%
Total	84	100.00%

Baseline school measures revealed that about half of the sample attended regularly, 77 percent had Individualized Education Programs (IEPs), and at least 31 (37%) had grades below a "C" average.

7a Reception Centers for Youth in Crisis (On Hold)

The original MIDD Plan for Strategy 7a was to develop a reception facility in order to give law enforcement personnel an option for dealing with youth in crisis. Such a center could be developed to serve as a central coordination point where staff assess the needs of youth and link them to treatment or other services.

When funding is restored for this strategy, a needs assessment will be conducted to ensure that any planned action will best meet the needs of the target population.

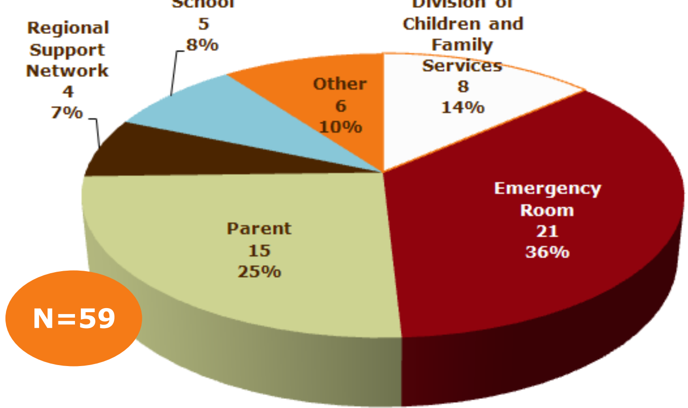
7b Expansion of Children's Crisis Outreach Response Service System

The Children's Crisis Outreach Response Service System (CCORS) expansion under Strategy 7b was funded in MIDD Year Three after a long delay caused by earlier budget shortfalls. Although planning and hiring began in April 2011, it was not until September that data collection instruments were finalized and implemented. Currently, performance targets are being proposed for measurement in MIDD Year Four.

The two key aspects of new programming at CCORS include:

- Providing in-home behavioral support specialists to implement specific interventions for up to eight hours at a time or overnight, as needed, to maintain youth safety
- Developing a marketing plan that reaches out to youth and families in need, diverting them away from unnecessary hospitalizations.

A total of 59 cases were opened in September 2011 that could be attributed to MIDD expansion. Several different sources were responsible for making referrals to CCORS (see graph below). Over half of the referred youth had behavior management issues, at least 47 percent were aggressive/violent or a danger to self, and 20 percent were potentially dangerous to others.



Referrals to CCORS in September 2011

8a Expand Family Treatment Court Services and Support to Parents

Family Treatment Court (FTC) monitors treatment compliance of parents diagnosed with chemical dependencies who have lost custody of their children due to their substance use. Successful "graduates" of FTC have the opportunity to reunite with their families. Expansion under the MIDD doubled the court's capacity to serve families. Performance measurement currently counts the number of children who benefit from parental enrollment, with a cap of 90 children actively engaged annually. In MIDD Year Three, the maximum child count reached 83.

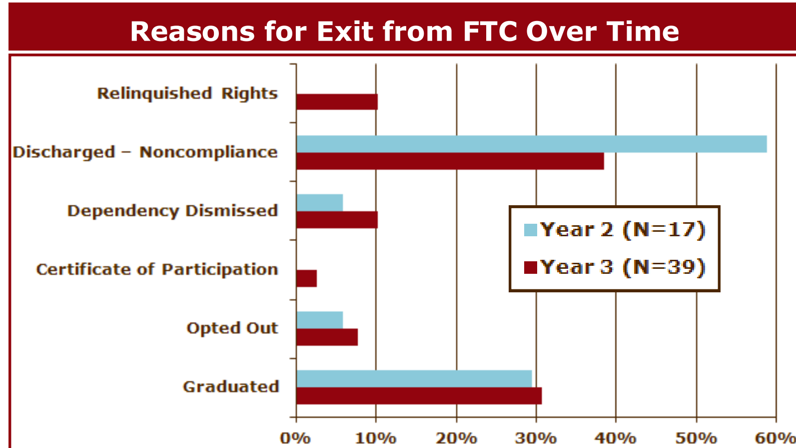
Of the 24 parents participating in FTC who were eligible for analysis of jail use trends, nineteen (79%) showed no increase in jail bookings during their first year in services, the best rate of any strategy included in the outcomes sample. Their aggregate jail days decreased from 685 to 439 (36%).

Reasons for exiting FTC during the second and third year of MIDD expansion are shown in the graphic below. The graduation rate held steady at about 30 percent, while the rate of discharges for noncompliance dropped dramatically.

Family Treatment Court Vision

To promote the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other service needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan.

Reasons for Exit from FTC Over Time



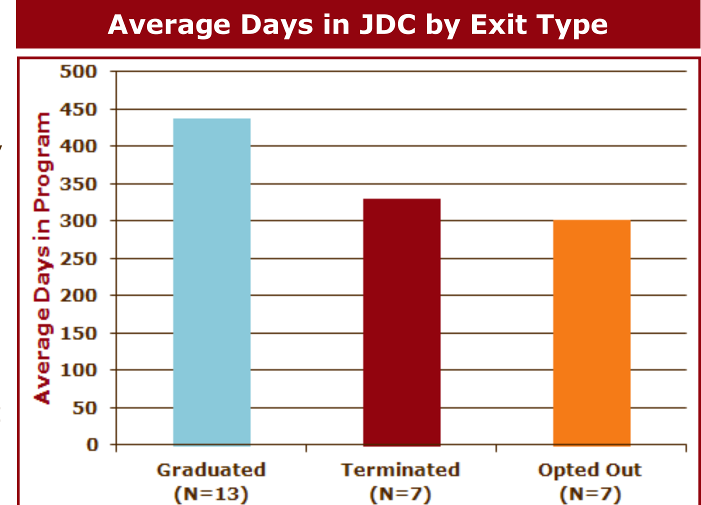
9a Expand Juvenile Drug Court Treatment

Youth with chemical dependencies who come into contact with the juvenile justice system are often given the opportunity to participate in the Juvenile Drug Court (JDC). Though not an easy path, youth who successfully complete the nine to 24 month program can have the charges against them dismissed. For many youth, this earned exoneration, and accompanying sobriety, is the turning point for putting their lives back on track. See the bottom of Page 17 for a success story that illustrates this point and highlights the interconnectivity between Strategy 5a (Juvenile Justice Youth Assessments) and JDC. In MIDD Year Three alone, 50 of the 81 youth served by JDC (62%) were also served by the JJAT team.

Between October 1, 2009 and September 30, 2011, a total of 28 youth exited from the MIDD-expanded JDC program. The average number of days for those who graduated is contrasted against the average number of program days for those terminated by the court for noncompliance and those who opted out of their own accord. As one can see in the graph at right, resources are typically tied up for 11 to 12 months in this strategy, even when the youth are unable for various reasons to fully complete all program phases.

First year jail or detention utilization outcomes for 40 eligible Strategy 9a participants indicated a trend toward increased incarcerations for 60 percent of them. This trend is expected to reverse over time, as the impact of sanctions associated with JDC treatment is most evident early in outcomes measurement.

Average Days in JDC by Exit Type



13b Domestic Violence Prevention

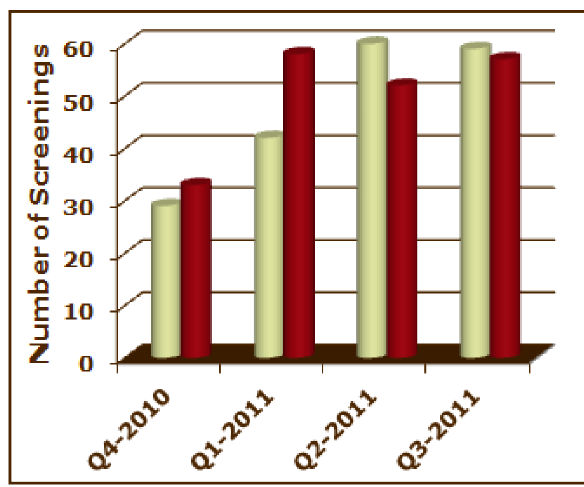
Domestic violence (DV) is estimated to impact 60,000 children per year in King County alone. The Children's Domestic Violence Response Team (CDVRT) reaches out to many children who have been exposed to DV in their homes. The CDVRT is a pioneering program in which Sound Mental Health collaborates with DV advocacy agencies countywide to provide integrated mental health and DV advocacy services.

Although MIDD funding is available to offer a series of group sessions for children dealing with their DV experiences, the "Kid's Club," which began in April 2011, had to be postponed in May, then cancelled in June, due to lack of referrals and attendance. A new start date was set for October 2011. In the meanwhile, the team continued to meet with children and their non-abusive parents either individually or in family sessions.

In September 2011, the CDVRT received training from the Washington State Association for Play Therapy, where they learned "the importance of play when working with children who have experienced trauma that affects the way they can process and use language skills."

In MIDD Year Three, 390 children were screened for CDVRT participation using the Pediatric Symptom Checklist–17. This instrument rates levels of internalizing, externalizing, and attentional behaviors with a maximum possible score of 34. Screening results by quarter are shown below. Total scale scores above 14 are considered above the clinical threshold. Positive screens rose throughout the year.

Number of Children Screened by CDVRT in MIDD Year Three



How to Help Children Who Have Witnessed Domestic Violence*

1. Do not be afraid to talk about what happened in their family.
2. Maintain a consistent, predictable structure and schedule.
3. Be aware of your physical boundaries.
4. Be clear with children about what your expectations for behavior are.
5. Talk to them!
6. Observe themes of play.
7. Protect the child.
8. Offer the child choices.
9. Ask for help. Resources are available!

* Tip sheet provided by Alicia Glenwell, featured on Page 13.

Potential Effects of DV on Children

Excerpts from a handout entitled "The Effects of Domestic Violence on Children".

Emotional

- Grief for family and/or personal losses
- Confusion about conflicting feelings toward each parent
- Anger, depression, or embarrassment

Cognitive

- Believe violence is their fault or blame others for their behavior
- Believe it is acceptable to hurt others
- Fear of expressing feelings

Behavioral

- Overly aggressive or overly passive
- Rigid defenses—aloof, sarcastic, defensive
- Excessive attention seeking or out of control

Social

- Isolation from friends and relatives
- Difficulty trusting—especially adults
- Engaged in exploitative relationships as either the victim or victimizer

Physical

- Stomach aches or headaches
- Nervous, anxious, short attention span
- Self harm, substance abuse, suicide

A caring, supportive network can lessen the negative impacts of DV on children. Feeling safe allows resumption of normal developmental tasks.

Jail and Hospital Diversion Strategies

Strategies grouped in the diversion category intend to help those with mental health and substance abuse issues avoid costly incarcerations and psychiatric hospitalizations by linking them with appropriate community treatment. Diversion programs include education and training for justice-system involved individuals, jail and hospital re-entry services, intensive case management, and therapeutic courts.

Program Utilization and Performance Measurement Targets for Jail and Hospital Diversion Strategies

As shown below, "Year Three Targets" were adjusted for three diversion strategies: 10a (Crisis Intervention Team Training), 12a-1 (Jail Re-Entry Capacity Increase), and 12b (Hospital Re-Entry Respite Beds). For example, several Train the Trainer offerings were added to the course catalog for Strategy 10a that necessitated adoption of a formula to credit the provision of these classes against targets previously published. Please note that the target success rating for Strategy 11b is now calculated based on "opt-ins" to the Regional Mental Health Court (RMHC), rather than on referrals made by area cities or screenings performed. Demographics and outcomes, however, will continue to track all persons screened by RMHC.

Strategy Number	Strategy "Nickname"	Year 3 Targets	Continued Services from Prior Year(s)	New in Year 3	Year 3 Totals [1]	Percent of Year 3 Target	Target Success Rating
10a	Crisis Intervention Team Training	375 trainees/yr (40-hr) 1,000 trainees/yr (1-day) **Adjust to count new offerings**	N/A	268 (40-hr) 265 (1-day) 142 (Train the Trainer)	275 (40-hr) 626 (1-day) (NOT unduplicated) [2]	73% (Adjusted) 63% (Adjusted)	→ ↓
10b	Adult Crisis Diversion [3]	3,000 adults/yr	N/A	N/A	N/A	N/A	N/A
11a	Increase Jail Liaison Capacity	200 clients/yr	8	187	195	98%	↑
11b	MH Court Expansion	115 clients/yr (9 FTE) [4*]	3	28 newly opted in	31 opt-ins *	27%	↓
12a	Jail Re-Entry Capacity Increase	300 clients/yr (3 FTE) **Adjust to 250 clients/yr (2.5 FTE)**	74	186	260	104% (Adjusted)	↑
	CCAP Education Classes	600 clients/yr	32	513	545 (NOT unduplicated) [5]	91%	↑
12b	Hospital Re-Entry Respite Beds	350-500 clients/yr [4] **Adjust to 29 clients per month**	began in 9/2011	26	26	90% (Adjusted)	↑
12c	PES Link to Community Services	75-100 clients/yr	37	74	111	148%	↑
12d	Behavior Modification for CCAP	100 clients/yr	17	114	131	131%	↑
15a	Adult Drug Court Expansion	250 clients/yr [4]	108	205	313	125%	↑
16a	New Housing and Rental Subsidies	40 rental subsidies/yr [4] Tenants in 25 capitally-funded beds without MIDD-funded support services through Strategy 3a	57	26	52 tenants (rental subsidies) 31 tenants (Brierwood)	130% 124%	↑ ↑
17a	Crisis Intervention/MH Partnership [3]		N/A	N/A	N/A	N/A	N/A
17b	Safe Housing - Child Prostitution [3]		N/A	N/A	N/A	N/A	N/A

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.

[2] Train the Trainer courses focused on: Youth, 9-1-1 Dispatch, Corrections, and MH First Aid and ranged from 12 to 40 hours each. Adjusted count = # of attendees X days or week. Those attending multiple trainings counted more than once.

[3] This strategy was not implemented or data were not ready or available for analysis within the reporting period.

[4] Working targets from Proposed MIDD Evaluation Plan Matrix Revisions transmitted to Council on October 1, 2010.

[5] Many clients take both GED/LSW classes and DV prevention classes - credit is given to each sub-strategy separately.

* Error in previously reported FTE count has been corrected. Performance measurement now based on number of opt-ins, not number of referrals/screens.

Key to Target Success Rating Symbols	
↑	Percentage of annual target is higher than 85%
→	Percentage of annual target is 65% to 85%
↓	Percentage of annual target is less than 65%

Photo by Don Gulla

10a Crisis Intervention Team Training for First Responders

In 2010, King County MHCADSD in partnership with the King County Sheriff's Office contracted with the Washington State Criminal Justice Training Commission (WSCJTC) to provide Crisis Intervention Team (CIT) training for first responders throughout the county. The CIT courses provide intensive training to law enforcement and other first responders, teaching them to effectively assist and respond to people with mental illness or substance use disorders and better equipping them to help individuals access the most appropriate and least restrictive services while preserving public safety.

Between October 2010 and September 2011, CIT education was provided to 533 participants, either through 40-hour trainings or eight-hour in-service trainings. In addition, the WSCJTC was able to provide Train the Trainer classes on Mental Health First Aid, CIT for Corrections and Dispatch, and CIT-Youth. This year also marked the first annual CIT Regional Training Conference, a three day event intended to bring together professionals and advocates in the community to address a variety of topics related to crisis intervention and responding to individuals in mental health and/or substance use crises. A total of 62 individuals attended the inaugural regional conference.

2011 Exemplary Service Award Recipient for Service Innovation

After attending CIT training, Deputy Winters of the Metro Transit Police, a unit of the King County Sheriff's Office, did not just file his class notes in a desk drawer. Instead he took his newly found knowledge onto the streets and immediately put what he had learned into practice. While serving as a role model to other officers, he became a champion of the CIT training programs, encouraging others in law enforcement to take advantage of this excellent resource which the MIDD makes available at no cost to participants.

Deputy Joseph R. Winters, center, with WSCJTC CIT trainers Lisbeth Eddy and Sergeant Don Gulla.

10b Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team

The Adult Crisis Diversion strategy consists of three linked programs:

1. A Crisis Diversion Facility (CDF) where police and other first responders may refer adults in crisis for short-term stabilization, crisis intervention and referral to appropriate community-based services
2. A Crisis Diversion Interim Services Facility (CDIS) which will serve as a place where people leaving the CDF who are homeless, or who need additional supports to return to their current living arrangement, may receive up to two weeks of further stabilization and linkage to housing and services
3. A Mobile Crisis Team (MCT) that will respond to police and other first responder requests for on-site evaluation and crisis resolution, as well as linkage to the CDF.

These programs await the disposition of the legal challenge to the City of Seattle's land-use designation for the selected site following a court hearing on September 30, 2011. Despite the delay in implementation, much was accomplished in regard to community relationship-building and program clarification this past year. The progress was in large part due to the formation of an advisory committee, a group consisting of neighborhood residents and stakeholders, who spent 20 hours over seven months writing a Good Neighbor Agreement with the Downtown Emergency Service Center (DESC), the provider selected for all three programs of the crisis diversion strategy.

Additionally, a pilot MCT program was implemented in the fall of 2011 to respond to calls for assistance from three law enforcement agencies and one fire department. This pilot will inform county-wide implementation practices and will help establish collaborative working relationships between the MCT and first responders.

On January 24, 2012, Superior Court Judge Susan Craighead issued her ruling on the Land Use Petition Act (LUPA) challenge by Jackson Place Alliance for Equity regarding the City of Seattle issuing a building permit for a crisis diversion facility to be operated by DESC at 1600 S. Lane, Seattle. Judge Craighead dismissed all the arguments presented by the Jackson Place Alliance and denied the LUPA challenge. The King County Department of Community and Human Services is currently working on next steps.

11a Increase Jail Liaison Capacity

Strategy 11a provides funding to offer liaison services to adjudicated individuals ordered to the King County Work and Education Release (WER) program. The jail liaison's job involves directly connecting adult offenders with community services with the goal of reducing jail recidivism.

Of the 268 WER liaison clients who were eligible for outcomes measurement in this reporting period, 200 (75%) had at least one jail booking in either the year before they began liaison services or in the year that followed, not counting the jail episode that remanded them to WER. Of the 200 with jail activity as mentioned above, 120 individuals (60%) decreased their jail bookings over time and 108 (54%) decreased their jail days. Longer term recidivism outcomes will be available in the Fifth Annual Report.

12a-1 Jail Re-Entry Program Capacity Increase

The Re-Entry Case Management Services (RCMS) program provides short term case management to jailed individuals with mental health and/or substance abuse problems who are close to release and in need of assistance to reintegrate into their communities. The long term goal of this strategy, like Strategy 11a, is reducing recidivism. Early outcome results are encouraging. For the 185 people eligible for longer term outcomes, jail days were reduced by 28 percent between the pre-MIDD and second year post periods.

Under MIDD expansion, more inmates in south King County were able to get help from the two case managers funded for the entire year and one other for half of the year. Overall capacity will be slightly reduced, however, due to cuts in state funding which previously funded the core program.

11b Increase Services for New or Existing Mental Health Court Programs

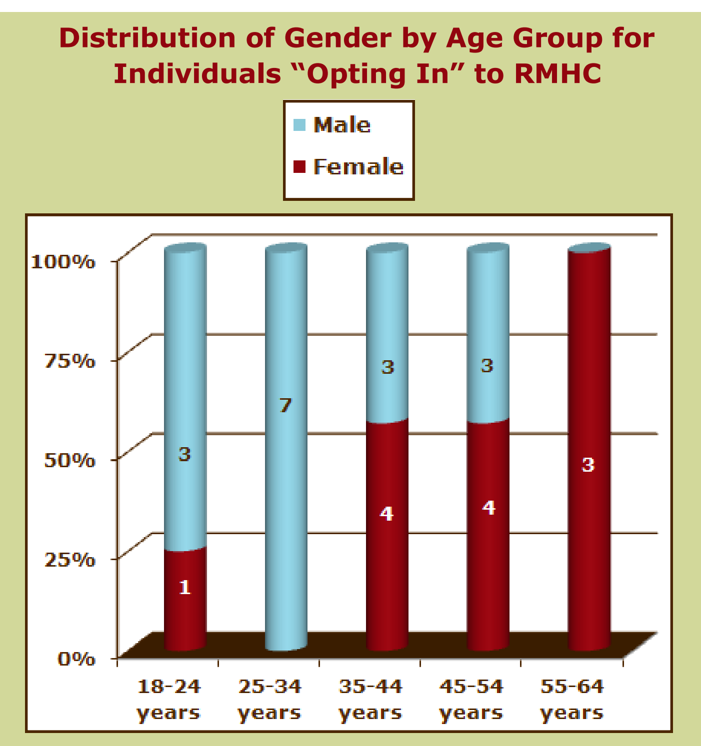
King County District Court's Regional Mental Health Court (RMHC) was expanded with MIDD funds to allow any city to refer any defendant with a misdemeanor offense for possible acceptance by the RMHC. Between October 1, 2010 and September 30, 2011, 156 unique individuals were referred on 175 different charges by 25 (of 38 possible) municipalities. Of those referred, 128 court candidates were screened for clinical diagnostic eligibility. Altogether, 28 people "opted in" to the court which is staffed by nine MIDD-funded personnel including attorneys, support staff, a social worker, and probation officers.

In August 2011, county leaders united in support of creating a new Veterans Treatment Court. The MIDD Oversight Committee reviewed a proposal to expand the RMHC court calendar to pilot a track dedicated to reducing incarceration for veterans suffering from war-related trauma. On September 12, 2012, the King County Council unanimously adopted an ordinance establishing the pilot project for one year.

MIDD and the Municipal Court of Seattle's Mental Health Court

Individuals booked into jail via a City of Seattle municipal charge are referred to the city's Mental Health Court (SMHC) when a determination must be made about whether they are well enough to take part in the legal process. These competency cases are seen by the competency court within SMHC. Currently, court liaisons (one is funded by the MIDD) working through Sound Mental Health see all of these competency cases and weigh in on the process to order an evaluation and assist in routing individuals to treatment if the charges against them are dismissed. When the Crisis Diversion Facility (see Page 22) is open, it is expected that many of the misdemeanants cycling through SMHC with frequent competency dismissals will be eligible for diversion. The CDF should be able to provide a more direct route to treatment and housing without the cost (both time and money) of extensive court procedures.

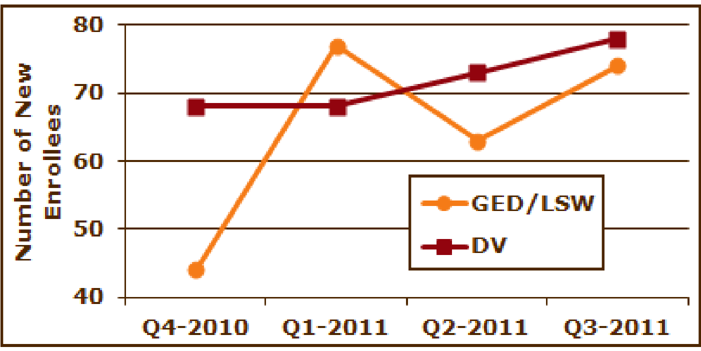
Distribution of Gender by Age Group for Individuals "Opting In" to RMHC



12a-2 Education Classes at Community Center for Alternative Programs (CCAP)

By providing education and skill-building opportunities to individuals serving time at CCAP under court-ordered alternative sentencing, the MIDD endeavors to prevent or reduce further criminal justice system involvement among participants. Class offerings under Strategy 12a-2 include job preparation, general education, and domestic violence prevention. In the last year, 258 individuals took either Life Skills to Work (LSW) or General Education Development (GED) courses, while 287 CCAP participants attended at least one class about breaking the cycle of domestic violence (DV). Sixty-seven people were enrolled in both GED and DV classes. The number of people starting each class type per quarter is shown below.

CCAP Education Class Enrollment by Quarter



12b Hospital Re-Entry Respite Beds (Recuperative Care)

The Medical Respite Center (MRC) at Jefferson Terrace is a collaborative effort to expand recuperation services for homeless individuals who need a safe place to heal following illness or injury. The center is a program of Public Health—Seattle & King County Health Care for the Homeless Network operated under a contract with Harborview Medical Center's Pioneer Square Clinic. Along with the MIDD, the following funders made the MRC possible:

- American Recovery & Reinvestment Act
- Harborview Medical Center
- University of Washington Medical Center
- Virginia Mason Medical Center
- HUD & HRSA grants
- Swedish Health Services
- Evergreen Healthcare
- St. Francis Hospital
- United Way of King County
- Valley Medical Center

With daily costs estimated at $200 per patient rather than $1,500 for inpatient hospital care, diversions from area hospitals to the MRC should net substantial savings. After opening in September 2011, the center quickly filled 26 of the 34 new beds available.

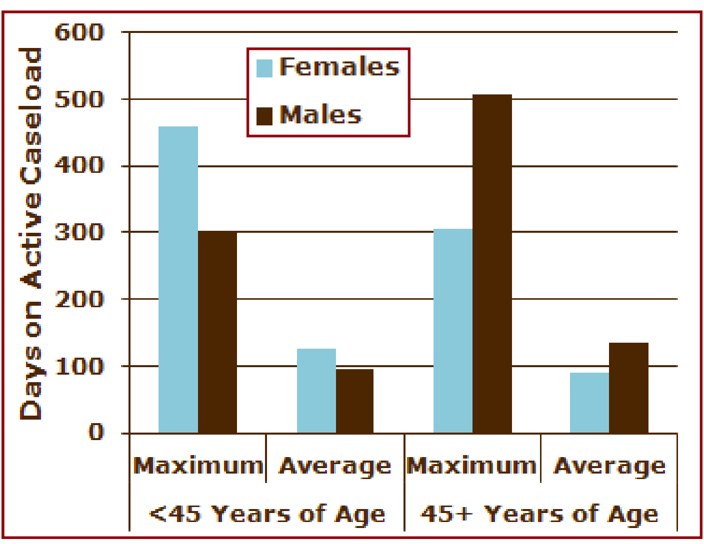
12c Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community-Based Services upon Discharge from Emergency Rooms

The High Utilizer Case Management Program at Harborview Medical Center began serving clients in November 2008 after receiving MIDD backing. Intensive case managers employ assertive techniques to reach primarily homeless individuals who have previously proven unreceptive to engaging in systems of care. By providing respectful and compassionate connections to services when people are in crisis, the social workers have been able to develop therapeutic relationships in unlikely places—under freeways, in fast food restaurants, and in parks. Outreach to those who have used the emergency department (ED) more than four times in a six month period is a top priority, although the majority served typically have 10 or more ED visits.

The program has access to hospital use outcomes from completed treatment episodes that indicate consistent reductions in ED utilization over time. Results of the jail and psychiatric hospitalization outcomes conducted by the MIDD Evaluation Team have also been encouraging. Jail bookings and days declined for over half of those eligible for analysis after one year (N=142), and 60 percent of those with any psychiatric hospital use (N=27) had decreased their usage by the end of the second year following their MIDD start.

During MIDD Year Three, 23 women and 70 men exited from Strategy 12c services. For females under the age of 45 (N=11), the average number of days on the active caseload was 127 days, or 38 more than for males of similar age (N=32). For individuals 45 and older, males stayed in services longer than females (average of 134 days vs. 89).

Days in Strategy 12c by Age and Gender



12d Behavior Modification Classes for CCAP Clients

Moral Reconation Therapy (MRT) classes are available through Strategy 12d to qualified candidates serving their court-ordered time at Community Center for Alternative Programs (CCAP). Delivered by a local mental health agency, MRT seeks to instill appropriate goals, motivation, and values by increasing moral reasoning. Structured group exercises and homework assignments are used to promote growth of a productive identity and facilitate development to higher stages of moral reasoning. Participants meet in groups weekly for three to six months.

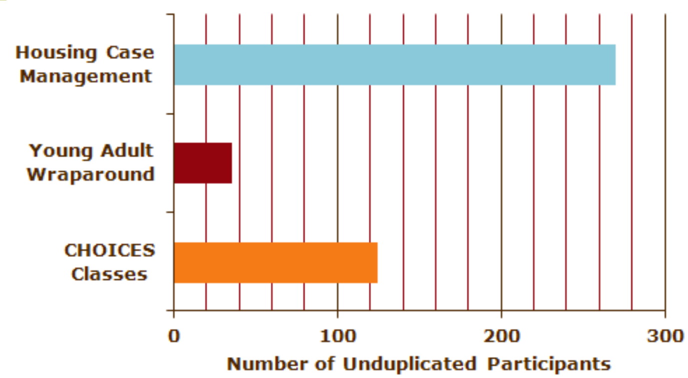
In the current reporting period, 131 people participated in CCAP behavior modification classes, up from 79 participants in the previous year. Several legal factors impacted their program completion, however, including termination of court orders that ended CCAP participation before MRT services could be finished. Of the 131 served, 91 (69%) were also involved in other strategies. The top five strategies overlapping with Strategy 12d, presented in descending rank order of number of MRT students, are shown in the table below. Note that multiple overlaps were possible; one individual was seen in six different strategies.

Strategy Number	Strategy Nickname	Number of 12d Participants
12a-2b	CCAP Education Classes: GED/LSW	44
12a-2a	CCAP Education Classes: DV	30
11a	Increase Jail Liaison Capacity	22
15a	Adult Drug Court	11
1b	Outreach & Engagement	6

Strategy 12d had the highest percentage of outcome eligible individuals with any jail use (at 89 percent), excluding the booking associated with their start of MIDD services. Comparing their number of bookings in the year after starting MRT with their pre-MIDD bookings, however, over 60 percent had posted decreases. Despite a one-year rise in aggregate jail days of 15 percent for this group, their one-year reduction in aggregate jail bookings was 41 percent. Full reporting on all strategy-level outcomes begins on Page 31.

15a Adult Drug Court Expansion

King County Judicial Administration's Adult Drug Court (ADC) continues to offer supplemental services with MIDD funding, including life skills classes for clients with learning disabilities (called CHOICES), wraparound services for transition aged youth, and housing case management. The graphic below shows the unduplicated number of people using each expanded program during MIDD's third year.



Altogether, ADC participants attended 3,710 CHOICES classes, or an average of 30 per person. Wraparound delivered 566 total direct service hours to individuals aged 18 to 24 years, or about 16 hours each. The average for hours of housing case management services in direct contact with individual clients was 3.16, although the housing case managers spend a great deal of time in indirect service and program development as evidenced in the narrative report summary below.

ADC Housing Case Management Highlights

In March 2011, work began to prepare materials and plan for delivery of new Drug Court Housing Workshops. In April, two workshops were offered to all ADC participants interested in learning more about housing resources in the community. Topics included in each workshop were:

- The variety of available housing options

- General housing acquisition strategies

- Completing applications for various programs.

On May 31, 2011, the housing case managers facilitated another workshop designed to assist ADC members interested in applying for King County Housing Authority's Section 8 program during their short open window for application acceptance. The ADC staff assisted with application completion and were able to submit all paperwork in time for the June 7 deadline.

16a New Housing Units and Rental Subsidies

By providing a spectrum of housing alternatives for those coping with mental illness or chemical addiction, the MIDD seeks to reduce recidivism and divert individuals away from costly psychiatric hospitalizations. Capital funding investments made in 2008, to make more housing available for this vulnerable population, continue to pay dividends as more housing units become available as each funded construction project is completed.

Between 2010 and 2011, the capacity to house MIDD clients was expanded from 398 to 445 (a 12 percent increase) in housing that offers support services under Strategy 3a, with another 73 units or voucher opportunities opening early in MIDD Year Four. The majority of physical units available now were created with the help of sales tax monies collected early in 2008.

The MIDD evaluation tracks most Strategy 16a participants under Strategy 3a, but follows about 40 individuals receiving rental subsidies as well. Strategy 16a also tracks tenants in 25 units at Brierwood, a housing project serving mentally ill clients that was capitally funded with MIDD dollars, but receives no support service funds. Only 29 of the 80 outcome eligible tenants in this strategy had any jail use, but that jail use group posted a 32 percent reduction in aggregate jail days (from 1,289 to 877) after only one year of receiving rental subsidies or living at Brierwood.

17a Crisis Intervention Team/Mental Health Partnership Pilot

In 2010, the City of Seattle secured a grant from the Federal Bureau of Justice Assistance to implement this pilot and hire a mental health professional (MHP) to assist police responding to behavioral crises. There are currently no MIDD funds encumbered by Strategy 17a, but updates are made available as the program grew out of MIDD strategy planning.

Early qualitative outcomes have shown that the MHP has been able to help resolve ongoing problems frequently seen by patrol officers on the streets. By using de-escalation techniques when called onto scenes involving persons with mental illness, the MHP has been able to increase the intervention options available to Seattle Police Department's Crisis Intervention Response Team (CIRT), with whom he is partnered. A key aspect of this pilot's success is the ability to conduct psychological assessments in the field without having to wait for an appointment elsewhere.

The MIDD Evaluation Team is unable to track individuals served by the CIRT at this time.

17b Safe Housing and Treatment for Children in Prostitution Pilot

In 2010, the MIDD contributed $100,000 under Strategy 17b to help provide mental health and substance abuse treatment services for children and youth placed in safe housing after their involvement in prostitution. Updates on this strategy are provided by the City of Seattle Human Services Department.

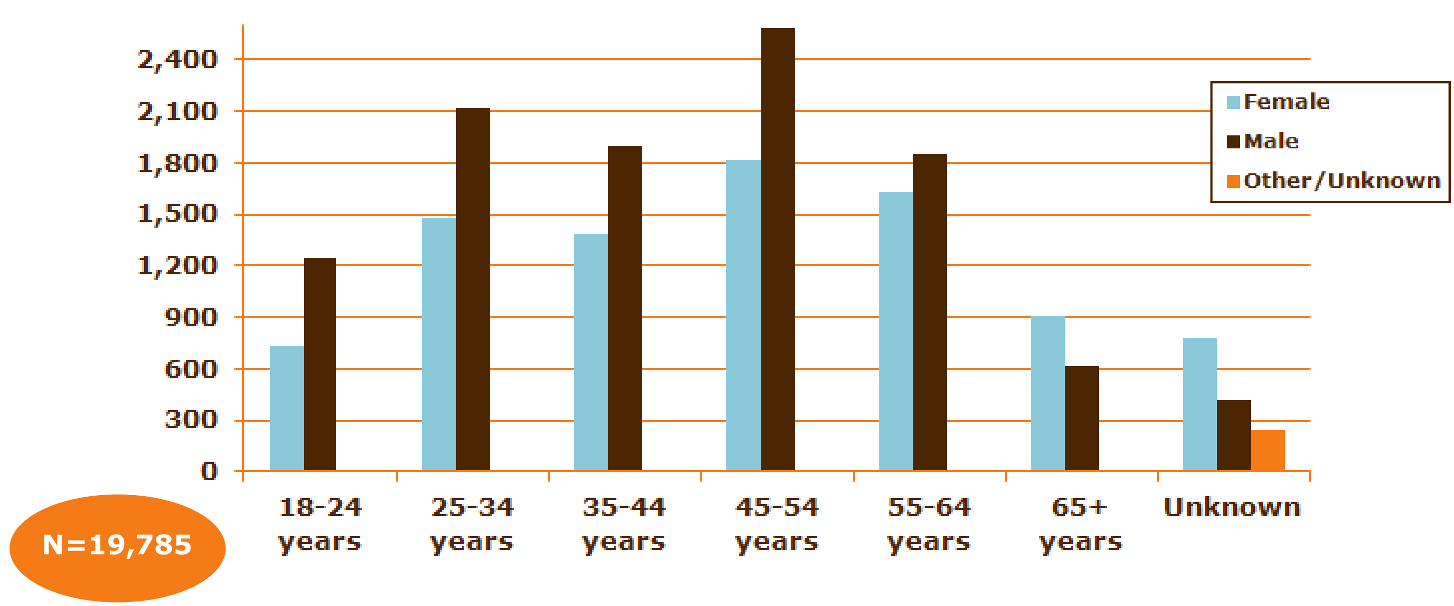
YouthCare operates a continuum of services to address the needs of the population targeted by this MIDD strategy. The Bridge, the residential recovery housing project, has been open for almost two years now. A total of twenty-seven youth have been served, with a capacity to serve six at a time. Seventy-one youth have been referred to the entire continuum of services provided by YouthCare (shelter, outreach, and linkages to other services).

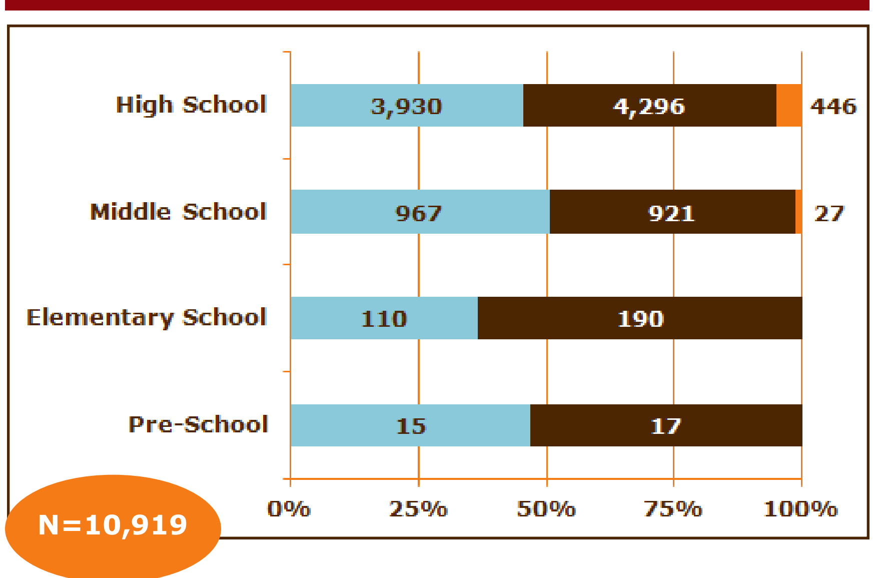
The Bridge program model consists of comprehensive on-site treatment and pre-employment services provided within a structured, therapeutic milieu. Seattle Public Schools supports a special classroom. Average length of stay at The Bridge is just under four months, although many youth stay considerably longer. Program staff indicate that they have been successful in engaging youth to remain in residence for sufficient time to involve them in treatment and school. In 2011, the program added a consulting psychiatrist at 12 hours per month.

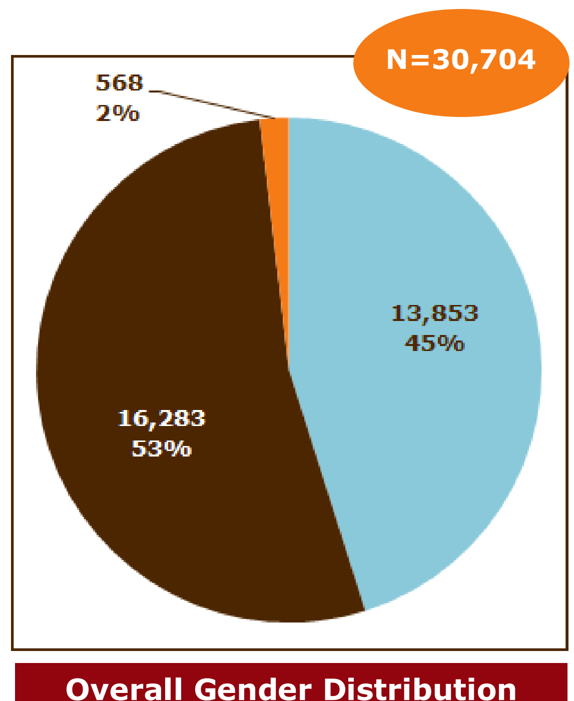
Training and consultation in the application of Trauma Focused Cognitive Behavioral Therapy has been provided by Harborview's Sexual Assault Center to YouthCare staff. In addition, YouthCare staff have provided numerous trainings for the treatment provider network about the needs of commercially sexually exploited children and youth (CSEC). A strong partnership based on a shared philosophy has developed between YouthCare, the Seattle Police Department Victims Unit, the King County Prosecutor's Office, and juvenile detention.

MIDD Demographic Information

Basic demographic information was available for 19,870 unduplicated* individuals who received at least one MIDD-funded service between October 1, 2010 and September 30, 2011. Partial data were available for an additional 1,896 individuals served by Strategy 4c (School-Based MH & SA Services) and 8,938 who received suicide prevention training through Strategy 4d. Age group, gender, race and geographic distribution are reported here for a grand total of 30,704 people. Individuals served under multiple MIDD strategies have their most reliable demographic information shown here. Note that some demographic elements such as homeless status, disabilities, and military service are not universally available due to the variety of sources from which these data are drawn.







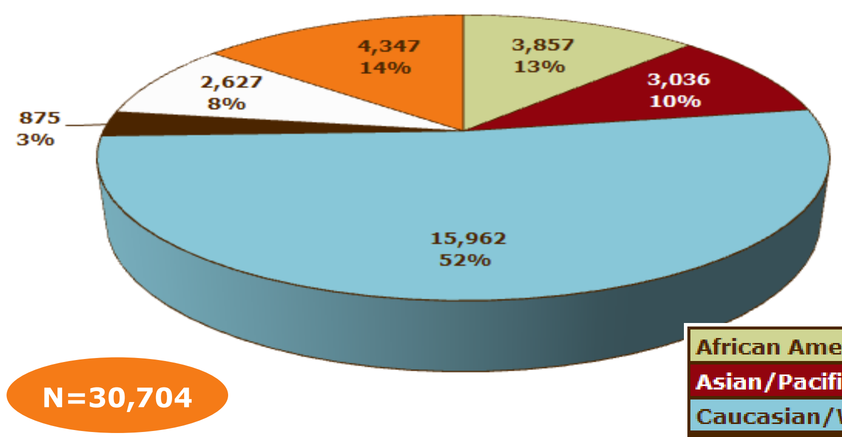
Overall Gender Distribution

***NOTE:** Individuals with duplicate demographics over 26 different strategies and three data sources are counted only once here.

Distribution of Primary Race and Hispanic Origin

The chart at below on the left shows the number of people and percent of the total for each race grouping listed in the table below. Hispanic origin is a separate data element, gathered independent of race. A total of 3,483 people, or 11 percent of the entire sample, said they were Hispanic.

When comparing the MIDD race distribution to estimates of King County as a whole (table below right), those who identify as African American or Black appear to be served at a higher rate, while the Asian and Pacific Islander group has a lower than expected rate. The MIDD "Other/Unknown" category likely accounts the lower rate of Caucasians found in the MIDD sample.



N=30,704

	MIDD Race Distribution	King County Census Estimate	Difference
African American/Black	13%	6%	+7%
Asian/Pacific Islander	10%	13%	-3%
Caucasian/White	52%	73%	-21%
Native American	3%	1%	+2%
Multiple Races	8%	7%	+1%
Other/Unknown	14%	0%	+14%

Primary Languages of MIDD Clients and Interpretation Services

Language information was available for 17,517 MIDD participants, the majority of whom (85%) listed their primary language as English. Forty-seven other languages contributed toward the remaining 15 percent, including American Sign Language. The top three non-English languages spoken by those receiving MIDD services were: Spanish (1,259 cases), Vietnamese (305 cases), and Russian (179 cases).

Looking only at Strategy 1a-1 (MH Treatment), 889 of the 3,090 unduplicated service recipients in this reporting period, or 29 percent, were in need of language interpretation services. Almost all of these people (733, or 82%) were served by two provider agencies, Consejo Counseling & Referral Service and Asian Counseling & Referral Service (ACRS). These providers specialize in delivering culturally-specific mental health services and have staff fluent in non-English languages.

Service in the U.S. Military

At least 1,020 unique individuals participating in various programs during MIDD Year Three were known to have served previously in the U.S. military. Over 100 of these former service members were involved with more than one MIDD strategy. In the 4,035 cases where MIDD clients were asked about family military service, 97 children and 107 spouses of military families were identified. The five strategies serving the highest number of veterans* are shown below, along with average age and standard deviation. Those in CD Treatment were slightly younger on average.

		Number of Veterans	Age on October 1, 2011	
			Average	Standard Deviation
1c	SA Emergency Room Intervention	435	51	13
1a-1	MH Treatment	126	55	12
1a-2	CD Treatment	117	49	12
1g	Older Adults Prevention MH & SA	112	59	7
3a	Supportive Housing	93	53	9

* As defined by former U.S. military service only.

Highest Level of Education

Grade level information was collected for 5,759 people receiving MIDD services. For adults aged 18 to 24, only 39 percent had a high school education or higher, compared to 71 percent of those aged 25 and older (Chi-square=283.45, p=.000). Over 33 percent of those with grade level data had some college or had earned college degrees.

Immigrant or Refugee Status

Some MIDD strategies track immigration status by asking clients if they were born with U.S. citizenship or not. In 578 of 4,801 cases (12%), individuals were not born in the U.S. and had moved to this country as immigrants or refugees. The strategy serving the highest proportion of the MIDD immigrant population was 13a (Domestic Violence & MH Services) at 42 percent.

Geographic Distribution of 30,704 Individuals Receiving MIDD Services during the Third Year of Implementation

North 2,423 (8%)

Seattle 9,769 (32%)

East 5,216 (17%)

South 10,760 (35%)

NOTE: Out-of-county zip codes are most often reported by Strategy 1c (Emergency Room Substance Abuse Early Intervention Program). The hospitals providing these services have a regional focus that extends beyond King County.

Zip Codes Outside of King County	1,418 (5%)
Invalid or Unknown Zip Codes	1,118 (4%)

MIDD Regions: North, East, South, Seattle. City Boundaries. Water.

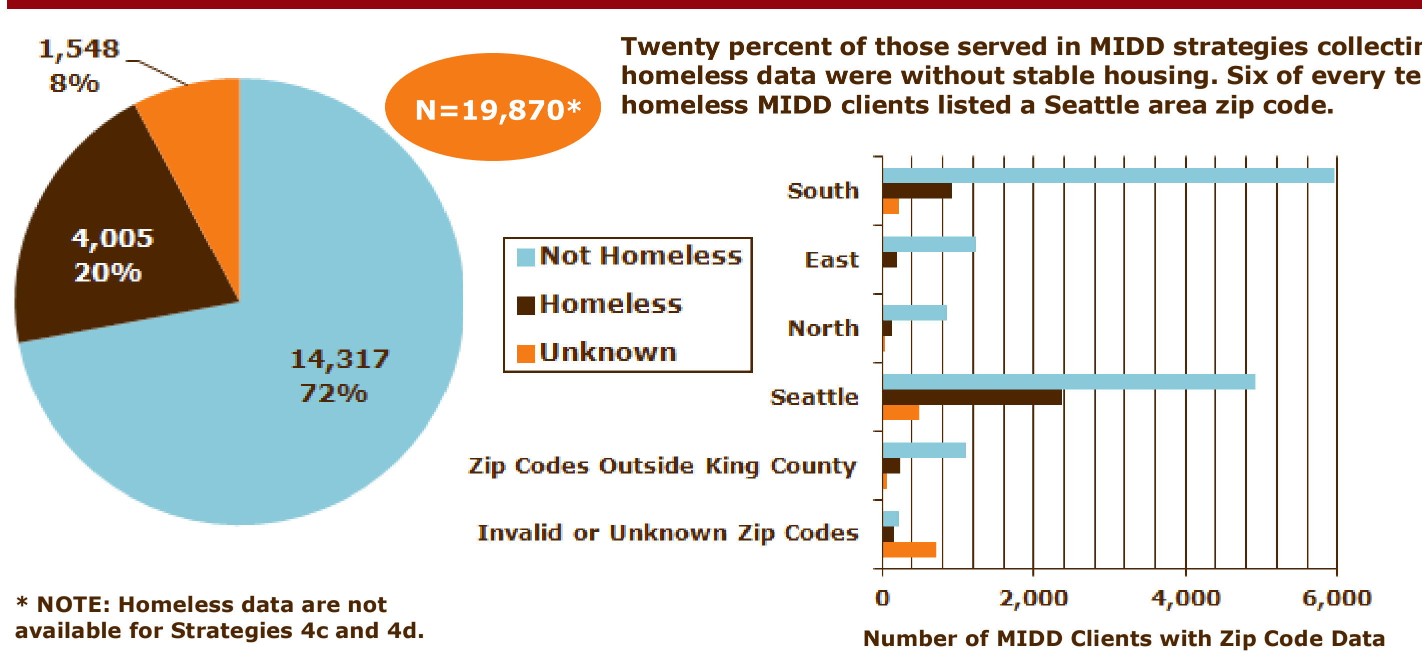
Feb. 6, 2012

King County GIS Center

Percentages do not equal 100 percent due to rounding.

Homeless Status On MIDD Start Date and Number of Homeless by King County Region

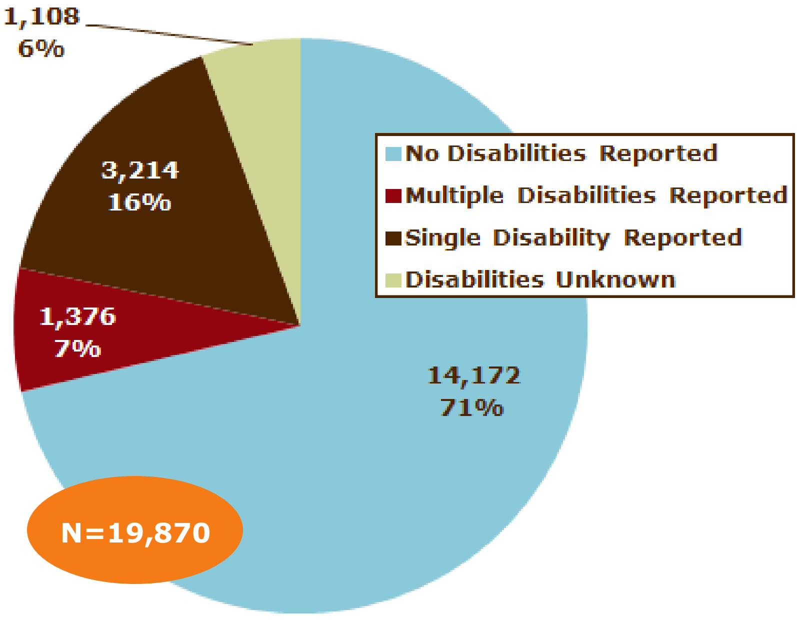
Twenty percent of those served in MIDD strategies collecting homeless data were without stable housing. Six of every ten homeless MIDD clients listed a Seattle area zip code.

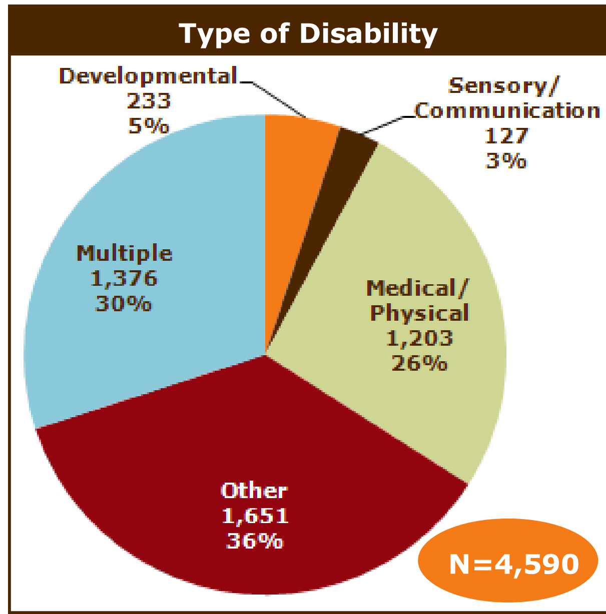


*** NOTE: Homeless data are not available for Strategies 4c and 4d.**

Documentation of Disabilities Among Those Served by the MIDD

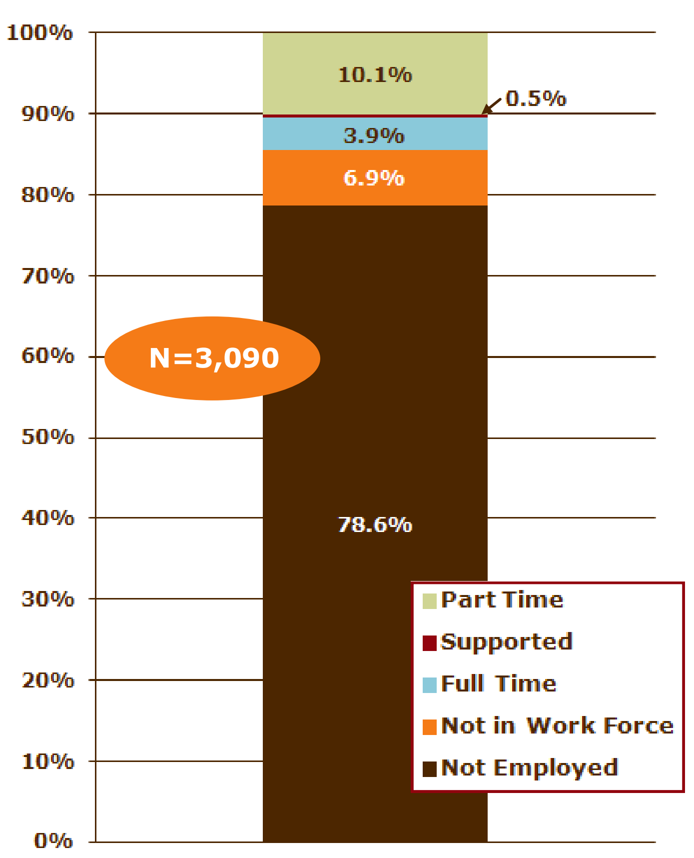
The MIDD served at least 4,590 individuals with disabilities in this reporting period, including 1,376 with multiple disabilities. Where a type of disability was known, the most commonly coded was "other" which includes psychiatric disabilities. Medical or physical disabilities were coded for nearly one in three cases.





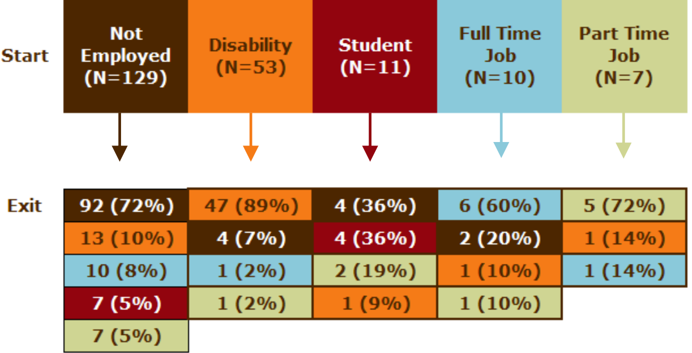
Employment at Start of MIDD-Funded MH Benefit and Changes in Employment Status

Historically, analysis of employment data has been hampered by incomplete information. In October 2011, new requirements were adopted to encourage submission of data that will more reliably show changes in employment status over time. The graphic below left shows the employment status of 3,090 individuals when they enrolled in MH benefits under Strategy 1a-1 (MH Treatment).



Net Job Gains Over Time

For Strategy 15a (Adult Drug Court Expansion), employment data were available at two points in time for 210 participants who exited the program during MIDD Year Three. Changes in their employment status between program start and exit are illustrated below:



At the start of Adult Drug Court services, 17 of 210 people (8%) were employed in either part time or full time jobs. Over time, 55 people changed their employment status. The net gain between program start and exit for this sample was another 17 jobs for a total of 34 part time or full time jobs, or 16 percent of all those exiting.

Strategy-Level Outcome Findings

A total of 25,205 records (one per person per strategy) are now eligible for outcomes measurement as shown in Exhibit 2 on Page 42, MIDD Outcomes Tracking. Those who began MIDD services prior to October 1, 2009 in the following strategies: 1a-1, 1a-2a, 1a-2b, 1d, 1h, 2b, 12c, 15a, and 16a have now been tracked long enough to examine their outcomes for a second post period. Similarly, two years worth of "after MIDD start" information is now available for individuals who entered services between January 1, 2009 and June 30, 2009 in these strategies: 1c (Harborview), 1g, 3a, 8a, 9a, 11a, and 12a-1.

The addition of cohorts with service starts prior to October 1, 2010 in all aforementioned strategies, plus the first cohort for the following strategies: 1b, 1c (South County), 5a, 6a, 12a-2, and 12d has further increased the outcomes-eligible sample size for the first post period. The combination of a continually growing sample and improved matching capabilities has boosted analysis possibilities beyond those first reported in the MIDD Third Annual Report. These more robust, strategy-level outcomes, with a primary focus on jail and psychiatric hospital utilization, are presented over the next several pages of this report.

How Many MIDD Service Recipients Had Jail Bookings in the Analysis Period?

Excluding strategies 1g, 1h, and 2a (where jail use was not identified as a relevant outcome), about 35 percent of those in the current analysis sample were characterized by at least one jail booking in either the year leading up to their MIDD "start"* (Pre Period) or during the year after that starting point (First Post Period). This is higher than the 25 percent figure reported for a much smaller sample in the initial jail findings published in the MIDD Third Annual Report. As shown in the grid below, the percentage of individuals with any recent jail use varied widely by strategy from a low of 16 percent for those receiving MIDD-funded mental health treatment to a high of 89 percent for those enrolled in behavior modification classes at the Community Center for Alternative Programs (CCAP). The recent inclusion of additional strategies offering criminal justice interventions and additional participants in those types of programs accounts for the higher overall rate of jail use by MIDD participants. This more diverse sample also accounts for lower overall first year post reductions in average jail bookings and days (down from about 23 percent for both bookings and days initially, to 19 percent for bookings and seven percent for days).

*See the bottom of Page 32 for more information about how jail bookings and days are counted.

Overall Jail Use by Individuals in Various MIDD Strategies				
Strategy Number	**Strategy Nickname**	**Total in Analysis Sample**	**Individuals with Any Jail Use**	**Percent with Any Jail Use**
1a-1	MH Treatment	3,627	576	16%
1a-2a	CD Treatment - Outpatient	4,697	1,712	36%
1a-2b	CD Treatment - Opiate Substitution	1,199	351	29%
1b	Outreach & Engagement	1,733	594	34%
1c	SA Emergency Room Intervention	4,318	1,301	30%
1d	MH Crisis Next Day Appts	1,750	486	28%
3a	Supportive Housing	172	69	40%
5a	Juvenile Justice Youth Assessments	299	246	82%
6a	Wraparound	236	74	31%
8a	Family Treatment Court Expansion	52	24	46%
9a	Juvenile Drug Court Expansion	62	40	65%
11a	Increase Jail Liaison Capacity	268	200	75%
12a-1	Jail Re-Entry Capacity Increase	425	371	87%
12a-2a	CCAP Education Classes: GED/LSW	215	152	71%
12a-2b	CCAP Education Classes: DV	268	186	69%
12c	PES Link to Community Services	221	142	64%
12d	Behavior Modification for CCAP	92	82	89%
15a	Adult Drug Court Expansion	256	214	84%
16a	New Housing and Rental Subsidies	80	29	36%
TOTAL		19,970	6,849	34%

What Sources of Information Are Used to Determine Jail Utilization?

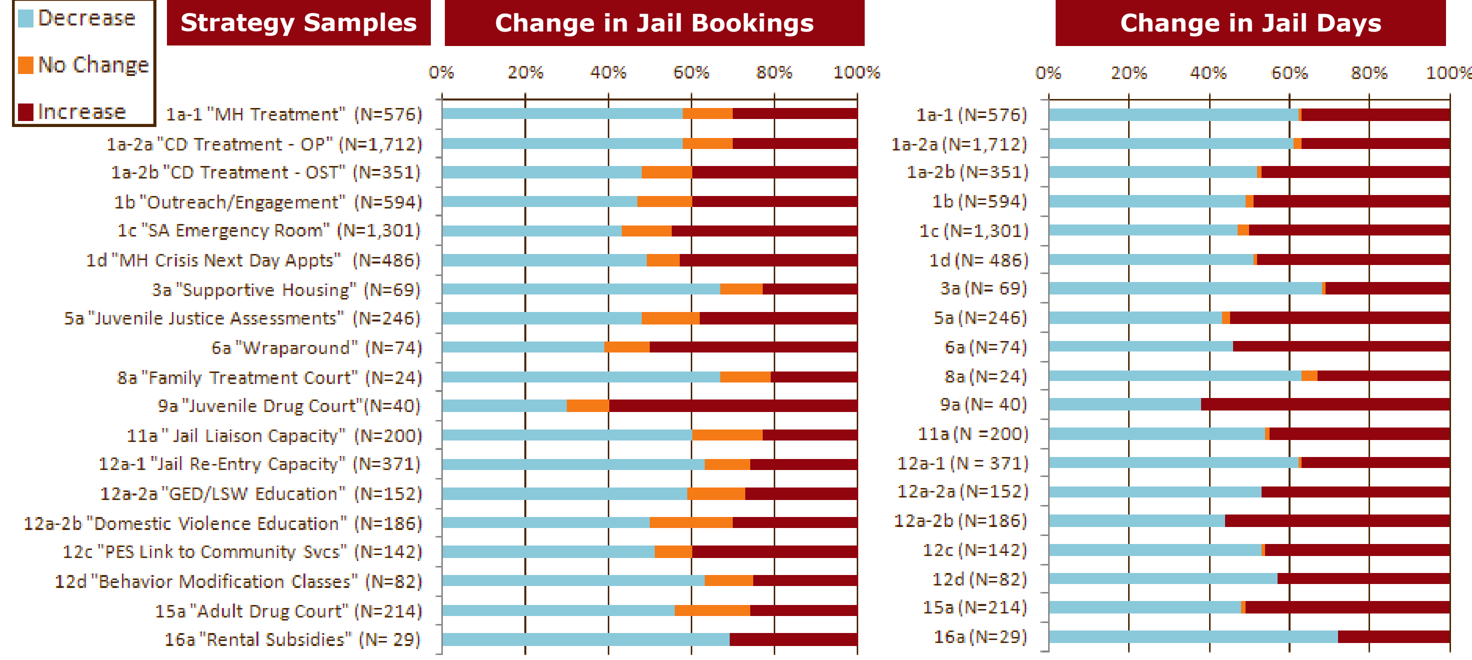
A total of 19,970 records for persons served in MIDD strategies which intend to reduce jail usage were analyzed in this reporting period. Nearly 7,000 of these records were linked to at least one jail booking during a time frame of interest. Patterns and trends in jail utilization for the MIDD population are based on the number of cases where matches could be found within criminal justice data sources. For the current* analysis, jail utilization is defined by bookings into any of the following:

- King County's Norm Maleng Regional Justice Center in Kent, WA
- King County Jail, Seattle Division
- Juvenile Detention Center in Seattle, WA
- Jails in these municipalities: Auburn, Enumclaw, Kent, Kirkland, Issaquah, and Renton.

* NOTE: Efforts are underway to secure data from the South Correctional Entity Multijurisdictional Misdemeanant Jail (SCORE), which opened in September 2011. This new facility is a cooperative effort by the cities of: Auburn, Burien, Des Moines, Federal Way, Renton, SeaTac, and Tukwila.

Do Different Strategies Show Similar Jail Use Trends?

Trends in jail bookings and days are presented by strategy in the graphs below. Looking only at individuals who had jail contacts in the year prior to their MIDD benefit start and/or during their first year of services, the percentage of individuals who demonstrated decreased jail utilization is contrasted against those with no change over time, and those who actually increased their jail use. Almost all strategies showed evidence of decreased jail utilization in the short term, but inclusion of criminal justice initiatives and therapeutic court strategies that often assign jail time as part of their plan of treatment does impact these findings, especially in the first year of service delivery. Complete strategy names corresponding with the strategy numbers and "nicknames" listed below can be found on Page 5.



How Are Jail Bookings and Days Counted?

Several strategies (see grid at right), employ a new counting method that creates a buffer around "index" bookings. When a person enters MIDD services *as a result of a specific criminal justice contact*, that particular jail episode (called the index booking) and its associated days* are excluded from both Pre Period and First Post Period counts to prevent bias in either time period. For records with the buffer applied, the pre period includes all jail episodes in the year prior to the index booking. The first post period then begins on the day after release from the index event, rather than the actual MIDD start date (used for all other strategies).

* NOTE: Booking days provided by jail sources are used as a proxy for custodial jail days.

Strategy Number	Percent with Any Jail Use	Index Booking Buffer Applied
5a	82%	X
6a	31%	X
8a	46%	X
9a	65%	X
11a	75%	X
12a-1	87%	X
12a-2a	71%	X
12a-2b	69%	X
12d	89%	X
15a	84%	X

How Do Aggregate Changes in Jail Utilization Vary Over Time by MIDD Strategy?

Just as overall jail utilization varied widely by strategy, changes in the total number of individuals with jail use and the sum of their bookings/days also differed by strategy when comparing two time periods. For example, Strategy 8a (Family Treatment Court) had a 50 percent *decline* in the number of jail users, but Strategy 9a (Juvenile Drug Court) showed a 19 percent *increase* in the first post period, likely due to sanctions associated with treatment. The strategy with the greatest first year reductions in jail bookings (-51%) and days (-54%) was Strategy 3a (Supportive Housing) as illustrated in the chart below.

Percent Change for Number of Individuals with Jail Use, Jail Bookings, and Jail Days From Pre Period to First Post Period by Strategy

Strategy Number	Individuals with Pre Period Jail Use	Individuals with First Post Period Jail Use	Percent Change in Number Using Jail	Total Jail Bookings in Pre Period	Total Jail Bookings in First Post Period	Percent Change in Jail Bookings	Total Jail Days in Pre Period	Total Jail Days in First Post Period	Percent Change in Jail Days
1a-1	464	356	**-23%**	1,160	764	**-34%**	24,284	17,386	**-28%**
1a-2a	1,416	1,022	**-28%**	3,057	2,216	**-28%**	57,126	45,109	**-21%**
1a-2b	259	237	**-8%**	568	495	**-13%**	11,253	8,712	**-23%**
1b	461	434	**-6%**	1,050	1,024	**-2%**	18,818	18,586	**-1%**
1c	940	989	**+5%**	2,485	2,514	**+1%**	40,383	46,216	**+14%**
1d	335	315	**-6%**	726	670	**-8%**	18,853	13,627	**-28%**
3a	61	43	**-30%**	184	91	**-51%**	2,837	1,294	**-54%**
5a	226	197	**-13%**	703	611	**-13%**	8,226	12,270	**+49%**
6a	52	57	**+10%**	119	171	**+44%**	2,766	2,500	**-10%**
8a	22	11	**-50%**	45	28	**-38%**	685	439	**-36%**
9a	32	38	**+19%**	103	136	**+32%**	1,876	2,706	**+44%**
11a	179	143	**-20%**	531	338	**-36%**	8,326	9,361	**+12%**
12a-1	347	271	**-22%**	1,203	814	**-32%**	30,383	22,319	**-27%**
12a-2a	139	111	**-20%**	379	233	**-39%**	7,566	7,612	**+1%**
12a-2b	158	148	**-6%**	477	331	**-31%**	6,382	10,024	**+57%**
12c	115	100	**-13%**	375	314	**-16%**	5,178	5,637	**+9%**
12d	73	50	**-32%**	160	94	**-41%**	2,967	3,423	**+15%**
15a	191	161	**-16%**	541	345	**-36%**	7,593	11,801	**+55%**
16a	22	12	**-45%**	47	35	**-26%**	1,289	877	**-32%**
TOTAL	5,492	4,695	**-15%**	13,913	11,224	**-19%**	256,791	239,899	**-7%**

Are Reductions or Increases in Jail Days Related to MIDD Service Types?

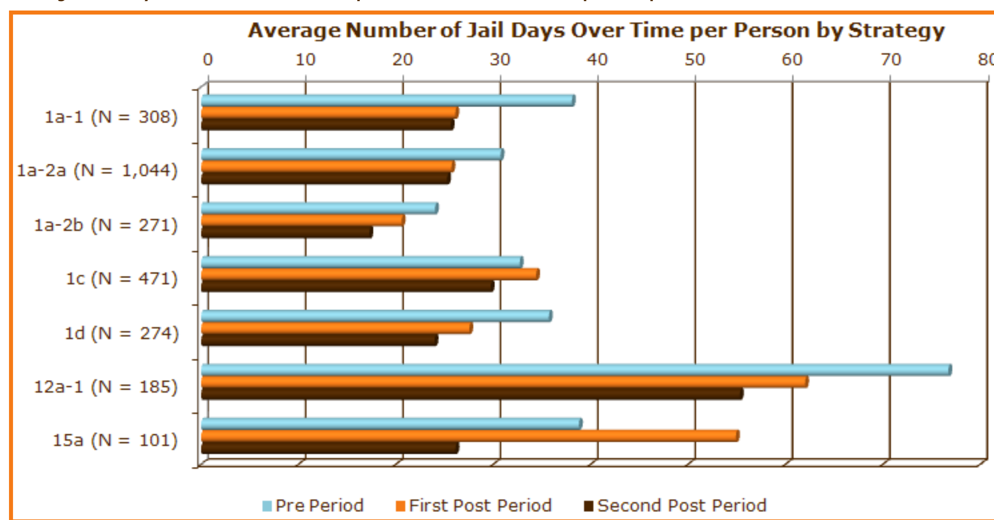
After combining various strategies together using broad service categories, analysis of variance (ANOVA) testing was conducted to further delineate the relationship between participation in a given type of service and shorter term (one year versus two year) jail outcomes. The post hoc results of the statistically significant ANOVA test are shown in the table below. While the average change in jail days for those in the Housing category differed significantly from those in Liaison/Linkage, Outreach, Education, and Therapeutic Courts, it did not differ significantly from the average for people in MH or CD Treatment. Individuals in the Therapeutic Courts grouping had significantly different changes in average number of jail days than those in all other categories except Education (which targets criminal justice system-involved participants). All observed First Post Period increases in average jail days are expected to decline in the longer term. Initial results of the analyses for jail outcomes in the second post period are shown on Page 34.

Type of Service	Strategies Included				N	Clustered Averages for Change in Jail Days Pre to First Post: 1	2	3	4
Housing	3a	16a			98	-19.95			
MH Treatment	1a-1	1d	6a		1,136	-10.52	-10.52		
CD Treatment	1a-2a	1a-2b			2,036	-7.06	-7.06		
Liaison/Linkage	5a	11a	12a-1	12c	959		-2.63	-2.63	
Outreach	1b	1c			1,895		2.96	2.96	
Education	12a-2a	12a-2b	12d		420			9.87	9.87
Therapeutic Courts	8a	9a	15a		278				17.23

$F = 13.34$, $p = .000$

What Happens to the Number of Days Spent in Jail During the Second Post Period?

Strategies with more than 100 eligible participants with MIDD starts prior to October 1, 2009, who had jail use in any of the following time periods: Pre (year prior to MIDD start or "index" booking), First Post (the year following their MIDD start or "index" days), or Second Post (the year after their MIDD anniversary) were included in an analysis sample to examine longer term jail outcomes. The overall sample included seven strategies and 2,654 unique records (one person per strategy). As shown in the graph below right, the average number of jail days was lowest in the second post period for all strategies, even those that experienced an average increase in jail days between the pre and the first post period.



When comparing change rates in the average number of jail days for three sets of time intervals (see below), five of the seven eligible strategies posted statistically significant declines (p<.01) from the first post period to the second post period. Note that for Strategy 1a-1 (MH Treatment) most of the drop in jail days occurred during the pre to first post interval, but for Strategy 15a (Adult Drug Court) a rise in days from the pre to first post was subsequently balanced out by the second post to a rate on par with Strategy 1a-1. Individuals provided jail re-entry liaison services under Strategy 12a-1 decreased average jail use from 77 days/year to 55 (graph) or –27.91 percent (table).

Percent Change in Average Jail Days for Eligible Sample

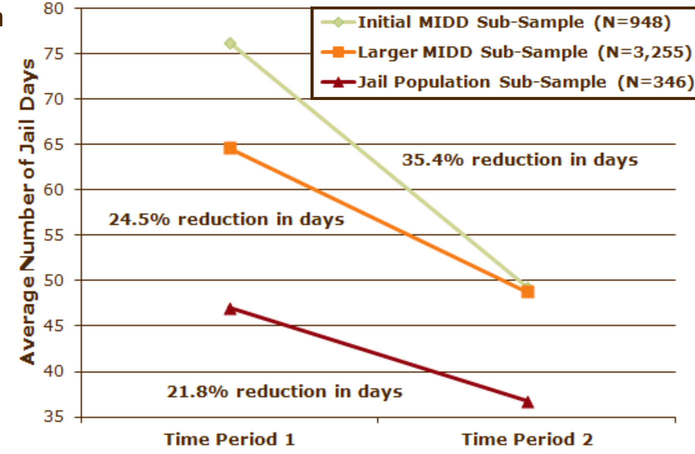
Strategy	N	Pre Period to First Post Period	First Post Period to Second Post Period	Pre Period to Second Post Period
1a-1	308	-31.44	-1.79	-32.67
1a-2a	1,044	-16.38	-1.76	-17.85
1a-2b	271	-14.23	-16.11	-28.05
1c	471	5.13	-13.56	-9.13
1d	274	-22.89	-12.96	-32.88
12a-1	185	-19.18	-10.80	-27.91
15a	101	+41.55	-52.43	-32.67

How Do We Know Changes in Jail Use Are Not Due to Factors Outside MIDD?

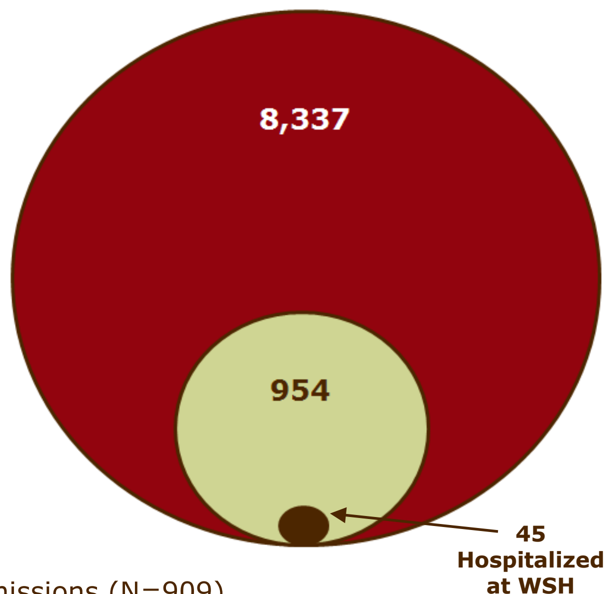
Analyses published in the MIDD Year Three Progress Report looked at the impact of criminal justice system changes on jail bookings and days from October 1, 2006 to September 30, 2010. While there was an overall decrease in jail use by both MIDD and non-MIDD offenders during this time, the rates of yearly change maxed out at -10.2 percent for bookings and at -13.1 percent for days. These overall declines in average jail use, however, were generally outpaced by the decreases associated with MIDD-only samples. While impacts of forces beyond the MIDD cannot be ruled out, early indicators support a strong relationship between MIDD participation and longer-term reductions in jail utilization.

How Do Jail Days for MIDD vs. non-MIDD Samples with Two or More Bookings Compare?

As reported in the MIDD Year Three Progress Report, a random "jail only" comparison sample was drawn to put MIDD jail use reductions into perspective. Since the MIDD sample had *double* the pre period jail use of its non-MIDD counterpart, the analysis was further restricted to those from each group with *two or more bookings* prior to the MIDD or in 2007 (for "jail only").The graphic published previously at right has been updated with information from a much larger MIDD sample of individuals with more than one jail booking. As the drop in jail days for the new sample was not as substantial as the initial analysis indicated, more research with larger groups of non-MIDD jail users will be conducted for future reports.



What Proportion of MIDD Participants Had Western State Hospitalizations?



Seven strategies with outcome eligible participants (N=8,337) were included in an analysis of psychiatric hospital utilization. For more information about outcomes eligibility, please see Exhibit 2 on Page 42. A total of 954 people (less than eight percent of this outcomes sample) had at least one stay at a community inpatient psychiatric facility in King County during the year leading up to their start in MIDD programming (Pre Period) and/or during their first year of services (First Post Period). Only 45 of these people were admitted (in either the pre or the first post period) to Western State Hospital (WSH), a psychiatric facility run by the state of Washington. The Venn diagram at right illustrates that only a small portion of the MIDD sample was hospitalized at WSH during the study time period. The average number of community hospitalizations recorded across both the pre period and the first post period combined was five for those with WSH admissions (N=45), but only two for those without WSH admissions (N=909).

Is There Evidence of Reductions in Community Psychiatric Inpatient Hospitalizations?

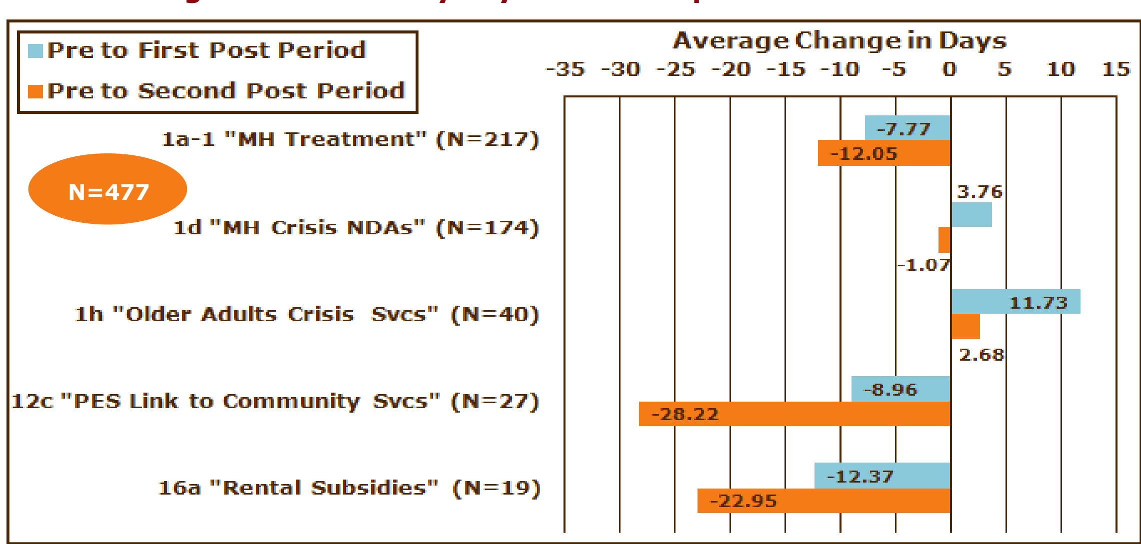
Altogether, 529 of the 954 people hospitalized in community inpatient settings for psychiatric care (55%) decreased the number of days they spent in the hospital between the pre and the first post period. During this time interval, the average number of days spent in the hospital was reduced from 16.06 days to 13.69 days, which was not statistically significant.

For the 479 records eligible for a second post period* analysis, however, average drops in the number of days hospitalized were significant (from 14.81 days in the pre period to 6.63 days in the second post period, t=6.41, p=.000). A total of 252 individuals (53%) decreased their days, while only 113 (23.5%) increased their days. The net difference between the pre and the second post period for this sub-sample was a reduction of 3,915 total psychiatric hospital days. The remaining 114 individuals (23.5%) were hospitalized only during the first post period (with no Pre or Second Post Period hospitalizations). The reduction in days for this group of 114 people totaled 2,394 days (from First to Second Post Period).

Average changes in the number of days people spent hospitalized, over the two time intervals analyzed, varied by MIDD strategy, as shown in the graph below. Note that Strategy 3a (Supportive Housing) was excluded as the N was only two. Average reductions over the pre period were evident for four of the five strategies by the second post period. For the strategies with 40 or more records, paired samples t-testing revealed that the differences between shorter term and longer term hospital utilization were statistically significant (p=.01).

As the samples for the other strategies continue to grow, the average changes in community psychiatric hospital days are expected to reach statistical significance as well.

Changes in Community Psychiatric Hospitalizations Over Time



* The second post period examined the year following each eligible person's first MIDD anniversary.

Are Supported Employment Programs Helping MIDD Clients Find and Keep Jobs?

Nine agencies are providing fidelity-based supported employment (SE) programs under Strategy 2b (Employment Services for Individuals with Mental Illness and Chemical Dependency). These programs are funded in part through the MIDD based on a "pay for outcomes" funding model in partnership with Washington State's Division of Vocational Rehabilitation (DVR). In MIDD's third year, providers were reimbursed by either MIDD or DVR as their clients reached various milestones on their journeys to get and keep mainstream jobs paying competitive wages.

Individuals enrolled in SE services prior to October 1, 2010 (N=1,224) were eligible for outcomes measurement in the current evaluation period. In the year following their MIDD start date, 209 enrollees (17%) had been placed in at least one competitive job for a total of 232 job placements. At least 119 (51%) of these SE jobs were known to have been retained for 90 days or longer. The average time from MIDD start to first job placement was just over 200 days or about seven months. Job placement rates (number of job placements divided by total number enrolled in services) ranged from 13 percent to 28 percent per agency. The two agencies with the highest job placement rates were Downtown Emergency Service Center and Asian Counseling and Referral Service.

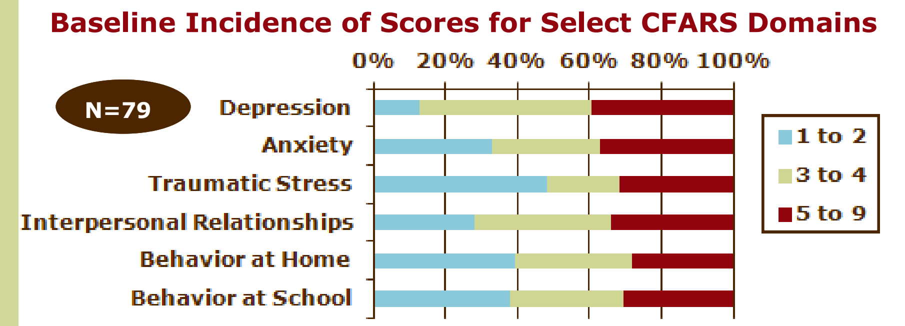
Historical data show the rate for gaining employment during a mental health benefit period for those receiving publicly-funded treatment for psychiatric disorders has been less than three percent in King County.

Are MIDD Programs Impacting Symptom Reduction?

Mental health outpatient providers were required to start reporting symptom reduction measures for adults in Strategy 1a-1 (MH Treatment) in January 2010, and for children in April 2010. The first set of symptom data (collected at intake, six months, and one year) became available for analysis in February 2011.

As reported in the MIDD Year Three Progress Report, the Problem Severity Summary (PSS) was used to measure the incidence of adult mental illness symptomatology such as depression, anxiety and psychosis, as well as changes in those symptoms over time. Initial findings indicated that of adults with severe/extreme anxiety (N=251) or depression (N=325) at baseline, 42 percent in each group improved (reduced symptoms) after one year in treatment or by exit.

The Children's Functional Assessment Rating Scale (CFARS) is a clinician-rated tool used to assess 16 domains, including depression and anxiety. Ratings for each item can range from 1 (no problem) to 9 (severe problem). Baseline incidence of grouped scores for six domains of interest are shown here for the first CFARS sample of 79 individuals, aged five to 22 years, who had two sets of scores taken one year apart. Groupings represent low to high clinical thresholds.



Reductions in depression (67%), anxiety (61%), traumatic stress (50%), and school behavior (65%) were found for those with baseline scores five or above. In other words, of the 31 children with initial depression scores between five and nine, 21 of them had reduced ratings of the severity of their symptoms after one year.

Has Sobering Center Use by MIDD Clients Gone Down Over Time

The Dutch Shisler Sobering Center in downtown Seattle, WA provides a safe place for King County residents to sleep off the effects of alcohol or drugs when they have no other place to go. Sobering Center utilization was analyzed for 279 MIDD clients with *any* use of the facility over a three-year period. Paired sample t-tests compared changes in the number of visits during three measurement periods: Pre to First Post, Pre to Second Post, and First to Second Post. The average number of visits for this sample during the pre period was 11.27, which did not differ significantly from the average number of visits in First Post (mean=7.95). By Second Post, utilization had dropped to an average of 6.80 visits, approaching significance ($t=2.31$, $p=.02$). For the subset of 46 people working with case managers under Strategy 12c (PES Link to Community Services), the average reduction from 15.98 at Pre to 5.85 at Second Post was significant ($t=2.59$, $p=.01$).

Recommendations for Plan Revisions

Implementation, evaluation, and oversight of the MIDD sales tax fund is an ambitious undertaking requiring flexibility and occasional modification to plans as more information becomes available for analysis. The MIDD Evaluation Plan and evaluation matrices were developed in May 2008 by MHCADSD staff based on strategy-level implementation plans. In August 2010, updates for all evaluation matrices were published in the MIDD Year Two Progress Report and additional updates were included in the MIDD Third Annual Report in May 2011. For the current reporting period, proposed adjustments to performance targets (in red text) and evaluation matrix revisions are outlined below.

Strategy Number	Strategy "Nickname"	MIDD Year 4 Revised Performance Target(s) or Evaluation Matrix Change	Explanation for Proposed Revision
1d	MH Crisis Next Day Appts	Add tracking of jail outcomes	Analysis indicates jail outcomes are appropriate for this strategy.
1e	CD Professionals Training	125 trainees/yr (reimbursed for certification) 250 trainees/yr (workforce development activities)	Need to count individuals engaged in workforce development activities (trainings or technical assistance), in addition to those counted previously for reimbursement of costs associated with professional certification of CD professionals.
1f	Parent Partners Family Assistance	Re-write evaluation plan	When strategy is finalized and implemented, a new evaluation matrix shall be developed.
1h	Older Adults Crisis & Service Linkage	Change long-term outcome measures	Rather than tracking linkages to MH and CD treatment, evaluation efforts shall count the number of individuals diverted away from homelessness and other costly dispositions, as reported by provider staff.
3a	Supportive Housing	Targets to update annually	The number of individuals to be served each year shall align with the capacity of available units with support services.
4c	School-Based MH & SA Services	Change long-term outcome measures	Measure reductions in the severity of MH and CD symptoms in youth served using Global Appraisal of Individual Needs (GAIN) tools. Remove measures reliant upon school data, which are not available for evaluation purposes.
6a	Wraparound	450 enrolled youth/yr Clarify the type of youth to be counted	Instead of counting both enrolled youth and non-enrolled youth in the families served, target will be lowered to reflect only the number of enrolled youth to be served.
7b	Expand Youth Crisis Services	300 youth/yr Add new Interventions/Objectives	MIDD expansion of the Children's Crisis Outreach Response Service System will offer community-based outreach and stabilization, including in-home behavioral specialist services lasting up to 90 days. Initial target is based on original implementation plan. Previous matrix indicated "additional youth" without a specific number. The matrix will also show the addition of marketing/communication plan development.
8a	Family Treatment Court Expansion	No more than 60 children at any given time and no more than 90 children per year Change long-term outcome measures	At current maximum capacity, the program shall serve no more 60 children at any given time and no more than 90 children per year. Evaluation will track positive child placements at parent exit from FTC, rather than a reduction in days between court hearings.
10a	Crisis Intervention Team Training	180 trainees/yr (40-hr) 300 trainees/yr (1-day) 150 trainees/yr in other CIT programs	Revised targets are based on average 2011 attendance and the following 2012 contract terms: Deliver a minimum of eight 40-hour trainings with a maximum of 25 students each and a minimum of nine 8-hour trainings with a maximum of 50 students each. Other training opportunities are to be developed and conducted in response to identified need.
11b	MH Court Expansion	115 clients/yr (9 FTE) for Regional MH Court 50 clients/yr (1 FTE) for Seattle Municipal MH Court Add new Interventions/Objectives	Targets have been revised to clarify the number of clients to be served by each of the courts participating in Strategy 11b. The matrix will show the addition of forensic peer support services and the pilot for a Veterans Track in the Regional MH Court, but will not alter the target numbers.
13a	Domestic Violence & MH Services	560-640 clients/yr	Adjusted targets reflect a 20 percent reduction in the original funding plan.

MIDD Financial Report

Financial information provided over the next three pages is for calendar year 2011 (January 1 through December 31, 2011). The MIDD Fund spent approximately $30.5 million in strategy funding and approximately $13 million in MIDD supplantation. The MIDD sales tax is strongly influenced by changes in the economy, such that as consumer spending declines, the MIDD Fund declines. Parts I and II show budgeted and actual spending by strategy. Also included in the financial report are summary revenues/ expenditures and detailed supplantation spending.

Mental Illness and Drug Dependency Fund - Part I

	Strategy	Revised Adopted Budget 2011	2011 Actual
1a-1	Increase Access to Community Mental Health Treatment	$ 8,519,105	$ 5,511,796
1a-2	Increase Access to Community Substance Abuse Treatment	$ 2,623,225	$ 2,098,449
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	$ 495,000	$ 449,405
1c	Emergency Room Substance Abuse Early Intervention Program	$ 717,000	$ 618,221
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	$ 225,000	$ 250,000
1e	Chemical Dependency Professional Education and Training	$ 679,994	$ 479,360
1f	Parent Partner and Youth Peer Support Assistance Program	$ 375,000	$ 60,621
1g	Prevention and Early Intervention Mental Health and Substance Abuse	$ 450,000	$ 450,000
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	$ 315,000	$ 315,000
2a	Workload Reduction for Mental Health	$ 4,000,000	$ 4,225,076
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	$ 1,000,000	$ 946,785
3a	Supportive Services for Housing Projects	$ 2,000,000	$ 1,985,542
4a	Services for Parents in Substance Abuse Outpatient Treatment	$ -	$ -
4b	Prevention Services to Children of Substance Abusers	$ -	$ -
4c	Collaborative School-Based Mental Health and Substance Abuse Services	$ 1,236,701	$ 1,085,626
4d	School-Based Suicide Prevention	$ 200,000	$ 200,000
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 176,938	$ 142,700
6a	Wraparound Services for Emotionally Disturbed Youth	$ 4,500,000	$ 3,244,977
7a	Reception Centers for Youth in Crisis	$ -	$ -
7b	Expansion of Children's Crisis Outreach Response Service System	$ 500,000	$ 498,730
8a	Expand Family Treatment Court Services and Support to Parents	$ 81,250	$ 75,000
9a	Expand Juvenile Drug Court Treatment	$ -	$ -
10a	Crisis Intervention Team Training for First Responders	$ 763,747	$ 580,687
10b	Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	$ 6,100,000	$ 1,020,388
11a	Increase Jail Liaison Capacity	$ 80,000	$ 74,515
11b	Increase Services for New or Existing Mental Health Court Programs	$ 545,282	$ 373,112
12a	Jail Re-Entry Program Capacity Increase	$ 320,000	$ 287,890
12b	Hospital Re-Entry Respite Beds	$ 508,500	$ 507,925
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	$ 200,000	$ 183,150
12d	Behavior Modification Classes for CCAP Clients	$ 75,000	$ 75,000
13a	Domestic Violence and Mental Health Services	$ 250,000	$ 313,077
13b	Domestic Violence Prevention	$ 224,000	$ 224,000
14a	Sexual Assault, Mental Health, and Chemical Dependency Services	$ 400,000	$ 323,799
15a	Drug Court: Expansion of Recovery Support Services	$ 103,778	$ 97,682
16a	New Housing Units and Rental Subsidies	$ -	$ -
	MIDD Administration	**$ 2,783,057**	**$ 1,595,949**
	Personnel		$ 932,496
	Other Costs		$ 663,454
	Total MIDD Operating Dollars	**$40,447,577**	**$28,294,464**
	Percentage of Appropriation		**69.95%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	Revised Adopted Budget 2011	2011 Actual
	Department of Judicial Administration	**$ 126,453**	**$ 120,266**
15a	Drug Court: Expansion of Recovery Support Services	$ 126,453	$ 120,266
	Prosecuting Attorney's Office	**$ 263,399**	**$ 272,263**
11b	Increase Services for New or Existing Mental Health Court Programs	$ 220,445	$ 229,309
9a	Expand Juvenile Drug Court Treatment	$ 42,954	$ 42,954
	Superior Court	**$ 1,059,694**	**$ 1,035,234**
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 209,791	$ 202,286
8a	Expand Family Treatment Court Services and Support to Parents	$ 308,829	$ 296,450
9a	Expand Juvenile Drug Court Treatment	$ 541,074	$ 536,499
	Sheriff Pre-Booking Diversion	**$ 164,475**	**$ 110,724**
10a	Crisis Intervention Team Training for First Responders	$ 36,615	$ -
	Sheriff MIDD	$ 127,860	$ 110,724
	Office of Public Defense	**$ 443,263**	**$ 429,284**
8a	Expand Family Treatment Court Services and Support to Parents	$ 98,414	$ 98,414
9a	Expand Juvenile Drug Court Treatment	$ 39,998	$ 39,006
11b	Increase Services for New or Existing Mental Health Court Programs	$ 304,851	$ 291,864
	District Court	**$ 321,354**	**$ 284,617**
11b	Increase Services for New or Existing Mental Health Court Programs	$ 321,354	$ 284,617
	Total Other MIDD Funds	**$ 2,378,638**	**$ 2,252,388**
	Percentage of Appropriation		**94.69%**
	Total All MIDD Funds	**$42,826,215**	**$30,546,851**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	Revised Adopted Budget 2011	2011 Actual
Revenue		
MIDD Tax	$ 42,206,316	$ 42,029,134
Streamlined Mitigation		$ 673,683
Investment Interest - Gross	$ 138,806	$ 161,605
Cash Management Svcs Fee		$ (2,424)
Invest Service Fee - Pool		$ 4,950
Prior Year Correction		$ 25,298
Total Revenues	**$ 42,345,122**	**$ 42,892,246**
Total MIDD Funds	$ 42,826,215	$ 30,546,851
Total MIDD Supplantation	$ 13,460,117	$ 13,037,121
Total Expenditures	**$ 56,286,332**	**$ 43,583,972**
Expenditures Over Revenues	**$ (13,941,210)**	**$ (691,726)**

Mental Illness and Drug Dependency Fund - Supplantation

Strategy	Revised Adopted Budget 2011	2011 Actual
Other MIDD Funds		
Department of Judicial Administration	**$ 1,339,134**	**$ 1,260,027**
Adult Drug Court Base	$ 1,339,134	$ 1,260,027
Prosecuting Attorney's Office	**$ 886,247**	**$ 835,634**
Adult Drug Court Base	$ 551,579	$ 551,578
Juvenile Drug Court Base	$ 121,778	$ 121,778
Mental Health Court Base	$ 212,890	$ 162,278
Superior Court	**$ 239,631**	**$ 229,844**
Adult Drug Court Base	$ 171,713	$ 166,784
Juvenile Drug Court Base	$ 33,959	$ 31,530
Family Treatment Court Base	$ 33,959	$ 31,530
Office of Public Defense	**$ 1,354,133**	**$ 1,307,720**
Adult Drug Court Base	$ 834,429	$ 802,863
Juvenile Drug Court Base	$ 24,758	$ 23,766
Mental Health Court Base	$ 346,107	$ 332,252
Family Treatment Court Base	$ 148,839	$ 148,839
District Court	**$ 643,478**	**$ 629,979**
Mental Health Court Base	$ 643,478	$ 629,979
Department of Adult and Juvenile Detention	**$ 406,000**	**$ 301,852**
Community Center for Alternate Programs (CCAP)	$ 100,000	$ -
Juvenile MH Treatment	$ 306,000	$ 301,852
Jail Health Services	**$ 3,250,372**	**$ 3,122,996**
Psychiatric Services	$ 3,250,372	$ 3,122,996
MIDD	**$ 362,000**	**$ 854,923**
Sexual Assault Supplantation	$ 362,000	$ 362,000
MH Non-Medicaid Mitigation	$ -	$ 492,923
Total Other MIDD Funds	**$ 8,480,995**	**$ 8,542,975**
Percentage of Appropriation		**100.73%**
MH & SA MIDD Supplantation	**$ 4,979,122**	**$ 4,494,146**
SA Administration	$ 399,738	$ 399,738
SA Criminal Justice Initiative	$ 983,906	$ 888,639
SA Contracts	$ 121,757	$ 121,757
SA Housing Voucher Program (increased by $106,375)	$ 708,990	$ 672,967
SA Emergency Service Patrol	$ 560,595	$ 559,372
SA CCAP	$ 472,981	$ 472,981
MH Co-Occurring Disorders Tier	$ 800,000	$ 611,750
MH Recovery (decreased by $106,375)	$ 217,549	$ 196,355
MH Juvenile Justice Liaison	$ 90,000	$ 90,000
MH Crisis Triage Unit	$ 263,606	$ 127,811
MH Functional Family Therapy	$ 272,000	$ 264,777
MH Mental Health Court Liaison	$ 88,000	$ 88,000
Total Other MH/SA MIDD Supplantation Funds	**$ 4,979,122**	**$ 4,494,146**
Percentage of Appropriation		**90.26%**
Total MIDD Supplantation Dollars	**$ 13,460,117**	**$ 13,037,121**
Percentage of Appropriation		**96.86%**

MIDD Provider Agencies by Strategy

Exhibit 1

Agency	Type	1a-1	1a-2	1b	1c	1d	1e	1f	1g	1h	2a	2b	3a	4a	4b	4c	4d	5a	6a	7a	7b	8a	9a	10a	10b	11a	11b	12a	12b	12c	12d	13a	13b	14a	15a	16a	17a	17b
Alpha Center	CD		x				x																															
Asian American CD Tx Svcs	CD		x				x																															
Asian CRS	MH & CD	x	x				x				x	x																										
Auburn Regional Med Ctr	MIDD				x																																	
Auburn Youth Resources	CD		x				x									x																						
Catholic Comm Svcs	MH & CD	x	x				x						x																							x		
City of Seattle	Partner																										x											x
Community House	MH	x									x																									x		
Comm Psych Clinic	MH & CD	x	x				x				x	x							x																			
Consejo	MH & CD	x	x				x				x																											
Crisis Clinic (+)	MH																x																					
Center for Human Svcs	CD		x				x									x			x																			
DAWN	MIDD																															x						
Downtown ESC	MH & CD	x	x				x				x	x	x												x											x		
Eastside DV Program	MIDD																															x						
Evergreen Healthcare	MH & CD	x	x				x			x	x																											
Evergreen Treatment Svcs	CD		x				x						x																									
Friends of Youth	CD		x				x									x																						
Harborview	MH & CD	x	x	x	x	x	x				x	x	x																x	x				x				
Hero House	MH											x																										
Highline Med Ctr	MIDD				x																																	
Integrative Couns Svcs	CD		x				x																															
Intercept Associates	CD		x				x																															
KC Coalition Against DV	MIDD																															x		x				
KC Dept Adult/Juv Detention (+)	Partner																											x			x							
KC Judicial Admin (+)	Partner																																		x			
KC Sexual Assault Res Ctr	MIDD																																	x				
Kent Youth & Family Svcs	CD		x				x									x																						
Muckleshoot	CD		x				x																															
Navos	MH & CD	x	x			x	x				x	x																										
Neighborcare Health	MIDD															x																						
New Beginnings	MIDD																															x						
New Traditions	CD		x				x																															
Northshore Youth & Family	CD		x				x									x																						
Perinatal Treatment Svcs	CD		x				x																															
Pioneer Human Svcs	MH & CD		x				x																															
Plymouth Housing Group	MIDD												x																							x		
Public Health (+)	Partner			x					x																				x									
Puget Sound ESD	Partner															x																						
Recovery Centers of KC	CD		x				x																															
Renton Area Youth Svcs	CD		x				x																															
ReWA	MIDD																															x		x				
Ruth Dykeman Youth & Family	CD		x				x									x																						
Ryther Child Center	CD						x																															
Sea Mar	MH & CD	x	x				x				x																											
Seattle Children's Home	MH	x									x																											
Seattle Children's (Hospital)	MH	x									x					x																						
Seattle Counseling Svcs	MH & CD	x	x				x				x																											
Seattle Indian Health Board	CD		x	x			x																															
Snoqualmie Tribe	CD		x				x																															
Sound Mental Health (+)	MH & CD	x	x			x	x				x	x	x						x							x	x	x			x		x			x		
St. Francis Hospital	MIDD				x																																	
Superior Court, Juvenile Div	Partner																	x				x	x															
Therapeutic Health Svcs	MH & CD	x	x				x				x	x				x			x																			
Transitional Resources	MIDD												x																							x		
Valley Cities CC	MH & CD	x	x	x		x	x				x	x	x						x								x									x		
Valley Medical Ctr	MIDD				x																																	
WAPIFASA	CD		x				x																															
WA St CJ Training Comission	Partner																							x														
YMCA	MH	x									x										x																	
Youth Eastside Svcs	CD		x				x																															

(+) = Over 30 subcontractors or community clinics receive MIDD funding through these agencies.

Implementation delays

Non-MIDD funding secured

MIDD Outcomes Tracking

Exhibit 2

Strategy Set	Strategy Number	Strategy Nickname	Cohort #1 Records	Cohort #2 Records	Cohort #3 Records	Cohort #4 Records	Total in Analysis Sample[1]	Outcome Measures: King County Jails	Psychiatric Hospitals	MH Treatment Link	CD Treatment Link	Jobs	Symptom Reduction[2]	ER
Strategy Set #1	1a-1	MH Treatment	988	1,058	855	726	3,627	X	X				PSS/CFARS	X
	1a-2a	CD Treatment - Outpatient	790	2,032	573	1,302	4,697	X					TARGET	X
	1a-2b	CD Treatment - Opiate Substitution	142	705	60	292	1,199	X					TARGET	X
	1d	MH Crisis Next Day Appts	495	403	441	411	1,750	X	X	X				X
	1h	Older Adults Crisis & Service Linkage	128	198	198	230	754		X	X	X			X
	2b	Employment Services MH & CD	438	298	238	250	1,224					X		
	12c	PES Link to Community Services	32	55	72	62	221	X	X	X	X			X
	15a	Adult Drug Court Expansion	93	32	74	57	256	X					TARGET	
	16a	New Housing and Rental Subsidies	9	18	34	19	80	X	X					X
Strategy Set #2	1c-1[a]	SA Emergency Room Intervention	1,392	1,180	984		3,556	X			X			X
	1g	Older Adults Prevention MH & SA	1,107	1,220	930		3,257			X	X		PHQ-9/GAD-7	X
	3a	Supportive Housing	107	21	44		172	X	X	X	X			X
	8a	Family Treatment Court Expansion	15	13	24		52	X			X		TARGET	
	9a	Juvenile Drug Court Expansion	16	23	23		62	X			X		TARGET	
	11a	Increase Jail Liaison Capacity	66	66	136		268	X		X	X			
	12a-1	Jail Re-Entry Capacity Increase	220	108	97		425	X		X	X			
Strategy Set #3	1b	Outreach & Engagement	761	972			1,733	X	X	X	X			X
	1c-2[b]	SA Emergency Room Intervention	282	480			762	X			X			X
	5a	Juvenile Justice Youth Assessments	81	218			299	X		X	X			
	6a	Wraparound	107	129			236	X					Other	
	12a-2	CCAP Education Classes: GED/LSW	139	76			215	X						
		CCAP Education Classes: DV	111	157			268	X						
	12d	Behavior Modification for CCAP	56	36			92	X					PSS	
							Sum by Outcome Type	19,970	8,337	8,879	11,561	1,224	-	-

X	Look-up and match to outside source
X (orange)	Analysis indicates outcome measure is appropriate for the strategy, although not listed in the evaluation matrix
X (green shading)	Source not yet available

[1] Most records have been unduplicated within strategy - retaining earliest MIDD start date, but duplicated individuals served across strategies remain

[2] Measures include Problem Severity Summary (PSS), Children's Functional Assessment Rating Scale (CFARS), TARGET milestone data, Patient Health Questionnaire - Depression (PHQ-9), Generalized Anxiety Disorder (GAD-7), and other customized tools

[a] Harborview Hospital

[b] South County Hospitals - one provider began serving clients on 5/1/2009

Service Start Dates for Individuals in Each Outcomes-Eligible Cohort	Set #1	Set #2	Set #3
Cohort 1	10/1/2008 - 3/31/2009	1/1/2009 - 6/30/2009	7/1/2009 - 12/31/2009
Cohort 2	4/1/2009 - 9/30/2009	7/1/2009 - 12/31/2009	1/1/2010 - 6/30/2010
Cohort 3	10/1/2009 - 3/31/2010	1/1/2010 - 6/30/2010	
Cohort 4	4/1/2010 - 9/30/2010		