Mental Illness and Drug Dependency

Implementation and Evaluation Progress for October 1, 2012—March 31, 2013

Year Five Progress Report

King County

Mental Illness and Drug Dependency Oversight Committee

August 2013

King County Department of Community and Human Services

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Year Five Progress Report

October 1, 2012—March 31, 2013

Report design by Lisa Kimmerly
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For further information on the current status of MIDD activities, please see the MIDD website at:

www.kingcounty.gov/healthservices/MHSA/MIDDPlan

Alternate formats available
Call 206-263-8663
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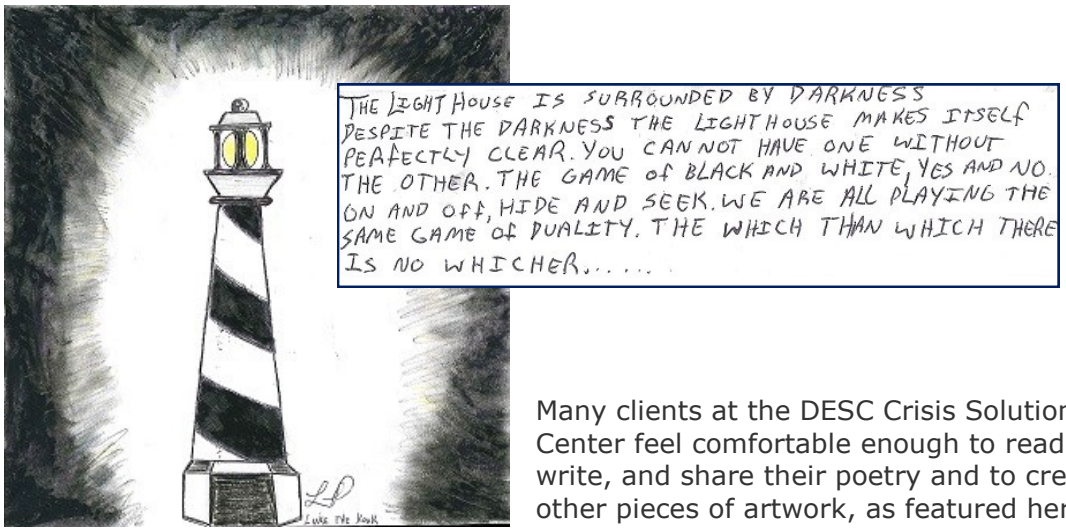


Many clients at the DESC Crisis Solutions Center feel comfortable enough to read, write, and share their poetry and to create other pieces of artwork, as featured here.

Complete Listing of Strategies

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

Introduction

In accordance with King County Ordinance 15949, this report updates the Metropolitan King County Council on programs supported with the one-tenth of one percent sales tax revenue for the delivery of Mental Illness and Drug Dependency (MIDD) fund services. The ordinance requires the King County Executive to submit reports twice yearly: a progress report and an annual report. This progress report, covering the time period from October 1, 2012 to March 31, 2013, includes these required elements:

a) *performance measurement statistics*
b) program utilization statistics
c) request for proposal and expenditure status updates
d) progress reports on evaluation implementation
e) geographic distribution of the sales tax expenditures across the county, including collection of residential ZIP code data for individuals served by programs and strategies
f) updated financial plan.

Background

Nearly six years ago, the Metropolitan King County Council enacted a sales tax that funds strategies and programs as outlined in King County's MIDD Action Plan. The MIDD seeks 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 plan via Motion 12598 in October 2007, and authorized the one-tenth of one percent 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 effective prevention, treatment, housing support, and therapeutic court services utilizing MIDD funds. This Year Five Progress Report covers the first half of the MIDD's fifth year from October 2012 through March 2013. It provides updates on all strategies, including relevant output measures, continuous quality improvement efforts and client success stories.

MIDD Policy Goals*

1. Reduce the number of people with mental illness and substance use disorders 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 youth and adults with mental illness and substance use disorders 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*

Year Five Progress Report Highlights

- Total revenues in the first half of calendar year 2013 were $22.9 million. Expenditures to implement MIDD strategies totaled $24.6 million in the same period.
- The MIDD Oversight Committee and subcommittee members contributed over 352 cumulative hours of service to monitor MIDD implementation and progress.
- An evaluation of programs supported by MIDD supplantation funds was carried out at the request of the County Executive.
- Members of the 2013 MIDD Prioritization Subcommittee reached consensus on recommendations for a methodology to address projected future budget shortfalls.
- Changes to the MIDD progress report format increased the capacity to provide information on strategy quality improvement efforts and linkages to other King County initiatives.
- Several MIDD strategies showed substantial growth in the number of clients served when compared to the same period a year ago. For example, Strategy 1a-1—Increase Access to Community Mental Health Treatment was able to serve 70 percent more clients due to a change in eligibility rules.
- Under Strategy 1f—Parent Partner and Youth Peer Support Assistance Program, a brand new agency began operations in Kent, WA.
- The Juvenile Justice Assessment Team under Strategy 5a added pre-assessment trauma screening services during the current period.
- The Children's Crisis Outreach Response System (Strategy 7b) is projected to serve 359 percent of their annual target in MIDD Year Five, due in part to increased marketing efforts.
- Increased demand from the court system led to a 55 percent increase in clients participating in the Moral Reconation Therapy supported by MIDD Strategy 12d.
- At least 23,604 individuals (15,275 adults and 8,329 youth/children) received one or more services during the first half of MIDD Year Five.
- Clients were from all areas of King County, including greater Seattle (34%), south King County (33%), east (16%), north (7%), and other/unknown (10%).
- At least 725 military veterans received services in the current period. Another 378 military spouses and dependent children were also served.

MIDD Implementation Progress

At the start of MIDD's fifth year of program delivery, three strategies continued to remain on hold due to lack of available funds. Those strategies are listed below.

- Strategy 4a—Services for Parents in Substance Abuse Outpatient Treatment
- Strategy 4b—Prevention Services to Children of Substance Abusers
- Strategy 7a—Reception Centers for Youth in Crisis.

MIDD Oversight Committee Activities

The full MIDD Oversight Committee (OC) met four times during the current reporting period to monitor program implementation and progress. Two subcommittees were also convened. A prioritization committee met six times, with over twenty members, and a crisis diversion committee met five times to provide additional oversight for utilization of Strategy 10a—Crisis Intervention Team Training and Strategy 10b—Adult Crisis Diversion. Committee and subcommittee members cumulatively contributed over 352 hours of service during these meetings. At each of the following OC meetings, the membership received updates and engaged in discussions on several key topics as shown below.

Meeting Date	Key Topics, Updates, and Discussions
10/25/2012	* MIDD Supplantation Evaluation Plan • Requested by the County Executive as part of the overall prioritization process • Generated supplantation program descriptions and goals • Used same model of comparing pre-post intervention system use as the MIDD strategy evaluation, where possible • Used existing data to inform budget process on program performance and outcomes * Strategy 12b—Hospital Re-Entry Respite Beds • Medical respite care offers a safe place for individuals experiencing homelessness to recuperate when leaving area hospitals • MIDD funds allow the program to serve those with complex behavioral health issues • A strong oversight group meets monthly to actively manage the program • Cost effective—$300 per bed day compared to $2,800 per day for an inpatient stay
12/13/2012	* King County Budget Update • The County Council adopted a 2013-2014 biennial budget for MIDD of $74.4 million • This budget was $7.9 million less than the Executive's proposed budget • Council indicated that revenue to be identified later would close the funding gap * Statewide Legislative Priorities for Mental Health and Substance Abuse in 2013 • Maintain critical funding to preserve safety net services • Fix the flaw in the criminal insanity statute • Fund enhanced services facilities and amend the involuntary treatment act to exclude dementia and organic disorders • Use liquor taxes to support substance abuse prevention, treatment, and recovery • Provide funding for tobacco treatment training and support * Strategy 10b—Adult Crisis Diversion • Updated information was provided about the Crisis Solutions Center (operated by DESC), including initial utilization statistics and client success stories
2/28/2013	* Strategy 7b—Expand Youth Crisis Services • Children's Crisis Outreach Response System utilizes MIDD funds to enhance their 24/7 response services for families in acute crisis involving children • Presented engagement and treatment methods along with outcomes information
3/28/2013	* MIDD Prioritization Subcommittee Presentation • Proposed recommendations to the King County Council and Executive regarding the prioritization of MIDD strategies when balancing the budget • 2014 projected budget deficit reduced from $7.9 million to $1.4 million due to MIDD Fund underspending in 2012 and increases in future revenue forecasts • Substantial budget deficits remain a factor looking ahead to 2015 and 2016 • Recommended targeted reductions as outlined on Page 5 of this report.

MIDD Oversight Subcommittee Recommendations

2013 Prioritization Subcommittee Reached Consensus on Methodology

Facing significant anticipated budget shortfalls after 2013, the MIDD OC convened a new prioritization subcommittee to work with county staff to develop recommendations for addressing these budget issues. The previous subcommittee had recommended the following when making budget cuts:

- Maintain a balance of core services at levels necessary for those services to be effective
- Preserve a continuum of services across age groups, intervention point, and type of service
- Seek individual strategy-level efficiencies
- Ensure equity and social justice priorities are maintained and that there are no disproportionate impacts on disadvantaged communities and geographic areas
- Consider program effectiveness, based on the achievement of performance measure targets and on outcomes for those programs that have had outcomes measured.

The 2012-2013 prioritization subcommittee, contributing a cumulative 189 hours, reiterated support for these concepts and agreed on a preferred methodology for reducing MIDD expenditures using targeted reductions in the following order of implementation:

- Strategies that significantly underspent (by 10 percent or more) in 2012 for reasons other than late implementation or other one-time causes
- Strategies that can be reduced due to implementation of Medicaid expansion in 2014
- Freezing all MIDD-funded County strategies to the 2013 budget for 2014, 2015, and 2016
- Review and consider the extent to which programs achieved performance targets and outcomes, with consultation from program managers, and evaluation staff
- Flat, across-the-board percentage cuts to all programs, including supplanted programs.

Additional considerations were to include looking to see if strategies received prior cuts, exempting strategies having only a single funded staff position, maintaining an adequate undesignated fund balance, and the state-mandated stepping down of cuts to supplantation strategies over time.

Crisis Diversion Subcommittee Met to Improve Program Utilization

First convened on October 1, 2012, the Crisis Diversion Subcommittee met five times in the current reporting period with members collectively contributing 60 hours of service. Topics of discussion were:

10/1/2012:	-Review of programs offered and law enforcement diversion protocols -Requests for additional information and robust evaluation plans
11/7/2012:	-Role and authority of the subcommittee -Seattle Police Department Crisis Intervention Team (CIT) training update -Transports made by the Emergency Service Patrol van at the request of DESC Crisis Solutions Center (CSC) staff -Program statistics for August, September, and October -Neighborhood Advisory Committee updates
1/17/2013:	-Program updates and reporting requirements -Backfill/overtime reimbursement and no-show/cancellation rates for CIT attendees -Background checking for felony convictions exclusionary for admission to CSC -Coordination of CSC with area hospitals re: medications for physical health needs
2/21/2013:	-Update on Washington State legislative bill to require CIT training -Need to educate law enforcement dispatchers on CSC referral process -Development of advanced CIT courses for additional hands-on practice/refreshers
3/21/2013:	-Training audit reports of CIT from external evaluators -Residential Treatment Facility licensure from State of Washington for CSC.

MIDD Requests for Proposals

No requests for proposals for MIDD services were needed between October 2012 and March 2013.

MIDD Evaluation Efforts

The MIDD Plan is evaluated by staff in King County's Department of Community and Human Services (DCHS), Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), Systems Performance Evaluation unit. Throughout late 2012 and early 2013, the team accomplished the following:

- Revised the reporting layout to enhance readability and increase capacity for providing information on each MIDD strategy
- Adopted a new report design template to streamline future editing capabilities and to increase the time available for more complex data analysis
- Participated in five cross-divisional evaluation team meetings intended to increase collaboration among the various DCHS systems performance units
- Tracked outcomes for over 35,000 "person by MIDD strategy" records
- Obtained and analyzed emergency department utilization data provided by the University of Washington's Harborview Medical Center in Seattle, WA
- Studied reductions in anxiety and depression symptoms for nearly 3,000 individuals
- Examined utilization of community inpatient psychiatric hospitals and Western State Hospital among 1,364 MIDD participants
- Confirmed jail use reductions in excess of 40 percent by a third post period for six MIDD strategies with jail data
- Performed continuous quality improvement analyses for targeted strategies and responded to special requests involving MIDD data
- Presented evaluation findings and/or MIDD overviews at the following: a MHCADSD monthly all-staff meeting, a meeting of hospitals delivering Strategy 1c—Substance Abuse Emergency Room Intervention, and for the Crisis Diversion Subcommittee.

Community-Based Care Strategies

All 14 strategies in this category have been implemented. Interventions within the community-based care set of strategies aim to:

- Increase access to community mental health (MH) treatment and chemical dependency (CD) treatment for uninsured children, adults, and older adults
- Reach out to populations that are difficult to engage in traditional systems of care
- Improve care quality by decreasing MH agency caseloads
- Provide individualized employment services at participating MH agencies
- Offer intensive support services within housing programs focused on meeting the needs of various MIDD populations
- Standardize screening of domestic violence and sexual assault survivors for mental illness and substance abuse and offer therapeutic interventions when appropriate.

1a-1 Increase Access to Community Mental Health Treatment

By providing continuous access to mental health services for individuals who lose their Medicaid eligibility, costly disruptions to their successful treatment and recovery are prevented. This strategy also helps those who meet clinical and financial criteria for services, but are otherwise Medicaid-ineligible. Twenty licensed community mental health agencies delivering highly-individualized, consumer-centered services in outpatient settings now have access to this vital fund source. Beneficiaries include uninsured King County residents of all ages.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
2,400 clients/yr	**4,112**	**1.3**	**223%**

Service Highlights

More than 4,000 people received Strategy 1a-1 benefits in the first half of MIDD Year Five, including 307 who were enrolled in clubhouse services (see box below). Just over 18 percent of the clubhouse members counted this period also had MIDD funding for their mental health treatment. The total number of unduplicated individuals served represents a 70 percent increase over the same period a year ago. A 2012 change in the eligibility criteria allowed individuals to be eligible for many more services.

Just over half of all participants were racial minorities, or of mixed race. Disabilities were recorded for 827 people.

Documented Disabilities for Strategy 1a-1

Disability Type	Number	Percent
Medical/Physical	420	51%
Sensory/Communication	76	9%
Developmental	71	9%
Multiple	158	19%
Psychiatric/Other	102	12%

MIDD Funding Supports Two Clubhouses

Clubhouses provide educational, work, and social opportunities for adults with mental illness. Programs in the clubhouse model foster meaningful relationships, a sense of purpose, and complement more traditional forms of treatment.

Quality Improvements

A primary goal in the delivery of mental health treatment involves helping individuals with severe and persistent mental illness to reduce the severity of their psychiatric symptoms so they may lead productive and fulfilling lives. In accordance with the King County Strategic Plan, Strategy 1a-1 seeks to "promote opportunities for...individuals to realize their full potential."

For the MIDD evaluation, measurement of symptom reduction relies on administration of the Problem Severity Summary (PSS) by community mental health providers to adults in treatment at six-month intervals. For children, the instrument used to collect symptom data is the Children's Functional Assessment Rating Scale (CFARS).

After 2010, when reporting of PSS and CFARS scores became mandatory, the completion rates for submitting these scores at baseline climbed from less than half to as high as 96 percent for some providers. Missing data are expected due to variances in client engagement over time, so the current average completion rates of 70 to 79 percent at six months and one year, respectively, are encouraging. For children, six-month CFARS were provided for fewer than one in four participants, but scores at one-year were available for more than half of all younger participants. Improving completion rates enables more robust data analysis.

1a-2 Increase Access to Community Substance Abuse Treatment

Assessment, individual counseling, group counseling, and case management are all aspects of substance abuse treatment for adults in outpatient (OP) settings. Treatment for youth includes all of these components, plus urinalysis. Individuals enrolled in opiate treatment programs (OTP) typically receive daily dosing of medications such as methadone. More than thirty provider agencies increased access to their services or enhanced treatment continuity because of this strategy.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
50,000 adult OP units **4,000 youth OP units** **70,000 OTP units**	**14,655 adult OP units** **2,560 youth OP units** **27,311 OTP units**	**2.0**	**59%** **128%** **78%**

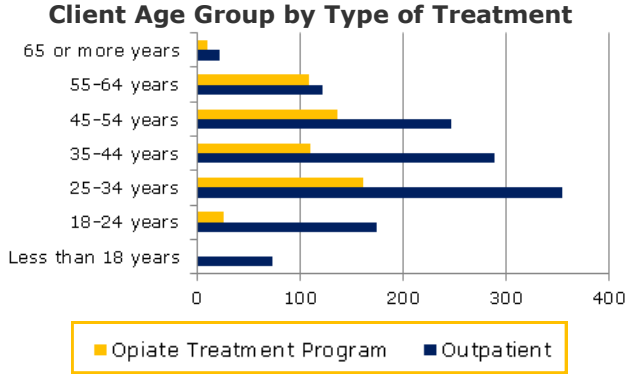
Service Highlights

The number of unduplicated individuals receiving MIDD-funded treatment for addiction to drugs and alcohol during late 2012 and early 2013 was 1,836. By treatment type, outpatient treatment enrolled 1,274 people, medication-assisted opiate treatment helped 553, and nine had both types of treatment.

Performance measurement counts the number of units purchased for each type of treatment. The projected percentages of annual target above are typically not very accurate due to fluctuating availability of other funds to pay for these services. For example, state funds must be spent down first and can reduce the need to purchase adult outpatient units with MIDD monies.

The number of clients served in each age group by treatment type is shown below.

Client Age Group by Type of Treatment



Quality Improvements

Data on substance abuse treatment services delivered within King County are collected by a statewide system called TARGET that is administered by the Washington State Division of Behavioral Health and Recovery (DBHR). In late 2009, a request was made to modify the TARGET system to allow for collection of "interim milestone records" to track substance use and recovery outcomes at time points other than intake and discharge from treatment. While DBHR was receptive to this change request, King County was informed that limited time and resources would impact the timeline for delivery of these new features.

After DBHR completed their programming changes, King County began requiring adult treatment providers to report the new interim data. Modifications were needed to fully capture all required information. The King County database that is populated by the TARGET download must now be modified before any of this new information will be available for evaluation purposes.

A Growing Overdose Epidemic

Between 1999 and 2010, nearly 48,000 women died of prescription painkiller overdoses in the U.S. For each woman who died, 30 went to emergency departments for painkiller misuse or abuse.

Source: Centers for Disease Control and Prevention

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

Through a partnership with Public Health—Seattle & King County's Healthcare for the Homeless and other providers, individuals coping with chronic homelessness and addiction to drugs or alcohol are engaged by outreach workers in an effort to link them with various service providers in the community. Successful engagement employs principles of harm reduction, motivational interviewing, and trauma-informed care. Outreach efforts are prioritized for those leaving hospital and jails.

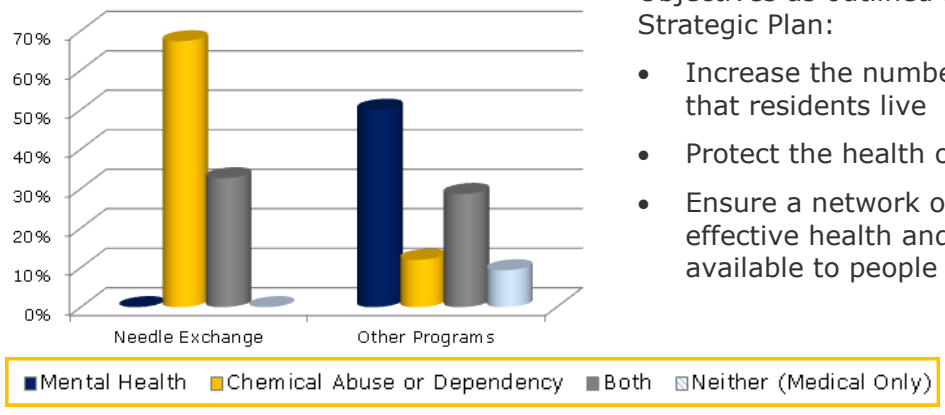
Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
675 clients/yr	**891**	**2.0**	**264%**

Service Highlights

Using MIDD money to leverage matching funds, Strategy 1b is again projected to serve nearly three times as many people in MIDD Year Five as one would expect based on the MIDD portion alone. In particular, Public Health's Needle Exchange Program (NEP) served 741 injection drug users, providing outreach and case management for those on the waiting list for opiate treatment. In 1,727 service encounters during this period, the NEP made 415 new referrals to substance use treatment and was able to confirm linkages to treatment for over half of those referrals.

In addition to the NEP, outreach services were provided to another 150 people by three other provider agencies. How client problems were diagnosed differed between the NEP and other programs as shown graphically below.

Percentage of Clients by Diagnosis Type



Quality Improvements

Annual narrative reports provide detailed information about how various MIDD programs have been implemented, along with challenges and successes faced by providers of these services. These reports can guide quality improvement efforts by highlighting what is working well, while offering opportunities to make changes when program aspects fall short of desired expectations.

In 2012, two successful providers of Strategy 1b services included Harborview Medical Center (in Seattle's downtown core) and Valley Cities Counseling and Consultation (in rural south and east King County). While their service models differ due to geographic disparities, one program aspect adopted by both is the level to which they are integrated and coordinate with staff at the sites they serve. This coordination addresses three Health and Human Potential Objectives as outlined in King County's Strategic Plan:

- Increase the number of healthy years that residents live
- Protect the health of communities
- Ensure a network of integrated and effective health and human services is available to people in need.

1c Emergency Room Substance Abuse Early Intervention Program

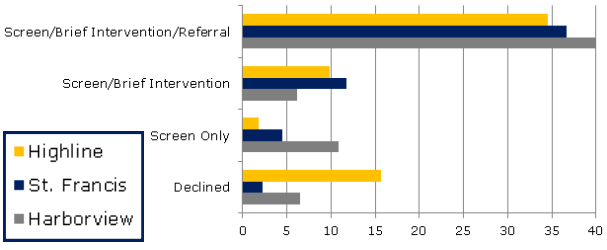
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice focused on engaging persons at early risk for substance use disorders. The MIDD supports SBIRT for patients who are admitted to selected emergency departments (ED) for a variety of reasons. Key tenets of the SBIRT approach include: Raising the subject (establishing rapport and asking to discuss the patient's alcohol/drug use), providing feedback (sharing the results of the screening), enhancing motivation (assessing each person's motivation to change), and assisting the individual with a referral for treatment if needed.

Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
5,600 screens/yr **3,798 brief interventions/yr**	**2,309 screens** **2,298 brief interventions**	**2.0**	**82%** **121%** **Adjusted**

Service Highlights

Between October 1, 2012 and March 30, 2013, chemical dependency professionals (CDPs) at three area hospitals approached a total of 2,292 unique individuals for the delivery of SBIRT services. The graphic below shows the monthly average (per staff person) for various encounter types by location. At Highline Medical Center, hospital protocol requires physicians to decide who should be referred to SBIRT services, rather than the CDP doing outreach to patients.

Average Encounters per Month by Location



Continuing Education for SBIRT Counselors

During the first quarter of 2013, training opportunities enabled participating SBIRT practitioners to increase their skills in motivational interviewing. The classes were funded by MIDD Strategy 1e, which offers trainings for CD professionals. The introductory course was 16 hours long and the advanced course was eight hours long.

Quality Improvements

Each year, the hospitals delivering SBIRT services have requested and received annual continuous quality improvement (CQI) presentations. Discussion points during their most recent CQI update were guided by findings from analysis of both demographic and service delivery data. For example:

- *Is gender parity evident?*
  Only 34 percent of all clients served since 2009 were female. Women were an estimated 39 percent of all regional drug-related ED visits from 2008 to 2012.
- *Do racial disparities require addressing?*
  African American/Blacks were served at a rate three times higher than population census and Asian/Pacific Islanders were served at a rate four times lower. Census data from area hospitals for comparison is unavailable to MIDD evaluators.
- *Is translation support sufficient?*
  SBIRT participants spoke 38 languages.
- *In order to meet performance targets, how should programs balance staff time spent on screening individuals versus providing intervention services?*
  Those with higher "risk" scores are already showing signs of dysfunctional use and require more time-consuming interventions than a simple screening.

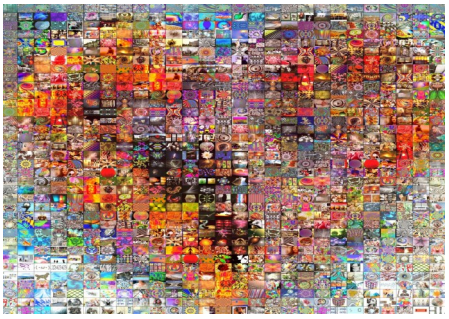
1d Mental Health Crisis Next Day Appointments and Stabilization Services

State-funded crisis stabilization services, including next day appointments, are enhanced with MIDD funding to provide additional services such as psychiatric medication evaluations. Following a mental health crisis, highly-trained medical professionals perform these face-to-face reviews to assess the need for initiation of or adjustments to prescribed psychiatric medications in order to increase effectiveness or manage side effects or other challenges. These "medical services" may also be provided in consultation with primary therapists or case managers. For the purposes of MIDD evaluation, medical services serve as a proxy to estimate how many clients receive various types of enhanced services.

Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
285 clients/yr with enhanced services	**154**	**2.0**	**108% Adjusted**

Service Highlights

Next day appointments (NDA) were reduced in 2011 due to state budget cuts, so enhancing these services was impacted as well. The number of NDA recipients in the current period who had medical or medication services was 154. The count of these medical services acts as a proxy to estimate how many people have benefitted from MIDD enhancement of crisis stabilization services.



How MIDD Strategy 1d Fits into the Crisis Services Mosaic

There are a range of crisis mental health services available for all residents of King County, regardless of age or income. Crisis services are available for any person for whom a mental illness or emotional disturbance may be present. The goal of crisis services is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering their strengths, resources, and choice. Interventions are age and developmentally appropriate and contribute to and support the individual's innate resiliency. The Crisis Clinic, Children's Crisis Outreach Response Services (CCORS), or Designated Mental Health Professionals make referrals for these services based on the person's area of residence, individual or family preference, and culture. King County residents not currently enrolled in outpatient services may access:

1. 24-hour phone line
2. Telephone screening services
3. Next Day Appointment services for adults and older adults (includes MIDD 1d)
4. Children's Crisis Outreach Response Services (CCORS)
5. Crisis diversion services (Crisis Diversion Facility, Crisis Diversion Interim Services and Mobile Crisis Team)
6. Inpatient diversion beds
7. Crisis and Commitment Services (CCS) outreach and involuntary detention services.

1e Chemical Dependency Professional (CDP) Education and Training

A workforce development plan was adopted in 2010 to incorporate evidence-based practices into service delivery throughout King County's chemical dependency treatment system. A key aspect of the plan involves training CDPs in motivational interviewing, then ensuring fidelity to this model through clinical supervision with performance feedback and coaching. Funding also reimburses expenses incurred earning/renewing CDP or Certified Prevention Professional (CPP) credentials.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
125 reimbursed trainees/yr	**218 (unduplicated)**	**1.3**	**227%**
250 workforce development trainees/yr	**202**		**105%**

Service Highlights

During this reporting period, the Northwest Frontier Addiction Technology Transfer Center delivered seven trainings, educating 136 attendees. In addition to courses in motivational interviewing, two treatment planning classes were offered. The learning objectives for treatment planning were:

1. Identify and write professional problem statements for clients
2. Prioritize problems using the American Society of Addiction Medicine criteria
3. Create goal statements for clients
4. Write objectives and interventions for a client-driven treatment plan
5. Establish a relationship between assessment, placement criteria, and the treatment plan.

Three other learning events were funded, with 65 more trainees. The annual report will give details on classes by Seven Challenges, LLC and Chestnut Health Systems.

Professional Education Reimbursements

Thirty provider agencies in the substance abuse treatment network participated in the reimbursement program this period.

Q4-2012	102 trainees	$36,673
Q1-2013	143 trainees	$51,227

Quality Improvements

In a preliminary effort to improve and update the CDP and CPP courses offered at local community colleges, a survey was drafted to allow trainees an opportunity to provide feedback about class objectives, relevance, and usefulness. After further revisions, the survey will be made available to individuals who are receiving expense reimbursements.

Evaluation data were collected for all trainings offered during the first part of MIDD Year Five. Overall course satisfaction ratings were very high, with 93 percent of all respondents indicating they were either "satisfied" or "very satisfied". For those attending Introduction to Motivational Interviewing, follow-ups at six months revealed average knowledge gains for each learning objective (from 2.2 to 3.3) on a five-point scale where 1 = "Basic", 3 = "Intermediate", and 5 = "Advanced."

The top three trainee professions were: addiction treatment (62), counseling (46), and social work (21). The majority were female (69%), Caucasian (72%), and from the Seattle core region of King County (68%). These demographics represent the existing CDP workforce population; potential future efforts could involve recruiting individuals to increase diversity.

1f Parent Partner and Youth Peer Support Assistance Program

A new family support organization, named Guided Pathways—Support (GPS) for Youth and Families, was developed in 2012 to provide services for families by families. The GPS program will serve King County families whose children or youth experience serious emotional or behavioral problems and/or have substance abuse issues. The primary purpose of this organization is to empower families with information and support to promote self-determination and family well-being.

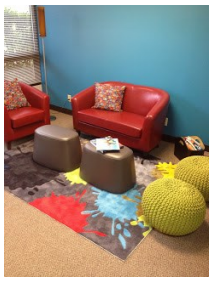
Year 5 Proposed Target	6 Month Progress	Projected Percent of Annual Target
400 clients/yr	**Start up only**	**N/A**

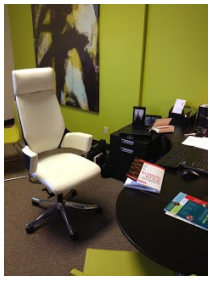
Start Up Highlights

Susan Millender, a parent of two children with mental health concerns, brought 15 years of nonprofit leadership experience to her new role when named the Executive Director of GPS in 2012. On November 14, she joined the GPS consultant, several GPS board members, and King County staff in Washington, D.C. to present at the National Federation of Families for Children's Mental Health conference. The workshop was entitled *Building a Sustainable Family Support Organization*, and was well received.

Beginning in December 2012, GPS spent several months recruiting and hiring staff with the goal of opening the organization's doors by April 2013 in Kent, WA. Positions to be filled included: administrative support, volunteer coordinator, and parent partners.

The website for GPS is very informative and updated on a regular basis. Visit them at www.guidedpathways.org.





Photos of the new agency by Susan Millender.

Evaluation Preparation

Meetings with King County's MIDD evaluation staff were held to develop tools for tracking services to be offered by GPS. The current plan is for the agency to submit data via the MIDD custom data submission process, which involves transmitting information by spreadsheet using the County's secure file transfer protocol.

In addition to gathering core demographics on individuals receiving direct one-on-one support from parent partners or youth peers, the evaluation plan calls for tracking process measures such as:

1) The total number of families provided parent partner support services
2) The number of peer support services provided
3) The number of people participating in other community-building events.

Initial targets will likely need to be modified over time, as actual demand and capacity cannot be known until the strategy becomes more fully implemented.

In the United States, an estimated one in every 10 children and teens is functionally impaired by severe mental illness. According to the National Federation of Families for Children's Mental Health, only 21 percent of those affected ever receive mental health care.

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

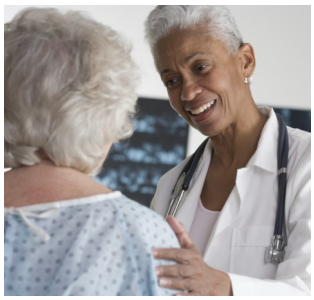
Older adults receiving primary medical care through a network of over 20 "safety net" clinics now have access to screening for depression, anxiety, and substance abuse disorders. If needed, short-term behavioral health interventions are available for both uninsured and underinsured individuals who are 50 years or older. This strategy has been on the cutting edge of healthcare integration efforts, serving over 9,000 clients since it was first implemented in 2009.

Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
2,196 clients/yr	**2,397**	**1.3**	**142% Adjusted**

Service Highlights

Each year, the medical clinics whose services are supported by MIDD Strategy 1g serve at least 35,000 low income adults over the age of 50. About 10 percent of all patients seen annually are currently being screened for mental health and substance use concerns. Of those found to be above clinical thresholds, approximately 44 percent agree to participate in interventions delivered within their primary healthcare settings. Those whose treatment needs cannot be managed at the primary care level are linked to qualified mental health or drug/alcohol treatment providers.

The number of unique patients screened in the current reporting period represents a 12 percent increase over the same period one year ago. As of March 30, 2013, 710 active cases remained open; 1,715 were closed between October 2012 and March 2013. The most common exit reasons given were: client requested an end to treatment (56%), treatment was completed (15%), or the client was referred out for additional services (14%). On average, engaged clients received about 10 total visits and six hours of intensive intervention care each.



Quality Improvements

Individuals who screen positive for either mental illness or substance abuse may choose to be clinically assessed by a mental health provider. These clinical assessments are comprehensive socio-emotional appraisals designed to better understand a person's mental health and chemical dependency treatment needs. Instruments such as the Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7) and Global Appraisal of Individual Needs (GAIN) measure depression, anxiety, and substance abuse. Scores from these instruments allow evaluators to track symptom reduction over time.

According to a 2012 report prepared by Public Health—Seattle & King County, providers received a psychiatric consultation for 74 percent of their clients whose mental health status did not appear to be improving. Tracking this metric and responding clinically are important components of quality mental health care and medication management.

A recent analysis of the relationships between service delivery and symptom reduction found that those who improved or stabilized below clinical thresholds for anxiety and depression had more contacts and more service minutes than those whose symptoms worsened or remained higher than threshold.

1h Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults

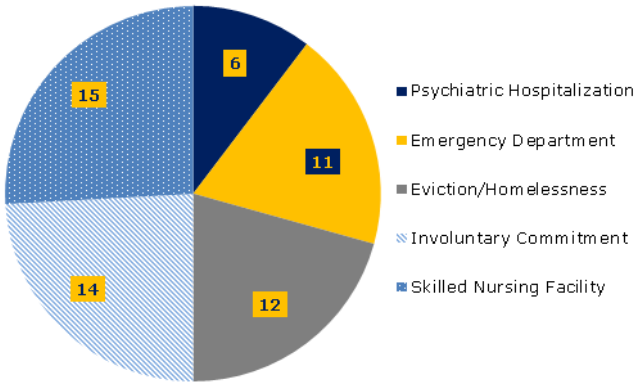
The Geriatric Regional Assessment Team (GRAT) delivers community-based crisis intervention services for adults aged 60 and older. In response to calls from police, other first responders, and community referents the team is deployed countywide to assess those in crisis and connect them with appropriate service providers. The GRAT often helps divert individuals from admission to emergency departments, psychiatric hospitalizations, and evictions from their homes. With MIDD funding, the team has hired additional geriatric specialists to serve more clients in a timely manner and has increased law enforcement collaboration.

Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
258 clients/yr	**218**	**1.9**	**160% Adjusted**

Service Highlights

During the fourth quarter of 2012, the GRAT staffed a total of 147 referrals within one day of receipt. Mental health referrals accounted for 129 community visits and chemical dependency referrals another 18 visits. In the first quarter of 2013, another 114 referrals were handled by the team. A total of 218 unduplicated clients were ultimately served. Diversions from costly alternatives were recorded by staff members as shown.

Staff-Recorded GRAT Diversions

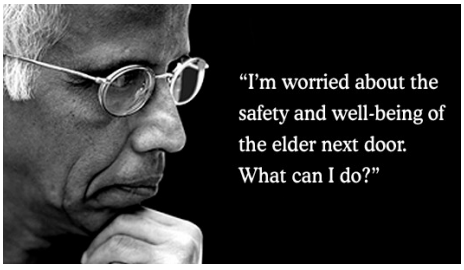


As of March 2013, the average age of current GRAT clients was 79 years. The age distribution was as follows: Less than 70 (18%), 70 to 79 (37%), 80 to 89 (34%), and 90 or greater (11%). The two oldest clients were 101 years old.

Quality Improvements

Discrepancies between original evaluation plan expectations and the requirements actually listed in the contract language related to the number of referrals to be handled were the subject of recent efforts to improve the quality of communication with the GRAT provider. Both the number of referrals handled each period (contractual requirement) and the number of people enrolled in GRAT (MIDD performance measurement) are reported here.

After observing a sharp decline in referrals being handled by the GRAT over a one year period beginning in September 2011, data analysts worked with contract monitors to explore reasons for the decline. Addressing both staffing and marketing issues, the GRAT focused efforts on building stronger relationships with law enforcement; efforts included providing monthly trainings and on-the-spot telephone consultation for first responders in the field. As law enforcement referrals continue to grow, the GRAT is expected to serve over 400 clients this year.



2a Workload Reduction for Mental Health

The workload reduction strategy was designed to increase the number of direct services staff in participating community mental health (MH) agencies. By funding more or different staff positions, overall caseload size can be reduced in order to improve the frequency and quality of MH services delivered to clients. This strategy is aligned with goals of the Mental Health Recovery Plan of King County that was adopted through Ordinance 15327 in November 2005.

Year 5 Target	6 Month Progress	Projected Percent of Annual Target
16 agencies participating	**17 agencies**	**106%**

How Peer Support Services Help Workload Reduction

Peer Support Specialists are one of the many direct service staff types that contribute to reduction of the workload for case management and clinical staff. Support provided by people already in recovery and who have been trained to share their strength, experience, and hope with their peers is among the most powerful of recovery supportive practices. They provide a range of services in the community and at area MH agencies. They include youth peers, parent partners, and peers working with adults and older adults. It is especially challenging to get and keep youth peer specialists, as they are required to be at least 18 years old. When youth are old enough to receive a peer support certification, many are ready to move on from mentorship roles to pursue education, careers, and families in adulthood. Youth peers assist with organizing, planning, and implementing summer programs. They attend workshops to develop skills as youth leaders, exploring topics such as racism, image, identity, job skills and education, job site and college visits, and self-awareness.

One valuable aspect of a peer support specialists' work is the proof they provide to people also living with behavioral health issues, and to professional staff, that recovery is possible. Peer Support Specialists serving adults and older adults provide many types of one-on-one and group services such as:

- One-on-one teaching, modeling, coaching, and support
- Accompanying people to appointments in their community (medical, dental, court hearings, supervised visits)
- Educating about, accessing, and accompanying to resources (utilities, phone, food bank, bank, stores, clothing)
- Developing and implementing recovery plans, life goals and steps to achieve them
- Conducting home visits
- Navigating the MH system
- Facilitating parent support groups and workshops
- Helping people find and retain jobs, education, and volunteer work
- Providing support in computer labs (job search, resume writing, setting up email)
- Leading meaningful social and recreational activities that promote a sense of purpose, structure, and inclusion in the community
- Assisting people in identifying strengths, recognizing success, and building hope.

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

Supported employment (SE) programs provide dedicated staff to help individuals enrolled in community treatment agencies find and maintain competitive-wage jobs. Following the evidence-based SE model developed at Dartmouth College, these programs focus on zero exclusion, rapid and individualized job searches, customized community-based job development, and post-employment support.

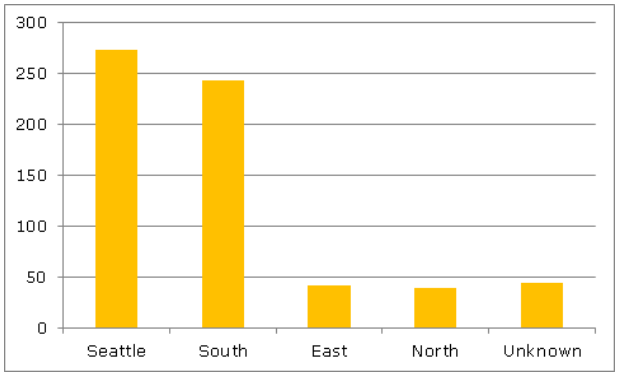
Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
700 clients/yr	**642**	**1.3**	**119% Adjusted**

Service Highlights

The average number of clients served by each of the nine King County mental health (MH) agencies with evidence-based SE programs this period was 71. Funds from the MIDD supplement those provided by the State of Washington's Division of Vocational Rehabilitation for these programs. Agencies are paid only for outcomes (achieving various job placement milestones), so success and sustainability are interwoven. One job placement per SE staff per month is the current expectation to sustain these programs.

The regional distribution for individuals currently enrolled in SE programs is shown below. Zip codes are unknown sometimes when clients are homeless, but 33 of the 44 with missing data were from an agency in Bellevue serving primarily the east and north regions. Efforts are under way to secure their information for the next report.

Number of SE Clients by Region



Quality Improvements

In September 2010, fidelity review teams were recruited and trained to assess how well each SE program with MIDD funding adhered to the model based on research into what produced the best outcomes for clients. For SE to be considered evidence-based, program components such as the following must be observable through client and staff interviews, chart reviews, and shadowing of job developers in the community:

- Small caseloads and individualized services
- Integration with mental health treatment
- Agency executive support for SE
- Discussion of client's choice to disclose about their mental illness or not reveal it
- Discussion of client's benefit situation and how wage-earning impacts each case.

Agencies reaching a total fidelity score of 100 became eligible for partial review addressing only their weak spots. The three agencies that had achieved "good" fidelity previously were not issued total scores in 2012-2013.

	2010-2011	2011-2012	2012-2013
Range	90 to 102	95 to 109	92 to 100
Agencies with Total Scores	9	9	6
Agencies Above 99	1 of 9	3 of 9	5 of 9

3a Supportive Services for Housing Projects

Overcoming homelessness can be especially challenging for individuals with mental illness and/or substance abuse issues. Research has shown that providing supportive services within housing programs increases the likelihood that people will remain safely housed for longer periods of time, enhancing their chances of maintaining successful recoveries. Examples of supportive services are housing case management, group activities, and individualized life skills assistance.

Year 4 Target	6 Month Progress	Projection Multiplier	Projected Percent of Last Annual Target
553 clients/yr	**653**	**1.3**	**154%**

Service Highlights

The MIDD Year Five target for Strategy 3a was not set as of March 2013 due to delays in announcing the new housing support awards. Each year, the target increases as more supportive housing beds are funded. Based on numbers served thus far, the strategy is projected to serve 850 clients before the end of September 2013.

Support services funding will likely be made available in 2013 for a total of 141 units at DESC's Evans House and Delridge projects. Evans House opened just east of Harborview Medical Center in Seattle in 2007 to serve both men and women with severe mental illness. Construction of the Delridge Supportive Housing in West Seattle began in November 2012 and completion is expected in December 2013.

A total of 653 supportive housing cases were covered by MIDD contracts in this period. Of the 639 unique adults served, 90 (14%) were military veterans.

Construction is underway at DESC Delridge. Photo by Kimberly Cisson.

Quality Improvements

In an effort to streamline reporting, required exit information for all MIDD supportive housing providers was modified in October 2012 to align with the Homeless Management Information System (also known as "Safe Harbors"). Prior to that time, exit dispositions were limited to the following:

- Moved to less supportive housing
- Moved to more supportive housing
- Returned to the streets
- Moved in with friends/family
- Moved for mental health treatment
- Moved for substance abuse treatment
- Incarcerated or jailed
- Hospitalized
- Moved to nursing home.

New exit dispositions that were added to the available options included moving to: an owned or rented apartment or house, emergency shelter, foster care/group home, hotel or motel paid with voucher, permanent or transitional housing for formerly homeless, and/or a place not meant for habitation. By using the same codes across data systems, providers submitting data to multiple funders are able to minimize their data handling burden and the overall quality of the information collected is enhanced.

13a Domestic Violence and Mental Health Services

Four King County agencies serving the needs of individuals dealing with the trauma of domestic violence (DV) receive MIDD funding to offer: 1) screening for mental illness and substance misuse, 2) therapeutic counseling by staff mental health professionals, and 3) consultation with DV advocates and others on issues pertaining to mental health and substance abuse. Strategy 13a also contributes toward retaining the services of a systems coordinator.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
560-640 clients/yr	**368**	**2.0**	**131% of minimum**

Service Highlights

Brief individual and/or group therapy sessions were provided to 368 survivors at area DV community advocacy, transitional housing, and shelter programs during the first half of MIDD Year Five. This represents a 17 percent increase over the same time period a year ago.

Of the 442 people screened, 87 percent were found to need additional follow-up for mental health (MH) issues (73%), substance misuse (2%), or both (12%). The average sum of individual MH hours per client was 5.6 at three agencies. At the fourth agency, this average was only 1.7, but the case management hours reported were nearly five times higher than the other agencies.

MIDD Enhances New Beginnings Programs

Services offered by the MIDD-funded therapist at one local DV agency included helping individuals to:

- Process their DV/trauma experience
- Enhance their awareness
- Use their existing strengths
- Learn skills to cope with anxiety, depression, and suicidal ideation
- Assess their tobacco use and receive "quit" resources upon request
- Receive therapeutic support through a pilot group while on the waiting list.

Quality Improvements

Communications between the DV and sexual assault communities and the MH and chemical dependency (CD) treatment fields have improved as a result of work done by the MIDD-funded systems coordinator. Evidence of increased coordination during the current reporting period included:

- Distributing a recently developed DV screening and response guideline to 450 MH and CD service providers
- Providing technical assistance and training to agencies interested in using the response guideline to update their policies
- Formulating guiding principles that consider safety, training requirements, and response needs for organizations when dealing with battering (abusive) behavior
- Developing a day-long workshop on screening for DV and the impacts of healthcare reform under the Affordable Care Act as it relates to DV and behavioral health treatment
- Engaging sexual assault programs across the county to increase collaboration in 2013, including a workshop for DV advocates on how to work with children who've been labeled as sexually aggressive in DV housing projects
- Strengthening and clarifying the role of the Triple Play Connections professional organization in interdisciplinary networking and training.

14a Sexual Assault and Mental Health and Chemical Dependency Services

By blending MIDD funds with other sources of revenue, four agencies serving survivors of sexual assault have been able to offer trauma-focused therapy to more of their clients. Implementation of universal screening for mental health issues and/or substance abuse is another key component of this strategy. In conjunction with Strategy 13a, a systems coordinator provides ongoing cross systems training, policy development, and consultation to bridge the gaps between the diverse cultures of mental health and drug abuse treatment agencies and those providing domestic violence and sexual assault advocacy.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
170 clients/yr	**262**	**2.0**	**308%**

Service Highlights

Of the 818 people screened for mental health and/or chemical dependency issues in the current reporting period, 698 (85%) had scores that warranted further attention. Referrals to the licensed MIDD therapists working on-site at area sexual assault agencies were made for 409 people (59%). Others were referred out to other providers.

A total of 50 children and 212 adults entered into a relatively brief course of therapy. At least 280 clients were referred out to other community agencies, private providers, or given resources such as legal assistance.

Cultural Barriers Present a Challenge

Immigrant and refugee women are typically reluctant to disclose sexual abuse, including marital rape. A sense of obligation to please their partners is common. Domestic violence and sexual assault are often normalized or regarded as a "family issue" in these communities.

Although reluctant to talk about these traumatic experiences, the best way to help survivors cope is to come up with strategies to help them heal. At ReWA, counseling helps clients work on their self-esteem, and provides tools to aid their recovery from depression and anxiety.

Quality Improvements

To gather richer qualitative program information from agencies providing mental health and substance abuse treatment to survivors of sexual assault, contract language requires submission of annual narrative reports. These reports describe the activities, successes, and challenges of each program. They also summarize accomplishments toward meeting the program's outcomes and goals.

In 2012, all four sexual assault agencies receiving MIDD funding reported that they had met or exceeded their performance measurement goals. One agency also included clinical outcomes statistics showing that nine of every 10 clients increased their coping skills, reduced negative symptoms, and/or met treatment goals.

Program successes included:

- Removing the financial barrier of accessing therapy for many sexual assault victims
- Promoting safety in the home and improving family relationships
- Expanding the scope of referrals made to include drug/alcohol treatment and domestic violence agencies.

Among challenges listed were 1) client transportation and 2) cultural beliefs about rape.

Strategies with Programs to Help Youth

Of the 11 strategies in this category, eight have been implemented. Interventions focused on helping youth were designed to:

- Expand prevention and early intervention programs
- Increase availability of assessments for those in the juvenile justice system
- Provide comprehensive teams for those enrolled in Wraparound programs
- Offer more response options for youth in crisis
- Increase capacity to serve more individuals in therapeutic courts
- Reduce the impact of domestic violence on affected children.

The following strategies have not been implemented:

4a Services for Parents in Substance Abuse Outpatient Treatment

4b Prevention Services to Children of Substance Abusers

7a Reception Centers for Youth in Crisis

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

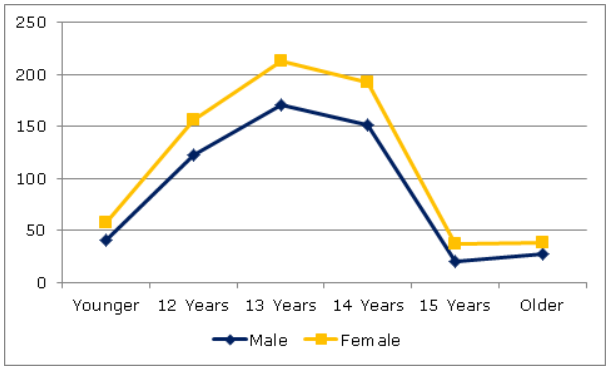
The earliest identification of youth with mental health (MH) or substance abuse problems often occurs within school settings. Strategy 4c supports partnerships between local MH/substance abuse agencies and neighboring schools, serving youth aged 11 to 15 years. Agency staff are integrated at the schools to provide services that include indicated prevention and early intervention, plus screening, brief intervention, and referral to treatment. Delivery of two specific suicide prevention curricula, SafeTalk and Applied Suicide Intervention Skills Trainings (ASIST) is another element of implementing this strategy.

Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
1,550 youth/yr	**1,227**	**1.5**	**119% Adjusted**

Service Highlights

In the first half of MIDD Year Five, services were provided to 1,227 identifiable youth from 21 King County schools by the ten providers delivering school-based services. Among those with individual-level data, 57 percent were female and 43 percent were male. Most clients were in their early teen years as shown below.

Number Served by Age and Gender



Another 25,718 students attended a total of 255 prevention events provided in large group contexts, such as school assemblies.

Staff from the Youth Suicide Prevention Project (YSPP) reviewed the crisis response plans and procedures for each school in Strategy 4c. All schools but one received a score of "average" or "above average." The YSPP delivered three ASIST trainings during the fourth quarter of 2012.

Quality Improvements

County staff who monitor contracts for the delivery of school-based services have worked diligently over the past year to streamline and simplify data collection processes. Due to the variety of programs offered by different agencies, modifications were needed to track group participation separately from individuals engaged in therapeutic activities. Although less detailed information is now gathered during large groups and school-wide assemblies, the duplicated numbers of people served are available in summary format. Only those who are identified individually count toward the performance targets and demographic totals.

In November 2012, results from the Global Appraisal of Individual Needs Short Screener were made available for 39 students attending Seattle School District's Secondary Bilingual Orientation Center. The screener found that 46 percent of the students scored high for internalizing disorders which suggest the need for MH treatment related to somatic complaints, depression, anxiety, trauma, or suicide. For externalizing disorders, 32 percent scored high, indicating the need for treatment related to attention deficits, hyperactivity, impulsivity, and conduct problems. Only three percent scored high for substance use disorders. These initial prevalence data may prove useful for measuring change over time.

4d School-Based Suicide Prevention

In 2009, the Washington State Department of Health published a plan for Youth Suicide Prevention. The report estimated that, on average, two youth take their own lives and 17 others are hospitalized for attempted suicide each week in Washington. With MIDD funding, youth suicide prevention trainings are delivered to both school-aged youth and concerned adults throughout King County in an effort to reduce these alarming statistics. The teen trainings offer a safe place to talk openly about suicide, self-harm, depression, concern for friends, and how to ask for and get help. Under this strategy, school districts have the opportunity to improve safety planning and their written crisis response policies as well.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
1,500 adults/yr **3,250 youth/yr**	**1,104** **5,375**	**1.5**	**110%** **248%**

Service Highlights

Funds from the MIDD were combined with other fund sources to train nearly 6,500 people from October 2012 to March 2013. The table below shows the regional distribution of trainees.

Number Trained by Region and Category

	North	South	East	Seattle	Other
Middle School	270	296	296	263	0
High School	305	1,411	1,794	740	0
Adults	137	307	219	247	194

Feedback from Adults Attending Trainings

When asked what they found most useful about the youth suicide prevention talks, several attendees drew attention to the eye-opening facts for special populations like LGBTQ* youth, youth of color, youth in foster care, and homeless youth. Some were surprised by "how much breakups contribute to depression and suicide." More information was requested on the role of technology in youth culture, including cyber-bullying.

*Lesbian, Gay, Bisexual, Transgender, Queer and Questioning.

Quality Improvements

Since many school districts in King County leave it up to their schools to develop their own specific crisis response plans, a shift was made from offering technical assistance at the district-level to working with individual schools. This effort began with an assessment of the response plans currently in place at all schools participating in MIDD Strategy 4c (see Page 23). Expansion to other schools will continue throughout MIDD Year Five.

Questions asked during the review process include the following:

1) Does the plan define a "crisis" and when the protocols will be used?
2) Following a suicide attempt, does the plan address the process by which a student is reintegrated into classes and school life?
3) In the event of a completed suicide, does the crisis plan provide specific, detailed information about necessary action steps?
4) Does the plan include announcement examples for faculty, students, parents, and the media?
5) Does the plan include strategies for debriefing and postvention process?

Answers to these and nine other questions determined the final scores given to each plan.

5a Expand Assessments for Youth in the Juvenile Justice System

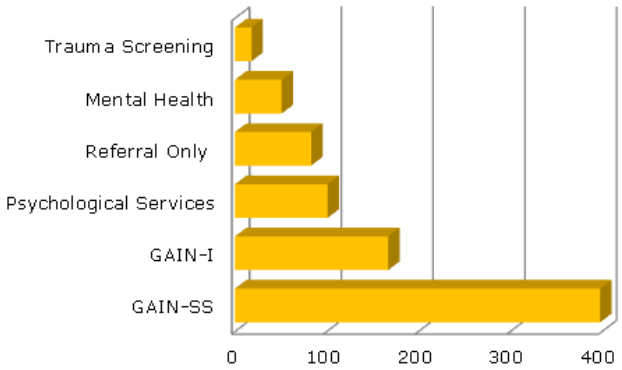
Accurately assessing youth who become involved with the criminal justice system for mental health (MH) and/or chemical dependency (CD) issues is the capstone of Strategy 5a. Assembling the Juvenile Justice Assessment Team (JJAT) began in 2010, increasing the availability of screening and evaluation options for youth. Other JJAT services include: triage, consultation, MH status exams, and psychological/psychiatric exams. Recently the team increased focus on understanding the impacts of trauma and implemented trauma screening prior to assessment. Helping youth reconnect with their families, communities, and schools motivates the team that serves, on average, nearly 20 youth each week.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
Coordinate 500 assessments/yr	**818**	**2.0**	**327%**
200 psychological services/yr	**101**		**101%**
140 MH assessments/yr	**51**		**73%**
165 CD assessments/yr	**167**		**202%**

Service Highlights

Type of assessment was recorded for each of the 818 coordination encounters between October 2012 and March 2013. Program delivery statistics are shown here.

Number of Encounters by Assessment Type



The youth served were racially diverse, identifying with over twenty different specific ethnic categories. Groups with five or more youth were: African-Ethnic, American Indian or Alaska Native, African American/Black, Filipino, Multiracial, Other (Hispanic), and Caucasian/White. Among the 575 unique individuals recently served, nearly one in five was of Hispanic origin.

Quality Improvements

In August 2012, the JJAT began tracking the number of Global Appraisal of Individual Needs short screeners (GAIN-SS) done, in addition to GAIN-Initial (GAIN-I) comprehensive assessments completed. The GAIN-SS takes only about five minutes to complete, whereas the GAIN-I can take between 1.5 and 2.5 hours, depending on interviewer experience and client severity.

Since assessment coordination is required regardless of the type of instrument used, performance measurement will now include GAIN-SS coordinations and, as such, will likely require a target adjustment during the next annual report. For the time being, only the GAIN-I data will be counted against the annual CD assessment targets.

While JJAT routinely screens for trauma in all MH and CD assessments, JJAT added pre-assessment trauma screening for those involved in At-Risk Youth cases in November 2012. The JJAT utilizes a trauma screen instrument developed by the Harborview Center for Sexual Assault and Traumatic Stress (HCSATS) for youth aged seven to 17. The team regularly consults with HCSATS staff to implement best practices.

6a Wraparound Services for Emotionally Disturbed Youth

Wraparound is an evidence-based practice that coordinates both formal and informal support for youth with serious emotional/behavioral disorders. The wraparound process customizes care for high-need youth throughout King County, focusing on their individual and/or family strengths and cultural factors. Teams at five mental health treatment agencies work collaboratively within their communities to surround all youth they serve with support and a package of services that addresses their unique needs and goals.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
450 enrolled youth/yr	**453**	**1.3**	**131%**

Service Highlights

Five teams (consisting of one coach, six facilitators, and three parent partners each) served 453 youth in the first half of MIDD Year Five. Females accounted for only 27 percent of those enrolled. Interpretation services were required for 14 individuals (3%). One third of the group reported successfully completing wraparound during this period.

The racial distribution of the youth served in wraparound this period was: Caucasian/ White (58%), African American/Black (16%), Multiracial (8%), Asian/Pacific Islander (5%), Native American (5%), and Other/Unknown (8%).

Quality Improvements

Through continuous data improvement efforts, zip codes will become available for inclusion in future reports, which will lead to improved reporting regarding the location of clients within King County.

The first contract compliance review in late 2012 indicated that the majority of wraparound teams in the County adhere to nationally-recognized wraparound program fidelity measures. King County and wraparound team staff presented information to school districts, juvenile justice system staff, and youth substance abuse treatment providers about wraparound, to enhance collaboration and to encourage referrals.

Comprehensive Data Analysis of Wraparound Outcomes for Youth and their Families

During the current reporting period, a comprehensive independent data analysis was completed by the King County Children's Mental Health Planner to examine wraparound outcomes for youth and their families. A total of 159 youth had both baseline (collected at program entry) and follow-up data (additional data collection at six, 12, and/or 18 months).

In this analysis, youth experienced statistically significant improvements in: youth behavior, compliance with home rules, and school performance. Youth also experienced statistically significant declines in: damage to property, harm to others, school suspensions, arrests, emergency room visits, and crisis stabilization bed usage.

Importantly, caregivers also reported statistically significant declines in caregiver strain and family conflict across all areas: disruptions in family/community life, negative feelings about their child, negative feelings experienced by the caregiver(s), and global (overall) strain. The results of this study illustrate the key role wraparound plays in stabilizing families and improving their well-being and safety.

7b Expansion of Children's Crisis Outreach Response System (CCORS)

Youth crisis services were expanded in 2011 to address increased demand and to augment staffing with in-home behavioral support specialists. The CCORS services provide direct assistance to families in order to maintain troubled youth safely in their own communities. Funding from MIDD also partially supports marketing and communication efforts to increase awareness and utilization of CCORS services. They now have posters and brochures available in English, Spanish, Somali, and Vietnamese. Evaluation efforts track all youth served by CCORS.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
300 youth/yr	**567**	**1.9**	**359%**

Service Highlights

Demographic information was available for 567 unique individuals served by CCORS in this reporting period. The gender split was almost down the middle, with slightly fewer males receiving services than females. Ages ranged from four to 18; the average age was 14.2 years.

The CCORS responded to 580 referrals during this period. Nearly half of all referrals came from emergency department social workers or staff, with parents and caregivers directly referring another 19 percent. The raw number of referrals made by school personnel increased by 65 percent, from 37 to 61, when compared to the same time period one year earlier. During this time, training and marketing expanded. Groups trained about CCORS' services included police officers, treatment providers, the MIDD Oversight Committee, foster parents, schools, churches, and the Somali Parent Partner Group at Juvenile Court. The CCORS staff also began attending Wraparound Community Resources Teams, thereby enhancing collaboration in and between both programs.

Detailed information was captured on 605 service episodes for 561 unique CCORS clients. Crisis stabilization services were most common (46%), followed by emergent crisis outreach (20%) and intensive stabilization services (13%).

Quality Improvements

During this time period, a report was developed summarizing outcome data for the first five years of CCORS' operations (2007-2011). Examining five years of CCORS data, it is clear that in the vast majority of cases, the goal of the referral was achieved. For example, the majority of children and youth who were referred out of concern that they would not be able to stay safely in their home, were able to remain safely in their present living situation (88%). Individuals referred for hospital diversion were kept in less restrictive settings that addressed their needs in approximately 75 percent of those cases.

Children and youth who had to transition from their home mostly went to relatives' homes or natural supports, or when needed (and in small numbers), entered hospital beds predominantly via voluntary admissions. State of Washington Division of Children and Family Services placement was avoided in most cases.

The rate of return for CCORS clients was found to be quite low; only 14 percent of clients returned for an additional crisis stabilization episode during 2007-2011.

8a Family Treatment Court Expansion

When parental substance abuse results in removal of children from their homes by the state, Family Treatment Court (FTC) provides an opportunity for families to alter their circumstances and ultimately be reunited. Enrolled individuals are closely monitored by this therapeutic court throughout their chemical dependency recovery, with the goal of minimizing involvement with the child welfare system.

Year 5 Target (Maximum)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target **(Reverse Scored*)**
90 children/yr **60 children at one time**	**75 children (weighted)** **58 average daily maximum**	**1.3** **-**	**92%** **103%**

Service Highlights

For the six month period beginning October 2012, there were 53 adults from 48 unique families in FTC; five families had two parents participating in the court's services. Thirty-nine individuals (74%) had documented disabilities at intake. Sixteen were homeless when they began services.

A critical contributor to the success of FTC participants is their enrollment in chemical dependency (CD) treatment. For those served thus far in MIDD Year Five, nearly all were admitted to the treatment appropriate for their individual needs, as shown below.

Adult CD Treatment Admissions for FTC

Not Admitted Yet	1	2%
Inpatient Treatment	5	9%
Outpatient Treatment	29	55%
Both Inpatient and Outpatient	18	34%
Total	53	100%

Twenty-five FTC participants received wraparound services coordinated by Valley Cities Counseling & Consultation. When families and their wraparound teams are involved in each step of the court process, they are able to be involved in decision making about their lives.

* Due to cap monitoring, reverse scoring is necessary in order to be comparable with other strategies.

Quality Improvements

The FTC has operated at full capacity since the end of MIDD Year Two and service caps continue to be monitored due to MIDD budget requirements. The count of children is further "weighted" so that when any child is an enrolled member of an Indian tribe, a value of 1.3 (rather than 1.0) is assigned to every child in that family. For this reporting period, 18 of the 70 unique children counted (26%) were in Native American families, so the rounded count of children is 75.

Some of the "best practices" employed by King County's FTC are:

- Integrated Systems—Parental substance abuse treatment and enhanced judicial oversight are integrated within the traditional dependency case processes.
- Intervene Early—Eligibility for court programs and CD assessment and treatment enrollment are completed as soon as possible.
- Comprehensive Services—The complete continuum of care includes CD and mental health treatment, individual counseling, case management, therapeutic child care, and more.
- Increased Judicial Supervision—Case review hearings occur every other week before tapering down progressively.
- Graduated Sanctions and Incentives—Both rewards and responses encourage parents to succeed in the program.

9a Juvenile Drug Court (JDC) Expansion

The MIDD funding has allowed JDC to expand by hiring four specialized juvenile probation counselors and one treatment liaison. This expansion has made therapeutic court services available to more youth living in south King County, often in lieu of incarceration. The court offers weekly hearings and introduces youth to drug treatment options.

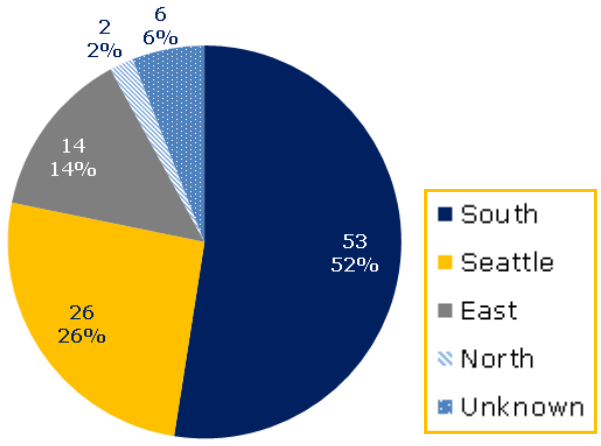
Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
36 new youth/yr	**45**	**2.0**	**228%**

Service Highlights

Although 101 youth received JDC services between October 2012 and March 2013, only the 45 whose services were initiated during that time period were counted toward the performance measurement target. Of the 45 new clients, 40 had already opted in; the other five were engaged in pre opt-in activities.

Nearly half of all JDC participants were also served by the Juvenile Justice Assessment Team under MIDD Strategy 5a. Regionally, the number of youth served in this period is shown below.

JDC Participants by Region



The top three racial and ethnic categories for these youth were: African American or Black (44%), Caucasian or White (30%), and Hispanic (16%). Three of every four JDC participants were male.

Quality Improvements

To increase referrals to their program and to better align with current national best practices, the JDC reorganized their structure in 2012 to accept youth into a pre opt-in phase. During this "engagement" phase, youth are assigned to JDC probation counselors, rather than mainstream probation officers within the juvenile court system. They are also exposed to substance abuse treatment concepts prior to making their decision about opting in to the court or not.

Once youth opt in, two new specialty tracks added in 2012 are now available to them:

1) For those diagnosed with co-occurring mental health disorders, Track II has been customized to address their needs. To date, 63 percent of the available slots assigned to this track have been filled.

2) For youth with less serious criminal offenses, Track III offers an opportunity to enter into a Stipulated Order of Continuance (SOC). The SOC is a court-approved contractual agreement in which criminal cases can be dismissed when individuals comply with all agreed terms. For the current period, 31 youth had enrolled in Track III; 90 percent of whom were new to the JDC in MIDD Year Five.

The traditional path through JDC, or Track I, was chosen by all five pre opt-in clients, by 12 clients who were new since October 2012, and by another 51 youth who began their services prior to that time and carried over.

13b Domestic Violence Prevention

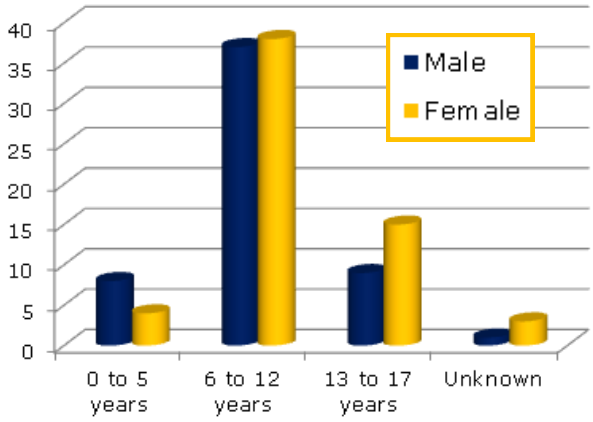
In collaboration with two domestic violence (DV) agencies, Sound Mental Health operates the Children's Domestic Violence Response Team (CDVRT), whose goal is reducing the severity of effects of DV-related trauma on children and non-abusive parents. The availability of CDVRT services in the south region of the county has been greatly enhanced because of MIDD funding. The CDVRT works to integrate mental health treatment with effective DV prevention and intervention strategies.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
85 families/yr	**96 families**	**1.3**	**147%**

Service Highlights

Over a six-month period, the CDVRT-South provided outreach and engagement to 96 different families exposed to violence in the home. Altogether, 81 women and 115 children were served. The age distribution for those under the age of 18, by gender, is shown below.

Age and Gender of Children Served



Among services recorded for individuals in the current period were:

- 87 hours in family team meetings
- 1,013 hours of advocacy
- 433 hours in Kids Club group treatment
- 47 hours of in-home services
- 785 hours of mental health treatment.

Quality Improvements

Team meetings are held every other week to ensure cross-coordination between the three provider agencies and to enhance service quality for all CDVRT families. Team members met 13 times during this reporting period to discuss program referrals and other matters.

In addition to providing coordinated services, the CDVRT provides community and professional education toward system improvement for survivors of DV and their children. The CDVRT Program Coordinator has been invited to speak at the annual DV Symposium at Seattle University for three years in a row and has been nominated for the King County Coalition Against Domestic Violence—Take Action Award. In the spring of 2013, the team extended their expertise on a national level when the Casey Family Foundation invited them to present on the CDVRT collaboration, via video technology, across the country. Topics presented included trauma symptoms in children, protective and resiliency factors available to children and their non-abusive parents, and how to talk to children and adults about DV.

Throughout the current reporting period, the CDVRT continued to create program policy that focuses on ensuring and maintaining the emotional and physical safety of the clients they serve. The CDVRT is emerging as a promising practice model.

Jail and Hospital Diversion Strategies

Of the 12 strategies in this category, 10 are currently implemented with MIDD funding. Two others were part of the early MIDD strategy planning efforts, but ultimately secured pilot and/or continuing funds from other sources. Strategies in the diversion category are intended to help individuals experiencing mental health or substance abuse problems:

- Avoid costly incarcerations and reduce recidivism
- Reduce psychiatric and medical hospitalizations
- Link up with appropriate community treatment and resources
- Receive targeted education, job training, and housing
- Engage in therapeutic court activities
- Re-enter their communities after jail or hospital stays.

The following strategies have no current updates to report:

17a Crisis Intervention Team/Mental Health Partnership Pilot

17b Safe Housing and Treatment for Children in Prostitution Pilot

10a Crisis Intervention Team Training for First Responders

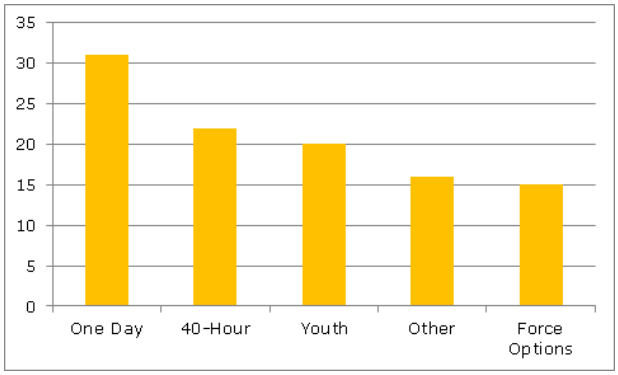
Crisis Intervention Team (CIT) trainings introduce law enforcement officers and other first responders to concepts, skills, and resources that can assist them when responding to calls involving individuals with mental illness or substance use disorders. Delivered at the Washington State Criminal Justice Training Commission (WSCJTC) in partnership with the King County Sheriff's Office, CIT trainings focus on diverting individuals to appropriate services while maintaining the safety of the public. Funds are also available to reimburse law enforcement agencies for backfill or overtime when officers are in training and away from their duties.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
180 trainees/yr (40-hour)	**141 (40-hour)**		**157%**
300 trainees/yr (one day)	**145 (one day)**	**2.0**	**97%**
150 trainees/yr (other)	**75 (other)**		**100%**

Service Highlights

In the first half of MIDD Year Five, a total of 19 CIT trainings were offered for law enforcement personnel and other first responders. The average number of King County trainees per course is shown below.

Average Class Size by Course Type



A statewide CIT needs assessment survey, required annually under contract, was conducted by WSCJTC early in 2013. Out of 82 respondents, 14 (17%) had ties to King County. Crisis intervention was found to be a high priority across the entire state of Washington. When asked if their agency had a mental health response policy, 56 (68%) said that they did. Among other answers, 28 respondents (34%) said they think of mental health when they hear the term "CIT."

Quality Improvements

In December 2012, the CIT training program underwent an external quality review, including monitoring by the founders of CIT, Retired Major Sam Cochran and Dr. Randolph Dupont. Findings from their detailed report are summarized below.

Program Strengths

- Available to a wide range of agencies
- Good quality control through evaluation
- Strong cadre of instructors
- Adherence to the CIT curriculum model
- Impressive training facility
- Emphasis on tactics, officer safety, and officer well-being.

Suggested Improvements

- Review course learning objectives
- Expand de-escalation practice and mental health advocacy group discussions
- Build on topics in systematic order
- Group all resource topics into a panel with a question and answer format
- Focus on creating a law enforcement and mental health system partnership.

In January 2013, a team from Bellingham, WA reviewed the CIT curriculum. Their findings will be shared in the annual report.

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

Strategy 10b relies on three interconnected programs: 1) a facility specializing in short-term stabilization for adults in crisis, 2) an interim services facility with up to two weeks of further services to address individualized needs after the initial crisis is resolved, and 3) the Mobile Crisis Team (MCT) responding to first responder requests for crisis de-escalation. The Crisis Solutions Center (CSC) opened in August 2012 and is operated by DESC, a Seattle-based nonprofit founded in 1979.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
3,000 adults/yr	**1,082**	**2.0**	**72%**

Service Highlights

The DESC's CSC delivered the following services in the current period.

Program	Served
Mobile Crisis Team	260
Crisis Diversion Facility (CDF)	519
Crisis Diversion Interim Services (CDIS)	303

From quarterly summary reports provided by the MCT, 367 referrals were fielded by mobile responders between October 2012 and March 2013. The top two referring agencies in Q1-2013 were the Bellevue and Seattle police departments. The average estimated response time provided to referents was about 30 minutes. Of the 260 engaged in services with the MCT, 65 (25%) were admitted to the CDF.

In the fourth quarter of 2012 after the CDF first opened, the average number of beds filled on a daily basis was nine. This statistic climbed to 11 during the first quarter of 2013, with 10 documented instances of being at the full capacity of 16. The number of beds filled each day for interim services was 15; a typical stay was eight days.

Performance measurement counts the total number of people served by each program component, so the count of 1,082 adults is not an unduplicated figure. A total of 721 unique people had a least one CSC service.

The CSC "is a Very Safe Place"

D (aged 42) states, "If it wasn't for the CSC, I wouldn't have made it." D moved to Washington when he was 12 years old. After high school, he had a variety of manual labor jobs and worked in construction. He was seriously injured outside of work in 1996. With extensive nerve damage, he was unable to work and became homeless for 16 years. D recounts "many nights and years under a bridge in Bellevue, WA watching ice form."

D's first contact with the MCT was in November 2012. The Bellevue Police Department made the initial referral when D was found in a makeshift tent by a railroad track. He had multiple medical issues and was seen by the MCT seven times.

A high utilizer of 9-1-1 services, D had 27 interventions by police, fire, or medics in 2011. He added another 37 in 2012. Not including the cost of police response or hospital admissions, since 2001, D had a total of 86 calls to 9-1-1 at a cost of $750 each ($64,500 total) for just the Fire Department to respond.

D was admitted twice to the CSC and received services from both the CDF and CDIS. They provided crisis stabilization, psychiatric evaluation/services, medication management, medical treatment, groups, and intensive peer counselor engagement. D says that CSC "is a very safe place" and staff "went the extra mile."

In January 2013, the CDIS found permanent housing for D at the DESC Aurora House, where he continues to reside successfully. He wants to get out of his wheel chair and to "give back what's been given to me." He says there is "still potential for me to succeed." D identifies feeling like a human being again with "love, honor, trust, dignity, and respect."

11a Increase Jail Liaison Capacity

During court proceedings, judges may assign individuals to King County Work and Education Release (WER), a program where offenders go to work, school, or treatment during the day and return to a secure facility at night. Prior to their release, those ordered to WER have the opportunity to work with a liaison who is funded by the MIDD. The liaison's job involves linking clients to services and resources, such as housing and transportation, that can reduce recidivism risks.

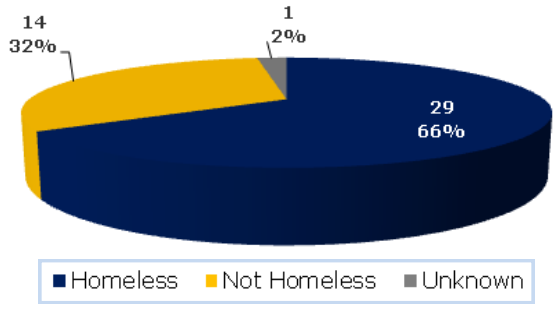
Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
200 clients/yr	**44**	**2.0**	**44%**

Service Highlights

The number of clients served by the WER liaison to start MIDD's fifth year was considerably lower than the same period a year ago; a reduction of 67 percent. This steep drop off was the result of staff turnover, position vacancy, and the amount of time required for new staff to be approved for access to jail inmates. The performance target will be adjusted in the annual report to reflect reduced staffing.

Two of the every three men who received intensive case management connecting them with community services were known to be homeless at service initiation as shown below.

Homeless Status at MIDD Start Date



Zip code information indicated that 33 WER participants in this period (75%) were from the Seattle core region of King County. Another 16 percent were from the south region. Just over half of those served were people of color, compared to a census estimate of 27 percent in the general King County population.

Quality Improvements

In October 2012, the King County Superior Court revised and updated the Conditions of Conduct for persons sentenced to WER to include information on a new graduated sanctions pilot program to address rules violations. In general, the program rules include:

- Commit no crimes
- Use no controlled substances without a valid prescription and consume no alcohol
- Attend all court-ordered therapy and treatment (compliance verified)
- Attend work or school
- Be on time when reporting back to WER
- Forge no document nor provide false information to monitoring staff.

Sentenced offenders who violate these rules may now be subject to a new process, whereby the number and severity level of violations determines their consequence. Rather than being immediately remanded back to secure jail, graduated sanctions will allow some rule violators to work with their caseworker during initial corrective actions. When violations or sanctions are contested, however, individuals must be securely detained while awaiting a hearing.

Having these new graduated sanctions in place should positively impact MIDD jail utilization outcomes as more opportunities exist to revisit treatment plans and remain engaged at WER, as opposed to being sent back to jail.

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

King County District Court's Regional Mental Health Court (RMHC) began accepting referrals from 39 municipalities throughout the county in 2010. The MIDD provided funding for nine staff, including a dedicated judge, prosecution and defense attorneys, probation officers, court staff and liaisons to manage these additional cases. Strategy 11b has expanded further over time to provide: 1) a court liaison for the Municipal Court of Seattle's Mental Health Court (SMHC) that handles mental competency cases for individuals booked into jail on charges originating in the City of Seattle, 2) forensic peer support for individuals who opt in to RMHC, and 3) a Veteran's Track within the existing RMHC that began accepting cases in September 2012 and is being piloted during MIDD Year Five.

Year 5 Target (Adjusted)	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
57 opt-in clients/yr for RMHC	**11**	**2.0**	**39%* Adjusted**
300 screened candidates/yr for SMHC	**131**	**2.0**	**87%**

Service Highlights

Between October 2012 and March 2013, 69 people were referred to the RMHC from municipalities in King County. These "city transfer" cases were screened for eligibility and 15 people received peer services. A total of 11 people chose to newly opt in. Demographics and outcomes are tracked for all referents, not just the opt-ins. The top three referring cities were as shown.

Cities with More than 10 Referrals to RMHC

City	# of Referrals
Shoreline	15
Renton	14
Federal Way	13

During the same time frame, 131 people were assessed by a court liaison at the SMHC for both clinical eligibility and their competency to stand trial. Although SMHC has two liaisons, only cases that have actual contact with the liaison whose position is MIDD-funded are counted. Eight military veterans were among the 200 screened by both courts. The SMHC has its own stand-alone Veteran's Treatment Court where most veterans get routed.

Quality Improvements

The RMHC is a two-year program and the maximum probation caseload size is 57 over a two-year period. Because the MIDD funds two probation positions, the performance target remains at 115 opt-in clients, but a clarification about the length of the program reduces the annualized target shown above to 57.

The spreadsheets that track participation in RMHC have recently been revised to clarify information and make it easier to monitor the court's actual capacity, but having no central database is an on-going barrier.

Mental Health Court

* The projected percent of annual target above does not account for: 1) fluctuations in referrals made by the municipalities, or 2) the many factors that may influence a client's decision to fully participate or opt in to therapeutic court services. The court will propose a strategy revision in 2013.

12a-1 Jail Re-Entry Program Capacity Increase

Short-term case management services are provided to incarcerated individuals with mental health (MH) and/or substance abuse issues who are near their release date. In January 2012, MIDD became the sole fund source for re-entry services at county-run jails after state budget cuts. Successful community reintegration is one immediate goal of the jail re-entry program, with reduced recidivism being a primary long-term goal.

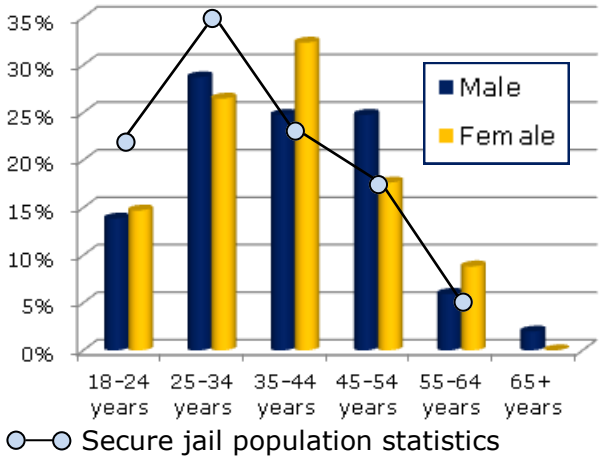
Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
300 clients/yr	**135**	**2.0**	**90%**

Service Highlights

During the first half of MIDD Year Five, three case managers provided services to 135 jail inmates as they approached their release dates. In order to meet their annual performance target, each re-entry worker would need to serve one additional client per month over their current rate. Case complexity, however, is an important factor in determining caseload size.

One of every four pre-release clients in the current period was female. This rate is higher than the secure jail population, at only 10 percent female. The oldest female served was 58 and the oldest male was 70. Client age is shown by gender in the graphic below. The population served by Strategy 12a-1 is slightly older than the distribution of the secure jail population, as illustrated by the trend line overlay.

Age Distribution of Clients by Gender



Quality Improvements

Adoption of the MIDD Action Plan in 2007 called for expanding services to adults exiting King County jails. With funding from the MIDD, additional staff positions were filled to serve more clients in the county's south and east regions. This strategy was implemented in coordination with the existing King County Criminal Justice Initiatives (CJI).

The CJI, which provide a wide array of treatment and support for justice-involved adults with MH and chemical dependency needs, were originally funded by a vote of the King County Council in 2002. Three years later, the Washington State Legislature passed a bill to implement Jail Transitions Services statewide. This state funding was used to expand a variety of CJI services and programs throughout the county.

With the economic downturn of recent years, state funding for vital CJI programming has become scarce. Where possible, local MIDD funding has been shifted to fill the gaps and preserve the continuity of services using a comprehensive, recovery-centered approach.

In cooperation with community provider agencies, all CJI programs are closely managed by county staff who take an active role in ensuring their quality and the integrity of the data they collect. These programs are rigorously evaluated and quarterly updates are made available on the King County website.

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

Adults in the criminal justice system may be court-ordered to serve time at CCAP and/or The Learning Center (TLC). The Community Corrections Division holds individuals accountable for attendance in various structured programs, including those made possible at CCAP and TLC. With MIDD funding, basic life-skills, job and general education (GED) preparation, and domestic violence prevention classes are available. These courses are intended to reduce the risk of re-offense.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
600 clients/yr	**298**	**2.0**	**99%**

Service Highlights

Eighty-four people began taking classes through TLC this period. The proportion enrolled in Life Skills to Work (LSW) classes was about 71 percent, compared to only 29 percent for GED courses. In LSW, individuals are exposed to skill-building opportunities like budgeting and time management, whereas GED preparation has an academic or knowledge-based focus.

Domestic violence (DV) education has become a key offering at CCAP since MIDD funding began in 2009. Between October 2012 and March 2013, at least 214 unique individuals participated in one or more DV classes. The DV topics are presented in gender-specific, small group sessions. This format facilitates discussion and sharing of individual experiences relevant to the subject matter. In the current reporting period, there were 130 participants in the classes for men and 84 in women's classes.

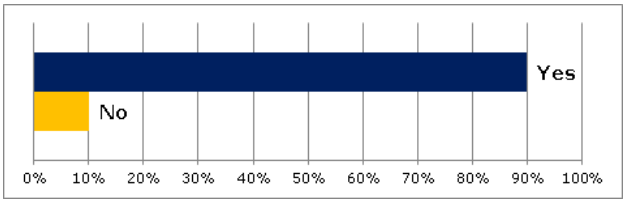
Domestic Violence Hurts Everyone!

Twenty-five people who signed in for DV classes were also engaged in either LSW or GED classes.

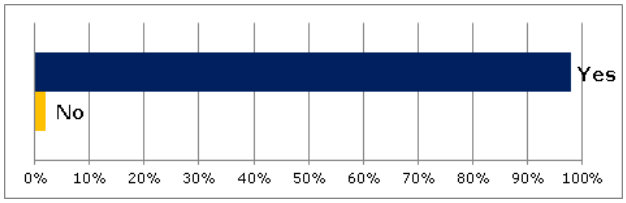
Quality Improvements

During the first quarter of 2013, the provider delivering DV prevention education at CCAP, New Beginnings, developed and distributed a class survey to collect feedback from female participants. Results from 61 returned surveys are summarized below.

Question: Based on the information you received today, did your understanding of domestic violence increase?



Question: Was the class easy to understand?



Question: What is your overall rating of today's class??

Average=9.73

Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **Excellent**

The instructor was described as:

- Sincere
- Honest
- Kind
- Funny
- Smart
- Helpful
- Well-spoken
- Open-minded
- Encouraging
- Positive
- Caring
- Trustworthy.

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

The September 2011 opening of an expanded medical respite program adjacent to Seattle's Harborview Medical Center (HMC) was made possible with funds from over 10 different sources, including the MIDD. The program serves homeless adults needing a safe place to recuperate upon discharge from area hospitals. The MIDD contribution goes toward providing mental health and substance abuse services on-site, including case management and treatment linkages.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
350-500 clients/yr	**202**	**1.9**	**115% of minimum**

Service Highlights

Mental health practitioners, specialists, and a supervisor were among the 6.82 FTE staff positions funded by the MIDD at the medical respite program this period. These professionals assessed and stabilized patients, in addition to providing assistance linking individuals to post-respite services.

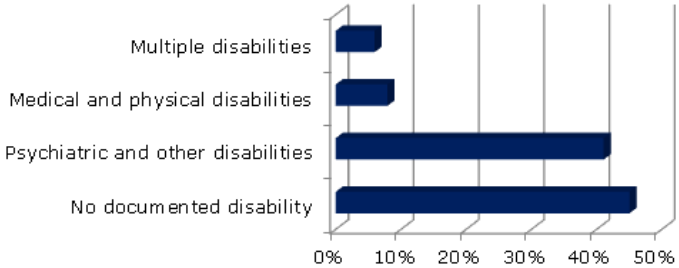
The goals of medical respite are:

1) Resolve medical problems
2) Provide assessment and referral for additional care and resources
3) Initiate the housing stabilization process.

In the first two quarters of MIDD Year Five, 202 patients came to medical respite. Performance measurement counts the unduplicated number served, regardless of diagnosis. All persons admitted must be without a stable living environment in which to recuperate or have no other community placement options that are appropriate.

Documentation of disabilities revealed that 56 percent of those served had either a physical or psychiatric challenge as shown.

Percentage of Patients by Disability Status



Quality Improvements

An independent steering committee is responsible for oversight of the expanded recuperative care facility. They meet on a monthly basis to troubleshoot emerging issues and to monitor implementation of the program. In October 2012, the committee engaged MIDD evaluation staff to provide feedback on a statistical dashboard showing information such as admission counts, referrals, discharge location, and payment source. Sharing data summaries from divergent sources is one way funders can collaborate to ensure continuous quality improvement.

Edward Thomas House

The new medical respite program at Jefferson Terrace was named for a man named Ed Thomas, who lived on the streets of Seattle for 20 years. While struggling with his serious mental illness, Ed was keen to avoid those offering to help him. After a visit to the emergency room in 2004, however, Ed needed respite care in a shelter to heal from leg wounds. While staying in a medical respite program, he made a positive connection with the nurses there. This ultimately led to him connecting with his case manager who was able to help him find housing. For nearly 10 years now, Ed has remained housed with no further emergency room visits! He serves as an inspiration to all who are working to end homelessness in King County.

12c Increase Harborview's Psychiatric Emergency Services (PES) Capacity to Link Individuals to Community Services upon Emergency Room Discharge

For Strategy 12c, intensive case managers use assertive techniques to engage hard to serve individuals who have been identified as high-utilizers of Harborview Medical Center's emergency department (ED). By developing therapeutic relationships during outreach efforts and while assisting with medically-centered services, social workers and chronically homeless individuals are able to work together to find solutions to problems that formerly presented insurmountable barriers to their successful investment in more traditional systems of care.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
75-100 clients/yr	**67**	**1.9**	**170% of minimum**

Service Highlights

The 67 PES clients served by the high utilizer case management team this period represents a 34 percent increase over the same time frame one year ago. Consistent with past demographic profiles, three of every four clients were male. Differential age statistics by gender are shown below.

Age Information for PES Clients

Gender	Minimum	Maximum	Average
Female	33	74	44
Male	20	70	48

About 40 percent of those served were racial minorities and 69 percent were homeless at intake. Through partnerships with the Client Care Coordination (CCC) activity and the High Utilizer Group (HUG), both funded by the Veterans and Human Services Levy, 36 percent of these PES clients were helped to find housing.

The MIDD provides funding for one program assistant and two full-time case managers at the PES. This team works closely with the CCC and HUG to conduct individual case planning for the most challenging clients, connecting them to harm reduction and substance dependence treatment. The PES team epitomizes the coordination between the MIDD and other King County Council directed efforts.

Quality Improvements

Harborview's 2012 PES annual report provides insight into the program's challenges and successes. Some highlights are presented below.

Integration with Primary Care

High utilizer case managers network with other agencies and use Harborview Medical Center's primary care and aftercare clinics to provide both urgent and long term connections to primary care.

Reconnecting Clients with Enrolling Agencies

When high usage of the emergency room is a result of a person losing contact with their mental health treatment provider, the case management team helps re-establish those linkages. Their caseloads can often be managed by providing screening and coordinating care with community mental health agencies.

Moving to a New Location

By moving their offices away from the emergency department and into the aftercare clinic, the team has greater access to primary care appointments and is better able to provide longer term follow up for clients.

Data Improvements

Complete service data has recently been cleaned and uploaded to the MIDD evaluation team.

12d Behavior Modification Classes for Community Center for Alternative Programs (CCAP) Clients

Moral Reconation Therapy (MRT) is an evidence-based cognitive-behavioral treatment program proven to be especially effective for substance-abusing offender populations. With funding from the MIDD, certified MRT facilitators work with enrolled clients to enhance their moral reasoning, to improve their decision-making skills, and to help them engage in more appropriate behaviors.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
100 clients/yr	**118**	**1.3**	**153%**

Service Highlights

The number of CCAP clients taking part in MRT continued to grow this period, recording a 55 percent increase over last year's progress report. One factor contributing to this observed growth was the demand from the courts to provide more MRT services. The community mental health agency responsible for delivering this group-based curriculum is Sound Mental Health. New information is being made available on an annual basis that allows evaluation staff to examine outcomes in light of the length of time clients remain engaged in MRT while serving out their CCAP time. As reported in the MIDD Fifth Annual Report, the average length of participation was about 70 days and most participants were able to complete only about one fourth of the 16 MRT levels before their discharge from CCAP.

Exactly half of the 118 recent MRT clients were Caucasian/White. Another 41 percent were African American/Black and the remaining nine percent were from other minority racial categories. The raw number of women trained thus far in MIDD Year Five was 20, up from only 12 in the previous two progress reports. Nearly 83 percent of the individuals served were from either Seattle or the south region of the county. Seven percent were from the east region.

Quality Improvements

Based in part on the successful use of MRT with MIDD clients at CCAP, in 2012 the Veteran Citizens Levy Oversight Board recommended a one-time allocation of funds from King County's Veterans and Human Services Levy to facilitate wider adoption of this treatment. The funding enabled five local service providers to participate in a lengthy train-the-trainer program that can ultimately certify up to 100 additional MRT facilitators. In addition to forensic MIDD populations, MRT has proven effective for helping veterans who have traumatic brain injuries.

Developed in 1985, more than 120 published reports have shown that those who complete MRT treatment have significantly lower recidivism rates than untreated peers. One estimate is that for every dollar spent on MRT, a savings of $11 in reduced criminal justice and lost productivity costs is possible.

As outlined by Correctional Counseling, Inc., the company that provides MRT supportive materials and trainings to King County, the seven basic treatment goals of MRT are:

1) Confront beliefs, attitudes, and behaviors
2) Assess current relationships
3) Reinforce positive behaviors and habits
4) Form positive identity
5) Enhance self-concept
6) Decrease hedonism and develop frustration tolerance
7) Develop higher stages of moral reasoning.

15a Adult Drug Court Expansion of Recovery Support Services

The Adult Drug Court (ADC) within King County's Judicial Administration is able to offer clients supplemental services as a result of MIDD support. In addition to enhancing educational opportunities for individuals with learning disabilities, the ADC employs two housing case management specialists. These case managers help clients find and keep drug-free housing. In 2012, the court was able to secure eight recovery-oriented transitional housing units with on-site case management services for youth aged 18 to 24, replacing Young Adult Wraparound.

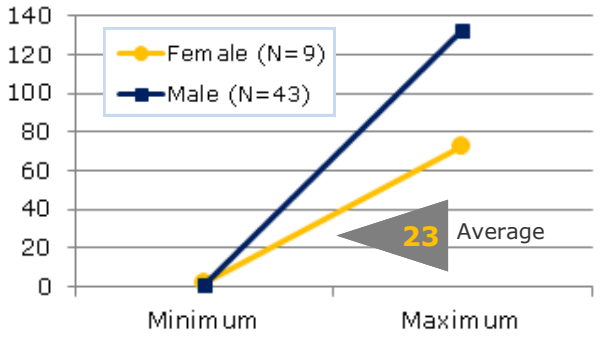
Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
250 clients/yr	**171**	**1.3**	**89%**

Service Highlights

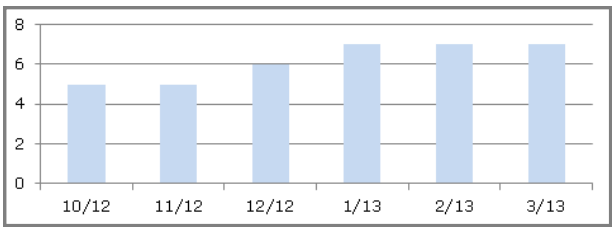
During the first half of MIDD Year Five, enhanced ADC services were delivered to 132 adults and 39 youth between the ages of 18 and 24. The oldest participant was 62 years old. The percentage of women served rose slightly this period to 29 percent.

Detailed service statistics for each funded program are illustrated below.

Number of CHOICES Life Skills Classes



Number of Housing Vouchers Per Month



Housing Case Management Hours

Participants	Minimum	Maximum	Average
151	.25	22	3.36

Quality Improvements

Throughout the current period, the housing case managers at ADC implemented several quality improvements intended to favorably impact their processes in the future. Some examples include the following:

- Met with the ADC program analyst to review outcome data in relationship to case management efficacy
- Discussed ways to strengthen case management for ADC graduates currently housed in Shelter Plus Care
- Coordinated efforts with Family Treatment Court program management to learn more about Family Housing Connection, King County's coordinated entry system for families enacted under the Family Homelessness Initiative
- Created protocols for referring ADC clients to new housing opportunities
- Provided feedback to the Seattle Housing Authority on their search tool for landlords who accept individuals with a criminal history
- Implemented changes to ADC's Transitional Housing Program family visitor policy, whereby overnight guests may be allowed up to twice weekly on a case by case basis
- Partnered with Plymouth Housing Group to set aside seven permanent units for single adults in recovery-based housing.

16a New Housing Units and Rental Subsidies

Prior to full implementation of the MIDD, Strategy 16a appropriated capital funding to expedite construction of new housing units to benefit MIDD's target population. While the majority of these housing units currently receive ongoing funding for supportive services under Strategy 3a, one capitally-funded project (Brierwood) does not, and those clients are tracked here. This strategy also provides five-year rental subsidies to serve up to 25 clients per year.

Year 5 Target	6 Month Progress	Projection Multiplier	Projected Percent of Annual Target
25 rental subsidies/yr	**25 subsidies** **30 Brierwood tenants**	**1.3** **-**	**130%** **-**

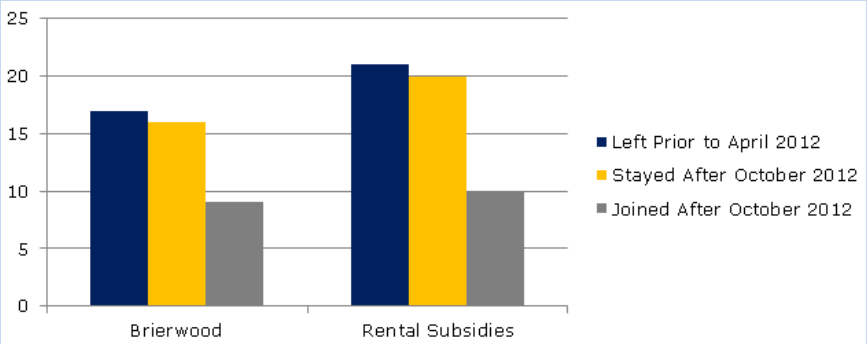
Service Highlights

The capacity to provide rental subsidies through Strategy 16a was decreased from 40 to 25 in November 2012. The number of beds available at Brierwood, a housing program that received MIDD capital funds in 2008, remained steady at 25.

Altogether, 55 people benefited from these housing opportunities during the six months of this period. The gender split for these services was 42 percent female and 58 percent male. The youngest person was 20 years of age and the oldest was 68.

Stability and Turnover in Strategy 16a Programs

Looking at individuals served over the same time period one year ago, a total of 16 tenants at Brierwood (64% of capacity) remained housed there. Twenty people were able to retain their rental subsidies for at least a portion of the time period spanning October 2012 to March 2013. Since the number of rental subsidies was cut by 38 percent in this period, at least five of the people who stayed in the program after October 2012 left to make room for the 10 people who joined after that point in time.

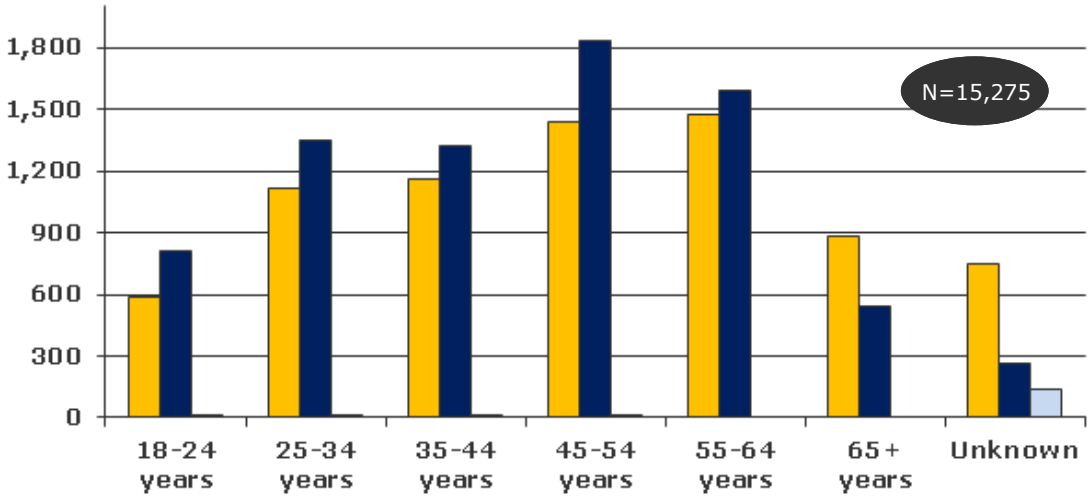


MIDD Demographic Information

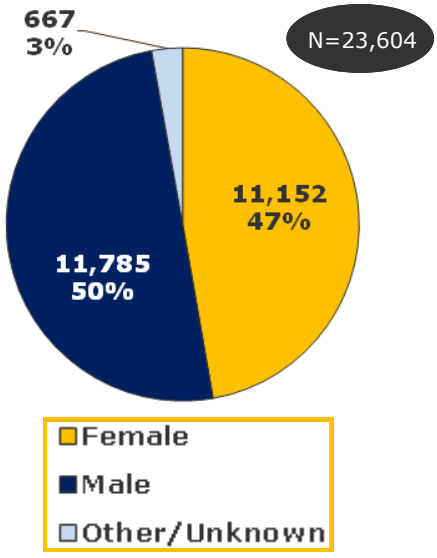
Information on age group and/or gender was available for 23,604 unduplicated people who received at least one MIDD-funded service between October 1, 2012 and September 30, 2013. Individuals with duplicate demographics over 28 different strategies and four data sources were counted only once in this section. Basic demographics were also collected for professionals in strategies that provide training and/or reimbursement for the purpose of workforce and capacity development, but those numbers are not included here.

In addition to their individual-level data, duplicated demographics from MIDD Strategy 4c—Collaborative School-Based Mental Health and Substance Abuse Services indicated that at least 25,718 people were served in large group settings. These were primarily students who attended events such as assemblies and health fairs, but also includes adults at parent forums. Attendance across events by the same students was possible.

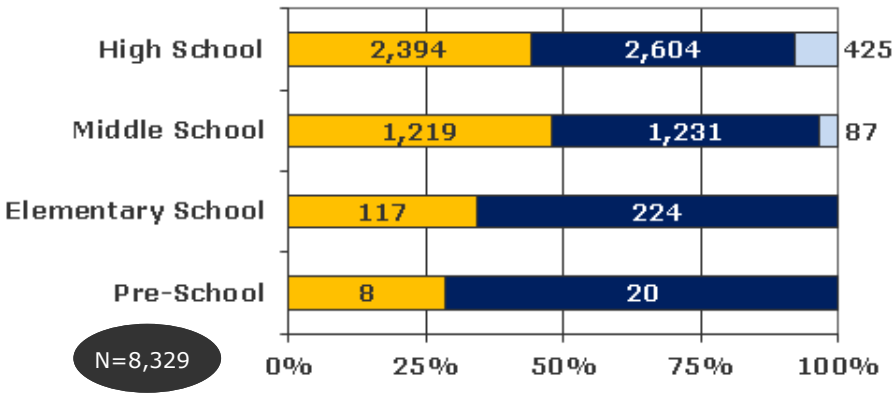
Unduplicated Gender by Age Group for Adults Receiving MIDD Services



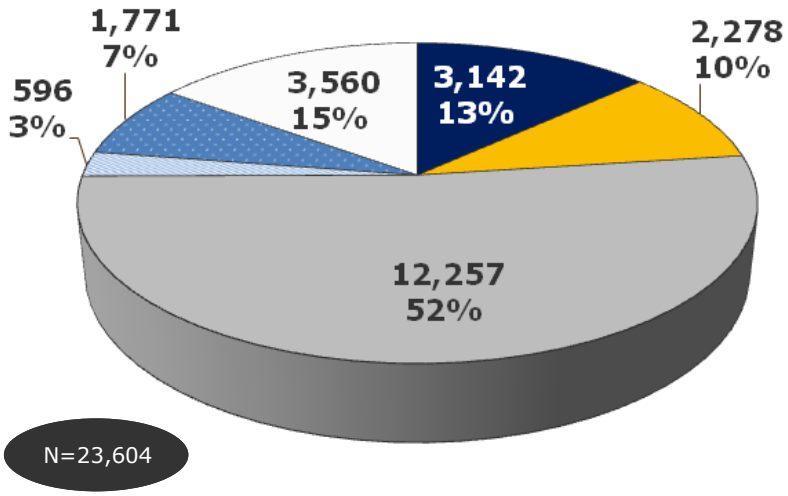
Overall Gender Distribution



Gender by School Age Grouping for Youth Receiving MIDD Services



Distribution of Primary Race

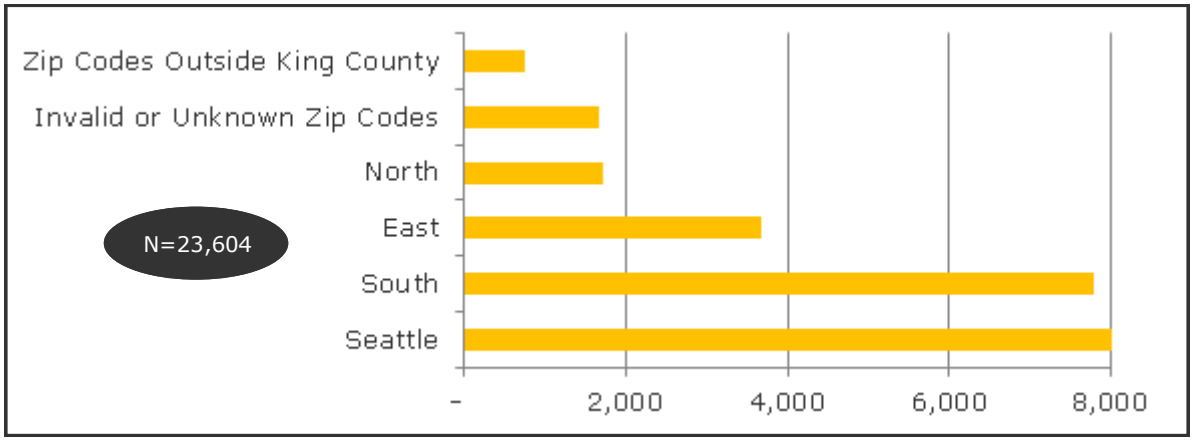


Race and Ethnicity

Information on Hispanic origin is tracked separately from one's primary race. In two of three cases, those having Hispanic ethnicity identified with the race coded as "other." A total of 2,297 people said they were Hispanic.

- African American/Black
- Asian/Pacific Islander
- Caucasian/White
- Native American
- Multiple Races
- Other/Unknown

Total Number Served in Current Period by King County Region



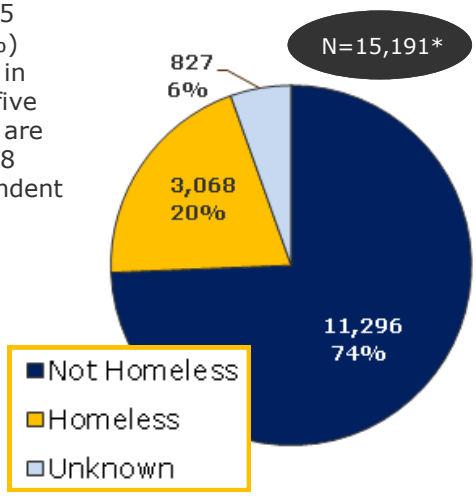
U.S. Military Service

N=14,506*

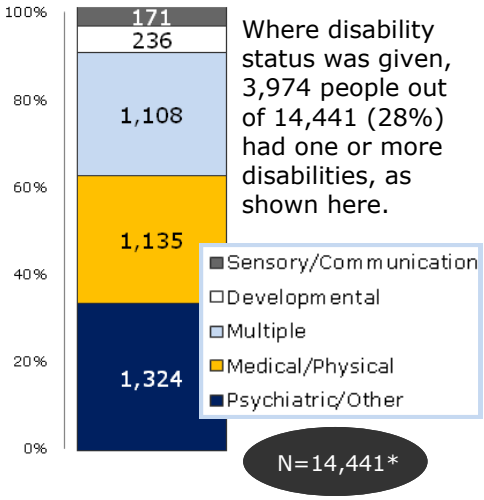
At least 725 clients (5%) had served in the U.S. military. The top five veteran-serving strategies are shown below. A total of 378 military spouses and dependent children were also served.

Strategy	Number
1a-1	212
1c	187
3a	91
1a-2	88
1g	71

Homelessness



Disabilities



Where disability status was given, 3,974 people out of 14,441 (28%) had one or more disabilities, as shown here.

* These demographics are not universally available. The number of valid cases for each element is provided.

MIDD Financial Report

Financial information provided over the next three pages is for calendar year 2013 (January 1 through June 30, 2013). The MIDD Fund spent approximately $18.9 million in strategy funding and approximately $5.6 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	2013 Annual Budget	Actual Year-to-Date (through June 2013)	2013 Projection (6/30/13)
1a-1	Increase Access to Community Mental Health Treatment & Club House	$ 8,520,000	$ 4,714,126	$ 8,520,000
1a-2	Increase Access to Community Substance Abuse Treatment	$ 2,650,000	$ 460,309	$ 2,650,000
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	$ 495,000	$ 206,000	$ 495,000
1c	Emergency Room Substance Abuse Early Intervention Program	$ 717,000	$ 177,930	$ 717,000
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	$ 225,000	$ 95,836	$ 225,000
1e	Chemical Dependency Professional Education and Training	$ 655,976	$ 257,519	$ 655,976
1f	Parent Partner and Youth Peer Support Assistance Program	$ 375,000	$ 157,166	$ 375,000
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	$ 450,000	$ 225,000	$ 450,000
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	$ 315,000	$ 157,750	$ 315,000
2a	Workload Reduction for Mental Health	$ 4,000,000	$ 2,000,002	$ 4,000,000
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	$ 1,000,000	$ 236,338	$ 1,000,000
3a	Supportive Services for Housing Projects	$ 2,000,000	$ 2,000,000	$ 2,000,000
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	$ 1,241,649	$ 419,727	$ 1,241,649
4d	School-Based Suicide Prevention	$ 200,000	$ 95,110	$ 200,000
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 176,938	$ 52,497	$ 176,938
6a	Wraparound Services for Emotionally Disturbed Youth	$ 4,500,000	$ 1,312,918	$ 4,500,000
7a	Reception Centers for Youth in Crisis	$ -	$ -	$ -
7b	Expansion of Children's Crisis Outreach Response Service System	$ 500,000	$ 166,244	$ 500,000
8a	Expand Family Treatment Court Services and Support to Parents	$ 81,250	$ 31,250	$ 81,250
9a	Expand Juvenile Drug Court Treatment (See Part II)	$ -	$ -	$ -
10a	Crisis Intervention Team Training for First Responders	$ 763,747	$ 135,585	$ 763,747
10b	Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	$ 6,100,000	$ 2,165,894	$ 6,100,000
11a	Increase Jail Liaison Capacity	$ 80,000	$ 28,232	$ 80,000
11b	Increase Services for New or Existing Mental Health Court Programs	$ 545,282	$ 124,268	$ 545,282
12a	Jail Re-Entry Program Capacity Increase	$ 320,000	$ 156,460	$ 320,000
12b	Hospital Re-Entry Respite Beds	$ 508,500	$ 254,250	$ 508,500
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	$ 200,000	$ 83,335	$ 200,000
12d	Behavior Modification Classes for CCAP Clients	$ 75,000	$ 31,250	$ 75,000
13a	Domestic Violence and Mental Health Services	$ 250,000	$ 129,005	$ 250,000
13b	Domestic Violence Prevention	$ 224,000	$ 74,672	$ 224,000
14a	Sexual Assault, Mental Health, and Chemical Dependency Services	$ 400,000	$ 119,992	$ 400,000
15a	Drug Court: Expansion of Recovery Support Services	$ 103,778	$ 64,255	$ 103,778
16a	New Housing Units and Rental Subsidies	$ -	$ -	$ -
	Sexual Assault Supplantation	$ 362,000	$ 362,000	$ 362,000
	MIDD Administration	**$ 3,081,384**	**$ 1,044,421**	**$ 3,081,384**
	Personnel	$ 3,081,384	$ 1,044,421	$ 2,417,930
	Other Costs	$ -	$ -	$ 663,454
	Total MIDD Operating Dollars	**$ 41,116,504**	**$ 17,539,341**	**$ 41,116,504**
	Percentage of Appropriation		**42.66%**	**100.00%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	2013 Annual Budget	Actual Year-to-Date (through June 2013)	2013 Projection (6/30/13)
	Department of Judicial Administration	**$ 136,595**	**$ 58,314**	**$ 136,595**
15a	Drug Court: Expansion of Recovery Support Services	$ 136,595	$ 58,314	$ 136,595
	Prosecuting Attorney's Office	**$ 126,737**	**$ 63,939**	**$ 126,737**
11b	Increase Services for New or Existing Mental Health Court Programs	$ 126,737	$ 63,939	$ 126,737
9a	Expand Juvenile Drug Court Treatment	$ -	$ -	$ -
	Superior Court	**$ 1,122,519**	**$ 885,450**	**$ 1,122,519**
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 226,798	$ -	$ 226,798
8a	Expand Family Treatment Court Services and Support to Parents	$ 329,369	$ 885,361	$ 329,369
9a	Expand Juvenile Drug Court Treatment	$ 566,352	$ 89	$ 566,352
	Sheriff Pre-Booking Diversion	**$ 139,785**	**$ 75,225**	**$ 139,785**
10a	Crisis Intervention Team Training for First Responders	$ -	$ -	$ -
	Sheriff MIDD	$ 139,785	$ 75,225	$ 139,785
	Office of Public Defense	**$ 454,412**	**$ 184,509**	**$ 454,412**
8a	Expand Family Treatment Court Services and Support to Parents	$ 101,600	$ 10,600	$ 101,600
9a	Expand Juvenile Drug Court Treatment	$ 43,665	$ 21,420	$ 43,665
11b	Increase Services for New or Existing Mental Health Court Programs	$ 309,147	$ 152,489	$ 309,147
	District Court	**$ 329,973**	**$ 141,482**	**$ 329,973**
11b	Increase Services for New or Existing Mental Health Court Programs	$ 329,973	$ 141,482	$ 329,973
	Total Other MIDD Funds	**$ 2,310,021**	**$ 1,408,919**	**$ 2,310,021**
	Percentage of Appropriation		**60.99%**	**100.00%**
	Total All MIDD Funds	**$ 43,426,525**	**$ 18,948,260**	**$ 43,426,525**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	2013 Annual Budget	Actual Year-to-Date (through June 2013)	2013 Projection (6/30/13)
Revenue			
MIDD Tax	$ 46,110,659	$ 22,597,291	$ 46,110,659
Streamlined Mitigation		$ 307,749	$ 307,749
Investment Interest - Gross	$ 56,168	$ 34,980	$ 56,168
Cash Management Svcs Fee		$ (525)	$ (525)
Invest Service Fee - Pool		$ (6,821)	$ (6,821)
Unrealized Gain/Loss		$ (67,100)	$ (67,100)
Total Revenues	**$ 46,166,827**	**$ 22,865,574**	**$ 46,400,130**
Total MIDD Funds	$ 43,426,525	$ 18,948,260	$ 43,426,525
Total MIDD Supplantation	$ 14,047,603	$ 5,646,419	$ 14,047,603
Total Expenditures	**$ 57,474,128**	**$ 24,594,679**	**$ 57,474,128**
Expenditures Over Revenues	**$ (11,307,301)**	**$ (1,729,104)**	**$ (11,073,997)**

Mental Illness and Drug Dependency Fund - Supplantation

Strategy	2013 Annual Budget	Actual Year-to-Date (through June 2013)	2013 Projection (6/30/13)
Other MIDD Funds			
Department of Judicial Administration	**$ 1,382,907**	**$ 405,495**	**$ 1,382,907**
Adult Drug Court Base	$ 1,382,907	$ 405,495	$ 1,382,907
Prosecuting Attorney's Office	**$ 1,111,149**	**$ 381,605**	**$ 1,111,149**
Adult Drug Court Base	$ 652,261	$ 274,889	$ 652,261
Juvenile Drug Court Base	$ 121,778	$ 60,889	$ 121,778
Mental Health Court Base	$ 337,110	$ 45,827	$ 337,110
Superior Court	**$ 501,856**	**$ 261**	**$ 501,856**
Adult Drug Court Base	$ 170,102	$ 261	$ 170,102
Juvenile Drug Court Base	$ 31,704	$ -	$ 31,704
Family Treatment Court Base	$ 300,050	$ -	$ 300,050
Office of Public Defense	**$ 1,270,876**	**$ 557,017**	**$ 1,270,876**
Adult Drug Court Base	$ 724,625	$ 371,145	$ 724,625
Juvenile Drug Court Base	$ 43,665	$ 13,800	$ 43,665
Mental Health Court Base	$ 350,186	$ 172,072	$ 350,186
Family Treatment Court Base	$ 152,400	-	$ 152,400
District Court	**$ 696,425**	**$ 251,668**	**$ 696,425**
Mental Health Court Base	$ 696,425	$ 251,668	$ 696,425
Department of Adult and Juvenile Detention	**$ 329,464**	**$ 329,464**	**$ 329,464**
Community Center for Alternate Programs (CCAP)	$ 28,644	$ 28,644	$ 28,644
Juvenile MH Treatment	$ 300,820	$ 300,820	$ 300,820
Jail Health Services	**$ 3,804,265**	**$ 1,318,575**	**$ 3,804,265**
Psychiatric Services	$ 3,804,265	$ 1,318,575	$ 3,804,265
Total Other MIDD Funds	**$ 9,096,942**	**$ 3,244,085**	**$ 9,096,942**
Percentage of Appropriation		**35.66%**	**100.00%**
MH & SA MIDD Supplantation	**$ 4,950,661**	**$ 2,402,334**	**$ 4,950,661**
SA Administration	$ 399,738	$ 199,869	$ 399,738
SA Criminal Justice Initiative	$ 986,584	$ 437,166	$ 986,584
SA Contracts	$ 121,757	$ 60,381	$ 121,757
SA Housing Voucher Program	$ 630,995	$ 285,719	$ 630,995
SA Emergency Service Patrol	$ 600,000	$ 358,023	$ 600,000
SA CCAP	$ 472,981	$ 191,670	$ 472,981
MH Co-Occurring Disorders Tier	$ 800,000	$ 329,580	$ 800,000
MH Recovery	$ 225,000	$ 85,457	$ 225,000
MH Juvenile Justice Liaison	$ 90,000	$ 37,500	$ 90,000
MH Crisis Triage Unit	$ 263,606	$ 160,316	$ 263,606
MH Functional Family Therapy	$ 272,000	$ 228,321	$ 272,000
MH Mental Health Court Liaison	$ 88,000	$ 28,332	$ 88,000
Total Other MH/SA MIDD Supplantation Funds	**$ 4,950,661**	**$ 2,402,334**	**$ 4,950,661**
Percentage of Appropriation		**48.53%**	**100.00%**
Total MIDD Supplantation Dollars	**$ 14,047,603**	**$ 5,646,419**	**$ 14,047,603**
Percentage of Appropriation		**40.19%**	**100.00%**

MIDD Oversight Committee Membership Roster

Mike Heinisch, Executive Director, Kent Youth and Family Services (Co-chair)
Representing: Provider of youth mental health and chemical dependency services in King County

Dan Satterberg, King County Prosecuting Attorney, (Co-Chair)
Representing: Prosecuting Attorney's Office

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

Gretchen Bruce, Interim 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

Jeanette Blankenship, Fiscal and Policy Analyst
Representing: City of Seattle

Merril Cousin, Executive Director, King County Coalition Against Domestic Violence
Representing: Domestic violence prevention services

Nancy Dow, Member, King County Mental Health Advisory Board
Representing: Mental Health Advisory Board

Rod Dembowski, Councilmember, Metropolitan King County Council
Representing: King County Council

Michael Finkle, Judge, King County District Court
Representing: District Court

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

Dennis Higgins, Kent City Council President, City of Kent
Representing: Suburban Cities Association

David Chapman, 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

John Urquhart, Sheriff, King County Sheriff's Office
Representing: Sheriff's Office

Mary Ellen Stone, Director, King County Sexual Assault Resource Center
Representing: Provider of sexual assault victim services in King County

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 3/31/2013

Appendix I: Performance Projections by Strategy Category

Community-Based Care Strategies

MIDD Strategy Number and Name		Year 5 Targets	6 Month Progress[1]	Projection Multiplier	Projected % of Annual Target	Target Success Rating
1a-1	Mental Health (MH) Treatment	2,400 clients/yr	4,112	1.3	223%	↑
1a-2	Chemical Dependency (CD) Treatment	50,000 adult outpatient (OP) units 4,000 youth OP units 70,000 opiate substitution (OST) units	14,655 adult OP units 2,560 youth OP units 27,311 OST units	2.0	59%[2] 128% 78%	↓ ↑ →
1b	Outreach & Engagement	675 clients/yr	891	2.0	264%[3]	↑
1c	Emergency Room Intervention	6,400 screens/yr with 8 full-time equivalent (FTE) staff 4,340 brief interventions/yr **Adjust for 7 FTE in Reporting Period**	2,309 of 5,600 screens 2,298 of 3,798 brief interventions	2.0	82% 121% (Adjusted)	→ ↑
1d	MH Crisis Next Day Appts (NDAs)	750 clients/yr with enhanced services **Adjust for 62% reduction in state funding for NDAs**	154 of 285 clients (enhanced)	2.0	108%	↑
1e	Training for CD Professionals	125 reimbursed trainees/yr 250 workforce development trainees/yr	218 reimbursed trainees 202 other trainees	1.3	227% 105%	↑ ↑
1f	Parent Partners Family Assistance	400 clients/yr[4]	Start up activities only			
1g	Older Adults Prevention MH & Substance Abuse	2,500 clients/yr (7.4 FTE) **Adjust to 2,196 clients/yr (6.5 FTE)**	2,397	1.3	142% (Adjusted)	↑
1h	Older Adults Crisis & Service Linkage	340 clients/yr (4.6 FTE) **Adjust to 258 clients/yr (3.5 FTE)**	218	1.9	160% (Adjusted)	↑
2a	MH Workload Reduction	16 agencies participating	17 agencies participating	-	106%	↑
2b	Employment Services MH & CD	920 clients/yr (23 FTE) **Adjust to 700 clients/yr (17.5 FTE)**	642	1.3	119% (Adjusted)	↑
3a	Supportive Housing	553 clients/yr **Note: Slots had not yet been increased during this reporting period**	653	1.3	154%[5]	↑
13a	Domestic Violence & MH Services	560-640 clients/yr	368	2.0	131% of minimum	↑
14a	Sexual Assault, MH & CD Services	170 clients/yr	262	2.0	308%[3]	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Providers were instructed to spend down expiring state funding for the adult outpatient population during this time period.
[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 target accepted by Council in motion of acceptance on 5/6/2012.
[5] The MIDD Year Five target was not set as of March 2013. Projection is against Year Four target.

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%

Projection Multipliers	Notes
2.0	Some strategies (for example, those based on encounters) are expected to serve twice as many clients in a full year as they serve in a 6-month period. The default projection multiplier is 2.0.
1.3	For programs now operating at capacity or with benefits lasting 365 days, the projection multiplier is 1.3, which factors in program turnover.
1.9	For shorter term programs (typically 1-3 months), a multiplier of 1.9 is used for projection. Since July 2009, the number of unduplicated people starting these types of programs has remained fairly stable.
1.5	School-based programs serve fewer students during the summer months, so the projection multiplier is 1.5.

Strategies with Programs to Help Youth

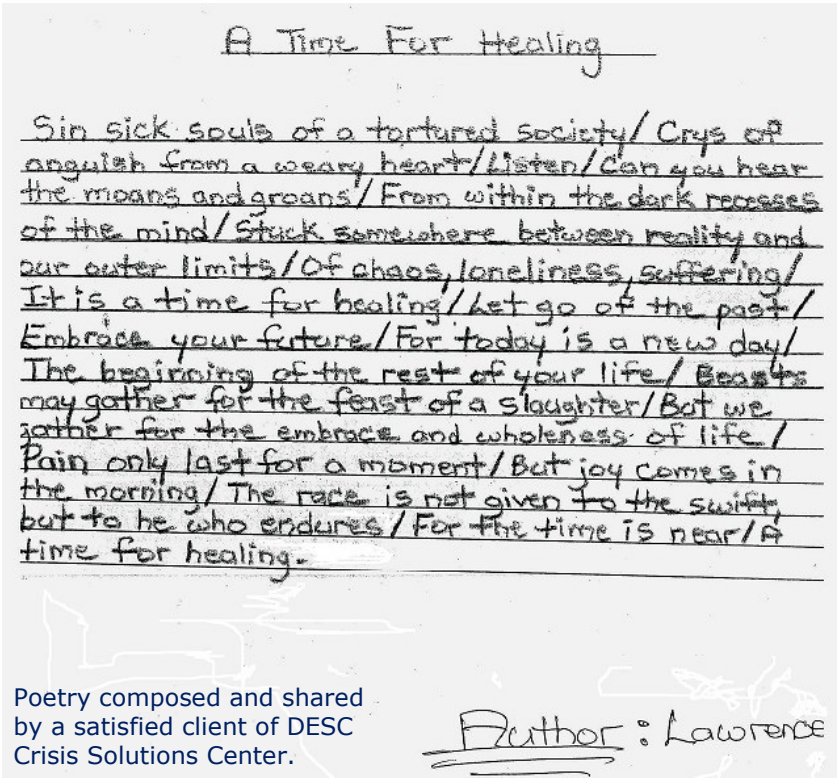
MIDD Strategy Number and Name		Year 5 Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
4a	Parents in Recovery Services	400 parents/yr				
4b	CD Prevention for Children	400 children/yr				
4c	School-Based Services	2,268 individuals (19 programs) **Adjust to 1,550 individuals/yr (13 programs)**	1,227	1.5	119% (Adjusted)	↑
4d	Suicide Prevention Training	1,500 adults/yr 3,250 youth/yr	1,104 adults 5,375 youth	1.5	110% 248%[2]	↑ ↑
5a	Juvenile Justice Assessments	Coordinate 500 assessments/yr Provide 200 psychological services/yr Perform 140 MH assessments Perform 165 CD assessments	818 coordinations 101 psychological services 51 MH assessments 167 CD assessments	2.0	327% 101% 73% 202%	↑ ↑ → ↑
6a	Wraparound	450 enrolled youth/yr	453	1.3	131%	↑
7a	Youth Reception Centers	TBD				
7b	Expand Youth Crisis Services	300 youth/yr	567	1.9	359%[2]	↑
8a	Family Treatment Court	No more than 90 children/yr No more than 60 children at one time	75 children (weighted) 58 average daily maximum	1.3	92%[3] 103%	↑ ↑
9a	Juvenile Drug Court	36 new youth/yr	45 new youth since 10/1/2011 5 in pre opt-in phase	2.0	228%[4]	↑
13b	Domestic Violence Prevention	85 families/yr	96 unduplicated families	1.3	147%	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Blended funds allow more clients to be served than the portion attributable to MIDD only, on which the performance measurement targets are based.
[3] Due to the cap-monitoring target, projection is reverse scored to be comparable with other strategies.
[4] Projection is based on counting both pre opt-ins and opt-ins.

Jail and Hospital Diversion Strategies

MIDD Strategy Number and Name		Year 5 Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
10a	Crisis Intervention Team Training	180 trainees/yr (40-hr) 300 trainees/yr (1-day) 150 trainees/yr (other CIT programs)	141 (40-hr) 145 (1-day) 75 (other)	2.0	157% 97% 100%	↑ ↑ ↑
10b	Adult Crisis Diversion	3,000 adults/yr	1,082	2.0	72%	→
11a	Increase Jail Liaison Capacity	200 clients/yr	44	2.0	44%[2]	↓
11b	Mental Health Court Expansion	115 clients/yr (9 FTE) for RMHC **Adjust to 57 to annualize the two-year caseload length** 300 clients/yr (1 FTE) for SMHC[4]	RMHC 11 new opt-ins over 6 months SMHC 131	2.0	39%[3] (Adjusted) 87%	↓ ↑
12a	Jail Re-Entry Capacity Increase	300 clients/yr (3 FTE)	135	2.0	90%	↑
	CCAP Education Classes	600 clients/yr	298	2.0	99%	↑
12b	Hospital Re-Entry Respite Beds	350-500 clients/yr	202	1.9	115% of minimum	↑
12c	PES Link to Community Services	75-100 clients/yr	67	1.9	170% of minimum	↑
12d	Behavior Modification for CCAP	100 clients/yr	118	1.3	153%	↑
15a	Adult Drug Court	250 clients/yr	171	1.3	89%	↑
16a	New Housing and Rental Subsidies	25 rental subsidies/yr[4]	25 rental subsidies 30 tenants at Brierwood	1.3 -	130% -	↑
17a	Crisis Intervention/MH Partnership					
17b	Safe Housing - Child Prostitution					

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Performance target will be adjusted in the MIDD Year Five annual report to reflect staff turnover and position vacancy.
[3] The court will propose a strategy revision in 2013.
[4] Revised targets accepted by Council in motion of acceptance on 5/6/2012.



A Time For Healing

Sin sick souls of a tortured society/ Cry's of anguish from a weary heart/Listen/Can you hear the moans and groans/ From within the dark recesses of the mind/ Stuck somewhere between reality and our outer limits/Of chaos, loneliness, suffering/ It is a time for healing/Let go of the past/ Embrace your future/For today is a new day/ The beginning of the rest of your life/ Beasts may gather for the feast of a slaughter/But we gather for the embrace and wholeness of life/ Pain only last for a moment/But joy comes in the morning/ The race is not given to the swift, but to he who endures/ For the time is near/A time for healing.

Author: Lawrence

Poetry composed and shared by a satisfied client of DESC Crisis Solutions Center.

Appendix II: Revised Evaluation Matrices

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1f - Parent Partner and Youth Peer Support Assistance Program≑ Target Populations: 1) Families whose children receive services from the public mental health or substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports for their children/youth 2) Youth who receive services from the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports	1. Provide parent partners/youth peer ~~counselors~~ support specialist that will empower 400 families and youth by assisting them to 1) increase their knowledge and expertise about services, systems and supports for families, 2) utilize effective coping skills and strategies to support children/youth, and 3) effectively navigate the complex child-serving systems, including juvenile justice, child welfare, and mental health and substance abuse treatment. 2. Provide education, training and advocacy to ~~4,000~~ 1,000 parents and youth involved in the different child-serving systems per year. 3. Provide information and resources for families and youth regarding services and supports available throughout King County.	Short-term measures: 1. Employ a 1.0 FTE parent partner specialist 2. Monthly King County-sponsored Parent Partner Network meetings 3. Fund a free-standing Family Support Organization (FSO) in King County 4. Hire parent partners and youth peer mentors to operate and staff the FSO 5. Increase # of families and youth receiving parent partner/peer ~~counseling~~ support services 6. Increase # of parent partner/peer ~~counseling~~ support service hours provided 7. Increase # of parents/youth engaged in support groups and other activities of the FSO or the Parent Partner Network 8. Increase # of education and training events held annually Longer-term measures: 9. Increase parent/caregiver/youth knowledge of service systems and how to access resources 10. Increase family empowerment and advocacy skills for parents/caregivers and youth 11. Increase protective factors for families and youth served 12. Decrease risk factors for families and youth served 13. Increase family connections to natural supports	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output 8. Output 9. Outcome 10.Outcome 11.Outcome 12.Outcome 13.Outcome	MHCADSD MHCADSD MHCADSD MHCADSD ~~MIS (php96)~~❶ MIDD Tools ~~MIS (php96)~~❶ MIDD Tools Contract report Contract report MIDD Tools MIDD Tools MIDD Tools MIDD Tools MIDD Tools

≑ The Parent Partner and Youth Peer Support Assistance Program is based upon a "promising" practice model.
❶ ~~Database revisions needed~~

Strategy 9 - Expand Juvenile Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
9a - Expand Juvenile Drug Court (JDC) Treatment Target Population: Youth involved in the juvenile justice system who are identified as having substance abuse issues or are diagnosed chemically dependent	1. Maintain and expand capacity of the Juvenile Drug Court model to enroll up to 36 additional youth per year, including both pre-opt in and opt in youth.	Short-term measures: 1. Hire 5.5 FTE staff to expand juvenile drug court capacity Longer-term measures: 2. Increase # of JDC youth linked to substance abuse treatment 3. Increase # of JDC youth completing substance abuse treatment 4. Reduce # of detention admissions for youth completing juvenile drug court 5. Reduce substance abuse and severity of CD symptoms for JDC youth served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	Contract report MIDD Tools TARGET Juvenile Justice data Assessments.com and MIDD Tools

Content revised 7/12/2010 (Previous draft amended 5/20/2009) Amended 5/01/2013

Strategy 16 – Increase Housing Available for Individuals with Mental Illness and/or Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
16a – Housing Development Target Population: Individuals with mental illness and/or chemical dependency who are homeless or being discharged from hospitals, jails, prisons, crisis diversion facilities, or residential chemical dependency treatment	1. Provide supplemental funding to expedite construction of new housing projects for MIDD target population. 2. Create 250 new housing units dedicated for the MIDD target population. 3. Provide 5-year rental subsidies to serve ~~40~~ 25 clients per year.	Short-term measures: 1. Increase # of residential units created 2. Increase # of rental subsidies disbursed Longer-term measures: 3. Increase # of people in target population housed 4. Increase # of individuals in target population who are able to remain in housing for at least one year 5. Reduce # of jail bookings and days for those served 6. Reduce # of psychiatric hospital admissions and days for those served 7. Reduce # of ER visits for those served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	MHCADSD MHCADSD MHCADSD Contract report Jail data Western State data and MIS (php96) ER data❶

❶ ~~Data sharing agreement(s) needed~~

Content revised 7/30/2010 (Previous draft amended 5/20/2009) Amended 5/01/2013