Attachment A

Mental Illness and Drug Dependency

Eighth Annual Report

Implementation and Evaluation Summary for Year Seven
October 1, 2014—September 30, 2015

King County

Mental Illness and Drug Dependency Oversight Committee

February 2016

King County Department of Community and Human Services

401 Fifth Avenue, Suite 500
Seattle, WA 98104

Phone: 206-263-9100

Adrienne Quinn - Director

Behavioral Health and Recovery Division

Jim Vollendroff - Division Director

Brad Finegood - Assistant Division Director and Acting RSN Administrator
Prevention and Treatment Coordinator

Kelli Carroll - Strategic Advisor

Andrea LaFazia-Geraghty - Mental Illness and Drug Dependency (MIDD)
and Prevention Section Manager

Laurie Sylla - Systems Performance Evaluation Coordinator

Lisa Kimmerly - MIDD Evaluator

Kimberly Cisson - MIDD Assistant Evaluator

Bryan Baird - MIDD Administrative Support

Eighth Annual Report
October 1, 2014—September 30, 2015

Cover photo depicts the Community Conversation event in Renton, Washington
(See the MIDD Review and Renewal Update on Page 1)
Cover photo by Sherry Hamilton

Report analysis and design by Lisa Kimmerly
Data support from Marla Hoffman and Genevieve Rowe
Provider features and client success stories by Kimberly Cisson

**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
or TTY Relay 711

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What is MIDD?

King County's Mental Illness and Drug Dependency (MIDD) is a countywide sales tax generating approximately $53 million per year for mental health and substance abuse services and programs. As required by state legislation (Revised Code of Washington 82.14.460), revenue raised under the MIDD is to be used for certain mental health and substance use disorder services, including King County's therapeutic courts. King County's MIDD was passed by the Metropolitan King County Council in 2007, and MIDD-funded services began in 2008. Unless renewed by the Council, the MIDD will expire on December 31, 2016. King County is one of 23 counties in Washington state that has authorized the tax revenue.

MIDD Review and Renewal Update

In March 2015 the King County Council passed Ordinance 17998, calling for a comprehensive historical review and assessment of MIDD I (due in June 2016) and a MIDD II service improvement plan (SIP) (due in December 2016). In order to inform the Council's 2017-2018 biennial budget deliberations that will occur in fall of 2016, the MIDD II SIP will be transmitted concurrently with the King County Executive's 2017-2018 Proposed Budget. Legislation to renew the sales tax is slated to be transmitted to the Council in June.

Executive staff and the MIDD Oversight Committee have undertaken a number of MIDD review and renewal planning activities. Please note that some of the items below occurred outside of the reporting period (ending September 2015). Highlights of the MIDD II renewal activities through February 2016 include:

- Creation of a website hub for information and resources related to the MIDD review and renewal process
- Development of MIDD Oversight Committee Values and Guiding Principles for renewal activities
- Open call for MIDD II new concepts between September 15 and October 31, 2015 that generated over 140 suggestions for potential use of MIDD II funding
- Development and analysis of new concepts and existing MIDD strategies
- Creation of a review process for new concepts and existing MIDD strategies that includes community participation at multiple points
- 20 community engagement meetings and focus groups, including five large, regional community conversations, with over 600 community members involved
- Transmittal of a MIDD renewal progress report to the Council in November 2015
- Report on MIDD renewal activities at each MIDD Oversight Committee meeting.

Photos by Sherry Hamilton

MIDD Reporting Requirements

This is the Eighth Annual MIDD Report, covering the time period of October 1, 2014, through September 30, 2015.

Through MIDD legislation (Ordinances 15949 and 16262), King County policymakers established the requirement to report on MIDD's services and programs. Legislation set forth MIDD's Policy Goals, along with key components that are to be included in every MIDD annual report, including:

a) A summary of semi-annual report data

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

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

d) Recommended revisions to the evaluation plan and processes

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

Legislation also adopted the schedule and timeframe of the annual reports.

The five adopted MIDD Policy Goals* are:

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*

As required, the annual MIDD reports are reviewed by the MIDD Oversight Committee and transmitted by the County Executive to the Council for acknowledgement by motion. MIDD progress reports are also compiled, reviewed and transmitted for the Council's review.

In this Eighth Annual MIDD Report, comprehensive performance measurement statistics and a summary of key outcomes results over the life of the MIDD are provided. Each reader is encouraged to study the information presented when drawing conclusions about the effectiveness of MIDD programming. Please note that steps for assessing strategy effectiveness are outlined on Page 8 to guide the process of critically evaluating each MIDD strategy.

MIDD Annual Report Purpose, Processes, Timelines and Terms

The purpose of the MIDD annual report is to provide transparent accountability to the King County Council, King County taxpayers and interested stakeholders on how MIDD sales tax funds are used, changes in how strategies are implemented, observed results achieved by people who receive MIDD services, and progress toward achieving MIDD policy goals.

Data submitted to the MIDD Evaluation Team by more than 100 providers, subcontractors and partners is currently stored in three major databases: 1) the statewide TARGET substance use treatment database (DB), 2) King County's mental health system, and 3) a separate MIDD database. Information is typically due, in accordance with contract requirements, on a monthly or quarterly basis. In some cases, providers query their own data systems and computers automatically process the data, while in other cases, spreadsheets are completed by hand and submitted via secure file transfer protocols, or uploaded to secure servers. When the data submission process is more manual than automated, significant staff time is generally required to clean, process and compile the information received. In order to produce demographic and outcomes findings, clients must be unduplicated and cross-referenced with their system-use results provided by all King County and municipal jails and select hospital partners. The timeline for data preparation and analysis is as follows:

Last Evaluation Data Due (through September 30)	Data Cleaned and Loaded in DB	Queries Run and Results Unduplicated	Outcomes Data Ready and Analysis Begins	Report Review Begins
Mid-November	Mid-December	Early January	Mid-January	Early February

Longitudinal Evaluation of Outcomes

For most strategies, client outcomes are studied using a longitudinal evaluation methodology. This method involves collecting data for the same group of individuals over time and then making comparisons between various time periods. In this report, outcomes are studied for up to five years after a person's MIDD start date. The following definitions for study time periods are used throughout the report:

- **Pre**: The one-year period leading up to a person's first MIDD start date within each relevant strategy.
- **First through Fifth Post**: Each subsequent one-year span following a person's start date.

Cohorts of clients become eligible for inclusion in various outcomes samples through the passage of time (time eligible) and their use of any given system, such as jails and hospitals, in each time period (use eligible). Tables and graphs on Pages 58 to 69 show MIDD strategies aligned with relevant outcome types, eligible sample sizes, the total number of bookings, admissions, or days in each time period, and the percent change, which is calculated by subtracting the Pre measure from each Post measure and dividing by the Pre measure. On some pages, data appears in strategy order, while on others it has been sorted to rank-order the strategies by various results.

Services may be delivered in a single encounter (service visit), or they may be ongoing for an extended time, such as months or even years. Service "dose" varies widely both within and between strategies. Analysts look for patterns in the data that can suggest relationships between measured variables without implying causation, as other factors not being measured could also be contributing to any observed results.

Definitions of Key Terms

Strategy — A program or series of programs that provide specific services or employ specific approaches to achieve intended goals.

Target — Quantifiable outputs expected of an entity implementing a strategy; How many people will be served and/or how many services will be provided.

Revised target — Changed expected output goals, usually permanent, due to new or better information.

Adjusted target — Changed expected output goals, usually temporary, due to changes in funding, staffing, policy or approach.

FTE — Full-time equivalent staffing. This is used to contextualize several MIDD targets.

Performance Measurement — The actual number of clients seen or services delivered; also represented as a percentage of the original, revised or adjusted target.

Targeted reductions — The amount of change expected in system use (jail, emergency department, psychiatric hospital) over time by individuals being served by particular strategies.

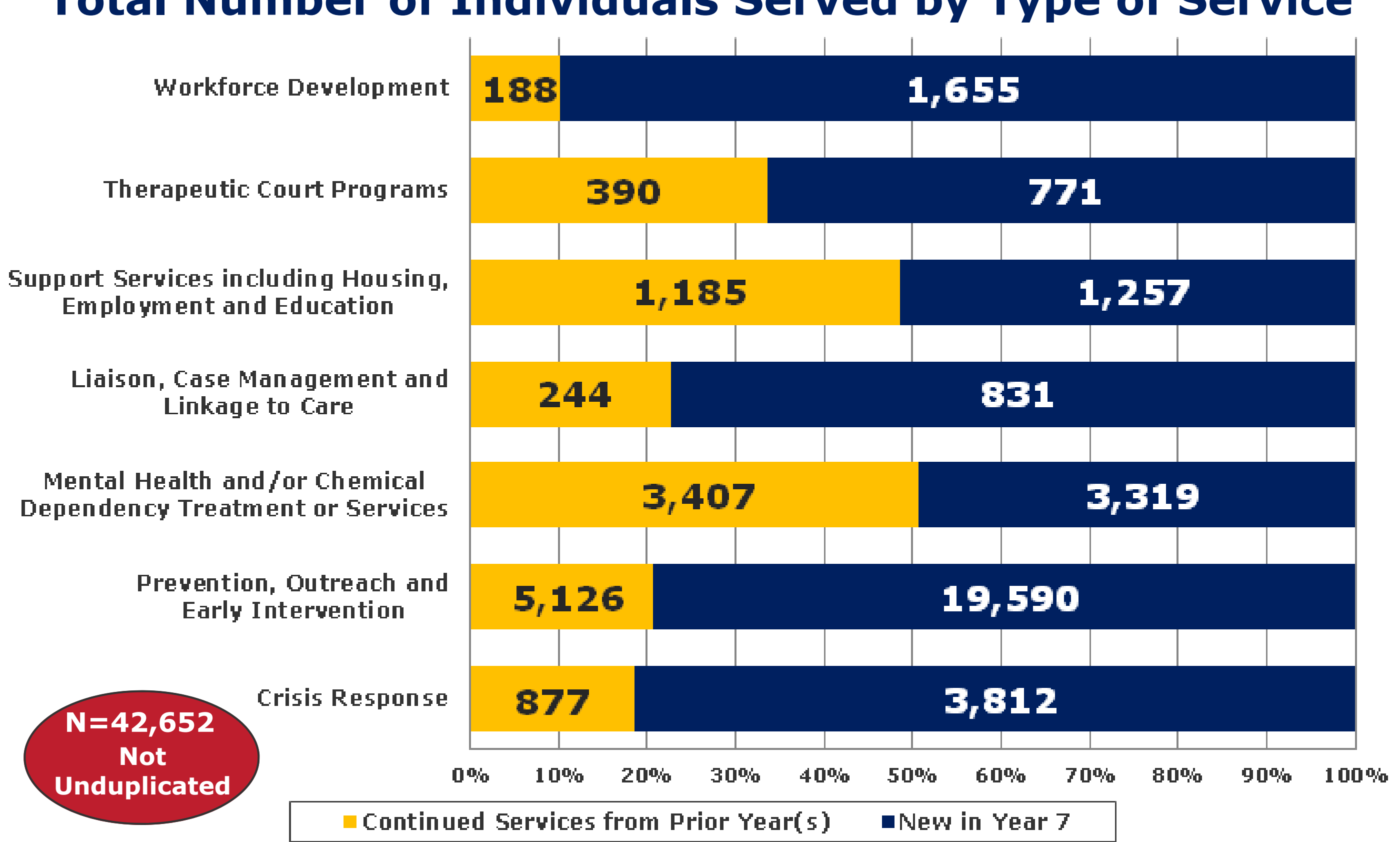
Outcomes — Measurable or observable end results or effects; something that happens as a result of an activity or process.

Annual Report Highlights

The following are key highlights from the annual report period of October 1, 2014, through September 30, 2015. Page numbers are shown where details are discussed:

- The MIDD Oversight Committee members contributed 446 cumulative hours in meetings and subcommittee activities. Non-members contributed an additional 184 hours. (Page 7)
- Individual-level information was available for at least 35,902 unduplicated clients served during the reporting period. An additional 21,730 people were counted in large group settings, but no personal identifiers were collected to unduplicate them. (Page 46)
- More people reporting zip codes from the south region of the county (35%) utilized services, compared to people with Seattle zip codes (33%), for the first time in over four years. (Page 46)
- Data from 2014 showed that $20 million was spent to help individuals reporting Seattle zip codes, $10 million for those with south county zip codes, and a combined $8 million for people reporting zip codes associated with the east and north regions. (Page 48)
- $57.9 million of the $59.5 million budgeted was spent on MIDD strategies and supplantation during the 2015 calendar year. The projected fund balance is $9.2 million. (Pages 49-51)
- Most strategies achieved positive target success ratings by meeting 85 percent or more of their performance measurement targets. For example, if a strategy was expected to serve 100 clients and they saw at least 86, they earned a green arrow. (Pages 54—56)
- Twenty strategies or sub-strategies were expected to reduce jail bookings and days for individuals served. It was more common for clients to reduce bookings than to reduce days (Pages 59-65)
- Fourteen strategies or sub-strategies were expected to reduce admissions to Harborview Medical Center's emergency department. Ten of these achieved reductions of 20 percent or greater in the second year after the start of MIDD services, which was a favorable outcome. (Page 66)
- Ten strategies were expected to reduce psychiatric hospitalizations for clients served. At least nine strategies achieved targeted reductions during at least one outcomes analysis period. (Pages 68-69)

Total Number of Individuals Served by Type of Service



Oversight Committee Membership Roster

Johanna Bender, Judge, King County District Court (Co-Chair)
Representing: District Court

Merril Cousin, Executive Director, King County Coalition Against Domestic Violence (Co-Chair)
Representing: Domestic violence prevention services

Dave Asher, Kirkland City Council Councilmember, City of Kirkland
Representing: Sound Cities Association

Rhonda Berry, Chief of Operations
Representing: King County Executive

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

Susan Craighead, Presiding Judge, King County Superior Court
Representing: Superior Court

Claudia D'Allegri, Vice President of Behavioral Health, SeaMar Community Health Centers
Representing: Community Health Council

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

Lea Ennis, Director, Juvenile Court, King County Superior Court
Representing: King County Systems Integration Initiative

Ashley Fontaine, Director, National Alliance on Mental Illness (NAMI)
Representing: NAMI in King County

Pat Godfrey, Member, King County Alcoholism and Substance Abuse Administrative Board
Representing: King County Alcoholism and Substance Abuse Administrative Board

Shirley Havenga, Chief Executive Officer, Community Psychiatric Clinic
Representing: Provider of mental health and chemical dependency services in King County

Patty Hayes, Director, Public Health—Seattle & King County
Representing: Public Health

William Hayes, Director, King County Department of Adult and Juvenile Detention
Representing: Adult and Juvenile Detention

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

Darcy Jaffe, Chief Nurse Officer and Senior Associate Administrator, Harborview Medical Center
Representing: Harborview Medical Center

Norman Johnson, Executive Director, Therapeutic Health Services
Representing: Provider of culturally specific chemical dependency services in King County

Ann McGettigan, Executive Director, Seattle Counseling Service (Co-Chair)
Representing: Provider of culturally specific mental health services in King County

Barbara Miner, Director, King County Department of Judicial Administration
Representing: Judicial Administration

Mark Putnam, Director, Committee to End Homelessness in King County
Representing: Committee to End Homelessness

Adrienne Quinn, Director, King County Department of Community and Human Services (DCHS)
Representing: King County DCHS

Lynne Robinson, Bellevue City Council Councilmember, City of Bellevue
Representing: City of Bellevue

Dan Satterberg, King County Prosecuting Attorney
Representing: Prosecuting Attorney's Office

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

Dave Upthegrove, Councilmember, Metropolitan King County Council
Representing: King County Council

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

Chelene Whiteaker, Director, Advocacy and Policy, Washington State Hospital Association
Representing: Washington State Hospital Association/King County Hospitals

Lorinda Youngcourt, Director, King County Department of Public Defense
Representing: Public Defense

Oversight Committee Staff:

Bryan Baird , Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

Kelli Carroll, Strategic Advisor, MHCADSD

Andrea LaFazia-Geraghty, MHCADSD

As of 9/30/2015

Letter from Oversight Committee Co-Chairs

Dear Reader:

The Eighth Annual MIDD Report before you comprises the Mental Illness and Drug Dependency (MIDD) Implementation and Evaluation Summary for Year Seven (October 1, 2014 – September 30, 2015). As noted, this report includes comprehensive performance measurement data and a summary of key outcomes results over the life of the MIDD. We encourage you to review the data provided as you consider the effectiveness of MIDD programs and services. Steps to help readers review strategies for effectiveness are included on Page 8.

New in this report is an overview of the MIDD reporting processes, timelines, and terms, found on Page 3. This is included to give readers, especially those who are new to MIDD, a more comprehensive understanding of MIDD reporting and the complexity of MIDD data collection and preparation. We also include a glossary of MIDD terms used in this report.

Individual MIDD strategy summary pages include a strategy overview, the particular MIDD policy goals addressed by the strategy, strategy performance measurement data and a summary of key findings. Where performance measurement information is provided, additional information may be included to contextualize targets and changes to targets.

Selected program and client success stories are highlighted at the beginning of each strategy category section, along with lists of contractors and partners providing MIDD services. On Page 9, the Bridges Program, which provides outreach and engagement in the King County's south and east regions, is featured as a community-based intervention. A story about youth peer partners appears on Page 25, and the experience of one behavior modification class participant is shared on Page 34, as an example of strategies that are intended to divert individuals from jail and unnecessary hospitalizations.

It is our hope that you find the content and format of this report to be engaging and informative. We are open to feedback and encourage all audiences to share what they find useful or interesting, or what information may be missing, as a means of improving our reports.

We invite you to attend a MIDD Oversight Committee meeting, held on the fourth Thursday of each month. A public comment period is included at each meeting. We would like to hear from you! Alternatively, you may contact us at midd@kingcounty.gov. For more information on MIDD renewal, please go to:

http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan/MIDDReviewandRenewalPlanning.aspx

We thank you for your interest and support of King County's MIDD.

Johanna Bender
Judge, King County Superior Court,
formerly Judge, King County District Court
Co-Chair

Merril Cousin
Executive Director, Coalition Ending Gender-Based Violence, formerly the King County Coalition Against Domestic Violence, Co-Chair

Acknowledgments

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

MIDD Oversight Committee Purpose

The Mental Illness and Drug Dependency (MIDD) Oversight Committee was formally established via Ordinance 16077 in 2008. The ordinance approved an oversight plan for the MIDD, including a description of the required membership for the MIDD Oversight Committee and its roles and responsibilities.

The MIDD Oversight Committee is an advisory body to the Executive and Council. Its purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the MIDD sales tax revenue are transparent, accountable, collaborative and effective.

The Committee is a unique partnership of representatives from government and communities, including the health and human services and criminal justice communities. Recognizing that King County is the countywide provider of mental health and substance abuse services, the Committee works to ensure that access to mental health and chemical dependency services is available to those who are most in need throughout the County.

The MIDD Oversight Committee met nine times during the reporting period to monitor program implementation and progress of the MIDD. Six regular meetings were held, along with three additional meetings that focused on MIDD renewal activities. Members of the committee cumulatively contributed 186 hours of service in these meetings. Furthermore:

- The Crisis Diversion Services subcommittee met four times for a total of eight cumulative member hours and 30 cumulative non-member hours.
- The Fund Balance Work Group met five times in 2015 for a total of 130 cumulative member hours and 60 cumulative non-member hours. This does not include time spent by members outside of meetings reviewing and responding to information.
- The Co-Chairs met monthly with County staff for a total of 24 cumulative member hours and 24 cumulative non-member hours. This does not include Co-Chair time spent on MIDD matters outside of meetings, including but not limited to emails and phone calls.
- The MIDD Renewal Strategy Team met monthly with County staff for a total of 98 cumulative member hours and 70 cumulative non-member hours. This does not include time spent by members outside of meetings reviewing and responding to information.

Please note that Oversight Committee members spend time on MIDD matters outside of meetings reading and responding to information provided about MIDD.

Updates Provided and Key Issues Discussed at Meetings

The Oversight Committee was briefed on the following topics during the current reporting period:

- Strategy 1c—Emergency Room Intervention
- Strategy 4a—School-Based Services
- Strategy 10a—Crisis Intervention Team Training
- King County Health and Human Services Transformation “Familiar Faces” Initiative
- Statewide Behavioral Health Integration.

In committee meetings, the following key issues were discussed:

- MIDD Finance and Budget Updates
- Fund Balance Work Group Advisory Recommendations
- MIDD Fund Review and Renewal Planning
- State and Local Legislative Updates
- MIDD Undesignated Fund Balance Survey Results.

Steps to Assess MIDD Strategy Effectiveness

The steps outlined below are intended to provide a basic framework for interpreting the findings presented throughout this report. Strategy success or effectiveness in meeting MIDD policy goals can be measured in a number of different ways. Consider relevant factors for each unique MIDD strategy to assess how well each one met its objectives.

Step 1 Examine each strategy's performance measurement statistics in tables on each strategy page.

- Were the targets, revised targets or adjusted targets met each year?
- If not, what explanations are shown to contextualize shortfalls or surpassed expectations?

Step 2 Review each strategy's related policy goals for relevant outcomes or linkages. Appendix I on Page 53 shows the alignment between strategies and the MIDD policy goals.

Step 3 Note reported increases or decreases in system use or symptoms, as well as linkages to other initiatives. Brief highlights or supporting narrative appear on each strategy page. Detailed changes in system use over time are shown in Appendix V: Aggregate System Use by Relevant Strategies (see Page 59). The total number of jail bookings, hospital admissions and days are shown for each post period in comparison to the pre period. For symptom reduction, references to detailed findings published in previous MIDD reports are provided for those interested in additional information.

Step 4 Examine reported results in relation to the targeted reduction goals shown below. These goals were established in September 2008. Because the overall adult jail population declined between 2008 and 2013, an additional five percent reduction per post period was added to the original reduction goals. For psychiatric hospital use, original targeted reductions were based on admissions alone; information on community inpatient psychiatric hospital and Western State days has been provided here as well.

	Adults							Youth	
	Jail or Detention Bookings/Days			Harborview ED Admits		Psychiatric Hospital Use		All Measures	
Period	Incremental	Additional	Cumulative	Incremental	Cumulative	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-5%	-5%	-10%	-10%	-10%	-10%
Post 2	-10%	-5%	-25%	-14%	-19%	-8%	-18%	-10%	-20%
Post 3	-10%	-5%	-40%	-13%	-32%	-8%	-26%	-10%	-30%
Post 4	-10%	-5%	-55%	-13%	-45%	-7%	-33%	-10%	-40%
Post 5	-10%	-5%	-70%	-15%	-60%	-7%	-40%	-10%	-50%

Step 5 Keep these factors in mind when interpreting effectiveness results:

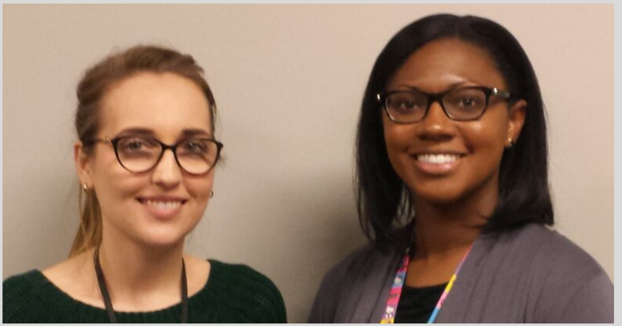
- None of the findings presented in this report can establish causality, as there are too many variables beyond the control of evaluators. Results show only patterns or trends observed in the data.
- Smaller samples are less likely to show significant results, because there is not enough statistical power to detect meaningful change over chance.
- It is difficult to find significant improvement if base symptoms or system use is low.
- Strategies that started later have fewer cases and less time to demonstrate change.
- Some therapeutic court programs use jail days as sanctions, sometimes related to actions that occurred prior to a participant's MIDD service start. In other strategies, hospital use may increase during the first post period as a result of successful linkage to needed care. Thus, first post period increases in days may be difficult to interpret. Later post period changes may be better indications of effectiveness.
- System use in the year before starting MIDD services is often quite low for youth. Increases over time, comparing post period counts to those low pre period numbers, are common.

Step 6 Some of the data provided in this report may suggest a need for strategy revisions. Plan modifications are recommended on Page 52. Please see the contact information on Page 6 in order to make any additional recommendations for future strategy revisions.

Community-Based Mental Health and Substance Use Disorder Intervention Strategies

Paying It Forward With Outreach Beyond the City Limits

Oftentimes people in need of behavioral health help are not aware of services available to them. "Outreach" is the process of raising awareness of available services and making connections between people in need and help that is available. Outreach fills gaps within the public mental health system, linking people to services like counseling, case management and care coordination. Outreach can be conducted anywhere: shelters, day centers, emergency centers, community meals, encampments, faith-based locations, and even in the woods. One key component of outreach is being ready to talk to people in the moment, wherever they are.



Bridges Team members Jessica Dean and Tonia Washington of Valley Cities—Renton.

Two staff from the Bridges Program at Valley Cities Counseling & Consultation, part of the Healthcare for the Homeless network, go where people who need help are. These outreach workers build relationships and trust so that they can provide referrals and other critical connections. One service the Bridges Team provides is assessing people for housing. People experiencing homelessness often want housing, but due to behavioral health issues, may need added supports to remain successfully housed. The team also assists with employment resources, such as résumés and cover letters, and clothes for interviews.

Sometimes the outreach counselors see people on an ongoing basis for a period of time. This process can help their clients move from accessing assistance to becoming self-sufficient. The counselors get to see growth as people who have experienced trauma, setbacks and disappointments move through feelings of shame to re-building their sense of self.

Even when people know about services in an abstract way, they often don't know the details about how to access services. Accessing services can be hard and disheartening for people with few resources or behavioral health issues. It may entail constantly facing rejection, overcoming a sense of hopelessness, or feeling stuck. Advocates in the Bridges Program help people through these challenges by facilitating connections and providing support. One professional calling another can often clear a pathway. People who are feeling disrespected or invalidated can be given tools that will help move them toward the point of standing on their own.

Problem solving in the moment can build a person's self-sufficiency. It may involve taking small steps in the right direction. With the right kind of outreach, however, change is possible and people can access services to improve their lives.

The Bridges Team conducts outreach at sites utilized by people experiencing homelessness, such as camp sites and churches. Due to great distances between service sites and the lower density of homeless populations outside the city of Seattle, the team visits multiple sites as clients frequently shift location. Outreach mobility helps eliminate clients' transportation barriers and increases their continuity of care. The Bridges outreach program offers guaranteed psychiatric appointments within seven days of request, including evaluations and medication management.

By Kimberly Cisson

Agencies Providing MIDD Community-Based Services

Agencies Providing MIDD Community-Based Services	Type*	1a-1	1a-2	1b	1c	1d	1e	1f	1g	1h	2a	2b	3a	13a	14a
Asian Counseling & Referral Service	MH & SUD	X	X				X				X	X			
Atlantic Street Center	MH	X									X				
Auburn Youth Resources	SUD		X				X								
Cascade Behavioral Health	SUD		X												
Catholic Community Services	MH & SUD	X	X				X						X		
Center for Human Services	SUD		X				X								
Chestnut Health System	MIDD						X								
Community House	MH	X									X				
Community Psychiatric Clinic	MH & SUD	X	X				X				X	X			
Consejo Counseling & Referral Services	MH & SUD	X	X				X				X				
Cowlitz Tribal Treatment	SUD		X				X								
DAWN	MIDD													X	
DESC	MH & SUD	X	X				X				X	X	X		
EvergreenHealth	MH & SUD	X	X				X			X	X				
Evergreen Recovery Services	SUD		X				X								
Evergreen Treatment Services	SUD		X				X						X		
Fairfax Hospital	MH & SUD		X												
Friends of Youth	SUD		X				X								
Guided Pathways – Support (GPS) for Youth & Families	MIDD							X							
Harborview	MH & SUD	X	X	X	X	X	X				X	X	X		X
Hero House	MH	X										X			
Highline Medical Center	MIDD				X										
Integrative Counseling Services	SUD		X				X								
Intercept Associates	SUD		X				X					X			
King County Coalition Against Domestic Violence	MIDD													X	X
King County Sexual Assault Resource Center	MIDD														X
Kent Youth & Family Services	SUD		X				X								
Lifewire	MIDD													X	
Muckleshoot	SUD		X				X								
Multicare Behavioral Health	MH & SUD	X													
Navos	MH & SUD	X	X			X	X				X	X			
New Beginnings	MIDD													X	
New Traditions	SUD		X				X								
Northshore Youth & Family	SUD		X				X								
Perinatal Treatment Services	SUD		X				X								
Pioneer Human Services	MH & SUD	X	X				X								
Plymouth Housing Group	MIDD												X		
Public Health (+)	Partner			X					X						
Recovery Café	MIDD		X												
Recovery Centers of King County	SUD		X				X								
Renton Area Youth Services	SUD		X				X								
Refugee Women's Alliance	MIDD													X	X
Ryther Child Center	MH & SUD	X					X								
Seadrunar	SUD						X								
Sea Mar	MH & SUD	X	X				X				X				
Seattle Area Support Groups	SUD		X												
Seattle Children's (Hospital)	MH	X									X				
Seattle Counseling Services	MH & SUD	X	X				X				X				
Seattle Indian Health Board	SUD		X	X			X					X			
Snoqualmie Indian Tribe	SUD		X				X								
Sound Mental Health (+)	MH & SUD	X	X			X	X				X	X	X		
St. Francis Hospital	MIDD				X										
Therapeutic Health Services	MH & SUD	X	X				X				X				
Transitional Resources	MIDD												X		
TRAC Associates	SUD											X			
Valley Cities Counseling & Consultation	MH & SUD	X	X			X	X				X	X	X		
WA Asian Pacific Islanders Families Against Substance Abuse	SUD		X				X								
WCHS, Inc / Renton Clinic	SUD		X												
YMCA	MH	X									X				
Youth Eastside Services	SUD		X				X								

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

* Types of providers include mental health (MH) and substance use disorder (SUD).

Strategy 1a-1

Mental Health Treatment

Increase Access to Community Mental Health Treatment

1a-1

This strategy provides treatment services for people who meet clinical and financial criteria for services, but who are otherwise Medicaid-ineligible. By providing continuous access to mental health (MH) services during Medicaid eligibility changes, emotionally and financially costly disruptions to treatment and recovery are prevented. Twenty licensed community MH agencies deliver highly-individualized, consumer-centered services in outpatient settings. Uninsured King County residents of all ages are served under this strategy.

Primary Policy Goal: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	2,400	Target	2,300	2,400	2,400	2,400	2,400	2,400	2,400
		Actual	2,047	3,481	3,090	4,345	4,612	3,117	2,730
		Percent	89%	145%	129%	181%	192%	130%	114%

Target Adjustments and Notes: Year 1 (11.5 months)

Strategy 1a-1 Key Findings Summary

Symptoms: Mental health treatment providers began submitting symptom measures for the MIDD evaluation in 2010. The Problem Severity Summary (PSS) assessed adult symptomology, while the Children's Functional Assessment Rating Scale (CFARS) provided measures for younger clients. Anxiety and depression were found to be the most common clinical symptoms for both adults and children.

Analyses of symptom data conducted every two years showed that the vast majority of clients remained stable over time. If symptom scores did change, improvements at some point during treatment were much more common (85%) than worsening symptoms (15%). Staying in treatment over time was associated with increased total percentages of adults who reduced their symptoms (up to 42% of all eligible participants).

For young people, extreme issues were rare, but two of every three youth with baselines above the clinical threshold for concern reduced their depression and anxiety scores below that threshold, indicating improved mental health.

Jail Use: Detailed information on system use over time appears in Appendix V, which begins on Page 59. The greatest reduction in total adult jail bookings for participants in this strategy was 62 percent, when jail days also fell by 58 percent. The greatest declines in youth detention bookings (-26%) and days (-8%) were found comparing pre measures to those in the fourth post period. In all other post periods, youth detentions declined slightly, while days increased by as much as 15 percent.

Emergency Department (ED) Use: Admissions to Harborview's ED decreased year after year, reaching a 36 percent reduction between the pre period and fifth post period. In a small sample analysis, one year reductions in use at other EDs (not Harborview) were found (-12%).

Psychiatric Hospital Use: Reduced hospitalizations, including at Western State, were realized for both adults and youth served by Strategy 1a-1. The pattern in their number of days hospitalized varied by age. Adult days decreased over all periods, but youth days increased after initial first post period reductions.

Strategy 1a-2

Substance Use Disorder Treatment

Increase Access to Community Substance Use Disorder Treatment 1a-2

Assessment, individual and group counseling, and case management are all units of substance use disorder (SUD) treatment services provided to adults in outpatient (OP) settings. Treatment for youth includes all of these components, plus urinalysis. People enrolled in opiate treatment programs (OTP) typically receive daily medications such as methadone in combination with other treatment support. More than 30 provider agencies participated in delivering these services.

Primary Policy Goal: Reduce incidence and severity of SUD symptoms

Secondary Policy Goal: Reduce jail and emergency room use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Adult Outpatient Units	50,000	Target	47,917	50,000	50,000	50,000	50,000	50,000	50,000
		Actual	36,181	43,751	26,978	30,053	31,409	30,366	20,362
		Percent	76%	88%	54%	60%	63%	61%	41%
Youth Outpatient Units	4,000	Target	3,833	4,000	4,000	4,000	4,000	4,000	4,000
		Actual	10,370	6,617	5,749	6,564	4,254	3,829	2,833
		Percent	271%	165%	144%	164%	106%	96%	71%
Opiate Treatment Program Units	70,000	Target	67,083	70,000	70,000	70,000	70,000	70,000	70,000
		Actual	66,957	82,560	72,677	79,017	88,189	53,791	21,231
		Percent	100%	118%	104%	113%	126%	77%	30%

Target Adjustments and Notes: Year 1 (11.5 months); Original target called for counting number of clients State and federal funds were available and expended first, so fewer treatment units were purchased with MIDD funds. In Year 7, more clients had access to Medicaid funds for SUD treatment, further reducing units purchased by MIDD. New targets for this strategy are recommended on Page 52.

Strategy 1a-2 Key Findings Summary

Symptoms: In February 2013, data from 2,699 adult outpatients showed the top three substances used were: alcohol (55%), marijuana (25%) and cocaine (6%). The one-year abstinence rates were highest for alcohol treatment (26%), with marijuana (24%) and cocaine (20%) slightly lower. A large sample analysis was published in the Year Seven Progress Report (August 2015).

Global Appraisal of Individual Needs (GAIN) information was available in February 2014 for 195 youth, 73 percent of whom were in treatment for marijuana. Average marijuana use “in the past 90 days” fell significantly from 36 days (Pre) to 28 (Post) for 130 youth with data at two time points. About 31 percent of youth (59 of 193) had abstained from marijuana by their second measure.

Jail Use: Adult jail use was cut in half over time for strategy participants in both OP and OTP settings (-51% in days by the fifth post period). For youth, booking reductions were often offset by increases in the number of days detained.

Emergency Department (ED) Use: While those in MIDD-funded OP reduced their use of the ED over time (-32% in Post 5), OTP clients increased use or had fairly modest declines (maximum -10% in Post 3).

Increased Number of Medicaid-Ineligible People Gained Access to SUD Treatment

Over six years, MIDD-funded services enabled 694 youth and 3,895 adults who would not have received treatment services to get the treatment they needed. Due to the Affordable Care Act coming on line in 2014, many of these people became eligible for Medicaid-supported treatment services.

Strategy 1b

Outreach & Engagement

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

1b

This strategy helps people with chronic homelessness, mental illness and addictions get the services they need from community service providers. Through partnerships with Public Health—Seattle & King County, Healthcare for the Homeless, and others, outreach is conducted to people in need of services, with priority serving people leaving hospitals and jails who would be exiting into homelessness. Outreach and engagement efforts employ principles of motivational interviewing, trauma-informed care and harm reduction.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

Secondary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	675 with 5.6 FTE	Target	239	675	675	675	675	675	675
		Actual	435	1,857	1,693	1,530	1,346	1,096	1,074
		Percent	182%	275%	251%	227%	199%	162%	159%

Target Adjustments and Notes: Year 1 (3 - 3.5 months and only 5 FTE)
Blended funds allowed more clients to be served than MIDD funds alone.

Strategy 1b Key Findings Summary

Initiative Linkage: This strategy furthers the goals of King County's Ten-Year Plan to End Homelessness (Ordinance 15284). Strategy 1b links people with services to help them exit homelessness.

The percentage of clients served under this strategy who were experiencing homelessness at the start of their services in MIDD Year Two was 69 percent. By MIDD Year Seven, this figure had risen to 75 percent. Where homeless details were known, one third of clients were experiencing homelessness for the first time at their MIDD service start, another third were intermittently housed, and the final third had experienced chronic homelessness.

Thousands of clients were successfully engaged to address the underlying factors potentially associated with homelessness, yet the cited statistics point to the growing issue of homelessness in the region.

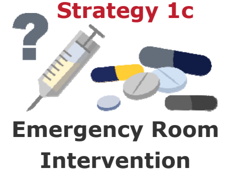
Please see the story about outreach by one strategy provider on Page 9 of this report.

Jail Use: Jail booking reductions for strategy participants in excess of 40 percent were found among those eligible for long-term analysis; days fell more than 35 percent.

Emergency Department (ED) Use: For Strategy 1b participants, total admissions to the Harborview ED were 10 percent less when comparing the pre and fifth post periods. Reductions in non-Harborview ED admissions were found (-6%) for a smaller strategy sample, as shown on Page 67.

Psychiatric Hospital Use: Short-term increases in psychiatric hospitalizations for earlier post periods were followed by a decrease of 37 percent in the fifth post period. The sum of days fell minimally over the long term (-3%).

Treatment Linkage: Within one year of MIDD service starts, 18 percent of strategy clients were linked to mental health care; 44 percent received public sector substance abuse treatment. Sobering service visits held stable for 4,630 people over their first year, from 9,333 (Pre) to 9,140 (Post 1).



Emergency Room Substance Abuse Early Intervention Program

1c

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based universal prevention practice used to engage persons who are at early risk for substance use disorders (SUD). The MIDD provides SBIRT for patients admitted to three emergency departments (ED): Harborview, St. Francis and Highline. The SBIRT approach involves establishing rapport with the person and asking to discuss their alcohol/drug use, then providing feedback, enhancing motivation for potential change, and making referrals to treatment if needed.

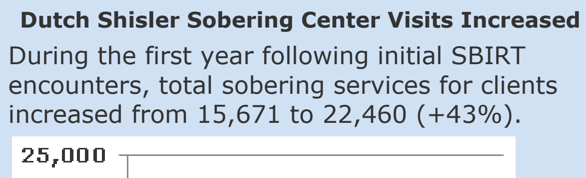
Primary Policy Goal: Reduce jail and emergency room use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Screenings	6,400 with 8 FTE	Target	3,333	4,800	6,000	5,600	5,600	4,000	4,560
		Actual	2,558	3,344	4,649	3,695	4,422	2,584	2,177
		Percent	77%	70%	77%	66%	79%	65%	48%
Brief Interventions	4,340 with 8 FTE	Target	2,260	3,255	4,069	3,798	3,798	2,688	3,092
		Actual	2,250	4,050	5,475	4,763	3,488	2,869	2,585
		Percent	100%	124%	135%	125%	92%	107%	84%

Target Adjustments and Notes:
Year 1 (5 - 9 months); Years 1 & 2 (6 FTE); Year 3 (7.5 FTE); Years 4 & 5 (7 FTE); Year 6 (5 FTE); Year 7 (5.7 FTE)
Screening numbers fell short of expectations due in part to provider prioritization of quality (time spent) over quantity.

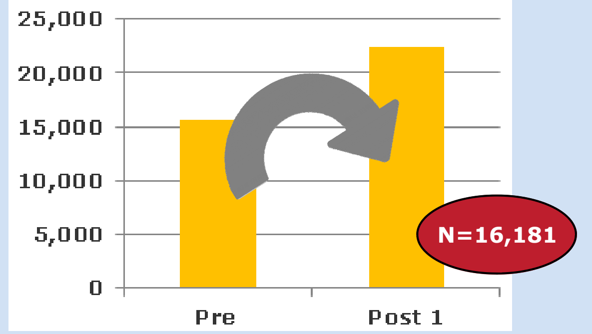
Strategy 1c Key Findings Summary

Emergency Department (ED) Use: Exclusive of Harborview admissions where SBIRT services marked the start of MIDD services for a person, total ED visits there were reduced for SBIRT participants (-36% by the fifth post period). By contrast, ED visits rose in the first year following MIDD-funded SBIRT services by more than 45 percent at Harborview and by 29 percent at other EDs in King County.



Dutch Shisler Sobering Center Visits Increased

During the first year following initial SBIRT encounters, total sobering services for clients increased from 15,671 to 22,460 (+43%).



Jail Use: Jail bookings and days rose for strategy participants by as much as 18 percent in the first two years following the first recorded SBIRT service. By the third year, jail use began to decline, with the greatest reductions noted in the fourth post period (-40% for bookings and -35% for days). Of the 2,082 clients served before July 2011 and who had any jail use, 61 percent lowered both jail bookings and days over time (64% of Harborview SBIRT clients and 53% of those initially served elsewhere).

Treatment Linkage: One of every five clients who received their first SBIRT service at Harborview Medical Center was linked to publicly-funded SUD treatment within a year of their first SBIRT service. For clients served in the south region of King County, the linkage to SUD treatment rate was 12 percent. Harborview SBIRT clients may be linked to treatment at higher rates, as they are more likely to receive brief ongoing therapy offered only at that location. Having more encounters may increase linkage rates.

Strategy 1d

Crisis Next Day Appointments

Mental Health Crisis Next Day Appointments and Stabilization Services 1d

State-funded crisis stabilization services, including next day appointments (NDAs), are enhanced with MIDD funding to provide additional services such as psychiatric medication evaluations. Following a mental health crisis, medical professionals meet with a person to perform face-to-face reviews to determine the need for medications, recommended medication adjustments and side effect/symptom management. These medical services may also be provided in consultation with primary therapists or case managers.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients with Enhanced Services	750	Target	688	750	413	285	285	285	634
		Actual	868	960	475	231	291	259	339
		Percent	126%	128%	115%	81%	102%	91%	53%

Target Adjustments and Notes:
Year 1 (11 months); Year 3 (9 months at 60% reduction); Years 4 to 6 (62% reductions); Year 7 (15% reduction)
For nearly four years, state funding for NDAs was severely cut, impacting the capacity to deliver enhanced services. Clients with medical services are counted to approximate the total number clients with enhanced services.

Strategy 1d Key Findings Summary

Jail Use: Reduced jail use peaked for NDA clients during the fourth post period. Aggregate jail bookings dropped from 851 in the pre period to 498 (-41%) and jail days were cut in half from 21,805 to 10,805 for the 2,121 people who were outcomes eligible over that time period. Of the 513 people in this group who had some jail use, 66 percent reduced their jail bookings and 67 percent reduced their jail days. Those who reduced their jail use had received slightly more medical service hours than those who did not, but the differences were not statistically significant.

Emergency Department (ED) Use: For the 1,750 strategy clients eligible for fifth post analysis, 858 (49%) had recorded admissions to Harborview's ED. The total number of admissions for this group was reduced from 1,785 (Pre) to 674 (Post 5), or 62 percent over the long term. As shown on Page 8 of this report, the ultimate goal for ED reductions was 60 percent.

Psychiatric Hospital Use: Only 218 NDA clients out of the 1,750 eligible by the passage of time (12%) had any use of community inpatient psychiatric hospitals or Western State Hospital during the fifth post period. The sum of their admissions fell from 276 in the pre period to 157 in the fifth post (-43%). The number of days hospitalized, however, was reduced by only four percent, from 3,938 days to 3,782. On average, days were reduced from 18 (Pre) to 17 (Post 5) per person served by this strategy.

Treatment Linkages: Several strategies track confirmed linkages to publicly-funded mental health (MH) treatment benefits within a year of MIDD-funded service starts. For clients who received enhanced NDAs, the linkage rate for MH treatment was 32 percent.

Strategy 1e

Chemical Dependency Trainings

Chemical Dependency Professional (CDP) Education and Training

1e

A 2010 workforce development plan was adopted by King County's Department of Community and Human Services to bring more industry-standard evidence-based practices into the substance use disorder treatment system. A key element of the plan involves training professionals in motivational interviewing, a universal skill set expected of all well-qualified CDPs. Additional trainings ensure fidelity to this and other treatment models. The MIDD provides reimbursement for expenses incurred while earning or renewing CDP or prevention professional credentials.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original and Added Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Reimbursed Trainees	125	Target	120	125	125	125	125	125	125
		Actual	165	194	344	349	374	341	345
		Percent	138%	155%	275%	279%	299%	273%	276%
Number of Workforce Development Trainees	250	Target	0	0	0	250	250	250	250
		Actual	0	0	0	253	400	369	482
		Percent	N/A	N/A	N/A	101%	160%	148%	193%

Target Adjustments and Notes: Year 1 (11.5 months); Workforce development target added in Year 4

Strategy 1e Key Findings Summary

Initiative Linkage: A 2005 Mental Health Recovery Plan (King County Ordinance 15327) called for 1) consumer-centered services and 2) strengths-based assessment and treatment planning. Professionals and trainees who learn motivational interviewing techniques through Strategy 1e are better able to meet clients where they are and to help facilitate changes chosen by clients. Clinical supervision then supports new trainees to deliver the evidence-based treatment methods with fidelity. Courses in treatment planning facilitate development of plans that are measurable, attainable, time-limited, realistic and specific. Together with new courses (see below), King County's CDP workforce remains focused on recovery.

Common Elements Treatment Approach (CETA)

A learning collaborative trained 20 clinicians, four supervisors and three consultants in CETA. This modularized cognitive-behavioral therapy offers a brief, structured intervention focused on symptom reduction for people exposed to trauma. An external evaluation of CETA found symptom score reductions for depression (-42%) and anxiety (-39%).

$ The average reimbursement per CDP/T or CPP was approximately $1,000.

Training Evaluations: Data collected immediately following each training are compared to follow-ups done 30 days later. About half of all trainees rated their training experience. Positive gains in knowledge and skills were consistently evident for the majority of those completing evaluations. Respondents also highly rated the quality and relevance of the courses offered.

Narrative responses provide insight into the skills and resources clinicians have gained by attending MIDD-funded trainings:

- "I've changed my language and started asking more open-ended questions to invite change talk. I've worked hard to stop trying to FIX the problem."
- "...remember the importance of letting a client go through the process."
- "The tools we reviewed were most helpful, for example the professional development template and the books we received."

Strategy 1f

Parent Partners Family Assistance

Parent Partner and Youth Peer Support Assistance Program

1f

A family support organization, Guided Pathways—Support (GPS) for Youth and Families, was developed in 2012 to provide services for families, by families with children or youth experiencing serious emotional or behavioral problems and/or who have substance abuse issues. Strategy 1f empowers families with information and support to promote self-determination and family well-being.

Primary Policy Goal: Link with other Council-directed initiatives

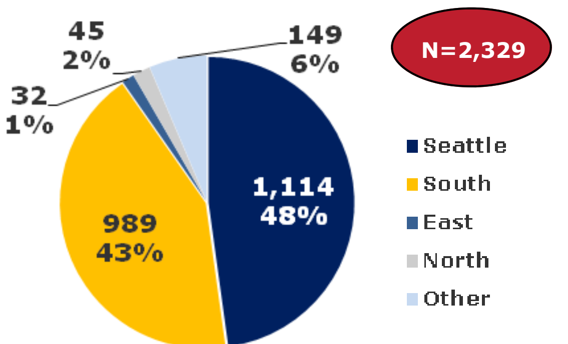
		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Individually Identified Clients	400	Target	0	0	0	0	0	200	300
		Actual	0	0	0	0	0	137	182
		Percent	N/A	N/A	N/A	N/A	N/A	69%	61%

Target Adjustments and Notes: Year 6 (startup); Year 7 (fully staffed 1/1/2015)
The implemented program design differed from the original MIDD conception.
A second target, to serve 1,000 people per year in group settings, is not shown above.

Strategy 1f Key Findings Summary

Initiative Linkage: The King County Strategic Plan adopted in 2010 (Ordinance 16897) promotes "opportunities for all communities and individuals to realize their full potential." In alignment with this initiative, GPS engages groups and individuals throughout King County to provide family assistance and support. While the number of people in individualized services has lagged below target during the startup period for this strategy, the number of people served through group outreach and education has exceeded expectations. This strategy also funds a parent partner specialist who facilitates monthly Parent Partner Network meetings.

GPS Surpassed Goal of Serving 1,000 People in Group Services in MIDD Year Seven



Other Outcomes: Key outcomes for Strategy 1f involve increasing protective factors for families and youth served, while decreasing their risk factors, by increasing knowledge of service systems and connections to natural supports. A total of 710 client visits were recorded for 289 unique people since 2013. The average number of support hours provided per person was nearly eight hours. In the grid below, services per visit are listed in descending order of frequency. Multiple services per client visit were possible.

Services Provided	N	Percent
Assisted in obtaining services*	568	80%
Systems navigation	487	69%
Life skills	466	66%
Gaining advocacy skills	359	51%
Self care	349	49%
Strengths assessment	331	47%
Basic needs assistance	197	28%
Identifying natural supports	171	24%

*Including treatment for mental illness and substance use disorders, as well as special education and other benefits.

Please see the story about GPS' new Youth Peer Partner on Page 25 of this report.

Strategy 1g

Older Adults Prevention

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

1g

Older adults receiving primary medical care through a network of "safety net" clinics have access to screening for depression, anxiety and substance use disorders (SUD). When needed, short-term behavioral health interventions are made available for people who are age 50 or older. This strategy continues to lead healthcare integration efforts and serves as a model for incorporating behavioral health care into primary care settings.

Primary Policy Goal: Reduce incidence and severity of mental illness or SUD symptoms

Secondary Policy Goal: Reduce emergency room use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	2,500 with 7.4 FTE	Target	1,875	2,196	2,196	2,196	2,196	2,196	2,196
		Actual	1,805	2,495	2,993	3,635	4,231	4,892	8,933
		Percent	96%	114%	136%	166%	193%	223%	407%

Target Adjustments and Notes: Year 1 (9 months); Years 1 to 7 (6.5 FTE)

Strategy 1g Key Findings Summary

Symptoms: As reported in February 2010, over half of all Strategy 1g participants with depression scores at two points in time reduced their symptoms (N=106). Further analysis with larger samples in August 2011 showed reductions in depression symptoms for 68 percent (N=1,096) and reductions in anxiety for 65 percent (N=742). The people who had more severe symptoms initially were more likely to improve over time. On average, successful outcomes for people served by this strategy were realized in as few as ten service visits or seven service hours (February 2012).

In August 2013, Public Health—Seattle & King County, a key partner in this strategy, reported that in cases where symptoms were not improving, 74 percent of patients received a psychiatric consultation. For most clients who received services beyond initial screening, those with more contacts and more service minutes had greater symptom reduction or stabilization.

Depression typically stabilized below the clinical threshold for concern with as few as eight hours of treatment (N=1,229), as reported in February 2014.

Emergency Department (ED) Use: Only those clients who engaged in mental health or SUD services beyond initial screening visits were entered into the outcomes analysis sample. Reductions in the total number of visits to the ED at Harborview were seen in each post period studied, with the greatest decline in the fifth post period where ED admissions dropped by 30 percent, from 589 (Pre) to 414 (Post 5), for the 341 people eligible by the passage of time and system use.

A small sample analysis explored short term changes in EDs statewide. In the new data set, first-year Harborview reductions of 23 percent were contrasted by an insignificant rise of three percent elsewhere in the state. Please see Page 67 for detailed results.

Treatment Linkages: Analysis of linkage data revealed that relatively few clients appeared to need additional publicly-funded treatment services. For mental health benefits, linkages were confirmed for 16 percent of the 4,105 people eligible within a year of their MIDD service start. The linkage figure for SUD treatment was much lower at five percent.

Strategy 1h

Older Adults Crisis & Service Linkage

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

1h

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

Primary Policy Goal: Reduce emergency room and psychiatric hospital use

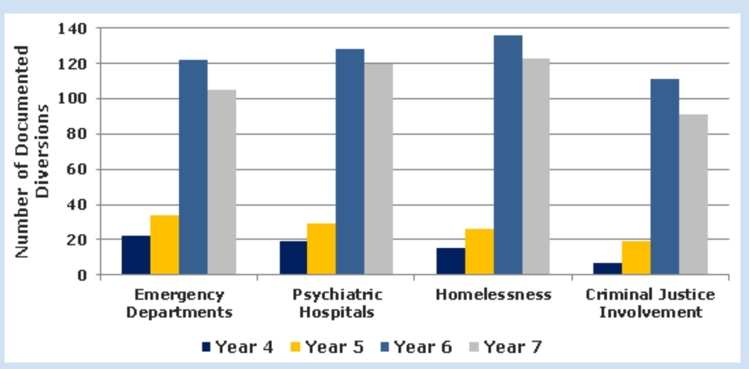
		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	340 with 4.6 FTE	Target	312	340	258	258	258	258	258
		Actual	327	444	424	326	435	443	294
		Percent	105%	131%	164%	126%	169%	172%	114%

Target Adjustments and Notes: Year 1 (11 months); Years 3 to 7 (3.5 FTE)

Strategy 1h Key Findings Summary

Specialized Outreach Crisis Intervention Helps Divert Older Adults from Costly Outcomes

In January 2012, the GRAT began tracking diversions of referred older adults from homelessness and other costly dispositions like psychiatric hospitals. The first two years of reporting counted relatively few diversions, but recent reports indicate that nearly all clients avoid entering at least one of the expensive systems or circumstances shown at right.



Emergency Department (ED) Use: After first-year increases in GRAT client visits to Harborview ED, each subsequent post period showed reductions as great as 90 percent in the fifth post period. While this period had only 53 people eligible by time and usage as explained on Page 3, the average reduction from 1.9 admissions (Pre) to 0.2 (Post 5) was statistically significant. Only nine percent of GRAT clients had used the Harborview ED during the MIDD evaluation, so it is recommended that future studies look to alternate data sources to fully understand ED utilization for this MIDD population.

Psychiatric Hospital Use: On average over the past six years, only four percent of the clients seen by GRAT were psychiatrically hospitalized. This low incidence rate led to relatively few clients being eligible for change over time analysis. In all post periods except the last, where the sample size was less than 10 people, both hospitalizations and days in the hospital tended to increase over time. One explanation for this finding may be GRAT discovery of clients with previously undiagnosed dementia, resulting in long inpatient stays after their initial MIDD services contact.

Strategy 2a
Workload Reduction

Workload Reduction for Mental Health 2a

The workload reduction strategy was designed to increase the number of direct services staff in community mental health (MH) agencies. The frequency and quality of services delivered to clients is improved when caseloads are reduced. Thus, by funding more or different staff positions, overall caseload sizes can be reduced. This strategy is aligned with goals of the Recovery and Resiliency-Oriented Behavioral Health Services Plan adopted in King County through Ordinance 17553 in April 2013.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Agencies Participating	16	Target	16	16	16	16	16	16	16
		Actual	16	16	16	17	17	16	16
		Percent	100%	100%	100%	106%	106%	100%	100%

Strategy 2a Key Findings Summary

Initiative Linkage: The workload reduction strategy allocated funds for MH provider agencies to implement new staffing plans intended to improve recovery efforts. As stated in the Recovery and Resiliency-Oriented Behavioral Health Services Plan, "...services will evolve to better support the recovery and resiliency of King County residents living with these challenges." The plan is further aligned with guiding principles of the King County Strategic Plan with core values and priorities to be collaborative, service-oriented, results-focused, accountable, fair and just, innovative, and professional.

Prior to the MIDD, at least 869 direct services staff members were employed by MH provider agencies participating in this strategy. As of September 2010, the number of direct services staff had risen to 1,160. Of the 291 additional staff brought on across the MH system to improve staff-to-client ratios and quality of care, over 45 percent were attributed to MIDD funding in summary reports submitted by each agency. By March 2011, total staffing attributed to workload reduction was 145 people, despite state budget cuts which led seven agencies to eliminate more than 75 staff positions.

A study by MIDD evaluators in 2012 assessed the impact of MIDD-funded staff increases on staff-to-client ratios. Data from 2011 for five agencies showed that each staff member served 17 to 57 clients, depending on the agency, with an average of 40 clients per staff member. Highs and lows over a four-year period balanced out such that overall caseloads were reduced from 42, on average, down to 35 clients per direct services staff member (-17%).

In the current reporting period, six agencies updated their workload reduction plans to include new direct staff positions such as peer specialists, screeners, youth counselors, housing specialists and care coordinators. One agency reported a 25 percent decrease in caseload size as a result of MIDD funding.

Despite MIDD initiatives to reduce caseloads, two key issues continue to drive agency caseloads: 1) the influx of newly eligible clients through the Affordable Care Act, and 2) the challenges of hiring and retaining qualified staff to provide mental health care.

The 2014 target for providing services to clients within seven days of hospital discharge was 84 percent; from jail was 76 percent. By year end, actual achievement of these goals was 81 percent for hospital discharges and 78 percent for jail releases.

Strategy 2b

Employment Services for Individuals with Mental Illness and Substance Use Disorders

2b

Supported employment (SE) programs help people who are enrolled in community mental health (MH) and substance use disorder (SUD) 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 job development in the client's community, and post-employment support.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	920 for both MH/SUD	Target	671	700	700	700	700	700	700
		Actual	734	820	793	834	884	935	871
		Percent	109%	117%	113%	119%	126%	134%	124%

Target Adjustments and Notes: Year 1 (11.5 months); Years 1 to 7 (MH clients only)
A pilot program for SUD clients began in 2015.

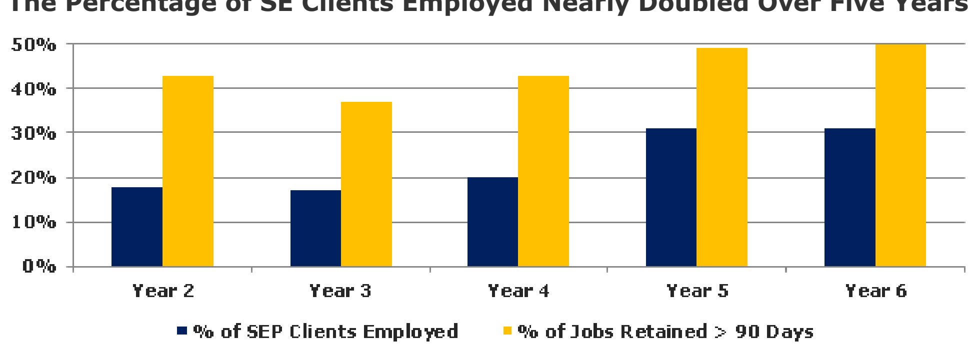
Strategy 2b Key Findings Summary

Initiative Linkage: Linked initially with the Mental Health Recovery Plan (2005) and later with the Recovery and Resiliency-Oriented Behavioral Health Services Plan (2012), MIDD Strategy 2b helps people in recovery to find and keep mainstream jobs.

Jobs: Prior to 2012, historical data showed that less than three percent of King County's publicly-funded MH treatment recipients gained employment during their benefit period. In 2012, the rate of new employment for persons receiving these year-long benefits rose to six percent. For clients actively enrolled in both a MH benefit and an SE program, employment rates rose from 18 percent as reported in MIDD Year Two to 31 percent in MIDD Year Six, as shown below.

The portion of SE jobs retained for at least 90 days rose from a low in MIDD Year Three of 37 percent to a high of 50 percent in MIDD Year Six. Of the 271 clients with one or more jobs in the sixth year, 177 (65%) kept at least one job more than 90 days.

The Percentage of SE Clients Employed Nearly Doubled Over Five Years



After demonstrating success with clients experiencing mental health challenges, the SE concept was expanded in 2015 to serve clients in SUD recovery. Given the late start for this pilot program, clients served were included in the total count shown above. A new target for MIDD Year Eight is proposed on Page 52.

Strategy 3a

Supportive Housing

Supportive Services for Housing Projects

3a

Overcoming homelessness can be especially challenging for people 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.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

Secondary Policy Goal: Link with other Council-directed initiatives

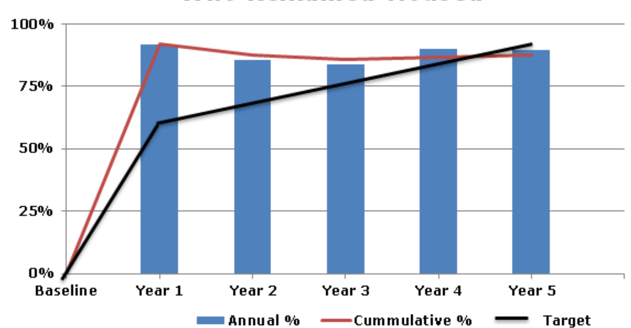
		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	Capacity grew annually until 2014	Target	70	251	445	553	614	690	690
		Actual	114	244	506	624	787	869	772
		Percent	163%	97%	114%	113%	128%	126%	112%

Target Adjustments and Notes: Year 1 (6 months)

Strategy 3a Key Findings Summary

Initiative Linkage: Linked with the Ten-Year Plan to End Homelessness in King County, Strategy 3a grew by nearly 400 percent from 2009 to 2014, from 140 to 690 "beds." Annual capacity to provide housing with supportive services grew annually until 2014. In this reporting period, renewal funding was granted to existing providers.

Housing Stability: Typically one in four exits from supportive housing is positive, including moving to independent or less intensive housing. Other exits may be due to clients' unmet medical or psychiatric needs, non-compliance with rules, criminal activity, or even client death. The good news is that nearly 90 percent of supportive housing clients remained housed over time.



Jail Use: About half of all clients housed in programs with MIDD support services had some contact with King County's criminal justice system. Remarkable jail use reductions were achieved by MIDD supported housing clients over time. For example, of the 910 clients eligible for a third post analysis, 457 had jail use data, and they collectively reduced jail bookings 60 percent, from 1,268 (Pre) to 508 (Post 3). The total number of days this group was incarcerated fell by 55 percent. Jail use was reduced by more than 70 percent (Post 5) for clients housed by Strategy 3a before October 2010.

Emergency Department (ED) Use: Harborview ED use was reduced in all five post periods studied, with the greatest reduction (-45%) in the second year after clients began services. Using a new data source, first-year reductions of 19 percent in admissions at other area hospitals (not Harborview) were found.

Psychiatric Hospital Use: One in five people in this strategy had utilized the psychiatric hospital system. The best reductions were in the first year after becoming housed for both admissions (-49%) and days (-54%).

Strategy 13a

Domestic Violence

Domestic Violence and Mental Health Services

13a

This strategy supports services for individuals dealing with the trauma of domestic violence (DV), with community agencies providing 1) screening for mental illness and substance misuse, 2) therapeutic counseling by staff mental health (MH) professionals, and 3) consultation with DV advocates and others on issues pertaining to MH and substance abuse. System coordination services are included in this strategy.

Primary Policy Goal: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Link with other Council-directed initiatives

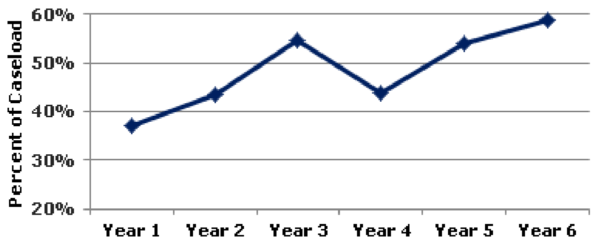
		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	560-640	Target	240	700	560	560	560	560	560
		Actual	197	489	517	514	583	558	595
		Percent	82%	70%	92%	92%	104%	100%	106%

Target Adjustments and Notes: Year 1 (3 - 7 months); Years 1 & 2 Target = 700 - 800
Target was adjusted to reflect 20% reduction in original funding plan.

Strategy 13a Key Findings Summary

Initiative Linkage: Linked with the 2010 King County Strategic Plan, Strategy 13a supports "safe communities and accessible justice systems for all" by offering survivors of DV, including children, psychosocial resources to help end the cycle of violence. Since the MIDD began, the portion of DV clients served by this strategy who identified as refugees or immigrants rose from 37 to 59 percent (see below). These clients received culturally-relevant MH services in their own languages.

Immigrants/Refugees Served at High Rate



Recent Changes in Screening Results

Comparing the current year to last year, a higher percentage of people offered screening services were willing to participate (78%, an increase of 9%). The percentage who screened negative, or without need for follow-up services, also increased from 19 percent to 23 percent.

Symptoms: As reported in August 2011, clients became eligible for symptom reduction outcomes after three separate months of therapy sessions. Of the 243 people eligible at that time, 202 (83%) agreed or strongly agreed that they were better able to manage stress in their lives.

In February 2012, additional clients provided evidence of increased coping mechanisms in surveys collected throughout the year. Every client agreed or strongly agreed with survey statements about the positive role of their MIDD therapist in helping them with stress management, decision-making, and self-care.

In the final year of using the original MIDD outcomes tool, 85 client or clinician-rated surveys were submitted. Most respondents (73%) felt they could better manage their stress after therapy (February 2013).

The therapists supported by Strategy 13a worked proactively with the systems coordinator over a two-year period to adopt new standardized outcomes measures based on symptoms. The chosen measures have yet to be validated for DV survivors and this particular service model (brief therapy on-site at DV agencies). Data will become available for analysis in 2016.

Strategy 14a

Sexual Assault Services

Sexual Assault and Mental Health Services

14a

This strategy supports trauma informed therapy services for survivors of sexual assault. By blending MIDD funds with other sources of revenue, providers can offer therapy to more of their clients. Universal screening for mental health (MH) issues and/or substance use disorders (SUD) 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 MH and drug abuse treatment agencies and the fields of domestic violence (DV) and sexual assault (SA) advocacy.

Primary Policy Goal: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	170	Target	260	400	170	170	170	170	170
		Actual	179	364	301	387	413	348	358
		Percent	69%	91%	177%	228%	243%	205%	211%

Target Adjustments and Notes: Year 1 (5 - 9 months); Years 1 & 2 Target = 400
Target was amended to reflect MIDD portion of service delivery budget.

Strategy 14a Key Findings Summary

Symptoms: Previously published evidence on outcomes for Strategy 14a is shown below.

August 2011: For 54 children and 26 adults, more than 88 percent had positive overall outcomes. Negative symptoms were reduced for 17 adults (65%).

February 2013: For 53 adults with outcomes data since the beginning of the MIDD, 49 (92%) achieved successful outcomes by meeting two or more of these metrics: understanding their experience, coping skills, symptom reduction and achieving treatment goals.

August 2013: In 2012, one sexual assault agency reported that 90 percent of clients increased their coping skills, reduced negative symptoms and/or met treatment goals.

February 2014: For youth, 29 of 32 (90%) had achieved positive outcomes related to emotional stability and behavior change during MIDD Year Five. Positive outcomes, including symptom reduction, were achieved by 71 of 80 adults (89%) in that period.

Trauma-Focused Care Nurtures Resiliency

King County's 2010 Recovery and Resiliency-Oriented Behavioral Health Services Plan speaks to the need to nurture people's inner capacity to successfully meet life's challenges. The trauma-focused therapy provided by Strategy 14a has been shown to effectively reduce debilitating symptoms resulting from sexual assault. Two agencies provide services using empirically-supported principles. A third organization uses a modified approach more suitable for their specific population.

Systems Coordination Efforts Continue

Through workshops, resource development, information dissemination, and focus group facilitation, the Systems Coordinator for Strategies 13a and 14a continued to help diverse agencies explore new ideas and to find common ground. In MIDD Year Seven, 40 consultations were provided, along with six trainings for 192 participants.

Half of all strategy clients in the past three years were immigrants or refugees.

Strategies with Programs to Help Youth

Guided Pathways—Support (GPS) for Youth and Families Added a Youth Peer Program Coordinator to Their Staff in 2015

Several strategies listed in the MIDD community-based care category also have youth-serving programs. One example is Strategy 1f—Parent Partner and Youth Peer Support Assistance Program. In 2015, GPS hired a new Youth Peer Program Coordinator. Ashley is a 26-year-old mother of four children who knows intimately many of the challenges faced by young people for whom she now advocates.

GPS Youth Peer Ashley Wrightsman-Peoples
Story and Photo by Kimberly Cisson

Ashley's parents split up when she was young. Her mother worked a lot and had mental health issues. Ashley experienced verbal, mental and physical abuse at home. As one of eight siblings, Ashley felt overwhelmed, had few social supports, and eventually became gang-involved. After a particularly poignant letdown by her mother, Ashley contacted her father and moved back to Washington from Louisiana.

Once here, she continued to struggle, becoming pregnant at 16, married at 18, then homeless with her children at 23. Ashley found shelter, but struggled with feelings of failure, and attempted suicide multiple times. Feeling misunderstood by counselors, she turned to her father for help.

Eventually she learned about peer specialists and felt she could use her own experiences to help others. She had learned from her father that she could "show people love and embrace them" in a non-judgmental way. Ashley recognizes that she is not at GPS to diagnose or medicate. Having learned Motivational Interviewing, Ashley is able to support people in their self-directed search for what they want out of life.

Strategy 1f
Parent Partners Family Assistance

Ashley builds trusting relationships with youth, goes to court with them, and follows them as they make positive progress. She often stays in touch through texting, helping youth to build resilience with her thoughtful messages.

Peers see the world through a different lens than professionals. As Ashley works on her own wellness and recovery, she helps others walking similar pathways.

Other Agencies Providing MIDD Youth Services	Type	4a	4b	4c	4d	5a	6a	7a	7b	8a	9a	13b
Auburn Youth Resources	SUD			X								
Center for Human Services	SUD			X			X					
Community Psychiatric Clinic	MH & SUD						X					
Crisis Clinic (+)	MH				X							
Friends of Youth	SUD			X								
Kent Youth & Family Services	SUD			X								
Neighborcare Health	MIDD			X								
Northshore Youth & Family	SUD			X								
Puget Sound Educational Service District	Partner			X								
Seattle Children's (Hospital)	MH			X								
Sound Mental Health (+)	MH & SUD						X					X
Superior Court, Juvenile Division	Partner					X				X	X	
Therapeutic Health Services	MH & SUD			X			X					
Valley Cities Counseling & Consultation	MH & SUD						X					
YMCA	MH								X			

(+) = Subcontractors also receive MIDD funding through these agencies.

Implementation delays

Strategy 4c

School-Based Services

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

The earliest identification of youth with mental health (MH) or substance use disorders (SUD) often occurs within school settings. Strategy 4c supports partnerships between local treatment agencies and neighboring schools, serving youth ages 11 to 15 years. Agency staff are integrated at selected middle schools to provide services that include indicated prevention and early intervention, plus screening, brief intervention and referral to treatment. Technical support is also made available to these schools by the Youth Suicide Prevention Program to bolster crisis plans and develop suicide prevention programs using best practices.

Primary Policy Goal: Reduce incidence and severity of mental illness or SUD symptoms

Secondary Policy Goal: Divert youth from initial or further justice system involvement

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Youth	2,268 with 19 programs	Target	0	0	1,550	1,550	1,550	1,550	1,550
		Actual	0	0	1,896	1,410	1,510	1,213	1,031
		Percent	N/A	N/A	122%	91%	97%	78%	67%

Target Adjustments and Notes: Years 3 to 7 (only 13 programs funded)
This strategy served 19,401 additional youth and families through group activities in MIDD Year 7.

Strategy 4c Key Findings Summary

Symptoms: As reported in August 2013, Global Appraisal of Individual Needs short screener (GAIN-SS) data for 39 students at one Strategy 4c school showed a higher incidence of internalizing disorders such as depression and anxiety (46%), than externalizing disorders like attention deficit or conduct problems. Very few (3%) scored high for substance use disorders (SUD).

In February 2015, it was reported that of the 1,043 youth served by this strategy who were eligible for outcomes, 109 (10%) had initial GAIN-SS data. In this sample, 60 percent scored high on anxiety or depression; 13 percent had high SUD screens. Data on change over is not yet available for analysis.

Detention Use: Out of the 2,037 Strategy 4c students eligible for first-year outcomes, only 28 (1%) had any utilization of King County's juvenile detention system. For this very small sample, bookings rose over the short term from six (Pre) to 50 (Post 1), while days increased from 39 to 783.

Survey Shows Strategy 4c Students More Aware of Help Available to Them

The Washington State Healthy Youth Survey (HYS) from 2012 was analyzed within the context of MIDD Strategy 4c, and detailed results were provided in February 2015. Of particular interest, the Healthy Youth Survey indicated that 90 percent of 8th graders did not drink alcohol. Of those who used alcohol, binge drinking was higher on average in 4c schools than in King County, but less than statewide. The incidence for depression was about 25 percent both statewide and in 4c schools. Suicidal thoughts were slightly lower in 4c schools than in King County as a whole. In 4c schools, 69 percent of 8th graders were aware of adults available to help them, versus only 46 percent countywide.

Washington State Healthy Youth Survey

Summary data from the 2014 HYS may be examined for inclusion in future reports.

In October 2014, Strategy 4c contracts set to expire in June 2015 were extended through December 2016 for continuity of services pending renewal decisions.

Strategy 4d

Suicide Prevention Training

School-Based Suicide Prevention

4d

In the 2012 Healthy Youth Survey, approximately 11,600 King County high school students (14% of all students) said they had made a plan to commit suicide within the past 12 months. In an effort to reduce alarming statistics such as these, MIDD youth suicide prevention trainings are delivered to both school-aged youth and concerned adults throughout the county. 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 also have opportunities to improve safety planning and their written crisis response policies.

Primary Policy Goal: Link with other Council-directed initiatives

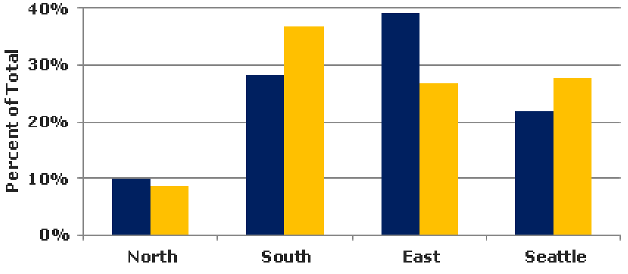
			Annual or Adjusted Targets and Performance Measurement						
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Adults	1,500	Target	192	1,500	1,500	1,500	1,500	1,500	1,500
		Actual	1,486	688	1,065	633	1,746	1,005	1,072
		Percent	774%	46%	71%	42%	116%	67%	71%
Number of Youth	3,250	Target	3,115	3,250	3,250	3,250	3,250	3,250	3,250
		Actual	4,764	7,600	7,873	8,129	8,634	9,721	8,530
		Percent	153%	234%	242%	250%	266%	299%	262%

Target Adjustments and Notes: Year 1 (11.5 months); Year 1 Target = 200 adults
Blended funds allowed more clients to be served than MIDD funds alone.

Strategy 4d Key Findings Summary

Initiative Linkage: This strategy links with King County's Strategic Plan to support safe communities. Over the past six years, trainings reached nearly three times as many youth as expected. For adults, however, attendance at the contracted 40 trainings per year has lagged below expectations. A corrective action plan was developed in 2012. Despite efforts to engage more adults, the provider only met the target one time after it was raised in 2009 to match the first year's success. More people in the east region of the county have received suicide prevention training over all MIDD years.

County's East Region Trained at Highest Rate



Early Research Demonstrated Program Effectiveness in Increasing Knowledge

The suicide prevention curriculum for youth was adopted after assessments of 2,503 youth who attended MIDD trainings in 2009 showed statistically significant increases in knowledge and/ or awareness in the following content areas:

- Teen Link (a teen crisis help line)
- Coping mechanisms
- Warning signs for people who may be suicidal
- How to help if someone seems suicidal.

For adults, 179 evaluations were analyzed and demonstrated training effectiveness in increasing knowledge about:

- Rates and incidence of youth suicide
- Signs of depression
- Suicide warning signs
- Resources and ways to help.

Expand Assessments for Youth in the Juvenile Justice System

Accurately assessing youth involved with the juvenile justice system for mental health (MH) and/or substance use disorder (SUD) issues is the capstone of Strategy 5a. The Juvenile Justice Assessment Team (JJAT) provides many screening and evaluation options for youth, including: triage, consultation, MH and SUD assessments and psychological evaluations. Referrals to psychiatric and neuropsychological evaluations within the community are also provided. This team helps teens reconnect with their families, schools and communities, as well as with appropriate treatment services to meet their behavioral health needs.

Primary Policy Goals: Divert youth from justice system involvement and reduce detentions

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original or Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Assessments Coordinated	1,200 (Revised)	Target	0	250	500	500	500	750	833*
		Actual	0	407	580	856	1,467	790	841
		Percent	N/A	163%	116%	171%	293%	105%	101%
Number of Psychological Services	200	Target	0	100	200	200	200	117	200
		Actual	0	32	98	209	186	101	311
		Percent	N/A	32%	49%	105%	93%	86%	156%
Number of Mental Health Assessments	140	Target	0	70	105	140	140	117	140
		Actual	0	124	143	128	123	116	139
		Percent	N/A	177%	136%	91%	88%	99%	99%
Number of Full SUD Assessments	165	Target	0	82	145	165	165	165	165
		Actual	0	251	234	420	291	225	190
		Percent	N/A	306%	161%	255%	176%	136%	115%

Target Adjustments and Notes: Year 2 (50% capacity); Years 3, 6 & 7 (staff vacancies)
The target for coordinations was 500 in Years 2 to 5, increasing in Year 6 to account for inclusion of quick screenings.

Strategy 5a Key Findings Summary

Symptoms: In August 2012, baseline data from the Global Appraisal of Individual Needs (GAIN) were summarized for 159 participants in Strategy 5a. Prior to any SUD treatment, only 12 of these JJAT youth (8%) had not used marijuana in the past 90 days, compared to 49 youth (31%) who had not used alcohol.

A follow-up GAIN analysis in February 2014 found that the average number of days in the past 90 with marijuana use fell from 40 (Pre) to 33 (Post). For youth who used alcohol, 57 percent of them reduced their frequency of alcohol use over time.

Detention Use: Of 299 JJAT youth eligible for fifth post outcomes by time alone, 217 (73%) were detained. Detention bookings for this group were reduced from 536 (Pre) to 287 (Post 5), nearly meeting the targeted goal of reducing youth detentions by 50 percent over five years (See Page 8).

Treatment Linkage: Within one year of their first JJAT contact, 345 of 2,049 youth (17%) were linked with mental health benefits paid via public funding. Similarly, 368 youth (18%) had confirmed linkages to SUD treatment.

* During Year 7, the coordination target was adjusted due to: 1) multiple staff turnovers (including a six-month vacancy in the position conducting short screeners), 2) the amount of time needed to onboard new staff, and 3) the fact that juvenile filings were down over five percent from January to September 2015 compared to a year ago, resulting in fewer arraignments and fewer assessments.

Strategy 6a

Wraparound

Wraparound Services for Emotionally Disturbed Youth

6a

Wraparound is an evidence-based practice that coordinates both formal and informal supports 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 community 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.

Primary Policy Goals: Divert youth from justice system involvement and reduce detentions

Secondary Policy Goal: Reduce incidence and severity of mental illness symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Enrolled Youth	450	Target	0	920	374	450	450	450	450
		Actual	0	282	414	520	635	593	558
		Percent	N/A	31%	111%	116%	141%	132%	124%

Target Adjustments and Notes: Year 2 (enrolled youth plus their siblings); Year 3 (staff vacancies) Only enrolled youth could be counted, so target was revised in 2010.

Strategy 6a Key Findings Summary

Detention Use: Only 25 percent of youth in Wraparound had any detention bookings. The number of days these youth were detained increased in all post periods, except the fifth (slight decline of –4%).

Other Outcomes: Evidence of the effectiveness of this strategy to meet other MIDD goals were published previously:

August 2013: An independent analysis by the King County Children's Mental Health Planner showed improved behavior, rule compliance, and school performance for 159 youth with multiple scores.

February 2015: Behavioral information was available for 638 youth with service starts before April 2014. Property damage and harm to others were both reduced markedly over time, while compliance with household rules increased significantly. At one year after initial assessment, 42 percent of caregivers felt youth behavior had improved, compared to only 28 percent surveyed at the six-month mark. Caregivers reported reductions in perceived problem severity across 21 items measured, such as worry, sadness and caregiver strain.

Independent Fidelity Review Pinpointed Strengths and Areas to Improve

Results of the University of Washington's fidelity review for MIDD Wraparound programs were made available in January 2015. Key strengths identified were:

- Linking families to community resources
- Involving caregivers in the child/family team
- Celebrating family successes.

Two areas for further development included: 1) increasing efforts to inform and engage families at the start, and 2) helping families build skills for success after exit.

Independent Outcomes Evaluation Highlighted Program Successes

Reports completed by Wraparound Evaluation & Research Team found that as a result of MIDD Wraparound:

- Full-time school enrollment increased
- School suspensions decreased
- Emergency room use decreased
- Fewer youth used substances
- Fewer youth were arrested.

Strategy 7b

Expand Youth Crisis Services

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

Youth crisis services were expanded in 2011 to address increased demand and to augment staffing with in-home behavioral support specialists. The CCORS team provides direct assistance to families in order to maintain troubled youth safely in their own homes and communities. The MIDD also partially supports marketing and communication efforts for the purpose of increasing awareness about CCORS services. Brochures and posters are available to the public in four languages: English, Spanish, Somali and Vietnamese.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

Secondary Policy Goal: Divert youth from justice system involvement

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Enrolled Youth	300	Target	0	0	0	300	300	300	300
		Actual	0	0	0	951	959	1,030	1,043
		Percent	N/A	N/A	N/A	317%	320%	343%	348%

Target Adjustments and Notes: Blended funds allowed more youth to be served than MIDD funds alone.

Strategy 7b Key Findings Summary

Detention Use: Of 2,710 CCORS youth eligible for first year outcomes, only 298 (11%) had juvenile justice detentions. The total number of both detention bookings and days increased greatly for this group between the pre and first post period. By the third post analysis, the observed increases in detention use were less dramatic as shown on Page 65. Due to the late start for this strategy, longer term data are not yet available to show any reductions.

Emergency Department (ED) Use: Admissions for CCORS youth to Harborview's ED decreased in the second post period by 28 percent, but increased in both the first and third post periods by as much as 14 percent. Admissions to EDs other than Harborview during the first year after their MIDD start date were studied for 487 youth. The total number of admissions at these other hospitals rose from 140 (Pre) to 243 (Post 1), a 74 percent increase. Detailed results of this analysis appear on Page 67.

Psychiatric Hospital Use: Fewer than 10 percent of outcomes-eligible youth had any psychiatric hospitalizations. After increases in admissions and days during the first post period, admissions declined by 13 percent in the second post, and by 33 percent in the third. The total number of days psychiatrically hospitalized increased in all post periods for those youth who received community inpatient psychiatric services.

Many Youth in Crisis Were Diverted from Hospitalization and Achieved Housing Stability

Detailed information was provided for 4,382 unique cases since MIDD funding of CCORS began. Of the 3,599 cases with direct services, outreach was provided for 35 percent, and crisis stabilization was provided for the remainder.

Where hospital diversion was listed as the referral reason (N=1,504), 68 percent of youth were diverted from hospitals, 20 percent were voluntarily hospitalized, and only 12 percent were involuntarily hospitalized.

Where the residential arrangement upon exit from services was known (N=2,232), 81 percent of youth remained in their homes and five percent returned home from other living arrangements.

Strategy 8a

Family Treatment Court

Family Treatment Court Expansion

8a

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 reunite. Enrolled individuals are closely monitored by this specialized therapeutic court throughout their substance use disorder (SUD) recovery, with the goal of minimizing their children's involvement in the child welfare system.

Primary Policy Goals: Reduce jail recycling and incidence and severity of SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Children in Families Served	90	Target	34	45	90	90	90	90	120
		Actual	27	48	83	103	90	93	103
		Percent	79%	107%	92%	114%	100%	103%	86%

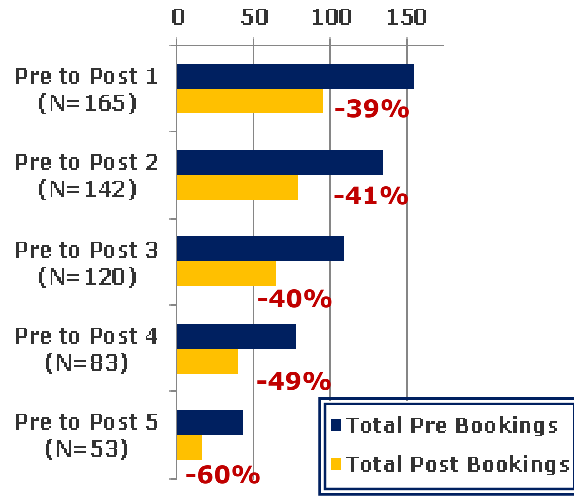
Target Adjustments and Notes: Year 1 (9 months); Years 1 & 2 Target = 45 (adjusted in 2011 due to budget proviso) Cap was lifted in Year 7 to allow 120 children per year, not to exceed 60 at any one time (FTC monitors capacity).

Strategy 8a Key Findings Summary

Using data provided by the court, 172 clients out of 193 (89%) were admitted to SUD treatment. About half enrolled in outpatient treatment, while the other half had both inpatient and outpatient care.

Jail Use: At least half of all participants in FTC had jail use other than the events that led to their enrollment in this therapeutic court. In all post periods, jail bookings declined over time as shown in the graphic below. The greatest reduction in the total number of days jailed (not shown) was 51 percent, recorded in the fifth post period.

Jail Bookings Ultimately Reduced by 60 Percent



Symptoms: As reported in August 2015, 139 adults in FTC were time eligible for substance use reduction outcomes. Information on SUD treatment admissions was matched to 86 of these people, the majority of whom were female (82%). The primary substance used by the most people was methamphetamine (27%), followed by cocaine and alcohol at 20 percent each.

Periodic milestone data, or information gathered at six-month intervals on changes in substance use over time, was available for 49 people. Thirty individuals (61%) reported no substance use in the 30 days before outpatient treatment began and had no change in use over time. Seventeen of the remaining 19 who said they did use substances (79%) decreased their use between admission and the first milestone time point.

For those without milestone data, changes were assessed using only admission and discharge data. Sixteen of the 36 people who reported using a substance in the month before treatment (44%) showed less use by their discharge time point.

The overall percentage of FTC clients with any outcomes data who reduced their substance use to zero (abstinence) or stayed use free over time was 78 percent.

Strategy 9a
Juvenile Drug Court

Juvenile Drug Court Expansion

9a

Juvenile Drug Court (JDC) expansion under the MIDD has allowed more youth living in the south region of King County to receive therapeutic court services, often in lieu of incarceration. The MIDD funded five additional positions: four specialized juvenile probation counselors and one treatment liaison. The court offers weekly hearings and introduces youth to substance use disorder (SUD) treatment through a number of different engagement track options.

Primary Policy Goals: Divert youth from justice system involvement and reduce SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of New Youth	36 with 5.5 FTE	Target	27	33	36	36	36	36	36
		Actual	29	41	26	50	84	76	89
		Percent	107%	124%	72%	139%	233%	211%	247%

Target Adjustments and Notes: Year 1 (9 months); Year 2 (5 FTE); Years 1 to 3 Target = opt-ins only
Program was re-designed in 2011 due to declining referrals—new tracks were offered and all youth were counted.

Strategy 9a Key Findings Summary

Detention Use: The best detention use outcomes were found in the fourth post period for JDC youth. Of the 93 youth enrolled prior to July 2011, 77 (83%) had one or more detention bookings in either the year before their MIDD start or in the fourth year after. Their total number of detention bookings fell by 48 percent, from 212 to 110. The total number of days detained, however, decreased by only 12 percent (from 2,622 to 2,311 days) over that same time period. With larger samples over time, the results are expected to improve.

All JDC Graduates Were Successfully Admitted to SUD Treatment

A total of 217 youth exited from MIDD-funded JDC services prior to September 2015. Of those, 106 (49%) had either successfully completed their engagement track or had graduated from the program after opting in. The remaining 111 (51%) opted out before completion, were terminated from the program or left early for other reasons.

For program graduates, the SUD treatment enrollment rate was 100 percent, compared to only 77 percent for those who completed the engagement track. The enrollment rate for youth who left the program before completing a track was also very high, at 93 percent.

Treatment Linkage: Enrollment in publicly-funded SUD treatment within a year of their MIDD service starts was confirmed for about half of all JDC youth. Since the overall SUD treatment enrollment rate as reported by the court was over 80 percent, it is likely that some JDC youth had access to private sector treatment through parental insurance.

Symptoms: Substance use symptom reduction was studied in February 2014 for six males enrolled in JDC. When combined with youth from other MIDD strategies, including 139 who participated in Strategy 5a - Juvenile Justice Youth Assessments, it was found that marijuana was the drug used most often. In the combined study sample, average days without any drug or alcohol use in the past 90 days rose from 50 to 60 (a 20% increase in “clean” days). The total number of youth reporting abstinence from substances rose from 22 to 60, a 173 percent increase. The very small number of youth in the “JDC only” sample precludes reporting of their results separately, but it should be noted that there is a great deal of overlap between youth strategies. In the current period, half of all JDC youth had also been served by the assessment team.

Strategy 13b

Domestic Violence Prevention

SAFE PLACES

Domestic Violence Prevention

13b

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 DV-related trauma effects on children and non-abusive parents. The availability of CDVRT services in the south region of the county has been greatly enhanced because of the MIDD. The CDVRT integrates mental health (MH) treatment with effective DV prevention/intervention practice.

Primary Policy Goals: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Unique Families	85	Target	78	85	85	85	85	85	85
		Actual	102	144	134	147	135	144	155
		Percent	131%	169%	158%	173%	159%	169%	182%

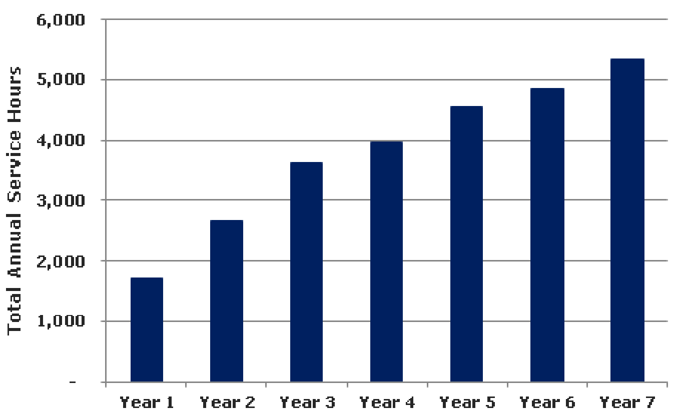
Target Adjustments and Notes: Year 1 (11 months)

Strategy 13b Key Findings Summary

Initiative Linkage: King County's commitment to creating safe communities is evident in strategic planning efforts, informed partly by a countywide needs assessment of infants, children and youth exposed to DV. The Safe and Bright Futures for Children Initiative (2004) explored the needs of this vulnerable population and recommended formulation of the CDVRT to mitigate the impacts of DV on children. In 2008, the MIDD furthered this aim by funding a second team whose geographic focus area was south King County. More recently, King County's 2014 Youth Action Plan (Ordinance 17738) reiterated the need to invest in prevention resources for youth exposed to adverse childhood experiences.

Total service hours delivered to CDVRT-South families increased each year since the MIDD began, as shown.

Total Service Hours Increased Year After Year



Symptoms: As reported in February 2012, a Pediatric Symptom Checklist (PSC-17) is used to screen children for CDVRT services. This instrument rates levels of internalizing, externalizing and attentional behaviors with a maximum score of 34. Total scale scores over 14 are considered above the clinical threshold, and about half of all children had screened above this level, indicating problems exist.

In 2013, an analysis of symptom reduction was completed using 97 cases with PSC-17 measures taken at least two months apart. Scores dropped below the threshold of concern for 43 children (44%) at some point during their treatment. Those who reduced symptoms were in treatment on average for 17 months versus only 14 months for those remaining at elevated symptom levels.

A recent study of 253 unique children with at least one PSC-17 measure after treatment began showed that 116 (46%) scored below the clinical threshold at some point during treatment.

Jail and Hospital Diversion Strategies

Moral Reconation Therapy (MRT) Really Does Work

L knows from experience that MRT works. Not only did he successfully complete the MRT program himself, but he now facilitates MRT groups and watches proudly as others succeed.

Raised in Texas during the 1960s, L spent more of his life incarcerated than free. Growing up, he saw many atrocities against African Americans, such as people being nailed to trees, having their skin burned off, and even hangings, including his own uncle. Seeing members of his community victimized, he developed hatred for and distrust of white people.

He first went to jail for stealing a bicycle when he was six years old and refusing to tell the cops who his parents were. They put him in an adult jail. From there, L continued to get in trouble and ended up in the State School for Boys where he was physically abused and sexually assaulted by the guards who were supposed to protect him. He became "hardened, only fit for incarceration" and quickly ended up back in jail after each release. He developed an institutionalized way of looking at life. Suffering from depression, there was no place for compassion in prison. He sat with his back to the wall and protected himself. Trust was not an option. He developed the view that all people lie, cheat and steal.

After relocating to the Seattle area, L continued to be in and out of both jail and prison. He went through MRT four times before he reached a point in his life when he really tried to apply the principles to his life. Where previously he fell back into a pattern of dishonesty, he realized that he had to be honest in order to build trust with people. Caught in the cycle of our criminal justice system, battling mental health and substance use issues, he slowly began to "accept life on life's terms" with help from Community Center for Alternative Programs (CCAP), Adult Drug Court, MRT and South Seattle Community College.

Strategy 12d

Behavior Modification Classes

RIGHT WAY
WRONG WAY

L said, "If I can change MY life, just think of how many lives can be changed!" Hope is essential, and "MRT gives you an opportunity to truly look at yourself." He is currently lobbying for people involved in the criminal justice system, especially around housing and life skills. Applying MRT principles to his own life, he encourages others to make similar changes, all while completing classes to become a chemical dependency counselor.

Story and Photo by Kimberly Cisson

Agencies Providing MIDD Diversion Services	Type	10a	10b	11a	11b	12a	12b	12c	12d	15a	16a	17a	17b
Catholic Community Services	MH & SUD										X		
City of Seattle	Partner				X								X
Community House	MH										X		
DESC	MH & SUD		X								X		
Harborview	MH & SUD						X	X					
KC Department of Adult & Juvenile Detention (+)	Partner					X			X				
King County Judicial Administration (+)	Partner									X			
Plymouth Housing Group	MIDD										X		
Public Health (+)	Partner						X						
Sound Mental Health (+)	MH & SUD			X	X	X			X		X		
Transitional Resources	MIDD										X		
Valley Cities Counseling & Consultation	MH & SUD										X		
WA State Criminal Justice Training Comission	Partner	X											

(+) = Subcontractors also receive MIDD funding through these agencies.

Non-MIDD funding secured

Strategy 10a

Crisis Intervention Team Training

Crisis Intervention Team (CIT) Training for First Responders

10a

Specialized trainings introduce law enforcement officers and other first responders to concepts, skills and resources that can assist them when responding to calls involving people with mental illness or substance use disorders. Delivered at the Washington State Criminal Justice Training Commission in partnership with the King County Sheriff's Office, CIT trainings focus on diverting people to appropriate services while maintaining public safety. Funds also reimburse agencies, as needed, for backfill when officers are in training.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of 40-Hour Trainees	180	Target	0	0	375	180	180	180	180
		Actual	0	0	275	256	251	200	199
		Percent	N/A	N/A	73%	142%	139%	111%	111%
Number of One-Day Trainees	300	Target	0	0	1,000	300	300	300	300
		Actual	0	0	626	266	268	657	553
		Percent	N/A	N/A	63%	89%	89%	219%	184%
Number of Other Trainees	150	Target	0	0	0	150	150	150	150
		Actual	0	0	0	185	163	159	312
		Percent	N/A	N/A	N/A	123%	109%	106%	208%

Target Adjustments and Notes: Year 3 Targets = 375 40-hour and 1,000 one-day trainees were too high
In Years 6 & 7, accommodations were made in order to train all Seattle Police Department officers in CIT.

Strategy 10a Key Findings Summary

Initiative Linkage: King County's Adult & Juvenile Justice Operational Master Plans (2000 and 2002) support collaborative work across partners "to ensure that the criminal justice system is fair, effective, efficient, and integrated." Making better use of alternatives to incarceration is a primary focus these initiatives. A review of Seattle Police Department data in 2015 found that arrests and use of force were very rare for people who were in drug-induced or mental health crises, due largely to enhanced CIT training and the deployment of trained officers.

Both Course Feedback and Independent Evaluations Support Program Effectiveness

Since CIT trainings began in October 2010, trainees have been asked to evaluate their learning experiences. The two classes with the highest "excellent" ratings over time (above 75%) were Excited Delirium and Communicating with Persons with Mental Illness/De-Escalation Techniques. Evaluation results are used to continuously improve the relevance and usefulness of all courses.

In 2012 and 2013, two external consulting firms evaluated the CIT training program. Identified strengths included availability to many agencies, quality control procedures, strong instructors and adherence to the CIT curriculum model. Suggested improvements included reviewing course learning objectives, building on topics in systematic order and grouping the resource topics into a panel with a question-and-answer format. Mock scenarios reinforced proficiency in CIT principles.

In June 2015, Seattle University's Department of Criminal Justice published findings on the effect of CIT curriculum changes on officer attitudes and knowledge. Using pre/post surveys, the researchers showed clear training effects with respect to support for CIT and broad cultural support for the CIT model. Every officer surveyed felt that CIT training was helpful and many wanted more training.

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

10b

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

Primary Policy Goals: Divert from and reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	3,000	Target	0	0	0	500	3,000	3,000	3,000
		Actual	0	0	0	359	2,353	2,905	3,352
		Percent	N/A	N/A	N/A	72%	78%	97%	112%

Target Adjustments and Notes: Year 1 (2 months)
Individuals are counted once for participation in each of the three different program components.

Strategy 10b Key Findings Summary

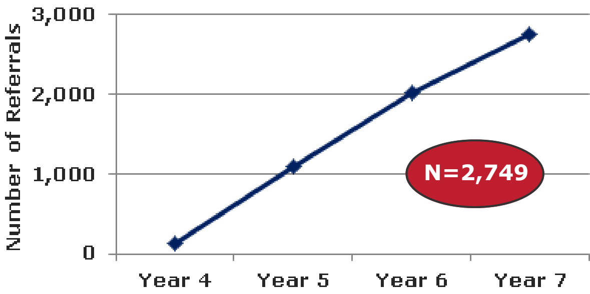
Jail Use: Delayed implementation of Strategy 10b has impacted the availability of long-term outcomes data. Of the CSC clients eligible for a third post analysis, jail bookings were reduced from a total of 184 to 140 (-24%). Days incarcerated, however, rose from 3,024 (Pre) to 3,427 (Post 3), an increase of 13 percent. Neither change was statistically significant.

Emergency Department (ED) Use: First-year increases in the use of the ED at Harborview were calculated at 51 percent. At other area EDs, the increase was found to be 22 percent. By the third year post period, admissions at Harborview were reduced by 28 percent.

Psychiatric Hospital Use: Psychiatric hospitalizations, including stays at Western State Hospital, decreased slightly (-5% in Post 2) and (-8% in Post 3), after increasing by 87 percent in the first post period. The total number of days housed in inpatient psychiatric care settings increased in all post periods when compared to the number of psychiatric hospital days in the year prior to each person's first CSC intake.

Other Outcomes: Two indicators of system-level performance were examined with data available from November 2011 to August 2015. The total number of referrals to behavioral health treatment increased over time as shown in the graphic below. Note that multiple referrals per person were possible, but more than a single referral per CSC admission was rare.

Nearly 3,000 Treatment Referrals Made



Documented diversions from area hospitals were common (nearly 4,500 over four years), while jail diversions were fairly rare (262 over that period). The provider could record only one diversion per admission to the CSC, so it is possible that jail diversions were underreported in the data. The greatest number of total diversions was recorded in MIDD Year Five at 1,739.

Strategy 11a

Increase Jail Liaison Capacity

Increase Jail Liaison Capacity

11a

During court proceedings, judges occasionally assigned individuals to King County Work and Education Release (WER), a program where clients can go to work, school or treatment during the day and return to a secure facility at night. Liaison services were available to WER participants prior to completion of their court-ordered time. The liaison's job involved linking clients to services and resources, such as housing and transportation, to reduce recidivism risks. In 2014, the capacity at WER was reduced from 160 to 79, so the work of the liaison was expanded to serve additional criminal justice system populations.

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

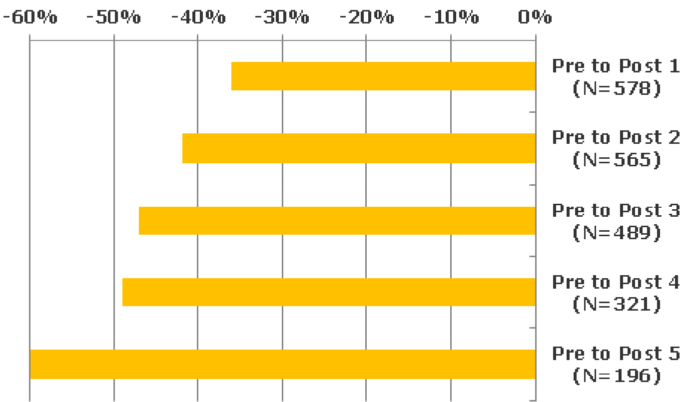
		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	200	Target	270	200	200	200	100	50	100
		Actual	116	279	195	192	69	13	35
		Percent	43%	140%	98%	96%	69%	26%	35%

Target Adjustments and Notes: Year 1 (9 months); Years 5 & 6 (staff vacancies); Year 7 (reduced capacity)
Year 1 Target = 360 (The initial target was based on previous liaison figures, but referrals were lower than expected.)
A new target was not set for MIDD Year 8, as program continues to adapt to try to reach its adjusted target.

Strategy 11a Key Findings Summary

Jail Use: Eight of ten Strategy 11a clients had jail utilization beyond the booking episode associated with their start of MIDD liaison services. The total number of jail bookings was reduced in all five post periods as shown below. The greatest reduction in aggregate jail days (not shown) was in the fifth post period (-29%).

Liaison Services Paired With Fewer Jail Bookings



Treatment Linkage: Of the 700 WER liaison clients who were eligible for analysis of first post outcomes, about one in four was linked with public sector behavioral health treatment within one year of their MIDD start date.

Treatment linkage rates varied by demographic variables. For example, clients linked to treatment were four years older, on average, than those not linked. Caucasians were linked to mental health treatment at a much lower rate (21%) than other ethnic groups, such as African American or Black (31%), Asian/Pacific Islander (32%) and Native American (42%). Those of Hispanic origin were more likely to be linked to SUD treatment (35%) than non-Hispanics (22%).

In a sample of 311 WER liaison clients, 57 (18%) were permanently housed at exit from services and 121 (39%) had temporary or transitional housing. The portion released to institutions was 20 percent and the remaining 23 percent experienced homelessness.

Strategy 11b

Increase Services for New or Existing Mental Health Court Programs

11b

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 over time to provide: 1) a court liaison for the Municipal Court of Seattle's Mental Health Court (SMHC) that handles legal competency cases for people booked into jail on charges originating in the City of Seattle; 2) forensic peer support for opt-ins to RMHC; and 3) a Veteran's Track piloted and now operating within the existing RMHC.

Primary Policy Goal: Divert clients with mental illness from justice system involvement

Secondary Policy Goal: Reduce incidence or severity of mental illness symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of RMHC Opt-In Clients	28 expansion cases	Target	0	44	57	38	57	28*	28
		Actual	0	26	31	22	53	44	28
		Percent	N/A	59%	54%	58%	93%	157%	100%
Number of SMHC Clients Screened	300	Target	0	0	0	50	300	300	300
		Actual	0	0	0	268	318	303*	287
		Percent	N/A	N/A	N/A	536%	106%	101%	96%

Target Adjustments and Notes: Year 2 (startup); Year 4 (staff vacancies); Years 2 to 5 Target = 57 expansion opt-ins RMHC underwent several revisions, including adding a target of 83 RMHC non-expansion cases in 2013 (not shown above). Year 4 Target = 50 SMHC clients who were not competent to stand trial
* Corrections to previously reported information were made here.

Strategy 11b Key Findings Summary

Expansion cases for RMHC are those opting in after referral from cities throughout King County. In MIDD Year Six, when funding switched from supplantation to core MIDD for all therapeutic courts, tracking of the non-expansion cases was added, including felony drop downs and misdemeanors, as shown on Page 56. Over 40 veterans were among those served this period by RMHC.

SMHC Independently Evaluated in 2013

Law and Policy Associates reported that only 24 percent of clients who successfully completed SMHC had any jail bookings in the two years afterwards, compared to 95 percent of those who failed to finish. Even non-completers increased their use of mental health services, however, and lowered jail use rates after participating in court supervision. The MIDD funds one court liaison position for SMHC.

Jail use: Deep reductions in jail bookings were found for both SMHC clients (-64% in Post 3) and RMHC clients (-57% in Post 4). The total number of jail days fell at less dramatic rates, with the maximum reduction coming for RMHC participants in the fourth post period (-22%).

Symptoms: About half of all RMHC and SMHC clients were linked to publicly-funded mental health treatment within a year of their service start. For a sample of 472 people who had anxiety and depression scores at two different points in time, it was found that 74 percent stayed stable over time. For remaining cases where change could be measured, 104 of 124 people with anxiety scores (84%) improved at some point during treatment. For depression, the improvement rate was 83 percent.

Strategy 12a-1

Jail Re-Entry & Education Classes

PLAN

Jail Re-Entry Program Capacity Increase

12a-1

Short-term case management services are provided to incarcerated individuals with mental health (MH) issues and/or substance use disorders (SUD) who are near their release date. Originally expanded through the MIDD to serve more people jailed in the county's south and east regions, MIDD now funds the base program, as previously available state funding was cut. Community reintegration and reduced recidivism are the primary goals of the jail re-entry program.

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	300 with 3 FTE	Target	480	200	250	300	300	300	300
		Actual	297	258	260	258	213	213	214
		Percent	62%	129%	104%	86%	71%	71%	71%

Target Adjustments and Notes: Year 1 (split with 12a-2); Year 2 (2 FTE); Year 3 (2.5 FTE)
Year 1 Target = 1,440 for all 12a combined
A new target was not set for MIDD Year 8, as program continues to adapt to try to reach its adjusted target.

Strategy 12a-1 Key Findings Summary

Jail Use: The number of clients eligible for fifth post outcomes in this strategy was 423. Of those, 364 (86%) had at least one jail booking unrelated to the one that connected them with MIDD services. Jail bookings were reduced for this group by 66 percent, from 1,220 (Pre) to 418 (Post 5). Total days in jail were reduced by 67 percent, from 30,928 (Pre) to 10,177 (Post 5). These long-term reduction rates are expected to improve even further as the size of the outcomes-eligible sample grows over time.

Treatment Linkages: Confirmed linkages to behavioral health treatment were studied for 1,100 people eligible for first post outcomes. Within a year of their MIDD service start, 412 clients (37%) began MH services and 362 (33%) were enrolled in treatment for substance issues. Individuals linked to treatment did not differ by race, Hispanic origin, or veteran status from those who were not linked.

Housing: In a sample of 516 jail re-entry clients with data on housing status at exit, the number of people permanently housed was 80 (16%). Another 162 had temporary or transitional housing (31%), while the rest experienced either homelessness (42%) or further institutionalization (11%). The rate of homelessness was much higher for this strategy than for Strategy 11a (at 23%).

King County Criminal Justice Initiative (CJI) Provided Overarching Vision for Re-Entry

The CJI was launched in 2003 to reduce long-term jail utilization by implementing ten programs that provided housing, MH and SUD services, and assistance for people involved with the local criminal justice system. The state legislature then implemented Jail Transitions Services in 2005, providing additional financial backing for CJI services. Adoption of the MIDD Plan in 2007 called for expanding these types of services to adults exiting King County jails, especially in the county's south and east regions. With the economic downturn of 2008, state funding for re-entry services became scarce and local MIDD funding was essential in filling the gaps and preserving the continuity of comprehensive, recovery-centered services. Programs under the CJI umbrella were rigorously evaluated and evidence of their effectiveness is available on the county website.

Strategy 12a-2

Jail Re-Entry & Education Classes

PLAN

Education Classes at Community Center for Alternative Programs (CCAP)

12a-2

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

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	600	Target	960	600	600	600	600	600	600
		Actual	114	449	545	579	520	590	532
		Percent	12%	75%	91%	97%	87%	98%	87%

Target Adjustments and Notes: Year 1 (split with 12a-1); Year 1 Target = 1,440 for all 12a combined
Individuals are counted once for participation in each different program component.

Strategy 12a-2 Key Findings Summary

Strategy 12a-2a: The Learning Center

Jail Use: In the fifth post period, aggregate jail bookings went down by 57 percent and the associated days in jail were reduced by 50 percent. For this sample of 152 people with jail bookings beyond those related to MIDD start dates, 54 percent had taken Life-Skills-to-Work (LSW) classes, while 46 percent took GED. Slightly more LSW students reduced their jail days (79%) over this long term than GED students (73%), but the difference was not statistically significant.

Overall, more males (83%) engaged in LSW or GED education opportunities than females (17%), but long-term jail use reductions were equally evident for both gender groups.

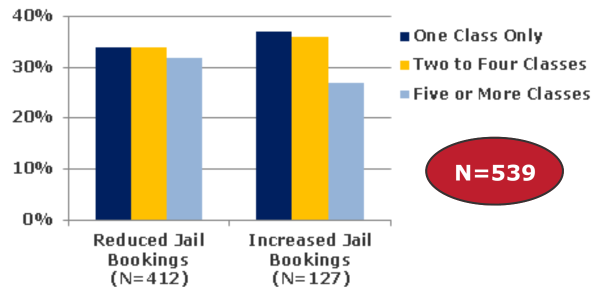
In late 2014, South Seattle College released outcomes for CCAP students enrolled in TLC programs. Of 1,492 in LSW, 435 (29%) had completed the program as of 9/27/2014. For GED, 205 of 1,131 (18%) received an equivalency certificate. These results included individuals enrolled prior to availability of MIDD funding.

Strategy 12a-2b: DV Classes at CCAP

Jail Use: Like those who took education classes at TLC, individuals taking DV courses at CCAP also reduced their jail use over the long range. By the fifth post period, bookings were down by 62 percent and the total number of days recorded for the 269 people who began services prior to July 2010 was reduced from 7,352 to 4,730 (-36%).

An analysis to examine the relationship between the number of DV courses taken and jail use change over time used data from the third post period. As shown below, reduced jail bookings did not appear to be dependent on the number of classes taken. For students whose bookings increased, however, a slightly higher percentage had taken only one class, as opposed to five or more classes.

Class Attendance Differences by Jail Use Changes



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

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 adults without housing who need a safe place to recuperate upon discharge from area hospitals. The MIDD helps provide mental health (MH) and substance use disorder (SUD) services, including case management, treatment referrals and housing linkages.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	350-500	Target	0	0	29	350	350	350	350
		Actual	0	0	26	342	395	334	366
		Percent	N/A	N/A	90%	98%	113%	95%	105%

Target Adjustments and Notes: Year 3 (1 month)

Strategy 12b Key Findings Summary

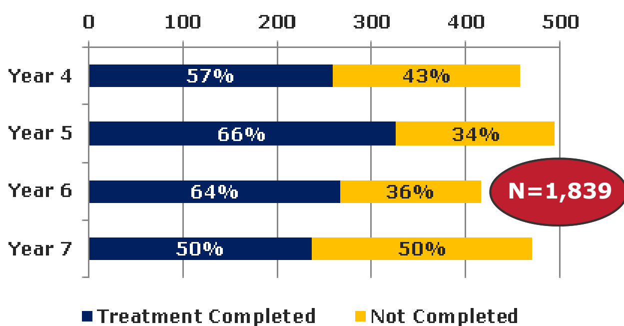
Jail Use: Delayed implementation of this strategy means that outcomes information for strategy participants is only available through the third post period. Total jail bookings were reduced from 231 (Pre) to 141 (Post 3), a 39 percent reduction. Aggregate jail days remained steady at 3,290 over this analysis period, as longer sentences were received in the third post period.

Emergency Department (ED) Use: Total admissions to the ED at Harborview fell from 842 to 586 (-30%) by the third post period, overcoming increases of 47 percent in the first year post. Using a new data source, first year Harborview increases were confirmed, accompanied by reductions (-9%) at other area EDs.

Psychiatric Hospital Use: Only about nine percent of the people who used the medical respite program had any psychiatric hospitalizations over the various outcomes study periods. In the third post period, total admissions were reduced from 36 to 11 (-69%), but the total number of days hospitalized at Western State Hospital or at inpatient psychiatric hospitals in the community rose from 340 to 441 (+30%).

Other Outcomes: Using exit data since medical respite was expanded, treatment completions varied slightly year to year, as shown below. Of the 1,087 patients who successfully completed treatment, 727 (67%) were sheltered, transitionally housed or permanently housed at exit.

Program Completions Outpaced Early Exits



Respite Program Earns Innovation Grant

The Centers for Medicare & Medicaid Services chose the medical respite program as a 2014 recipient of an innovation grant award. The goal of this grant is to improve health, reduce readmissions and reduce costs. The program will track patients receiving respite services in an effort to decrease hospital readmissions by 20 percent and to reduce the length of hospital stays by 30 percent.

Strategy 12c
Psychiatric Emergency Services Linkage

Increase Harborview's Psychiatric Emergency Services (PES) Capacity 12c

For Strategy 12c, intensive case managers use assertive techniques to engage reluctant clients 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 work together with people experiencing homelessness to find solutions to problems that formerly presented insurmountable barriers to their successful investment in more traditional systems of care.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	75-100	Target	69	75	75	75	75	75	75
		Actual	87	175	111	77	104	86	81
		Percent	126%	233%	148%	103%	139%	115%	108%

Target Adjustments and Notes: Year 1 (11 months)

Strategy 12c Key Findings Summary

Jail Use: Reductions in jail bookings for PES clients were evident for each post period studied, with the greatest drop (-65%) calculated in Post 5. The maximum reduction in jail days was 34 percent (Post 4).

Emergency Department (ED) Use: Harborview ED admissions fell from a total of 2,517 (Pre) to 809 (Post 5), a long-term reduction of 68 percent.

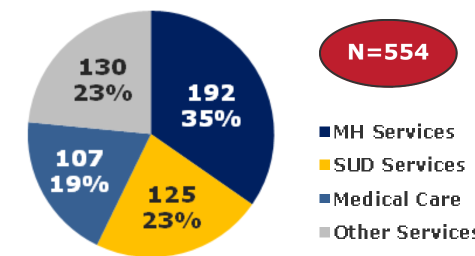
Psychiatric Hospital Use: At 30 percent, this strategy had the second highest average incidence of psychiatric hospital use for all eleven strategies listing this measure as a relevant outcome. Reductions topped out during the third post period for both admissions (-62%) and days (-40%), following increases during the first post period of more than 20 percent.

Intervention Reduced Hospital Charges

In a poster presentation at the 2015 National Behavioral Health Conference, Harborview PES shared that patients reduced ED use by 55 percent and inpatient charges by 63 percent. Pre/post studies showed a significant decline in ED charges for high utilizers receiving brief intensive case management ($5.5M to $2.2M).

Other Outcomes: Referrals to mental health (MH) and substance use disorder (SUD) treatment and other services were tracked over the course of MIDD funding for 338 PES clients. Multiple referrals per person were possible. The total number of referrals made, which differ from confirmed linkages, are shown in the graphic below.

Mental Health Referrals Were Most Common



Treatment Linkage: Within one year of starting MIDD services, 223 of the 462 eligible clients (48%) were linked with public sector MH benefits. Slightly fewer individuals were linked to SUD treatment, at 37 percent. A higher percentage of the Asian/Pacific Islanders and multiracial individuals served (over 80%) were linked to MH treatment. A higher percentage of Native Americans clients served (53%) began SUD treatment.

Strategy 12d

Behavior Modification Classes

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

12d

Moral Reconation Therapy (MRT) is an evidence-based cognitive-behavioral treatment program proven to be especially effective for clients with substance use disorders (SUD). With MIDD funding, a certified MRT facilitator works with enrolled clients to enhance moral reasoning, to improve their decision-making skills, and to help them engage in more appropriate behaviors. In October 2014, the clinician funded by MIDD transitioned to facilitating MRT classes for a group of individuals assigned to CCAP for domestic violence (DV) offenses.

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

Secondary Policy Goal: Reduce incidence or severity of mental illness or SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Original Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	100	Target	25	100	100	100	100	100	40
		Actual	42	79	131	189	162	129	43
		Percent	168%	79%	131%	189%	162%	129%	108%

Target Adjustments and Notes: Year 1 (3 months); Year 7 Target = 40 (change in target population served)

Strategy 12d Key Findings Summary

Jail Use: Total jail bookings for MRT clients were reduced in all five post periods studied. Days associated with these bookings rose in the first two post periods, then fell in the last three. For the 94 people eligible for the fifth post period analysis, aggregate bookings were reduced from 162 to 42 (-74%); jail days declined from 2,943 to 1,087 (-63%).

An analysis was done using a sample of 116 MRT clients who began services before July 2012 and had both level-of-completion information and some change in jail use over time. On average, those who reduced their jail bookings had slightly higher levels of completion than individuals whose jail bookings increased. Reductions in jail days, however, appeared to be more closely related to service completions. For example, only half of those at the lowest completion level reduced jail days compared to 64 percent of clients with higher completion levels. Of the 38 people who had fewer than 30 service hours, 26 (68%) reduced jail days, while 22 of 27 with over 125 service hours (82%) reduced jail days.

Symptoms: Problem Severity Summary (PSS) scores were available at two different time points for 235 MRT participants. Anxiety scores remained stable for 113 people (48%). Of the remaining 122 people who experienced a change, 103 (84%) had improved symptoms as some point during their program participation. For depression, half of all clients remained stable, but 101 of the 117 with change over time (86%) showed improvements.

In a report entitled "Describing the Community Center for Alternative Programs Client Population Behavior Health Needs" written for calendar year 2010, author Geoff Miller used data from the Global Appraisal of Individual Needs Short Screener (GAIN-SS) to show the need for mental health and substance use disorder treatment. In a sample of 530 CCAP clients, 366 (69%) screened indicating probable high severity behavioral health treatment needs. Co-occurring disorders were evident in 334 of these clients (63%).

Please see the client success story for MRT on Page 34 of this report.

Strategy 15a

Adult Drug Court

Adult Drug Court Expansion of Recovery Support Services

15a

The Adult Drug Court (ADC) within King County's Judicial Administration has offered clients supplemental services with MIDD support. In addition to enhancing educational opportunities for people with learning disabilities, the ADC employs 1.5 housing case management specialists. These case managers help clients with substance use disorders (SUD) find and keep drug-free housing. In 2012, the court secured eight recovery-oriented transitional housing units with on-site case management for transition age youth (18 to 24 years), replacing Young Adult Wraparound. In 2015, MIDD evaluation began tracking all ADC clients in the base court, in addition to those engaged in the expansion services.

Primary Policy Goal: Divert clients with SUD from justice system involvement

Secondary Policy Goal: Reduce incidence or severity of SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Clients	250 expansion cases	Target	113	300	250	250	250	250	250
		Actual	125	337	313	294	268	261	388
		Percent	111%	112%	125%	118%	107%	104%	155%

Target Adjustments and Notes: Year 1 (3 months); Year 1 Target = 450; Year 2 Target = 300
Adding a target of 300 base court cases (non-expansion) per year has been recommended on Page 52.

Strategy 15a Key Findings Summary

Jail Use: Participants in ADC reduced their jail bookings in each of the five post periods studied. The third and fourth post samples reduced use by 57 percent each, with the fifth period sample topping out at 59 percent. The sum of jail days for individuals in their first program year rose from 29,822 (Pre) to 72,502 (Post 1), an increase of 143 percent. Reductions were evident by the third post (-27%), followed by greater long-term declines in excess of 40 percent.

Analysis of services indicated that higher levels of participation may have a positive impact on jail use changes over time. For example, using the fourth post sample, 72 percent of clients with less than two hours of housing case management reduced their jail bookings versus 78 percent of those with more than two hours.

In a recent analysis, 78 percent of ADC clients reduced drug use to zero or stayed drug free from admission to discharge.

Symptoms: As reported in the MIDD Year Seven Progress Report (August 2015), 937 ADC clients were eligible for outcomes assessment. Case matching found 1,199 treatment starts for 629 people (a 67% match rate). The average number of treatment episodes per person was 1.9, whereby each episode spanned from admission to discharge or loss to follow-up. The most common substance used by ADC clients was marijuana (22%).

Changes in drug use were assessed at two time points, depending on data availability, as shown.

Many people report no drug use in the 30 days before they start treatment.

	Admission to First Milestone		**Admission to Discharge**	
	N	%	N	%
Decreased use	43	74%	168	46%
Increased use	13	22%	21	6%
Use not changed	2	3%	177	48%
Total with use	58	100%	366	100%
No use/No change	159	-	569	-
Total cases	217	-	935	-

Strategy 16a

New Housing & Rental Subsidies

New Housing Units and Rental Subsidies

16a

Prior to full implementation of the MIDD, Strategy 16a appropriated capital funding to expedite construction of new housing units to benefit the 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, so those clients are tracked here, rather than on Page 22. This strategy also provides 25 rental subsidies per year, from previously allocated funds.

Primary Policy Goals: Reduce jail, emergency room and psychiatric hospital use and link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	**Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**
Number of Tenants	25	Target	0	25	25	25	25	25	25
		Actual	0	25	31	29	28	26	23
		Percent	N/A	100%	124%	116%	112%	104%	92%
Number of Rental Subsidies	25	Target	38	50	40	40	25	25	25
		Actual	27	52	52	41	31	25	19
		Percent	71%	104%	130%	103%	124%	100%	76%

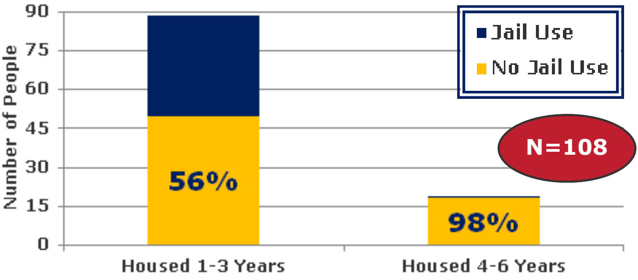
Target Adjustments and Notes: Year 1 (9 months); Years 1 & 2 Target = 50 + Years 3 & 4 Target = 40 (subsidies)

Strategy 16a Key Findings Summary

Initiative Linkage: As stated in 2007's King County Council Ordinance 15949, programs funded by the MIDD were intended to "enable the implementation of a full continuum of treatment, housing and case management services that focus on the prevention and reduction of chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency." Linked with King County's Ten-Year Plan to End Homelessness, the MIDD budgeted $18 million in 2008 and another $6.4 million in 2009 toward housing capital expenditures. These funds supported seven housing projects that created 335 new "beds" for individuals coping with mental illness or substance use disorders. Since the start of the Ten-Year Plan, 6,314 new units of permanent housing with supportive services were created, bringing the countywide total in 2015 to 8,337 units, yet homelessness persists and continues to rise in the region.

Jail use: Reductions in aggregate jail bookings for strategy clients ranged from 40 percent (Post 1) to 77 percent (Post 4). Days in jail were reduced by a maximum of 74 percent, from 2,099 days (Pre) to 555 (Post 4). No jail use was recorded for 98 percent of the 19 clients who remained housed for at least four years as shown below.

Housing Retention Related to Jail Use



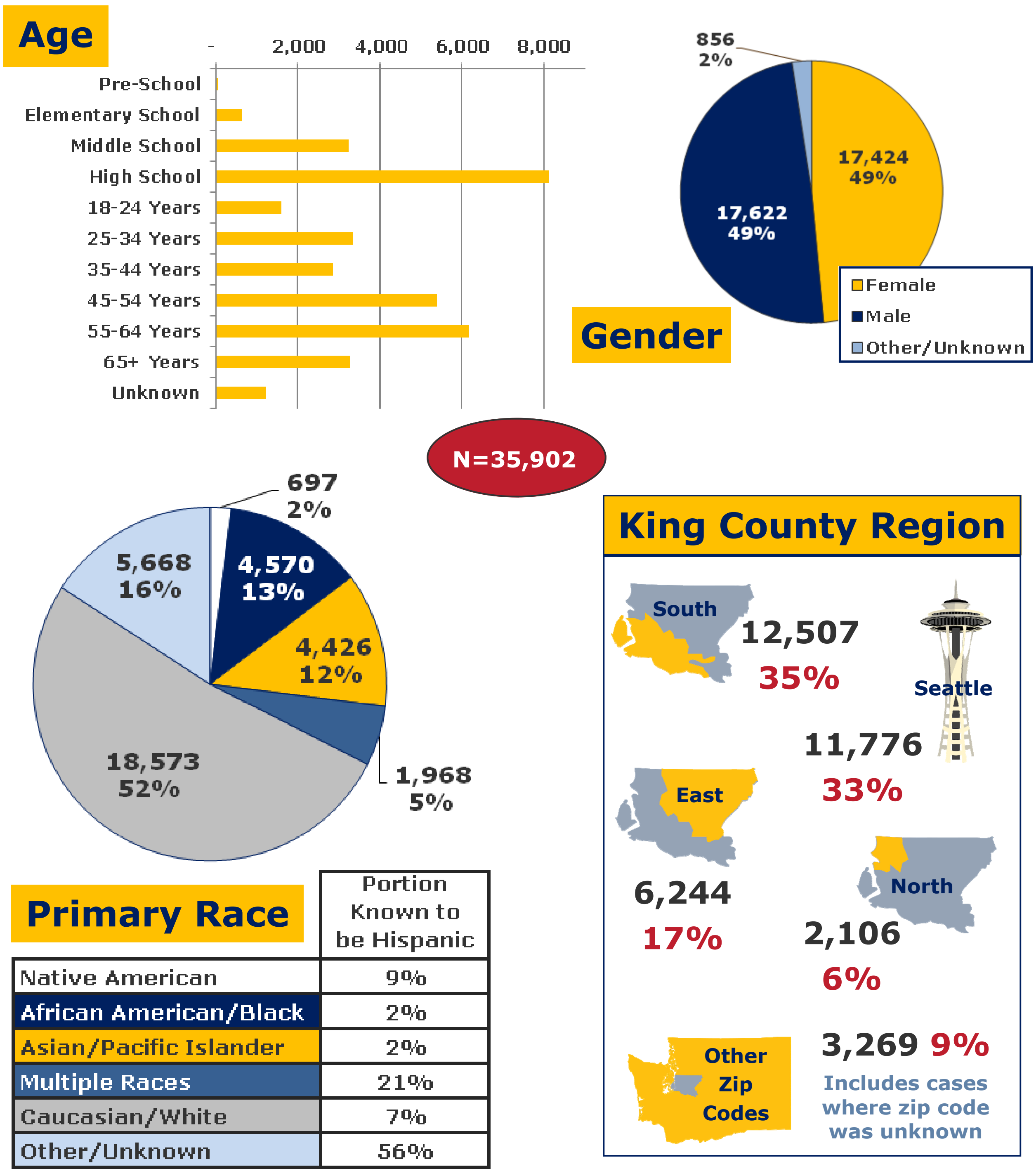
Emergency Department (ED) Use: Harborview ED admissions declined in all five post periods. The greatest decline was 49 percent (Post 4).

Psychiatric Hospital Use: Both psychiatric hospitalizations (-77%) and days (-86%) were reduced the most in the fifth post period.

MIDD Demographics and Access to Services

Information on age group, gender, primary race and King County region was available for 35,902 unduplicated people who received at least one MIDD-funded service between October 2014 and September 2015. Those with duplicate demographics across strategies and multiple data sources were counted only once here. The number of unduplicated people with demographics represents a six percent increase over the prior year, largely due to a substantial increase in older adults screened in primary care settings. Even more clients, who could not be unduplicated, were served in large groups through school-based services (N=19,401) and the MIDD's family support organization (N=2,329).

Demographic Distributions for Unduplicated MIDD Year Seven Clients



Primary Race	Portion Known to be Hispanic
Native American	9%
African American/Black	2%
Asian/Pacific Islander	2%
Multiple Races	21%
Caucasian/White	7%
Other/Unknown	56%

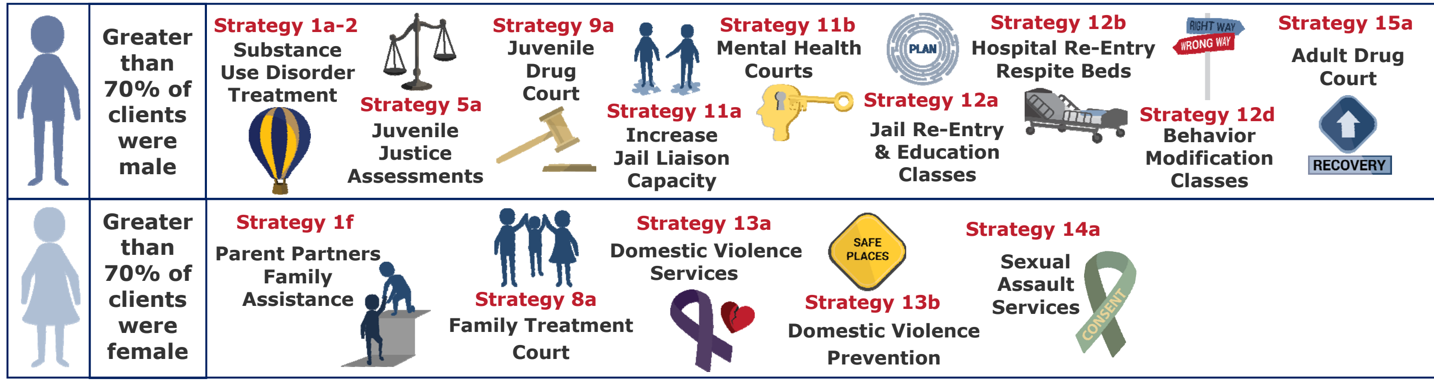
Demographic Profiles by MIDD Strategy Using Representative Samples

	MIDD Strategies	Earliest MIDD Start	Sample Size*	Gender			Race			Veteran Status			Age		
				Female	Male	Other or Unk	White	Persons of Color	Unk	Yes	No	Unk	Child or Youth	Adult	Unk
1a-1	Mental Health Treatment	10/1/2008	8,588	51%	49%	0%	46%	54%	0%	4%	64%	31%	16%	84%	0%
1a-2	Substance Use Disorder Treatment	10/1/2008	11,777	29%	71%	0%	51%	40%	9%	3%	77%	20%	11%	89%	0%
1b	Outreach & Engagement	7/1/2009	4,637	37%	62%	1%	55%	36%	9%	5%	83%	12%	0%	97%	3%
1c	Emergency Room Intervention	1/1/2009	16,192	34%	66%	0%	64%	33%	3%	7%	88%	5%	1%	99%	0%
1d	Crisis Next Day Appts	10/1/2008	2,820	43%	57%	0%	65%	35%	0%	3%	47%	50%	0%	100%	0%
1e	Chemical Dependency Trainings														
1f	Parent Partners Family Assistance	8/5/2013	137	91%	9%	0%	49%	50%	1%	0%	96%	4%	0%	98%	2%
1g	Older Adults Prevention	1/1/2009	11,359	58%	42%	0%	52%	36%	12%	4%	68%	28%	0%	100%	0%
1h	Older Adults Crisis & Svcs Link	10/1/2008	2,206	63%	37%	0%	81%	19%	0%	17%	61%	22%	0%	100%	0%
2a	Workload Reduction														
2b	Employment Services	10/1/2008	2,867	49%	51%	0%	54%	46%	0%	3%	65%	32%	0%	100%	0%
3a	Supportive Housing	1/1/2009	1,290	31%	69%	0%	50%	48%	2%	15%	79%	6%	0%	100%	0%
4a	Parents in Recovery Services														
4b	SUD Prevention for Children														
4c	School-Based Services	7/7/2011	1,979	54%	46%	0%	35%	61%	4%	0%	0%	100%	98%	2%	0%
4d	Suicide Prevention Training	(Years 4-6)	29,868	44%	44%	12%	44%	40%	16%				89%	11%	0%
5a	Juvenile Justice Assessments	7/1/2009	2,048	28%	72%	0%	32%	67%	1%	0%	1%	99%	96%	4%	0%
6a	Wraparound	7/1/2009	1,267	32%	68%	0%	57%	42%	1%	0%	22%	78%	95%	5%	0%
7a	Youth Reception Centers														
7b	Expand Youth Crisis Services	10/1/2011	2,710	53%	47%	0%	50%	39%	11%	0%	9%	91%	98%	2%	0%
8a	Family Treatment Court	1/1/2009	164	81%	19%	0%	53%	46%	1%	3%	96%	1%	1%	99%	0%
9a	Juvenile Drug Court	1/1/2009	247	21%	79%	0%	19%	72%	9%	0%	20%	80%	96%	4%	0%
10a	Crisis Intervention Team Training														
10b	Adult Crisis Diversion	10/1/2011	3,465	42%	58%	0%	60%	31%	9%	7%	59%	34%	0%	100%	0%
11a	Increase Jail Liaison Capacity	1/1/2009	700	1%	99%	0%	45%	47%	8%	5%	61%	34%	0%	100%	0%
11b	Mental Health Courts	10/1/2010	1,354	28%	72%	0%	54%	44%	2%	5%	68%	27%	0%	99%	1%
12a	Jail Re-Entry& Education Classes	1/1/2009	3,536	26%	71%	3%	42%	42%	16%	2%	38%	60%	0%	97%	3%
12b	Hospital Re-Entry Respite Beds	10/1/2011	913	22%	78%	0%	60%	37%	3%	9%	87%	4%	0%	100%	0%
12c	Psychiatric Emergency Svcs Link	10/1/2008	462	23%	77%	0%	54%	45%	1%	6%	65%	29%	0%	100%	0%
12d	Behavior Modification Classes	7/1/2009	584	17%	83%	0%	52%	47%	1%	4%	62%	34%	0%	100%	0%
13a	Domestic Violence Services	2/1/2009	2,030	95%	1%	4%	50%	49%	1%	1%	96%	3%	0%	98%	2%
13b	Domestic Violence Prevention	10/1/2008	984	68%	32%	0%	50%	48%	2%	1%	66%	33%	57%	39%	4%
14a	Sexual Assault Services	10/1/2008	1,191	84%	14%	2%	48%	51%	1%	3%	83%	14%	34%	65%	1%
15a	Adult Drug Court	10/1/2008	1,054	28%	72%	0%	42%	57%	1%	5%	94%	1%	0%	100%	0%
16a	New Housing & Rental Subsidies	10/1/2008	161	44%	56%	0%	61%	38%	1%	3%	68%	29%	0%	100%	0%

* Samples of MIDD participants with service starts prior to 9/30/2014, unduplicated within stategy.

Grayed strategies were not implemented or do not currently track individual-level demographic information.

Highlighted Demographic Differences by MIDD Strategy



Top Three Strategies Serving Persons of Color

Strategy 4c

School-Based Services

Strategy 5a

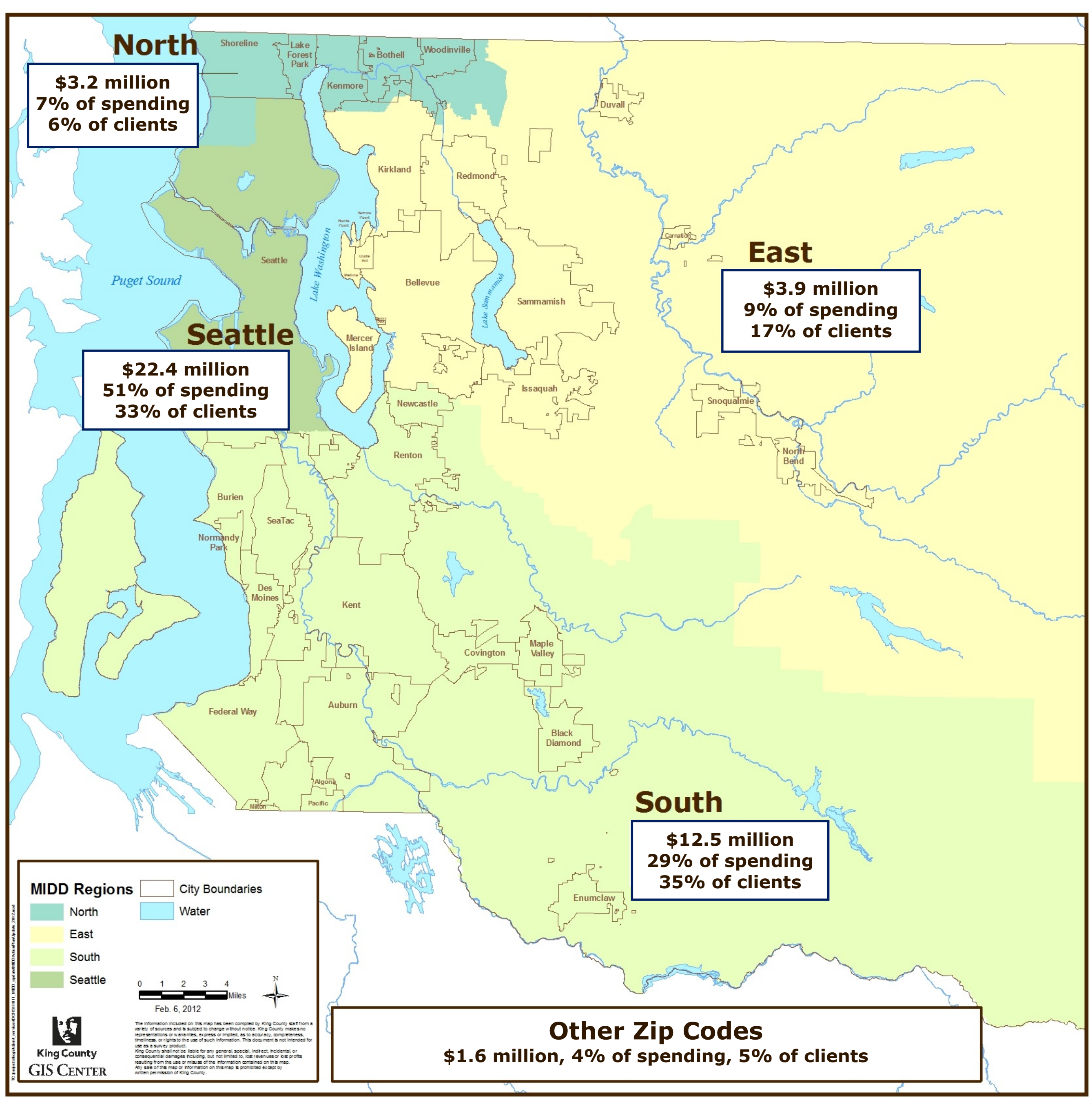
Juvenile Justice Assessments

Strategy 9a

Juvenile Drug Court

Homeless status was tracked for 29,273 cases (one person per strategy) in the current period. Of those cases, 5,886 (20%) were experiencing homelessness. More than 80 percent of clients in Strategy 1b—Outreach & Engagement and Strategy 12b—Hospital Re-Entry Respite beds were not housed at the start of MIDD services.

Approximate 2015 MIDD Spending Exclusive of Supplantation Expense and Percent of Year Seven Clients by King County Region



For most strategies, known and valid zip codes for MIDD program participants between October 2014 and September 2015 were used to calculate approximate regional distributions for each MIDD strategy. Where zip codes were not available (four percent of all MIDD Year Seven clients), provider catchment areas or other location data contributed to determining regional distributions. Actual funds expended during calendar year 2015 (January 1 through December 31, 2015) were then apportioned to each King County region by multiplying the total strategy expense, as reported in Parts I and II of the MIDD Financial Report (see Pages 49 and 50), by the regional distributions for each strategy. The rounded sums of all strategy expenditures attributed to each region are shown above. Supplantation expenses, in excess of $8.5 million during 2015, are not factored into this graphic. Four strategies with spending over $2 million each were heavily weighted toward the Seattle region: Strategy 2a—Workload Reduction, Strategy 3a—Supportive Housing, Strategy 10b—Adult Crisis Diversion, and Strategy 11b—Mental Health Courts.

MIDD Financial Reports

Financial information provided over the next three pages is for calendar year 2015 (January 1 through December 31, 2015). The MIDD sales tax fund spent just over $49.3 million in strategy, therapeutic courts, and other funding and over $8.5 million in MIDD supplantation. The unreserved fund balance on December 31, 2015 was nearly $9.2 million. Parts I and II show budgeted and actual spending by category. Also included in the financial report are detailed supplantation spending, summary revenues/expenditures, and fund balance information. Please note that strategies 13a and 14a share funds, as needed.

	Strategy	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)	Actual vs Budget (Rounded)
1a-1	Increase Access to Community Mental Health Treatment & Club House	$ 8,042,759	$ 7,319,006	91%
1a-2	Increase Access to Community Substance Abuse Treatment	$ 2,485,124	$ 3,333,243	134%
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities	$ 502,100	$ 473,292	94%
1c	Emergency Room Substance Abuse Early Intervention Program	$ 660,790	$ 594,464	90%
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	$ 228,700	$ 253,693	111%
1e	Chemical Dependency Professional Education and Training	$ 688,542	$ 714,254	104%
1f	Parent Partner and Youth Peer Support Assistance Program	$ 380,465	$ 466,811	123%
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	$ 450,000	$ 439,906	98%
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	$ 319,653	$ 319,653	100%
2a	Workload Reduction for Mental Health	$ 4,000,000	$ 4,000,000	100%
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	$ 1,000,215	$ 1,161,455	116%
3a	Supportive Services for Housing Projects	$ 2,000,000	$ 2,000,000	100%
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	$ 1,277,853	$ 1,180,704	92%
4d	School-Based Suicide Prevention	$ 202,954	$ 200,000	99%
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 179,006	$ 142,068	79%
6a	Wraparound Services for Emotionally Disturbed Youth	$ 4,565,770	$ 4,363,035	96%
7a	Reception Centers for Youth in Crisis	$ -	$ -	
7b	Expansion of Children's Crisis Outreach Response Service System	$ 507,366	$ 506,096	100%
8a	Expand Family Treatment Court Services and Support to Parents	$ 82,476	$ 76,108	92%
9a	Expand Juvenile Drug Court Treatment (See Part II)	$ -	$ -	
10a	Crisis Intervention Team Training for First Responders	$ 775,278	$ 538,292	69%
10b	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	$ 6,190,100	$ 5,680,206	92%
11a	Increase Jail Liaison Capacity	$ 81,256	$ 57,919	71%
11b	Increase Services for New or Existing Mental Health Court Programs	$ 703,404	$ 624,937	89%
12a	Jail Re-Entry Program Capacity Increase	$ 323,988	$ 322,464	100%
12b	Hospital Re-Entry Respite Beds	$ 516,011	$ 507,272	98%
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	$ 202,954	$ 202,954	100%
12d	Behavior Modification Classes for CCAP Clients	$ 76,107	$ 83,264	109%
13a	Domestic Violence and Mental Health Services	$ 254,720	$ 318,064	125%
13b	Domestic Violence Prevention	$ 227,308	$ 227,308	100%
14a	Sexual Assault, Mental Health and Chemical Dependency Services	$ 404,880	$ 325,285	80%
15a	Drug Court: Expansion of Recovery Support Services	$ 103,778	$ 103,685	100%
16a	New Housing Units and Rental Subsidies	$ -	$ -	
	Behavioral Health Data Integration - MIDD Data System	$ 982,633	$ 982,633	100%
	MIDD Evaluation and Treatment Capital	$ 1,214,770	$ 1,214,770	100%
	Sexual Assault Supplantation	$ 362,000	$ 362,000	100%
	MIDD Administration	$ 3,121,252	$ 3,208,454	103%
	Total MIDD Operating Dollars	**$ 43,114,212**	**$ 42,303,296**	**98%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)	Actual vs Budget (Rounded)
	Department of Judicial Administration	**$ 1,636,165**	**$ 1,492,027**	**91%**
	Adult Drug Court Base	$ 1,636,165	$ 1,342,564	82%
15a	Drug Court: Expansion of Recovery Support Services	$ -	$ 149,463	
	Prosecuting Attorney's Office	**$ 1,247,185**	**$ 1,281,670**	**103%**
	Adult Drug Court Base	$ 583,770	$ 646,303	111%
	Juvenile Drug Court Base	$ 121,774	$ 81,185	67%
	Mental Health Court Base	$ 541,641	$ 544,712	101%
11b	Mental Health Court Expansion	$ -	$ 9,470	
	Superior Court	**$ 1,702,141**	**$ 1,718,256**	**101%**
	Adult Drug Court Base	$ 172,480	$ 171,899	100%
	Juvenile Drug Court Base	$ -	$ -	
	Family Treatment Court Base	$ -	$ -	
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 235,182	$ 221,546	94%
8a	Expand Family Treatment Court Services and Support to Parents	$ 672,591	$ 712,706	106%
9a	Expand Juvenile Drug Court Treatment	$ 621,888	$ 612,105	98%
	Sheriff Pre-Booking Diversion	**$ 175,527**	**$ 171,161**	**98%**
10a	Crisis Intervention Team Training for First Responders	$ 175,527	$ 171,161	98%
	Department of Public Defense	**$ 1,482,761**	**$ 1,423,325**	**96%**
	Adult Drug Court Base	$ 638,434	$ 719,720	113%
	Juvenile Drug Court Base	$ 83,443	$ 82,274	99%
	Mental Health Court Base	$ 440,119	$ 301,247	68%
	Family Treatment Court Base	$ 320,765	$ 320,000	100%
8a	Expand Family Treatment Court Services and Support to Parents	$ -	$ -	
9a	Expand Juvenile Drug Court Treatment	$ -	$ -	
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 84	
	District Court	**$ 1,039,385**	**$ 925,412**	**89%**
	Mental Health Court Base	$ 1,039,385	$ 918,693	88%
11b	Mental Health Court Expansion	$ -	$ 6,719	
	Total Other MIDD Funds	**$ 7,283,163**	**$ 7,011,850**	**96%**
	Total All MIDD Funds	**$ 50,397,375**	**$ 49,315,146**	**98%**

Mental Illness and Drug Dependency Fund - Supplantation Details

Strategy	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)	Actual vs Budget (Rounded)
MIDD Supplantation			
Department of Adult and Juvenile Detention	**$ 367,363**	**$ 367,360**	**100%**
Community Center for Alternate Programs (CCAP)	$ 28,644	$ 28,644	100%
Juvenile MH Treatment	$ 338,719	$ 338,716	100%
Jail Health Services	**$ 3,738,671**	**$ 3,648,425**	**98%**
Psychiatric Services	$ 3,738,671	$ 3,648,425	98%
MH & SUD MIDD Supplantation	**$ 4,984,807**	**$ 4,528,609**	**91%**
SUD Administration	$ 399,752	$ 399,752	100%
Criminal Justice Initiative	$ 1,031,111	$ 838,452	81%
SUD Contracts	$ 271,757	$ 138,351	51%
Housing Voucher Program	$ 602,615	$ 602,615	100%
SUD Emergency Service Patrol	$ 505,325	$ 519,133	103%
CCAP	$ 472,981	$ 475,458	101%
MH Co-Occurring Disorders Tier	$ 800,000	$ 629,735	79%
MH Recovery	$ 187,660	$ 187,760	100%
MH Juvenile Justice Liaison	$ 90,000	$ 91,665	102%
MH Crisis Respite Beds	$ 263,606	$ 297,196	113%
MH Functional Family Therapy	$ 272,000	$ 251,582	92%
MH Mental Health Court Liaison	$ 88,000	$ 96,910	110%
Total MH/SUD MIDD Supplantation Funds	**$ 9,090,841**	**$ 8,544,394**	**94%**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)
MIDD Tax	$ 54,238,144	$ 55,812,826
Streamlined Mitigation	$ 650,000	$ 594,183
Investment Interest - Gross	$ 55,000	$ 51,405
Cash Management Svcs Fee		$ (771)
Invest Service Fee - Pool		$ 3
Other Miscellaneous Revenue		$ 217
Total Revenues	**$ 54,943,144**	**$ 56,457,862**
Total MIDD Funds	$ 50,397,375	$ 49,315,146
Total MIDD Supplantation	$ 9,090,841	$ 8,544,394
Total Expenditures	**$ 59,488,216**	**$ 57,859,540**
Revenues Over Expenditures	**$ (4,545,072)**	**$ (1,401,678)**

Mental Illness and Drug Dependency Fund Balance Analysis

MIDD Fund Balance Analysis	
Unreserved Fund Balance as of December 31, 2014	$ 10,966,498
Revenue Stabilization Reserve as of December 31, 2014	$ 5,275,885
Revenue	56,457,862
Expenditures	57,859,540
	(1,401,678)
Unreserved Fund Balance December 31, 2015	**$ 9,194,919**
Revenue Stabilization Reserve December 31, 2015	**$ 5,645,786**

Recommended Strategy Revisions

Implementation, evaluation and oversight of the MIDD sales tax fund requires occasional plan modifications. The MIDD Evaluation Plan and associated evaluation matrices were developed in May 2008 by Mental Health, Chemical Abuse and Dependency Services Division staff based on the strategy-level implementation plans available at that time. In August 2012, updated matrices were published in the MIDD Year Four Progress Report and matrices modified since that time were published in August of 2013, 2014, and 2015. For the current reporting period, proposed adjustments to performance targets and/or methods of measurement are provided below.

Strategy Number	Strategy Name	MIDD Year 8 Revised Performance Target	Explanation for Proposed Revision
1a-2	Substance Use Disorder Treatment	To Be Determined	Current targets are not reflective of all services being provided by this strategy.
2b	Employment Services	Set target to serve 75 clients in substance use disorder (SUD) treatment per year who express a desire to work.	Pilot program was renewed for one year. Target is based on the number of clients specified in contract.
11b	Mental Health Courts (MHC)	Reset the target for Regional Mental Health Court (RMHC) expansion cases to serving 110 additional clients over a two-year period, or 55 annually, with two full-time equivalent (FTE) expansion probation staff. Continue to track outcomes for 165 non-expansion cases over a two-year period, or 83 annually.	The new target is based on a budget restoration from one FTE expansion probation staff (whose caseload size limits the number of clients to be served) to two FTE expansion staff. Three non-expansion staff continue to serve the remaining clients.
15a	Adult Drug Court (ADC)	Set target of 300 base ADC clients served per year, in addition to the 250 clients per year who receive expanded recovery support services. Adjust expansion clients down to 230 per year if the contract to provide CHOICES classes is not renewed.	The proposed target is based on reporting of 315 base ADC clients during MIDD Year Seven. An adjustment to the expansion target may be necessary if a contracted staff position cannot be filled.

Appendix I: MIDD Strategy Alignment with Policy Goals

			MIDD Policy Goals				
Strategy Number	Strategy Name	Strategy Description	#1	#2	#3	#4	#5
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	✚		✪		
1a-2	Substance Use Disorder Treatment	Increase Access to Community Substance Use Disorder (SUD) 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	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪				
1e	Chemical Dependency Trainings	Chemical Dependency Professional Education and Training					✪
1f	Parent Partners Family Assistance	Parent Partner and Youth Peer Support Assistance Program					✪
1g	Older Adults Prevention	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	Workload Reduction	Workload Reduction for Mental Health					✪
2b	Employment Services	Employment Services for Individuals with Mental Illness and Substance Use Disorder					✪
3a	Supportive Housing	Supportive Services for Housing Projects	✪				✚
4a	Parents in Recovery Services	Services for Parents in Substance Abuse Outpatient Treatment			✪		
4b	SUD Prevention for Children	Prevention Services to Children of Substance Abusing Parents			✪	✚	
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 Service System (CCORS)	✪			✚	
8a	Family Treatment Court	Family Treatment Court Expansion		✪	✪		
9a	Juvenile Drug Court	Juvenile Drug Court Expansion			✪	✪	
10a	Crisis Intervention Team Training	Crisis Intervention 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	Mental Health Courts	Increase Services for New or Existing Mental Health Court Programs			✚	✪	
12a	Jail Re-Entry & 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	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪				
12d	Behavior Modification Classes	Behavior Modification Classes for CCAP Clients		✪	✚		
13a	Domestic Violence Services	Domestic Violence and Mental Health Services			✪		✚
13b	Domestic Violence Prevention	Domestic Violence Prevention			✪		✚
14a	Sexual Assault Services	Sexual Assault and Mental Health Services			✪		✚
15a	Adult Drug Court	Adult Drug Court Expansion of Recovery Support Services			✚	✪	
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪				✪
17a	Crisis Intervention/MH Partnership	Crisis Intervention Team/Mental Health Partnership Pilot	✚				✪
17b	Safe Housing - Child Prostitution	Safe Housing and Treatment for Children in Prostitution Pilot				✚	✪

Key: ✪ = Primary Goal ✚ = Secondary Goal

Note: Grayed items were not implemented or were piloted only.

Goals:

#1	Reduce jail, emergency room and/or hospital use by mentally ill or drug dependent clients
#2	Reduce jail recycling for mentally ill or drug dependent clients
#3	Reduce incidence and severity of mental illness and/or drug dependency symptoms
#4	Divert mentally ill or drug dependent clients from initial or further justice system involvement
#5	Linkage with other Council-directed initiatives such as the Plan to End Homelessness, the Veterans and Human Services Levy and the King County Mental Health Recovery Plan

Appendix II: Performance Measures by Strategy Category

Community-Based Mental Health and Substance Use Disorder Intervention Strategies

More than 85% of target 65% - 85% of target Less than 65% of target

Year 7 Targets	Continued Services from Prior Year(s)	New in Year 7	Year 7 Totals [1]	Percent of Year 7 Target	Target Success Rating
1a-1 - Increase Access to Community Mental Health (MH) Treatment					
2,400 clients/yr	1,866	864	2,730	114%	↑
1a-2 - Increase Access to Community Substance Use Disorder (SUD) Treatment					
50,000 adult OP units	N/A	20,362 adult OP units		41%	↓
4,000 youth OP units		2,833 youth OP units		71%	→
70,000 OTP units		21,231 OTP units		30% [2]	↓
1b - Outreach and Engagment to Individuals Leaving Hospitals, Jails or Crisis Facilities					
675 clients/yr	385	689	1,074	159% [3]	↑
1c - Emergency Room Substance Abuse Early Intervention Program					
6,400 screens/yr (8 FTE) **Adjust to 4,560 screens/yr (5.7 FTE)**	N/A	2,177 screens		48% (Adjusted)	↓
4,340 brief interventions (BI)/yr (8 FTE) **Adjust to 3,092 BI/yr (5.7 FTE)**		2,585 brief interventions		84% (Adjusted)	→
1d - Mental Health Crisis Next Day Appointments and Stabilization Services					
750 clients/yr with enhanced services **Adjust to 634 with funding restored 1/2015**	20	319	339	53% (Adjusted)	↓
1e - Chemical Dependency Professional Education and Training [4]					
125 reimbursed trainees/yr	188	157	345	276%	↑
250 workforce development trainees/yr	N/A	482	482	193%	
1f - Parent Partner and Youth Peer Support Assistance Program					
400 clients/yr **Adjust to 300 clients/yr (fully staffed 1/2015)**	38	144	182	61%	↓
1g - Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+					
2,500 clients/yr (7.4 FTE) **Adjust to 2,196 clients/yr (6.5 FTE)**	3,762	5,171	8,933	407% (Adjusted)	↑
1h - Expand Availabilty of Crisis Intervention and Linkage to Ongoing Services for Older Adults					
340 clients/yr (4.6 FTE) **Adjust to 258 clients/yr (3.5 FTE)**	50	244	294	114% (Adjusted)	↑
2a - Workload Reduction for Mental Health					
16 agencies participating	16	0	16	100%	↑
2b - Employment Services for Individuals with Mental Illness and SUD					
920 clients/yr **Adjust to 700 clients/yr (MH clients only)**	477	394	871	124% (Adjusted)	↑
3a - Supportive Services for Housing Projects					
690 clients for MIDD Year Seven	599	173	772	112%	↑
13a - Domestic Violence and Mental Health Services					
560-640 clients/yr	240	355	595	106%	↑
14a - Sexual Assault and Mental Health Services					
170 clients/yr	182	176	358	211% [3]	↑

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

[2] During the current period, the MIDD funded over $1.75 million in detoxification services.

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

[4] A total of 107 unduplicated CDPTs received clinical supervision funded by Strategy 1e.

Strategies with Programs to Help Youth

More than 85% of target 65% - 85% of target Less than 65% of target

Year 7 Targets	Continued Services from Prior Year(s)	New in Year 7	Year 7 Totals [1]	Percent of Year 7 Target	Target Success Rating
4a - Services for Parents in Substance Abuse Outpatient Treatment					
400 parents/yr	N/A	N/A	Not implemented	N/A	N/A
4b - Prevention Services to Children of Substance Abusing Parents					
400 children/yr	N/A	N/A	Not implemented	N/A	N/A
4c - Collaborative School-Based Mental Health and Substance Abuse Services					
2,268 youth/yr (19 programs) **Adjust to 1,550 youth/yr (13 programs)**	265	at least 766 [2]	1,031	67% (Adjusted)	
4d - School-Based Suicide Prevention					
1,500 adults/yr 3,250 youth/yr	N/A	1,072 adults 8,530 youth		71% 262% [3]	
5a - Expand Assessments for Youth in the Juvenile Justice System					
Coordinate 1,200 **(833)** assessments/yr Provide 200 psychological services/yr Conduct 140 MH assessments Conduct 165 full SUD assessments **Adjusted coordinations due to staff vacancies**	N/A	841 coordinations for 379 unique youth 311 psychological services 139 MH assessments 190 full SUD assessments		101% 156% 99% 115%	
6a - Wraparound Services for Emotionally Disturbed Youth					
450 enrolled youth/yr	255	303	558	124%	
7a - Reception Centers for Youth in Crisis					
TBD	N/A	N/A	Not implemented	N/A	N/A
7b - Expansion of Children's Crisis Outreach Response System (CCORS)					
300 youth/yr	172	871	1,043	348% [3]	
8a - Family Treatment Court Expansion					
120 children per year[4] No more than 60 children at one time	N/A	103 children (in MIDD Year 7) Program monitors daily capacity		86%	
9a - Juvenile Drug Court Expansion					
36 **new** youth/yr	56	83 new opt-ins 6 new pre opt-ins	145	247% (Total new)	
13b - Domestic Violence Prevention					
85 families/yr	97	58	155 unique families	182%	

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Program also serves numerous youth in large groups and assemblies.
[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 7/20/2015.

Jail and Hospital Diversion Strategies

More than 85% of target

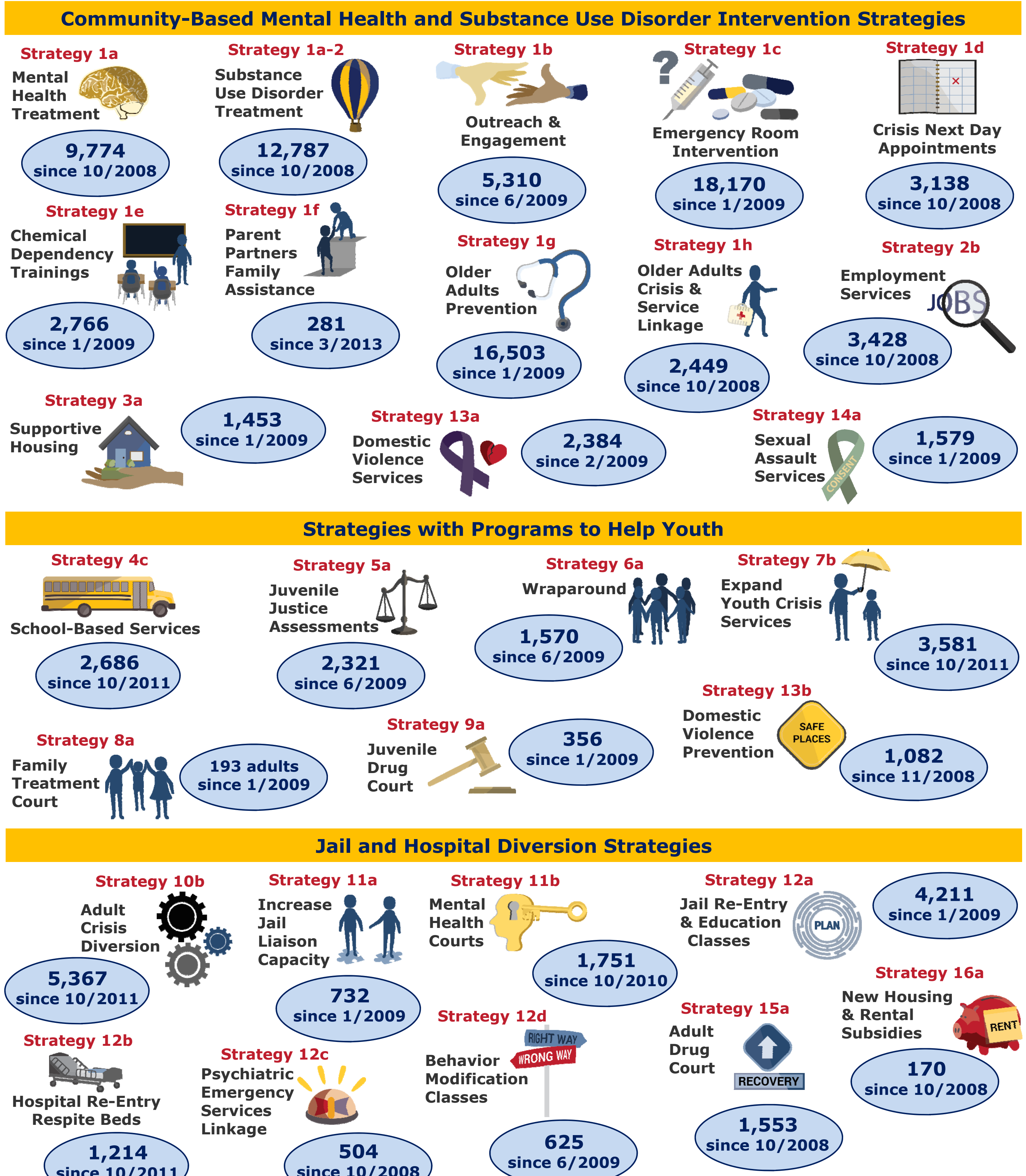
65% - 85% of target

Less than 65% of target

Year 7 Targets	Continued Services from Prior Year(s)	New in Year 7	Year 7 Totals [1]	Percent of Year 7 Target	Target Success Rating
10a - Crisis Intervention Team Training for First Responders					
180 trainees/yr (40-hour) 300 trainees/yr (One-day) 150 trainees/yr (Other) [2]	N/A	199 (40-hour) 553 (One-day) 312 (Other CIT programs) [3]		111% 184% 208%	↑
10b - Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team					
3,000 adults/yr	655	2,697	3,352 [3]	112%	↑
11a - Increase Jail Liaison Capacity					
200 **(100)** clients/yr **Adjust as noted due to staff vacancies**	3	32	35	35% (Adjusted)	↓
11b - Increase Services for New or Existing Mental Health Court Programs					
28 new opt-in expansion clients/yr and [4] 83 non-expansion clients/yr for Regional Mental Health Court (RMHC)	32 expansion 77 non-exp.	28 expansion 101 non-exp.	60 expansion 178 non-exp.	100% 122%[5] (New cases)	↑
300 clients/yr for Seattle Mental Health Court	21	266	287 screened candidates	96%	
12a-1 - Jail Re-Entry Program Capacity Increase					
300 clients/yr (3 FTE)	33	181	214	71%	→
12a-2 - Education Classes at Community Center for Alternative Programs (CCAP)					
600 clients/yr	36	496	532 [3]	89%	↑
12b - Hospital Re-Entry Respite Beds (Recuperative Care)					
350-500 clients/yr	65	301	366	105%	↑
12c - Increase Harborview's Psychiatric Emergency Services (PES) Capacity					
75-100 clients/yr	39	42	81	108%	↑
12d - Behavior Modification Classes for CCAP Clients					
40 clients/yr [4]	2	41	43	108%	↑
15a - Adult Drug Court Expansion of Recovery Support Services					
250 expansion clients/yr	204	184	388 [6]	155%	↑
16a - New Housing Units and Rental Subsidies					
25 rental subsidies/yr Tenants in 25 capitally-funded beds without MIDD-funded support services through Strategy 3a	14 19	5 4	19 (rental subsidies) 23 tenants (Brierwood)	76% 92%	→ ↑
17a - Crisis Intervention Team/Mental Health Partnership Pilot			COMPLETED		
17b - Safe Housing and Treatment for Children in Prostitution Pilot			COMPLETED		

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Other trainings included Youth and Force Options.
[3] Not unduplicated - individuals are counted once for participation in each different program component.
[4] Revised target accepted by Council in motion of acceptance on 7/20/2015.
[5] Error in Progress Report calculation has been corrected here.
[6] Began tracking base court clients on 1/1/2015. There were 315 during this reporting period.

Appendix III: Unique Individuals Served from Strategy Start



Note: Unique individuals are not tracked for the following strategies: 2a—Workload Reduction, 4d—Suicide Prevention Training, and 10a-Crisis Intervention Team Training. Two strategies, 1f—Parent Partners Family Assistance and 4c– School-Based Services serve large groups in addition to individuals reported above. Several strategies blend funds to serve more clients.

Appendix IV: MIDD Outcomes Samples and Average Incidence of System Use Over Time for Relevant Strategies

		Eligible for Outcomes on Time Alone					Jail	Harborview Emergency Department	Psychiatric Hospitals
		Post 1	Post 2	Post 3	Post 4	Post 5			
1a-1a	Mental Health Treatment	8,587	7,901	6,806	4,547	3,623	16%	22%	13%
1a-1b	MH Clubhouse Participation Only	313	261	142	0	0	10%	18%	15%
1a-2a	Outpatient SUD Treatment	9,725	8,764	7,582	6,223	4,692	48%	19%	
1a-2a	Detoxification Only	290	0	0	0	0	27%		
1a-2b	Opiate SUD Treatment	2,084	1,930	1,653	1,356	1,201	35%	32%	
1b	Outreach & Engagement	4,630	4,040	3,441	2,686	1,798	40%	43%	5%
1c	Emergency Room Intervention	16,181	14,236	11,225	7,346	4,304	28%	50%	
	Harborview	11,493	10,189	8,030	5,441	3,548	30%	61%	
	South County	4,688	4,047	3,195	1,905	756	22%	19%	
1d	Crisis Next Day Appointments	2,830	2,584	2,325	2,121	1,750	24%	51%	14%
1g	Older Adults Prevention*	4,105	3,545	2,964	2,300	1,443		27%	
1h	Older Adults Crisis & Svc Linkage	2,205	1,838	1,447	1,145	754		9%	4%
2b	Employment Services	3,059	2,512	2,044	1,610	1,224			
3a	Supportive Housing	1,302	1,081	910	694	380	49%	62%	20%
4c	School-Based Services	2,037	1,164	97	0	0	1%		
5a	Juvenile Justice Assessments	2,049	1,629	825	599	299	69%		
6a	Wraparound	1,271	996	718	422	237	25%		
7b	Expand Youth Crisis Services	2,710	1,814	951	0	0	12%	8%	12%
8a	Family Treatment Court	165	142	120	83	53	55%		
9a	Juvenile Drug Court	254	205	124	93	62	83%		
10b	Adult Crisis Diversion	3,464	1,819	290	0	0	33%	54%	28%
11a	Increase Jail Liaison Capacity	700	687	614	413	267	79%		
11b-1	Seattle MH Court Expansion	823	561	267	0	0	94%		
11b-2	Regional Mental Health Court	563	396	242	148	0	75%		
12a-1	Jail Re-Entry Capacity	1,100	954	788	590	423	90%		
12a-2a	Education Classes at CCAP	970	829	661	447	215	79%		
12a-2b	CCAP Domestic Violence Education	1,465	1,106	809	469	269	75%		
12b	Hospital Re-Entry Respite Beds	913	641	297	0	0	41%	77%	9%
12c	PES Linkage	462	415	346	300	226	56%	95%	30%
12d	Behavior Modification Classes	584	494	363	204	94	83%		
15a	Adult Drug Court	1,223	976	816	630	425	84%		
16a	New Housing & Rental Subsidies	161	136	122	108	84	38%	55%	73%

* Limited to those with services beyond screening

Top Three Strategies with Jail Use

Strategy 11b-1 **94%**

Mental Health Courts

Seattle MH Court Expansion

Strategy 12a-1 **90%**

Jail Re-Entry Capacity

Strategy 15a **84%**

Adult Drug Court

Top Three Strategies with ED Use

Strategy 12c **95%**

Psychiatric Emergency Services Linkage

Strategy 12b **77%**

Hospital Re-Entry Respite Beds

Strategy 3a **62%**

Supportive Housing

Top Three Strategies with Psychiatric Hospital Use

Strategy 16a **73%**

New Housing & Rental Subsidies

Strategy 12c **30%**

Psychiatric Emergency Services Linkage

Strategy 10b **28%**

Adult Crisis Diversion

Appendix V: Aggregate System Use by Relevant Strategies

All strategies (and sub-strategies) that track relevant system utilization over time as an outcome are first listed in strategy order in the pages which follow. For jail and detention use, the number of people eligible for analysis by time alone appears in the "Time Eligible" column. The number of people who had any system use in a given analysis period is shown in the "Use Eligible" column. The total number of bookings, admissions and/or days (as appropriate) for the year-long period prior to the start of MIDD services appears in subsequent columns, followed by aggregate measures for each post period studied. The percent change is calculated as: (Post measure minus Pre measure) divided by Pre measure. Rows marked in gray are subsets of data for which the combined totals appear directly above. Tables sorted on jail/detention booking reductions by age group begin on Page 62. Reductions in excess of the targeted reduction goals, as explained on Page 8, are highlighted in light green. Changes in emergency department use begin on Page 66, followed by psychiatric hospitalizations on Page 68. It is generally expected that as each sample grows with the passage of time and the addition of newly qualified cohorts, more strategies will achieve long-term reductions in system use that will meet the targets established in 2008.

Total Jail/Detention Bookings and Days in Each Post Period

First Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment[1]	8,698	1,501	3,146	2,348	-25%	69,023	47,481	-31%
	Adults	7,395	1,416	3,025	2,246	-26%	67,543	45,772	-32%
	Youth[2]	1,303	85	121	102	-16%	1,480	1,709	+15%
1a-2a	Outpatient SUD Treatment[3]	10,015	4,889	8,733	5,751	-34%	160,819	107,858	-33%
	Adults	8,181	4,321	7,723	4,832	-37%	146,949	92,573	-37%
	Youth[2]	1,834	568	1,010	919	-9%	13,870	15,285	+10%
1a-2b	Opiate SUD Treatment	2,084	757	1,313	1,092	-17%	24,913	19,811	-20%
1b	Outreach & Engagement	4,630	1,913	3,398	3,390	0%	53,308	57,501	+8%
1c	Emergency Room Intervention	16,181	4,519	7,541	8,355	+11%	123,671	146,438	+18%
	Harborview	11,493	3,441	5,912	6,264	+6%	101,883	112,613	+11%
	South County	4,688	1,078	1,629	2,091	+28%	21,788	33,825	+55%
1d	Crisis Next Day Appointments	2,830	703	947	975	+3%	23,882	18,533	-22%
3a	Supportive Housing	1,302	626	1,626	972	-40%	32,575	18,105	-44%
4c	School-Based Services	2,037	28	<10	50	+733%	39	783	+1,908%
5a	Juvenile Justice Assessments	2,049	1,340	1,965	3,168	+61%	21,141	57,152	+170%
6a	Wraparound	1,271	251	385	496	+29%	5,581	6,770	+21%
7b	Expand Youth Crisis Services	2,710	298	251	550	+119%	3,071	7,508	+144%
8a	Family Treatment Court	165	91	155	95	-39%	1,616	1,347	-17%
9a	Juvenile Drug Court	254	210	489	608	+24%	6,915	14,456	+109%
10b	Adult Crisis Diversion	3,464	1,156	1,778	2,315	+30%	25,937	43,433	+67%
11a	Increase Jail Liaison Capacity	700	578	1,535	988	-36%	24,923	26,747	+7%
11b-1	Seattle MH Court Expansion	823	777	2,192	1,432	-35%	30,389	37,157	+22%
11b-2	Regional Mental Health Court	563	450	1,025	752	-27%	25,230	18,232	-28%
12a-1	Jail Re-Entry Capacity	1,100	1,024	3,560	2,370	-33%	86,984	61,119	-30%
12a-2a	Education Classes at CCAP	970	803	1,942	1,487	-23%	32,373	40,612	+25%
12a-2b	CCAP Domestic Violence Education	1,465	1,125	2,564	2,106	-18%	36,019	56,407	+57%
12b	Hospital Re-Entry Respite Beds	913	387	783	598	-24%	10,618	13,195	+24%
12c	PES Linkage	462	267	662	566	-15%	8,884	9,465	+7%
12d	Behavior Modification Classes	584	509	1,139	866	-24%	19,168	28,313	+48%
15a	Adult Drug Court	1,223	1,072	2,525	2,074	-18%	29,822	72,502	+143%
16a	New Housing & Rental Subsidies	161	59	93	56	-40%	2,213	1,358	-39%

[1] Including Clubhouse participants
[2] Ages 9 to 18 at MIDD start
[3] Including Detoxification Only clients

Second Post

		Time Eligible	Use Eligible	Jail/Detention Bookings			Jail/Detention Days		
				Pre	Post 2	% Change	Pre	Post 2	% Change
1a-1a	Mental Health Treatment[1]	7,982	1,371	2,904	1,685	-42%	63,661	40,465	-36%
	Adults	6,825	1,283	2,787	1,595	-43%	62,198	38,460	-38%
	Youth[2]	1,157	88	117	90	-23%	1,463	2,005	+37%
1a-2a	Outpatient SUD Treatment	8,764	4,295	7,761	4,142	-47%	143,051	90,414	-37%
	Adults	7,377	3,908	7,117	3,677	-48%	134,536	81,119	-40%
	Youth[2]	1,387	387	644	465	-28%	8,515	9,295	+9%
1a-2b	Opiate SUD Treatment	1,930	696	1,227	811	-34%	22,787	14,770	-35%
1b	Outreach & Engagement	4,040	1,650	2,983	2,483	-17%	47,774	48,826	+2%
1c	Emergency Room Intervention	14,236	3,829	6,546	6,978	7%	108,884	116,528	+7%
	Harborview	10,189	2,946	5,216	4,522	-13%	90,940	89,663	-1%
	South County	4,047	883	1,330	1,456	9%	17,944	26,865	+50%
1d	Crisis Next Day Appointments	2,584	620	919	705	-23%	23,141	16,308	-30%
3a	Supportive Housing	1,081	521	1,440	715	-50%	28,599	13,889	-51%
4c	School-Based Services	1,164	28	5	61	+1120%	37	1,099	+2870%
5a	Juvenile Justice Assessments	1,629	1,012	1,751	1,650	-6%	19,900	34,591	+74%
6a	Wraparound	996	216	345	419	+21%	5,163	6,072	+18%
7b	Expand Youth Crisis Services	1,814	216	186	349	+88%	2,128	6,282	+195%
8a	Family Treatment Court	142	78	135	79	-41%	1,312	1,091	-17%
9a	Juvenile Drug Court	205	166	419	366	-13%	5,805	7,721	+33%
10b	Adult Crisis Diversion	1,819	555	919	927	+1%	14,112	19,382	+37%
11a	Increase Jail Liaison Capacity	687	565	1,501	865	-42%	24,397	22,513	-8%
11b-1	Seattle MH Court Expansion	561	528	1,590	827	-48%	20,923	23,801	+14%
11b-2	Regional Mental Health Court	396	302	698	514	-26%	10,848	13,150	+21%
12a-1	Jail Re-Entry Capacity	954	874	3,084	1,706	-45%	76,008	45,997	-39%
12a-2a	Education Classes at CCAP	829	675	1,665	966	-42%	28,979	23,763	-18%
12a-2b	CCAP Domestic Violence Education	1,106	846	1,995	1,229	-38%	28,295	28,609	+1%
12b	Hospital Re-Entry Respite Beds	641	257	531	303	-43%	7,471	7,349	-2%
12c	PES Linkage	415	231	597	406	-32%	7,845	8,213	+5%
12d	Behavior Modification Classes	494	420	990	561	-43%	16,486	17,065	+4%
15a	Adult Drug Court	976	826	2,021	1,256	-38%	23,886	26,096	+9%
16a	New Housing & Rental Subsidies	136	53	87	48	-45%	2,135	1,890	-11%

Third Post

		Time Eligible	Use Eligible	Jail/Detention Bookings			Jail/Detention Days		
				Pre	Post 3	% Change	Pre	Post 3	% Change
1a-1a	Mental Health Treatment[1]	6,786	1,123	2,417	1,183	-52%	52,233	26,821	-49%
	Adults	5,774	1,045	2,319	1,092	-54%	50,994	25,439	-50%
	Youth[2]	1,012	78	98	91	-7%	1,239	1,382	+11%
1a-2a	Outpatient SUD Treatment	7,582	3,659	6,581	3,198	-51%	123,302	64,998	-47%
	Adults	6,340	3,324	6,011	2,781	-54%	115,950	57,878	-50%
	Youth[2]	1,242	335	570	417	-27%	7,352	7,120	-3%
1a-2b	Opiate SUD Treatment	1,653	591	1,020	550	-46%	18,983	9,385	-51%
1b	Outreach & Engagement	3,441	1,413	2,637	1,860	-29%	43,617	34,832	-20%
1c	Emergency Room Intervention	11,225	3,025	5,367	3,981	-25%	90,925	80,405	-12%
	Harborview	8,030	2,366	4,374	3,048	-30%	77,244	62,981	-18%
	South County	3,195	659	993	933	-6%	13,681	17,424	+27%
1d	Crisis Next Day Appointments	2,325	559	891	606	-32%	22,350	13,886	-38%
3a	Supportive Housing	910	457	1,268	508	-60%	25,856	11,631	-55%
4c	School-Based Services	97	0	0	0	0%	0	0	0%
5a	Juvenile Justice Assessments	825	600	1,318	852	-35%	16,410	18,340	+12%
6a	Wraparound	718	173	279	285	+2%	3,874	5,493	+42%
7b	Expand Youth Crisis Services	951	121	111	143	+29%	1,180	1,964	+66%
8a	Family Treatment Court	120	69	109	65	-40%	1,091	1,220	+12%
9a	Juvenile Drug Court	124	107	309	198	-36%	4,322	4,369	+1%
10b	Adult Crisis Diversion	290	100	184	140	-24%	3,024	3,427	+13%
11a	Increase Jail Liaison Capacity	614	489	1,331	707	-47%	21,569	16,564	-23%
11b-1	Seattle MH Court Expansion	267	248	736	267	-64%	9,184	7,794	-15%
11b-2	Regional Mental Health Court	242	176	417	235	-44%	7,209	7,132	-1%
12a-1	Jail Re-Entry Capacity	788	704	2,482	1,115	-55%	59,343	28,005	-53%
12a-2a	Education Classes at CCAP	661	522	1,312	754	-43%	23,783	15,038	-37%
12a-2b	CCAP Domestic Violence Education	809	599	1,497	796	-47%	21,690	16,129	-26%
12b	Hospital Re-Entry Respite Beds	297	116	231	141	-39%	3,290	3,289	0%
12c	PES Linkage	346	190	502	263	-48%	6,804	6,413	-6%
12d	Behavior Modification Classes	363	294	722	359	-50%	12,222	10,477	-14%
15a	Adult Drug Court	816	680	1,712	742	-57%	21,068	15,310	-27%
16a	New Housing & Rental Subsidies	122	48	84	31	-63%	2,101	887	-58%

[1] Including Clubhouse participants

[2] Ages 9 to 18 at MIDD start

Fourth Post

		Time Eligible	Use Eligible	Jail/Detention Bookings Pre	Jail/Detention Bookings Post 4	Jail/Detention Bookings % Change	Jail/Detention Days Pre	Jail/Detention Days Post 4	Jail/Detention Days % Change
1a-1a	Mental Health Treatment	4,429	715	1,537	616	-60%	33,387	14,482	-57%
	Adults	3,719	661	1,453	564	-61%	32,316	13,456	-58%
	Youth[1]	710	54	84	52	-38%	1,071	1,026	-4%
1a-2a	Outpatient SUD Treatment	6,223	2,985	5,436	2,244	-59%	101,288	46,175	-54%
	Adults	5,208	2,694	4,940	1,895	-62%	95,020	40,992	-57%
	Youth[1]	1,015	291	496	349	-30%	6,268	5,183	-17%
1a-2b	Opiate SUD Treatment	1,356	474	835	421	-50%	15,834	8,178	-48%
1b	Outreach & Engagement	2,686	1,067	2,054	1,202	-41%	34,552	22,013	-36%
1c	Emergency Room Intervention	7,346	2,082	3,878	2,522	-35%	65,099	45,860	-30%
	Harborview	5,441	1,676	3,280	1,977	-40%	57,075	37,091	-35%
	South County	1,905	406	598	545	-9%	8,024	8,769	+9%
1d	Crisis Next Day Appointments	2,121	513	851	498	-41%	21,805	10,805	-50%
3a	Supportive Housing	694	338	1,019	343	-66%	21,421	7,974	-63%
5a	Juvenile Justice Assessments	599	434	959	571	-40%	12,321	12,364	0%
6a	Wraparound	422	118	193	205	+6%	3,006	3,956	+32%
8a	Family Treatment Court	83	49	78	40	-49%	637	466	-27%
9a	Juvenile Drug Court	93	77	212	110	-48%	2,622	2,311	-12%
11a	Increase Jail Liaison Capacity	413	321	864	439	-49%	13,616	12,202	-10%
11b-2	Regional Mental Health Court	148	108	263	113	-57%	4,432	3,476	-22%
12a-1	Jail Re-Entry Capacity	590	518	1,757	682	-61%	44,256	16,908	-62%
12a-2a	Education Classes at CCAP	447	358	899	461	-49%	16,615	11,194	-33%
12a-2b	CCAP Domestic Violence Education	469	347	922	431	-53%	12,708	9,169	-28%
12c	PES Linkage	300	168	476	178	-63%	6,593	4,353	-34%
12d	Behavior Modification Classes	204	163	403	164	-59%	6,729	5,554	-17%
15a	Adult Drug Court	630	513	1,274	549	-57%	16,524	9,522	-42%
16a	New Housing & Rental Subsidies	108	40	83	19	-77%	2,099	555	-74%

Fifth Post

		Time Eligible	Use Eligible	Jail/Detention Bookings Pre	Jail/Detention Bookings Post 5	Jail/Detention Bookings % Change	Jail/Detention Days Pre	Jail/Detention Days Post 5	Jail/Detention Days % Change
1a-1a	Mental Health Treatment	3,519	546	1,156	497	-57%	24,630	13,572	-45%
	Adults	2,967	498	1,089	446	-59%	23,722	12,576	-47%
	Youth[1]	552	48	67	51	-24%	908	996	+10%
1a-2a	Outpatient SUD Treatment	4,692	2,186	3,986	1,648	-59%	71,415	35,229	-51%
	Adults	3,905	1,966	3,611	1,376	-62%	67,250	30,273	-55%
	Youth[1]	787	220	375	272	-27%	4,165	4,956	+19%
1a-2b	Opiate SUD Treatment	1,201	396	673	359	-47%	12,217	6,025	-51%
1b	Outreach & Engagement	1,798	631	1,178	694	-41%	20,636	12,843	-38%
1c	Emergency Room Intervention	4,304	1,266	2,522	1,575	-38%	41,139	33,145	-19%
	Harborview	3,548	1,097	2,301	1,321	-43%	37,689	28,318	-25%
	South County	756	169	221	254	+15%	3,450	4,827	+40%
1d	Crisis Next Day Appointments	1,750	407	723	382	-47%	18,824	8,818	-53%
3a	Supportive Housing	380	184	561	150	-73%	10,130	2,874	-72%
5a	Juvenile Justice Assessments	299	217	536	287	-46%	6,640	6,380	-4%
6a	Wraparound	237	72	101	95	-6%	2,095	2,014	-4%
8a	Family Treatment Court	53	26	43	17	-60%	484	237	-51%
9a	Juvenile Drug Court	62	50	143	98	-31%	1,927	2,124	+10%
11a	Increase Jail Liaison Capacity	267	196	545	220	-60%	8,333	5,925	-29%
12a-1	Jail Re-Entry Capacity	423	364	1,220	418	-66%	30,928	10,177	-67%
12a-2a	Education Classes at CCAP	215	152	385	167	-57%	7,568	3,769	-50%
12a-2b	CCAP Domestic Violence Education	269	192	543	206	-62%	7,352	4,730	-36%
12c	PES Linkage	226	126	390	138	-65%	5,452	3,712	-32%
12d	Behavior Modification Classes	94	75	162	42	-74%	2,943	1,087	-63%
15a	Adult Drug Court	425	345	874	359	-59%	11,840	6,653	-44%
16a	New Housing & Rental Subsidies	84	30	55	16	-71%	1,419	617	-57%

[1] Ages 9 to 18 at MIDD start

Adult Jail Use in Each Post Period Sorted on Booking Reductions

Separate targeted jail use reduction goals for adults and youth were established in 2008, going out five years beyond each individual's MIDD start date. For adults, an extra five percent reduction per year was added to account for overall jail use reductions throughout King County, as shown in the table below. In the first post period, reductions in excess of ten percent for adult jail bookings were achieved by 16 of the 20 strategies or sub-strategies (80%) intended to reduce jail utilization. These same strategies saw reductions greater than 25 percent in the second post period, and almost all had achieved 40 percent reductions by the third post period. Of the 17 strategies eligible for a fourth post analysis, nine (53%) had jail booking reductions of more than 55 percent. The lofty goal of achieving 70 percent jail reductions by the fifth post period was accomplished with fairly small sample sizes by three of the 16 strategies with data (19%), as shown on Page 64.

Targeted reductions in adult jail days were harder to achieve than booking reductions, due in part to the use of sanctioning and the imposition of longer jail sentences on individuals who re-offended. While treatment and housing strategies tended to achieve reductions in days that aligned with their booking reductions, therapeutic courts and diversion strategies often had to overcome steep initial increases in jail days before achieving desirable reductions. The one exception to this rule was Strategy 12a-1—Jail Re-Entry Capacity, where reductions in days often mirrored booking declines over time.

Adult Jail Bookings or Days			
Period	Incremental	Additional	Cumulative
Post 1	-5%	-5%	-10%
Post 2	-10%	-5%	-25%
Post 3	-10%	-5%	-40%
Post 4	-10%	-5%	-55%
Post 5	-10%	-5%	-70%

First Post

				Jail Bookings			Jail Days		
		Time Eligible	Use Eligible	Pre	Post 1	% Change	Pre	Post 1	% Change
3a	Supportive Housing	1,302	626	1,626	972	-40%	32,575	18,105	-44%
16a	New Housing & Rental Subsidies	161	59	93	56	-40%	2,213	1,358	-39%
8a	Family Treatment Court	165	91	155	95	-39%	1,616	1,347	-17%
1a-2a	Outpatient SUD Treatment	8,181	4,321	7,723	4,832	-37%	146,949	92,573	-37%
11a	Increase Jail Liaison Capacity	700	578	1,535	988	-36%	24,923	26,747	+7%
11b-1	Seattle MH Court Expansion	823	777	2,192	1,432	-35%	30,389	37,157	+22%
12a-1	Jail Re-Entry Capacity	1,100	1,024	3,560	2,370	-33%	86,984	61,119	-30%
11b-2	Regional Mental Health Court	563	450	1,025	752	-27%	25,230	18,232	-28%
1a-1a	Mental Health Treatment	7,395	1,416	3,025	2,246	-26%	67,543	45,772	-32%
12b	Hospital Re-Entry Respite Beds	913	387	783	598	-24%	10,618	13,195	+24%
12d	Behavior Modification Classes	584	509	1,139	866	-24%	19,168	28,313	+48%
12a-2a	Education Classes at CCAP	970	803	1,942	1,487	-23%	32,373	40,612	+25%
12a-2b	CCAP Domestic Violence Education	1,465	1,125	2,564	2,106	-18%	36,019	56,407	+57%
15a	Adult Drug Court	1,223	1,072	2,525	2,074	-18%	29,822	72,502	+143%
1a-2b	Opiate SUD Treatment	2,084	757	1,313	1,092	-17%	24,913	19,811	-20%
12c	PES Linkage	462	267	662	566	-15%	8,884	9,465	+7%
1b	Outreach & Engagement	4,630	1,913	3,398	3,390	+0%	53,308	57,501	+8%
1d	Crisis Next Day Appointments	2,830	703	947	975	+3%	23,882	18,533	-22%
1c	Emergency Room Intervention	16,181	4,519	7,541	8,355	+11%	123,671	146,438	+18%
10b	Adult Crisis Diversion	3,464	1,156	1,778	2,315	+30%	25,937	43,433	+67%

Second Post

		Time Eligible	Use Eligible	Jail Bookings Pre	Jail Bookings Post 2	Jail Bookings % Change	Jail Days Pre	Jail Days Post 2	Jail Days % Change
3a	Supportive Housing	1,081	521	1,440	715	-50%	28,599	13,889	-51%
1a-2a	Outpatient SUD Treatment	7,377	3,908	7,117	3,677	-48%	134,536	81,119	-40%
11b-1	Seattle MH Court Expansion	561	528	1,590	827	-48%	20,923	23,801	+14%
12a-1	Jail Re-Entry Capacity	954	874	3,084	1,706	-45%	76,008	45,997	-39%
16a	New Housing & Rental Subsidies	136	53	87	48	-45%	2,135	1,890	-11%
1a-1a	Mental Health Treatment	6,825	1,283	2,787	1,595	-43%	62,198	38,460	-38%
12b	Hospital Re-Entry Respite Beds	641	257	531	303	-43%	7,471	7,349	-2%
12d	Behavior Modification Classes	494	420	990	561	-43%	16,486	17,065	+4%
11a	Increase Jail Liaison Capacity	687	565	1,501	865	-42%	24,397	22,513	-8%
12a-2a	Education Classes at CCAP	829	675	1,665	966	-42%	28,979	23,763	-18%
8a	Family Treatment Court	142	78	135	79	-41%	1,312	1,091	-17%
12a-2b	CCAP Domestic Violence Education	1,106	846	1,995	1,229	-38%	28,295	28,609	+1%
15a	Adult Drug Court	976	826	2,021	1,256	-38%	23,886	26,096	+9%
1a-2b	Opiate SUD Treatment	1,930	696	1,227	811	-34%	22,787	14,770	-35%
12c	PES Linkage	415	231	597	406	-32%	7,845	8,213	+5%
11b-2	Regional Mental Health Court	396	302	698	514	-26%	10,848	13,150	+21%
1d	Crisis Next Day Appointments	2,584	620	919	705	-23%	23,141	16,308	-30%
1b	Outreach & Engagement	4,040	1,650	2,983	2,483	-17%	47,774	48,826	+2%
10b	Adult Crisis Diversion	1,819	555	919	927	+1%	14,112	19,382	+37%
1c	Emergency Room Intervention	14,236	3,829	6,546	6,978	+7%	108,884	116,528	+7%

Third Post

		Time Eligible	Use Eligible	Jail Bookings Pre	Jail Bookings Post 3	Jail Bookings % Change	Jail Days Pre	Jail Days Post 3	Jail Days % Change
11b-1	Seattle MH Court Expansion	267	248	736	267	-64%	9,184	7,794	-15%
16a	New Housing & Rental Subsidies	122	48	84	31	-63%	2,101	887	-58%
3a	Supportive Housing	910	457	1,268	508	-60%	25,856	11,631	-55%
15a	Adult Drug Court	816	680	1,712	742	-57%	21,068	15,310	-27%
12a-1	Jail Re-Entry Capacity	788	704	2,482	1,115	-55%	59,343	28,005	-53%
1a-1a	Mental Health Treatment	5,774	1,045	2,319	1,092	-54%	50,994	25,439	-50%
1a-2a	Outpatient SUD Treatment	6,340	3,324	6,011	2,781	-54%	115,950	57,878	-50%
12d	Behavior Modification Classes	363	294	722	359	-50%	12,222	10,477	-14%
12c	PES Linkage	346	190	502	263	-48%	6,804	6,413	-6%
11a	Increase Jail Liaison Capacity	614	489	1,331	707	-47%	21,569	16,564	-23%
12a-2b	CCAP Domestic Violence Education	809	599	1,497	796	-47%	21,690	16,129	-26%
1a-2b	Opiate SUD Treatment	1,653	591	1,020	550	-46%	18,983	9,385	-51%
11b-2	Regional Mental Health Court	242	176	417	235	-44%	7,209	7,132	-1%
12a-2a	Education Classes at CCAP	661	522	1,312	754	-43%	23,783	15,038	-37%
8a	Family Treatment Court	120	69	109	65	-40%	1,091	1,220	+12%
12b	Hospital Re-Entry Respite Beds	297	116	231	141	-39%	3,290	3,289	0%
1d	Crisis Next Day Appointments	2,325	559	891	606	-32%	22,350	13,886	-38%
1b	Outreach & Engagement	3,441	1,413	2,637	1,860	-29%	43,617	34,832	-20%
1c	Emergency Room Intervention	11,225	3,025	5,367	3,981	-25%	90,925	80,405	-12%
10b	Adult Crisis Diversion	290	100	184	140	-24%	3,024	3,427	+13%

Fourth Post

		Time Eligible	Use Eligible	Jail Bookings Pre	Jail Bookings Post 4	Jail Bookings % Change	Jail Days Pre	Jail Days Post 4	Jail Days % Change
16a	New Housing & Rental Subsidies	108	40	83	19	-77%	2,099	555	-74%
3a	Supportive Housing	694	338	1,019	343	-66%	21,421	7,974	-63%
12c	PES Linkage	300	168	476	178	-63%	6,593	4,353	-34%
1a-2a	Outpatient SUD Treatment	5,208	2,694	4,940	1,895	-62%	95,020	40,992	-57%
1a-1a	Mental Health Treatment	3,719	661	1,453	564	-61%	32,316	13,456	-58%
12a-1	Jail Re-Entry Capacity	590	518	1,757	682	-61%	44,256	16,908	-62%
12d	Behavior Modification Classes	204	163	403	164	-59%	6,729	5,554	-17%
11b-2	Regional Mental Health Court	148	108	263	113	-57%	4,432	3,476	-22%
15a	Adult Drug Court	630	513	1,274	549	-57%	16,524	9,522	-42%
12a-2b	CCAP Domestic Violence Education	469	347	922	431	-53%	12,708	9,169	-28%
1a-2b	Opiate SUD Treatment	1,356	474	835	421	-50%	15,834	8,178	-48%
8a	Family Treatment Court	83	49	78	40	-49%	637	466	-27%
11a	Increase Jail Liaison Capacity	413	321	864	439	-49%	13,616	12,202	-10%
12a-2a	Education Classes at CCAP	447	358	899	461	-49%	16,615	11,194	-33%
1b	Outreach & Engagement	2,686	1,067	2,054	1,202	-41%	34,552	22,013	-36%
1d	Crisis Next Day Appointments	2,121	513	851	498	-41%	21,805	10,805	-50%
1c	Emergency Room Intervention	7,346	2,082	3,878	2,522	-35%	65,099	45,860	-30%

Fifth Post

		Time Eligible	Use Eligible	Jail Bookings Pre	Jail Bookings Post 5	Jail Bookings % Change	Jail Days Pre	Jail Days Post 5	Jail Days % Change
12d	Behavior Modification Classes	94	75	162	42	-74%	2,943	1,087	-63%
3a	Supportive Housing	380	184	561	150	-73%	10,130	2,874	-72%
16a	New Housing & Rental Subsidies	84	30	55	16	-71%	1,419	617	-57%
12a-1	Jail Re-Entry Capacity	423	364	1,220	418	-66%	30,928	10,177	-67%
12c	PES Linkage	226	126	390	138	-65%	5,452	3,712	-32%
1a-2a	Outpatient SUD Treatment	3,905	1,966	3,611	1,376	-62%	67,250	30,273	-55%
12a-2b	CCAP Domestic Violence Education	269	192	543	206	-62%	7,352	4,730	-36%
8a	Family Treatment Court	53	26	43	17	-60%	484	237	-51%
11a	Increase Jail Liaison Capacity	267	196	545	220	-60%	8,333	5,925	-29%
1a-1a	Mental Health Treatment	2,967	498	1,089	446	-59%	23,722	12,576	-47%
15a	Adult Drug Court	425	345	874	359	-59%	11,840	6,653	-44%
12a-2a	Education Classes at CCAP	215	152	385	167	-57%	7,568	3,769	-50%
1a-2b	Opiate SUD Treatment	1,201	396	673	359	-47%	12,217	6,025	-51%
1d	Crisis Next Day Appointments	1,750	407	723	382	-47%	18,824	8,818	-53%
1b	Outreach & Engagement	1,798	631	1,178	694	-41%	20,636	12,843	-38%
1c	Emergency Room Intervention	4,304	1,266	2,522	1,575	-38%	41,139	33,145	-19%

Youth Detention Use in Each Post Period Sorted on Booking Reductions

Prior to MIDD implementation in 2008, it was expected that certain strategies could bring about annual reductions of 10 percent in youth detention bookings or days, ultimately cutting such measures in half by the fifth post period. With few exceptions, these targeted reductions were not realized. Possible reasons for this include: 1) detentions prior to MIDD services, against which subsequent use was compared, were rare or few for younger clients, 2) as youth aged and gained independence, their opportunities to become involved with the juvenile justice and criminal justice systems increased, and 3) longer detentions may have been imposed early on to impact behavioral changes over the long term.

Youth Detention Bookings or Days		
Period	Incremental	Cumulative
Post 1	-10%	-10%
Post 2	-10%	-20%
Post 3	-10%	-30%
Post 4	-10%	-40%
Post 5	-10%	-50%

First Post

				Detention Bookings			Detention Days		
		Time Eligible	Use Eligible	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment	1,303	85	121	102	-16%	1,480	1,709	+15%
1a-2a	Outpatient SUD Treatment	1,834	568	1,010	919	-9%	13,870	15,285	+10%
9a	Juvenile Drug Court	254	210	489	608	+24%	6,915	14,456	+109%
6a	Wraparound	1,271	251	385	496	+29%	5,581	6,770	+21%
5a	Juvenile Justice Assessments	2,049	1,340	1,965	3,168	+61%	21,141	57,152	+170%
7b	Expand Youth Crisis Services	2,710	298	251	550	+119%	3,071	7,508	+144%
4c	School-Based Services	2,037	28	<10	50	+733%	39	783	+1,908%

Second Post

				Detention Bookings			Detention Days		
		Time Eligible	Use Eligible	Pre	Post 2	% Change	Pre	Post 2	% Change
1a-2a	Outpatient SUD Treatment	1,387	387	644	465	-28%	8,515	9,295	+9%
1a-1a	Mental Health Treatment	1,157	88	117	90	-23%	1,463	2,005	+37%
9a	Juvenile Drug Court	205	166	419	366	-13%	5,805	7,721	+33%
5a	Juvenile Justice Assessments	1,629	1,012	1,751	1,650	-6%	19,900	34,591	+74%
6a	Wraparound	996	216	345	419	+21%	5,163	6,072	+18%
7b	Expand Youth Crisis Services	1,814	216	186	349	+88%	2,128	6,282	+195%
4c	School-Based Services	1,164	28	5	61	+1120%	37	1,099	+2870%

				Detention Bookings			Detention Days		
		Time Eligible	Use Eligible	Pre	Post 3	% Change	Pre	Post 3	% Change
9a	Juvenile Drug Court	124	107	309	198	-36%	4,322	4,369	+1%
5a	Juvenile Justice Assessments	825	600	1,318	852	-35%	16,410	18,340	+12%
1a-2a	Outpatient SUD Treatment	1,242	335	570	417	-27%	7,352	7,120	-3%
1a-1a	Mental Health Treatment	1,012	78	98	91	-7%	1,239	1,382	+11%
4c	School-Based Services	97	0	0	0	0%	0	0	0%
6a	Wraparound	718	173	279	285	+2%	3,874	5,493	+42%
7b	Expand Youth Crisis Services	951	121	111	143	+29%	1,180	1,964	+66%

Fourth Post

				Detention Bookings			Detention Days		
		Time Eligible	Use Eligible	Pre	Post 4	% Change	Pre	Post 4	% Change
9a	Juvenile Drug Court	93	77	212	110	-48%	2,622	2,311	-12%
5a	Juvenile Justice Assessments	599	434	959	571	-40%	12,321	12,364	0%
1a-1a	Mental Health Treatment	710	54	84	52	-38%	1,071	1,026	-4%
1a-2a	Outpatient SUD Treatment	1,015	291	496	349	-30%	6,268	5,183	-17%
6a	Wraparound	422	118	193	205	+6%	3,006	3,956	+32%

Fifth Post

				Detention Bookings			Detention Days		
		Time Eligible	Use Eligible	Pre	Post 5	% Change	Pre	Post 5	% Change
5a	Juvenile Justice Assessments	299	217	536	287	-46%	6,640	6,380	-4%
9a	Juvenile Drug Court	62	50	143	98	-31%	1,927	2,124	+10%
1a-2a	Outpatient SUD Treatment	787	220	375	272	-27%	4,165	4,956	+19%
1a-1a	Mental Health Treatment	552	48	67	51	-24%	908	996	+10%
6a	Wraparound	237	72	101	95	-6%	2,095	2,014	-4%

Total Harborview Emergency Department Admissions in Each Post Period

Targeted reductions in the number of admissions to Harborview Medical Center's emergency department (ED) were set in 2008 for MIDD strategies expected to have an impact on ED utilization, as shown at right. The number of people included in the analysis for each post period is displayed in the first table below, followed by ED use changes over time in strategy order, then in order of best reductions for the second post period where 10 of 14 strategies (71%) exceeded the reduction targets. The only strategy that met these targets in every post period was Strategy 12c—Psychiatric Emergency Services (PES) Linkage.

Harborview ED Admissions				
Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-10%
Post 2	-14%	-19%	-10%	-20%
Post 3	-13%	-32%	-10%	-30%
Post 4	-13%	-45%	-10%	-40%
Post 5	-15%	-60%	-10%	-50%

		Eligible by Time and Use				
		Post 1	Post 2	Post 3	Post 4	Post 5
1a-1a	Mental Health Treatment[1]	2,049	1,822	1,487	1,000	747
	Adults	2,010	1,781	1,449	967	726
	Youth[2]	39	41	38	33	21
1a-2a	Outpatient SUD Treatment	1,908	1,659	1,405	1,153	879
	Adults	1,814	1,574	1,335	1,085	833
	Youth[2]	94	85	70	68	46
1a-2b	Opiate SUD Treatment	652	597	527	456	381
1b	Outreach & Engagement	2,147	1,731	1,470	1,124	706
1c	Emergency Room Intervention	9,086	6,631	5,163	3,489	2,219
	Harborview	8,142	5,957	4,640	3,165	2,049
	South County	944	674	523	324	170
1d	Crisis Next Day Appointments	1,505	1,319	1,182	1,069	858
1g	Older Adults Prevention[3]	1,247	1,049	791	587	341
1h	Older Adults Crisis & Svc Linkage	261	164	121	96	53
3a	Supportive Housing	854	694	580	416	209
7b	Expand Youth Crisis Services	215	131	84	N/A	N/A
10b	Adult Crisis Diversion	1,988	892	162	N/A	N/A
12b	Hospital Re-Entry Respite Beds	754	471	219	N/A	N/A
12c	PES Linkage	433	390	324	286	217
16a	New Housing & Rental Subsidies	90	74	68	57	46

Top Three Strategies Reducing ED Use at Harborview Over the Long Term

Strategy 12c
Psychiatric Emergency Services Linkage

Strategy 1d
Crisis Next Day Appointments

Strategy 1h
Older Adults Crisis & Service Linkage

[1] Including Clubhouse participants
[2] Ages 9 to 18 at MIDD start
[3] Limited to those with services beyond

Strategy Order

		Pre	Post 1	% Change	Pre	Post 2	% Change	Pre	Post 3	% Change	Pre	Post 4	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	3,924	3,279	-16%	3,447	2,415	-30%	2,791	1,954	-30%	1,809	1,187	-34%	1,347	867	-36%
	Adults	3,903	3,249	-17%	3,426	2,387	-30%	2,772	1,918	-31%	1,791	1,161	-35%	1,331	859	-35%
	Youth	21	30	+43%	21	28	+33%	19	36	+89%	18	26	+44%	16	8	-50%
1a-2a	Outpatient SUD Treatment	3,562	2,930	-18%	3,036	2,266	-25%	2,532	2,049	-19%	2,079	1,455	-30%	1,661	1,135	-32%
	Adults	3,490	2,866	-18%	2,977	2,197	-26%	2,488	1,987	-20%	2,039	1,399	-31%	1,627	1,099	-32%
	Youth	72	64	-11%	59	69	+17%	44	62	+40%	40	56	+40%	34	36	+6%
1a-2b	Opiate SUD Treatment	1,149	1,253	+18%	1,065	1,091	+2%	890	805	-10%	740	790	+7%	641	620	-3%
1b	Outreach & Engagement	5,262	6,222	+9%	4,260	4,128	-3%	3,678	3,489	-5%	2,687	2,430	-10%	1,697	1,521	-10%
1c	Emergency Room Intervention	17,127	25,074	+46%	14,937	12,539	-16%	12,103	9,393	-22%	8,869	6,479	-27%	5,971	3,801	-36%
	Harborview	15,995	23,027	+44%	14,074	11,281	-20%	11,412	8,378	-27%	8,362	5,813	-30%	5,698	3,459	-39%
	South County	1,132	2,047	+81%	863	1,258	+46%	691	1,015	+47%	507	666	+31%	273	342	+25%
1d	Crisis Next Day Appointments	2,609	2,675	+3%	2,448	1,420	-42%	2,292	1,186	-48%	2,146	882	-59%	1,785	674	-62%
1g	Older Adults Prevention	2,152	1,999	-7%	1,741	1,353	-22%	1,277	1,132	-11%	978	795	-19%	589	414	-30%
1h	Older Adults Crisis & Svc Linkage	430	486	+13%	284	186	-35%	211	65	-69%	175	41	-77%	99	10	-90%
3a	Supportive Housing	4,309	2,722	-37%	3,148	1,734	-45%	2,495	1,489	-40%	1,766	1,036	-41%	780	535	-31%
7b	Expand Youth Crisis Services	150	171	+14%	109	78	-28%	58	64	+10%	N/A	N/A	N/A	N/A	N/A	N/A
10b	Adult Crisis Diversion	5,210	7,854	+51%	3,094	2,424	-22%	693	496	-28%	N/A	N/A	N/A	N/A	N/A	N/A
12b	Hospital Re-Entry Respite Beds	2,741	4,021	+47%	1,794	1,564	-13%	842	586	-30%	N/A	N/A	N/A	N/A	N/A	N/A
12c	PES Linkage	5,819	4,469	-23%	4,959	2,030	-59%	3,638	1,585	-56%	3,125	1,339	-57%	2,517	809	-68%
16a	New Housing & Rental Subsidies	182	115	-37%	131	79	-40%	120	70	-42%	104	53	-49%	86	53	-38%

Best Reductions Order

		Pre	Post 1	% Change	Pre	Post 2	% Change	Pre	Post 3	% Change	Pre	Post 4	% Change	Pre	Post 5	% Change
12c	PES Linkage	5,819	4,469	-23%	4,959	2,030	-59%	3,638	1,585	-56%	3,125	1,339	-57%	2,517	809	-68%
3a	Supportive Housing	4,309	2,722	-37%	3,148	1,734	-45%	2,495	1,489	-40%	1,766	1,036	-41%	780	535	-31%
1d	Crisis Next Day Appointments	2,609	2,675	+3%	2,448	1,420	-42%	2,292	1,186	-48%	2,146	882	-59%	1,785	674	-62%
16a	New Housing & Rental Subsidies	182	115	-37%	131	79	-40%	120	70	-42%	104	53	-49%	86	53	-38%
1h	Older Adults Crisis & Svc Linkage	430	486	+13%	284	186	-35%	211	65	-69%	175	41	-77%	99	10	-90%
1a-1a	Mental Health Treatment	3,924	3,279	-16%	3,447	2,415	-30%	2,791	1,954	-30%	1,809	1,187	-34%	1,347	867	-36%
7b	Expand Youth Crisis Services	150	171	+14%	109	78	-28%	58	64	+10%	N/A	N/A	N/A	N/A	N/A	N/A
1a-2a	Outpatient SUD Treatment	3,562	2,930	-18%	3,036	2,266	-25%	2,532	2,049	-19%	2,079	1,455	-30%	1,661	1,135	-32%
1g	Older Adults Prevention	2,152	1,999	-7%	1,741	1,353	-22%	1,277	1,132	-11%	978	795	-19%	589	414	-30%
10b	Adult Crisis Diversion	5,210	7,854	+51%	3,094	2,424	-22%	693	496	-28%	N/A	N/A	N/A	N/A	N/A	N/A
1c	Emergency Room Intervention	17,127	25,074	+46%	14,937	12,539	-16%	12,103	9,393	-22%	8,869	6,479	-27%	5,971	3,801	-36%
12b	Hospital Re-Entry Respite Beds	2,741	4,021	+47%	1,794	1,564	-13%	842	586	-30%	N/A	N/A	N/A	N/A	N/A	N/A
1b	Outreach & Engagement	5,262	6,222	+9%	4,260	4,128	-3%	3,678	3,489	-5%	2,687	2,430	-10%	1,697	1,521	-10%
1a-2b	Opiate SUD Treatment	1,149	1,253	+18%	1,065	1,091	+2%	890	805	-10%	740	790	+7%	641	620	-3%

Statewide Emergency Department Admissions Using Small Sample Comparisons

For the first time since MIDD began, information on emergency department (ED) use throughout the State of Washington became available for purchase. Budget considerations restricted the strategies for which data were sought and the size of samples submitted for matching purposes. Recent cohorts representative of individuals served in ten different MIDD strategies were chosen to pilot the use of this new ED data source (as shown in the table below). As expected, the statewide incidence of ED admissions was higher than the incidence of use found for each strategy using only Harborview data, because all King County hospitals contribute information to the source. Where the incidence rates were similar, people in these strategies are more likely to utilize Harborview than other EDs. Where the rates differ markedly, it is essential to consider ED use beyond Harborview in order to fully understand the relationship between participation in MIDD strategies and overall reductions in ED use.

Sample Characteristics

		Earliest Pre Date	Last Post 1 Date	Small Sample N[1]	ED Use Found	Incidence in Statewide Data Set (Sample Cohort)	Incidence in Harborview Data Set (All Cohorts)
1a-1a	Mental Health Treatment	10/2012	3/2015	410	235	57%	23%
1a-2a	Outpatient SUD Treatment	10/2012	3/2015	460	219	48%	20%
1a-2b	Opiate SUD Treatment	10/2012	3/2015	88	57	65%	31%
1b	Outreach & Engagement	7/2012	12/2014	371	200	54%	46%
1c	Emergency Room Intervention	1/2013	6/2015	818	626	77%	56%
	Harborview	1/2013	6/2015	511	403	79%	71%
	South County	1/2013	6/2015	307	223	73%	20%
1g	Older Adults Prevention[2]	7/2012	12/2014	280	155	55%	30%
3a	Supportive Housing	7/2012	12/2014	76	62	82%	66%
7b	Expand Youth Crisis Services	10/2012	3/2015	487	104	21%	8%
10b	Adult Crisis Diversion	10/2012	3/2015	812	536	66%	57%
12b	Hospital Re-Entry Respite Beds	10/2012	3/2015	146	122	84%	83%

[1] Data were requested for cohort(s) most representative of entire sample for each strategy

[2] Limited to those with services beyond screening

Using the new data source only, which provides information on both Harborview and non-Harborview EDs, first post period reductions in excess of five percent are highlighted in light green below. The strategies that met the reduction targets here had also met those targets using only the Harborview data source, as shown on Page 66. The one exception to this finding was for Strategy 1a-2b—Opiate Substance Use Disorder Treatment, which showed a short-term increase in admissions using the Harborview data source (+18%), but a decrease (-24%) using a smaller sample and the new data source. In general, if ED use increased over time at Harborview, it tended to increase at other hospitals within the state, too. An exception to this was for Strategy 1b—Outreach & Engagement, where increased use of Harborview's ED was somewhat offset by a reduction in use at other EDs.

New Data Source Only

		Harborview ED			Non-Harborview EDs			Combined		
		Pre	Post 1	% Change	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment	266	207	-22%	545	478	-12%	811	685	-16%
1a-2a	Outpatient SUD Treatment	235	166	-29%	364	364	0%	599	530	-12%
1a-2b	Opiate SUD Treatment	58	44	-24%	134	99	-26%	192	143	-26%
1b	Outreach & Engagement	503	566	+13%	622	583	-6%	1,125	1,149	+2%
1c	Emergency Room Intervention	873	1,301	+49%	1,885	2,433	+29%	2,758	3,734	+35%
	Harborview	771	1,103	+43%	1,081	1,295	+20%	1,852	2,398	+29%
	South County	102	198	+94%	804	1,138	+42%	906	1,336	+47%
1g	Older Adults Prevention[2]	99	76	-23%	197	203	+3%	296	279	-6%
3a	Supportive Housing	283	255	-10%	220	179	-19%	503	434	-14%
7b	Expand Youth Crisis Services	5	12	+140%	140	243	+74%	145	255	+76%
10b	Adult Crisis Diversion	773	1,346	+74%	2,425	2,951	+22%	3,198	4,297	+34%
12b	Hospital Re-Entry Respite Beds	425	528	+24%	390	353	-9%	815	881	+8%

To test the reliability of the new data source, ED use counts for individuals in the small sample request were compared to counts for those same people using the Harborview data source. For 64 percent of the matched cases, both ED data sources returned identical Harborview admission counts. Where differences existed, the Harborview source had reported ED admissions that the new source did not (29%), while in the remaining cases (7%), the new source reported Harborview ED admissions that the Harborview source did not. The identification criteria for matching requested individuals with their ED data may have led to the noted discrepancies.

Total Psychiatric Hospital Admissions and Days in Each Post Period

The targeted reduction goals for psychiatric hospitalizations as determined in 2008 are shown separately for adults and youth at right. In the first post period, three of 10 strategies (30%) were able to achieve reductions in both admissions and days greater than the 10 percent goal. By the third post analysis, six strategies plus the adult portion of Strategy 1a-1a—Mental Health Treatment showed reductions in admissions in excess of the goal for both adults (-26%) or youth (-30%). The sample reaching the greatest reductions (-86% by Post 5) in the number of combined days spent in community inpatient psychiatric hospitals and Western State Hospital was Strategy 16a—New Housing & Rental Subsidies, as shown on Page 69.

Psychiatric Hospital Admissions or Days

Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-10%	-10%	-10%	-10%
Post 2	-8%	-18%	-10%	-20%
Post 3	-8%	-26%	-10%	-30%
Post 4	-7%	-33%	-10%	-40%
Post 5	-7%	-40%	-10%	-50%

First Post

		Time Eligible	Use Eligible	Psychiatric Hospital Admits Pre	Post 1	% Change	Psychiatric Hospital Days Pre	Post 1	% Change
1a-1a	Mental Health Treatment[1]	8,900	1,255	2,262	1,280	-43%	35,166	20,512	-42%
	Adults	7,395	1,205	2,210	1,245	-44%	34,518	20,090	-42%
	Youth[2]	1,505	50	52	35	-33%	648	422	-35%
1b	Outreach & Engagement	4,630	240	242	293	+21%	3,318	3,780	+14%
1d	Crisis Next Day Appointments	2,830	514	438	623	+42%	5,450	7,677	+41%
1h	Older Adults Crisis & Svc Linkage	2,205	193	63	323	+413%	698	5,873	+741%
3a	Supportive Housing	1,302	273	665	341	-49%	15,633	7,263	-54%
7b	Expand Youth Crisis Services	2,710	467	168	643	+283%	1,670	8,497	+409%
10b	Adult Crisis Diversion	3,464	1,115	1,381	2,588	+87%	18,340	38,360	+109%
12b	Hospital Re-Entry Respite Beds	913	82	124	141	+14%	1,384	1,577	+14%
12c	PES Linkage	462	163	288	356	+24%	4,264	5,221	+22%
16a	New Housing & Rental Subsidies	161	126	415	130	-69%	11,565	2,864	-75%

[1] Including Clubhouse participants

[2] Ages 0 to 18 at MIDD start

Second Post

		Time Eligible	Use Eligible	Psychiatric Hospital Admits Pre	Post 2	% Change	Psychiatric Hospital Days Pre	Post 2	% Change
1a-1a	Mental Health Treatment[1]	8,162	1,100	1,952	899	-54%	29,369	17,791	-39%
	Adults	6,827	1,053	1,905	863	-55%	28,787	16,917	-41%
	Youth[2]	1,335	47	47	36	-23%	582	874	+50%
1b	Outreach & Engagement	4,040	194	208	232	+12%	3,038	3,143	+3%
1d	Crisis Next Day Appointments	2,584	376	418	373	-11%	5,253	5,400	+3%
1h	Older Adults Crisis & Svc Linkage	1,838	78	53	107	+102%	619	3,664	+492%
3a	Supportive Housing	1,081	241	536	322	-40%	13,836	7,774	-44%
7b	Expand Youth Crisis Services	1,814	148	139	121	-13%	1,287	1,629	+27%
10b	Adult Crisis Diversion	1,819	453	789	752	-5%	11,566	14,614	+26%
12b	Hospital Re-Entry Respite Beds	641	54	82	69	-16%	1,005	1,066	+6%
12c	PES Linkage	415	125	239	155	-35%	3,912	2,993	-23%
16a	New Housing & Rental Subsidies	136	101	342	123	-64%	9,935	2,574	-74%

Third Post

		Time Eligible	Use Eligible	Psychiatric Hospital Admits Pre	Post 3	% Change	Psychiatric Hospital Days Pre	Post 3	% Change
1a-1a	Mental Health Treatment[1]	6,806	881	1,485	771	-48%	23,536	17,684	-25%
	Adults	5,632	383	1,441	739	-49%	22,976	16,800	-27%
	Youth[2]	1,174	43	44	32	-27%	560	884	+58%
1b	Outreach & Engagement	3,441	162	180	175	-3%	2,532	3,020	+19%
1d	Crisis Next Day Appointments	2,325	324	390	274	-30%	4,908	4,692	-4%
1h	Older Adults Crisis & Svc Linkage	1,447	42	32	47	+47%	463	1,648	+256%
3a	Supportive Housing	910	188	384	274	-29%	10,795	6,982	-35%
7b	Expand Youth Crisis Services	951	88	90	60	-33%	899	1,347	+50%
10b	Adult Crisis Diversion	290	78	155	142	-8%	2,224	2,911	+31%
12b	Hospital Re-Entry Respite Beds	297	26	36	11	-69%	340	411	+30%
12c	PES Linkage	346	100	193	74	-62%	3,328	2,000	-40%
16a	New Housing & Rental Subsidies	122	90	285	106	-63%	8,727	2,417	-72%

Fourth Post

		Time Eligible	Use Eligible	Psychiatric Hospital Admits			Psychiatric Hospital Days		
				Pre	Post 4	% Change	Pre	Post 4	% Change
1a-1a	Mental Health Treatment	4,547	568	919	506	-45%	15,371	12,723	-17%
	Adults	3,719	538	886	481	-46%	14,930	12,154	-19%
	Youth[2]	828	30	33	25	-24%	441	569	+29%
1b	Outreach & Engagement	2,686	124	134	134	0%	1,978	2,164	+9%
1d	Crisis Next Day Appointments	2,121	269	352	220	-38%	4,630	4,640	0%
1h	Older Adults Crisis & Svc Linkage	1,145	25	15	33	+120%	230	827	+260%
3a	Supportive Housing	694	131	369	189	-30%	7,552	6,804	-10%
12c	PES Linkage	300	82	172	87	-49%	2,988	2,216	-29%
16a	New Housing & Rental Subsidies	108	76	238	55	-77%	7,755	1,403	-82%

Fifth Post

		Time Eligible	Use Eligible	Psychiatric Hospital Admits			Psychiatric Hospital Days		
				Pre	Post 5	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	3,623	425	677	361	-47%	11,149	8,922	-20%
	Adults	2,971	400	651	342	-47%	10,786	8,383	-22%
	Youth[2]	652	25	26	19	-27%	363	539	+60%
1b	Outreach & Engagement	1,798	60	78	49	-37%	1,208	1,166	-3%
1d	Crisis Next Day Appointments	1,750	218	276	157	-43%	3,938	3,782	-4%
1h	Older Adults Crisis & Svc Linkage	754	<10	<10	<10	-63%	163	94	-42%
3a	Supportive Housing	380	73	132	118	-11%	4,231	4,546	+7%
12c	PES Linkage	226	65	139	73	-47%	2,547	2,338	-8%
16a	New Housing & Rental Subsidies	84	57	163	38	-77%	5,515	756	-86%