ATTACHMENT 1

King County

Mental Illness and Drug Dependency Review and Renewal Progress Report

As Required by Ordinance 17998

November 2015

Contents

Executive Summary

King County's Mental Illness and Drug Dependency Tax and Services

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 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.

Please note that in this report, the first eight years of the MIDD sales tax is referred to as MIDD I, while the potential renewal of MIDD for 2017 and beyond is referenced as MIDD II.

Ordinance 17998

Ordinance 17998 calls for two major work products to be submitted to the Council:

1. **Comprehensive, Historical Review and Assessment of MIDD: Due June 30, 2016**
   This work includes an extensive examination and assessment of MIDD I strategies, programs, and services. It also calls for recommendations on improvements to MIDD performance measures, evaluation data gathering and a review of the MIDD evaluation processes.

2. **MIDD Service Improvement Plan: Due December 1, 2016**
   The MIDD II service improvement plan requires detailed descriptions of each proposed MIDD II program to be funded by a renewed MIDD sales tax. Spending plans, implementation schedules, performance measures, outcomes, and process changes are also to be included in the report. The programs recommended for funding in the MIDD service improvement plan must demonstrate that they are related to successful outcomes and best or promising practices, incorporate the goals and principles of recovery, reflect the County's policy goals, and integrate with other policy and planning endeavors.

   The Office of Performance, Strategy and Budget (PSB) has requested that the MIDD II service improvement plan be transmitted concurrently with the 2017-2018 biennial budget in September 2016.

Each product requires major data gathering, synthesis, and determination of findings.

Scope of This Report

This report outlines the approach and activities to date by King County and the MIDD Oversight Committee in fulfilling the requirements of Ordinance 17998.

This report also provides important contextual information, outlining the background and impacts of the changes to the behavioral health system in King County and Washington in recent years. Improvements and innovations initiated or influenced by King County and its partners, as well as coordination with other related work in the community, are detailed in this report.

Approach and Progress to Date

The Department of Community and Human Services (DCHS) began work on MIDD I review and MIDD II planning in December 2014. Committed to transparency and broad stakeholder involvement, the department has engaged in a vigorous and inclusive planning process with the MIDD Oversight Committee and other stakeholders. Using a collaborative staffing approach to develop and share information and processes, DCHS works closely with Council and Executive staff, including staff from the Office of Performance, Strategy and Budget, along with Public Health, Department of Public Defense, Executive Office, and other agencies and departments in King County.

The MIDD Oversight Committee continues to play a critical role in advising and guiding staff on MIDD I review and MIDD II planning work. A Strategy Team comprised of individuals from the MIDD Oversight Committee meets twice a month with County staff to facilitate a higher degree of planning and collaboration between the County and the MIDD Oversight Committee. Each MIDD Oversight Committee meeting includes a briefing on the work of the Strategy Team at each meeting.

The Department of Community and Human Services determined that in order to develop a comprehensive, balanced, and forward-thinking MIDD II service improvement plan, and fulfill the requirements of Ordinance 17998, it was necessary to create extensive public and stakeholder input opportunities, along with detailed data gathering and careful data analysis. To these ends, DCHS, in collaboration with the MIDD Oversight Committee, has launched:

- dynamic and inclusive community engagement and information sharing activities that include a variety of in-person community and stakeholder conversations;
- a website hub where all things MIDD-related are available for the public, from meeting announcements to relevant policy documents;
- a survey (available electronically and hard copy) to gather feedback broadly; and
- a new concepts process whereby interested parties can suggest a new idea for potential consideration in the MIDD II service improvement plan.

Additionally, to support and instruct MIDD review and planning matters, the MIDD Oversight Committee has established values and guiding principles. The Department of Community and Human Services' staff and the MIDD Oversight Committee have developed a MIDD II framework that identifies and organizes the key components of MIDD moving forward. The MIDD II framework includes concepts from other county-wide policy and planning work, including behavioral health integration, Accountable Communities of Health (ACH), King County's Strategic Plan, Youth Action Plan (YAP), and Health and Human Services Transformation Plan (HHSTP). The framework was developed using Results Based Accountability (RBA) principles. The Results Based Accountability uses a data-driven, decision-making process to help communities and organizations get beyond talking about problems to taking action to solve problems.

Foundational to the department's approach to MIDD I review and MIDD II planning work is the intentional effort to involve members of the King County Council and their staff in MIDD-related activities. In addition to offering individual member briefings and being available to brief Council committees, DCHS has established standing monthly MIDD meetings with Council staff.

Next Steps

County staff, in partnership with the MIDD Oversight Committee, have developed and initiated comprehensive plans and processes to accomplish the tasks called for by Ordinance 17998. These plans and processes will result in delivering to Council and the public a thorough, clear, and strategic MIDD II Service Improvement Plan along with the detailed, objective assessment of MIDD I.

The next components of the MIDD review and renewal planning work consists of carrying out community and stakeholder meetings, and continuing to gather and review data, synthesize survey feedback, and begin the complex tasks of drafting briefing papers. Momentum is building around the results of the New Concepts suggestions, which are anticipated to result in exciting new ideas to consider for MIDD.

Background

State Authorizes Revenue Tool

The Washington State Legislature passed the Omnibus Mental Health and Substance Abuse Act in 2005. In addition to promoting a series of strategies to enhance the State's chemical dependency and mental health treatment services, the law authorized counties to levy a one-tenth of one percent sales and use tax to fund new mental health, chemical dependency, or therapeutic court services. Revised Code of Washington (RCW) 82.14.460 states:

> *(1)(a) A county legislative authority may authorize, fix, and impose a sales and use tax in accordance with the terms of this chapter.*
>
> *(b) If a county with a population over eight hundred thousand has not imposed the tax authorized under this subsection by January 1, 2011, any city with a population over thirty thousand located in that county may authorize, fix, and impose the sales and use tax in accordance with the terms of this chapter. The county must provide a credit against its tax for the full amount of tax imposed under this subsection (1)(b) by any city located in that county if the county imposes the tax after January 1, 2011.*
>
> *(2) The tax authorized in this section is in addition to any other taxes authorized by law and must be collected from those persons who are taxable by the state under chapters 82.08 and 82.12 RCW upon the occurrence of any taxable event within the county for a county's tax and within a city for a city's tax. The rate of tax equals one-tenth of one percent of the selling price in the case of a sales tax, or value of the article used, in the case of a use tax.*
>
> *(3) Moneys collected under this section must be used solely for the purpose of providing for the operation or delivery of chemical dependency or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services. For the purposes of this section, "programs and services" includes, but is not limited to, treatment services, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service.*
>
> *(4) All moneys collected under this section must be used solely for the purpose of providing new or expanded programs and services as provided in this section, except as follows:*
>
> *(a) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposed the tax authorized under this section prior to January 1, 2012, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding in calendar years 2011-2012; up to forty percent may be used to supplant existing funding in calendar year 2013; up to thirty percent may*

be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016;

(b) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposes the tax authorized under this section after December 31, 2011, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding for up to the first three calendar years following adoption; and up to twenty-five percent may be used to supplant existing funding for the fourth and fifth years after adoption;

(c) For a county with a population of less than twenty-five thousand, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to eighty percent may be used to supplant existing funding in calendar years 2011-2012; up to sixty percent may be used to supplant existing funding in calendar year 2013; up to forty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016; and

(d) Notwithstanding (a) through (c) of this subsection, moneys collected under this section may be used to support the cost of the judicial officer and support staff of a therapeutic court.

(5) Nothing in this section may be interpreted to prohibit the use of moneys collected under this section for the replacement of lapsed federal funding previously provided for the operation or delivery of services and programs as provided in this section.

The state statute has been amended several times since its origination in 2005. The first change (2008) allowed for housing that is a component of a coordinated chemical dependency or mental health treatment program or service. Most notably, the statue was amended twice (2009 and 2011) to allow for supplantation (backfill) of lost revenues by sales tax funds on a predetermined schedule, specifying a percentage of revenue per year allowed to be used as backfill. Another modification of the law specified the revenue may be used to support the cost of the judicial officer and support staff of a therapeutic court without being considered as supplantation. During the 2015 legislative session, transportation was added to the list of mental health programs and services that may be supported by the revenue.

King County's Mental Illness and Drug Dependency Sales Tax Enacted

In 2006 after hearing from county criminal justice and human services agency leaders that many people with mental illness and chemical dependency were caught up in the costly justice system due to lack of access to appropriate treatment options, the King County Council called for the development of a three-phase action plan: "*... to prevent and reduce 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 by implementing a full continuum of treatment, housing and case*

management services" (Motion 12320). The action plan was accepted by the Council in 2007 and set the stage for subsequent Council action on the sales tax.

In 2007, the King County Council enacted the Mental Illness and Drug Dependency (MIDD) sales tax based on RCW 82.14.1460 via Ordinance 15949. In addition to authorizing the collection of sales tax revenue, Ordinance 15949 created a sunset date of January 1, 2017 for the sales tax. (The first eight years of the MIDD sales tax is referred to in this report as MIDD I, while potential renewal of MIDD for 2017 and beyond is referenced as MIDD II.) Ordinance 15949 states:

> *The expiration of the tax is established to enable progress toward meeting the county's policy goals outcomes, and to enable evaluations of the programs funded with the sales tax revenue to take place and for the county to deliberate on the success of meeting policy goals and outcomes.* [1]

Ordinance 15949 established five policy goals for King County's MIDD sales tax shown below. These goals have guided and informed all aspects of the MIDD policy and services work since 2007.

MIDD Adopted Policy Goals

Policy Goal 1: *Reduce the number of mentally ill and chemically dependent people using costly interventions, such as, jail, emergency rooms, and hospitals*

Policy Goal 2: *Reduce the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.*

Policy Goal 3: *Reduce the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.*

Policy Goal 4: *Divert mentally ill and chemically dependent youth and adults from initial or further justice system involvement.*

Policy Goal 5: *Explicit linkage with, and furthering the work of, other Council directed efforts including, the Adult and Juvenile Justice Operational Master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.*

Ordinance 15949 also included the Council's direction in two areas not addressed by the Action Plan. The Council required that the Implementation Plan address expansion of King County's Adult Drug Diversion Court. The Council also required programs that supported specialized mental health or substance abuse counseling, therapy, and support for survivors of sexual assault and domestic violence for adults and children be integrated into the MIDD implementation planning.

MIDD Implementation: Oversight, Implementation, and Evaluation Plans

Ordinance 15949 called for key foundational planning documents necessary to the successful and transparent implementation of the MIDD. The legislation called on the Departments of Community and Human Services, Adult and Juvenile Detention, Public Health, the Offices of the Public Defender and

[1] King County Ordinance 15949, section 1 H, lines 73-76.

Prosecuting Attorney, and Superior and District Courts to develop and submit to the Council MIDD oversight, implementation, and evaluation plans.

The MIDD Oversight Plan, adopted by Ordinance 16077, established the MIDD Oversight Committee. It set the role and duties of the Oversight Committee, and established the composition of the Oversight Committee. As described in legislation, the Oversight Committee is responsible for the ongoing oversight of MIDD services and programs funded with the sales tax revenue. It acts as an advisory body to the Executive and the Council, reviewing and making recommendations on the implementation and effectiveness of the sales tax programs in meeting the five established policy goals. It reviews and comments on all required reports and on emerging and evolving priorities for use of the MIDD funds. Ordinance 16077 states that the Oversight Committee "should promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers, and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts."[2] Ultimately, the Oversight Committee's purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable, and collaborative.

The 30-member MIDD Oversight Committee meets regularly to discuss, review, and at times make recommendations on MIDD-related matters. Membership purposely includes a wide array of subject matter experts and stakeholder groups, including the Sound Cities Association (formerly Suburban Cities Association), and the cities of Bellevue and Seattle. There are eleven King County government seats on the committee. A complete list of current MIDD Oversight Committee seats and current members are included in Appendix A.

The MIDD Implementation Plan was adopted via Ordinance 16261 on October 6, 2008. Per Ordinance 15949, the MIDD I Implementation Plan was developed in collaboration with the Oversight Committee. The Implementation Plan described the implementation of the programs and services outlined in the MIDD Action Plan. As required, it included a discussion of needed resources (staff, information, and provider), milestones for implementation of programs, and a spending plan. It also addressed expansion of Adult Drug Court and mental health and substance abuse services for survivors of domestic violence and sexual assault.

The Implementation Plan outlined the steps and timeline for creation of the comprehensive programming that became MIDD I programs. The Implementation Plan summarized the collaborative work of many entities over a two-year period to organize and develop the work that eventually became the MIDD. The document states that the Implementation Plan is "a product of a comprehensive, multi-jurisdictional plan to help youth and adults who are at risk for or suffer from mental illness or substance abuse."[3]

The Sequential Intercept Model was used as an organizing framework to determine what services were needed under MIDD I to help prevent incarceration, hospitalization, and homelessness. The Sequential Intercept Model presents a framework for communities to examine the cross-systems "flow" of persons with mental health and co-occurring disorders as they come into contact with the criminal justice and behavioral health systems. Entities (such as law enforcement, hospitals, courts, jails, and community supports) within the systems are categorized into five "intercepts" based on the predictable order in which a person would come into contact with them. The Sequential Intercept Model has been adopted by a number of communities across the nation as an action blueprint for planning system change in the

[2] Ordinance 16077 Section 1 E, lines 44-47.

[3] Ordinance 16261, Attachment A Mental Illness and Drug Dependency Implementation Plan Version 6 – Revised October 6, 2008 – FINAL, page 5.

way that communities address the problem of people with mental illness in their criminal justice systems.

The Implementation Plan grouped programs into five service areas: the first three were included in the MIDD Action Plan that was accepted by the King County Council in October 2007. The fourth service area of the MIDD Implementation Plan reflected the Council's direction to address domestic violence and sexual assault, mental health and substance abuse programs and Adult Drug Diversion Court. The fifth and final service area addresses the housing needs of individuals with serious mental illness and chemical dependency based in a change in State law which clarified the use of sales tax collections for housing. The five areas are detailed below:

MIDD I Service Areas and Programming

MIDD I Service Area	MIDD Programs and Strategies
Community Based Care	• Increase access to community mental health and substance abuse treatment for uninsured children, adults, and older adults • Improve the quality of care by decreasing mental health caseloads and providing specialized employment services • Provide supportive services for housing projects serving people with mental illness and chemical dependency treatment needs
Programs Targeted to Help Youth	• Expand prevention and early intervention programs • Expand assessments for youth in the juvenile justice system • Provide comprehensive team-based, intensive "wraparound" services • Expand services for youth in crisis • Maintain and expand Family Treatment Court and Juvenile Drug Court
Jail and Hospital Diversion	• Divert people who do not need to be in jail or hospital through crisis intervention training for police and other first responders and by creating a crisis diversion facility • Expand mental health courts and other post-booking services to get people out of jail and into services faster • Expand programs that help individuals re-enter the community from jails and hospitals
Domestic Violence and Sexual Assault and Adult Drug Court	• Address the mental health needs of children who have been exposed to domestic violence • Increase access to coordinated, early intervention mental health and substance abuse services for survivors of domestic violence • Increase access to treatment services for victims of sexual assault • Enhance services available through the King County Adult Drug Diversion Court
Housing Development	• Support capital projects and rental subsidies for people with mental illness and chemical dependency

The Implementation Plan contained information on each individual program (strategy) including the following:

- A needs statement;
- A description of services;
- A discussion of needed resources, including staff, information and provider contracts; and
- Milestones for implementation of the program.

The plan also included a schedule for the implementation of programs, a 2008 spending plan, and a financial plan for the mental illness and drug dependency fund. Finally, each program (strategy) included a list of linkages to other programs and planning and coordinating efforts, highlighting critical collaboration and coordination are necessary to the successful implementation of the MIDD I Plan.

Additionally, the adopted MIDD Implementation Plan included two additional programs added by the Council that were not in the Executive's transmitted plan: Crisis Intervention Team/Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project.

A list of all MIDD I programs & strategies are shown in Appendix B.

The MIDD Evaluation Plan, the third required component of Ordinance 15949, was adopted by the Council on October 10, 2008 via Ordinance 16262. As specified in Ordinance 15949, the Evaluation Plan submitted to the Council was to contain process and outcome evaluation components, a schedule for evaluations, performance measurements and performance measurement targets, and data elements used for reporting and evaluations. Detailed direction on performance measures was also outlined in Ordinance, along with a quarterly report schedule and the specific components of annual and quarterly reporting. The legislation that adopted the Evaluation Plan also outlined how and when revisions to the Evaluation Plan and processes, and performance measures and targets were to be communicated to the Council and the public.

The MIDD Evaluation Plan identified a framework for evaluating most of the programs (strategies) in the MIDD Implementation Plan except the two added by the Council: Crisis Intervention Team / Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project. The Evaluation Plan stated that evaluation would be accomplished "by measuring what is done (output), how it is done (process), and the effects of what is done (outcome)."[4]

The approach to the MIDD I evaluation contained in the plan notes the role of quality management approaches used by the Department of Community and Human Services' Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) in fulfilling its responsibilities for the publicly funded mental health and substance abuse treatment systems:

> *MHCADSD must demonstrate to federal, state, and county government the capacity to operate and monitor a complex network of service providers. This is accomplished through well-established quality assurance and improvement strategies, including contract development and monitoring, setting expectations for performance, conducting periodic review of performance, and offering continuous feedback to providers regarding successes and needed improvements. In that context, all MIDD contracts will specify what the provider is expected to do, including service provision, data submission, and reporting of key deliverables. The MIDD evaluation will extend beyond the contract monitoring process to assess whether services were performed effectively, and whether they resulted in improved outcomes for the individuals involved in those services.*[5]

The Evaluation Plan stated that evaluation matrices for strategies were developed from the programs and strategies outlined in the Implementation Plan. It also noted that some strategies were in the

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[4] Ordinance 16262 Attachment A Mental Illness and Drug Dependency Action Plan Part 3 – Evaluation Plan Version 2 REVISED 9-2-08, page 11.

[5] Ibid, page 18.

process of being developed at the time that the Evaluation Plan was finalized and the evaluation plan for those strategies would be revised as plans are finalized.

Updates to the Evaluation Plan were and continue to be included in the quarterly, bi-annual, and annual reports reviewed by the MIDD Oversight Committee and transmitted to the King County Executive and the Council.

In April 2012, a Supplantation Evaluation Plan was completed by DCHS. It outlined the approach and framework to completing evaluations for programs receiving supplanted MIDD funds. Supplantation is discussed below.

Supplantation

The 2005 legislation that authorized counties to implement a one-tenth of one percent sales and use tax did not permit the revenues to be used to supplant other existing funding. During the 2009 and the 2011 Legislative sessions, Washington State Legislators approved changes to the state statute that modified the non-supplantation language of the law, and allowed MIDD revenue to replace (supplant) funds for existing mental health, chemical dependency, and therapeutic court services and programs, not only new or expanded programs. It also permitted MIDD funds to be used to support the cost of the judicial officer and support staff of a therapeutic court. The step down in supplantation funds was modified in 2011 as follows:

- 2015: 20 percent
- 2016: 10 percent
- 2017: 0 percent (the King County MIDD I expires in 2017; should MIDD I be renewed as MIDD II, the 2017-2018 budget would reflect it)

King County is currently budgeted to supplant about $13.9 million in MIDD revenue during the 2015-2016 biennium for programs formerly supported by the General Fund. Programs currently supplanted by MIDD funds in 2015 are shown in Appendix C.

Please note that this figure does not reflect increased revenue projections over the biennium.

MIDD Today

The MIDD today is going strong, building on success and looking toward the future. Data from the Seventh Annual MIDD Report covering the period of October 1, 2013 to September 30, 2014 shows:

- Clients served by MIDD substance use disorder treatment programs reduced their jail bookings by 72 percent over the long term.
- Significant reductions in Harborview Emergency Department visits were seen in 11 strategies with longer term data.
- Intensive services provided to youth under strategy 7b helped more than 80 percent of youth in crisis remain at home rather than going to foster care, group care, or to relatives.
- At least 33,929 individuals (20,421 adults and 13,508 children) were served by one or more MIDD funded programs during the reporting period.
- Among programs/strategies where data about performance targets were available, 80 percent met more than 85 percent of goals.

Of the 37 original programs/strategies conceived by MIDD planners in 2006-2008, 32 are operational as of the writing of this progress report. Two strategies, Crisis Intervention Team/Mental Health Partnership (17a) and Safe Housing and Treatment for Children in Prostitution (17b) secured funding from other sources and did not require MIDD funds. Three youth strategies: Services for Parents in Substance Abuse Outpatient Treatment (4a); Prevention Services to Children of Substance Abusing Parents (4b); and Reception Centers for Youth in Crisis (7a) remain on hold. At the time of drafting this report, a modified version of Strategy 7a is under review by the Council for supplemental appropriation.

For the first time since 2008, the MIDD I fund had a modest undesignated fund balance this year. Compared to 2009 and 2011 when the Oversight Committee was asked to make recommendations on programmatic reductions necessitated by gravely reduced revenues resulting from the recession, the unplanned fund balance has resulted in the opportunity to restore programs and address other emerging needs. The Oversight Committee is initiating a standing Fund Balance Review subcommittee to have analysis and recommendations ready for future opportunities to utilize undesignated fund balance.

The MIDD Oversight Committee is also deeply engaged with the tasks required by Ordinance 17998, as described in subsequent sections of this report.

The current MIDD provides a strong foundation on which to plan MIDD II, building on the very best of what worked and positioning the County's behavioral health system to serve more people and achieve more notable outcomes even as conditions evolve.

Policy and Environmental Changes Since 2007

Since the passage of MIDD in 2007 there have been seismic shifts in the mental health and substance abuse worlds, including the forthcoming merging of mental health and substance abuse systems into one behavioral health system by April 2016 state legislation. The leading change factors necessitating retooling of MIDD I into MIDD II are highlighted below. Notably, many of the change drivers are interconnected.

Affordable Care Act

The Affordable Care Act (ACA) builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal parity protections to millions of Americans. The parity law seeks to establish conformity of coverage for mental health and substance use conditions with coverage for medical and surgical care. The ACA builds on the parity law by requiring coverage of mental health and substance use disorder benefits for people who lacked these benefits, and expanding parity requirements to those whose coverage did not previously comply with those requirements.

Since January 1, 2014, when Medicaid eligibility expanded under ACA implementation, King County has seen a significant increase in the number of people enrolled in Medicaid. As of August 1, 2015, approximately 146,000 individuals have become newly eligible for Medicaid services in King County; of those, about 10,000 have accessed outpatient mental health services from the King County Regional Support Network (RSN). As of August 1, 2015, there are approximately 395,000 Medicaid-covered individuals in King County's RSN.

Because the RSN is paid on a per member per month basis from the state, the increase in clients has resulted in revenue growth. This in turn has allowed the King County RSN to raise outpatient case rates paid to providers. It is important to recognize that although case rates went up, caseloads remain high. Unfortunately, the system is experiencing a bow wave, which is exacerbated because there were too few providers available before the advent of expanded ACA coverage. Because practitioners can still be paid more outside of the community mental health system, the mental health system is struggling to find and/or retain trained, licensed, and qualified staff to provide services to this expanded population. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Workforce development is discussed in detail a subsequent section of this document.

Prior to the advent of ACA, most people serviced in the substance use disorder system were not eligible for Medicaid, as substance use disorders were not considered as a "qualifying benefit". Those with a dual diagnosis (substance use disorder with mental health diagnosis) were required to prove that the mental health diagnosis was in existence and diagnosed prior to starting their substance use or had to have remained abstinent for a considerable amount of time to show the continued presence of a mental health condition. Thus, prior to the ACA, the ability to treat individuals for Substance Use Disorder (SUD) services was most often reliant on a finite pool of local and state funds. Additionally, people treated in the SUD disorder system without Medicaid, did not have access to medical and dental coverage, unable to treat conditions that may have been exacerbated by their use. Under the ACA, persons no longer need to qualify for eligibility based on diagnosis, but qualify for services based on income. This has resulted in a significant increase in clients becoming eligible for Medicaid-supported substance use treatment. In the most recent quarter, 63 percent of people receiving SUD treatment were on Medicaid, compared to 10-15 percent in 2013 prior to ACA implementation.

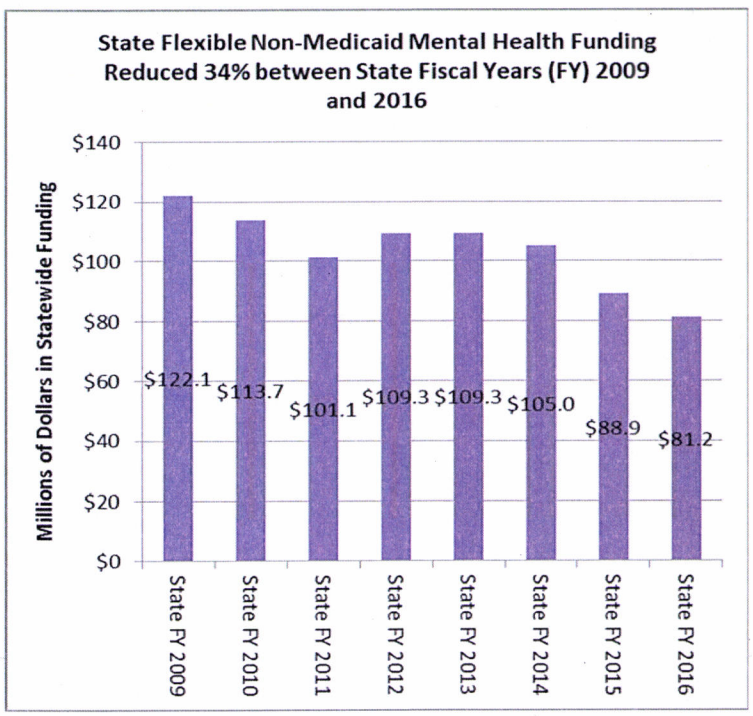
As with the mental health system, the large scale conversion to Medicaid has impacted substance use providers. On average, Medicaid reimbursement rates are 20-25 percent less than what treatment agencies were paid for the same clients for the same service provided prior to ACA. The previous rates were already low, but the Medicaid rate has been even more difficult to for providers. These lower rates prevent agencies from providing appropriate pay for well-qualified staff, hence leading to staff leaving, and the inability to hire qualified staff turning into a workforce drought. While the legislature did provide for some rate increases for substance use during the most recent session ($6.8M statewide), the impact of reduced rates is still deeply experienced by providers.

There is a common misconception that Medicaid expansion under the ACA would greatly reduce or eliminate the need for other revenue sources for behavioral health services. One important aspect to note with regard to Medicaid expansion is that despite expansion, there remains a portion of King County residents who are not covered by Medicaid or private insurance. Most refugees, along with any undocumented person, do not receive Medicaid insurance. Further, Medicaid does not always cover many essential services like long term (more than 30 days) inpatient hospitalization (such as at Western State), designated mental health professionals for crisis outreach, residential services, detoxification and sobering services, and emergency mobile outreach services for homeless adults.

Resource Scarcity

Over the years since MIDD was first authorized, there have been significant reductions in a variety of critical resources. Major cuts to flexible non-Medicaid mental health funds from the state have deeply impacted access to behavioral health services. These non-Medicaid funds are prioritized for crisis, involuntary commitment, residential, and inpatient services and play an important role in creating and maintaining a comprehensive continuum of community-based behavioral care. They also enable King County to facilitate treatment access for individuals who do not have Medicaid.

As shown below, between state fiscal years 2009 and 2015, there was a loss of $33.2 million (27 percent) statewide for these critical services. During the most recent legislative session there were further cuts to flexible non-Medicaid for the 2016-2017 biennium. Consequently, the reductions have had deep and dramatic effects on the community's ability to respond to growing needs and maintain or develop creative solutions to improve outcomes for individuals with mental illnesses or substance use disorders.



This severe resource scarcity has coexisted with a very high prevalence of treatment need in Washington as compared to other states. Analysis of data from the federal Substance Abuse and Mental Health Administration (SAMHSA) 2010-11 Mental Health Surveillance Survey found that

Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (7 percent).[6]

More and more people are seeking psychiatric care via hospital EDs – in 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of psychiatric ED visits, 41 percent result in a hospital admission, over two and a half times the rate of ED visits for other conditions,[7] and between 2001 and 2006 the average duration of such visits were 42 percent longer than for non-psychiatric issues.[8] The growth in these figures may result from the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally, that began as part of deinstitutionalization in the 1960s and has continued until very recently.[9]

Population Growth: The population of King County grew by an estimated 20 percent between 2000 and 2014 – almost 343,000 people. Meanwhile, the state's population increased by approximately 20 percent as well – or nearly 1.2 million.[10] Just this one factor alone – the addition of so many additional residents – would have placed more pressure on an overstretched community behavioral health treatment system.

In King County and Washington, rescource scarcity has been driven by a confluence of factors: community and inpatient resources are scarce, while at the same time the treatment need is very high, the population is growing quickly, and laws are changing.

Behavioral Health Integration

In March 2014, the Washington State Legislature passed Senate Bill 6312 calling for the integrated purchasing of mental health and substance abuse treatment services through managed care contracts by April 2016, with full integration of physical and behavioral health care by January 2020. The law necessitated the creation of Behavioral Health Organizations (BHOs) to purchase and administer Medicaid funded mental health and substance use disorder services under managed care. BHOs are single, local entities that will assume responsibility and financial risk for providing substance use disorder treatment and the mental health services currently overseen by the counties and RSNs. BHO services will include inpatient and outpatient treatment, involuntary treatment and crisis services, jail provided services, and services funded by federal block grants. The King County Mental Health, Chemical Abuse and Dependency Services Division will serve as the BHO for the King County region.

Implementation of 2SSB 6312 will bring changes to how behavioral health (including both mental health and substance abuse treatment) services are administered and delivered in King County. The biggest changes will be to the substance use disorder treatment system as it moves from its current fee for service payment structure to managed care. This includes new "books of business" for the County as

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[6] Burley, M. & Scott, A. (2015).

[7] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality (2010), as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[8] Slade EP, Dixon LB, Semmel S. Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv* 2010, 61(9), 878-84, as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[9] Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[10] U.S. Census Bureau State and County QuickFacts, retrieved from http://quickfacts.census.gov/qfd/states/53/53033.html, and Population for the 15 Largest Counties and Incorporated Places in Washington: 1990 and 2000, retrieved from https://www.census.gov/census2000/pdf/wa_tab_6.PDF.

well as changes to contracting, payment structures, data collection and reporting, and other administrative processes. An integrated behavioral health system will allow more flexibility to deliver holistic care especially for individuals with co-occurring mental health and substance use disorders. Notably, Senate Bill 6312 requires that King County's new behavioral health system provide access to recovery support services, such as housing, supported employment and connections to peers.

One notable change initiated by behavioral health integration is the evolution of terminology used to define and describe the mental health and substance use disorder systems. King County is making the conscious effort to use the term "behavioral health" when referencing mental health and substance use disorder systems, reflecting the joining of systems through behavioral health integration.

More information on statewide BHO development can be found here: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/developing-behavioral-health-organizations.

Other State Legislation and Court Rulings

Psychiatric Boarding: On August 7, 2014, the Washington State Supreme Court ruled that hospital boarding of individuals in mental health crisis, absent medical need, is unconstitutional. Psychiatric boarding or "boarding" became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as emergency departments until a psychiatric bed became available. This has been a nationwide problem that had been affecting Washington and King County since at least 2009.

The Washington State Supreme Court, in its 2014 In re the Detention of D.W. et al decision, defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, the Court emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of bed capacity.[11]

Psychiatric boarding is a treatment access crisis that hurts patients and drives resources away from community-based and preventive care. Nationally, studies show that prolonged waits in emergency departments for psychiatric patients are associated with lower quality mental health care, as the chaotic ED environment increases stress and can worsen patients' conditions[12] and due to the fact that adequate psychiatric services are often not provided.[13]

Forensic Competency Evaluations: In April 2015, a US District Court judge issued a permanent injunction ordering the Washington Department of Social and Health Services to provide competency evaluations to individuals in jails within seven days of booking. Judges order competency evaluations for individuals who are detained when they have concerns about whether the person arrested is able to assist with his or her defense. If the person is found incompetent, the judge orders treatment to have competency

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[11] *In re the Detention of D.W., et al.* Case 90110-4. Washington State Supreme Court, retrieved from http://www.courts.wa.gov/opinions/pdf/901104.pdf.

[12] Bender, D., Pande, N., Ludwig, M. (2008). *A Literature Review: Psychiatric Boarding: Office of Disability, Aging and Long-Term Care Policy*. Retrieved from http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf.

[13] American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey (2008), as cited in Abid, Z., Meltzer, A., Lazar, D., Pines, J. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

restored. Two key drivers impacting the length of time individuals spend in jails awaiting competency evaluation also impact bed capacity in King County's behavioral health system: lack of evaluation services and the lack of bed space and staffing at the state's two forensic hospitals.

Community Behavioral Health Workforce in Crisis

As previously mentioned, there are many cascading effects of the expansion of services provided under ACA along with the realities of resource scarcity that are gravely impacting the workforce charged with providing services to a growing population. Major workforce challenges impact the functionality of the publicly funded behavioral health care system when trained, licensed, and qualified staff are difficult to find and/or retain in community provider organizations. High caseloads and low wages make it easy for qualified staff to be recruited away by entities like the Veteran's Administration and private health care systems that can pay more and/or forgive student loans. It is also difficult to recruit psychiatrists, nurse practitioners, and nurses to public sector behavioral health due to a small candidate pool and challenges in offering competitive salaries. The behavioral health workforce, particularly in public sector settings, also experiences high turnover due, in part, to burnout, stress, and lack of social support. Ongoing reductions in funding for public behavioral health contribute to staff turnover and recruitment challenges.

Without workforce improvements, King County will not be able to meet service needs. Individuals who require lifesaving services could go untreated, resulting in high costs, both human and financial. The County is uniquely positioned to both participate in and lead aspects of workforce development in partnership with providers, consumers, and policy makers.

Other Change Drivers

The factors below reflect new directions or policies taken by King County in the provision of behavioral health services since 2007 when the MIDD was first authorized. In addition, each element echoes a MIDD Oversight Committee-identified guiding principle for the development of MIDD II.

Recovery and Reentry: A recovery-oriented framework has at its center the individual: a person-centered approach to services and treatment that is embedded in self-determination. The framework asks that each individual be honored for their own healing process, supported by the belief that people can and will recover despite winding up at the extreme ends of crisis systems – in jails or hospitals.

The initial MIDD was based on the concept of decriminalization of mental health and substance use following the National GAINS Center Sequential Intercept model. Building on the model and following emerging practices, King County embraces a recovery-oriented framework for all individuals served in its behavioral health system. This practice enables King County to better address the needs of individuals with complex behavioral and other health conditions who are incarcerated, or at risk of incarceration, throughout King County. It is well documented that individuals with complex behavioral conditions are overrepresented in criminal justice settings nationally. Reentry and transition from hospital or jail planning can work well when behavioral health and criminal justice systems collaborate to support recovery.[14]

MIDD-supported programs have resulted in reduced jail bookings and shorter hospital stays. However, individuals with mental health and substance use conditions continue to end up in jails and emergency

[14] *Blanford, Alex M. and Fred C. Oshe. Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, 2013.*

services because other options are not available – to them or to first responders who come into contact with them – during times of crisis. Reentry begins at the point of initial jail booking or hospitalization, starting the reentry planning and engagement process as early as possible so as to divert individuals from further involvement in the criminal justice or crisis systems. Individuals with behavioral health conditions are often also impacted by homelessness, receive uncoordinated and fragmented services, and experience other significant barriers to getting the resources and supports needed in order to thrive in the community. Behavioral health conditions are further exacerbated by lack of diverse culturally and linguistically competent services available in the community.

King County recognizes that it is critical to view reentry from a recovery lens in order to best serve some of our most marginalized populations. Reentry services must be rooted in a recovery-oriented framework with interventions that include peer support, diverse culturally competent services, holistic healthcare that is integrated across mental health, substance use and primary care, along with housing assistance and employment support; it is also necessary to address essential and basic needs. As the Sequential Intercept model notes, community-based services are key for individuals leaving jails and hospitals, and successfully integrating into communities of their choice.

Trauma-Informed Care Emphasis: King County is moving to utilizing a trauma-informed care framework whenever possible. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Trauma-informed care seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?". Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors so as to be more supportive and avoid re-traumatization.

Most individuals seeking public behavioral health and other public services have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system.

Providing services under a trauma-informed framework can result in better outcomes than "treatment as usual." A variety of studies have revealed that programs utilizing a trauma-informed model are associated with a decrease in psychiatric symptoms and substance use. Some programs have shown an improvement in daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms.[15, 16] Trauma-informed care may lead to decreased utilization of crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed services.[17]

Health and Human Services Transformation: The 2013 King County Transformation Plan was developed in response to King County Council Motion 13768, passed in 2012, calling for the King County Executive, in partnership with community stakeholders, to develop a plan for an accountable, integrated system of health, human services, and community-based prevention, referred to as the Transformation Plan. The County's Transformation Plan charts a five-year course to a better performing health and human service system for the residents and communities of King County.

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[15] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.B., Reed, B.G., & Fallot, R. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. Journal of Substance Abuse Treatment, 28(2), 109-119.

[16] Morrissey, J.P., and Ellis, A.R. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. Journal of Substance Abuse Treatment, 28(2), 121-133.

[17] Community Connections. (2002). Trauma and Abuse in the Lives of Homeless Men and Women. Online PowerPoint presentation. Washington, DC: Authors. Retrieved September 3, 2007, from http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt

The Transformation Plan is intended to help positively impact, along with other King County policy and planning work, the fragmented health and human services delivery system that inequities in health and well-being experienced by residents. It is the goal of the Transformation Plan that by 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to a response that focuses on prevention, embraces recovery, and eliminates disparities. The Transformation Plan identifies two levels for system improvement, the individual and community level, and calls for alignment around outcomes. The Transformation Plan is a foundational component to the development of MIDD II. Its influence is particularly notable in the MIDD II Planning Framework, described in a subsequent section of this report.

King County's Equity and Social Justice Agenda: The County's Equity and Social Justice (ESJ) Agenda recognizes that race, place, and income impact quality of life for residents of King County. People of color, those who have limited English proficiency and who are low-income persistently face inequities in key educational, economic, and health outcomes. These inequities are driven by an array of factors including the tax system, unequal access to the determinants of equity, subtle but pervasive individual bias, institutional and structural racism and sexism. These factors, while invisible to some, have profound and tangible impacts for others.

At the same time, King County's adopted Strategic Plan identifies the principle of fair and just as a cornerstone incorporated into the work of all aspects of King County government. The region's economy and quality of life depends on the ability of all people to contribute and King County seeks to remove barriers that limit the ability of some to fulfill their potential. While King County government has made progress, especially with regard to pro-equity policies, there is still a long way to go. Though the County's ability to create greater levels of institutional and regional equity may be limited by the scope of its services and influence, by working collaboratively with providers, consumers, and other stakeholders, further improvements will be made.

In October of 2014 Executive Dow Constantine signed an Executive Order calling for the advancing of equity and social justice in King County, along with the development of a countywide Equity and Social Justice Strategic Plan. Planning of MIDD II is driven in large part by the County's commitment to enacting its ESJ Agenda.

King County's Approach to Fulfilling Requirements of Ordinance 17998

Transparency and collaboration were the hallmarks of MIDD I. The County's approach to fulfilling the requirements of Ordinance 17998 seeks to enhance transparency and expand collaboration, while planning for innovation and building on partnerships. The County is committed to conducting an open, inclusive, rigorous process to assess MIDD I and plan for a potential MIDD II.

At the same time, the world of behavioral health has evolved and continues to evolve. Positioning the County and our provider partners to respond nimbly to changes, while ensuring the right service is available at the right time, also frames the County's approach to fulfilling the requirements of Ordinance 17998.

Below are key components of how the County is working to complete a comprehensive historical review of the MIDD and prepare a deliberate, robust, planful MIDD II Service Improvement Plan.

Driven by Shared Values and Guiding Principles

At the March 26, 2015 MIDD Oversight Committee meeting, Committee members participated in a collective discussion that included the question of what are the most important values and guiding prinicples necessary to engage in as the County moves into MIDD review and renewal work.

The following values and guiding principles were articulated by the MIDD Oversight Committee. The values and guiding principles are informing all aspects of the development of a renewed MIDD II. They were reviewed and discussed at two subsequent Oversight Committee meetings and may be reviewed and modified over time.

MIDD Oversight Committee Values & Guiding Principles Revised August 6, 2015
• Cultural competency lens with an Equity and Social Justice (ESJ) focus • Client centered; developed with consumer input • Ensure voices of youth and disenfranchised populations are represented • Self sustaining; partnerships that leverage sustainability when possible • Community driven, not county driven • Transparent • Recovery focused • Driven by documented outcomes • Based in promising or best practices; evidence-based when possible • Common goal(s) across all organizations • Strategies move us toward integration and are transformational • MIDD funding leverages criminal justice (CJ) system (youth and adult) changes • Supports King County's vision for health care; reflects the triple aim: improved patient care experience, improved population health, and reduced cost of health care • More upstream / prevention services • Coordinated services • Community based organizations on equal status with County for compensation • Continue legacy of CJ/human services coming together • Open to new ways of achieving results • Build on strengths of the system • Services are accessible to those with limited options

The Department of Community and Human Services' staff and Oversight Committee members rely on these values and guiding principles as benchmarks as well as checks and balances for all aspects of MIDD I review and renewal tasks, from developing outreach and communications plans, to developing written materials and policy documents for review by the MIDD Oversight Committee and others. The values and guiding principles serve as cues for the continued and expanded transparent and collaborative approach the County has for the review of MIDD I and planning for a potential MIDD II.

The Oversight Committee

In addition to its ongoing oversight of the current MIDD, the Oversight Committee has a critically important role in MIDD I review and MIDD II planning. In March 2016, the MIDD Oversight Committee established values and guiding principles to inform all aspects of MIDD I review work and MIDD II renewal planning activities.

The Oversight Committee continues and expands its pivotal advisory role for MIDD review and renewal planning. Oversight Committee meetings that were taking place every other month were increased to monthly, given the fast paced nature of MIDD review and renewal planning activities, so that the Oversight Committee can review information and provide input and guidance to county staff. All MIDD Oversight Committee meetings are open to the public and a public comment period is included in each meeting. The monthly meetings include updates on MIDD I review and MIDD II renewal planning work.

All aspects of MIDD review and planning are brought before the Oversight Committee for discussion and feedback. County staff provide draft written materials electronically to members in advance of the Oversight Committee meeting so that members can spend meeting time in meaningful analysis and discussion. To date, the Oversight Committee has reviewed and provided feedback on all major MIDD review and renewal planning documents including:

- Milestone and Major Tasks Timeline (updated often);
- Values and Guiding Principles;
- MIDD II Organizing Framework; and
- MIDD II New Concept and Existing Program Review Process.

In addition to helping shape the components of MIDD review and planning, the MIDD Oversight Committee will have a critically important role in the months ahead of reviewing existing strategies and suggested new concepts for potential inclusion into MIDD II programming. The Oversight Committee will formally review all findings and recommendations related to the MIDD I retrospective report and the MIDD II programming and service improvement plan report that will be transmitted to Council in 2016.

MIDD Oversight Committee Strategy Team: In order to facilitate a higher degree of collaboration and input from the Oversight Committee, the Oversight Committee has appointed a Strategy Team, a diverse group of individuals from the MIDD Oversight Committee including community providers as well as staff from the County's Executive and legislative branches. The Strategy Team provides ongoing guidance and expertise for MIDD I review and MIDD II planning activities. Intended to augment Oversight Committee feedback and input, the MIDD Oversight Committee Strategy Team is comprised of eight Oversight Committee members, representing an array of populations and stakeholders. County staff from PSB, along with DCHS staff, supports the work of the Strategy Team. The Strategy Team meets twice a month with County staff, providing an in-depth review of all aspects of MIDD I review and MIDD II planning. The Strategy Team serves in part as a sounding board, helping to shape information and concepts for full

vetting and discussion at the MIDD Oversight Committee. The Strategy Team facilitates analysis, identifies issues, offers subject matter expertise, and helps problem-solve with County staff charged with completing the tasks required by Ordinance 17998. The full Oversight Committee receives a briefing on the work of the Strategy Team at each Oversight Committee meeting.

Dynamic and Inclusive Community Engagement and Information Sharing

Ordinance 17998 requires the MIDD II service improvement plan be developed with input from the MIDD Oversight Committee and community stakeholders. The MIDD Oversight Committee's guiding principles also require MIDD II planning to be developed with consumer input and be community driven. Thus, in response to these imperatives, the County has developed and is implementing a multi-pronged approach to engage the wide array of communities and stakeholders impacted by King County's MIDD.

Website Hub: On September 4, 2015, DCHS launched the MIDD Review and Renewal website, the information hub for MIDD I review and MIDD II planning. The website provides accessible timeline information on all aspects of MIDD work, including meeting announcements, meeting notes and other documentation, reports, link to a community-wide MIDD survey, and historical documents. The website includes an "email us" button so members of the public can provide feedback to County staff and the Oversight Committee. The website can be found here: http://www.kingcounty.gov/MIDDrenewal.

Intentional and Direct Community Engagement: The Centers for Disease Control and Prevention defines community engagement as "the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to issues affecting their well-being."[18] During the County's 2014-2015 Youth Action Plan process, community feedback emphasized the need for more community conversations where the County goes to the people rather than making people come to the County. There was also strong conviction articulated that the County must both provide opportunities for community input and also listen to the input once given.[19] These findings are echoed by the MIDD Oversight Committee in their values and guiding principles statements and foundational to the County's approach to community engagement.

Therefore, the basis of community engagement and involvement around MIDD II planning is providing multiple in-person forums for community members, consumers, and other stakeholders to meet and participate in conversations on MIDD-related matters. The primary purpose of connecting with communities is to hear from them what they need, what works, what doesn't work, and what they don't need. These in-person discussions are planned to take many forms, including:

- Broad, geographically based facilitated community conversations in each region of King County;
- Smaller specific focus groups involving specific populations, issues, or service areas (such as domestic violence and sexual assault service providers, specific cultural or ethnic groups, or consumers of behavioral health services);
- 1-1 meetings/interviews with key stakeholders, elected officials, and municipal representatives; and
- Presentations and question-and-answer sessions with interest groups, forums, and other associations.

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[18] Principles of Community Engagement, Second Edition. Clinical and Translational Science Awards Consortium, Community Engagement Key Function Committee, Task Force on the Principles of Community Engagement. National Institute of Health Publication 11-7782 (June, 2011). Retrieved September 10, 2015, from http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf.

[19] Youth Action Plan, pg. 47

Data will be gathered from each discussion, collated and synthesized for sharing, including posting on the website. Staff will identify themes, concepts, and suggestions articulated during the engagement sessions. All feedback will be taken under consideration. Every effort will be made to appropriately integrate suggestions into MIDD II planning and implementation when feasible.

The first Community Conversation occurred on September 22, 2015 at the Renton Community Center and was attended by over 90 people. As of the writing of this report, staff are collating and synthesizing the data gathered at the event. Planning is underway for additional Community Conversations across King County, in collaboration with other countywide community engagement efforts.

Council Involvement

While the King County Council has a seat on the MIDD Oversight Committee with Councilmember Dave Upthegrove as the Council's representative, DCHS recognizes the need to provide opportunities for the Council to be more involved in MIDD I review and MIDD II planning work. Thus, in addition to the Council's participation on the MIDD Oversight Committee and on the Strategy Team, DCHS has offered individual briefings on the MIDD I review and MIDD II planning to all members and staff. DCHS has also established standing monthly briefings of Council staff to share information, discuss issues, provide input, and jointly develop options.

It is the intention of DCHS to work closely and collaboratively with the Council on all aspects of MIDD I review and MIDD II planning.

Answering the Questions Posed by Ordinance 17998

Answering the questions posed in Ordinance 17998 necessitates comprehensive and thorough data gathering and analysis of all components of the MIDD, retrospectively and prospectively. County staff and Oversight Committee members have commenced this substantial work for the two reports called for in Ordinance 17998, as highlighted below.

Comprehensive, Historical Review and Assessment of MIDD: Due June 30, 2016
Staff are methodically reviewing all evaluation data and findings gathered over the life of the MIDD, comparing it to legislative requirements, changed strategies, and evolution of performance measurement targets and outcomes in order to respond to the questions of the Ordinance.

The legislation specifically calls for a review of the MIDD evaluation process. To support this work, DCHS is engaging the assistance of an outside consultant to conduct an independent assessment the County's evaluation and reporting approach.

Another key element of conducting the retrospective analysis is seeking feedback from the community, providers, consumers, and others impacted by MIDD. To that end, DCHS is utilizing both a survey and in person meetings to better understand the strengths and challenges of MIDD and inform programming and processes moving forward. In order to capture feedback from consumers who may not have access to electronic devices, DCHS is distributing paper copies of the survey to community providers to share with consumers.

MIDD Service Improvement Plan: Due December 1, 2016
The service improvement plan called for by Ordinance 17998 that will be provided to the Council for consideration entails creating detailed programmatic, evaluation, and implementation plans that reflect

findings and recommendations collected from analyzed data, community and stakeholder input, best and promising practices, and King County's policies. In order to methodically and transparently accomplish these important planning tasks, DCHS has developed a timeline and milestones, a comprehensive planning framework and detailed processes to review existing and potential new MIDD programs. The MIDD II planning framework and review processes are described below.

The service improvement plan is due on December 1, 2016. It has been requested by PSB that the plan be transmitted to the Council concurrently with the Executive's 2017-2018 biennial budget request. The timeline shown in Appendix D assumes a September 2016 transmittal of the MIDD service improvement plan.

MIDD II Organizing Framework: The MIDD II framework clearly identifies and organizes the key components of MIDD II: 1) its primary objective; 2) the theory of change behind it; and 3) key strategies and outcomes intended to achieve MIDD's II objective. The framework is a communication tool and policy document intended to inform discussion of MIDD II with policymakers, stakeholders, and the public across the region. It is also a reference document for those who may wish to suggest new MIDD programming or service concepts to potentially be funded by MIDD II and to inform review of existing MIDD supported programs.

MIDD Framework Highlights
***MIDD Objective**: Improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders.* ***MIDD Theory of Change**: When people living with mental illness and substance abuse disorders utilize culturally appropriate prevention and intervention opportunities, crisis diversion, and reentry and recovery services, they reduce their contact with the justice and hospital systems, improve their quality of life, and experience wellness and recovery.*

A major component of the MIDD framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and includes a vital system support area.

MIDD Strategy Area Name	Purpose
Prevention and Early Intervention	Keep people healthy by stopping problems before they start and preventing problems from escalating
Crisis Diversion	Assist people who are in crisis or at risk of crisis get the help they need
Recovery and Reentry	Empower people to become healthy and safely reintegrate into community after crisis
System Improvements	Strengthen the behavioral health system to become more accessible and deliver on outcomes

Each of the framework's four strategy areas includes sample program (performance) outcomes, sample, individual (population) outcomes, and sample measures and indicators. They are noted as "sample" because they are expected to change over time based on community and stakeholder feedback through 2016.

As noted earlier, the MIDD II Organizing Framework is deeply influenced by County's Health and Human Services Transformation Plan. The four MIDD strategy areas for MIDD II reflect a new emphasis of MIDD funds on prevention and early intervention work, along with focusing on recovery and reflective of the Transformation Plan vision. Additionally, the framework outlines potential alignment of MIDD outcomes.

The framework also includes concepts from behavioral health integration, Accountable Communities of Health, King County's Strategic Plan, and Youth Action Plan. The framework was developed using Results Based Accountability (RBA) principles. RBA uses a data-driven, decision-making process to help communities and organizations get beyond talking about problems to taking action to solve problems, as is reflected in the MIDD framework.

Results Based Accountability[20]

What is RBA?

- *RBA is a disciplined way of thinking and taking action that communities and organizations use to improve the lives of children, families and the community as a whole.*
- *RBA can also be used by agencies to improve the performance of their programs.*

How does RBA work?

- *RBA starts with ends and works backward, step by step, towards means.*
- *RBA is a process that gets from talk to action quickly.*
- *It uses plain language and common sense methods that everyone can understand.*

RBA's three questions:

- *How much did we do?*
- *How well did we do it?*
- *Is anyone better off?*

RBA is an inclusive process where diversity is an asset and everyone in the community can contribute.

The framework was shared with the MIDD Oversight Committee for review and input over the last few months and revised based on member feedback. It is expected that the framework will evolve over time with additional information and input. The Oversight Committee will review all substantive changes. (Please see Appendix E for the MIDD organizing framework.)

MIDD II New Concept and Existing Programs Review Process: As MIDD resources are finite; the County must assess existing programs and potential new concepts for fit, value, and ability to help the County achieve the MIDD Objective. The County, in collaboration with the MIDD Oversight Committee, developed a four phased process that enables the widest possible access to MIDD II funding and facilitates a structured analysis of new concepts and existing MIDD I programming. The process is outlined below.

[20] Results Based Accountability Flyer. Retrieved May 15, 2015 http://resultsaccountability.com/wp-content/uploads/2014/03/RBA-Brochure-2.0.pdf

- **PHASE I**

Interested parties will submit a New Concepts form electronically to the County. The time frame for submission of forms is September 15, 2015 – October 31, 2015. DCHS staff will conduct an initial screening of the concept forms. The initial screening will review concepts to ensure that they are:

1. Allowable under MIDD's statutory requirements under the RCW;
2. Feasible; and
3. Fit into the four MIDD II strategy areas.

Should the concept meet all three criteria, it will be forwarded to Phase II, the next phase of the process, detailed below.

Not all submitted concepts will be moved forward to Phase II. It is expected that some concepts may be combined with other ideas or programs. Additional information may be requested by the County from the person/or persons submitting the concept at any point in the consideration process. Decisions regarding new concepts, including which concepts advance to the Phase II, and the briefing paper phase are final.

- **PHASE II**

County staff will develop detailed briefing papers based on the information in the Concept Form and additional information and data (if needed). County staff will draft briefing papers in consultation with appropriate behavioral health partners, providers, and subject matter experts. Phase II briefing papers will be developed for new concepts and existing MIDD supported programs.

Key Questions for Briefing Papers

- What is the estimated resource need (financial, workforce or FTE, technological)?
- How long will it take to fully implement?
- What are the barriers or challenges to success for this program/concept? How would barriers be overcome?
- Does this program/concept positively address disproportionality or enhance cultural competency and if so, how?
- Is it client centered?
- What populations does it serve?
- What MIDD II Framework Strategy Area does this program/concept fall under?
- What measurable outcomes are there or would be for this program/concept?
- Plus requirements from Ordinance 17998

Please note that additional analytical questions that may be addressed in Briefing Papers; additional information may be included.

The Phase II briefing papers will be reviewed by a team comprised of MIDD Oversight Committee members, County staff including but not limited to DCHS, PSB, Public Health, Department of Public Defense, and other stakeholders as appropriate. The review teams will then sort the concepts into high, medium, and low categories for consideration. There will be no decisions made regarding programming or resource allocation during the team review of briefing papers.

- **PHASE III**
  After the Phase II review teams have analyzed, discussed, and sorted the briefing papers, County staff will enter the Phase III work of aligning programs and concepts with available funds. County staff will be responsible for making programmatic and funding recommendations for the MIDD II service improvement plan, including initial budget recommendations. This work will be conducted internally by King County. These recommendations will be shared with the MIDD Oversight Committee during Phase IV.

- **PHASE IV**
  The final phase of MIDD II Programming Process is a public and MIDD Oversight Committee review of the County's MIDD II programming and funding recommendations. Similar to other County plans, the draft service improvement plan that includes recommendations will be released electronically for a period of time so that a wide public review can occur, with feedback to County staff and the MIDD Oversight Committee. As with all MIDD matters, the Oversight Committee's recommendations will then be forwarded to Executive Dow Constantine who will transmit the final recommendations to the King County Council for final adoption.

This work will require a significant investment of time from MIDD Oversight Committee members and other parties through 2016, including participation and input of staff across King County, including but not limited to DCHS, Public Health, PSB, and Executive Office staff.

While every effort will be made to reflect the recommendations of the Oversight Committee and public feedback in the MIDD II Service Improvement Plan that is transmitted to the Council, please note that the Executive determines contents of the final Service Improvement Plan that will be transmitted.

Please see Appendix F for an overview of the MIDD II new concept and existing programs review process, including approximate timelines.

Early Findings: MIDD I Assessment and MIDD II Planning

Though data gathering and assessment activities are ongoing, DCHS has identified early findings in some areas. These areas will be closely monitored as additional information is made available, with special attention given to developing collaborative solutions or options to undertake them. Issues include:

- Data challenges: Issues around data include availability, timeliness, quality, and compatibility.
- Workforce diversity: There are not enough providers offering culturally or ethnically appropriate services; few services available in languages other than English.
- Declining workforce: There is more need for trained, licensed personnel in community based agencies.
- Availability of services: Some areas of King County do not have accessible behavioral health services.
- Flexible spending and reserve: As the economy improves and MIDD resources grow beyond allocated budgets, there is a need to utilize fund balance for emerging needs through clearly defined and transparent processes.

Many of these issues point to the need for system wide improvements, something MIDD II could help to address.

Conclusion and Next Steps

County staff, in partnership with the MIDD Oversight Committee, have developed and initiated comprehensive plans and processes to accomplish the tasks called for by Ordinance 17998. These plans and processes include broad and specific community and stakeholder activities, extensive data gathering and analysis, and continuous feedback loops with the Oversight Committee and the Council. These plans and processes will result in delivering to Council and the public a thorough, clear, and strategic MIDD II Service Improvement Plan and detailed, objective assessment of MIDD I.

The behavioral health world is rapidly evolving. Actions such as state mandated behavioral health integration, court rulings and legislative statute changes, along with the implementation of the Affordable Care Act, require King County and its behavioral health and criminal justice partners to work together to make meaningful system improvements. The MIDD II planning processes have taken into account the changing landscape of behavioral health, while continuing to build on the strong foundation of MIDD I. County staff are prepared to lead the work necessary to re-envision and re-tool MIDD programs to achieve an even greater impact and outcomes.

The work of County staff and the Oversight Committee has resulted in major progress towards fulfilling the requirements of Ordinance 17998. MIDD II planning is guided by mutually agreed-upon values and guiding principles, informing all aspects of MIDD work. The MIDD II framework succinctly organizes MIDD's objective, theory of change, and strategies into one concise document, providing context and structure to MIDD II activities. The County's commitment to community engagement is expected to yield a wealth of information that will be used to further develop and enhance MIDD moving forward. Capitalizing on the collaborative culture of MIDD II planning, County staff are working to develop strategically significant areas where MIDD can have an broad and lasting impact.

The next components of MIDD review and renewal planning work consists of carrying out community and stakeholder meetings, and continuing to gather and review data, synthesize survey feedback, and begin the complex tasks of drafting briefing papers. Momentum is building around the results of the New Concepts suggestions, which are anticipated to result in exciting new ideas to consider for MIDD II.

APPENDICES

Appendix A

MIDD Oversight Committee Membership Roster September 2015

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 President
Councilmember, City of Kirkland
Representing: Sound Cities Association

Rhonda Berry, Chief of Operations
Representing: 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 for Behavioral Health, Sea Mar Community Health Centers
Representing: Community Health Council of Seattle and King County

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
Representing: Harborview Medical Center

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

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

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

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, 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

Vacant Representing: Labor, representing a *bona fide* labor organization

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

Appendix B

LIST OF MIDD I STRATEGIES

Community Based Care	
1a-1	Increase access to community mental health treatment
1a-2	Increase access to community substance abuse treatment
1b	Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities
1c	Emergency room substance abuse early intervention program
1d	Mental health crisis next day appointments and stabilization services
1e	Chemical dependency professional education and training
1f	Parent partner and youth peer support assistance program
1g	Prevention and early intervention mental health and substance abuse services for adults age 55+
1h	Expand availability of crisis intervention and linkage to on-going services for older adults
2a	Workload reduction for mental health
2b	Employment services for individuals with mental illness and chemical dependency
3a	Supportive housing services
Programs Targeted to Help Youth	
4a	Services for parents in substance abuse outpatient treatment
4b	Prevention services to children of substance abusers
4c	School district based mental health and substance abuse services
4d	School based suicide prevention
5a	Expand assessments for youth in the juvenile justice system
6a	High fidelity wraparound initiative
7a	Reception center for youth in crisis
7b	Expansion of children's crisis outreach response service system
8a	Expand family treatment court services and support to parents
9a	Expand juvenile drug court treatment
Jail and Hospital Diversion Programs	
10a	Crisis intervention training program
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team
11a	Increase capacity for jail liaison program
11b	Increase services available for new or existing mental health court programs
12a	Increase jail re-entry program capacity
12b	Hospital re-entry respite beds
12c	Increase Harborview's Psychiatric Emergency Services capacity to link individuals to community services upon discharge from ER
12d	Behavior Modification Classes for Community Center for Alternative Programs clients
Domestic Violence, Sexual Assault, and Expansion of Adult Drug Court	
13a	Domestic violence and mental health services
13b	Domestic violence prevention
14a	Sexual assault and mental health services
15a	Adult drug court expansion
Housing Development	
16a	New housing units and rental subsidies
New Strategies – 24 month Pilot Project	
17a	Crisis Intervention Team / Mental Health Partnership (CIT/MHP) Pilot Project
17b	Safe Housing and Treatment for Children in Prostitution Pilot Project

MIDD Supplantation
Department of Adult and Juvenile Detention (DAJD)
Community Center for Alternative Programs
Juvenile Mental Health Treatment
Public Health: Jail Health Services
Psychiatric Services
Mental Health and Substance Use Disorder MIDD Supplantation
Substance Use Disorder Administration
Criminal Justice Initiative
Substance Use Disorder Contracts
Housing Voucher Program
Substance Use Disorder Emergency Services Patrol
Community Center for Alternative Programs
Mental Health Co-Occurring Disorders Tier
Mental Health Recovery
Mental Health Juvenile Justice Liaison
Mental Health Crisis Respite Beds
Mental Health Functional Family Therapy
Mental Health Mental Health Court Liaison

Appendix D

MIDD Review and Renewal Timeline
September, 2015

Month	Major Tasks	Notes
September	MIDD Community Conversation Kick Off New Concept Window Open Existing Strategy Briefing Papers Started	Sept 22 Sept 15
October	Focus Group #1 Domestic Violence and Sexual Assault Provider Group Community Conversation #2 Community Conversation #3 New Concept Window Closes Briefing paper drafting begins (through mid January)	October 8 October 22 October 28 October 31
November[21]	Behavioral Health Legislative Forum Focus Group #2 – Behavioral Health Providers Community Conversation #4	November 5 November 5 November TBD
December	Behavioral Health Legislative Forum Focus Group #3 - TBD Community Conversation #5	November 5 November TBD
2016		
January	Focus Groups #4 & #5 – TBD Community Conversations #6 & #7 Briefing Paper Review Teams selected Report writing - Retrospective MIDD I Report begins	
February	Briefing Paper Review Teams Meet-review & sort briefing papers	
March	County staff drafts MIDD II Service Improvement Plan recommendations & align budget	
April	Draft Retrospective MIDD I Report to MIDD OC Draft Service Improvement Plan (SIP) Recommendations to MIDD OC Report writing- MIDD II SIP begins	April 26-REVIEW &DISCUSSION April 26-REVIEW & DISCUSSION
May	Final Retrospective MIDD I Report-MIDD OC Final Program Recommendations-MIDD OC Retrospective MIDD I Report to Exec	May 26-FOR APPROVAL May 26-FOR APPROVAL May 27
June	Draft Service Improvement Plan report to MIDD OC *****TRANSMIT RETROSPECTIVE MIDD I REPORT TO COUNCIL*****	June 23-REVIEW &DISCUSSION **June 30**
July	Draft Service Improvement Plan report posted for public comment Final Service Improvement Plan report-MIDD OC	Two weeks July 28-FOR APPROVAL
August	Service Improvement Plan report to Executive	August 25
September	*****EXECUTIVE TRANSMITS SERVICE IMPROVEMENT PLAN TO COUNCIL WITH BUDGET*****	September 26

MIDD II PROCESS OVERVIEW
New Concept & Existing Programs Review
Please note that this an OVERVIEW. This document should be paired with the MIDD II Framework.
Revised 10.6.15

PHASE I
A. Call for New Concepts
B. Review of Existing Strategies

Open Call Timeframe: 9/15-10/31

Existing MIDD Programs* Analysis**

- Did the program do what it was planned to do?
- How well did it do it?
- Can the program as is achieve outcomes that further the adopted policy goal(s) of MIDD & deliver on individual and program outcomes?
- What changes could be made (or were made) to the program to further the adopted goal(s) of MIDD & deliver on outcomes?
- What is the impact of changing the program?
- What happens if this program is eliminated?
- Could it be merged with different or new programs?
- Identify unanticipated outcomes, challenges, or benefits.

"Programs" refers to all currently funded and operating MIDD strategies

***These are not the only analytical questions that may be addressed; additional information may be included*

MHCADSD coordinates analysis of existing programs

PHASE II
Analysis and Collective Review

Briefing Papers: New Concepts and Existing Programs
Drafted by County staff in consultation with partners/ providers/subject matter experts

New Concepts Address/Identify

- What is the specific need that concept addresses?
- How does the concept address need?
- What results/outcomes would the program have?
- What partnering entities are necessary for this concept to be successful?
- Of the four strategy areas in the MIDD II Framework, what strategy area does this concept fall under?

New Concepts template will be available electronically on the MIDD website, with instructions and additional information

Submission of New Concepts will be electronic

Additional information may be requested by MHCADSD staff in template or during review

Not all submitted concepts will move to Phase II

MHCADSD screens new concepts for forwarding to Phase II

Sept-Dec Briefing Paper Drafting

Key Questions for Briefing Papers**

- What is the estimated resource need ($, # and type of positions, technology)?
- How long will it take to fully implement?
- What are the barriers or challenges to success for this program/concept? How would barriers be overcome?
- Does this program/concept positively address disproportionality or enhance cultural competency and if so, how?
- Is it client centered?
- What populations does it serve?
- What MIDD II Framework Strategy Area does this program/concept fall under?
- What measureable outcomes are there for this program?
- Plus requirements from Ordinance 17998.

***These are not the only analytical questions that may be addressed in Briefing Papers; additional information may be included*

Jan & Feb Teams Review

Phase II Workgroup/Team Review of Briefing Papers
Review, discussion, and sorting into high, medium, low categories for consideration

March & April

Phase III
MIDD II Service Improvement Plan Recommendations Development
Align MIDD II programs and budget
County staff drafts recommendations and identifies funding levels; MIDD Oversight Committee will review recommendations in Final Phase

May-July

Final Phase: Drafting and Review of MIDD II Service Improvement Plan

- Recommended programs will be included in the MIDD II Service Improvement plan that is sent to the Executive for his review and forwarding to Council; transmitted September 2016
- DRAFT of report to be provided to MIDD OC and posted for public comment (estimated June/July 2016)
- Changes may be made to the recommendations by the Executive AND/OR the Council at any point

SIP drafted by County staff

DRAFT DATE 10.6.15

MIDD II FRAMEWORK Updated 8.27.15

MIDD OBJECTIVE

Improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders.

MIDD THEORY OF CHANGE

When people living with mental health and substance use disorders utilize culturally appropriate prevention and early intervention opportunities, crisis diversion, and reentry and recovery services, they reduce their contact with the justice and hospital systems, improve their quality of life, and experience wellness and recovery.

2007 Adopted MIDD Policy Goals: (will be recommended to be revised over the course of the MIDD II development process)

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

MIDD Strategy Areas	SAMPLE[i] MIDD Program Outcomes (performance)	SAMPLE[ii] MIDD Individual Outcomes (population)	SAMPLE[iii] MIDD Measures & Indicators
Prevention and Early Intervention *Keep people healthy by stopping problems before they start and preventing problems from escalating*	• Increased access to person centered, culturally appropriate treatment, education, and training services • Increased availability of behavioral health information in non-traditional settings (day cares, schools, primary care) • Reduced risk factors for substance use and mental health disorders • Increased access to housing • Increased access to employment and education services • Increased access to primary care services	• Increased use of person centered, culturally appropriate prevention, treatment, and training services by individuals & families • Reduced use of drugs & alcohol in youth & adults • Increased employment and education outcomes • Increased housing stability • Increased use of primary care services • Reduced barriers to services	• # Individuals and families utilizing person centered, culturally appropriate prevention, training, and information services • # Behavioral health information provided in non-traditional settings (day cares, schools, primary care) • # Youth reporting use of drugs and alcohol • # Employment and education • # Housing stability • # Crisis events • # Meaningful life activities
Crisis Diversion *Assist people who are in crisis or at risk of crisis get the help they need*	• Increased access to person centered, culturally appropriate outpatient treatment on demand • Increased access to: community alternative options; diversion and crisis centers including sobering and detox; youth reception, and/or other crisis centers • Increased availability of medication assisted treatment • Increased access to treatment courts	• Reduction in use of detention, jail, and emergency departments for crisis services • Increased use of person centered, culturally appropriate outpatient treatment services for individuals and families • Improved access to necessary inpatient services • Decreased length of crisis events • Increased utilization of treatment courts • Reduced barriers to services	• # Parents and youth utilizing treatment services • # Detention, jail, and emergency department utilization (bookings & length of stay) • # Community alternatives to detention available & usage • # Reversed overdoses • # Narcan distributed • # Involuntary commitment

MIDD Strategy Areas	SAMPLE MIDD Program Outcomes (performance)	SAMPLE MIDD Individual Outcomes (population)	SAMPLE MIDD Measures & Indicators
Recovery and Reentry *Empower people to become healthy and safely reintegrate to community after crisis*	• Increased person centered, culturally appropriate treatment services • Increased availability of peer services • Increased access to housing • Increased access to employment and education services • Increased access to reentry services from jail or hospital • Increased application of recovery and resiliency principles in services provided • Increased access to culturally appropriate recovery services	• Reduction in detention, jail, and ED utilization • Increased utilization of appropriate treatment services • Increased employment and education outcomes • Increased housing stability • Increased utilization of peer services • Increased utilization of reentry services from jail or hospital • Increased utilization of culturally appropriate recovery services • Reduced barriers to services	• # Detention, jail, and ED utilization • # Diversions from jail, hospital, or court • # Re-hospitalization rates • # Peer services utilized • # Culturally appropriate recovery services utilized • # Reentry services from jail or hospital • # Recovery of function • # Employment and education • # Housing stability • # Providers utilizing recover and resiliency framework in services • # Meaningful life activities
System Improvements *Strengthen the behavioral health system to become more accessible and deliver on outcomes*	• Increased provider workforce retention & expanded workforce • Increased cultural diversity of workforce and providers • Reduced disproportionate representation in the criminal justice and emergency department systems and hospitalizations • Increased geographic availability of services • Increased accessibility of services & treatment on demand • Increased use of evidence based practices and assessment tools • Improved care coordination • Improved quality of care • Improved client experience • Recovery oriented system of care • MIDD is funder of last resort	• Right treatment, at the right time, in the right amount (service on demand) • (and everything else above)	• # Turnover, time to hire, new positions • # Disproportionality • # Culturally diverse providers • # Services available by location/area • # Utilization of appropriate treatment resources • # Services available within one bus ride • # Client satisfaction rating • # Using shared care plan/shared data • $ Leveraged

Please note that the contents of this document are subject to change and modification.

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i, ii: SAMPLE OUTCOMES are not intended to capture an exhaustive list of outcomes. They are a representative example of the types of outcomes for the strategy areas. It is expected that outcomes will change over time based on community and stakeholder feedback as the MIDD II Review and Renewal work continues through 2015 and 2016.

iii: SAMPLE MEASURES AND INDICATORS are not intended to capture an exhaustive list of outcomes. They are a representative example of the types of measures and indicators for the strategy areas. It is expected that measures and indicators will change over time based on community and stakeholder feedback as the MIDD II Review and Renewal work continues through 2015 and 2016.