Mental Illness and Drug Dependency

Implementation and Evaluation Summary for Year Two
October 1, 2009—September 30, 2010

Third Annual Report

King County

Mental Illness and Drug Dependency Oversight Committee

February 2011

King County Department of Community and Human Services

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Third Annual Report:

Report design by Lisa Kimmerly

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

www. kingcounty.gov/healthservices/MHSA/MIDDPlan

Alternate formats available
Call 206-263-8663
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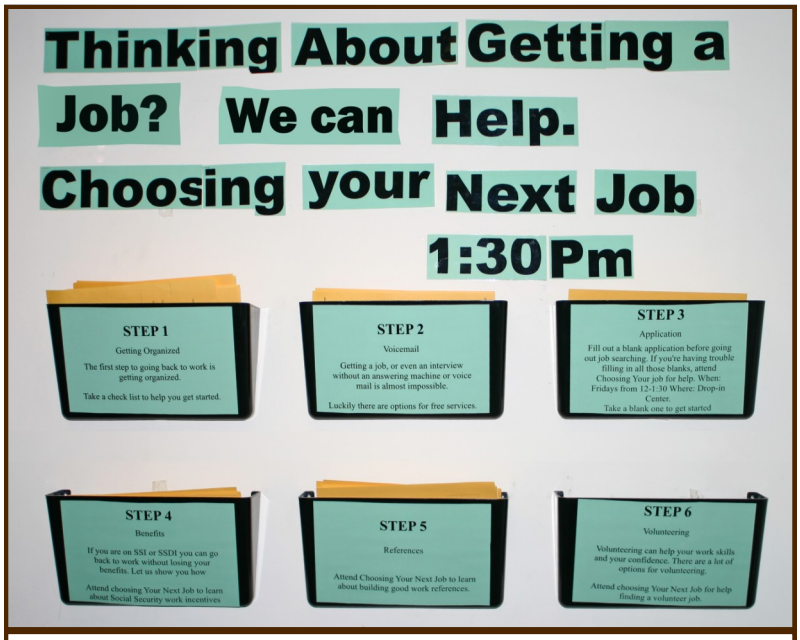


A posting on the wall that reaches out to mental health consumers at the Downtown Emergency Services Center (DESC) office in Seattle's Belltown neighborhood.

Acknowledgments

Thank you to the citizens of King County, the elected officials of King County, the MIDD Oversight Committee and co-chairs, and the many dedicated providers of MIDD-related services throughout King County. A special thank you to those sharing their experiences and photos in this document.

Introduction

The Implementation and Evaluation Summary for Year Two of the Mental Illness and Drug Dependency Action Plan covers the time period from October 1, 2009 through September 30, 2010. This is the third annual Mental Illness and Drug Dependency (MIDD) report, as required by Ordinances 15949 and 16262 and includes the following:

a) A summary of semi-annual report data

b) Updated performance measure targets for the following program year

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

d) Recommended revisions to the evaluation plan and processes

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

Background

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

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

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

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

King County continues to implement a full continuum of prevention, treatment, housing support, and therapeutic court services to the extent possible given current economic conditions. This third annual report covers the second year of MIDD programming from October 2009 through September 2010 and provides updates on all strategies, including process indicators (outputs), success stories, and preliminary outcomes for those strategies with earlier start dates.

MIDD Policy Goals*

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.

* *From Ordinance 15949*

Oversight Committee Membership Roster

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

Barbara Linde, Presiding Judge (Co-Chair)
King County District Court
Representing: District Court

Jim Adams, National Alliance on Mental Illness (NAMI) member
Representing: NAMI in King County

Bill Block, Project Director, Committee to End Homelessness in King County
Representing: Committee to End Homelessness

Linda Brown, Board Member, King County Alcohol and Substance Abuse Administrative Board
Representing: King County Alcohol and Substance Abuse Administrative Board

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

John Chelminiak, Councilmember, City of Bellevue
Representing: City of Bellevue

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

Bob Ferguson, Councilmember
Metropolitan King County Council
Representing: King County Council

David Fleming, Director and Health Officer
Public Health–Seattle & King County
Representing: Public Health

Jaime Garcia, Executive Director, Health Work Force Institute, Washington State Hospital Association
Representing: Washington State Hospital Association/King County Hospitals

Richard McDermott, Presiding Judge, King County Superior Court
Representing: Superior Court

Zandrea Hardison, Program for Assertive Community Treatment Team Nurse, Downtown Emergency Service Center
Representing: Labor, representing a *bona fide* labor organization

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

David Hocraffer, Director, King County Office of the Public Defender
Representing: Public Defense

Darcy Jaffe, Assistant Administrator, Patient Care Services
Representing: Harborview Medical Center

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

Bruce Knutson, Director, Juvenile Court, King County Superior Court
Representing: King County Systems Integration Initiative

Catherine Cornwall, Senior Policy Analyst
Representing: City of Seattle Budget Office

Jackie MacLean, Director, King County Department of Community and Human Services (DCHS)
Representing: King County DCHS

Donald Madsen, Director, Associated Counsel for the Accused
Representing: Public defense agency in King County

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

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

Susan Rahr, Sheriff, King County Sheriff's Office
Representing: Sheriff's Office

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

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

Crystal Tetrick, Associate Director for Health Care Operations, Seattle Indian Health Board
Representing: Council of Community Clinics

Dwight Thompson, Councilmember
City of Lake Forest Park
Representing: Suburban Cities Association

Claudia Balducci, Director, King County Department of Adult and Juvenile Detention
Representing: Adult and Juvenile Detention

Rhonda Berry, Assistant County Executive
Representing: County Executive

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

Dear Friend:

We are pleased to report on the Mental Illness and Drug Dependency (MIDD) Plan Implementation and Evaluation Summary for Year Two (October 1, 2009 – September 30, 2010). The MIDD-funded programs are making a difference in the lives of people throughout King County.

Thirty-one of the 37 strategies were launched in the first two years of MIDD implementation (2009 and 2010); the remaining six strategies are on hold. During the 2010 calendar year, $31.8 million of the $40 million budgeted were spent implementing MIDD strategies, with the remaining being spent on MIDD supplantation and fund balance.

Among the year's highlights:

- Approximately 27,027 unique individuals were touched by the MIDD.
- 1,770 individuals are being served by more than one strategy.
- Strategies 4c - School-Based Mental Health and Substance Abuse Services and 10b - Adult Crisis Diversion were implemented.
- MIDD clients were from throughout King County, including greater Seattle, south, east, and north King County.
- King County contracted or partnered with **60 community and local government agencies to provide MIDD services**.
- Of the MIDD clients served, approximately 737 served in the U.S. Military.

During this evaluation period (October 1, 2009 – September 30, 2010), a sampling of MIDD clients showed a 23.1 percent reduction in jail bookings and a 23.5 percent reduction in jail days. Psychiatric hospitalizations decreased by 19 percent for the sample eligible for outcomes analysis in this reporting period. In a sample of 2,902 recipients of MIDD services, 25 percent were linked to subsequent mental health treatment. For chemical dependency treatment, 527 of 3,375, or 16 percent, were linked to substance use disorder treatment services.

We look forward to continuing our oversight role, monitoring programs firsthand, and reviewing evaluation reports to ensure the MIDD-funded programs achieve their intended results.

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

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

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

Shirley Havenga
Chief Executive Officer, Community Psychiatric Clinic
Co-Chair

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

Early MIDD Milestones

Council Motion 12320	**July 4, 2006**	Authorizes creation of **MIDD Action Plan** to improve the lives of those impacted by mental illness and chemical dependency by diverting them from jails and hospitals into treatment and recovery support services.
	June 1, 2007	**MIDD Action Plan Completed**
Council Motion 12598	**October 9, 2007**	**Council Accepts MIDD Action Plan**
Ordinance 15949	**November 13, 2007**	**Council Authorizes Sales Tax Levy** and calls for development of three plans: Oversight, Implementation, and Evaluation
Ordinance 16077	**April 28, 2008**	**Council Approves MIDD Oversight Plan** and creates the MIDD Oversight Committee
	July 24, 2008	**Formal Oversight Committee (OC) Convenes for First Time**
Ordinance 16261 and 16262	**October 6, 2008**	**Council Approves MIDD Implementation and Evaluation Plans**
	October 16, 2008	**Services Begin for First of 37 Unique MIDD Strategies**

This Second Year Implementation and Evaluation Summary provides information on:

* MIDD Oversight Committee briefings in Year Two
* Performance measures over the first two years of service delivery and Year Two target percentages
* Progress toward implementing all strategies
* Highlighted statistics for key services delivered
* People who are being helped by the MIDD
* Recommendations for future strategy revisions
* Expenditures and budget information by strategy

Glossary of Acronyms

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

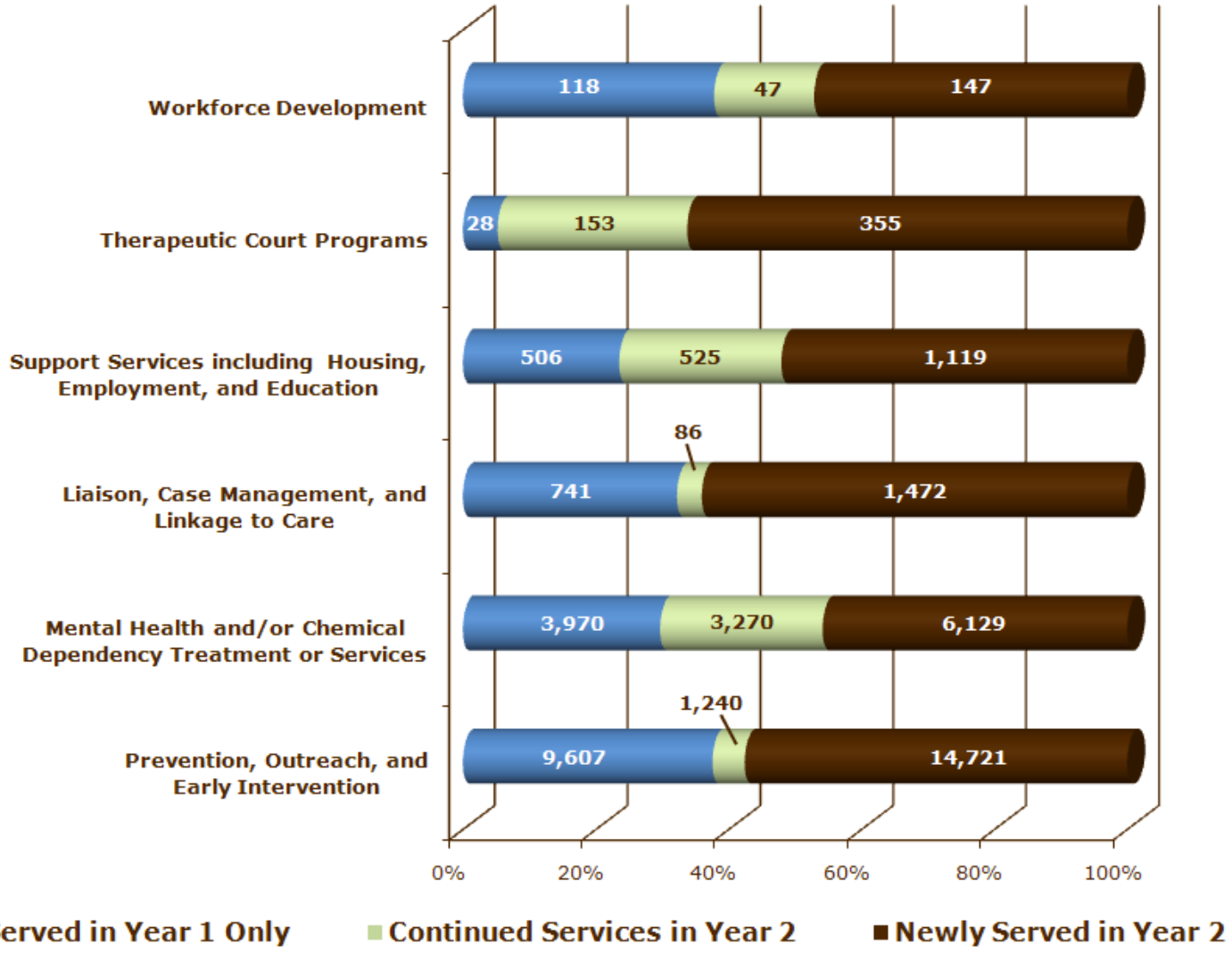
MIDD Strategies by Service Categories

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

Executive Summary

- $31.8 million of the $40 million budgeted were spent implementing MIDD strategies during the 2010 calendar year.
- Thirty-one of 37 strategies were launched in the first two years of MIDD implementation. The others remain on hold, awaiting funding resources.
- Requests for Proposals were awarded for Strategy 4c (School-Based MH & SA Services) and 10b (Adult Crisis Diversion).
- At least 27,027 unique individuals were touched by the MIDD; 1,770 were served by more than one strategy.
- MIDD clients were from greater Seattle (37%), south King County (32%), east (16%), and north (8%).
- King County contracted or partnered with 60 community and local government agencies to provide MIDD services (see detailed list on Page 35).
- At least 737 MIDD clients had served in the U.S. military.
- Jail utilization for a sampling of MIDD clients revealed a 23.1 percent reduction in bookings and a 23.5 percent reduction in jail days.
- Psychiatric hospitalizations decreased by 19 percent for the sample eligible for outcomes analysis in this reporting period.
- In an sample of 2,902 recipients of MIDD services, 25 percent were linked to *subsequent* MH treatment. For CD treatment, 527 of 3,375 (16%) had confirmed linkages.

Total Number of Individuals Served by Type of Service



Key Oversight Committee Briefings

The MIDD Oversight Committee (OC), comprised of 30 individuals and elected officials representing governments, health and human services, and criminal justice systems, is an advisory body to the King County Executive and King County Council. The purpose of the OC is to ensure that the implementation and evaluation of the strategies and programs funded by the MIDD revenue are transparent, accountable, collaborative and effective. From October 1, 2009 through September 30, 2010, the MIDD OC met 10 times and OC members cumulatively contributed 300 hours of service during the same period. Key briefings and discussions that occurred at MIDD Oversight Committee meetings during the second year of the MIDD included:

- The MIDD evaluation progress, including data collection and management efforts, collaborative efforts to resolve privacy concerns, selection of symptom reduction measures, and pursuit of options for obtaining hospital data to evaluate reductions in Emergency Department (ED) utilization for appropriate MIDD strategies
- The announcement of 13 community-based providers to deliver collaborative school-based mental health and substance abuse services **(MIDD Strategy 4c)** across King County for prevention, early intervention, brief treatment, and referral to treatment for middle school aged youth
- The MIDD support of youth suicide prevention **(MIDD Strategy 4d)** throughout King County
- Expansion progress of the Juvenile Justice Assessment Team (JJAT) **(MIDD Strategy 5a)**, which provides assessments for juvenile justice involved youth
- The announcement of five providers to deliver Wraparound Services **(MIDD Strategy 6a)** for children and youth involved in multiple service delivery systems
- Implementation of the Crisis Intervention Team (CIT) training program (**MIDD Strategy 10a)** for police and other first responders through a contract with the Washington State Criminal Justice Training Commission (WSCJTC)
- Status updates on the Crisis Diversion Facility (CDF), Crisis Diversion Interim Services (CDIS) and Mobile Crisis Team **(MIDD Strategy 10b)**
- Expansion of King County's Regional Mental Health Court (RMHC) **(MIDD Strategy 11b)** to clients from all municipalities within King County
- Intensive case management for those frequently using Psychiatric Emergency Services (PES) **(MIDD Strategy 12c)** at Harborview Regional Medical Center
- Expansion of Adult Drug Court **(MIDD Strategy 15a)** services, including specialized services for individuals 18 to 24 years old and provision of housing case management
- The City of Seattle's funding of the Safe Housing and Treatment for Children in Prostitution Pilot Project **(MIDD Strategy 17b)**
- Progress by the Committee to End Homelessness toward its goals
- A **Client Care Coordination** system for coordinating entry to new housing beds **for** chronically homeless single adults dealing with severe mental illness or chemical dependency, including both "high-utilizers" and those most "vulnerable"
- Supplantation legislation: In 2009, the Washington State Legislature passed legislation that allows for a percentage of MIDD revenues to be utilized to supplant lost revenues previously supporting existing criminal justice, therapeutic courts, mental health (MH) and chemical dependency (CD) service programs. In 2010, just over $13 million in MIDD revenues were used for supplantion.

Performance Measurement Targets

As of the end of this reporting period (September 30, 2010) King County has at least **175** contracts and/or agreements for **31** different MIDD strategies. The tables below provide program utilization statistics and performance measures for the second full year of the MIDD, presented under the three key service categories: Community-Based Care, Programs to Help Youth, and Jail and Hospital Diversion. Grayed-out rows indicate strategies without reportable data for the period due to implementation delays caused by lack of available funding or delayed implementation.

Community-Based Care Strategies

Strategy Number	Strategy "Nickname"	Reported in Year 1	Continued Services in Year 2	New in Year 2	Year 2 Totals*	Key Performance Target(s) for Year 2**	Percent of Year 2 Target+	Target Success Rating	Notes or Explanation (If Applicable)
1a-1	MH Treatment	2,047	1,656	1,825	3,481	2,400 clients/yr	145%	↑	
1a-2	CD Treatment	N/A (A)	-	43,751 adult OP units 6,617 youth OP units 82,560 OST units	See "New in Year 2"	(B) 50,000 adult OP units 4,000 youth OP units 70,000 OST units	88% 165% 118%	↑	
1b	Outreach & Engagement	435	196	1,661	1,857	675 clients/yr	275%	↑	MIDD funds leverage federal match in some of these programs
1c	SA Emergency Room Intervention	2,255	288	2,889	3,177	7,680 clients/yr with 9 FTE 5,120 clients/yr with 6 FTE	41% (Unadjusted) 62% (Adjusted)	↓	Not all programs running at full capacity, but number served represents 40% increase over Year 1
1d	MH Crisis Next Day Appts	1,151 (A)	64	896	960	Enhanced services for 750 clients/yr	128%	↑	868 clients received "enhanced" services in Year 1
1e	CD Professionals Training	165	47	147	194	125 trainees/yr	155%	↑	22 of 34 agencies reporting
1f	Parent Partners Family Assistance					4,000 clients/yr			
1g	Older Adults Prevention MH & SA	1,805	677	1,818	2,495	At least 2,500 clients/yr with 7.4 FTE At least 2,196 clients/yr with 6.5 FTE	99% (Unadjusted) 114% (Adjusted)	↑	% based on minimum in range of 2,500 to 4,000 clients/yr
1h	Older Adults Crisis & Service Linkage	327	15	429	444	340 clients/yr	131%	↑	
2a	MH Workload Reduction	—	—	—	—	16 plans approved	—	—	(See Analysis on Page 11)
2b	Employment Services MH & CD	734	367	453	820	(B) 920 clients/yr with 23 FTE 700 clients/yr with 17.5 FTE	89% (Unadjusted) 117% (Adjusted)	↑	Services for CD clients delayed
3a	Supportive Housing	114	98	146	244	(C) 400 clients/yr with 398 beds 251 clients/yr with 250 beds	61% (Unadjusted) 96% (Adjusted)	↑	7 of 9 programs new in Year 2 with start-up late in the reporting period for most
13a	Domestic Violence & MH Services	197	88	401	489	700-800 clients/yr	70%	→	% based on minimum in range
14a	Sexual Assault, MH & CD Services	179	46	318	364	400 clients/yr	91%	↑	

Strategies with Programs to Help Youth

Strategy Number	Strategy "Nickname"	Reported in Year 1	Continued Services in Year 2	New in Year 2	Year 2 Totals*	Key Performance Target(s) for Year 2**	Percent of Year 2 Target+	Target Success Rating	Notes or Explanation (If Applicable)
4a	Parents in Recovery SA Services					400 parents/yr			
4b	Prevention - Children of SA					400 children/yr			
4c	School-Based MH & SA Services					(C) 2,268 youth/yr with 19 programs 1,550 youth/yr with 13 programs			
4d	Suicide Prevention Training	4,764 youth 1,486 adults	—	7,600 youth 688 adults	see "New in Year 2"	3,250 youth/yr 1,500 adults/yr (B)	234% 46%	↑↓	Blended funding allows more youth to be trained than targeted number attributable only to the MIDD
5a	Juvenile Justice Youth Assessments	—	—	402	402	(C) **up to** 1,230 youth/yr with 4 FTE **up to** 615 youth/yr with 2 FTE	32% (Unadjusted) 65% (Adjusted)	→	Program running at 50% capacity, but program efficiences reduced need for some evaluation types (See Details on Page 11)
6a	Wraparound	—	—	282	282	920 clients/yr	31%	↓	Program ramp up continues throughout Year 2
7a	Youth Reception Centers					TBD			
7b	Expand Youth Crisis Services					TBD			
8a	Family Treatment Court Expansion	27	27	48	75	45 new children/yr	107%	↑	Target is based on **new** children served per year
9a	Juvenile Drug Court Expansion	29	29	41	70	36 new youth/yr with 5.5 FTE 33 new youth/yr with 5 FTE	114% (Unadjusted) 124% (Adjusted)	↑	Target is based on **new** youth served per year
13b	Domestic Violence Prevention	102	79	65	144	85 families/yr (B)	169%	↑	

* Year 2 totals are unduplicated individuals per strategy (with at least one service record in the reporting period) where identifiers are available, unless otherwise indicated

** Original performance targets were estimated based on information available during planning phases and are subject to revision over time

\+ Adjustments shown where programs are not fully funded

(A) Reporting criteria changed from Year 1 to Year 2

(B) Modification accepted by Council in motion of acceptance on 5/10/2010

(C) Modification proposed to original target on 10/1/2010

(D) Individuals counted more than once if enrolled in both GED/LSW and Domestic Violence Prevention classes

(E) Most capitally-funded new housing units also have support services (as counted under Strategy 3a)
An additional 25 individuals were housed in new units without MIDD-funded support services

Strategies without reportable data for the current reporting period

Continued on Page 10

Key to Target Success Rating Symbols	
↑	Annualized percentage of Year 2 Target is higher than 85%
→	Annualized percentage of Year 2 Target is 65% to 85%
↓	Annualized percentage of Year 2 Target is less than 65%

Jail and Hospital Diversion Strategies									
Strategy Number	**Strategy "Nickname"**	**Reported in Year 1**	**Continued Services in Year 2**	**New in Year 2**	**Year 2 Totals***	**Key Performance Target(s) for Year 2****	**Percent of Year 2 Target+**	**Target Success Rating**	**Notes or Explanation (If Applicable)**
10a	Crisis Intervention Training					480 trainees/yr (40-hr) 1,200 trainees/yr (1-day)			
10b	Adult Crisis Diversion					3,600 adults/yr			
11a	Increase Jail Liaison Capacity	116	32	247	279	200 clients/yr (B)	140%	↑	
11b	MH Court Expansion	—	—	26	26	115 clients/yr (C) with 2 FTE 44 clients in 9 mos with 1 FTE	23% (Unadjusted) 59% (Adjusted)	↓	Initial referrals not made until February of 2010 and ramp up continues
12a-1	Jail Re-Entry Capacity Increase	297	12	246	258	300 clients/yr (B) with 3 FTE 200 clients/yr with 2 FTE	86% (Unadjusted) 129% (Adjusted)	↑	
12a-2	CCAP Education Classes	114	19	430	449 (D)	600 clients/yr (B)	75%	→	Domestic Violence Prevention class sign-in sheets not submitted for Q3 of 2010
12b	Hospital Re-Entry Respite Beds					TBD (B)			
12c	PES Link to Community Services	87	27	148	175	75-100 clients/yr	233%	↑	% based on minimum in range
12d	Behavior Modification for CCAP	42	19	60	79	100 clients/yr (B)	79%	→	
15a	Adult Drug Court Expansion	125	97	240	337	300 clients/yr (B)	112%	↑	
16a	New Housing and Rental Subsidies	27	22	30	52	50 rental subsidies 250 new units (E)	104%	↑	
17a	Crisis Intervention/MH Partnership								
17b	Safe Housing - Child Prostitution	—	—	—	—	—	—	—	Output data from City of Seattle not yet available

Additional Performance Indicators for Select Strategies

Number of Individuals Served by Multiple Strategies - Most Common Overlaps

A total of 1,770 people received MIDD-funded services from more than one strategy or from multiple providers within the same strategy from October 1, 2009 through September 30, 2010. The most common strategy overlaps are seen in three areas: 1) individuals receiving mental health (1a-1) and chemical dependency treatment (1a-2a); 2) individuals encountered through both outreach (1b) and hospital early intervention programs (1c); and 3) individuals enrolled in MIDD-funded mental health services (1a-1) who also received supported employment benefits (2b) via the MIDD. The grid to the right shows where the various strategies intersect most often. For example, 76 clients of Adult Drug Court (15a) were also able to access outpatient CD treatment (1a-2a) through the MIDD. The strategy with the most overlaps, 1c - Substance Abuse Emergency Room Intervention, saw nearly 600 people who were previously or subsequently enrolled in other MIDD strategies, potentially indicating high utilization of system resources.

	1a-1	1b	1c	1d	12c	15a
1a-2a	204		82			76
1a-2b		141				
1c	63	196	81	87	88	
2b	140					

Tracking Full-Time Equivalents for Strategies with Explicit FTE Goals

Strategy Number	FTE Goal from Revised Matrices	FTE Type*	Year 1 FTEs Hired	Year 2 Changes in FTEs	% of Goal
1b	5.6	NC	5.0	+0.6	100%
1c	9.0	NC	6.0	+0.0	67%
1e	1.0	C	1.0	+0.0	100%
1f	1.0	C	1.0	+0.0	100%
1g	7.4	NC	6.5	+0.0	88%
1h	4.6	NC	4.6	-1.1	76%
2b	23.0	NC	15.8	+1.7	76%
4d	3.0	NC	3.0	+0.0	100%
5a	4.0	C	1.0	+1.0	50%
6a	1.0	C	1.0	+0.0	100%
8a	3.5	C/NC	3.5	+0.0	100%
9a	5.5	C	3.2	+1.8	91%
10a	2.0	NC	1.0	+1.0	100%
10b	1.0	C	0.0	+1.0	100%
11a	1.0	NC	1.0	+0.0	100%
11b	2.0	NC	0.0	+1.0	50%
12a-1	3.0	NC	2.0	+0.0	67%
12c	3.0	NC	3.0	+0.0	100%
13a	4.0	NC	4.0	-0.8	80%
13b	3.0	NC	3.0	+0.0	100%
14a	4.5 (A)	NC	4.5	-0.9	80%
15a	1.5	C	1.5	+0.0	100%

*C = County Staff and NC = Not County Staff

(A) Error in previously reported has been corrected

Strategy 2a—Workload Reduction for Mental Health

Prior to the MIDD, 16 of the 17 mental health provider agencies now delivering MIDD services reported employing 869 direct services staff members. As of September 30, 2010, the number of direct services staff within these 16 agencies had risen to 1,160. Of these 291 "new" staff brought on across the MH system to improve staff-to-client ratios and quality of care, over 45 percent were attributed to Strategy 2a in summary reports submitted by each agency in compliance with contract requirements.

Detailed Performance Measures for 5a

	Matrix Goals as of 5/19/2010	Actuals for Year 2	Unadjusted Percent of Target	Adjusted Percent of Target
Psychiatric Consults	75	7	9%	19%
Psychological Evals	200	25	13%	25%
MH Assessments	140	124	89%	177%
CD Evals (GAIN)	165	251	152%	304%

Community-Based Care Strategies

1a-1 Increase Access to Community Mental Health Treatment

The MIDD helped 3,481 King County residents gain access to outpatient mental health (MH) treatment services between October 1, 2009 and September 30, 2010. Approximately half of those served were new in MIDD Year Two while the other half were able to continue treatment which began in MIDD Year One.

The number of service visits per person ranged from only one in the reporting period to twice daily for an entire year. On average clients had three service visits per month throughout the year as shown below:

Service Visit Statistics for Outpatient MH

Minimum	Maximum	Average	St Dev
1	709	33.55	48.27

Treatment services for clients of all ages are provided through a network of outpatient service providers licensed as community mental health centers. Please see Page 35 for a detailed listing of provider agencies.

1a-2 Increase Access to Community Substance Abuse Treatment

Outpatient service units for substance abuse outpatient (OP) treatment include hours for assessments, individual therapy, group therapy, and case management. For youth, these service units include urinalysis testing as well. For opiate substitution therapy (OST), service units are dose days when individuals receive medications. MIDD provided payment for the following service units, which helped 3,823 people in MIDD Year Two:

	Units Paid	Payments
Youth OP Treatment	6,617	$ 252,036
Adult OP Treatment	43,751	$ 1,316,146
Adult OST Treatment	82,560	$ 1,157,332

More youth were served by MIDD than expected, due to a lack of available state funds during this funding cycle. Fewer adults, however, used MIDD funds than expected, as other adult fund sources were available during this time.

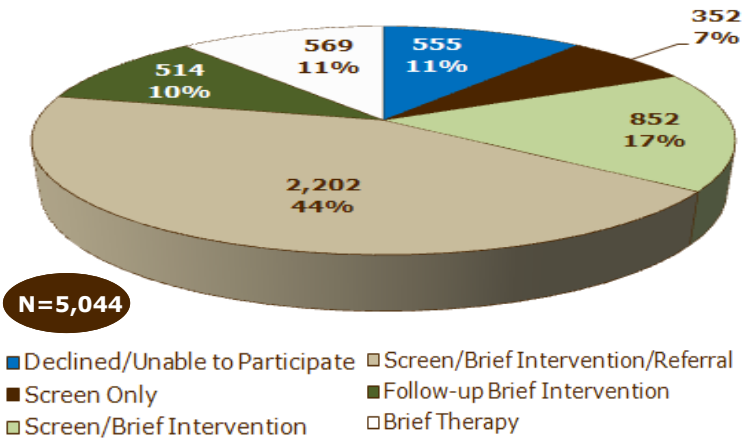
1b Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities

Homeless individuals and those battling chronic addiction to alcohol and/or intravenous drugs are chief targets of Strategy 1b. Partnering with Public Health - Seattle & King County's Healthcare for the Homeless Network and two other agencies, this strategy provided case management for 1,857 high-need individuals. Through a total of 5,648 documented encounters, case managers helped those on treatment waiting lists, often linking them to other vital services.

Using MIDD funds to leverage matching federal dollars, this strategy has been able to serve three times the number of individuals indicated in the performance measurement targets (1,857 vs. 675). Initial outcomes for those reached by Strategy 1b will be available in the Year Three Progress Report.

1c Emergency Room (ER) Substance Abuse Early Intervention Program

Strategy 1c provides an evidence-based, comprehensive, integrated approach to substance abuse early intervention and treatment in medical hospitals in King County. This strategy targets persons at risk for substance use disorders who are admitted to the ER for a variety of reasons. Currently implemented in emergency departments at Harborview Medical Center, Highline Medical Center, and St. Francis Hospital, a total of 5,111 service encounters were documented for 3,177 people during this reporting period. Where type was known, these encounters were categorized as follows:



During its second year of implementation, 69 percent of those served by Strategy 1c were men and 31 percent were women. In the 2,629 encounters that had referral activity, a total of 4,330 referrals were made. The top three specified referrals in descending order of frequency were to sobering support organizations such as Alcoholics Anonymous (979), detoxification services (735), and brief therapy at Harborview Medical Center in Seattle (533). [Note: Multiple referrals per encounter or individual are possible.]

Understanding the "SBIRT" Model

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is the model* at the heart of Strategy 1c. Certified chemical dependency professionals (CDPs) engage people who have not sought treatment for alcohol or drug-related problems, but whose behaviors or symptoms while in the ER indicate they might have a substance use disorder. The SBIRT steps involve:

Screening Using standardized tools such as the AUDIT (Alcohol Use Disorders Identification Test) and DAST (Drug Abuse Screening Test), those with risky use behaviors can be identified.

Brief Intervention Individuals who score at moderate to high levels of risk are candidates for brief (lasting from five to 60 minutes) interventions. The basic steps of this process include:

- Raising the Subject
  - Building rapport
  - Assessing comfort
  - Reflective listening
- Providing Feedback
  - Illustrating usage patterns with data
  - Making connections to health issues
- Enhancing Motivation
  - Assessing readiness
  - Developing reasons that support change
- Negotiating and Advising
  - Securing an agreement for changes in drinking or drug use
  - Expressing concern
  - Scheduling follow-up

Referral to Treatment The MIDD-funded CDPs are well-versed in the local treatment delivery and recovery systems and can facilitate linkage to higher levels of care when necessary, then follow up as time allows.

Note: Brief therapy (longer term brief intervention) provides a "bridge" to engage those in need of the most intensive treatments.

**Source: Addiction Technology Transfer Center Network's "SBIRT Part 2—Breaking the Model Down" (August 2010).*

1d Mental Health Crisis Next Day Appointments and Stabilization Services

Next Day Appointments (NDAs) provide follow up from face-to-face crisis services delivered by certified clinicians with timely direct crisis intervention, resolution, referral, and aftercare services for individuals in need. This help is available for those who are in crisis but who may not be eligible for, or need, ongoing MH services. The existing mental health NDA program run by contracted providers was enhanced through MIDD funding to provide additional medical services, such as psychiatric medication evaluations, to clients in crisis situations. Comparing the number clients who received these specialized services during three different time periods, results confirm substantial increases in clients with medical services, medical service hours, and medical service episodes.

	Unduplicated Clients with Medical Services	Percent Increase Over Pre-MIDD	Medical Service Hours	Percent Increase Over Pre-MIDD	Medial Service Episodes	Percent Increase Over Pre-MIDD
Pre-MIDD	706	-	1,162	-	1,587	-
MIDD Year 1	896	27%	1,499	29%	2,099	32%
MIDD Year 2	960	36%	1,683	45%	2,395	51%

Another MIDD-funded enhancement to NDAs involves engaging those in need of substance abuse treatment. Analysis results of referrals to CD treatment after mental health NDAs are presented on Page 34.

1e Chemical Dependency Professional (CDP) Education and Training

At least 194 chemical dependency professionals from 22 agencies received reimbursement for expenses incurred while earning or renewing their CDP certifications. Tuition, books, testing and recertification fees are among the expenses reimbursed for professionals employed by providers within the substance abuse treatment system. Strategy 1e also increases adoption of evidence-based treatment practices that have been proven by research to be most effective.

Creating an effective, sustainable chemical dependency treatment workforce in King County with the capacity to deliver high quality recovery-oriented care is a primary focus of this strategy. See inset on Page 14 for additional information.

Training Consultant in Substance Use Disorder Evidence-Based Practices

Part of MIDD Strategy 1e

To build a sustainable evidence-based practices education and training plan for all King County chemical dependency providers, Strategy 1e adopted a Workforce Development Plan (WDP) in March, 2010. The Northwest Frontier Addiction Technology Transfer Center was selected to provide training, technical assistance, and leadership services to work with King County in developing and implementing this plan. The primary goal is to raise awareness and speed up adoption of scientifically validated clinical interventions in recovery-oriented service settings.

Through the WDP, chemical dependency professionals will build competence in evidence-based skills such as motivational interviewing (MI). This empowering intervention involves posing open-ended questions, using affirmations, and doing active reflective listening. Simply learning about MI techniques does not ensure their effective practice, however, so clinical supervision that includes performance feedback and coaching has been built into the plan. Collaborative learning groups will be the primary vehicle for infusing this hands-on type of clinical supervision into standard practice. Ultimately, providing the highest quality of care will lead to improved service outcomes for clients and will indicate the successful transfer of innovation into practice.

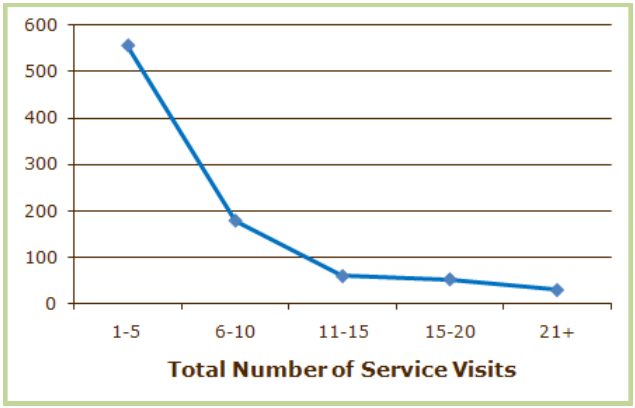
1f Parent Partner and Youth Peer Support Assistance Program

The Strategy 1f request for proposal (RFP) was re-released in March of 2010 for a single King County Family Support Organization to provide peer support, mentoring, training, technical assistance, networking opportunities and resources to families. The RFP did not result in a contract. Efforts are underway to implement this strategy in order to help families increase their understanding about available services and supports while helping them to use effective coping skills and increase their self-advocacy skills. The program will provide trained peer partners for parents and/or youth in families experiencing emotional or behavioral problems and/or substance use disorders in King County.

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

Public Health - Seattle & King County continues to coordinate service delivery for Strategy 1g with over 20 "safety net" community health clinics and public health centers. This program provides MH and CD screenings to older adults in low-income medical settings. It is designed to identify potential mental health and/or substance abuse issues in their early stages and intervene quickly.

Of the 2,495 people screened, 877 (35%) completed short-term treatment or were referred to treatment specialists before October 1, 2010. The graph below shows the majority of those treated were able to finish successfully within 10 service visits or less.



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

Strategy 1h continues to fund expansion of the Geriatric Regional Assessment Team (GRAT). The team responds to requests for in-home assessments of mental illness and substance use disorders in King County residents over the age of 55. The GRAT is a team of specially trained clinicians that deploys to all regions of King County when crisis referrals involving older adults are made. MIDD expansion has allowed GRAT to provide 24-hour turnaround response times.

GRAT Crisis Services

- Comprehensive psychiatric, medical, social, and functional assessments
- Crisis intervention and stabilization
- Prompt referral and linkage to mental health, aging, and health care providers
- Consultation, care planning and education for professionals, families, and other care providers

2a Workload Reduction for Mental Health

As indicated on Page 11, Strategy 2a seeks to reduce workloads for MH case managers in accordance with approved agency plans. The success of MIDD strategies such as 1b, 1c and 1g that are designed to identify and engage individuals with MH needs has increased demand on the mental health system. In order to expand capacity to meet this need, along with a desire to increase service accessibility and reduce wait times for service entry, community mental health agency direct service staffing has increased by 25 percent. The impact of this increased staffing on staff-to-client ratios will be analyzed in MIDD Year Three.

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

Having meaningful work and the ability to make a living are important factors in maintaining wellness. In this reporting period, Strategy 2b helped 453 new MH clients look for competitive jobs in the community. A total of 428 vocational assessments were conducted for this group of MH consumers.

Employment specialists are now integrated with clinical teams at eight area MH provider agencies*. Their work involves assisting clients by teaching job search and interviewing skills, providing benefits counseling to dispel myths about the impact of earned income on certain disability payments, linking job seekers to resources such as new clothing, and helping them decide whether or not to disclose their mental health status to potential employers. Once placed in jobs with fair wages, employment specialists provide individualized supports so individuals can retain those jobs or find better ones.

Throughout MIDD Year Two, Supported Employment programs benefited from multiple training opportunities (in conjunction with Washington State's Supported Employment Initiative) and ongoing fidelity assessments (see inset at right). The focus of trainings was "the importance of integrating mental health and vocational services." The trainings were followed up with on-site, in person coaching on job development led by the Washington Institute for Mental Health Research and Training (WIMHRT).

* Note: Implementation of Strategy 2a for chemical dependency treatment agencies is still on hold due to budget reductions.

Supported Employment (SE) Makes a Difference

K. started hearing voices after experiencing trauma at a very young age. His family moved for a new start, but the change to an urban area led to its own troubles. K. had difficulty adjusting and started smoking, drinking, and ditching school to cope. As a teen, his mother took him to a doctor because of the voices, but he was told nothing was wrong. K. ended up in detention for truancy, where he stayed locked up until he was 21 due to his behavior.

As an adult, K. went to another doctor who diagnosed PTSD and depression. Regular doctor visits and medications helped him feel "normal" and stable. He stopped using drugs and built a life and a small business. It all fell apart after a breakup with his wife. He started taking drugs again and ended up on the street. In 2006, he went to the Downtown Emergency Service Center (DESC) in Seattle and said, "Please, I want help." The next 10 months were spent in inpatient CD treatment.

After his treatment, K. volunteered for three years at DESC where he gained experience working in their thrift store and drop-in center. In 2009, he was assigned an employment specialist through MIDD Strategy 2b. With support from the SE program, K. has completed his education and training to become a Washington State Certified Peer Counselor. He now works at Therapeutic Health Services (THS) as a Peer Counselor, coordinating THS' drop-in center and supporting MH consumers. On the way to work on his first day he said to himself, "Wow, I am going to work like everybody else. I am a part of society. I am being helpful."

K. continues to experience symptoms. While he "hears voices all of the time", they are "not always a negative experience." He takes his medication and believes "success is knowing who you are and doing your best." He reports being "reconnected to the community" and feeling like he is "an asset, not a liability" to society. K's spiritual community is an important source of support. He enjoys jazz with his friends and seeks a significant other to make his life complete.

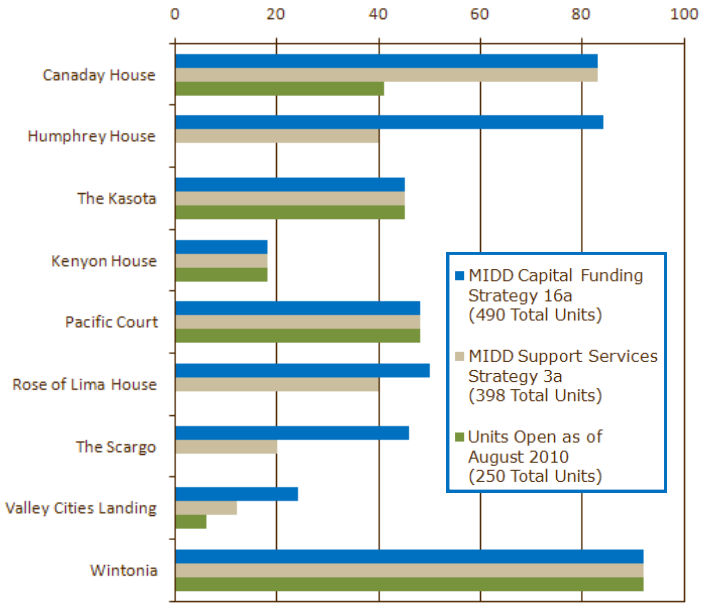
Fidelity Assessment of Supported Employment

In September 2010, three interdisciplinary teams made up of mental health consumers, Washington State Department of Vocational Rehabilitation employees, and County staff were trained by nationally-recognized experts to conduct fidelity assessments of MIDD-funded supported employment (SE) programs. To measure adherence to the evidence-based model for delivery of SE services, teams learned to examine 25 different program components. By interviewing agency managers, clinicians, employment specialists and SE clients, and by reviewing charts, fidelity teams were taught how to rate each scale item and provide detailed, actionable feedback. Items on the fidelity scales include zero exclusion (serving all who request help), disclosure of client mental illness, and individualized job development. In MIDD Year Three, these teams will conduct two-day assessments at each of the eight MH agencies involved in providing SE services.

3a Supportive Services for Housing Projects

Just as supported employment helps keep people in real jobs with real pay, Strategy 3a is designed to offer supplemental services that enable those dealing with mental illness or substance use disorders to stay off the streets and live independently in stable housing. By tailoring service offerings to individual client needs, supported housing programs have proven to be adept at preventing homelessness for typically vulnerable populations. In conjunction with the efforts of the Committee to End Homelessness in King County, 398 units with MIDD-funded support services will become available for occupancy in MIDD Year Three. For each housing program, units developed with MIDD Strategy 16a capital funds released in 2008, units with support services through Strategy 3a, and units currently housing MIDD clients are shown below:

Supported Housing Units for MIDD Clients



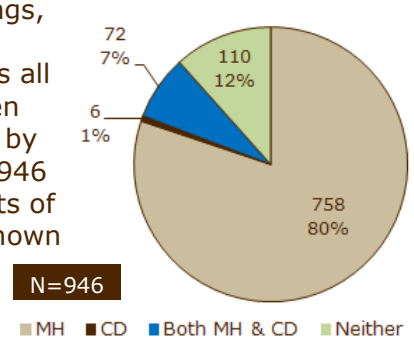
Strategy 3a Supported Housing Outcomes

A total of 65 people exited supported housing during the first two years of MIDD funding. The most common reason for leaving (N=19) was program completion or no longer needing the high level of support offered, in contrast to those needing more support (N=4). Other exit reasons included returning to the street (N=14) and moving for MH or CD treatment (N=11).

Fourteen of those who left (22%) had utilized the Dutch Shisler Sobering Center in the year prior to their supported housing experience, for a combined total of 986 days in sobering (an average of 70 days per person). While these clients were living in supported housing units, their combined days in sobering dropped to only 78, a reduction of 92 percent.

13a Domestic Violence and Mental Health Services

Licensed mental health professionals continue to offer MH counseling services at four area domestic violence advocacy agencies: Domestic Abuse Women's Network (DAWN), Eastside Domestic Violence Program, New Beginnings, and Refugee Women's Alliance (ReWA). Across all programs, 1,141 women were offered screening by agency advocates and 946 (83%) accepted. Results of those screenings are shown at right. Of the 830 who screened positive for either "MH" or "Both MH & CD" concerns, 676 (81%) were referred to agency MH professionals and 489 (72% of those referred) had at least one group, individual, or case management service in MIDD Year Two.



14a Sexual Assault and Mental Health Services

At four area sexual assault survivor agencies, MIDD funds are blended with other revenues to offer specialized trauma-focused therapy services to more of their clients. Universal MH and CD screening has also been implemented across the sexual assault care system, as a result of the MIDD. Below are the combined screening results for MIDD Year Two:

Screening Results	Frequency	Percent
MH	844	66%
CD	1	<1%
Both MH & CD	95	7%
Neither	337	26%
Totals	1,277	99%

While only 364 (39%) of those with a positive screening engaged in one or more services, it should be noted that these resources are limited to serving approximately 400 clients in a given year. In MIDD Year Two, 82 percent of those served were female, and 56 percent were under the age of 18. Of 64 language interpreter services used, 16 (25%) were for Vietnamese and 15 (23%) for Spanish.

At King County Coalition Against Domestic Violence, a full-time coordinator worked under MIDD strategies 14a and 13a to integrate the sexual assault and domestic violence systems with the MH and CD systems by providing resources, trainings, and consultations, while networking across systems.

ReWA Helps Clients Overcome Cultural Barriers to Mental Health Recovery

Culturally sensitive therapy begins with an assessment of a client's identified culture. At Refugee Women's Alliance (ReWA), clients feel safe and comfortable talking about their issues with counselors who speak their languages and understand their needs. ReWA's advocates and licensed therapists are specially trained to maintain competence in working with individuals of diverse backgrounds and to respect their diverse perspectives, values, and attitudes. ReWA offers programming dedicated to providing support, legal assistance, referral, and case management services to survivors of domestic violence and sexual assault, along with MIDD-funded behavioral health services in a variety of languages.

In October 2009, Anh* came to ReWA for help after a long history of domestic violence and sexual assault by her husband. In one of her first therapy sessions, Anh indicated she had "very little energy", could not "concentrate at home or work" and felt very "hopeless". She was frightened by men and showed symptoms of PTSD due to sexual abuse endured for over 12 years. After leaving her husband, Anh was still afraid to be around people and experienced nightmares brought on by death threats her abuser had made. At ReWA, Anh has received help with her behavioral health issues, plus case management services to help her cope with her pending dissolution of marriage, financial issues, and housing.

During therapy, Anh would often close her eyes to avoid feeling pain and to help her feel safe. She was feeling sad, hopeless, and lonely. After several therapy sessions in her native language, however, Anh began processing her anger, working through the stages of grief, and learning effective ways to cope with stress. Away from therapy, she writes in her journal and practices different breathing techniques.

Currently, Anh continues to deal with her grief. She is optimistically working toward her goals and learning to accept the reality of her situation, given the pain and turmoil she has experienced. She is finding a way forward. With a smile, Anh opens her eyes and says, "I feel blessed that there is someone who listens to me and actually understands. Without [ReWA's] services, I would not be where I am today".

*Not her real name

Strategies with Programs to Help Youth

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

The evidence-based project serving as Strategy 4a's foundation is called "Families Facing the Future" which was developed through research by the University of Washington, School of Social Work, Social Development Research Group in Seattle. This program is designed to help parents in substance use disorder recovery to become more effective parents. This is part of an effort to reduce the risk that their children will abuse drugs or alcohol in the future. When funding is made available, an estimated 400 parents per year are expected to participate.

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

Inclusion of this strategy in the MIDD implementation plan was meant to address the King County policy goal of reducing the incidence and severity of chemical dependency and/or mental and emotional disorders in youth and adults. By targeting the children of substance abusers with proven prevention practices, Strategy 4b attempts to break the cycle of addiction using proactive, family-based approaches. When funded, the *Celebrating Families!*™ curriculum (from The National Association for Children of Alcoholics) consisting of 16 two-hour long sessions will be delivered to 400 area youth and children whose parents are participating in treatment or are in recovery for their substance use disorders.

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

Awards for 10 providers to deliver 13 different programs at schools throughout King County were announced after review of responses to the RFP for Strategy 4c in April 2010. Depending upon the school district and area, targeted students are those attending either middle school or junior high. The strategy invests in MH and SA services with a focus on indicated prevention, early intervention, screening, brief intervention, and referral to treatment. While the scope of school-based MH and SA is broad and inclusive of a number of approaches, it is designed to invest resources in therapeutic direct services for youth. The services align with school-wide policies and address the continuum of need from primary prevention through recovery, moving beyond more traditional disciplinary responses.

While start-up work with agencies and schools began with the 2010-2011 school year (see related story on Page 21), no clients were actually served until after October 1, 2010. Initial demographic and service data will be available for the MIDD Year Three Progress Report.

New MH & CD Programs for Students

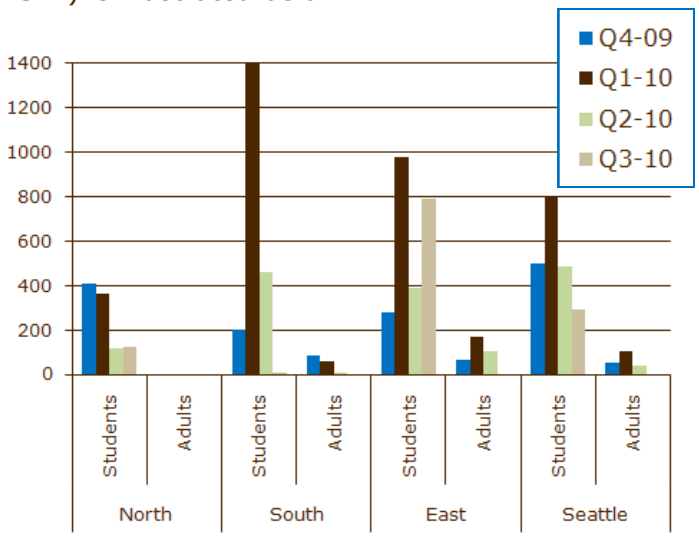
Organization	School District, Schools, & Partners	Region
Auburn Youth Resources	Auburn SD/ Cascade, Mt. Baker, Rainier, and Olympic MS	South
Center for Human Services	Northshore SD/ Kenmore JH; Ryther Child Center and Sundown M Ranch	North
Friends of Youth	Issaquah SD/ Beaver Lake and Maywood MS	East
	Riverview SD/ Tolt MS and Snoqualmie SD/ Twin Falls MS	East (Outlying)
Kent Youth & Family Services	Kent SD/Mill Creek MS	South
Neighborcare Health	Seattle SD/Hamilton International School; Sound Mental Health	Seattle
	Seattle SD/Secondary Bilingual Orientation Center (SBOC); Sound Mental Health	Seattle
Northshore Youth & Family Services	Skykomish SD	East (Outlying)
Puget Sound Educational Service District	Renton SD/ Dimmit, McKnight, and Nelson MS	South
	Tukwila SD/ Showalter MS	South
Ruth Dykeman Youth & Family Services	Highline SD/ Sylvester and Cascade MS	South
Seattle Children's Hospital	Seattle SD/Eckstein MS	Seattle
Therapeutic Health Services	Seattle SD/Madrona K-8 School	Seattle

Key:
SD = School District **MS** = Middle School **JH** = Junior High

4d School-Based Suicide Prevention

In addition to suicide prevention trainings, staff funded by Strategy 4d visit area schools to evaluate their policies and procedures for intervening with students who are at risk for suicide. The Youth Suicide Prevention Project (YSPP) has reviewed policies from 17 of 19 school districts within King County, rating 11 "average" (having a few policies around intervention or post incident) and six "below average" (having no policies that mention suicide prevention). Work continued in MIDD Year Two to move more districts and individual schools toward "exceptional" crisis response policies that encompass prevention, intervention, and post incident concerns. Technical assistance is available to school districts to assist with improving crisis response policies.

The Teen Link program affiliated with Crisis Clinic had a very busy year, training 7,600 youth (more than double their MIDD goal) by combining MIDD funds with other revenues. The trainings are designed to help youth talk openly about not only suicide, but also self-harm, peer pressure, violence, self-image, gender roles, parental expectations, and the recession. They also help youth build skills around helping their friends through life's tough situations. The geographic dispersion for suicide prevention work for both the total number of youth and adults (presented by YSPP) is illustrated below.



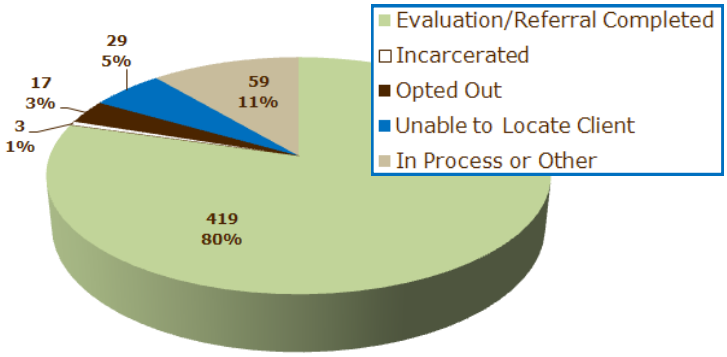
Suicide Prevention Trainings Under MIDD 4c

Two curricula options, developed by LivingWorks Education and delivered by YSPP, will be offered to personnel at schools across King County: 1.) Applied Suicide Intervention Skills Training (ASIST) workshops , and 2.) SafeTALK trainings that teach participants to recognize and engage persons who may be having suicidal thoughts and linking them to help.

5a Expand Assessments for Youth in the Juvenile Justice System

Despite hiring staff for only half of their MIDD-funded expanded capacity, the Juvenile Justice Assessment Team* (JJAT) began coordinating assessment services for King County juvenile justice system youth in October 2009. One full-time coordinator helped process requests for comprehensive screening and arranged team triage and consultation meetings to determine the most appropriate services or referrals. Adding a team psychologist enhanced the professional capacity for offering relevant assessments in a timely manner. Proper screening of juvenile justice involved youth, for both substance misuse and mental illness, is essential for linking them to resources that address their specific needs.

Altogether, 402 youth were served in this reporting period for a total of 527 encounters including assessments and referrals. The top referral made was to Juvenile Drug Court (55 referrals with 38 linkages confirmed). Another 38 referrals were made to two evidence-based practices, Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT). See the blue inset on Page 27 for further explanation. Exit data for each encounter are shown here.



In MIDD Year Two, the JJAT also developed an RFP to add two additional professionals (MH and CD specialists) to their team. Those new positions were filled in December 2010.

* **NOTE:** In MIDD Year One, JJAT implemented a new approach based on cross-systems triage and best practices for assessing MH and CD needs of youth. They developed a menu of services (including triage, consultation, substance abuse screening, MH status exams, MH assessments, psychological evaluations and psychiatric consultations). The team implemented procedures for referral to psychological testing/evaluation and psychiatric consultation for youth, educated stakeholders on best practices for framing referral questions, and designed a program to identify, screen and assess youth affected by violence and trauma and linking them to services.

6a Wraparound Services for Emotionally Disturbed Youth

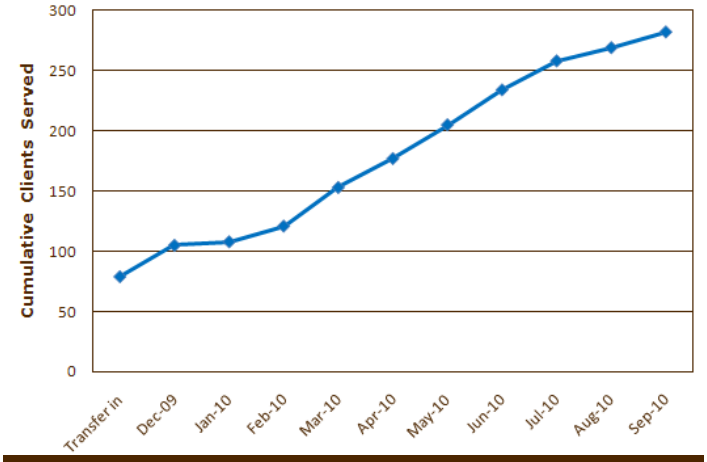
Wraparound is a coordinated system of support to streamline individualized care for youth with severe mental illnesses. The wraparound process is available to youth involved in more than one service system across all regions of King County and is provided by five MH treatment agencies.

During the wraparound process, a team of individuals who are relevant to the well-being of the child or youth (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized care plan, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, family, and other people drawn from the family's social networks. The team convenes frequently to measure the plan's components against relevant indicators of success. Plan components and strategies are revised when outcomes are not being achieved.

The process of engaging the family, convening the team, developing and implementing the plan, and transitioning the youth out of formal wraparound is facilitated by a trained wraparound coordinator. The wraparound process, and the plan itself, is designed to be culturally competent, strengths-based, and organized around family members' own perceptions of needs, goals, and the likelihood of success for specific strategies.

The program continued ramping up throughout the year as the graph below shows. In the MIDD's second year, data were available for 282 youth and their families who participated.

Wraparound Ramp Up



Please see Page 20 for one family's wraparound experience and success story.

Wraparound Services Help Families Stay Together

Imagine that you are out walking with your family on a pleasant, sunny afternoon when all of a sudden a dark cloud appears overhead and lightning strikes your 12-year-old brother! Schizophreniform disorder, characterized by rapid onset of symptoms such as delusions, hallucinations, social withdrawal, and even catatonic behavior within the individual, is often experienced as a major storm event by unsuspecting family members. In the case of Hamud, "everything was fine" until the day he "went out of it", landing him at Children's Hospital as a danger to himself and potentially others.

After several visits, the hospital recommended that Hamud apply for placement in the Washington State Children's Long-term Inpatient Program*, but the close-knit family of eight siblings was opposed to sending their brother away. That is when they learned about Community Psychiatric Clinic's MIDD-funded Wraparound program. With the help of a Wraparound Delivery Team Coordinator, a mental health therapist, a parent partner, and school professionals, Hamud's family has been able to ensure his safety through tailored environmental and behavioral interventions, teamwork, and dedication to his care. As his body adjusts to the medications that help alleviate his symptoms, he is surrounded by those who love him as they quietly "ground" him back to reality by appealing to his heightened senses of sight, smell, taste, and touch. The work they must do is not easy and the siblings (who all share a passion for pursuing their education), have had to make great sacrifices. Thanks to Wraparound, however, Hamud is engaged in his community with activities both in and outside of school, such as going to the movies with other kids, exercising, attending mosque with his father, and even the occasional therapeutic field trip to Top Pot Doughnuts!

* This scarce resource provides only 73 psychiatric beds statewide for this age group.

Pictured left to right standing in the back row: Ada (mental health therapist), Samantha (classroom teacher), Cooper (individual aide), Fadumo (sister/guardian), Mahamed (brother), Muna (sister), and Brandin (Wraparound Coordinator). Seated in the front row: Fardus (sister), Hamud, and Mohamood (brother). Not pictured: Ahmed (father), Duhdi (mother), Amal (sister), Eman (sister) and Afua (parent partner).

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

How can the King County juvenile justice system best respond to the needs of arrested youth who are not eligible for juvenile detention and who do not have a readily available parent or guardian?

The recommendation of the MIDD Plan was to meet the needs of this target population through development of a reception center that would provide an immediate option for law enforcement and serve as a central coordination point. As envisioned, reception center staff would have assessed the youth's needs for treatment and services and link them to those services.

At this juncture, a needs assessment and planning process is an essential next step to help evaluate the feasibility of the original plan. In particular, the needs assessment must gather information about the projected use of a reception center. The planning for this strategy will be coordinated with the planning processes for related MIDD strategies (especially 7b), with the goal of developing a crisis response system that meets the needs of the target population and comprises a full continuum of service options. This work remains unfunded in the current budget and the strategy is on hold.

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

Children and youth experiencing acute crises because of their emotional and/or behavioral problems may inappropriately enter the most restrictive and costly settings, including inpatient hospitalization, juvenile detention, foster care, and eventually, the Children's Long-term Inpatient Programs (CLIP) or Juvenile Rehabilitation Administration institutions. Youth who become involved in the child welfare and juvenile justice systems because of their emotional or behavioral problems face many barriers later in life related to education, employment, and housing.

The current Children's Crisis Outreach Response System (CCORS) offers a continuum of crisis outreach, crisis stabilization, and intensive in-home services to children, youth, and families in King County. MIDD funding will expand capacity to serve additional youth and families, particularly those youth involved in the justice system whose placement is at risk. Funding will support a comprehensive needs assessment and planning process with the goal of enhancing the continuum of children's crisis services, incorporating elements of national best practice models such as short-term crisis beds and reception centers. During the second year of the MIDD, this planning process was still on hold.

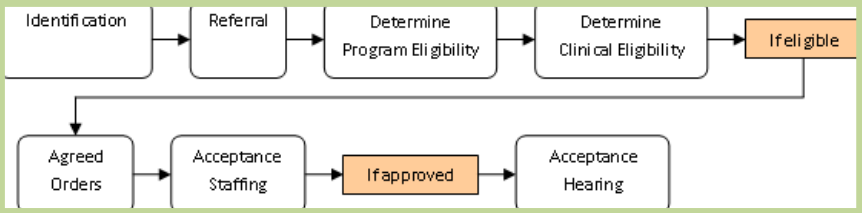
Students Get Involved with MIDD Strategy 4c Start-Up

Students at Seattle Public School's Secondary Bilingual Orientation Center (SBOC) will receive mental health and substance abuse services through MIDD Strategy 4c. These services include prevention, screening, early intervention, and referral to treatment. Many of SBOC's students have been separated from their parents for years before they can move to the United States and reunite as a family. The challenge of reconnecting with parents after lengthy separations and being in a new environment leaves many students struggling at school. Some students lose hope and become suicidal. Counselors can work with these students to ensure safety, rekindle hope and make referrals to other services when needed. Additionally, counselors will use a strengths-based approach in all prevention groups at the school to teach participants to focus on helping others. Altruism and good citizenship become part the group process. For example, a Somali group is working to develop a team to welcome and guide new students. Similarly, a Latino girl's group is hoping to support students with observable disabilities after experiencing the benefits of mutual support themselves.

8a Expand Family Treatment Court Services and Support to Parents

Family Treatment Court (FTC) provides a formal structure for monitoring treatment compliance of parents identified as chemically dependent who have lost custody of their children due to their substance use. Successful "graduates" of FTC have the opportunity to reunite with their families and their children are often the ultimate beneficiaries of the court's expanded supports. With MIDD's help, FTC expanded to provide services in south King County at the Norm Maleng Regional Justice Center. Acceptance into FTC is a seven-step process as the diagram below illustrates.

Steps for Entry into Family Treatment Court Services



FTC Graduation Criteria

* Completed all four levels of FTC
* Clean and sober consecutive six months
* Children home or permanently placed
* Completed certified CD treatment program
* Attend sober support program consistently
* Housing arranged, legal issues resolved
* Support system, relapse prevention, life plan

In this reporting period, 29 new families (33 parents with 48 children) began FTC, and a total of 47 families (54 parents with 75 children) received services. Altogether, 17 parents from 15 families exited the program. While 10 of these parents were discharged for non-compliance with FTC protocols, five made it all the way to graduation. On average, those who graduated spent 459 days in the program compared to only 307 for those leaving early for any reason (including opt out and dependency dismissal).

9a Expand Juvenile Drug Court Treatment

The Juvenile Drug Court (JDC) is an intensive therapeutic treatment court providing the highest level of care to young offenders diagnosed as chemically dependent. JDC is organized around the 10 key components that define a drug court:

1) Integrated systems (substance abuse treatment services and the court)
2) Protection and assurance of legal rights, advocacy and confidentiality
3) Early identification and intervention
4) Access to comprehensive services and individualized case planning
5) Frequent case monitoring and drug testing
6) Graduated responses and rewards
7) Increased judicial supervision
8) Deliberate program evaluation and monitoring
9) A collaborative, non-adversarial, cross-trained team; and
10) Partnerships with public agencies and community-based organizations.

Of the 70 youth served by JDC in MIDD Year Two, four graduated, two were dismissed, and 64 continued to be engaged in the program. The vast majority (81%) of participants are male and minority or multi-racial (79%). The average program length for graduates was 350 days.

13b Domestic Violence Prevention

Strategy 13b funds the Children's Domestic Violence Response Team (CDVRT) to reach out to children exposed to domestic violence in their homes. Once families are engaged in services, children up to 12 years of age can go to Kid's Club, a series of group sessions offering support and information to help children deal with their domestic violence experiences. Based on a national model, Kid's Club strives to increase feelings of safety while decreasing anxiety and depression. The goal is to interrupt the cycle of violence within families.

In its second year with MIDD funding, the CDVRT screened 222 families and delivered services to 257 unique individuals. Trauma Focused Cognitive Behavioral Therapy (TF-CBT) was used in eight of 249 MH therapy sessions lasting less than one hour (3%) and 47 of 603 (8%) of those lasting over an hour. Altogether, 20 unique clients had TF-CBT. See Page 27 to learn more about TF-CBT.

17b Safe Housing and Mental Health and Chemical Dependency Treatment for Children in Prostitution Pilot

MIDD made a one-time allocation of funds to the City of Seattle for MH and CD services for prostituted youth housed in specialized residential treatment. Evaluation information will be shared by the City of Seattle and included in future MIDD reports.

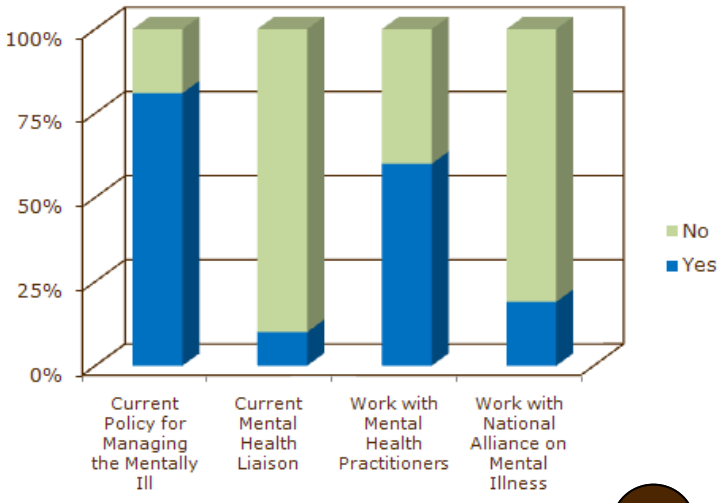
Jail and Hospital Diversion Strategies

10a Crisis Intervention Training for First Responders

Research shows Crisis Intervention Team (CIT) training to be effective in improving front-line response to individuals with mental illness and chemical dependency. Typical results include increasing use of jail diversion options, reducing the number of people with mental illness going to jail, and reducing police officer injury rates. The current plan is to provide 40-hour CIT trainings to police officers in any King County jurisdiction who request the full training and to provide one-day training for other interested officers and first responders. Classes started in fall 2010.

In August 2010, MIDD staff stationed at the Washington State Criminal Justice Training Commission in Burien, WA conducted a needs assessment survey to gauge interest in the CIT program and to determine law enforcement current practices related to mental health. Twenty-one agencies participated in the survey, including several municipal police departments, the King County Sheriff's Office, and the Washington State Patrol. Over half of all respondents indicated a preference for regional CIT training versus agency-level. The majority (57%) also reported having fewer than six officers currently trained as CIT members. The survey findings shown below give a snapshot view of law enforcement agency practices prior to MIDD funding of regional CIT training.

Current Practices for Law Enforcement Agencies



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

Strategy 10b establishes a crisis diversion facility (CDF) to which law enforcement and other crisis first responders can refer adults who are in crisis brought on by mental illness or substance use. The facility will evaluate and stabilize individuals in crisis and refer them to appropriate community-based services. Respite beds will also be created to provide short-term housing for homeless individuals leaving the center, and a mobile crisis team of MH and CD specialists will provide increased access and linkage to crisis response for police.

After a thorough RFP process, all three components of the adult crisis diversion strategy were awarded to Downtown Emergency Service Center (DESC) in MIDD Year Two. The Crisis Diversion Interim Services (respite beds) portion was awarded on November 4, 2009 after the first round of proposals. In March 2010, the original RFP was revised and re-advertised for the CDF and mobile crisis team. Awards for these services were publically announced on July 7, 2010 and DESC began planning immediately to deliver an operational "Crisis Solutions Center" before the end of MIDD Year Three.

11a Increase Jail Liaison Capacity

Jail liaisons help directly connect adult defendants with community services they need to help keep them from returning to jail. This strategy funds liaison services for those ordered by a judge to the King County Work and Education Release (WER) program. Please see Strategy 12a-1 on Page 24 for more information.

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

In February 2010, initial referrals to King County District Court's Regional Mental Health Court (RMHC) were made. The model for this therapeutic court allows any city to refer any defendant with a misdemeanor offense for possible acceptance by the RMHC. The diagram below shows the referral and acceptance process.

1. City prosecutor refers to the King County RMHC Prosecutor
2. Defendant must be legally competent
3. Expansion Court Monitor screens for clinical eligibility
4. Case is filed into RMHC
5. No cost to the city after county files the case
6. Defendant must opt in / agree to case being in RMHC

Prior to MIDD Mental Health Court (MHC) expansion funding, only county misdemeanors and felony drop-downs were eligible for the District Court's MHC. Now all County cases and municipal cases from 39 different cities are open for consideration. Seattle Municipal Court retains its own MHC, but received MIDD expansion funding for another court liaison in late 2010.

The MHC Team is made up of a front-end clinical Court Monitor, dedicated prosecutors and defense attorneys, experienced Master's level probation officers, other court staff and paralegals, and a dedicated judge. The core court (unexpanded version) has been in existence for over 11 years.

In this reporting period, the court opened a total of 26 expansion cases. Ages of defendants ranged from 21 to 62 years, and 58 percent indicated they were racial minorities. Referring cities included: Bothell (north); Bellevue, Kirkland, Redmond, and Woodinville (east); Burien, Federal Way, Kent, Renton, SeaTac, and Tukwila (south), and Seattle.

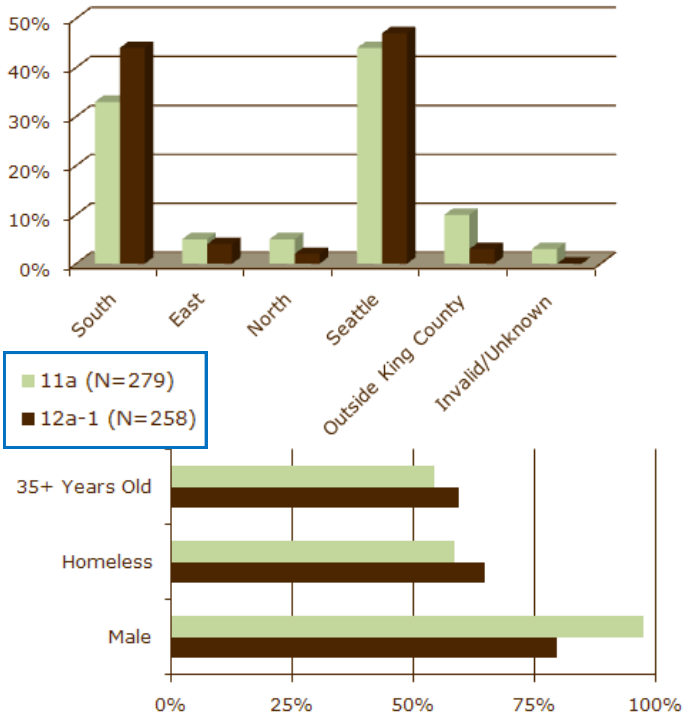
12a-1 Jail Re-Entry Program Capacity Increase

The Re-Entry Case Management Services (RCMS) program is intended to provide intensive, short term case management to jailed individuals with mental health and/or substance abuse problems who are close to release and in need of assistance to reintegrate back into the community in order to keep from re-offending and returning to jail. Services offered through RCMS included:

- Re-entry needs assessment
- Pre-release engagement consisting of a minimum of one face-to-face meeting
- Facilitation of application for public entitlements and other benefits
- Medication monitoring
- Linkage to mental health services and substance abuse treatment
- Assistance with basic needs
- Assistance with transportation (i.e., bus tickets)
- Assistance with physical health care resources
- Assistance with shelter and transitional housing
- Linkage to pre-vocational and employment services and resources.

In the current time period, two re-entry case managers and one WER liaison (see Strategy 11a) served a total of 537 people. These snapshots show how the two programs differ only slightly demographically, with 12a-1 serving more in the south region of King County and more women.

Demographics Profile Comparison



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

Class offerings have been enhanced with MIDD support to help prepare individuals re-entering the community upon completion of their court-ordered alternative sentencing. Job preparation, general education, and domestic violence classes are the focus of Strategy 12a-2. Over a year's time, 181 individuals took either Life Skills to Work or General Education Development (GED) courses and at least seven earned their GED diplomas. In a nine-month period, 268 CCAP participants attended at least one class to learn about breaking the cycle of domestic violence (DV). Thirty-four people were enrolled in both GED and DV classes.

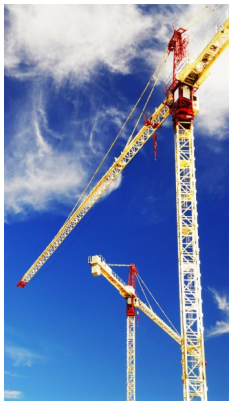
Basic Life Skills

- Getting along with others
- Making good decisions
- Time & money management
- Productivity & responsibility
- Coping with stress

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

In September 2010, Public Health - Seattle & King County and Seattle Housing Authority (SHA) signed a lease agreement for a new recuperative care facility at Jefferson Terrace in the First Hill neighborhood of Seattle. With renovation planning underway (see Construction Schedule Highlights below), the proposed service model being considered by the Respite Expansion/Hospital Discharge Project planning group includes staffing by health care professionals, MH and CD professionals, and discharge planners.

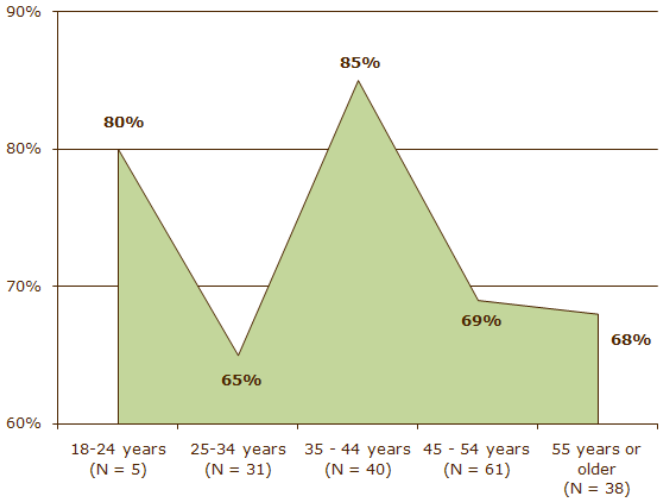
Through a partnership with local hospitals, services are slated to include case management, medical and medication management, transportation to appointments and housing options, and the provision of basic needs such as food, hygiene, and laundry. Case management will focus on linking homeless people to more stable housing and ongoing medical and mental health care and substance abuse treatment. When fully operational, Strategy 12b under the MIDD will provide funding for the MH and CD services portion of the project for an estimated 350 to 500 people per year.



12c Increase Harborview's Psychiatric Emergency Services (PES) Capacity to Link Individuals to Community-Based Services upon Discharge from ER

Strategy 12c employs assertive case management to engage a designated high-utilizer caseload drawn from Harborview's PES, a long-standing "safety net" program for disadvantaged patients with severe mental illness and substance abuse histories. Using a harm reduction approach, case managers successfully engaged 175 clients (mostly homeless) in MIDD Year Two. This was double their target goal. Please see the story on Page 27 for additional information.

Percent Homeless by Age Group for Strategy 12c



Outcome Highlight: Strategy12c referrals to mental health treatment rose from 17 percent in MIDD Year One to 43 percent in MIDD Year Two.

Strategy 12b Construction Schedule Highlights*

Major Tasks (Completed in MIDD Year 2)	Start	Finish
Fee Proposal and Negotiations	7/1/2010	8/20/2010
Contract Negotiations and Execution	8/23/2010	9/29/2010
Lease Negotiation	9/13/2010	10/1/2010
Floor Plan Development, Review, and Finalization	8/26/2010	10/1/2010
Major Tasks (Scheduled for MIDD Year 3)	**Start**	**Finish**
Design Development	10/5/2010	10/15/2010
Permit Constuction Documents	10/18/2010	11/17/2010
Bid Construction Documents	11/15/2010	12/31/2010
Bidding and Contracting	1/5/2011	2/18/2011
Constuction	2/18/2011	6/30/2011
Move-in and Opening	7/11/2011	7/18/2011

* Subject to change without notice

12d Behavior Modification Classes for CCAP Clients

Evidence-based therapeutic classes based on cognitive behavioral therapy are at the heart of Strategy 12d. The program enrolls qualified candidates serving their court-ordered time at Community Center for Alternative Programs (CCAP). Various types of behavior modification, Moral Reconation Therapy (MRT) and Dialectical Behavior Therapy (DBT), for example, have proven effective in reducing recidivism for criminal justice populations. To understand more about the basics of MRT and DBT, please refer to the article on Page 27.

The total number of CCAP clients participating in behavior modification classes in MIDD Year Two was 79. Two MRT classes were offered, with one group meeting in the morning and one in the afternoon. Each group met for three hours twice a week. Although the class size is limited to 16, the typical daily attendance is closer to 10. Several legal factors impact program completion, including termination of court orders that can end CCAP participation and thus MRT services.

16a New Housing Units and Rental Subsidies

Some studies estimate that homeless adults receiving outpatient mental health services are four times as likely to be jailed as those who have housing. By providing a spectrum of housing alternatives for those coping with mental illnesses or chemical addictions, the MIDD seeks to reduce recidivism and divert individuals away from costly hospitalizations. In 2008, capital funding investments for housing programs created 250 units for MIDD populations (see Strategy 3a on Page 16), with another 150 units opening soon.

In MIDD Year Two, 77 additional MH outpatient clients found homes in capitally-funded units with support services funded by sources other than the MIDD, or received rental subsidies to keep their current housing.

17a Crisis Intervention Team/Mental Health Partnership Pilot

The City of Seattle was able to secure other funding to hire dually-certified MH and CD professionals to assist police responding to behavioral crises.

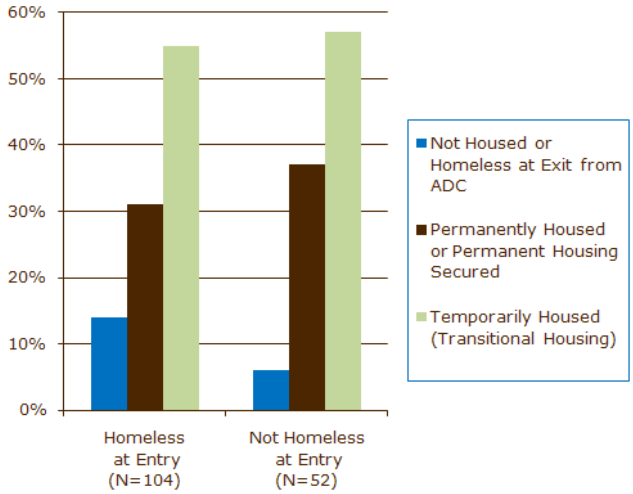
15a Adult Drug Court Expansion

The MIDD expansion of King County Judicial Administration's Adult Drug Court (ADC) services includes provision of the following supplemental services: life skills classes tailored for clients with learning disabilities (known as CHOICES), wraparound services for those aged 18 to 24, and housing case management services. The grid at right shows use statistics for expanded programs.

Adult Drug Court Expanded Services Utilization Statistics

	Number of Unduplicated Participants	Total Sessions	Sum of Reported Hours	Minimum	Maximum	Average per Participant
CHOICES Classes	138	3,664	-	1	47	27
Young Adult Wraparound	38	178	619	0.15 hrs	17 hrs	16 hrs
Housing Case Management	268	723	986	0.25 hrs	21.5 hrs	3.7 hrs

Housing Status upon Exit from ADC



Of the 337 participants with at least one service in the reporting period, 156 exited from ADC. Fifty-eight (37%) of these people graduated from the program, 42 (27%) left voluntarily, 40 (26%) were terminated from services for not complying with rigorous program requirements, and 16 (10%) had other exit reasons. The graphic to the left shows that regardless of homeless status at entry to ADC, housing outcomes for both groups are nearly identical. Eighty-eight percent of those exiting, including those dismissed for non-compliance, are housed. These encouraging results have been attributed to the work of two MIDD housing case managers who have cleared away many of the barriers to finding housing for this difficult to house demographic group (having criminal backgrounds, typically associated with illegal drug use).

Strategy 12c Helps Make Care Plans "Stick"

Psychiatric Emergency Services (PES) is a unit within Harborview Medical Center's Emergency Department (ED). When someone uses the emergency room frequently it is referred to as high utilization. For PES, high utilization is four ED visits in a six month period. People who regularly use the ED often lack effective engagement with systems of help or feel alienated from traditional resources. MIDD Strategy 12c funds high-utilizer case managers to provide assertive outreach and engagement to change this pattern of frequent hospital use. Many of the people receiving these case management services share similar characteristics. Most have concurrent mental health, chemical dependency, and medical concerns. J. had a chaotic home life while growing up. She lived in multiple foster homes and eventually ended up in long-term residential mental health treatment. After she turned 18, she moved into the adult outpatient treatment system yet went to the ED frequently, sometimes multiple visits per day, with self-harm or suicidal thoughts. Through this MIDD strategy, PES was able to coordinate with her mental health agency which led to her improved engagement in those mental health services.

Care plan strategies include the use of motivational interviewing and behavioral positive reinforcement to improve client time management and communication skills. High-utilizer case managers follow up on progress. Reviews may be needed when care plans are not working. Meetings are coordinated with case managers, police, treatment providers, family, and program participants. The main goal is identifying and removing barriers that can prevent participants from following the plan of care that will allow them to continue on a path to their long-term success. J. was able to work on risk reduction and self management strategies with the assistance of her care team. She has been empowered to make step-by-step changes to reach her goals. J. is now in supportive housing and seeing her mental health provider regularly. She goes to the ED far less and is using other supports rather than calling an ambulance. J. expresses pride in her progress and accomplishments, and feels hopeful about her future.

"Alphabet Soup" - Some of the Evidence-Based Practices Supported by MIDD

TF-CBT
Trauma Focused Cognitive Behavioral Therapy is a therapy approach to help adults, children, and families cope with the effects of traumatic life experiences. TF-CBT is effective with individuals who have a wide range of traumatic experiences, including domestic violence and loss. People learn to deal with trauma-related thoughts and feelings. They gain new skills to manage and resolve distressing thoughts, feelings, and behaviors. TF-CBT is generally delivered in 12-16 sessions. It may be provided longer depending upon individual and family needs.

MST
Multi-Systemic Therapy is an intensive in-home and community-based treatment program for juvenile offenders and their families. It is found to be effective in reducing acting out behaviors in youth. It increases the ability of families to effectively parent their teens. MST can help reduce a teen's criminal activity and antisocial behaviors. MST has been proven effective with families from a range of socioeconomic and ethnic backgrounds. Those in MST work with a therapist for four to six months. The therapist is available 24 hours a day, seven days a week.

FFT
Functional Family Therapy is a proven family therapy for youth involved in the juvenile justice system or who are at risk of becoming involved. Sessions are held in the family's home. The focus is on teaching communication and problem-solving skills. Other goals include identifying possible solutions to family problems and finding ways to change behavior. FFT usually lasts three to four months, with an average of 12 hours of counseling.

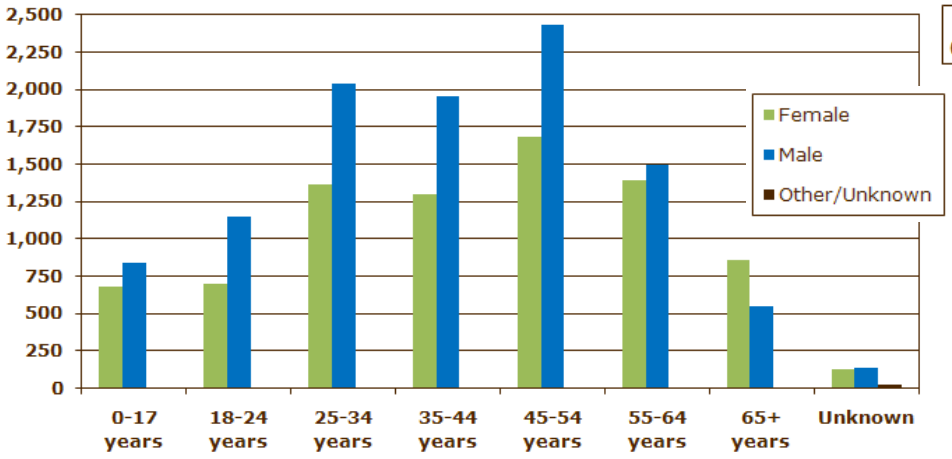
MRT
Moral Reconation Therapy is a treatment program to decrease recidivism among criminal offenders. MRT seeks to instill appropriate goals, motivation, and values. It does this by increasing moral reasoning. Structured group exercises and homework assignments are used to promote growth of a productive identity and facilitate the development to higher stages of moral reasoning. Participants meet in groups weekly for three to six months.

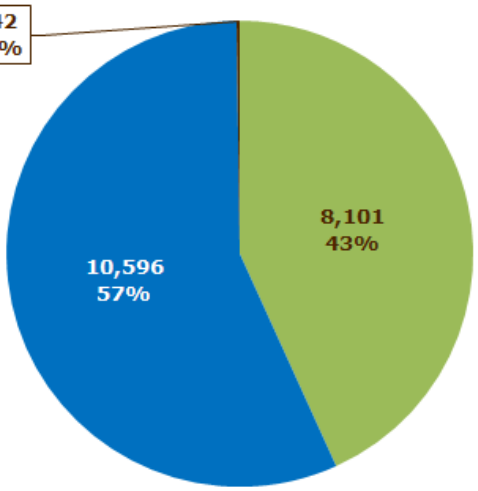
DBT
Dialectical Behavior Therapy is a therapy approach for people who engage in suicidal, self-harm, or other self-destructive behaviors. It works to develop skills for coping with stress and improving relationships with others. Individual and group sessions focus on learning to use the new skills and changing destructive behaviors. DBT may last six months to a year. Shorter lengths of therapy are also used.

Touched by the MIDD

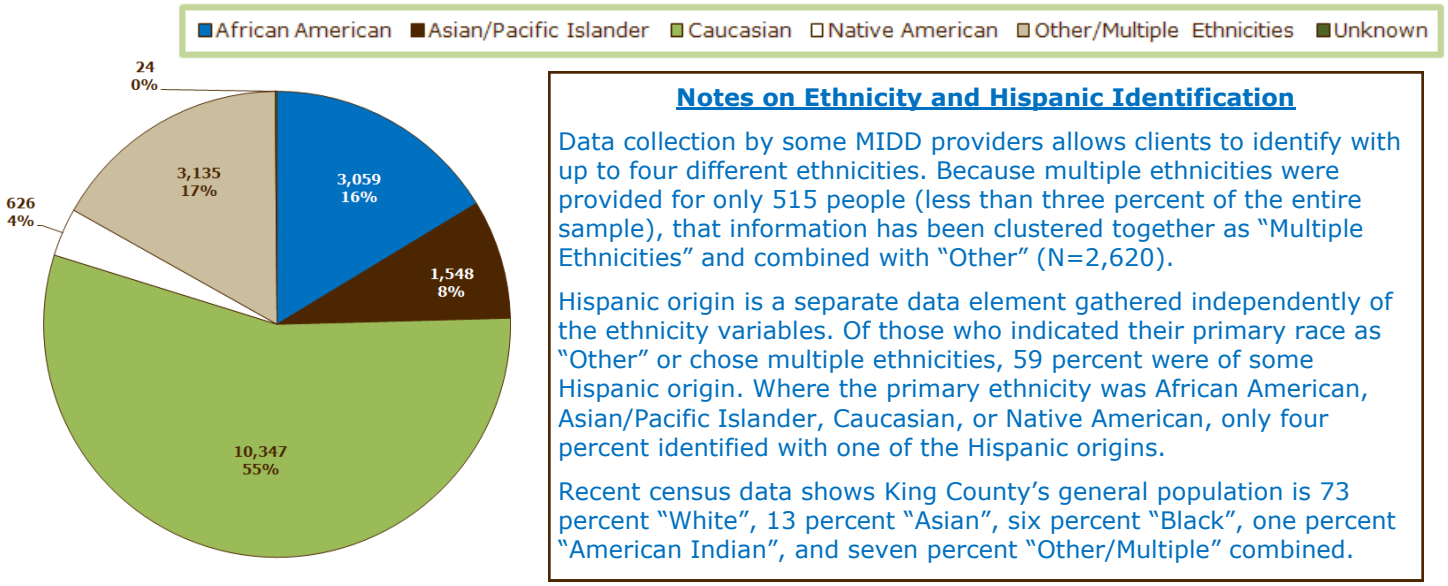
Partial demographic information was available for **18,739** unduplicated* individuals who received at least one MIDD-funded service between October 1, 2009 and September 30, 2010. Geographic distribution information was available for an additional **8,288** individuals who received suicide prevention training for a total of **27,027** with zip code data. Individuals served under multiple MIDD strategies have their most recent demographic information shown here.

Unduplicated Gender by Age Group and Overall Gender Distribution





Distribution of Primary Ethnicity and Hispanic Origin



Notes on Ethnicity and Hispanic Identification

Data collection by some MIDD providers allows clients to identify with up to four different ethnicities. Because multiple ethnicities were provided for only 515 people (less than three percent of the entire sample), that information has been clustered together as "Multiple Ethnicities" and combined with "Other" (N=2,620).

Hispanic origin is a separate data element gathered independently of the ethnicity variables. Of those who indicated their primary race as "Other" or chose multiple ethnicities, 59 percent were of some Hispanic origin. Where the primary ethnicity was African American, Asian/Pacific Islander, Caucasian, or Native American, only four percent identified with one of the Hispanic origins.

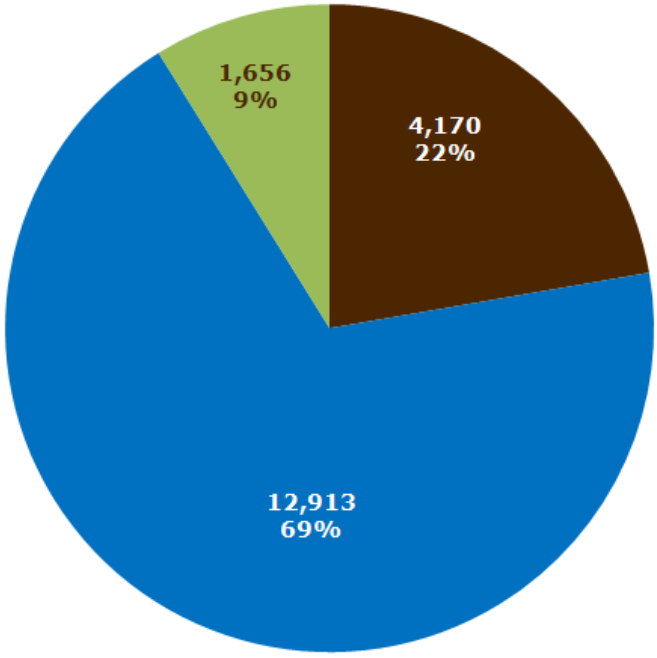
Recent census data shows King County's general population is 73 percent "White", 13 percent "Asian", six percent "Black", one percent "American Indian", and seven percent "Other/Multiple" combined.

Hispanic Origin	For "Other"/Multiple Ethnicities		Where Primary Ethnicity Not "Other"	
	Frequency	Percent	Frequency	Percent
Not Hispanic	1,294	41.3%	15,033	96.3%
Cuban	9	0.3%	4	0.0%
Mexican	191	6.1%	64	0.4%
Puerto Rican	9	0.3%	10	0.1%
Other Spanish/Hispanic	75	2.4%	30	0.2%
Hispanic (General)	1,557	49.7%	463	3.0%
	3,135	100%	15,604	100%

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

Documentation of Disabilities Among Those Served by the MIDD

While disability information often goes undocumented, it is worth noting that the MIDD served over 4,000 individuals identified with various disabilities, including 410 with multiple disabilities. About one third of those with known disabilities were categorized as medically or physically disabled and another third had sensory or communication challenges. The "other" category (which includes psychiatric disabilities) represented 24 percent of the sample of people with documented disabilities (N = 4,170).



Types of disabilities:	Frequency	Percent
Medical/Physical	1,214	29%
Sensory or Communication	1,302	31%
Other	1,004	24%
Multiple	410	10%
Developmental	240	6%

Primary Languages of MIDD Clients and Interpretation Services

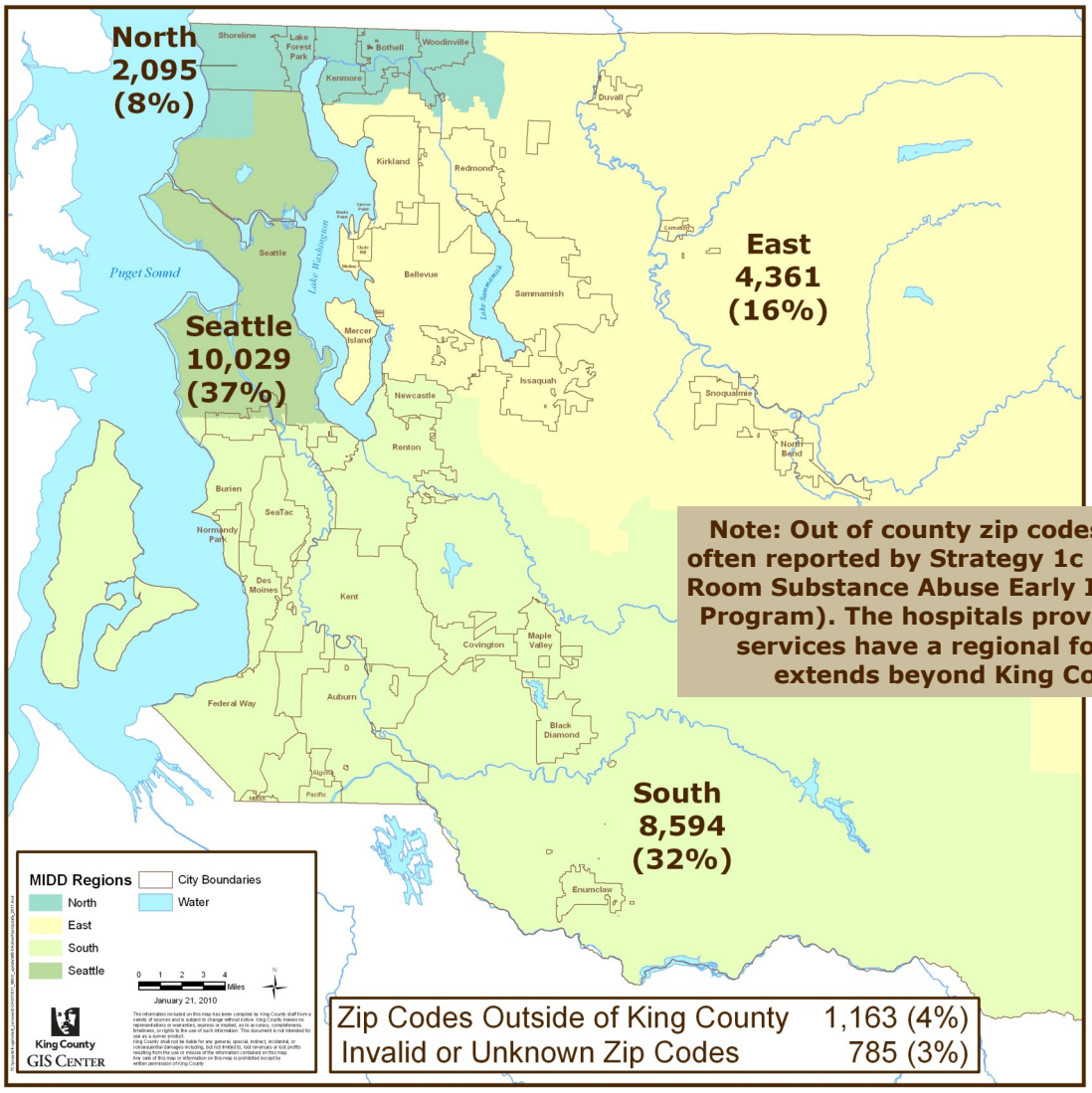
Primary languages were reported for 16,018 individuals. While 13,285 (83%) of these MIDD service recipients spoke English as their primary language, the remaining 2,733 spoke one of at least **42** different languages. The top five foreign languages in descending rank order of frequency are displayed in the table to the right. The first column shows how many listed each language as primary and the second column shows the number who required the services of an interpreter for each language. Altogether, interpreters were needed to help 1,357 people.

Top Five Non-English Languages of MIDD Clients

	Number Listing Language as Primary	Number Requiring Interpretation Services
Spanish	1,312	700
Vietnamese	329	126
Russian	143	89
Cantonese	121	35
Cambodian	95	46
Other Non-English	736	361

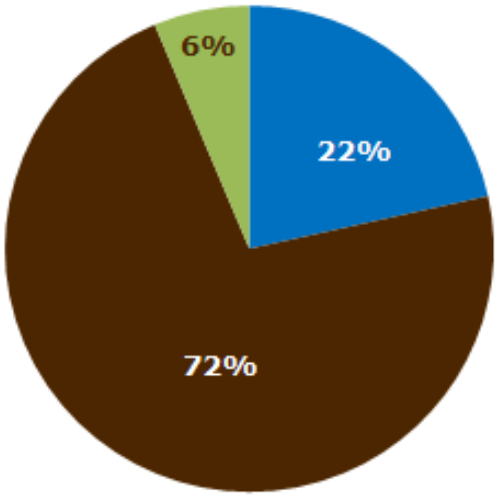
The MIDD served at least seven hundred thirty-seven U.S. Military veterans!!

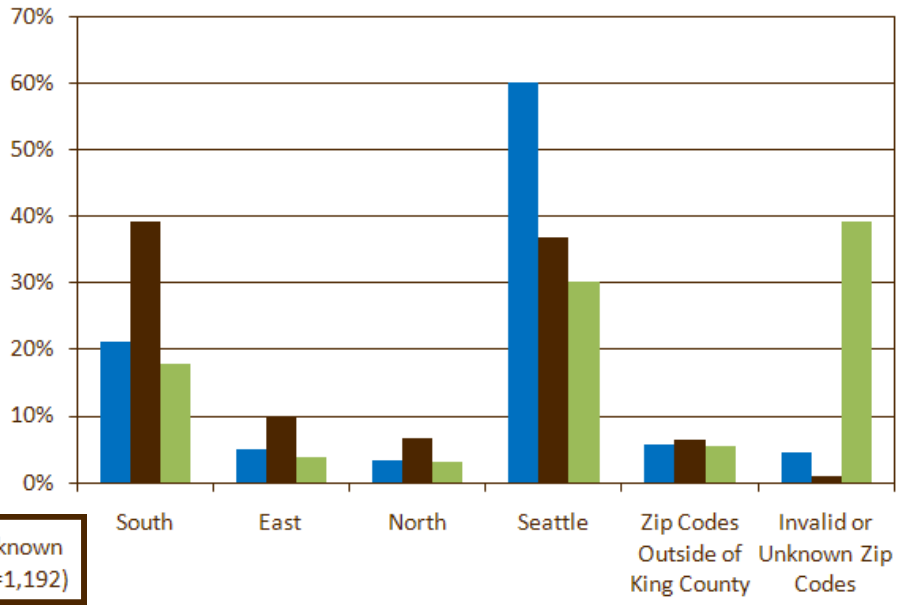
Geographic Distribution of 27,027 Individuals Receiving MIDD Services during the Second Year of Implementation



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

Homeless Status On Start Date and Homelessness by Region





Initial Outcome Findings

A total of 10,970 records are now eligible for outcomes measurement. Please see Exhibit 1 on page 39 for the current analysis scope within the outcomes evaluation timeline. Those who began MIDD services prior to October 1, 2009 in any of the following strategies: 1a-1, 1a-2a, 1a-2b, 1d, 1h, 2b, 12c, 15a, and 16a have been engaged in services long enough to be ready for preliminary outcomes assessment. Similarly, outcome information is now available for individuals who started receiving services between January 1, 2009 and June 30, 2009 in these strategies: 1c, 1g, 3a, 8a, 9a, 11a, and 12a-1. The table below shows the number of records examined by strategy sets, cohorts, and relevant outcome measures.

Outcome Measures Examined by Strategy and Cohort Samples

						Outcome Measures						
	Strategy Number	Strategy Nickname	Cohort #1 Records[1]	Cohort #2 Records	Total in Analysis Sample	King County Jail	Psychiatric Hospitals	MH Treatment Link	CD Treatment Link	Jobs	Symptom Reduction[2]	ER
Strategy Set #1	1a-1	MH Treatment	991	1,073	2,064	X	X				PSS/CFARS	X
	1a-2a	CD Treatment - Outpatient	795	2,134	2,929	X					ASI	X
	1a-2b	CD Treatment - Opiate Substitution	144	727	871	X					ASI	X
	1d	MH Crisis Next Day Appts	501[3]	426	927	X	X	X				X
	1h	Older Adults Crisis & Service Linkage	130	198	328		X	X	X			X
	2b	Employment Services MH & CD	437[4]	297	734					X		
	12c	PES Link to Community Services	32	55	87	X	X	X	X			X
	15a	Adult Drug Court Expansion	93	31	124	X					ASI	
	16a	New Housing and Rental Subsidies	9	18	27	X	X					X
Strategy Set #2	1c	SA Emergency Room Intervention	1,369		1,369	X			X			X
	1g	Older Adults Prevention MH & SA	1,188		1,188			X	X		PHQ-9/GAD-7	X
	3a	Supportive Housing	100		100	X	X	X	X			X
	8a	Family Treatment Court Expansion	15		15	X			X		ASI	
	9a	Juvenile Drug Court Expansion	16		16	X			X		ASI	
	11a	Increase Jail Liaison Capacity	52		52	X		X	X			
	12a-1	Jail Re-Entry Capacity Increase	220		220	X		X	X			
		Sum by Outcome Type				8,801	3,533	2,902	3,375	734	-	-

Set #1 - Cohort #1: Services began 10/1/2008 - 3/31/2009
Set #1 - Cohort #2: Services began 4/1/2009 - 9/30/2009
Set #2 - Cohort #1: Services began 1/1/2009 - 6/30/2009

X	Look-up and match to outside source
X	Analysis indicates this outcome measure is appropriate for the given strategy, although not currently listed in the evaluation matrix
X	Source not yet available or not reportable until Year 3 Progress

[1] Records reviewed for outcomes may differ from the number of unique individuals served due to multiple service episodes per person

[2] Measures include Problem Severity Summary (PSS), Children's Functional Assessment Rating Scale (CFARS), Addiction Severity Index (ASI), Patient Health Questionnaire - Depression (PHQ-9), and Generalized Anxiety Disorder (GAD-7)

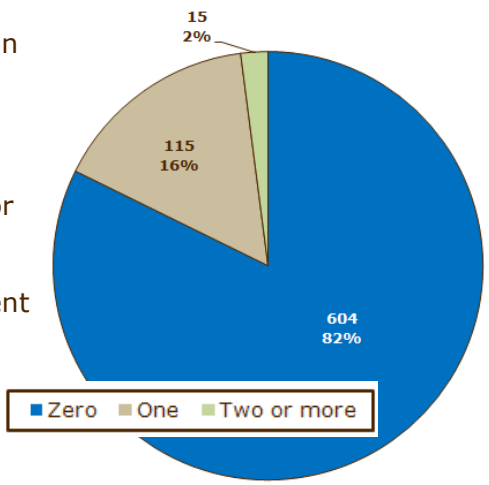
[3] Fewer records than previously reported were included here due to a change in the criteria for inclusion ("enhanced services only")

[4] Several additional records were added to the analysis after initial reporting of 2b outcomes in the Year 2 Progress Report

Supported Employment Services Outcomes for Mental Health Consumers

Getting and keeping jobs in mainstream work environments that pay competitive wages are key outcome indicators for the success of **Strategy 2b** (Employment Services for Individuals with Mental Illness and/or Drug Dependency). For the 734 mental health clients enrolled in this program between the start of MIDD funding and September 30, 2009, 130 (18%) became employed in a total of 147 job placements. Sixty-three of these placements (43%) were known to have lasted a minimum of 90 days in length. These figures represent a much higher success rate for finding jobs in the community than is typically seen for those completing MH programs without supported employment (SE) benefits. Historically in King County, the rate for gaining employment during a MH benefit period for those receiving publicly-funded treatment for psychiatric disorders is less than three percent. Supported employment services for clients of stand-alone CD treatment agencies are still on hold due to budget reductions.

Number of Placements in Competitive Wage Jobs



Utilization of King County Detention and Correctional Facilities

Records from 8,202 unique individuals served by strategies intending to impact reductions in jail usage were analyzed in this reporting period. A total of 8,801 records were examined to characterize jail use patterns and trends for the MIDD population. For purposes of the present* analysis, jail utilization has been limited to bookings into any of the following:

- King County's Norm Maleng Regional Justice Center in Kent, WA
- The King County Jail, Seattle Division
- The Juvenile Detention Center in Seattle, WA

***Note:** Future analysis will also be able to take into consideration data provided by several municipal jails within King County limits.

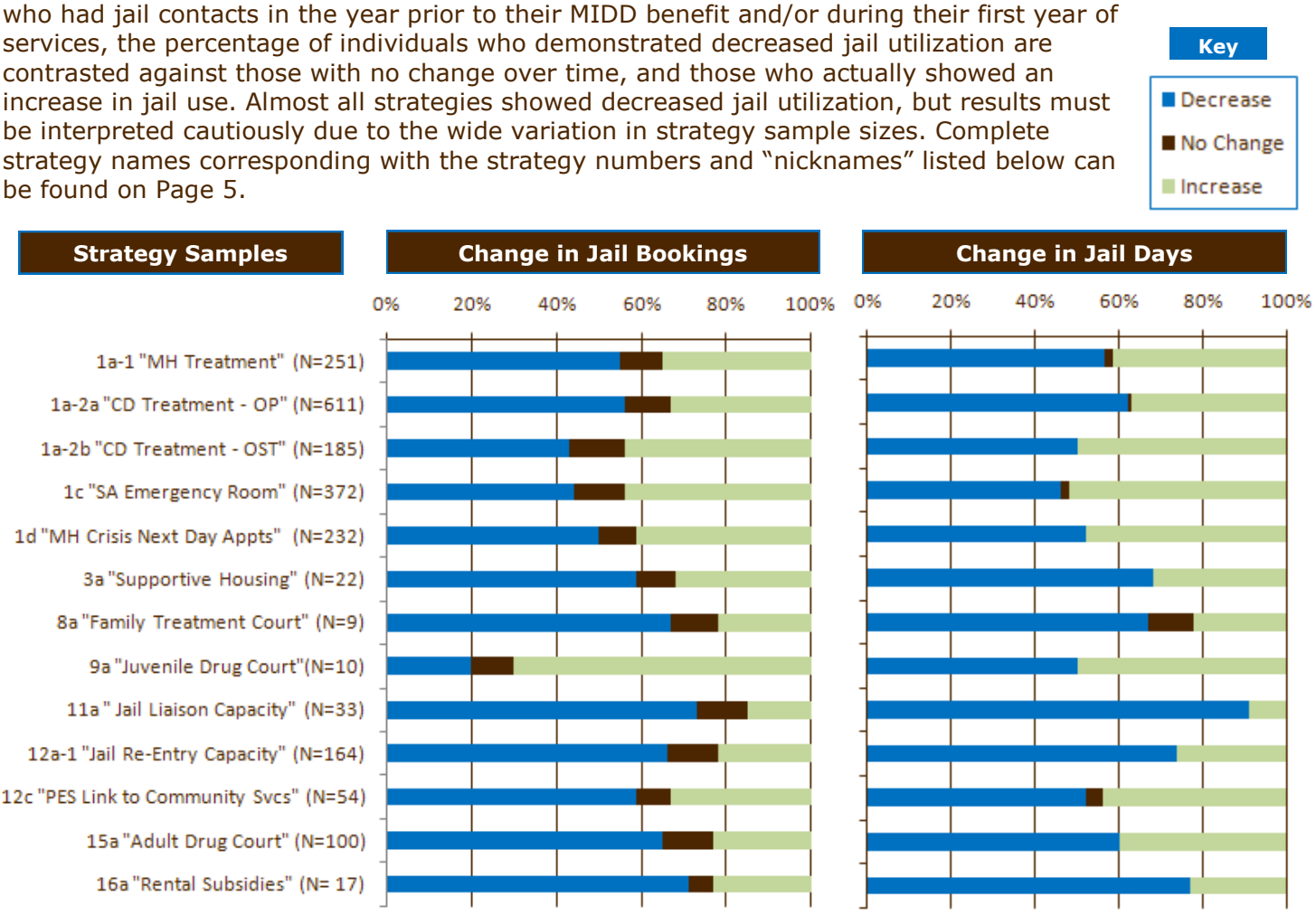
Use of Jails

(N = 8,801)

Jail Bookings in Year Prior to MIDD Funding	Jail Bookings during First Year of MIDD Services: Yes	Jail Bookings during First Year of MIDD Services: No
Yes	927 (10.5%)	700 (8.0%)
No	433 (4.9%)	6,741 (76.6%)

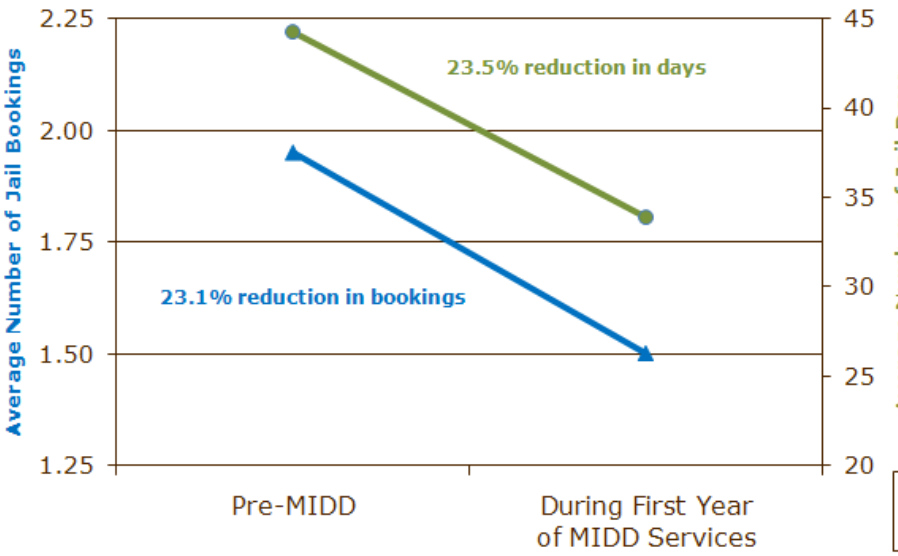
Excluding strategies 1g, 1h, and 2a (where jail use was not identified as a relevant outcome), just under 25 percent of the remaining outcome records were characterized by at least one jail booking at some point during either the year leading up to the start of MIDD funding or during the first year in which MIDD services were delivered to each individual. This means that the majority of people enrolled in MIDD strategies were not detained by county-run facilities during "baseline" nor during their initial year of service delivery. The grid at left reflects the relationship between jail bookings during these two distinct time periods.

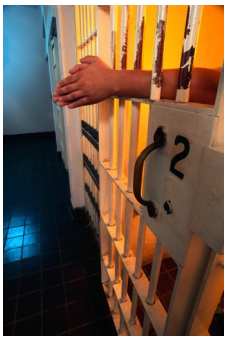
Trends in jail bookings and days are presented by strategy in the graphs below. Looking only at individuals who had jail contacts in the year prior to their MIDD benefit and/or during their first year of services, the percentage of individuals who demonstrated decreased jail utilization are contrasted against those with no change over time, and those who actually showed an increase in jail use. Almost all strategies showed decreased jail utilization, but results must be interpreted cautiously due to the wide variation in strategy sample sizes. Complete strategy names corresponding with the strategy numbers and "nicknames" listed below can be found on Page 5.



Average Number of Jail Bookings and Days Over Time Within Individuals

Within subjects paired sample t-testing (comparing two different time periods) was conducted on the 2,060 records that had jail utilization activity as measured by jail bookings and days in jail. The overall reductions, on average, for both bookings and days were statistically significant ($p < .01$). The average number of bookings in the year prior to the MIDD was 1.95 (SD=1.97); this average dropped to 1.50 (SD=1.84) during the first year of MIDD services. The average number of days in jail was reduced from 44.27 (SD=62.38) to 33.88 (SD=55.64).





Overall, the sum of jail bookings went down for this sample from 4,008 to 3,094 and the sum of jail days went down from 91,205 to 69,795. This is a remarkable finding, as it is typical for jail bookings to decrease but jail days to increase during the first year of program evaluations of this type.

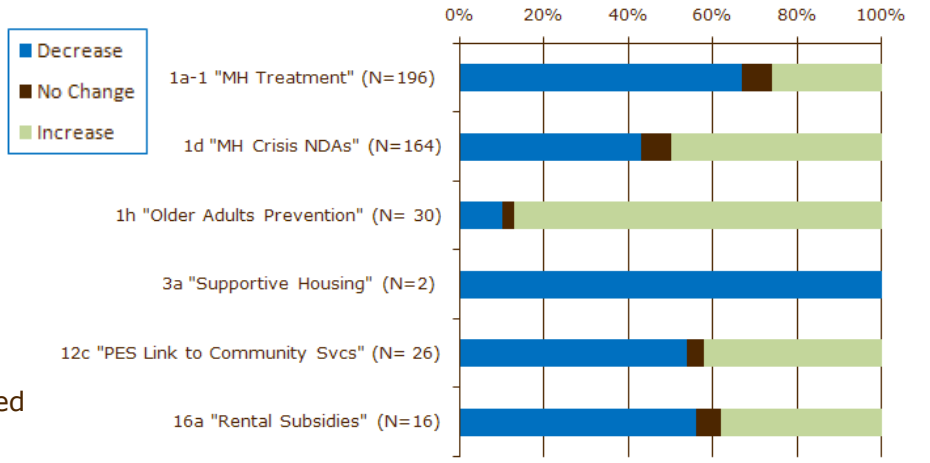
Psychiatric Inpatient Hospitalizations

Six strategies with outcome eligible participants (N=3,533) were included in the analysis of psychiatric hospital utilization. Only ten admissions to Western State Hospital (WSH) were documented for this sample in the one year period prior to their MIDD starts. Of those 10, only one was also hospitalized at WSH during the first year of MIDD services (along with 12 others who had not been hospitalized there during the baseline comparison). All of those hospitalized at Western also had other psychiatric inpatient hospitalizations in the community. A total of 434 people (12% of this outcomes sample) had at least one stay at an area inpatient psychiatric facility between October 1, 2008 and September 30, 2010.

Comparing numbers of psychiatric hospital admissions within individuals in the year-long period prior to the MIDD with those during the first complete year of services, most relevant strategies experienced a trend toward decreased usage (see upper right illustration). These results are impacted by variations in sample size and should not be used to imply causal relationships between strategy participation and subsequent hospitalization. Altogether for this sample, 522 hospital admissions were reduced to 423; Days spent hospitalized went from 7,319 down to 6,219.

Changes in days hospitalized are shown by strategy in the lower right table. Four of six strategies showed decreased inpatient days, ranging from 7.50 (for Strategy 3a) to 14.69 (for Strategy 16a) fewer days per person, on average. Large standard deviations indicate substantial variation in the data.

Change in Psychiatric Hospital Admissions for Select Strategies



Average Change in Psychiatric Hospital Days by Strategy

Strategy	Direction	Average	Standard Deviation	Strategy	Direction	Average	Standard Deviation
1a-1 (N = 196)	Decrease	9.46	29.56	3a (N = 2)	Decrease	7.50	0.71
1d (N = 164)	Increase	4.73	25.18	12c (N = 6)	Decrease	9.30	47.18
1h (N = 30)	Increase	15.60	20.86	16a (N = 16)	Decrease	14.69	58.29

Linkages to Mental Health and/or Chemical Dependency Treatment and Other Outcomes

Enrollment in treatment programs AFTER participation in certain MIDD strategies was examined for both mental health (2,902 individuals) and chemical dependency (3,375 individuals) treatment. Altogether, 715 (25%) of the MH sample were linked to other mental health services tracked within the county data system. For the CD sample, the total number of linkages was 527 (16%). On average, the start date of the subsequent MH program fell 143 days (SD=104) after the start of MIDD services. The average difference between the MIDD start and CD program start date, however, was just 97 days (SD=101). Linkage rates presented below by strategy do not factor in referral information.

Strategy Number	Strategy "Nickname"	N	% Linked to Subsequent MH Program	% Linked to Subsequent CD Program
1c	SA Emergency Room Intervention	1,369	N/A	23%
1d	MH Crisis Next Day Appts	927	35%	N/A
1g	Older Adults Prevention MH & SA	1,188	14%	4%
1h	Older Adults Crisis & Service Linkage	328	9%	<1%
3a	Supportive Housing	100	32%	21%
8a	Family Treatment Court Expansion	15	N/A	67%
9a	Juvenile Drug Court Expansion	16	N/A	88%
11a	Increase Jail Liaison Capacity	52	33%	21%
12a-1	Jail Re-Entry Capacity Increase	220	43%	33%
12c	PES Link to Community Services	87	52%	36%

Symptom Reduction

MH outpatient providers were required to start reporting symptom reduction measures for adults in January 2010, and for children in April 2010. The first set of those data (collected at intake, six months, and one year) will be available for analysis in February 2011. For CD symptom reduction, the capacity to accept interim Addiction Severity Index (ASI) data is still in development.

Linkage to CD Treatment After MH Next Day Appointments (NDAs)

While not currently included as an outcome measure in the evaluation matrix for Strategy 1d, original implementation plans indicated that "Referrals to chemical dependency treatment" could be a potential additional service of MIDD expansion of treatment and stabilization beyond the next day appointment. For the five-year period leading up to MIDD, 433 (8%) of the unduplicated people with NDAs (N=5,222) had documented referrals to CD treatment. In MIDD's first year, the number given those specific referrals was 63 (9%) of 722. This represents a 12.5 percent increase.

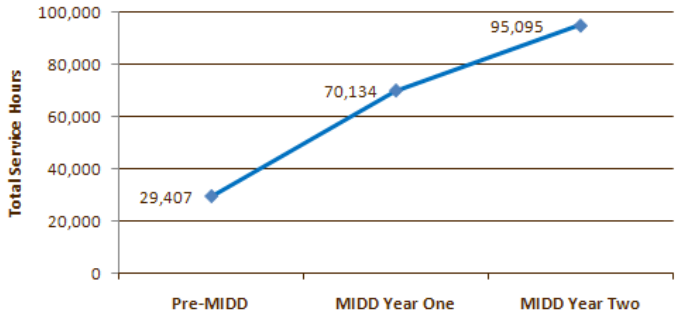
A separate analysis of the outcomes sampling of 927 NDA authorizations with medical services (the analysis proxy for "enhanced services") showed that 115 (12%) had confirmed linkages to CD treatment. Further analysis of all NDAs since MIDD inception is needed to fully explore the relationship between documented referrals and subsequent linkages to treatment.

Linkage to MH Treatment after Strategy 1g Referral

To illustrate the relationship between referrals and linkages, data from the 1g outcomes sample (N=1,188) were analyzed. Of the 76 with documented referrals to MH treatment, 44 linkages could be confirmed (58%). Another 127 links to MH treatment, however, were made for those WITHOUT documented referrals to MH care. This indicates a need for better referral tracking.

System-Wide Impacts of the MIDD by Select Strategies

The short-term output objective of Strategy 1a-1 was to increase the number of non-Medicaid eligible clients served in outpatient settings. In the year prior to MIDD start-up 2,406 non-Medicaid clients were served, compared to 4,828 in MIDD's first year, and 5,890 in MIDD's second year. The graph below shows the total service hours associated with these services.



Counting all authorizations open during each time period (rather than just starts), the total number of unduplicated people receiving services for certain MIDD strategies are shown below:

	Unduplicated Clients with Open Authorizations			
	1a-2a (OP)	1a-2b (OST)	"Enhanced" 1d	1h
Pre-MIDD	4,555	730	706	184
MIDD Year One	5,079	758	898	361
MIDD Year Two	4,609	504	961	517
Avg. Yearly Change	+ 6.4%	- 13.6%	+ 31.7%	+ 138.6%

Community Providers by MIDD Strategy

For a complete listing of the strategy names and categories associated with the strategy numbers in the column headings below, please reference the grid provided on Page 5.

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

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

Implementation delays

Non-MIDD funding secured

Recommendations for Plan Revisions

Strategy Number	Strategy "Nickname"	Year 3 Revised Performance Target(s)	Explanation
1c	SA Emergency Room Intervention	6,400 screens/yr with 8 FTE 4,340 brief interventions/yr	Contracts for 2011 have set these new goals
5a	Juvenile Justice Youth Assessments	TBD	Change number of evaluations needed due to program efficiencies
14a	Sexual Assault, MH & CD Services	Reduce to 170 clients/yr from 400 clients/yr	Providers requested reduction in performance targets to more accurately reflect MIDD portion of service delivery budget

MIDD Financial Report

The MIDD financial information is provided for the calendar year 2010 (January 1 - December 31, 2010). The MIDD Fund spent approximately $31.8 million in strategy funding and approximately $13.4 million in MIDD supplantation. The MIDD sales tax is strongly influenced by changes in the economy, as consumer spending declines, the MIDD fund declines. Parts I and II show projected and actual spending by strategy. Also included in the financial report are summary revenues/expenditures and detailed supplantation spending.

Mental Illness and Drug Dependency Fund - Part I

	Strategy	Spending Plan 2010	2010 Actual
1a-1	Increase access to community mental health treatment	$ 8,520,000	$ 8,001,905
1a-2	Increase access to community substance abuse treatment	$ 2,623,225	$ 2,498,419
1b	Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities	$ 514,709	$ 529,973
1c	Emergency room substance abuse early intervention program	$ 717,000	$ 540,668
1d	Mental health crisis next day appointments and stabilization services	$ 225,000	$ 250,000
1e	Chemical dependency professional education and training	$ 555,000	$ 472,537
1f	Peer support and parent partner family assistance	$ 375,000	$ 1,475
1g	Prevention and early intervention mental health and substance abuse services for older adults	$ 450,000	$ 450,000
1h	Expand availability of crisis intervention and linkage to on-going services for older adults	$ 315,000	$ 315,000
2a	Caseload reduction for mental health	$ 4,000,000	$ 4,000,000
2b	Employment services for individuals with mental illness and chemical dependency	$ 1,000,000	$ 753,222
3a	Supportive Services for Housing Projects	$ 2,000,000	$ 2,000,000
4a	Services to parents participating in substance abuse outpatient treatment programs	$ -	$ -
4b	Prevention Services - Children of substance abusers	$ -	$ -
4c	School district based mental health and substance abuse services	$ 1,235,000	$ 973,292
4d	School Based Suicide Prevention	$ 200,000	$ 200,000
5a	Increase capacity for social and psychological assessments for juvenile justice youth	$ 184,538	$ 15,900
6a	Wraparound family, professional and natural support services for emotionally disturbed youth	$ 3,328,342	$ 2,835,384
7a	Reception Centers for Youth in Crisis	$ -	$ -
7b	Expanded crisis outreach and stabilization services for children and youth	$ 500,000	$ -
8a	Expand Family Treatment Court & Support to parents	$ 123,926	$ 110,577
9a	Expand Juvenile Drug Court Treatment	$ 237,766	$ 55,000
10a	Crisis Intervention Training	$ 763,747	$ 423,864
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	$ 4,600,000	$ 2,301,693
11a	Increase capacity for jail liaison program	$ 80,000	$ 75,090
11b	Increase services available for new or existing mental health court programs	$ 1,295,000	$ 41,109
12a	Increase jail re-entry program capacity	$ 320,000	$ 260,250
12b	Hospital Re-Entry Respite Beds	$ 508,500	$ 206,241
12c	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community based services upon discharge from Emergency Room	$ 200,000	$ 198,085
12d	Urinalysis supervision for Community Center for Alternative Program clients	$ 75,000	$ 75,000
13a	Domestic Violence and mental health services	$ 250,000	$ 313,014
13b	Domestic Violence prevention	$ 224,000	$ 224,000
14a	Sexual assault and mental health and chemical dependency services	$ 400,000	$ 320,403
15a	Drug Court Expansion of Recovery Support Services	$ 103,778	$ 65,004
16a	Housing Projects		$ -
17a	Crisis Intervention Team/MH Partnership Pilot	$ -	$ -
17b	Safe Housing, MH & CD treatment for youth prostitution pilot	$ 100,000	$ 100,000
	MIDD Administration	**$ 2,455,325**	**$ 995,322**
	Personnel		812,050
	Other Costs		183,272
	Total MIDD Operating Dollars	**$ 38,479,856**	**$ 29,602,426**
	Percentage of Appropriation		**76.93%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	Spending Plan 2010	2010 Actual
	Dept Judicial Admin	**$ 141,222**	**$ 105,875**
15a	Drug Court Expansion of Recovery Support Services	141,222	105,875
	Prosecuting Attorney Office	**$ 245,958**	**$ 149**
11b	Mental Health Court Expansion	205,686	
9a	Expand Juvenile Drug Court Treatment	40,272	149
	Superior Court	**$ 852,021**	**$ 807,950**
5a	Increase capacity for social and psychological assessments for juvenile justice youth	186,887	186,398
8a	Expand family treatment court services and support to parents	223,409	211,363
9a	Expand Juvenile Drug Court Treatment	441,725	410,188
	Sheriff Pre-Booking Diversion	**$ 186,746**	**$ 42,182**
10a	Crisis Intervention Trng Program	186,746	8,091
	Sheriff MIDD	-	34,091
	Office of the Public Defender	**$ 417,060**	**$ 350,784**
8a	Family Treatment Court Expansion	84,932	84,134
9a	Juv Drug Court Expansion	41,146	40,067
11b	MH Court Expansion	290,982	226,583
	Total Other MIDD Funds	**$ 1,843,007**	**$ 1,306,940**
	Percentage of Appropriation		**70.91%**
	Total All MIDD Funds	**$ 40,322,863**	**$ 30,909,366**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

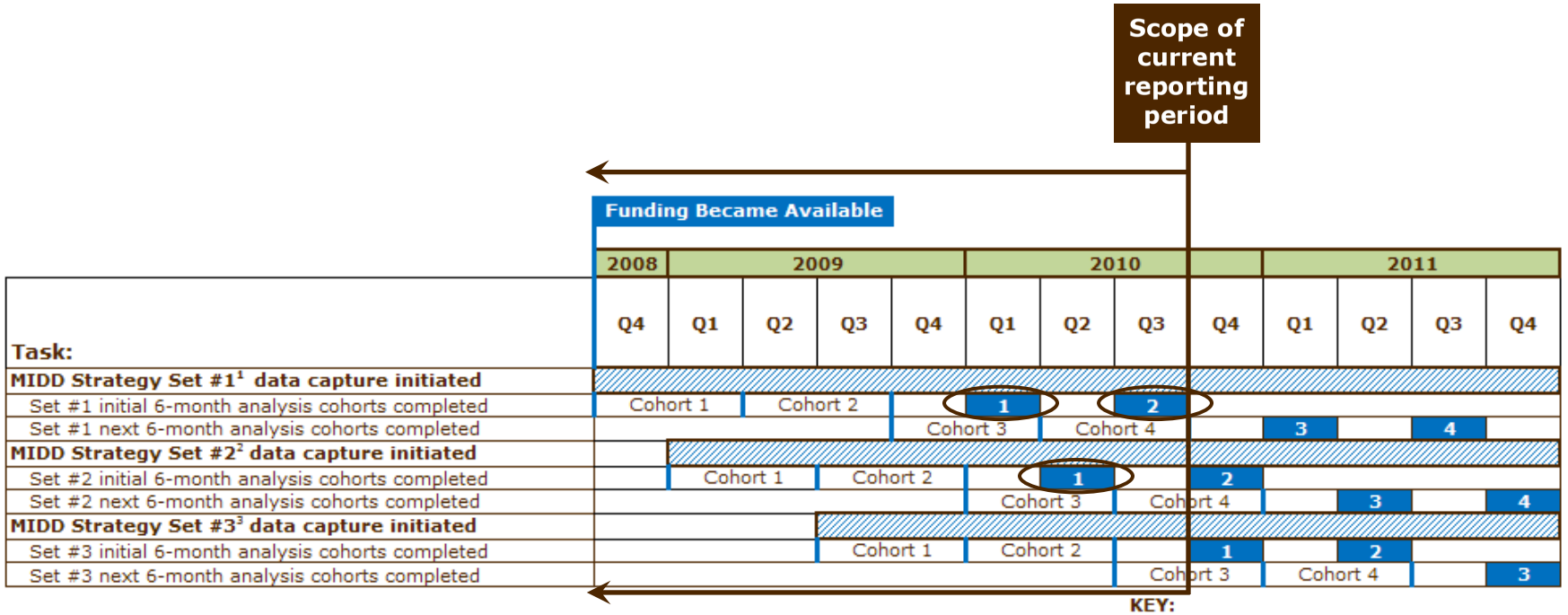
	Spending Plan 2010	2010 Actual
Revenue		
MIDD TAX	$43,210,000	$39,821,510
Streamlined Mitigation		$693,894
Investment Interest - Gross	$290,000	$293,157
Cash Management Svcs Fee		-$3,116
Invest Service Fee - Pool		-$8,839
Prior Year Correction		$41,128
Total Revenues	**$ 43,500,000**	**$ 40,837,734**
Total MIDD Funds	$40,322,863	$30,909,366
Total MIDD Supplantation	$13,300,372	$13,456,966
Total Expenditures	**$ 53,623,235**	**$ 44,366,331**
Expenditures Over Revenues	**$ (10,123,235)**	**$ (3,528,597)**

Mental Illness and Drug Dependency Fund - Supplantation

Strategy	Spending Plan 2010	2010 Actual
Other MIDD Funds		
Dept Judicial Admin (DJA)	**$ 1,269,249**	**$ 1,298,754**
Adult Drug Court Base	1,269,249	1,298,754
Prosecuting Attorney Office (PAO)	**$ 858,865**	**$ 580,109**
Adult Drug Court Base	538,045	457,461
Juvenile Drug Court Base	121,778	121,778
Mental Health Court Base	199,042	870
Superior Court	**$ 227,976**	**$ 225,529**
Adult Drug Court Base	162,651	163,871
Juv Drug Court Base	32,663	30,829
Family Trmt Court Base	32,662	30,829
Office of the Public Defender	**$ 1,278,144**	**$ 1,315,054**
Adult Drug Court Base	752,270	794,694
Juv Drug Court Base	25,906	24,827
MH Court Base	330,102	325,667
Family Treatment Court Base	169,866	169,866
District Court	**$ 882,907**	**$ 764,928**
Mental Health Court Base	629,857	617,230
Mental Health Court Expansion	253,050	147,698
Dept Adult and Juvenile Detention (DAJD)	**$ 406,000**	**$ 401,936**
CCAP	100,000	100,000
Juv MH Treatment	306,000	301,936
Jail Health Services	**$ 3,115,024**	**$ 3,112,878**
Psychiatric Services	3,115,024	3,112,878
MIDD	**$ 362,000**	**$ 362,000**
Sexual Assault Supplantation	362,000	362,000
MIDD	$ -	**$ 616,767**
MH Non-Medicaid Mitigation (Supplatation)	-	616,767
Total Other MIDD Funds	**$ 8,400,165**	**$ 8,677,955**
Percentage of Appropriation		**103.31%**
MH & SA MIDD Supplantation	**$ 4,900,207**	**$ 4,779,011**
SA Administration	399,738	399,738
SA Criminal Justice Initiative	988,500	916,012
SA Contracts	121,757	124,319
SA Housing Voucher Program	602,615	589,487
SA ESP	593,806	593,837
SA CCAP	472,981	470,046
MH Co-Occurring Disorders Tier	800,000	788,930
MH Recovery	207,204	204,750
MH Juvenile Justice Liaison	90,000	86,383
MH Crisis Triage Unit	263,606	263,606
MH Functional Fam Therapy	272,000	256,261
MH Mental Health Court Liaison	88,000	85,642
Total Other MH/SA MIDD Supplantation Funds	**$ 4,900,207**	**$ 4,779,011**
Percentage of Appropriation		**97.53%**
Total MIDD Supplantation Dollars	**$ 13,300,372**	**$ 13,456,966**
Percentage of Appropriation		**101.18%**

Timeline for MIDD Outcomes Evaluation

Exhibit I



[1]Set #1 includes individual-level data for the following strategies: 1a-1, 1a-2, 1d, 1h, 2b (MH),12-c, 15a, 16a

[2]Set #2 includes individual-level data for the following strategies: 1c (Harborview), 1g, 3a, 8a, 9a, 11a, 12a-1

[3]Set #3 includes individual-level data for the following strategies: 1b, 1c (S. County), 1f, 4c, 5a, 6a, 12a-2, 12d

KEY:

- Services in place
- Demographic and service data collection period
- Cohort outcome (e.g., jail, linkage, psychiatric hospital) data available