King County

DRAFT

Mental Illness and Drug Dependency II Service Improvement Plan

As Required by Ordinance 17998

6/17/16: Please note that some of this document's appendices are under revision. They will be included in the revised Service Improvement Plan that is scheduled to be released on 7/22/16.

June 2016

Contents

I. Executive Summary

In the eleven years since the Washington State Legislature passed the Omnibus Mental Health and Substance Abuse Act in 2005 to enhance the state's chemical dependency and mental health treatment services, and in the nine years since King County's subsequently authorized the one-tenth of one percent sales and use tax to fund new mental health, chemical dependency, or therapeutic court services enabled by the Legislature, much has changed locally, at the state level, and nationally in the realm of mental health and chemical dependency. From the integration of the formerly separate mental health and chemical dependency services into one behavioral health system, to the economic downturn and uptick, to the enactment of the Affordable Care Act, to changes in state laws, King County's Mental Illness and Drug Dependency (MIDD) has become more than a revenue source. The MIDD has become a platform for cross system engagement and improvement, collaboration, and policy dialogue.

As required by Ordinance 17998, this Service Improvement Plan makes operational, programmatic, funding, and policy recommendations for MIDD II. The recommendations reflect the current and evolving behavioral health needs of King County's citizens, the reality of a challenged behavioral health workforce, and a growing understanding of social justice and equity in the provision of behavioral health services.

King County embraced the opportunity to review and learn from MIDD I and plan for a robust, forward looking MIDD II. This MIDD II Service Improvement Plan represents the collaborative efforts over a nearly two-year period from a wide range of internal and external stakeholders including representatives from communities, provider agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, Council staff, and many others to thoughtfully plan for a renewed MIDD sales tax.

This blueprint for MIDD II builds on the success of the first MIDD which was a groundbreaking partnership between health and human services, criminal justice, King County government and community providers, and sets forth a path to overcome the few challenges of MIDD I. The recommended initiatives, policies, and processes that comprise MIDD II are:

- informed by community and Oversight Committee input;
- grounded in the County's Social Justice and Equity work;
- driven by outcomes;
- guided by the behavioral health continuum of care; and
- aligned with other County policy initiatives.

Successful MIDD I programs are proposed to continue into MIDD II, though some are merged or will be retooled during the implementation planning or request for proposal (RFP) process.

Sixteen new proposed initiatives are recommended for MIDD II, bringing the total number of initiatives to 47.

MIDD II reflects the integrated behavioral health system, "busting silos" so that services are person centered, not program centered. MIDD II was intentionally developed in collaboration with initiatives like Best Starts for Kids so that services and funding can be braided to achieve maximum impact.

The proposed MIDD II initiatives prioritize:

- Funding services and programs to keep people out of or returning to jail and the criminal justice system, including upstream prevention and diversion activities. These include initiatives like:
    - Law Enforcement Assisted Diversion (LEAD)
    - Housing Capital and Rental Assistance
    - Crisis Diversion and Mobile Crisis Services, including expanding to South King County
    - Recovery Café

- Investing in a treatment on demand system that delivers treatment to people who need it, how they need it, and when they need it so crises can be avoided or shortened. These include initiatives like:
    - Behavioral Health Urgent Care Walk In Clinic Pilot
    - Next Day Appointments
    - Peer Bridger and Peer Support

- Creating community-driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs.

Community voices and priorities significantly influenced the development of the proposed MIDD II funding and programmatic recommendations.

MIDD II planning was conducted in a clear and straightforward way, involving the Oversight Committee at each step**.** As guided by the Oversight Committee, the county turned to citizens and community partners across the region for input and guidance in developing the MIDD II recommendations. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas, including a focus group with individuals in the King County Jail. Between in person meetings, an electronic survey, and other electronic feedback, close to 1,200 citizens and community members provided direct input into the development of the MIDD II recommendations.

MIDD II continues the county's work to transform the approach to health and human services by **improving health and well-being and creating conditions that allow residents of King County to achieve their full potential.**

MIDD II is organized by the MIDD II Framework into four strategy areas that reflect a continuum from prevention to crisis services, linked to outcomes. The MIDD II Framework is an accountability structure driven by the results policymakers and stakeholders want to see in the community as the result of investment of MIDD funds; the indicators that the county will use to signal that it's headed down the right path to get there; and the actions the county and its partners will take to create the change stakeholders want to see.

A major component of the MIDD II Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area. Each of the proposed MIDD II initiatives are included in one of the four MIDD II Strategy Areas.

MIDD II Strategy Area Name	Purpose
Prevention and Early Intervention	*People get the help they need to stay healthy and keep problems from escalating*
Crisis Diversion	*People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*
Recovery and Reentry	*People become healthy and safely reintegrate to community after crisis*
System Improvements	*Strengthen the behavioral health system to become more accessible and deliver on outcomes*

The MIDD II Framework is a living document that will be further updated over the life of MIDD II to reflect specific programmatic and services once they are determined by the Executive and Council in 2016. The Framework will continue to be updated over the life of MIDD II as a companion to the MIDD policy goals.

Best Starts for Kids is proposed to support an estimated $2.9 million annually for prevention based behavioral health services for children and youth.

Aligning MIDD II and Best Starts for Kids (BSK) has been a primary focus of the Department of Community and Human Services (DCHS). From holding joint Community Conversations, to collaborating on strategies and initiatives, to jointly reviewing MIDD II concepts and briefing papers, MIDD II planning and recommendations development has been a synergistic endeavor with BSK. This strong partnership will continue throughout the life of each of these initiatives, through planned joint meetings of the MIDD Oversight Committee and the Children and Youth Advisory Board and shared approaches to accomplishing the work of each initiative. Operationally, MIDD II and BSK are working to coordinate approaches to evaluation, contracting, and reporting among other aspects.

Summary of DRAFT MIDD II Service Improvement Plan Recommendations

Recommendations that may require legislation are noted with ""*

Area of Recommendation	SIP Recommendations
MIDD Fund Financial Policies Recommendations	1. Revise MIDD Fund reserve policy to 60 days of expenditure in the Rainy Day Reserve. 2. Allocate at least $750,000 annually to the Rainy Day Reserve. 3. Prioritize use of fund balance.

Adding, Deleting, or Modifying MIDD Initiatives, Strategies, Services, and Programs or Initiatives	1. Use updated MIDD I revision processes for modifying or adjusting MIDD initiatives, strategies, services, and programs. 2. Utilize Emerging Issues initiative to support emerging services and programs for up to two years.
Proposed Schedule for Reporting	1. Revise data collection periods to January to January fiscal/calendar year. * 2. Revise annual report due date to the Council to August.* 3. Launch web data dashboard.
Recommended Modifications to the MIDD Oversight Committee	1. Maintain role as advisory body to the Executive and Council.* 2. Revise membership to reflect changed organizations, boards, or entities.* 3. Add four new member seats.* 4. Create Consumers and Communities Subcommittee. 5. Initiate an array of operational improvements. 6. Change the name of the MIDD Oversight Committee to the MIDD Advisory Committee.*

Recommended Additional Seats to MIDD Oversight Committee

Please note that the net increase of seats is four after realigning existing seats to reflect organizational changes.
See report pages 48-56 for details

Focus or Population	Specific Entity
Consumers & Communities – 2 Representatives	Elected from Consumers and Communities Subcommittee
Recovery	Washington Recovery Alliance
Education	Puget Sound Educational Services District
Philanthropy	Many Minds Collaborative
Managed Care	Medicaid Managed Care Plans

Highlighted Recommended Improvements to the MIDD Oversight Committee

Establish Consumers and Communities Subcommittee – 2 Representatives from Subcommittee Appointed to MIDD Oversight Committee

The subcommittee would be comprised of individuals with lived experience of the behavioral health system (consumers) and individuals who are a part of communities with marginalized identities or experiences, including but not limited to:

- Trans
- Youth
- Immigrant/refugee
- African American
- Asian/API
- Hispanic
- Rural
- Faith
- Peers

This recommendation reflects several key principles of community engagement, including the "nothing about us, without us" concept, where the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy. The subcommittee invites communities identified as needing a voice in MIDD while not creating an unwieldy Oversight Committee of 50 or more that would not be feasible to operate. A notable component of the Consumers and Communities Subcommittee is that subcommittee members will be paid for their participation, similar to the current Familiar Faces Advisors model. Two Consumers and Communities Subcommittee members would be recommended to serve as full members of the MIDD Oversight Committee, subject to the existing appointment and confirmation process.

Undertake an array of operational improvements based on feedback and suggestions from Oversight Committee members, as well as lessons learned from staffing the MIDD Oversight Committee over time.

Change the Name of the Oversight Committee Reflective of the established duties and functions of the Committee that are recommended to continue for MIDD II, it is recommended that the name of the Committee be amended to reflect its duties as an advisory body: The MIDD Advisory Committee.

Next Steps & Conclusion

The information in this report responds to the requirements of Ordinance 17998.

Ordinance 17998 called for the MIDD II Service Improvement Plan (SIP) in December of 2016. In order to support the King County Council's desire for expanded review and input of the MIDD II SIP, the SIP report called for by Ordinance 17998 is submitted three months earlier than required. The impact of this changed timeline is that two elements of the MIDD II – Implementation and Evaluation Plans---require further development, conducted in collaboration with the MIDD Oversight Committee and providers. Additionally, the policy goals that were established for MIDD I are recommended to be revised, which impacts implementation and evaluation planning outcomes.

Three specific next steps are necessary for MIDD II - completion of the MIDD II Implementation and Evaluation Plans and a process to change the name of the MIDD. Each step will be developed collaboratively with the MIDD Oversight Committee and other stakeholders. The Executive recommends transmitting MIDD II Implementation and Evaluation Plans to the Council in mid-2017 for review and acceptance, similar to the sequencing of MIDD I. Additional planning is needed for most of the new initiatives contained in the proposed MIDD II, many of them requiring community engagement components.

Through the course of MIDD I review and MIDD II planning, the county received feedback that the name of the MIDD---the Mental Illness and Drug Dependency sales tax and programs—is outdated, negative, disrespectful, and stigmatizing. In essence, the name of the MIDD is not itself recovery based and may be counterproductive to wellness. It is recommended that the name of the MIDD be changed to something that more meaningfully and positively reflects the hope of recovery. Changing the name of the MIDD will require revision to the King County Code and other adopted legislation. Executive staff will work with the Code Reviser, the Prosecutor's Office, and Council staff on this issue

II. MIDD I and Key Environmental Changes

History of MIDD I

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

> *(1)(a) A county legislative authority may authorize, fix, and impose a sales and use tax in accordance with the terms of this chapter.*
>
> *(b) If a county with a population over eight hundred thousand has not imposed the tax authorized under this subsection by January 1, 2011, any city with a population over thirty thousand located in that county may authorize, fix, and impose the sales and use tax in accordance with the terms of this chapter. The county must provide a credit against its tax for the full amount of tax imposed under this subsection (1)(b) by any city located in that county if the county imposes the tax after January 1, 2011.*
>
> *(2) The tax authorized in this section is in addition to any other taxes authorized by law and must be collected from those persons who are taxable by the state under chapters 82.08 and 82.12 RCW upon the occurrence of any taxable event within the county for a county's tax and within a city for a city's tax. The rate of tax equals one-tenth of one percent of the selling price in the case of a sales tax, or value of the article used, in the case of a use tax.*
>
> *(3) Moneys collected under this section must be used solely for the purpose of providing for the operation or delivery of chemical dependency or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services. For the purposes of this section, "programs and services" includes, but is not limited to, treatment services, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service.*
>
> *(4) All moneys collected under this section must be used solely for the purpose of providing new or expanded programs and services as provided in this section, except as follows:*
> *(a) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposed the tax authorized under this section prior to January 1, 2012, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding in calendar years 2011-2012; up to forty percent may be used to supplant existing funding in calendar year 2013; up to thirty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016;*
> *(b) For a county with a population larger than twenty-five thousand or a city with a population*

over thirty thousand, which initially imposes the tax authorized under this section after December 31, 2011, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding for up to the first three calendar years following adoption; and up to twenty-five percent may be used to supplant existing funding for the fourth and fifth years after adoption;
(c) For a county with a population of less than twenty-five thousand, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to eighty percent may be used to supplant existing funding in calendar years 2011-2012; up to sixty percent may be used to supplant existing funding in calendar year 2013; up to forty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016; and
(d) Notwithstanding (a) through (c) of this subsection, moneys collected under this section may be used to support the cost of the judicial officer and support staff of a therapeutic court.

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

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

King County's Mental Illness and Drug Dependency Sales Tax Enacted: In 2007, the King County Council enacted the Mental Illness and Drug Dependency (MIDD) sales tax based on RCW 82.14.1460 via Ordinance 15949. In addition to authorizing the collection of sales tax revenue, Ordinance 15949 created a sunset date of January 1, 2017 for the sales tax. Ordinance 15949 states:

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

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

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

MIDD Adopted Policy Goals

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

Policy Goal 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.*

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

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

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

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

It is important to note that King County's MIDD was a groundbreaking collaboration between health and human service (HHS) and criminal justice (CJ) service domains. Driven by compelling evidence from HHS and CJ leaders, policymakers created MIDD so that King County could begin to collectively address the high human and financial costs of individuals with behavioral health conditions (mental illness, substance use disorders, and co-occurring disorders) recycling through the expensive criminal justice system. MIDD represented unprecedented coordination, collaboration, and teamwork between the formerly standalone CJ and HHS systems.

MIDD I was organized based on the Sequential Intercept Model, providing a framework to determine what services were needed under MIDD I to help prevent incarceration, hospitalization, and homelessness. It is included as Appendix A to this report.

MIDD Implementation: Oversight, Implementation, and Evaluation Plans: Ordinance 15949 called for key foundational planning documents necessary to the successful and transparent implementation of the MIDD. The legislation called on the Departments of Community and Human Services, Adult and Juvenile Detention, and Public Health; the Offices of the Public Defender and Prosecuting Attorney; and Superior and District Courts to develop and submit to the Council MIDD oversight, implementation, and evaluation plans.

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

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

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

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

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

MIDD I Service Areas and Programming

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

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

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

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

The adopted MIDD Implementation Plan included two additional programs added by the Council that

were not in the Executive's transmitted plan: Crisis Intervention Team / Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project.

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

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

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

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

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

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

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

Replacement of lost Federal funds is permitted.

MIDD in 2016: MIDD serves thousands of people annually[5], providing services to those who otherwise would not receive services. MIDD funding provides:

- housing and supportive housing and case management services;
- crisis diversion and mobile crisis services; and,
- full support for all of King County's therapeutic courts.

Of the 37 original programs/strategies conceived by MIDD planners in 2006-2008, 32 are operational. Two strategies, Crisis Intervention Team/Mental Health Partnership (17a) and Safe Housing and Treatment for Children in Prostitution (17b) secured funding from other sources and did not require ongoing MIDD funds. Three youth strategies: Services for Parents in Substance Abuse Outpatient Treatment (4a); Prevention Services to Children of Substance Abusing Parents (4b); and, Reception Centers for Youth in Crisis (7a), remain on hold. A substantially modified version of Strategy 7a known as FIRS (Family Intervention and Restorative Services) was awarded one time supplemental funding during 2015.

Financially, the MIDD fund benefits from a healthy economy: in 2015 and again in early 2016, the MIDD fund saw an undesignated fund balance. Compared to the economic downturn starting in 2009, when the Oversight Committee was asked to make recommendations on programmatic reductions necessitated by gravely reduced revenues, 2015 and 2016 fund balance resulted in opportunities to restore programs and address emerging needs. The Oversight Committee initiated a standing Fund Balance Review subcommittee to conduct analysis and have a menu of recommendations at the ready for future opportunities to utilize undesignated fund balance.

Key Changed Conditions Impacting MIDD

Since the passage of MIDD in 2007 there have been major seismic shifts in the mental health and substance abuse worlds, including the April 1, 2016 merging of mental health and substance abuse systems into one behavioral health system. The leading change factors that necessitate retooling of MIDD are highlighted below.

Behavioral Health Integration: In March 2014, the Washington State Legislature passed Senate Bill 6312 calling for the integrated purchasing of mental health and substance abuse treatment services through managed care contracts by April 2016, with full integration of physical and behavioral health care by January 2020. The law necessitated the creation of Behavioral Health Organizations (BHOs) to purchase and administer Medicaid funded mental health and substance use disorder services under managed care. BHOs are single, local entities that will assume responsibility and financial risk for providing substance use disorder treatment and the mental health services currently overseen by the counties and the former Regional Support Networks (RSNs). The BHO services include inpatient and outpatient

[5] MIDD Eighth Annual Report, pg. 46: 35,902 unduplicated clients during the October 1, 2014 to September 30, 2015 reporting period, with an additional 21,730 people served in large group settings.
http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/Reports/160413_MIDD_8th_Annual_Report.ashx?la=en

treatment, involuntary treatment and crisis services, jail provided services, and services funded by federal block grants. King County Behavioral Health and Recovery Division will serve as the BHO for the King County region.

Implementation of ESSB 6312 has brought about changes to how behavioral health (including both mental health and substance abuse treatment) services are administered and delivered in King County. The biggest changes have been to the substance use disorder treatment system as it moved from its current fee for service payment structure to managed care. This includes new "books of business" for the County as well as changes to contracting, payment structures, data collection and reporting, and other administrative processes. An integrated behavioral health system allows more flexibility to deliver holistic care especially for individuals with co-occurring mental health and substance use disorders. Notably, Senate Bill 6312 requires that King County's new behavioral health system provide access to recovery support services, such as housing, supported employment and connections to peers.

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

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

Please also see pages 62-64 for additional discussion of Behavioral Health Integration.

Affordable Care Act: The Patient Protection and Affordable Care Act (ACA) builds on the Mental Health Parity and Addiction Equity Act of 2008 and extends federal parity protections to millions of Americans. The parity law seeks to establish conformity of coverage for mental health and substance use conditions with coverage for medical and surgical care. The ACA builds on the parity law by expanding access to insurance coverage to more Americans through state based Health Insurance Exchanges and by expanding the financial eligibility for Medicaid to 133% of Federal Poverty Level. Expanded coverage and access coupled with parity ensures coverage of mental health and substance use disorder benefits for people who have historically lacked these benefits.

Since January 1, 2014, when Washington State took advantage of Medicaid expansion under the ACA, King County has seen a significant increase in the number of people enrolled in Medicaid. As of August 1, 2015, approximately 146,000 individuals have become newly eligible for Medicaid services in King County; of those, about 10,000 had accessed outpatient mental health services from the King County RSN. As of August 1, 2015, there are approximately 395,000 Medicaid-covered individuals in King County.

Because the RSN (and now the BHO) is paid on a per member per month basis from the state, the increase in Medicaid eligible individuals has resulted in revenue growth. This in turn has allowed the

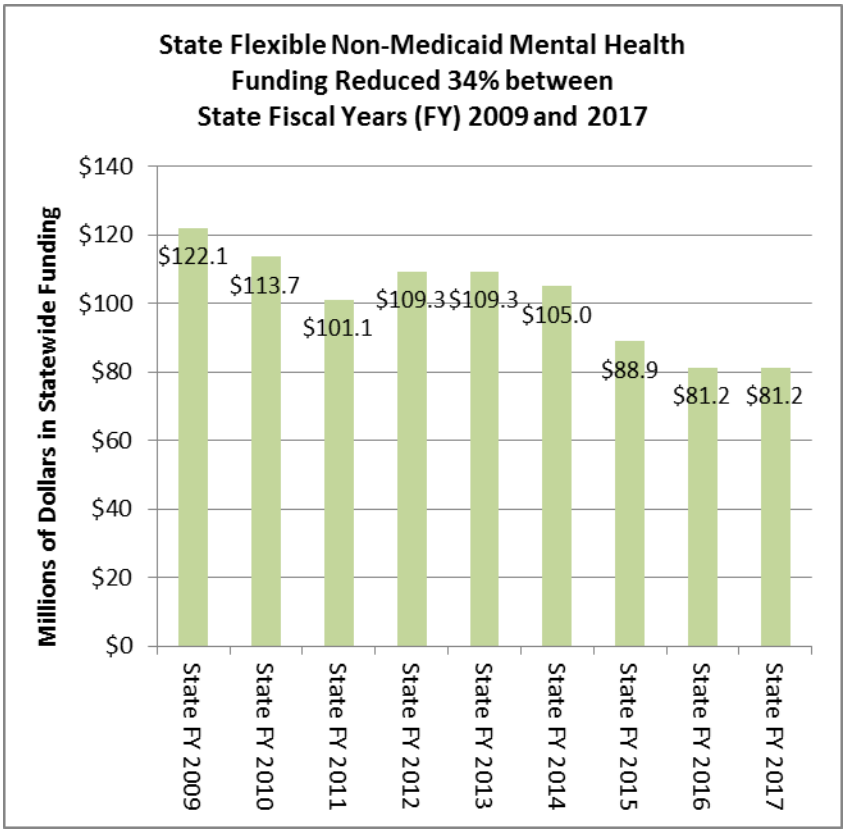
King County BHO to raise outpatient case rates paid to providers. Unfortunately, the system is experiencing a bow wave: the behavioral health system is struggling to find and/or retain trained, licensed, and qualified staff to provide services to this expanded population. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Workforce development is discussed in detail in a subsequent section of this document.

Prior to implementation of the ACA, most people served in the substance use disorder system were not eligible for Medicaid, as Medicaid eligibility was determined by a combination of income and disability and having solely a substance use disorder was not considered a qualifying condition for federal disability. Those with a dual diagnosis (substance use disorder with mental health diagnosis) were required to prove that the mental health diagnosis was present and diagnosed prior to beginning substance use or had to be able to remain abstinent for a considerable amount of time to show the continued presence of a mental health condition. Thus, prior to ACA, many individuals with co-occurring disorders did not receive needed substance use disorder services. Under the ACA, persons no longer needed to qualify for eligibility based on disability, but rather can qualify for Medicaid solely based on income. This has resulted in a significant increase in clients becoming eligible for Medicaid and therefore eligible to receive Medicaid funded substance use treatment. As of February 2016, 87 percent of publicly funded adults and 76 percent of youth in substance use disorder outpatient treatment were on Medicaid.

As with the mental health system, the massive conversion of funding for treatment to Medicaid has impacted providers. On average Medicaid reimbursement rates are 20-25 percent less than what treatment agencies were paid for the same clients for the same service provided prior to ACA. The previous rates were already unsustainable, but the Medicaid rate has been even more difficult for providers to operate under. These lower rates prevent agencies from providing appropriate pay for well-qualified staff, hence leading to staff leaving, and the inability to hire qualified staff turning into a workforce drought. While the legislature did provide for some rate increases on the substance use side during the most recent session ($6.8M statewide), the impact of reduced rates is still deeply experienced by providers. Moving the system to managed care in April 2016 provides another opportunity to increase rates to providers, although the system continues to be significantly underfunded.

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

Table 1



As shown in Table 1 between state fiscal years 2009 and 2016, there was a loss of $40.9 million (34 percent) statewide for these critical services, and funding continues at this low level for state fiscal year 2017 as well. The reductions have had deep and dramatic effects on communities' ability to respond to growing need and maintain or develop creative solutions to improve outcomes for individuals with mental illnesses or substance use disorders.

Another aspect to resource scarcity is the ongoing structural deficit of King County's General Fund. For the upcoming 2017-2018 biennium, the General Fund is facing a $50m deficit. About 75 percent of the General Fund is used to support the county's criminal justice system, including the jail, the courts, prosecution and defense, and the Sheriff's Office. Due to the $50m General Fund deficit, the County is exploring all options to have other funding sources, like the MIDD sales tax, support programs that would relieve pressure on the General Fund. However, the ability to use MIDD revenue to support previously existing programs is limited by a supplantation restriction in the state MIDD statute, which requires MIDD funding be used on "new or expanded programs or services." One exception to the supplantation restriction in the MIDD statute is therapeutic court activities (e.g. Mental Health Court or Drug Court). Therapeutic courts were originally funded by the General Fund before being funded by the first MIDD. The MIDD II spending plan that is included with this report reflects the continued support of King County's four existing therapeutic courts by the MIDD.

High Treatment Need: Severe resource scarcity has coexisted with a very high prevalence of treatment

need in Washington as compared to other states. Analysis of data from the federal Substance Abuse and Mental Health Administration (SAMHSA) 2010-11 Mental Health Surveillance Survey found that Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (seven percent).[6]

Population Growth: The population of King County grew by an estimated 22 percent between 2000 and 2015 – almost 380,000 people. Meanwhile, the state's population increased by approximately 22 percent as well – or nearly 1.3 million.[7] Even this one factor alone – the addition of so many more residents – would have placed more pressure on an overstretched community behavioral health treatment system.

Emergency System Use: More and more people are seeking psychiatric care via hospital emergency departments (EDs) – in 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of psychiatric ED visits, 41 percent result in a hospital admission, over two and a half times the rate of ED visits for other conditions,[8] and between 2001 and 2006 the average duration of such visits was 42 percent longer than for non-psychiatric issues.[9] The growth in these figures may result from the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally, that began as part of deinstitutionalization in the 1960s and has continued until very recently.[10]

In King County and Washington, treatment access challenges and associated emergency system use have been driven by a confluence of factors: community and inpatient resources are scarce, while at the same time treatment need is very high and the population is growing quickly.

Court Rulings

Psychiatric Boarding: On August 7, 2014, the Washington State Supreme Court ruled that hospital boarding of individuals in mental health crisis, absent medical need, is unconstitutional. Psychiatric boarding or "boarding" became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate

[6] Burley, M. & Scott, A. (2015). Inpatient psychiatric capacity and utilization in Washington State (Document Number 15-01-54102). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.

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

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

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

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

available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as hospital EDs until a psychiatric bed became available.

Psychiatric boarding hurts patients and drives resources away from community-based and preventive care. Studies show that prolonged waits in EDs for psychiatric patients are associated with lower quality mental health care.[11] This has been a nationwide problem that had been affecting Washington and King County since at least 2009.

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, the Court emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of bed capacity.[12]

State and local partners, including King County's Community Alternatives to Boarding Task Force, are developing system innovations and deploying new resources strategically to improve access to care. Local flexible resources like MIDD play a key part in expanding treatment capacity in King County.

Forensic Competency Evaluations: In April 2015, a US District Court judge issued a permanent injunction ordering the Washington Department of Social and Health Services to provide competency evaluations to individuals in jails within seven days of booking. Judges order competency evaluations for individuals who are detained when they have concerns about whether the person arrested is able to assist with his or her defense. If the person is found incompetent, the judge orders treatment to have competency restored. Two key drivers impacting the length of time individuals spend in jails awaiting competency evaluation also impact King County's behavioral health system: lack of evaluation services and the lack of bed space and staffing at the state's two forensic hospitals.

As part of the state's response to this new mandate, resources have been committed to start pilot programs in King County to address competency in local communities, expediting evaluation and diverting some defendants away from state hospital stays for competency restoration.

Other Change Drivers

Community Behavioral Health Workforce in Crisis: There are many cascading effects of the expansion of services provided under ACA along with the realities of resource scarcity that are gravely impacting the workforce charged with providing services to a growing population. Major workforce challenges negatively impact the publicly funded behavioral health care system when trained, licensed, and qualified staff are difficult to find and/or retain in community provider organizations.

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

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

The workforce crisis crosses all levels of care, as insufficient recruitment and retention of qualified behavioral health workers is presenting significant problems for community providers and hospitals, and the problem is getting worse. It is a concern of providers and public behavioral health systems both nationally and in Washington State, where it has been a focus of attention for the Adult Behavioral Health System Task Force's Workforce Development Workgroup,[13] the Washington Community Mental Health Council,[14] and the Washington State Hospital Association.[15]

A confluence of competing factors is contributing to the behavioral health workforce crisis. Studies of the situation in Washington have found that there is now a greater awareness of behavioral health needs among human service providers, faith communities, medical, and housing providers; an aging population coping with chronic conditions including mental health and substance abuse issues; and greater attention to the behavioral health needs of veterans. Also, there is increasing need for workers with multiple credentials in order to serve clients who have multiple behavioral health treatment needs or who are receiving care in integrated care settings. At the same time, many longtime behavioral health professionals are retiring or nearing retirement, and fewer younger workers are seeking a career in human services, leading to significant competition in the labor market.[16]

High caseloads and low wages in community behavioral health make it easy for qualified staff to be recruited away by entities like the Veteran's Administration and private health care systems that can pay more and/or forgive student loans. It is also difficult to recruit psychiatrists, nurse practitioners, and nurses to public sector behavioral health due to a small candidate pool and challenges in offering competitive salaries. The behavioral health workforce, particularly in public sector settings, also experiences high turnover due, in part, to burnout, stress, and lack of social support. Ongoing reductions in funding for public behavioral health contribute to staff turnover and recruitment challenges.

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

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

---

[13]Excerpt from the 2SSB 5732 Report to the Governor and Legislature. (June 2014). Presented to Adult Behavioral Health System Task Force, July 24, 2015. Retrieved from https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=SaPxhsSWbJM&att=false

[14]Christian, A. (July 24, 2015). Washington Community Mental Health Council: Adult Behavioral Health System Task Force 7/24/15, The Community Behavioral Health Workforce. Retrieved from https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=rvfuBcZu20w&att=false.

[15] Whiteaker, C. (July 24, 2015). Washington State Hospital Association: The Behavioral Health Workforce in Washington State, Adult Behavioral Health System Task Force 7/24/15. Retrieved from https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=W9HEpD6ldfA&att=false.

[16]Christian, A. (July 24, 2015). Washington Community Mental Health Council: Adult Behavioral Health System Task Force 7/24/15, The Community Behavioral Health Workforce. Retrieved from https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=rvfuBcZu20w&att=false.

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

The initial MIDD was based on the concept of decriminalization of mental health and substance use following the National GAINS Center Sequential Intercept model. Building on the model and following emerging practices, King County embraces a recovery-oriented framework for all individuals served in its behavioral health system. This practice enables King County to better address the needs of individuals with complex behavioral and other health conditions who are incarcerated, or at risk of incarceration, throughout King County. It is well documented that individuals with complex behavioral conditions are overrepresented in criminal justice settings nationally. Reentry and transition from hospital or jail planning can work well when behavioral health and criminal justice systems collaborate to support recovery.[17]

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

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

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

Providing services under a trauma-informed framework can result in better outcomes than "treatment as usual." A variety of studies have revealed that programs utilizing a trauma-informed model are associated with a decrease in psychiatric symptoms and substance use. Some programs have shown an improvement in daily functioning and a decrease in trauma symptoms, substance use, and mental

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

health symptoms. [18, 19] Trauma-informed care may lead to decreased utilization of crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed services.[20]

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

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

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

MIDD I Comprehensive Historical Review and Assessment Report Findings

As noted, Ordinance 17998 called for two major MIDD related work products to be submitted to the Council: this **Service Improvement Plan** and the **Comprehensive Historical Review and Assessment Report.** The latter is an extensive examination and assessment of MIDD I strategies, programs, and services and was submitted to the Council on June 30. It included recommendations on improvements to MIDD performance measures, evaluation data gathering and a review of MIDD evaluation processes. The Comprehensive Historical Review and Assessment Report contained the following findings on MIDD I:

1. Aggregating results from all relevant strategies, MIDD is recognized as SUCCESSFUL and EFFECTIVE

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

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

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

in meeting the established policy goals.

2. **<u>Significant reductions</u> in jail and emergency department use, and psychiatric hospitalizations, are documented by MIDD evaluation data.**

Policy Goal 1: Emergency Department Utilization SIGNIFICANT REDUCTION
Data indicates that over the long term, emergency department utilization decreased significantly. After a modest initial increase in emergency department use in the first year, **reductions in emergency department use exceeded 25 percent for every year thereafter, peaking at 39 percent** in the fifth year after initial MIDD service contact.

Policy Goal 1: Psychiatric Hospital Utilization SIGNIFICANT REDUCTION
Over the long term, inpatient psychiatric hospital utilization (including local hospitals and Western State Hospital) decreased significantly. After a modest initial increase in psychiatric hospital use in the first year, **the total number of admissions dropped 44 percent**, and the **total number of hospital days were reduced by 24 percent**, in the third through fifth years after initial MIDD service contact.

Policy Goals 1, 2, and 4: Jail Utilization SIGNIFICANT REDUCTION
Over both the short and long term, **jail bookings decreased significantly, ranging from 13 percent in the first year to 53 percent** in the fifth year after initial MIDD service contact. Total jail days increased slightly in the first year after MIDD service contact, but then **reductions in jail days that reached a 44 percent reduction** by the fifth year were consistently evident starting in the second year.

Policy Goal 3: Symptom Reduction NOTABLE REDUCTION
When change was evident and could be measured, **about three out of every four people showed reduced mental health symptom severity or reduced substance use** at some point over the course of their treatment.

Policy Goal 5: Furthering Other Initiatives INTENTIONAL LINKAGE
In general, strategies intended to further the work of other Council-directed efforts were determined to have done so.

The Comprehensive Historical Review and Assessment Report also identified a number of recommendations to improve evaluations of MIDD II. The potential renewal of MIDD presents a tremendous opportunity to examine MIDD and its evaluation. Informed by an independent assessment of the MIDD Evaluation by King County's Office of Performance, Strategy, and Budget (PSB), as well as other internal assessments and stakeholder feedback, a range of improvements to the MIDD evaluation approach were recommended. The 22 potential changes to the MIDD II evaluation fall into these four broad categories:

- Updating and revising the evaluation framework;
- Revising performance measures, targets, and outcomes;

- Upgrading data collection and infrastructure; and
- Enhancing reporting and improving processes.

III. Key Components of MIDD II

Overview

The 2016 MIDD Service Improvement Plan represents the collaborative efforts over a nearly two-year period from a wide range of internal and external stakeholders, including representatives from communities, provider agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, Council staff, and many others. The product of this work is the MIDD II Service Improvement Plan which is a comprehensive, multi-jurisdictional proposal to help people living with, or at risk of behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement. It builds on the success of the first MIDD which was a groundbreaking partnership between health and human services and criminal justice and King County government and community providers, and sets forth a path to overcome the few challenges of MIDD I.

The recommended initiatives, policies, and processes that comprise MIDD II are:

- informed by community and Oversight Committee input;
- grounded in the County's Social Justice and Equity work;
- driven by outcomes;
- guided by the behavioral health continuum of care; and
- aligned with other County policy initiatives.

Differences between MIDD I and Proposed MIDD II

MIDD I	Proposed MIDD II
• **Organized into five service areas that are a mix of services and populations**	• **Organized into four strategy areas corresponding to the behavioral health continuum of care**
• **Constructed to support two separate systems: mental health and substance use**	• **Based on an integrated system of behavioral health services**
• **Envisioned to support expansion of therapeutic courts**	• **Supports entirety of therapeutic courts**

Development of Proposed MIDD II Recommendations

The MIDD II planning process was co-created by the MIDD Oversight Committee. It was intentionally crafted to be transparent and provide ample opportunities for review and input. Hundreds of citizens and community members engaged in the various elements of the MIDD II planning process, from completing a survey, to submitting a new concept, to participating in a community conversation or focus group. Regular updates were provided on MIDD II planning to provider networks, jurisdictional coalitions, elected officials, Council and Executive staff and internal county stakeholders. A website was launched so that all relevant MIDD II planning documents and updates could be easily accessed. Below highlights some of more notable elements of MIDD II planning.

Oversight Committee Guidance and Input: The MIDD Oversight Committee performed a critically important role in MIDD II planning. In March 2015, the MIDD Oversight Committee established Values

and Guiding Principles to inform all aspects of MIDD I review work and MIDD II renewal planning activities. County staff and Oversight Committee members relied on these values and guiding principles as benchmarks as well as used them as checks and balances throughout MIDD II planning. The Values and Guiding Principle informed everything about MIDD II from the development of outreach and communications plans, to recommendations contained in this report. The values and guiding principles served as cues for the transparent and collaborative approach the County executed for the review of planning for, and implementation of a potential MIDD II.

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

MIDD Oversight Committee members and/or the MIDD Renewal Strategy Team[21] reviewed and provided feedback on the recommendations contained within this report. Additionally, the Oversight Committee has reviewed and provided feedback on major MIDD review and renewal planning documents, including the MIDD II Framework which is the basis of recommended revisions to the MIDD policy goals and a key driver of recommended revisions to the potential MIDD II evaluation approach. The MIDD II Framework is discussed in detail later in this section of the report.

By the time this report is transmitted to the Council, it will have been formally reviewed and discussed in at least two MIDD Oversight Committee meetings. Every effort will be made to reflect MIDD Oversight

[21] The Oversight Committee appointed a MIDD Renewal Strategy Team comprised of eight Oversight Committee members, representing an array of populations and stakeholders and including staff from the county's executive and legislative branches, to facilitate a higher degree of collaboration and input from the Oversight Committee. The Strategy Team provided guidance and expertise for MIDD I review and MIDD II planning activities to BHRD staff. Intended to augment Oversight Committee feedback and input, the MIDD Oversight Committee Strategy Team provided in-depth reviews of MIDD I review and MIDD II planning activities and documents. The Strategy Team facilitated analysis, identified issues, offered subject matter expertise, and helped to problem-solve with county staff charged with completing the tasks required by Ordinance 17998.

Committee feedback into the final version of this report that is transmitted to the Council.

Citizen and Community Input: In order to develop responsive and relevant MIDD II initiatives, King County turned to residents and community partners across the region for input and guidance. Informed by the MIDD Oversight Committee's Values and Guiding Principles, King County staff conducted a robust outreach and engagement process around MIDD renewal. From September 2015 through February 2016, King County invited citizens and communities to participate in five regional Community Conversations on MIDD[22]. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas, including a focus group with individuals in the King County Jail. The purpose of these engagement efforts was to hear ideas about services and programs for people living with mental illness and substance use disorders from those who need, use, or engage with our county systems. The conversations were intentionally designed so that community members had a role in informing the County's decisions around its investments for children and youth and investments for mental health and substance use disorder services and programs. Focus groups ranged in size from as few as four to over 100 participants. Groups included, in order of meeting:

- Domestic Violence and Sexual Assault Service Providers
- Behavioral Health Organization Leaders
- Real Change Vendors (consumers)
- Southeast King County/Maple Valley
- Asian/ Pacific Islander Communities
- Hispanic Communities
- Recovery Café (consumers)
- Refugee Forum
- African American Communities
- Northeast King County/Snoqualmie Valley
- Native American Communities
- Trans* Individuals
- Somali Health Board
- King County Jail Detainees

MIDD staff also conducted an electronic survey between September and February. Over 360 respondents took the time to answer key questions about MIDD. Summaries and themes from these groups are available on the MIDD Renewal website, along with the MIDD survey data.

Please see Appendix C for a summary of community engagement themes.

Three Phased MIDD Renewal Process: In addition to the vigorous community engagement work, a structured three phased review and renewal process was established in collaboration with the MIDD Oversight Committee. This process enabled the widest possible access to MIDD II funding and facilitated a coordinated analysis of new concepts and existing MIDD I programming. The process included:

[22] Community Conversations were held in partnership with King County staff planning for what became Best Starts for Kids.

I. **PHASE I -** Interested parties submitted New Concepts to the County between September 15, 2015 and October 31, 2015. After initial screening of the concept forms to ensure fitness under the RCW, they were forwarded to Phase II. Only a handful of concepts were not moved forward out of the 141 received.

II. **PHASE II -** County staff drafted over 90 briefing papers in consultation with behavioral health partners, providers, and subject matter experts. Briefing papers provided answers to important analytical questions. The process specifically involved review of the papers by concept submitters and every effort was made by DCHS to reflect feedback from concept submitters whenever possible while striving to provide objective analysis[23].

The second step of Phase II were panel reviews of existing strategy and new concept briefing papers, with the panels sorting the strategies and concepts into high, medium, and low categories for potential funding consideration. Four panels, corresponding to the four MIDD II strategy areas, convened in March 2016. Over 50 individuals participated on the review panel teams. The panels were intentionally constructed to bring in a diverse array of lived experiences, skills, knowledge, perspectives, and insights to the sorting process. Each review panel team had a mix of community members and MIDD Oversight Committee members or their designees. Guiding factors provided to the review panels to use as they conducted their reviews of the briefing papers included questions on community needs, equity and social justice, integration, and recovery and reentry. See Appendix D for the briefing paper panel sorting results. Briefing Papers can be found on the MIDD website: http://www.kingcounty.gov/MIDDrenewal.

III. **PHASE III –** County staff aligned MIDD II programmatic recommendations, developing the recommendations and identifying funding levels. County staff assessed all existing MIDD I programs and potential new concepts for fit, value, and ability to help the County achieve MIDD policy goals. The initial recommendations were released to the MIDD Oversight Committee and for public review and a two week public comment period on April 22. Over 200 public comments were received. County staff made revisions to the draft MIDD II funding and programmatic recommendations in May, with revised recommendations being released on May 20. Two Oversight Committee meetings (April and May) were dedicated to the review of and feedback on the draft funding and programmatic recommendations.

Please see Appendix E for the detailed MIDD II process overview.

MIDD I Policy Goals & Proposed Modifications

MIDD I's adopted policy goals are the foundational expression of what policymakers expected the MIDD to achieve, or work towards achieving. The policy goals provided the essential framing for all elements of the MIDD, the MIDD I Implementation and Evaluation Plans. The primary focus of the MIDD I evaluation was to determine progress of MIDD supported programs toward meeting the five policy goals.

[23] Instructions for the New Concept process clearly noted that concepts may be altered or revised in briefing papers.

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

MIDD 2007 Adopted Policy Goals

Policy Goal 1: A reduction in the number of mentally ill and chemically dependent people using costly intervention like, jail, emergency rooms, and hospitals;

Policy Goal 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;

Policy Goal 3: A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults;

Policy Goal 4: Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement; and

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

Calling for proposed modifications to the MIDD policy goals through Ordinance 17998[24], the Council recognized that the behavioral health and criminal justice environments have changed since 2007 when the MIDD I policy goals were established via Ordinance 15949 and that refined policy goals may be necessary for MIDD II. As required, the requested modifications to the adopted MIDD policy goals were submitted to the Council in the Comprehensive Historical Assessment Report submitted to the Council on June 30, 2016.

Because of the fundamental role of the MIDD policy goals for the Implementation of MIDD II, this Service Improvement Plan includes the proposed modifications to the goals that were recommended in the Comprehensive Historical Assessment Report submitted to the Council on June 30. They are also included in this report because the Proposed MIDD II Initiative Descriptions reference the 2007 policy goals AND the proposed modified goals.

Person Centered Goals: MIDD Oversight Committee members serving on the MIDD Renewal Strategy Team reviewed and discussed the recommended revisions to the policy goals. Strategy Team members noted that a key driver of the modified policy goals is the desire to *focus on meeting the needs of people rather than on meeting system needs.* For example, the recommended revision for policy goal 1 below reflects the recognition that diverting people with behavioral health needs out of the justice system is a more constructive goal than reducing the number of people who are using costly interventions.

[24] Ordinance 17998, lines 103-104

RECOMMENDED REVISIONS TO MIDD POLICY GOALS	
2007 Policy Goal	**Recommended Revised Policy Goal**
1. A reduction in the number of mentally ill and chemically dependent people using costly interventions, such as, jail, emergency rooms, and hospitals	1. Divert individuals with behavioral health needs from 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	2. Reduce the number, length, and frequency of behavioral health crisis events.
3. A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.	3. Increase culturally appropriate, trauma informed behavioral health services.
4. Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement.	4. Improve health and wellness of individuals living with behavioral health conditions.
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.	5. Explicit linkage with, and furthering the work of, other King County and community initiatives.

Recommended Policy Goal 1 captures the primary intended outcome described in the 2007 policy goals 1, 2, and 4 by directly addressing criminal justice system involvement as an indicator of return on investment. The goal is revised to use recovery-oriented person-first language, and now explicitly includes efforts to completely prevent criminal justice system contact via diversion alongside efforts to serve those who have a history of criminal justice system involvement.

Recommended Policy Goal 2 addresses the emergency medical system use aim of the 2007 policy goal 1 by addressing reduction of behavioral health crises. It further recognizes that return on investment in this area can be achieved either by reducing how often people are in crisis, or helping people in crisis stabilize more quickly.

Recommended Policy Goal 3 targets a common and significant theme from MIDD's community outreach efforts around improving and supporting culturally appropriate services. It further reflects recent years' advancements in recovery-oriented approaches to care, and actively supports King County's equity and social justice aims.

Recommended Policy Goal 4 builds on the vision of the 2007 policy goal 3 by recasting reduction of behavioral health disorders and symptoms within the positive frame of improving health and wellness. In so doing, this goal now supports current system change efforts to provide people with behavioral health conditions with an integrated care experience that addresses needs across different domains including physical health care, and reflects an approach to recovery.

Recommended Policy Goal 5 refines 2007 policy goal 5 by recognizing that linkage with system change efforts are essential and that such system work is constantly evolving. As recommended, this policy goal would support MIDD's engagement with a broad range of initiatives in King County, including community driven initiatives.

This report acknowledges an underlying factor related to the MIDD policy goals and to MIDD overall: **MIDD programs and services alone cannot achieve the policy goals.**

- For example, simple changes to policing practices or prosecution policies can greatly impact the number of people who enter the criminal justice system. After such a shift, data could suggest that MIDD services were either more or less successful in reducing the number of people who returned to jail, irrespective of the individuals' behavioral health conditions, when the larger driver may actually have been the criminal justice policy changes.

- Likewise, shifts in federal or state funding or policies for behavioral health services impact the amount, availability, and/or quality of behavioral health services, which in turn influences the incidence and severity of behavioral health conditions. For example, many MIDD services provide enhancements to underlying services provided via federal or state funding, or are designed to address gaps between such services. When core state or federal services are reduced, or more rarely expanded, this is likely to affect the apparent effectiveness and/or relevance of the MIDD-funded service.

- Finally, macroeconomic factors including access to employment and affordable housing – both of which are well beyond MIDD's capacity to impact in a substantive way – have a major effect on recovery outcomes.

In light of these factors, the recommended policy goal revisions clearly highlight the fundamental intentions of MIDD II while at the same time recognizing its limitations. These proposed revised MIDD policy goals focus primarily on **expected results for MIDD program participants and improvements in access to services**.

MIDD II Framework

MIDD II is rooted in the County's work to transform the approach to health and human services by improving health and well-being and creating conditions that allow residents of King County to achieve their full potential. This is reflected throughout the planning and development of MIDD II recommendations and summarized in the MIDD II Framework.

The MIDD II Framework is an accountability framework driven by the results policymakers and stakeholders want to see in the community as the result of investment of MIDD funds; the indicators that the county will use to signal that it's headed down the right path to get there; and the actions the county and its partners will take to create the change stakeholders want to see. To inform this framework, DCHS drew upon the principles of results-based accountability practices among other

elements, including the Sequential Intercept Model[25]. The MIDD II Framework is shown in Appendix F.

The MIDD II Framework identifies and organizes the central components of MIDD II. It identifies the MIDD II approach at four different levels:

1) what will happen as a result of MIDD services;
2) the theory of change driving the result of MIDD;
3) key strategies and outcomes intended to achieve MIDD's II result; and
4) sample performance measures used to demonstrate progress toward outcomes.

MIDD II Framework Highlights
***MIDD Result**: People living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement.* ***MIDD Theory of Change**: When people who are living with or who are at risk of behavioral health disorders utilize culturally relevant prevention and early intervention, crisis diversion, community reentry, treatment, and recovery services, and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.*

The MIDD II Framework shows the outcomes of MIDD II as divided into two areas: population and individual outcomes. Each level of outcomes has associated indicators and measures. There are two very important caveats associated with MIDD outcomes and indicators.

1. Population outcomes are predicated on the understanding that MIDD alone is not responsible for broader population outcomes. MIDD, along with other King County and community initiatives work together to contribute to the overall health and well-being of King County residents that is demonstrated by positive outcomes.

2. Performance measures and indicators for MIDD II will be identified after the funding and programmatic decisions are made by the Executive and Council. The measures and indicators must be developed in partnership with providers and other stakeholders.

3. The MIDD II Evaluation Framework will include performance measures and indicators necessary to gather and report on population and individual outcomes and progress toward policy goals.

A major component of the MIDD II Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area. Each proposed MIDD II initiative is included in one of the four MIDD II Strategy Areas.

[25] The Sequential Intercept Model is discussed on page 59.

MIDD II Strategy Area Name	Purpose
Prevention and Early Intervention	*People get the help they need to stay healthy and keep problems from escalating*
Crisis Diversion	*People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*
Recovery and Reentry	*People become healthy and safely reintegrate to community after crisis*
System Improvements	*Strengthen the behavioral health system to become more accessible and deliver on outcomes*

Each of the framework's four strategy areas includes sample performance measures for individuals along with outcomes and indicators for the wider population. They are noted as "sample" because they represent examples of the types of information to be sought in evaluation of MIDD II strategy areas and programming. Indicators reflected in the framework will change based on final MIDD II programming decisions and community and stakeholder feedback. Subsequent updates to the MIDD II Framework will be shared with the MIDD Oversight Committee for their review and feedback.

As discussed in the MIDD Renewal Progress Report that was submitted to the Council in November 2015, and the Comprehensive Historical Review and Assessment Report submitted to the Council in June 2016, King County BHRD, in consultation with the MIDD Oversight Committee, developed the MIDD II Framework as a tool to succinctly summarize the MIDD II approach, activities, policies and outcomes. Updates to the MIDD II Framework have been made based on stakeholder input and further clarifying the intent of sections that address potential performance measures.

The MIDD II Framework is a living document that will be further updated over the life of the MIDD II to reflect specific programmatic and services once they are determined by the Executive and Council in 2016. The Framework will continue to be updated over the life of MIDD II as a companion to the MIDD policy goals.

VI. Proposed MIDD II Initiatives

MIDD II planning work was carefully conducted in clear and straightforward ways. From establishing the MIDD II Framework that simply and explicitly explains the purpose and outcomes of MIDD, to developing the review and renewal processes that prioritized the voices of communities, every step of the process that has resulted in the recommendations proposed in this Service Improvement Plan has been transparently shared with stakeholders.

The Proposed MIDD II initiatives prioritize:

- Funding services and programs to keep people out of or returning to jail and the criminal justice system, including upstream prevention and diversion activities.

- Investing in a treatment on demand system that delivers treatment to people who need it, when they need it, so crises can be avoided or shortened.

- Creating community driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs.

Aligning MIDD II and Best Starts for Kids (BSK) has been a primary focus of DCHS. From holding joint Community Conversations, to collaborating on strategies and initiatives, to jointly reviewing MIDD II concepts and briefing papers, MIDD II planning and recommendations development has been a synergistic endeavor with BSK. This strong partnership will continue throughout the life of each of these initiatives, through planned joint meetings of the MIDD Oversight Committee and the Children and Youth Advisory Board and shared approaches to accomplishing the work of each initiative. Operationally, MIDD II and BSK are working to coordinate approaches to evaluation, contracting, and reporting among other aspects.

As a result of this collaboration, BSK is proposed to support an estimated $2.9 million (annually) for prevention based behavioral health services for children and youth. This includes expanding screening, brief intervention, and referral to treatment (SBIRT) into middle schools across the county along with an infant mental health program.

Leveraging Medicaid to a greater extent is an underlying consideration of the proposed MIDD II, with some MIDD funding replaced by expected Medicaid dollars. BHRD has concluded that King County and its partner providers can better leverage Medicaid funds, and in doing so, free up MIDD funds for other uses. The proposed MIDD II recommendations assume an estimated $4.8 million in Medicaid funds replace MIDD revenue. These assumptions impact not only providers, but also BHRD as well. BHRD is developing technical assistance and support for providers to ensure that they have the tools, training, and support process Medicaid billing. Because getting the Medicaid assumptions accurate is critically important, BHRD engaged a consulting firm to analyze the Medicaid assumptions.

Successful MIDD I programs are proposed to continue into MIDD II, though some are merged or will be retooled during the implementation planning or request for proposal (RFP) process. Existing MIDD programs received strong support from stakeholders; those programs that were initially slated for marginal reductions launched effective public comment campaigns to restore funds.

Sixteen new proposed initiatives are recommended for MIDD II, bringing the total number of initiatives to 47. Please note that most newly proposed initiatives, along with existing MIDD I initiatives, have other sources of support. Very few MIDD I or MIDD II initiatives are solely supported by MIDD funds. The following are the new initiatives included in the proposed MIDD II funding and programmatic allocations.

- Law Enforcement Assisted Diversion (LEAD)
- South County Crisis Diversion
- Alternatives to Incarceration for Youth
- Family Intervention Restorative Services (FIRS)
- Community Driven Behavioral Health Grants
- Behavioral Health Services in Rural King County
- Multipronged Opioid Response
- Behavioral Health Urgent Care Walk In
- Mental Health First Aid
- Zero Suicide Pilot
- Recovery Café
- Peer Bridgers/Peer Support
- Rapid Rehousing-Oxford House Model
- Housing Capital and Rental Assistance
- Emerging Issues Initiative
- Youth and Young Adult Homelessness Services

Therapeutic courts[26] are proposed to be fully supported by MIDD due to the continued constriction of the County's General Fund. While expanding treatment courts was included under MIDD, treatment courts were funded by MIDD as authorized by supplantation[27] starting in 2009. State law was modified to enable sales tax revenue to be used to support the cost of the judicial officer and support staff of a therapeutic court without being considered as supplantation.

The MIDD II funding and programmatic proposal includes a recommended expansion of the Family Treatment Court to south King County due to demand. No other expansions of the courts are recommended, due in large part to strong and consistent feedback from stakeholders who were not supportive of expanding "deep end" criminal justice costs. This is perhaps the most contentious of recommendations in the MIDD II plan.

The MIDD resource is finite, and while the MIDD Fund has benefitted from a robust regional economy experiencing increasing projected sales tax growth, not all of the suggested MIDD II concepts were able to be funded, despite increased revenue. The MIDD's new concept process yielded about $180 million in requests for the estimated $63 million of available MIDD funds. The collaboratively designed MIDD II review and renewal process balanced the needs for objectivity, analysis, transparency, and community feedback. While most of the feedback on the MIDD review and renewal process has been positive, as with any process where funding recommendations are involved, there has been some expected

[26] King County's Therapeutic Courts are: Adult Drug Court, Juvenile Drug Court, Family Treatment Court, and Regional Mental Health Court.

[27] See page 14 for a discussion of supplantation and MIDD.

frustration articulated. The dissatisfaction with the process has largely been from entities whose particular suggestions were not recommended for funding or were recommended to be funded at a lower level.

A survey of the MIDD II review and renewal process will occur in early 2017 to inform future similar endeavors.

Economic Adjustments for Providers are included in MIDD II, to be funded by fund balance in the 2017-2018 biennium. This is a major difference between MIDD II and MIDD I, as MIDD I did not provide for adjustments to allocations based on inflation. In most years, but not all, county agencies operating MIDD programs received inflationary adjustments while community providers did not. Consequently, partner agencies have been managing the erosion of MIDD funds while being expected to provide a constant level of services, resulting in provider subsidy of MIDD programs. MIDD II seeks to address this inequity by providing economic adjustments to providers. Should future MIDD II revenues decline, the county will need to explore the impact of continued economic adjustments on the MIDD II services and initiatives.

Supporting and improving the behavioral health system is a vital component of the proposed MIDD II funding and programmatic recommendations. As discussed in an earlier section of this report the community behavioral health workforce is in crisis. These challenges negatively impact the publicly funded behavioral health care system when trained, licensed, and qualified staff are difficult to find and/or retain in community provider organizations. Without the people qualified to provide the services, the system is crippled. The proposed MIDD II funding and programmatic recommendations maintains the important MIDD I initiative, Workload Reduction (formerly "Caseload Reduction") and expands the Workforce Development initiative (formerly "Chemical Dependency Professional Education and Training"). While maintained and expanded respectively, each of these initiatives is planned to be revised and restructured in 2017 in part due to the integration of substance use and mental health services.

MIDD Operations and Management

As with MIDD I, DCHS will continue to have overall responsibility for the management and implementation of MIDD II, including managing the budget; behavioral health systems and programmatic development; oversight of the request for proposal (RFP), memorandum of agreement (MOU), and contracting processes; and evaluation of MIDD.

The great majority of services provided through the MIDD will be contracted out to community agencies, though not all MIDD initiatives will be subject to an RFP process. For example, MIDD I services that are provided under an MOU with another King County department and will continue into MIDD II will not be RFPd, (but will have a revised MOU). MIDD II will use the same approach as was use for MIDD I to determine whether proposed MIDD II initiatives will engage in a competitive RFP process. Please see Appendix G for the decision model BHRD will continue to use to determine the need for competitive procurement.

Because of MIDD and BHRD's commitment to equity and social justice and community engagement,

many of the initiatives proposed in the MIDD II funding and programmatic recommendations (both new and existing under MIDD I) will involve intentional partnering with communities, particularly around services and RFP development. For example, the revisions needed for the Workload Reduction initiative to include substance use providers will be developed with a workgroup of providers and other stakeholders. A new initiative such as the Youth Behavioral Health Alternatives to Secure Detention requires deliberate and planned community engagement to ensure that the determined approach is truly responsive to community needs.

Not only does MIDD II propose funding and programmatic recommendations, the next iteration of MIDD will include a number of internal operating and process improvements designed to enhance transparency, streamline processes, promote collaboration, share information, and make progress on overcoming challenges.

V. Responses to Ordinance 17998

Ordinance 17998 called for the MIDD II Service Improvement Plan (SIP) to be submitted to the King County Council in December 2016. In order to support the King County Council's desire for expanded review and input of the MIDD II SIP, the SIP report called for by Ordinance 17998 is submitted *three months earlier than required*.

One impact of this changed timeline is that two elements of the MIDD II SIP called for by Ordinance 17998 –Implementation[28] and Evaluation information[29] -- are included at *high levels* in this SIP. This is due to the fact that these two elements require further development that needs to occur in collaboration with the MIDD Oversight Committee and providers. The shortened time line impacted BHRD's ability to conduct thoughtful implementation planning in partnership with providers and others.

During the Briefing Paper Review Panels, a number of themes around implementation of MIDD II were articulated repeatedly by dozens of community members who participated. Thoughtful implementation planning must:

1. Involve communities and consumers in a meaningful and intentional way;
2. Recognize that *how* services are provided is critical for success, particularly for ethnic and cultural communities and populations served; and
3. Put the consumer, not systems, at the center of decisions.

Developing a MIDD II Implementation Plan requires the County to collaborate with providers, consumers, and communities which takes time and resources.

Additionally, policy goals that were established for MIDD I were recommended to be revised as per the MIDD Comprehensive Historical Report, and have not been reviewed, discussed, amended, or finalized by the Council. The MIDD I policy goals played a major role in developing implementation and evaluation outcomes; they are foundational to the entire MIDD I evaluation approach. Having MIDD II policy goals will enable the county to efficiently and effectively develop meaningful, collaborative implementation and evaluation plans. Finally, adoption of the King County 2017-2018 in mid-November will have a significant impact on the final programmatic and funding array for the MIDD II and final budgetary decisions which would need to be reflected in the MIDD II Implementation and Evaluation Plans.

It is therefore the recommendation of the Executive that the MIDD II Implementation and Evaluation Plans be submitted in mid-2017 for review and acceptance by the Council. This approach is similar to the sequencing of MIDD I Implementation and Evaluation plans. This timeline allows for BHRD to conduct an intentional implementation and evaluation planning process in collaboration with communities, consumers, and the MIDD Oversight Committee; align with BSK and other county endeavors, and thoughtfully enact recommendations related to MIDD evaluation contained in the Comprehensive Historical Review and Assessment Report.

[28] Ordinance 17998, lines 119-120

[29] Ordinance 17998, lines 127-128

Appendices Table

Ordinance Component	Appendix Name	Appendix Number
A detailed description of each proposed strategy, service and program to be funded from the MIDD sales tax beginning in 2017, including strategy goals, outcomes, expected number of individuals to be served and whether the services are provided by the county or by a contracted provider (lines 115-118) *Explanation of how each recommended MIDD strategy, service and program supports the adopted and/or recommended MIDD policy goals (lines 119-120)* *An initial list of performance measures, outcomes, and/or evaluation data for each proposed strategy, service and program that will inform annual reporting to the executive, the council, the MIDD oversight committee, and the public regarding the investment of MIDD sales tax funds (lines 127-130)*	**MIDD II Initiative Descriptions**	**H**
A schedule for the implementation of the strategies, programs, and services outlined in the MIDD service improvement plan (lines 121-122)) ***Also referenced in Initiative Description documents.*	**MIDD II Implementation Schedule**	**N**
A spending plan for each strategy, program and service outlined in the MIDD service improvement plan, including recommended 2017-2018 biennial budget levels for each proposed strategy, service and program (lines 123-126) ***Also referenced in Initiative Description documents.*	**MIDD II Spending Plan**	**M**
The proposed MIDD Service Improvement Plan strategies, services, and programs shall: *Demonstrate that they are based on evidence related to successful outcomes for chemical dependency or mental health treatment programs and services;* *Demonstrate that they are based on best or promising practices for chemical dependency or mental health treatment programs and services and that they incorporate the goals and principles of recovery and resilience within a trauma informed framework, as specified by K.C.C, chapter 2.43 and King County's adopted behavioral health system principles set out in Ordinance 17553 (lines 145-151)*	**MIDD II Evidence Practice Type**	**J**

Please note that the Initiative Description documents that are included in this Plan as Appendix H provide initial implementation and evaluation information. The information in these documents is preliminary and subject to revision based on revised policy goals, the adopted budget, and community feedback that might occur during the upcoming implementation planning work or as a result of changed

funding levels that may occur during the County's budget adoption process.

Please note that in most instances, information for the proposed new MIDD II initiatives is very preliminary due to the need to conduct detailed implementation planning in collaboration with stakeholders and communities. Additionally, most existing MIDD I initiatives that are recommended to continue into MIDD II will also undergo some form of operational updating to increase efficiency, effectiveness, and meet revised policy goals. All initiatives will be included & detailed in a MIDD II Implementation Plan that is recommended to be submitted to the Council in 2017.

The sections below detail the specific recommendations called for by Ordinance 17998. In some instances, the recommendations may require legislation; these items are indicated by an asterisk (*) in the summary table associated with each area.

MIDD Fund Financial Policies Recommendations

Ordinance Component	SIP Recommendations
Recommend MIDD fund balance reserve policies for the fund, taking into consideration the county's existing fund balance and reserve policies (lines 170-171)	1. Revise MIDD Fund reserve policy to 60 days of expenditure in the Rainy Day Reserve. 2. Allocate at least $750,000 annually to the Rainy Day Reserve. 3. Prioritize use of fund balance.

Reserve Policies: In 2007 when the MIDD I Fund was created, a Rate Stabilization Reserve[30] of 5.25% of expected revenues was established. Since then, the County has refined and standardized its reserve policies (Motion 14110). Page 21 of the Comprehensive Financial Management Policies states, "the majority of operating funds, including Enterprise Funds and Special Revenue Funds, should maintain a Rainy Day Reserve equal to 30-60 days of expenditures."

In consultation with PSB, it is recommended that the MIDD fund establish a reserve policy of 60 days of expenditure. PSB's reserve analysis concluded that revising the MIDD Fund's reserve policy to 60 days of expenditure would ensure the reserve is adequate to mitigate the volatility of sales tax collections. This would also bring the MIDD fund's reserve into alignment with current County policies.

The effect of this recommendation will be an increase in the level of reserves. In order to achieve this higher level of reserves, it is recommended that at least $750,000 be allocated to the reserves annually, or $1.4 M per biennium.

Annual Allocation to Rainy Day Reserve: In order to achieve the higher level of reserves, it is

[30] These reserves set aside fund balance to minimize rate, fee or revenue increases needed in future years to provide the current level of service. For example, a fund that is primarily funded through central rate allocations can fund a rate stabilization reserve with excess contributions or with underexpenditures in order to limit the annual increases to inflation plus population growth. *Source: King County Fund Balance Reserve and Contingency Guidelines*

recommended that at least $750,000 be allocated to the reserves annually, or $1.4 M per biennium, until the target is met. The County may elect to allocate additional funds to the reserve when feasible.

As a result of the 2008 economic downturn, MIDD I was forced to cut funding to strategies, services, and programs due to deeply reduced sales tax revenue. Establishing and maintaining the Rainy Day Reserve will help the county preserve services as long as possible during the next economic decline.

Fund Balance: In instances where the MIDD Fund has under expended revenue and/or collected higher than planned for revenue, a fund balance is generated. When a fund balance exists for the MIDD fund, it is recommended that the funds be allocated in the following order:

1. Allocate funds for provider economic adjustments for following year-ensures adjustments can occur without reducing services or funding for existing initiatives (estimated to be 2.5 percent and 2.6 percent in 2017 and 2018 respectively)

2. Allocate funds to the Emerging Issues initiative to $650,000 annually; and,

3. Allocate to the Rainy Day Reserve up to $750,000 annually until the 60 days of expenditure level is met.

Over the course of MIDD I, the MIDD Oversight Committee utilized subcommittees and work groups to inform its financial recommendations to the Council and Executive. Most recently in 2015, the MIDD Oversight Committee created an ad hoc work group to generate recommendations for potential use of MIDD fund balance for the Council and Executive to consider during supplemental budget processes. It is recommended that the county continue to utilize MIDD Oversight Committee workgroups/subcommittees when fund balance remains after applying it as outlined above[31].

Adding, Deleting, or Modifying MIDD Initiatives, Strategies, Services, and Programs or Initiatives

Ordinance Component	SIP Recommendations
Identified processes and procedures to add, delete or modify MIDD strategies, services and programs, including specifying how and when the MIDD oversight committee is to be engaged in the recommendations (lines 167-169)	1. Use updated MIDD I revision processes for modifying or adjusting MIDD initiatives, strategies, services, and programs. 2. Utilize Emerging Issues initiative to support emerging services and programs for up to two years.

The MIDD initiative revision processes outlined below will ensure that revisions of MIDD funded

[31] In general, the charge of the Fund Balance workgroups/subcommittees is to develop recommendations on the use of the MIDD fund's undesignated fund balance. In turn, the FBWG recommendations are considered, approved, amended, or rejected by the MIDD Oversight Committee. Approved recommendations are subsequently forwarded to the King County Executive and Council for potential inclusion in 2016 budget supplementals.

initiatives, strategies, services, and programs are communicated clearly to MIDD providers, policymakers, and the MIDD Oversight Committee. The processes also specify how and when the MIDD Oversight Committee is to be engaged in recommended changes. The modifications to the MIDD I strategy revision process, along with other improvements to the operations of the MIDD Oversight Committee, provide the means to transparently share information and develop recommendations regarding changes or additions to MIDD initiatives, strategies, services, and programs.

Modifications to MIDD I Strategies: In March of 2009, a process to modify strategies, services, and programs was established for MIDD I. It was reviewed and discussed by the MIDD Oversight Committee in March 2009. The process outlined when revisions were to be brought before the Oversight Committee for review and discussion and when revisions could occur at the discretion of the division. Three thresholds were identified that triggered when strategy revisions were to be brought to the MIDD Oversight Committee for consultation, review, and comment. They were:

- A proposed change of funding of 15 percent or more
- A proposed elimination of a strategy
- Changes to provider resources/processes/funding methodology/FTE/RFP or contract processes.

When one of the thresholds was met, the suggested revision was brought to the Oversight Committee to conduct a review of the request. For example, in 2011, expansion of the Regional Mental Health Court under Strategy 11b was brought to the OC to create a pilot program for Veterans. In 2012, the revisioning of Strategy 1f Parent Partners Family Assistance underwent Oversight Committee review, as well as changing services at Adult Drug Court (Strategy 15a) from young adult wraparound to transitional housing resources. The Committee's review included analysis and vetting of the requested changes and taking public comment. If approved by the MIDD Oversight Committee, the change was made and was reflected in the MIDD annual reports.

In the instances when the threshold criteria for MIDD Oversight Committee review were not met (i.e., the change was less than 15 percent in funding, a strategy was not eliminated, nor a change to resources, processes, FTE, etc.), the change was made and reflected in the annual and quarterly reports. This process was used frequently in the first few years of MIDD I as strategies were evolving. For example, in 2010, a project with the University Of Washington School Of Social Work was piloted to allow students perusing Masters' degrees to jointly earn their chemical dependency professional certificate. Over time, as strategies matured, fewer modifications were required, and the process for modifying strategies was used less. Each annual report continues to include strategy revisions.

Recommended MIDD II Processes for Modifying Initiatives, Strategies, Services, and Programs: Building on the MIDD I revision approach, MIDD II will use the same approach to revisions process with some modification to one of the thresholds for clarity. The third type of threshold modification that would trigger a review by the MIDD Oversight Committee will be revised as shown below.

MIDD Strategy Revision Process

MIDD I Strategy Revision Process	MIDD II Initiative Revision Process
1. A proposed change of funding of 15 percent or more (increase or decrease)	No Change
2. A proposed elimination of a strategy	No Change
3. Changes to provider resources/processes/funding methodology/FTE/RFP or contract processes	Changes to Population served Outcomes or results Intervention Performance measures

Revisions to MIDD initiatives, strategies, services, and programs will be brought to the MIDD Oversight Committee for consultation, review, and comment when revisions meet one of three thresholds:

- A proposed change of funding of 15 percent or more (increase or decrease)
- A proposed elimination of a strategy
- Changes to:
    - Population served
    - Outcomes or results
    - Intervention
    - Performance measures

Similar to the revision process for MIDD I, in the instances when the threshold criteria for MIDD Oversight Committee review are not met in MIDD II (i.e., the change was less than 15 percent in funding, a strategy was not eliminated, nor changes to population served, intervention, outcomes, performance measures, etc.), the change will be made and reflected in the annual reports. Please see Appendix I for the MIDD II Initiative Revisions Process Flow Chart.

In addition to the formalized process above, BHRD staff will provide regular updates on all changes to MIDD initiatives to the MIDD Oversight Committee at least two times per year at Oversight Committee meetings. Additionally, BHRD staff and leadership will receive trainings on the revision process to ensure it is used appropriately.

New MIDD Initiatives: Given that MIDD is a limited resource that is proposed to be fully programmed, including the allocation of fund balances to reserves, it is not recommended that new, ongoing initiatives, strategies, services, and programs be added to the MIDD during the biennium. Should it be determined by BHRD and PSB that MIDD revenues greatly outpace projections for a sustained period, and that economic adjustments can continue for existing initiative providers, BHRD in collaboration with the MIDD Oversight Committee may elect to initiate a new initiative process. Such a process would follow a similar approach and methodology to the MIDD I Fund Balance Work Group (FBWG) and MIDD II New Concepts processes. The MIDD I FBWG, comprised of MIDD Oversight Committee members and county staff, reviewed financial and programmatic information and made recommendations to the Oversight Committee regarding services and funding. The New Concepts process for MIDD II was a structured, time limited invitation to suggest new ideas for MIDD II funding.

Emerging Issues: MIDD II is proposed to include an Emerging Issues initiative whereby certain programs or services can seek to be funded for up to two years by the MIDD II. As was done for certain MIDD I strategies, it is recommended that the MIDD Oversight Committee, in partnership with BHRD, develop criteria and processes for utilization of Emerging Issues funds. Among other criteria to be included:

- Allowable under RCW 82.14.460;
- Furthers the MIDD's continuum of care;
- Based on best or promising practices;
- Reflects a recovery oriented system of care; and,
- Demonstrates financial sustainability outside of MIDD revenues.

Emerging Issues Initiative Protocols

The MIDD initiative revision processes outlined above specify how revisions to MIDD funded initiatives, strategies, services, and programs occur and how and when the MIDD Oversight Committee is to be engaged in recommended changes. This section outlines protocols for utilization of the recommended Emerging Issues initiative of MIDD II.

The Emerging Issues initiative provides a flexible source of MIDD funds for certain items to be funded for a short term. The Emerging Issues initiative is not intended to be used as an ongoing source of funds for new MIDD II initiatives, programs, or services, because MIDD is a limited resource that is fully programmed, including the programming of fund balances.

The Emerging Issues initiative is modeled in part on the New Strategy reserve that was established early in MIDD I via Ordinance 16261. The purpose of the reserve was to support new strategies not provided for in the then current MIDD plan that would meet the established policy goals. Ordinance 16261 stated,

> *The council recognizes that the needs of the county's residents may change over time and that new and innovative mental health, substance abuse and therapeutic court programs and services are continually being developed and implemented across the country. Therefore, it is the policy of the county that the county's mental illness and drug dependency shall maintain flexibility to respond to the changing needs of the county's population as well as to accommodate new mental health, substance abuse and therapeutic court strategies and programs*[32].

The Ordinance tasked the MIDD Oversight Committee with proposing a new strategies process and schedule. The new strategies process approach was reviewed at the February 2009 MIDD Oversight Committee meeting and was included in the subsequent MIDD Annual Report that was transmitted to the Council. The new strategy process was never launched due to the economic downturn. MIDD strategies were reduced when sales tax revenues declined sharply.

[32] Ordinance 16261, lines 68-74

Emerging Issues Policies and Protocols: The following outline the key components of the proposed MIDD Emerging Issues initiative.

A. Emerging Issues funds are one time funds for one to two years. Emerging Issues funds would not be provided in an ongoing fashion for the concepts.

B. The Emerging Issues initiative would be budgeted and appropriated as an expenditure rather than as a reserve, which is not included in the appropriation level approved by the Council.

C. BHRD and the MIDD Oversight Committee would review requests for Emerging Issues funds, recommending to the Executive items to be funded from the Emerging Issues initiative, similar to the existing Fund Balance workgroup/subcommittee approach.

D. Emerging Issues schedule would be established so that at least one time a year Emerging Issues requests would be considered by the MIDD Oversight Committee.

E. How and whether programs supported by Emerging Issues funds are evaluated will be included in the MIDD II evaluation framework that is planned to be transmitted to the Council in 2017.

F. A MIDD Oversight Committee workgroup will be established to develop and review criteria and operational details of the Emerging Issues initiative in collaboration with BHRD staff.

The proposed MIDD Emerging Issues initiative recognizes that unexpected behavioral health needs in King County occur. It positions MIDD funds to be deployed in a targeted way to address such issues. The policies and protocols for the proposed Emerging Issues initiative provide a thoughtful and transparent approach to accessing the funds based on MIDD Oversight Committee expert review and recommendation.

Proposed Schedule for Reporting

Ordinance Component	SIP Recommendations
A proposed schedule for reporting to the council, at least annually, on progress and performance of the MIDD funded strategies, services and programs (lines 131-133)	1. Revise data collection periods to January to January fiscal/calendar year. * 2. Revise annual report due date to the Council to August.* 3. Launch web data dashboard.

Reporting on the progress of MIDD towards meeting the established policy goals is a vital aspect of MIDD that must continue with MIDD II. Reporting is the chief mechanism to share the growth and evolution of MIDD or highlight its challenges. The recommendations included in this section are based on internal and external stakeholder feedback and are intended to streamline and make more efficient the reporting processes for providers and the county.

Recommendations 1 and 2 are linked, as explained below, and intended to be enacted together.

1. **One annual report transmitted to the Council in August:** Ordinance 15949 established the annual report due date to the King County Council as April 1 each year. Moving the due date to August enables the following recommendation to move forward.

   Another key element of this recommendation is based in feedback from the Oversight Committee regarding its review of the MIDD evaluation reports. Some members expressed a desire to spend more time in meaningful review and discussion of the report and its data before it is finalized for transmittal to the Council. In order to accommodate this request, additional time is needed for the Committee to conduct its review.

2. **Revise data collection periods to January to January fiscal/calendar year.** The current data collection period for MIDD I strategies is October 1-September 30 each year, with the MIDD annual report due to the Council on April 1[33]. The MIDD I data collection timeline was established to enable the preparation and analysis of data to meet the April 1 timeline. As experienced over eight years of MIDD I evaluation work, it requires several months to gather, clean, prepare and analyze data for MIDD evaluations. This is due in part to the sheer quantity of data, in part due to the quality of data, and in part to the methodology that providers use to submit their data[34].

Changing the data collection period would align the MIDD data collection cycles with other entities' (local, state, federal, philanthropic) for providers, making it easier and more efficient for them to provide data. It would necessitate a revised due date for the annual report, as recommended above to be August.

3. **Launch web data dashboard.** This recommendation also stems from MIDD Oversight Committee and stakeholder feedback to have more readily accessible and updated MIDD data available. It is also related to recommendations to improve data infrastructure from the PSB Evaluation Assessment Report that was a component of the MIDD I Comprehensive Historical Review and Assessment Report[35]. This recommendation also aligns with Best Starts for Kids which is considering a similar dashboard.

Fulfilling this recommendation will take time and resources, due in part because collaboration with internal county stakeholders (such as IT) and external (such as providers) is vital.

All annual reports for MIDD II will contain the following information:

- performance measurement statistics and updated performance measurement targets;
- service and program utilization statistics;
- request for proposal, revenue and expenditure status updates;
- an updated financial plan showing current year revenue and expenditure

[33] Ordinance 15949

[34] Recommendations on improving the MIDD II evaluation approach were included in the Comprehensive Historical MIDD I Report that was submitted to the Council on June 30.

[35] See recommendation III A-E in the Comprehensive Historical MIDD I Report.

- projections, along with adopted and actual expenditure, revenue and reserves identified; and
- recommendations on program and/or process changes to the initiatives and the rationale for the recommendations.

Recommended Modifications to the MIDD Oversight Committee

Ordinance Component	SIP Recommendations
Review and confirm or recommend modifications to the purpose, role, and composition of the MIDD Oversight Committee (lines 167-169)	1. Maintain role as advisory body to the Executive and Council.* 2. Revise membership to reflect changed organizations, boards, or entities.* 3. Add four new member seats.* 4. Create Consumers and Communities Subcommittee. 5. Initiate an array of operational improvements. 6. Change the name of the MIDD Oversight Committee to the MIDD Advisory Committee.*

**Items marked with "*" require legislative action to change.*

Background: In April 2008 the King County Council adopted Ordinance 16077 which established the MIDD Oversight Committee and identified the role of the Committee as an advisory body to the King County Executive and the Council. Ordinance 16077 states,

> The purpose of the oversight committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative. The committee reviews and comments on quarterly, annual and evaluation reports as required in Ordinance 15949. It also reviews and comments on emerging and evolving priorities for the use of the mental illness and drug dependency sales tax revenue. The oversight committee members bring knowledge, expertise and the perspective necessary to successfully review and provide input on the development, implementation and evaluation of the tax funded programs.
>
> The oversight committee should: promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts and groups.
>
> Recognizing that King County is the countywide provider of mental health and substance abuse services, the committee should work to ensure that access to mental health and

chemical dependency services is available to those who are most in need throughout the county, regardless of jurisdiction[36].

As outlined by Ordinance 16077, members of the Oversight Committee are appointed by the Executive and confirmed by the Council. Committee member terms are staggered in accordance with K.C.C. 2.28.010.C. The Committee appoints two co-chairs, rules in 2008, one from county government and one from the community.

The MIDD I Oversight Committee is comprised of the following entities as required by Ordinance 16077. King County government seats are noted with "*".

MIDD Oversight Committee Members

1. *The Council;
2. *The Executive;
3. *The Superior Court;
4. *The District Court;
5. *The Prosecuting Attorney's Office;
6. *The Sheriff's Office;
7. *The Department of Public Health;
8. *The Department of Judicial Administration;
9. *The Department of Adult and Juvenile Detention;
10. *The Department of Community and Human Services;
11. The King County Mental Health Advisory Board;
12. The King County Alcoholism and Substance Abuse Administrative Board;
13. A provider of both mental health and chemical dependency services in King County;
14. A provider of culturally specific mental health services in King County;
15. A provider of culturally specific chemical dependency services in King County
16. A provider of domestic violence prevention services in King County;
17. A provider of sexual assault victim services in King County;
18. An agency providing mental health and chemical dependency services to youth;
19. Harborview Medical Center;
20. The Committee to End Homelessness in King County;
21. *King County systems integration initiative, which is an ongoing work group established by the executive for addressing juvenile justice matters;
22. The Community Health Council;
23. Washington State Hospital Association, representing King County hospitals;
24. The Suburban Cities Association;
25. The city of Seattle;
26. The city of Bellevue;
27. Labor representing a bona fide labor organization;
28. *The Office of the Public Defender;
29. The National Alliance on Mental Illness; and
30. A representative from a public defender agency that the county contracts with to provide services.

[36] Ordinance 16077, lines 34-51.

Please see Appendix B for a list of MIDD Oversight Committee members as of June 2016.

Recommendations: Most of the recommendations included in this section were generated by Oversight Committee members during committee meetings where specific feedback on role and composition was sought, during other meetings, or through 1-on-1 interviews. Some components of the recommendations were generated from community engagement activities or other feedback mechanisms used by the county during MIDD renewal work. These recommendations were reviewed and revised by the Oversight Committee and/or the Oversight Committee's Strategy Team. Details of the recommendations for the role and composition of the MIDD Oversight Committee are described below.

Maintain role as advisory body to the Executive and Council.
The members of MIDD Oversight Committee provide essential advice and input to King County policymakers on matters involving the MIDD. Each member brings their individual and systems wide experience and knowledge to the MIDD Oversight Committee table to inform discussions and develop recommendations for policymakers. This crucial role is proposed to continue into MIDD II.

The Oversight Committee should continue to promote coordination and collaboration between entities involved with MIDD programs; educate the public, policymakers and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts and groups.

While the ordinance-established role of the Oversight Committee is not proposed to be changed, *how* the Oversight Committee functions and *what else it can accomplish* within its role and with its unique array of leaders from the behavioral health, physical health and criminal justice systems will evolve with MIDD II. Based on strong feedback from Oversight Committee members, particularly those who participated in the MIDD II planning work on MIDD II Briefing Paper Review Panels, the Oversight Committee is envisioned to leverage its position to move systems forward and collaboratively resolve issues. System stakeholders can utilize MIDD to work collectively to explore and align solutions to complex problems. Specific areas and tasks that the Oversight Committee will engage on during MIDD II include:

- Engaging in intentional and deep systems discussions that inform, initiate, innovate, and enhance outcomes for those served
- Creating a "well connectedness" of systems
- Emphasizing community engagement and two way information sharing
- Building trust and credibility, particularly in communities of color or other marginalized communities
- Developing a deeper understanding of MIDD II initiatives, data, and evaluation approaches.

Other operational improvements related to the MIDD Oversight Committee are outlined at the end of this section.

Revise membership to reflect changed organizations, boards, or entities.
Since its inception in 2008, some of the various entities named in the Oversight Committee's organizing ordinance have evolved and changed. The following revisions are recommended to the composition of

the MIDD Oversight Committee along with the basis for the recommended change.

MIDD I Oversight Committee Seat	Recommend Revision to MIDD II Oversight Committee	Basis of Change
• King County Mental Health Advisory Board • King County Alcoholism and Substance Abuse Administrative Board	A. Eliminate seat for dissolved board B. Eliminate seat for dissolved board C. Establish one seat for King County Behavioral Health and Recovery Board Net change: -1	On April 1, 2016, King County's mental health and substance use disorder services systems were integrated into one seamless, managed care treatment system as required by state legislation (2SSB 6312). The formerly separate King County Mental Health Advisory Board and the King County Alcoholism and Substance Abuse Administrative Board were merged into one Behavioral Health and Recovery Board.
A representative from a public defender agency that the county contracts with to provide services	Eliminate seat for this entity; Public Defense is represented by existing Office of Public Defense seat Net change: -1	In 2013, King County established the Department of Public Defense (DPD) as a charter-created department within county government and transitioned from a public defense system in which the county contracted with four defender organizations to provide defense services. Defense services are provided by DPD and the county no longer holds contracts with defender agencies.

These changes result in the opportunity to repurpose two of the 30 MIDD Oversight Committee seats as recommended below.

While some input was received suggesting that the number of King County government seats on the committee be reduced, it is important to recognize that each King County government seat represents a key system element. Thus, maintaining the 11 King County government seats ensures the necessary representation to conduct intentional and deep systems discussions that inform, initiate, innovate, and enhance outcomes for those served, creating a "well connectedness" of systems that was also called for by community input. Other input stated that no specific King County government member should be eliminated, but that "equalizing" was needed. Please note that just over one third of the committee seats are King County government seats (11 out of 30); with the addition of more seats, the ratio of community to government seats would be even greater than the current 2:1 community to government seats.

Among the changes to be made to the MIDD Oversight Committee, several organizations have changed their names which require updating the ordinance established member list including:

- Suburban Cities Association is now Sound Cities Association

- Committee to End Homelessness is now All Home
- Office of the public defender is now Office of Public Defense

Add four new seats to the Oversight Committee.
Throughout the course of MIDD II planning, Oversight Committee members recognized and articulated the need to have additional perspectives represented on the committee. From the committee's establishment of Values and Guiding Principles in March 2015 to its explicit feedback on the roles and composition of the committee in January and March of 2016, members have been exceedingly clear about the need to have MIDD II intentionally informed by the voices and experiences of consumers, youth, immigrants and refugees, the faith community, and specific cultural populations.

The recommended additions to the MIDD Oversight Committee are also driven by the County's Equity and Social Justice Agenda which finds that race, place, and income impact quality of life for residents of King County and people of color, and those who have limited English proficiency and/or low-incomes persistently face inequities in key educational, economic, and health outcomes. These inequities are driven by an array of factors including the tax system, unequal access to the determinants of equity[37], subtle but pervasive individual bias, and institutional and structural racism and sexism. These factors, while invisible to some, have profound and tangible impacts for others, particularly those who also may be living with behavioral health conditions and experiencing criminal justice involvement.

With this in mind and based on the guidance of the MIDD Oversight Committee, the county recommends the following entities be added to the MIDD Oversight Committee.

Recommended Additional Seats to MIDD Oversight Committee

Focus or Population	Specific Entity
Consumers & Communities – 2 Representatives	Elected from Consumers and Communities Subcommittee
Recovery	Washington Recovery Alliance
Education	Puget Sound Educational Services District
Philanthropy	Many Minds Collaborative
Managed Care	Medicaid Managed Care Plans

Each of the recommended additions to the composition of the MIDD Oversight Committee is intended to enrich and deepen the advice and guidance provided by the Committee to the King County Executive and Council. The added seats expand the expertise around the table and strengthen system connections. The following details the basis of the recommended additions.

A. *Establish Consumers and Communities Subcommittee – 2 Representatives from Subcommittee Appointed to MIDD Oversight Committee*
After much discussion with subject matter experts (including specific feedback during the

[37] http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2015/The_Determinants_of_Equity_Report.ashx?la=en

community engagement process), individual MIDD Oversight Committee members, and building off of the learnings from recent efforts that included consumers and communities, the county recommends establishing a standing Consumers and Communities Subcommittee of the MIDD Oversight Committee. The subcommittee would be comprised of individuals with lived experience of the behavioral health system (consumers) and individuals who are a part of communities with marginalized identities or experiences, including but not limited to:

- Trans
- Youth
- Immigrant/Refugee
- African American
- Asian/Pacific Islander
- Hispanic
- Rural
- Faith
- Peers

Consumer inclusion is called for in King County's adopted Recovery and Resiliency Oriented Behavioral Health Services Plan 2012-2017.

This recommendation reflects several key principles of community engagement, including the "nothing about us, without us" concept, where the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy. It further recognizes that no one person should be asked to speak for an entire population or experience, particularly in an environment where lay people are sharing decision- or recommendation-making platforms with those who have significant positional authority, such as elected officials.

Given the number of communities identified as needing a voice in MIDD, and because there are many diverse lived experiences involved with behavioral health, an additional 12-20 consumer and community positions to the MIDD Oversight Committee would be required. An Oversight Committee of 50 or more would not be feasible to operate as the MIDD Oversight Committee has operated, and more so given the operational improvements planned; therefore, the recommendation to establish a Consumers and Communities Subcommittee balances the need to enable a greater number of experiences and perspectives to be brought forward to the Oversight Committee with efficiency and effectiveness of operation.

One of the chief barriers to ongoing and meaningful consumer and community participation is the expectation that individuals will donate their time to participate and advise. Unlike separately elected or other city or county officials, or executive directors of behavioral health organizations whose jobs include participation with MIDD, community members' time has not been considered for compensation. A notable component of the Consumers and Communities Subcommittee is that subcommittee members will be paid for their participation, similar to the current Familiar Faces Advisors model. Following contracting protocols, BHRD will contract with subcommittee members for up to $5,000 annually for their participation on the subcommittee. This is reflective of the

County and MIDD II's commitment to enacting principles of social justice and equity.

It is currently envisioned that the subcommittee will have between 12-20 members, with at least half to be people with lived experience as a consumer of behavioral health services. The subcommittee members will be given extra support and preparation to help them fulfill their duties. The charter of the subcommittee, along with other processes including identifying members of the subcommittee, will be developed by BHRD in collaboration with the MIDD Oversight Committee. It is expected that the subcommittee will begin meeting at the beginning of the second quarter of 2017.

Two Consumers and Communities Subcommittee members would be recommended to serve as full members of the MIDD Oversight Committee, subject to the existing appointment and confirmation process.

B. *Recovery*

Recovery from mental health and/or substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to achieve their full potential[38]. The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. "Fundamentally, recovery is not a practice; it is a culture. It is not as much what you do, but how you do it. Recovery focuses on values and meaning more than on behaviors."[39]

In 2013 Ordinance 17553, King County established that the principles of recovery are foundational to behavioral health services, thus adding a recovery seat to the MIDD Oversight Committee further enacts the vision of recovery as outlined in Ordinance 17553. Bringing the perspective of recovery to the MIDD Oversight Committee will further embed recovery into the work of the MIDD and help ensure that recommendations from the MIDD Oversight Committee are infused with recovery principles such as trauma-informed care.

Oversight Committee feedback stated that coalitions and alliances representing a group of entities should be considered when possible, rather than individual entities. This would enable broader involvement than one individual or entity. In keeping with that charge, it is recommended that the recovery seat be established for the Washington Recovery Alliance[40]. The Washington Recovery Alliance is a group of organizations and individual from across Washington State that educates, promotes, and advocates for recovery issues.

C. *Education*

Bringing a representative of the education domain to the MIDD Oversight Committee provides another connection to children, youth, and families served by MIDD and the other systems represented by MIDD Oversight Committee members. Early identification of social, emotional, and behavioral problems in children often happen in schools. Schools are critical in linking youth and

[38] https://www.mentalhealth.gov/basics/recovery/index.html
[39] King County Recovery and Resiliency Oriented Behavioral Health Services Plan 2012-2017, pg. 10; attachment A to Ordinance 17553
[40] https://washingtonrecoveryalliance.org

families with crisis support, respite care, case management, counseling, and behavioral health interventions. Schools are directly connected to MIDD via prevention, intervention, treatment, and crisis services, so creating a seat for the education domain is a natural evolution of MIDD.

D. *Philanthropy*

King County has become proficient at braiding funds to create a system of care; between state, federal and local resources a continuum of care from early intervention/prevention to crisis services has been created and is demonstrated through MIDD II. Despite the County's best efforts, gaps remain. The philanthropic community has become an important community partner to advance the public behavioral health system. The Many Minds Collaborative is partnering with King County to research, assess and document the public mental health landscape in King County. That work has grown into early catalytic investments in proven behavioral health programs. Their investments demonstrate commitment to improving the behavioral health system and rationale for participation in the MIDD Oversight Committee.

E. *Managed Care*

As King County is moving toward addressing the question of what form "full" integration of behavioral and physical health care will take, it is clear that whatever the answer, Managed Care Organizations (MCOs) will have some kind of role. In recognition of the future role that MCOs may have with full integration[41], it is recommended that a seat on the Oversight Committee be held by the MCOs. Following the approach that the King County Accountable Community of Health Interim Leadership Council outlined in its charter,

> Two people from different organizations may co-hold a seat, for purposes of assuring adequate sector representation and participation in meetings. For Medicaid managed care plans, all plans under contract with the Washington Health Care Authority are invited to participate. In cases where there is more than one representative from a sector, each sector would constitute one "vote" in decision making[42].

This recommendation was not uniformly supported by all members of the MIDD Strategy Team where it was reviewed and discussed prior to being included in this Service Improvement Plan. Some MIDD Oversight Committee representatives on the Strategy Team articulated grave concerns about inviting the MCOs to participate on the Oversight Committee. Questions were raised regarding whether MCOs could serve individuals and communities most in need while being a for profit entity. Alternatively, some articulated that involving MCOs in the deep systems discussions around behavioral health and the criminal justice systems could help them better understand the needs, populations, and services touched by MIDD and the behavioral health system.

In the spirit of inclusivity and in order to further develop the behavioral health system across sectors, it was determined that the benefits of inviting the MCOs to the MIDD Oversight Committee are notable.

[41] A more in-depth discussion of integration of behavioral and physical health care takes place on pages 62-64 of this report.
[42] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/~/media/exec/HHStransformation/ACH-Charter.ashx , page 4.

Other suggestions for additional member seats were made over the course of the last year that are not included in these recommendations. The additional seats that are recommended to be included represent key system voices that bring a needed perspective to the Committee and its advisory role. It is important to remember that holding a seat on the Oversight Committee is not the only way to participate with MIDD. All MIDD Oversight Committee meetings are open to the public and public comment will continue to be included in each meeting.

Initiate an Array of Operational Improvements: In collaboration with the MIDD Oversight Committee, BHRD is planning a number of operational improvements involving or related to the MIDD Oversight Committee. The majority of these activities are based on feedback and suggestions from Oversight Committee members, while some are based on lessons learned from staffing the MIDD Oversight Committee over time. They are intended to support the systems-spanning work requested by committee members to inform the review and recommendation functions of the MIDD Oversight Committee.

Type of Improvement	Details
1. Alignment & Collaboration	• Co-convene an annual King County Boards and Commissions Summit with Children and Youth Advisory Board, Veterans and Human Services Levy boards, Behavioral Health and Recovery Board and others to jointly engage in planning, data sharing and review, and to coordinate and align work • Explore development of Executive Committee of board co-chairs to ensure ongoing alignment of respective committee work and outcomes
2. Training & Education	• Hold annual Oversight Committee retreat to develop annual work plan, create cohesion and shared understanding of role and objectives • Develop and implement training program that may include such matters as: o Trauma and trauma-informed care o Anti-racism o Cultural sensitivity o Evaluations and data o The involuntary court process o How treatment courts work & their outcomes • Conduct new member orientation for each new committee member within two months of appointment and one annual refresher meeting for existing members • Members representing coalitions or groups will be asked to make an annual presentation on their group and how information is shared and gathered
3. Operational & Logistical	• Utilize Oversight Committee workgroups and/or subcommittees to inform the design and development of key MIDD II deliverables such as Implementation Plan, RFPs, and Evaluation Framework • Create evaluation subcommittee to work with MIDD evaluation team on MIDD data and analysis • Hold at least one Oversight Committee meeting per quarter in the

	community, at times and locations that enable wider community participation, with interpretation and childcare available

Change the Name of the Oversight Committee.
Reflective of the established duties and functions of the Committee that are recommended to continue to MIDD II, it is recommended that the name of the Committee be amended to reflect its duties as an advisory body: The MIDD Advisory Committee.

Generally, an oversight body has the capacity to make final decisions or substantive decisions which the current committee does not. Rather, as an advisory body, the committee makes recommendations to the Executive and the Council. This change would clarify the role of the committee both to members and other stakeholders.

Executive staff have consulted with the Prosecutor's Office on this matter and no potential legal issues were raised.

The MIDD Oversight Committee is recommended to continue as an advisory body comprised of leaders who represent an array of systems, populations, and experiences. Its membership is deliberately constructed to bring the knowledge, expertise, and perspectives needed to review and provide input on the development, implementation and evaluation of the MIDD as a whole. The Oversight Committee is also uniquely positioned to leverage the opportunity to engage in deeper, more meaningful behavioral health and criminal justice systems discussions to create innovation and enhance outcomes for individuals served by MIDD. The MIDD Oversight Committee should also be utilized as a forum to create a "well connectedness" between systems, build trust and credibility, particularly with communities of color or other marginalized communities, and resolve systems issues to move whole person care forward.

Evidence Based, Best, and Promising Practices - Goals and Principles of Recovery and Resiliency

The proposed MIDD Service Improvement Plan strategies, services, and programs shall: demonstrate that they are based on best or promising practices for chemical dependency or mental health treatment programs and services and that they incorporate the goals and principles of recovery and resilience within a trauma-informed framework, as specified by K.C.C, chapter 2.43 and King County's adopted behavioral health system principles set out in Ordinance 17553 (lines 143-151)

Evidence, Outcomes, and Accountability: Accountability for achieving results is a major policy driver and as such, a significant element of the development of MIDD II recommendations. One way to achieve results is to support programs that have been shown to be effective. This section describes the categories of practices and how those practice categories are reflected in the recommended MIDD II initiatives. Programs supported by MIDD funds are expected to show evidence that they advance the MIDD policy goals.

Ordinance 17998 specifically addressed the use of evidence for determining MIDD II's strategies,

services, and programs, including basing them on "best or promising practices"[43] . Through the course of MIDD renewal, in part driven by the Values and Guiding Principles for MIDD established by the MIDD Oversight Committee, and in part due to community feedback, BHRD added the category of Emerging Practices to the array of practice considerations for MIDD II concepts. It was determined important to include Emerging Practices in the consideration of MIDD programming due to limitations of more rigorous, research-based practices for marginalized communities. Subject matter experts and community engagement participants communicated that research is often conducted with mainstream participants and results may not be valid or reliable for communities of color or other marginalized groups. Additional information on the use of Evidence Based Practices is included in a discussion of Social Justice and Equity on page 61 of this report.

The established categories of practices are known as Emerging, Best, Promising, and Evidence-Based Practices. The categories are described below:

- *Emerging Practices* are those not based on research results "but for which anecdotal evidence and professional wisdom exists. These include practices that practitioners have tried and claimed effectiveness. Emerging practices also include new technologies that have not yet been researched."[44]

- *Promising Practices* are those developed based on theory or research, but for which an insufficient amount of research results "have determined the effectiveness of the practice. If a study uses a weak design resulting evidence is categorized as promising." [45]

- *Best Practice*s are those that have "been shown by research and experience to produce optimal results and that [are] established or proposed as a standard suitable for widespread adoption."[46]

- *Evidence-Based Practices* are those for which research has been used "to determine the effectiveness of the practice. The research utilizes scientifically-based rigorous research designs (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research)." [47]

A key facet of the review and consideration of new MIDD concepts and existing programs was analysis of evidence that pointed to inclusion of a program into MIDD II. As outlined in the **MIDD II Evidence Practice Type (Appendix J)**, each proposed MIDD II initiative, whether previously supported by MIDD I or new to MIDD, identifies a specific practice type.

Incorporating the Goals of Recovery and Resiliency within a Trauma-Informed Care Framework: Building on research, practice, and the lived experiences of individuals in recovery from mental and/or

[43] Ordinance 17998, line 147.
[44] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc
[45] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc
[46] http://www.merriam-webster.com/dictionary/best%20practice
[47] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc

substance use disorders, the MIDD will use the following working definition of recovery developed by the Substance Abuse Mental Health Services Administration (SAMHSA): A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. "Recovery" means a process in which an individual achieves management of the individual's symptoms and regains or develops sufficient skills and autonomy to enable the individual to live, work and participate fully in the community. "Resiliency" means an innate capacity that empowers people across the life span to successfully meet life's challenges with a sense of self-determination, mastery and hope. "Trauma-informed framework" means an approach to engage an individual with a history of trauma that recognizes the presence of trauma symptoms and acknowledges the impact that trauma has had on the individual's life.

Overarchingly, the proposed MIDD II initiatives promote and support people in all phases of their recovery, analogous to the behavioral health continuum of care reflected in the MIDD II Framework. The proposed MIDD II initiatives work tougher and with the broader health and human services and criminal justice systems to provide opportunities for people involved with the behavioral health system to realize their full potential.

The Sequential Intercept Model in MIDD II

Describe how they will integrate and expand the application of the federal substance abuse and mental health services administration sequential intercept model that addresses the criminalization of mentally ill individuals (lines 152-154)

The strategies that made up MIDD I were first developed by several community workgroups using the Sequential Intercept Model as a framework to determine what services needed to be provided for which people at what locations in order to help prevent incarceration, hospitalization, and homelessness. This model is in use today by a number of communities across the nation as an action blueprint for planning system change in the way that communities address the problem of people with mental illness in their criminal justice systems.

King County further adapted the organizing principles of this model to include people who may have no mental illness but who are at risk for criminal justice involvement due to substance use, and to include diversion from emergency medical services as another priority. These principles remain in place for MIDD II and the initiatives recommended to be funded by MIDD II.

The recognition that the greatest opportunities for diversion exist when individuals are still in the community, and that diversion options decrease as individuals move through the criminal justice system, is reflected throughout MIDD II. While MIDD I articulated the importance of prevention services, early assessment and intervention, and comprehensive and integrated community-based services, MIDD II furthers this understanding by grounding the MIDD II initiatives in the continuum of care as reflected by the MIDD II Framework. As with MIDD I, MIDD II is devoting considerable resources to supporting a community services system that will serve to divert many individuals from the criminal justice and emergency medical systems while also providing the infrastructure needed to help people who have entered these systems rejoin the community in a safe and effective manner.

Through the MIDD programs, individuals with behavioral health needs will be linked to services designed to help them become stable and productive, and prevent unnecessary incarceration and hospitalization. The MIDD II Strategy Areas reflecting the behavioral health continuum of care are:

- **Prevention and Early Intervention -** *People get the help they need to stay healthy and keep problems from escalating*

- **Crisis Diversion -** *People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*

- **Recovery and Reentry -** *People become healthy and safely reintegrate to community after crisis*

- **System Improvements -** *Strengthen the behavioral health system to become more accessible and deliver on outcomes*

Together, the MIDD II initiatives will result in improved quality of life for people with mental illness and chemical dependency and their families throughout King County. The Sequential Intercept Model is shown in Appendix A.

Equity & Social Justice in the Implementation of MIDD II Programs

Demonstrate that they will reflect the county's existing adopted policy goals included in the Equity and Social Justice Initiative and Strategic Plan (lines 155-156)

Equity and Social Justice is a key initiative in King County and is critical to the implementation of the Service Improvement Plan for MIDD II. Moreover, guided by the Values and Guiding Principles for MIDD developed by the MIDD Oversight Committee that emphasized social justice and equity, the planning and development of MIDD II was conducted with a deep focus a social justice and equity[48].

Below is a list of several key principles that MIDD II considers in the procurement, contracting, training, and/or implementation of programs supported by MIDD II. Appendix K includes an equity tool that will be used as help guide and inform system improvement/system change processes related to MIDD II.

Culturally Responsive and Informed: The U.S. Department of Health and Human Services (HHS) Office of Minority Health has released *The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care,*[49] which provides some guideposts for providers of behavioral health services to align with the populations they serve and ensure that services are culturally responsive and informed. In the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities,*[50] several strategies directly relate to the provision of care management teams, including *reduce disparities*

[48] See page 27 and Appendix C for more information on MIDD II planning community engagement efforts.
[49] https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards.
[50] U.S. Department of Health and Human Services. *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care***.** Washington, D.C.: U.S. Department of Health and Human Services, (April 2011).

(strategy I.B.[51]) in access to primary care services and care coordination, which focuses on migrant workers, people experiencing homelessness and residents of public housing. Using such models as community-based health teams (e.g. health home model) are recommended to establish agreements with primary care providers and other health care providers to improve care coordination. Another HHS Action Plan strategy (II.C.3[52]) calls for an increase in the diversity and cultural competency of clinicians, including behavioral health workers. This guidance provides an opportunity for King County to implement MIDD II with a heightened emphasis on serving the County's most marginalized populations, and align with national best practices on care coordination and treatment services that are culturally responsive and informed.

It is the intent of King County that services provided under MIDD II be **culturally responsive** and **culturally specific**. Enacting this intention requires the willingness of both providers and King County to acknowledge historical and cultural trauma as sources of substance use and other behavioral health conditions and the willingness to do business differently to serve people in culturally responsive and specific manners. MIDD-supported direct services should address individual level discrimination that those served encounter in their daily lives by recognizing institutional and structural racism, classism, and ableism.

Community-based agencies providing culturally specific and culturally responsive behavioral health, primary care and reentry support services will be sought to provide these services under MIDD II. Addressing trauma as a result of both interpersonal violence and childhood experiences as well as historical and cultural trauma will be critical for serving the individuals served by publicly-funded behavioral health services. MIDD II providers should explore and implement the use of alternative interventions which are culturally informed, such as substance use disorder treatment for historically disempowered communities,[53] which may yield more meaningful treatment outcomes for marginalized populations.

Evidence-Based Practices and Equity: It is expected that whenever possible, evidence-based practices (EBPs) are to be embedded in the service continuum of MIDD II. Because most mental health/substance use disorder treatment EBPs are researched on predominantly mainstream/White populations, it is important to have a critical and continuous improvement lens to these behavioral health services to ensure that services are not perpetuating marginalization and negatively impacting those individuals being served, furthering their disenfranchisement. It is necessary that whenever possible, MIDD II use anti-oppressive practices to complement recovery oriented and person-centered approaches.

Harm Reduction: Where possible, MIDD II initiatives should employ a harm reduction model. Harm reduction activities "meet people where they're at", enabling individuals to access better health and human potential outcomes, irrespective of whether the individual engages in substance use. Harm reduction is a grass-roots and "user-driven" set of compassionate and pragmatic approaches to

[51] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed 12/28/15.
[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed 12/28/15.
[53] White, W. & Sanders, M. (2004). *Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities*. Posted at www.bhrm.org.

reducing substance-related harm and improving quality of life[54].

While there is no universal definition or formula for harm reduction given the multiple different interventions and policies designed to serve an individual in need of behavioral health services, there are key principles for harm reduction that MIDD II initiatives are encouraged to demonstrate such as:

- accepting the individual regardless of their behavior;
- understanding the complex continuum of behaviors while acknowledging that there are safer ways to engage in certain behaviors; and
- establishing quality of individual/community life and well-being as criteria for successful interventions.

Harm reduction is linked to social justice and equity because provision of services should be nonjudgmental, non-coercive and recognize the realities of poverty, class, racism, social isolation, past trauma, sex-based discriminations and all other social inequalities that affect an individual's vulnerability to, and capacity for, effectively changing behavior[55].

Serving Individuals Who Have Contact with the Criminal Justice System: Though the County is actively working to address over representation of individuals from non-white racial and ethnic groups, disproportionality currently exists in the County's justice system. When providing MIDD II services to people involved with the justice system, there is a need to ensure that an anti-oppressive practice lens is applied to the behavioral health services provided to non-white and other marginalized groups. MIDD II should provide or leverage the provision of culturally responsive and specific services and reentry opportunities.

Integration with the County's Policy and Planning Work

Demonstrate how they will expand, enhance, and integrate with the County's planning and policy endeavors such as, but not limited to, the Health and Human Services Transformation Plan, the Youth Action Plan, the Veterans and Human Services Levy, the Ten Year Plan to End Homelessness, and recommendations of the Task Force on Prevention, Early Intervention, and Least Restrictive Alternatives for Individuals in Mental Health and Substance Abuse Crisis (lines 157-162)

The MIDD II Framework explicitly conveys the expected linkage between MIDD II and other county and community initiatives. MIDD II is grounded in a collaborative approach to information sharing, evaluation, aligning of services, and braiding of funds.

As with MIDD I, the proposed MIDD II initiatives are expected to individually and as a whole advance/integrate with the County's planning and policy initiatives. For example, the proposed Youth Behavioral Health Alternatives to Secure Detention initiative is intended to link to and further the work of the Juvenile Justice Equity Steering Committee. School based services supported by MIDD II will align with BSK work. The proposed Multipronged Opioid initiative is planned to support recommendations from the Opioid Task Force. Proposed initiatives involving housing supports and resources for capital

[54] Collins, Clifasefi et al. 2011; Marlatt, 1998
[55] http://harmreduction.org/about-us/principles-of-harm-reduction/.

and rental assistance further the goals of the All Home[56] strategic plan. Elements of the county's Equity and Social Justice[57] strategic plan are reflected throughout the MIDD II, from how the MIDD II recommendations were determined, to the recommended revised composition of the Oversight Committee.

The MIDD II Implementation Plan that will be submitted to the Council in 2017 after adoption of the 2017-2018 MIDD II budget will include how each initiative will link to the County's policy and planning work.

Affordable Care Act and Behavioral Health Integration Opportunities

Demonstrate how they will leverage opportunities provided by the federal Affordable Care Act and the state's requirements for a single behavioral health contract with regional support networks as specified by Chapter 225, Laws of Washington 225 (lines 163-165)

Medicaid Expansion: One of the main goals of the Affordable Care Act (ACA) is to increase access to health care coverage for individuals. As a Medicaid expansion state, more individuals than ever are covered by Medicaid in Washington and in King County, allowing them to access and receive Medicaid covered physical, mental health and substance use disorder services. As such, Medicaid can now pay for more traditional outpatient and inpatient mental health and substance use disorder treatment services for a larger number of covered children, youth and adults. The increase in Medicaid eligible individuals and subsequent increase in Medicaid funding, allows King County to continue to direct MIDD II funding toward services that are not covered by Medicaid and/or individuals who remain uninsured to help build a robust continuum of care.

Behavioral Health Integration: A second goal of the ACA is to achieve the "Triple Aim" - improved care, improved outcomes, and reduced overall costs in healthcare services. One significant strategy to achieve this goal is through the integration of physical and behavioral healthcare. In 2014, Washington State legislature passed ESSB 6312 calling for the integrated purchasing of mental health and substance use treatment services (collectively behavioral health) for the Medicaid program through a single managed care contract by April 1, 2016. The previous, siloed system of Regional Support Networks (RSNs) and County Chemical Dependency Coordinators went away and were replaced by Behavioral Health Organizations (BHOs). BHOs are local entities at full risk and responsibility for providing the continuum of Medicaid funded inpatient and outpatient mental health and substance use disorder treatment services. On April 1, 2016, King County, through the Behavioral Health and Recovery Division, became the Behavioral Health Organization (BHO) for the region. Today, BHRD is able to braid together multiple funding sources including Medicaid, state general fund, mental health and substance use disorder block grant and MIDD dollars to ensure a comprehensive continuum of behavioral health services are available to clients in need.

MIDD II will support and leverage opportunities provided under the ACA and through implementation of

[56] Formerly the Committee to End Homelessness. The All Home strategic plan outlines steps end homelessness. http://allhomekc.org/the-plan/

[57] http://kingcounty.gov/elected/executive/equity-social-justice/strategic-plan.aspx

ESSB 6312 in a variety of ways, including

- Increasing access to behavioral health treatment for people with mental health, substance use, or co-occurring disorders;

- Supporting earlier interventions for people with mental illness and substance use or co-occurring disorders to prevent unnecessary use of jail, emergency rooms, avoidable hospitalizations, and crisis services;

- Supporting models of care that deliver or drive toward fully integrated physical and behavioral health care, a model known to improve overall health and social outcomes;

- Supporting the development and use of mechanisms that engage individuals with mental health, substance use and co-occurring disorders and link to comprehensive treatment through the King County Behavioral Health Organization (KCBHO);

- Enhancing the continuum of care offered through the KCBHO by providing services that are not Medicaid eligible or serving individuals who would not otherwise have insurance coverage; and,

- Serving as entry points to get people enrolled in Medicaid so that their physical and behavioral health care needs can be covered through the Medicaid program and the KCBHO.

Fully Integrated Managed Care: The 6312 legislation also called for full integration of mental health, substance use and physical health care by January 1, 2020. This includes aspects of both clinical integration and financial integration for the state Medicaid program. Today, Medicaid physical health care services are purchased through five Managed Care Organizations (MCOs) while Medicaid behavioral health services are purchased through regional BHOs. In King County the five MCOs are Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina, and United Health Care.

As the state moves forward with plans to fully integrate physical and behavioral health care, King County has significant decisions to make related to what the financial infrastructure for fully integrated managed care will be and what the optimal role of the county is in that model. King County is considering a number of potential options and working with community stakeholders and partners to identify the best path forward. The decisions King County makes regarding its future role in fully integrated managed care will significantly impact how and what programs are implemented under the MIDD and could require a complete retooling of the MIDD II programming.

Earlier this year, the Health Care Authority and the Department of Social and Health Services jointly issued a letter to counties identifying three potential timelines for moving to fully integrated managed care. Those options include a start date of: July 1, 2017; July 1, 2018; or January 1, 2020. King County is considering the 2018 and the 2020 options and will make recommendations in late 2016 or early 2017 to the King County Executive and Council regarding the recommended path forward and the optimal timeline for implementation based on the magnitude of change required and community readiness.

The implications of this decision for MIDD II could be significant regardless of what option King County chooses. For example, if King County selects an option that includes Managed Care Organizations (MCOs) having primary risk and responsibility for the full continuum of physical and behavioral health care for Medicaid eligible individuals through a single managed care contract with the state, the role of King County in the administration and delivery of behavioral health services related to Medicaid would shift to one of primary monitoring/oversight and assurance. This would require revisiting MIDD II investments in light of the county's revised role for behavioral health.

Research shows that fully integrated physical and behavioral health care achieves better outcomes for clients. As King County works to determine the optimal path to full integration for the region, the focus will be on keeping clients at the center of planning and ensuring a system care that provides the best experience, improves outcomes and reduces overall costs to the system. Once the decisions about the fully integrated managed care infrastructure and timeline for implementation are known, King County will need to revisit all MIDD II supported programs to evaluate them in relationship to the system transformation that will occur.

BHRD commits to sharing progress on this decision openly and frequently with policymakers and the MIDD Oversight Committee. There will be clear points of public comment established and the Oversight Committee and MIDD stakeholders will be invited to weigh in on the recommendations.

VI. Next Steps

This section acknowledges three specific next steps necessary for MIDD II: completion of the MIDD II Implementation and Evaluation Plans and a process to change the name of the MIDD. Each component will be developed collaboratively with the MIDD Oversight Committee and other stakeholders.

Components of the MIDD II Implementation Plan: Additional planning is needed for most of the new initiatives contained in the proposed MIDD II, many of them requiring community engagement components. For each MIDD II initiative, the MIDD II Implementation Plan will include[58]:

- Description of the initiative/program/services
- How the initiative advances the MIDD II policy goals
- Goal of the initiative
- Outcomes and performance measures
- Expected number of individuals served
- Provided by contractor or county
- Spending plan (based on adopted budget)
- Implementation schedule (for new initiatives)
- Procurement and contracting details
- Services start date (new)
- What community engagement will occur and when
- Other relevant information as directed by the Council or requested by stakeholders

The MIDD Oversight Committee was deeply involved in the development and review of MIDD I implementation plan documents. Similarly, it is expected that the Oversight Committee will play a significant role with the implementation planning for MIDD II that will occur in 2017.

Evaluation Plan: The MIDD I Evaluation Plan adopted by the Council in 2008 served as the blueprint for conducting the evaluation and assessment of MIDD. The MIDD I Evaluation Plan was developed in conjunction with the MIDD I Implementation Plan, after the individual MIDD I strategies were established in the Council adopted MIDD Action Plan. The MIDD I Implementation Plan specified how each MIDD I strategy would be executed and individual MIDD strategy implementation information was used to develop an evaluation approach for each program supported by MIDD funds. MIDD policy goals and strategies were linked to the results, which in turn provided a structure for identifying performance indicators, targets and data sources, and for collecting and reporting results[59].

A detailed MIDD II Evaluation Plan will be transmitted to the Council in 2017. In order to complete an Evaluation Plan for MIDD II, final MIDD II funding and programmatic decisions are needed, which are

[58] Please note that the Initiative Description Documents that are included in this Plan are not Implementation Plans. The information in these documents as will be revised to include updated policy goals, adopted budget, and community engagement plans and other required information. Implementation Plans will be reviewed by the MIDD Oversight Committee and stakeholders.

[59] The MIDD Oversight Committee reviewed and provided input into the development of the MIDD Evaluation Plan that was adopted by the Council, in accordance with Ordinance 15949. See the MIDD Evaluation Plan that is Appendix E to this report.

expected with adoption of the County's 2017-2018 biennial budget. Further, it is necessary to develop a MIDD II Evaluation Plan that is built on the recommendations contained in the MIDD Comprehensive Historical Assessment Report, which includes stakeholder involvement in the development of the MIDD II Evaluation Plan. See Appendix L for the MIDD evaluation recommendations. To the extent possible, DCHS will align its approach to MIDD II evaluation planning with evaluation planning for BSK. The MIDD II Evaluation Plan will contain most if not all of the same elements as called for in the MIDD I Evaluation Plan:

Requirements of the MIDD I Evaluation Plan

- Process and outcome evaluation components
- A proposed schedule for evaluation
- Performance measurements and performance measurement targets
- Data elements that will be used for reporting and evaluation
- Performance measures including:
  - the amount of funding contracted to date
  - the number and status of request for proposals to date
  - individual program status and statistics such as individuals served
  - data on utilization of the justice and emergency medical systems.

As with BSK, the MIDD II Evaluation Plan will include the overarching principles, framing questions and approaches that will guide the evaluation and performance measurement of MIDD II. As MIDD II initiatives are refined and programs are selected over the remainder of 2016, the MIDD evaluation framework will be developed, particularly with respect to initiative-level performance metrics and targets. The structure for MIDD II evaluation and performance measurement will be based on the MIDD II Framework (Appendix F).

Much has changed in the eight years since the MIDD I Evaluation Plan was completed, including behavioral health integration and technological advances. Yet, the purpose for evaluating MIDD II remains the same: providing the public and policy makers with the tools to evaluate the effectiveness of the MIDD strategies in meeting the established MIDD policy goals, as well as to ensure transparency and accountability.

Changing the Name of the MIDD

Through the course of MIDD I review and MIDD II planning, the county received feedback that the name of the MIDD---the Mental Illness and Drug Dependency sales tax and programs—is outdated, negative, disrespectful, and stigmatizing. In essence, the name of the MIDD is not itself recovery based and may be counterproductive to wellness.

Initially, changing the name of MIDD was not pursued as part of MIDD review and planning based on the understanding that MIDD is known statewide as a King County brand. Given the feedback BHRD has received over the last few months, this item is now identified as something that will be staged to move forward in 2017. Community input as well as Oversight Committee leadership will be critically important.

Changing the name of the MIDD will require revision to the King County Code and other adopted legislation. Executive staff will work with the Code Reviser, the Prosecutor's Office, and Council staff on this issue.

VII. Conclusion

This report fulfills the requirements of Ordinance 17998 calling for a MIDD Service Improvement Plan. County staff, in partnership with the MIDD Oversight Committee, accomplished this work through broad and specific community and stakeholder activities, extensive community processes, and analysis.

The groundbreaking MIDD I provided a strong foundation on which to plan and build MIDD II, taking the very best of what worked and retooling where needed to address challenges so that the MIDD is positioned to help the County's behavioral health and criminal justice systems to serve more people and achieve more notable outcomes.

The proposed MIDD II programmatic and funding recommendations are a holistic approach to the continuum of behavioral health services, grounded in the principles of equity and social justice and recovery and resiliency. The proposed initiatives were deliberately and intentionally developed with input from a wide array of stakeholders and communities; they were subject to wide public review and comment, which yielded meaningful changes to the proposals. The services, programs and systems supported by MIDD II are interwoven and interdependent.

Recommended improvements to the composition of the MIDD Oversight Committee are intended to bring greater depth and breadth of skills and experiences to the review of MIDD initiatives and outcomes, while operational improvements are intended to make full use of the capabilities of the committee. Revised fund balance and reserve policies are intended to strengthen the MIDD Fund's financial position and provide clarity around use of fund balance. MIDD II is deeply aligned with BSK and other initiatives.

If the recommendations in this report are supported by the King County Council, it is the intent of the Department of Community and Human Services to implement them in collaboration with providers, stakeholders, and the MIDD Oversight Committee. The recommendations range from low cost and easily executed, such as "align evaluation reporting period to calendar year" to those that may involve additional resources and be more complex to enact, such as developing a digital dashboard, or establishing a Consumers and Communities Subcommittee. Many of the recommendations require retooling internal processes and will necessarily lead to changes in data collection approaches, reporting, and timelines. Fulfilling these recommendations will require time, MIDD resources, and willingness of systems and organizations to embark upon and enact change. All MIDD stakeholders, internal and external to King County, including citizens, policymakers, providers, separately elected officials, and jurisdictional partners are impacted by these recommendations, and as such, their support and participation is critical for the ongoing success of MIDD.

While it has been demonstrated that MIDD I-supported programs have resulted in reduced jail bookings and shorter hospital stays, individuals with mental health and substance use conditions continue to end up in jails and emergency services because other options are not available – to them or to first

responders who come into contact with them – during times of crisis. Individuals with behavioral health conditions are often also impacted by homelessness, receive uncoordinated and fragmented services, and experience other significant barriers to getting the resources and supports needed in order to thrive in the community. Behavioral health conditions are further exacerbated by lack of diverse culturally and linguistically competent services available in the community. MIDD is but one element to address these issues.

As documented in this and other reports, the world of behavioral health care is rapidly evolving. Actions such as state mandated behavioral health integration, court rulings, along with the implementation of the Affordable Care Act, require King County and its behavioral health and criminal justice partners to continue the historical collaboration initiated by the development of MIDD I over eight years ago to make further meaningful systems improvements. The MIDD planning processes have taken into account the changing landscape of behavioral health, while continuing to build on the strong foundation of MIDD I. County staff are prepared to lead the work necessary to re-envision and re-tool MIDD programs to achieve even greater impact and outcomes.

VII. Appendices

6/17/16: Please note that some of this document's appendices are under revision. They will be included in the revised Service Improvement Plan that is scheduled to be released on 7/22/16.