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.

Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness

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The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. (*Psychiatric Services* 57:544–549, 2006)

Over the past several years, Summit County (greater Akron), Ohio has been working to address the problem of overrepresentation, or "criminalization," of people with mental illness in the local criminal justice system (1,2). As part of that effort, the Summit County Alcohol, Drug Addiction, and Mental Health Services Board obtained technical assistance consultation from the National GAINS Center for People with Co-occurring Disorders in the Justice System. From that collaboration, a conceptual model based on public health principles has emerged to address the interface between the criminal justice and mental health systems. We believe that this model—Sequential Intercept Model—can help other localities systematically develop initiatives to reduce the criminalization of people with mental illness in their community.

The Sequential Intercept Model: ideals and description

We start with the ideal that people with mental disorders should not "penetrate" the criminal justice system at a greater frequency than people in the same community without mental disorders (personal communication, Steadman H, Feb 23, 2001). Although the nature of mental illness makes it likely that people with symptomatic illness will have contact with law enforcement and the courts, the presence of mental illness should not result in unnecessary arrest or incarceration. People with mental illness who commit crimes with criminal intent that are unrelated to symptomatic mental illness should be held accountable for their actions, as anyone else would be. However, people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment—nor should such people be detained in jails or prisons longer than others simply because of their illness.

With both this ideal and current realities in mind, we envision a series of "points of interception" or opportunities for an intervention to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points. Each point of interception can be considered a filter (Figure 1). In communities with poorly developed mental health systems and no active collaboration between the mental health and criminal justice systems, the filters will be porous. Few will be intercepted early, and more people with mental illness will move through all levels of the criminal justice system. As systems and collaboration develop, the filter will become more

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finely meshed, and fewer individuals will move past each intercept point.

The Sequential Intercept Model complements the work of Landsberg and colleagues (3) who developed an action blueprint for addressing system change for people with mental illness who are involved in the New York City criminal justice system. The Sequential Intercept Model expands that work by addressing Steadman's (4) observation that people with mental illness often cycle repeatedly between the criminal justice system and community services. The model addresses his key question of how we can prevent such recycling by showing the ways in which people typically move through the criminal justice system and prompting considerations about how to intercept those with mental illness, who often have co-occurring substance use disorders.

Interception has several objectives (4,5): preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to community treatment upon release from incarceration, and decreasing the rate of return to the criminal justice system.

In contrast to the six critical intervention points identified in Landsberg's conceptual roadmap (3), we have specified the following five intercept points to more closely reflect the flow of individuals through the criminal justice system and the interactive nature of mental health and criminal justice systems (Figure 2):

♦ Law enforcement and emergency services

♦ Initial detention and initial hearings

♦ Jail, courts, forensic evaluations, and forensic commitments

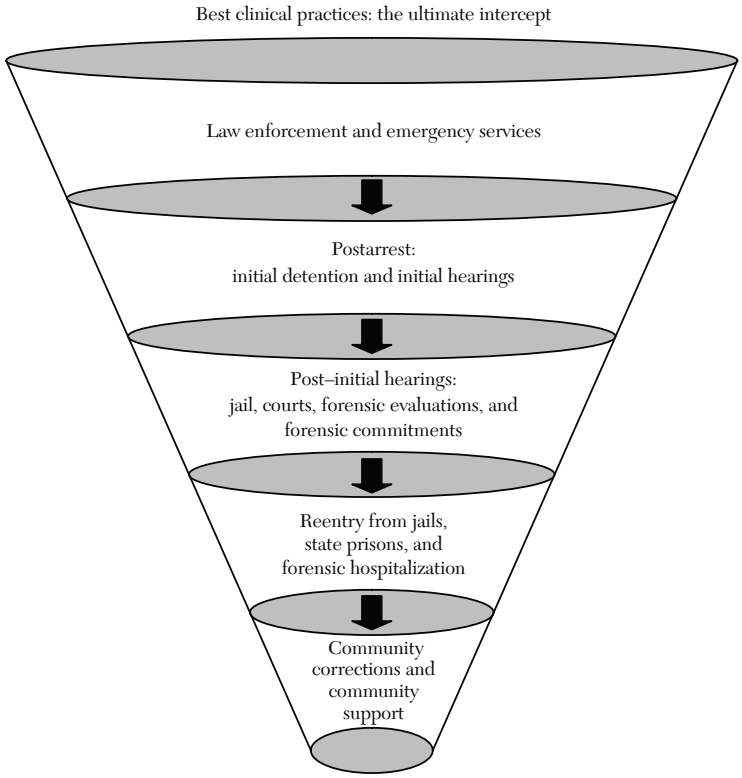
♦ Reentry from jails, state prisons, and forensic hospitalization

♦ Community corrections and community support services

In the next sections we describe the points of interception and illustrate them with examples of relevant interventions from the research and practice literature.

Figure 1

The Sequential Intercept Model viewed as a series of filters



An accessible mental health system: the ultimate intercept

An accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness. The system should have an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. These services must be available and easily accessible to people in need. Unfortunately, few communities in the United States have this level of services (6).

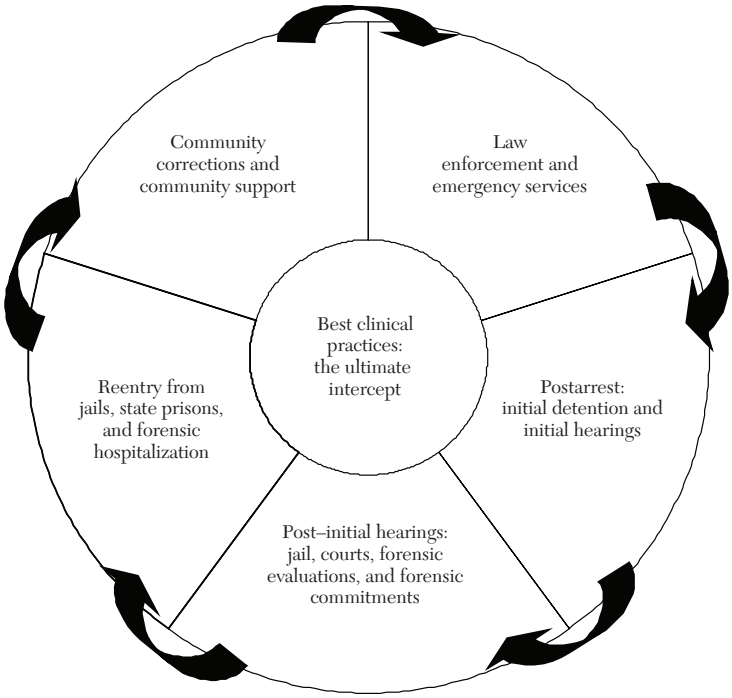
In addition to accessible and comprehensive services, it is increasingly clear that clinicians and treatment systems need to use treatment interventions for which there is evidence of efficacy and effectiveness (7,8). In many systems, evidence-based treatments are not delivered consistently (9). Examples of such interventions include access to and use of second-generation antipsychotic medications, including clozapine (10); family psychoeducation programs (11); assertive community treatment teams (12); and integrated substance abuse and mental health treatment (13). Integrated treatment is especially critical, given the fact that approximately three-quarters of incarcerated persons with serious mental illness have a comorbid substance use disorder (14,15).

Intercept 1: law enforcement and emergency services

Prearrest diversion programs are the first point of interception. Even in the best of mental health systems, some people with serious mental disorders will come to the attention of the police. Lamb and associates' (16) review of the police and mental health systems noted that since deinstitutionalization "law enforcement agencies have played an increasingly important

Figure 2

The Sequential Intercept Model from a revolving-door perspective with best practices at the core



role in the management of persons who are experiencing psychiatric crises." The police are often the first called to deal with persons with mental health emergencies. Law enforcement experts estimate that as many as 7 to 10 percent of patrol officer encounters involve persons with mental disorders (17,18). Accordingly, law enforcement is a crucial point of interception to divert people with mental illness from the criminal justice system.

Historically, mental health systems and law enforcement agencies have not worked closely together. There has been little joint planning, cross training, or planned collaboration in the field. Police officers have considerable discretion in resolving interactions with people who have mental disorders (19). Arrest is often the option of last resort, but when officers lack knowledge of alternatives and cannot gain access to them, they may see arrest as the only available disposition for people who clearly cannot be left on the street.

Lamb and colleagues (16) described several strategies used by police departments, with or without the participation of local mental health systems, to more effectively deal with persons with mental illness who are in crisis in the community: mobile crisis teams of mental health professionals, mental health workers employed by the police to provide on-site and telephone consultation to officers in the field, teaming of specially trained police officers with mental health workers from the public mental health system to address crises in the field, and creation of a team of police officers who have received specialized mental health training and who then respond to calls thought to involve people with mental disorders. The prototype of the specialized police officer approach is the Memphis Crisis Intervention Team (CIT) (20,21), which is based on collaboration between law enforcement, the local community mental health system, and other key stakeholders. A comparison of three police-based diversion models (22) found the Memphis CIT program to high uti-lization by patrol officers, rapid re-sponse time, and frequent referrals to treatment.

Intercept 2: initial hearings and initial detention

Postarrest diversion programs are the next point of interception. Even when optimal mental health service systems and effective prearrest diversion programs are in place, some individuals with serious mental disorders will nevertheless be arrested. On the basis of the nature of the crime, such individuals may be appropriate for diversion to treatment, either as an alternative to prosecution or as an alternative to incarceration. In communities with poorly developed treatment systems that lack prearrest diversion programs, the prototypical candidate for postarrest diversion may have committed a nonviolent, low-level misdemeanor as a result of symptomatic mental illness.

If there is no prearrest or police-level diversion, people who commit less serious crimes will be candidates for postarrest diversion at intercept 2. In communities with strong intercept 1 programs, postarrest diversion candidates are likely to be charged with more serious acts. In such cases, although diversion at the initial hearing stage is an option and treatment in lieu of adjudication may be a viable alternative, some courts and prosecutors may look only at postconviction (intercept 3) interventions.

Postarrest diversion procedures may include having the court employ mental health workers to assess individuals after arrest in the jail or the courthouse and advise the court about the possible presence of mental illness and options for assessment and treatment, which could include diversion alternatives or treatment as a condition of probation. Alternatively, courts may develop collaborative relationships with the public mental health system, which would provide staff to conduct assessments and facilitate links to community services.

Examples of programs that intercept at the initial detention or initial

hearing stage include the statewide diversion program found in Connecticut (23) and the local diversion programs found in Phoenix (24) and Miami (25). Although Connecticut detains initially at the local courthouse for initial hearings and the Phoenix and Miami systems detain initially at local jails, all three programs target diversion intervention at the point of the initial court hearing. A survey of pretrial release and deferred prosecution programs throughout the country identified only 12 jurisdictions out of 203 that attempt to offer the same opportunities for pretrial release and deferred prosecution for defendants with mental illness as any other defendant (26).

Intercept 3: jails and courts

Ideally, a majority of offenders with mental illness who meet criteria for diversion will have been filtered out of the criminal justice system in intercepts 1 and 2 and will avoid incarceration. In reality, however, it is clear that both local jails and state prisons house substantial numbers of individuals with mental illnesses. In addition, studies in local jurisdictions have found that jail inmates with severe mental illness are likely to spend significantly more time in jail than other inmates who have the same charges but who do not have severe mental illness (27,28). As a result, prompt access to high-quality treatment in local correctional settings is critical to stabilization and successful eventual transition to the community

An intercept 3 intervention that is currently receiving considerable attention is the establishment of a separate docket or court program specifically to address the needs of individuals with mental illness who come before the criminal court, so-called mental health courts (29–32). These special-jurisdiction courts limit punishment and instead focus on problem-solving strategies and linkage to community treatment to avoid further involvement in the criminal justice system of the defendants who come before them. The National GAINS Center estimates that there are now 114 mental health courts for adults in the United States (33).

Intercept 4: reentry from jails, prisons, and hospitals

There is little continuity of care between corrections and community mental health systems for individuals with mental illness who leave correctional settings (34). Typically, communication between the two systems is limited, and the public mental health system may be unaware when clients are incarcerated. Mental health systems rarely systematically follow their clients once they have been incarcerated. In a recent survey of jails in New Jersey, only three jails reported providing release plans for a majority of their inmates with mental illness, and only two reported routinely providing transitional psychotropic medications upon release to the community (35).

Nationally, the issue of facilitating continuity of care and reentry from correctional settings is receiving increasing attention. In part these efforts are fueled by class action litigation against local corrections and mental health systems for failing to provide aftercare linkages, such as the successful *Brad H* case against the New York City jail system (36). In addition, pressure is increasing on corrections and mental health systems to stop the cycle of recidivism frequently associated with people with severe mental illness who become involved in the criminal justice system (37–39). The APIC model for transitional planning from local jails that has been proposed by Osher and colleagues (40) breaks new ground with its focus on assessing, planning, identifying, and coordinating transitional care. Massachusetts has implemented a forensic transitional program for offenders with mental illness who are reentering the community from correctional settings (41). The program provides "in-reach" into correctional settings three months before release and follows individuals for three months after release to provide assistance in making a successful transition back to the community.

Intercept 5: community corrections and community support services

Individuals under continuing supervision in the community by the criminal justice system—probation or parole—are another important large group to consider. At the end of 2003, an estimated 4.8 million adults were under federal, state, or local probation or parole jurisdiction (42). Compliance with mental health treatment is a frequent condition of probation or parole. Failure to attend treatment appointments often results in revocation of probation and return to incarceration. Promising recent research by Skeem and colleagues (43) has begun to closely examine how probation officers implement requirements to participate in mandated psychiatric treatment and what approaches appear to be most effective.

Other research by Solomon and associates (44) has examined probationers' involvement in various types of mental health services and their relationship to technical violations of probation and incarceration. Similar to mental health courts, a variety of jurisdictions use designated probation or parole officers who have specialized caseloads of probationers with mental illness. The probation and parole committee of the Ohio Supreme Court advisory committee on mentally ill in the courts (45,46) has developed a mental health training curriculum for parole and probation officers.

Discussion

Some people may argue that the basic building blocks of an effective mental health system are lacking in many communities, and therefore efforts to reduce the overrepresentation of people with mental illness in the criminal justice system are futile. This argument is not persuasive. Even the most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems.

The Sequential Intercept Model provides a framework for communities to consider as they address concerns about criminalization of people with mental illness in their jurisdiction. It can help communities un-

derstand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time. Different communities can choose to begin at different intercept levels, although the model suggests more "bang for the buck" with interventions that are earlier in the sequence.

Five southeastern counties in Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia) used the Sequential Intercept Model as a tool to organize their work in a forensic task force charged with planning coordinated regional initiatives (47). As a result of that year-long effort, Bucks County staff organized a countywide effort to improve the local continuum of interactions and services of the mental health and criminal justice systems (48), and Philadelphia County started a forensic task force that uses the model as an organizing and planning framework. The model is also being used in a cross-training curriculum for community change to improve services for people with co-occurring disorders in the justice system (49).

Conclusions

Although many communities are interested in addressing the overrepresentation of people with mental illness in local courts and jails, the task can seem daunting and the various program options confusing. The Sequential Intercept Model provides a workable framework for collaboration between criminal justice and treatment systems to systematically address and reduce the criminalization of people with mental illness in their community.

Acknowledgments

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Mental Illness and Drug Dependency (MIDD) II
Community Conversations & Focus Group Themes

County staff conducted a robust outreach and engagement process around MIDD II planning. From September through December 2016, King County invited communities to participate in five regional Community Conversations on MIDD[1]. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas.

The purpose of these engagement efforts was to hear ideas about services and programs for people living with mental illness and substance use disorders. The conversations were intentionally designed so that community members could have 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. For the Community Conversations, participants engaged in small discussions based on birth to young adult age groups and MIDD Strategy Areas. Conversations were flexible and welcome to all ideas to allow participants to fully engage. A summary of their thoughts on MIDD Strategy Areas are below.

MIDD II Planning Community Conversations September – December 2016		
MIDD Strategy Area Table	**What's working?**	**What's not working or needed?**
Prevention & Early Intervention	• Wraparound • Peer Mentors/Counselors • School-based Services • Trauma Informed Care • Suicide Prevention	• Family/In-home Support • Youth-Young Adult Support • Culturally Diverse Resources • Crisis Line Texting • Provider Trainings
Crisis Diversion	• Mental Health First Aid Training • Police De-escalation Training • Crisis Clinic • Crisis Solution Services • Children's Crisis Outreach Response System/Geriatric Regional Assessment Team	• Waiting for Services • Mental Health Aftercare for Young Adults • Mobile Van for Mental Health • Respite Housing/ Crisis beds • Culturally Sensitive Services
Recovery & Reentry	• Non-Medicaid services • Wraparound • Recovery Café • Peer/Mentoring Support • Clubhouses	• Non-Medicaid Services, more needed • Restorative Justice • Recovery House/Oxford House • Treatment on Demand • Recovery High Schools
System Improvement	• Harm Reduction Programs • Specialty Population Behavioral Health Services • MIDD Mental Health/Substance Use Disorder funds • Staff Trainings • Behavioral Health/Physical Health Integration	• High Staff Turnover and Burnout • Caregiver/Parent Resources are lacking • Lack of services in south and rural county areas • Culturally Competent Services • Facility-based Mental Health/Substance Use Disorder services limit access

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

Focus Groups: Groups ranged in size from as few as four to over 100. Groups included:

- Domestic Violence and Sexual Assault Service Providers
- Behavioral Health Organizations
- Real Change Vendors (consumers)
- Southeast King County/Maple Valley
- Asian/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 Inmates

A summary of themes from the focus groups on MIDD and behavioral health services are below.

1. **Culturally specific organizations and groups need to be a central part of development and delivery of programs and services.**

2. **Stigma is a barrier to seeking services.**

3. **Outreach and engagement services are needed. Outreach is needed to educate people about available resources. Engagement is important to develop trust to increase commitment and active involvement in services.**

4. **More affordable housing/housing programs are needed.**

5. **Non-Medicaid services are necessary to fill a significant gap in the service system since many people still do not qualify for Medicaid.**

Primary Needs and Gaps Identified by Respondents to the Mental Illness and Drug Dependency (MIDD) Review and Renewal Survey September 2015 – February 2016

As part of the Mental Illness and Drug Dependency (MIDD) renewal work by King County, an electronic survey was made available between September 2015 and February 2016. The purpose of the survey was to gather feedback on a number of aspects of MIDD. The County received 362 responses.

One question specifically asked respondents to describe in narrative the specific mental health or substance abuse service gaps in their communities where new or expanded mental health, substance abuse, or therapeutic court services could make a difference.

Narrative responses to this question from 262 survey participants identified the following as the top 12 areas of need. Please note that not all survey respondents elected to answer this question.

MIDD SURVEY: TOP AREAS OF NEED OR SERVICE GAPS

1. **Outpatient mental health and substance abuse treatment access, including funding for people who do not have Medicaid**

2. **Housing, including housing supports and improved services for homeless individuals**
3. **Services for youth, especially in schools, including prevention**
4. **Culturally and linguistically competent services**
5. **Support for families**
6. **Inpatient substance use disorders treatment capacity/access**
7. **Crisis services and diversion, including mobile crisis teams**
8. **Support for people with behavioral health needs whose private insurance is insufficient or too expensive**
9. **Improved coordination and continuity of care**
10. **Inpatient mental health treatment capacity/access**
11. **Workforce challenges including high caseloads and turnover and low salaries**
12. **Hospital re-entry services including stepdown options**

Additional information from the survey will be made available as it is reviewed.

MIDD II Briefing Paper Review Panel Sorting

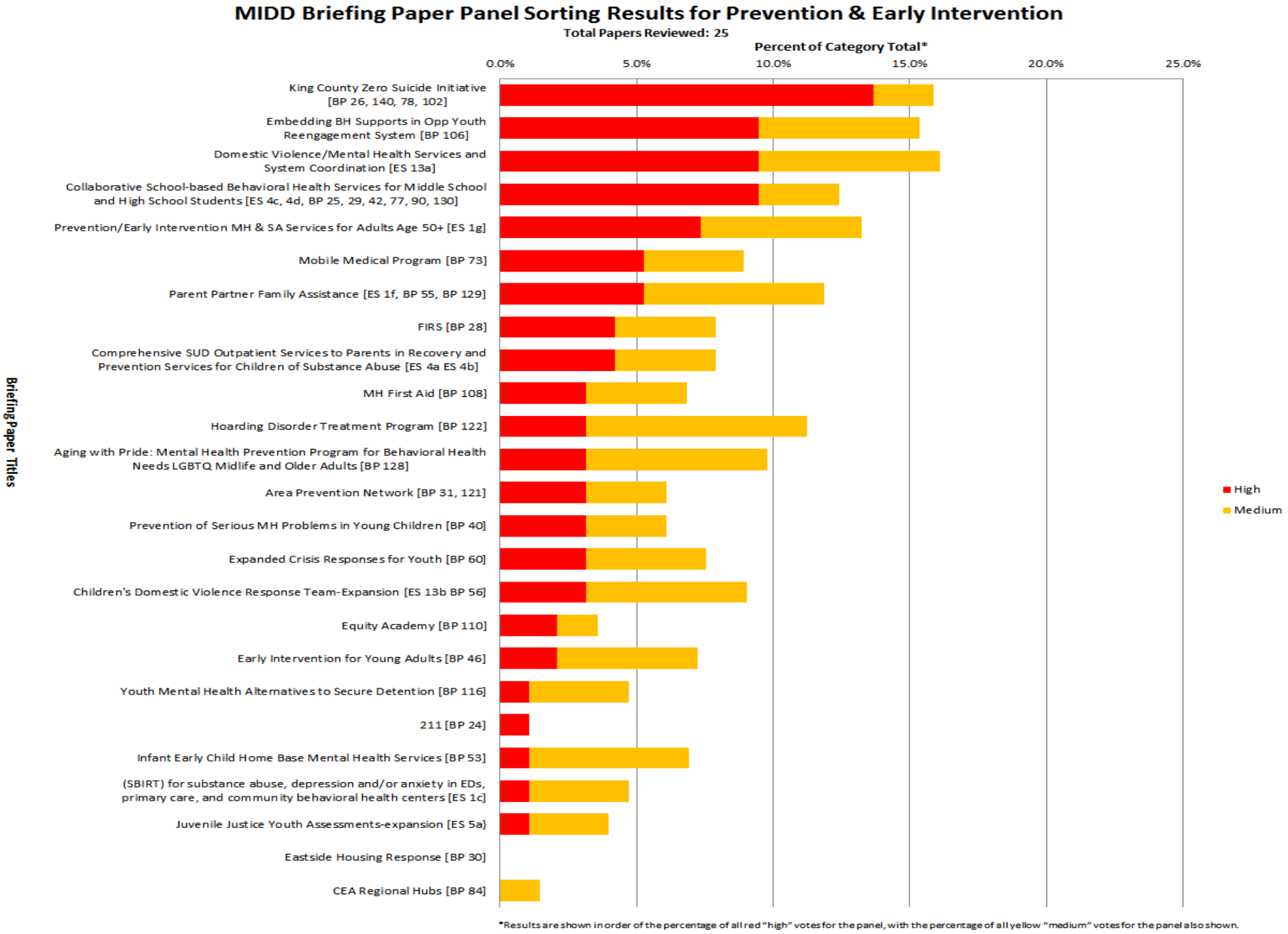
Briefing Paper Review Panel Information

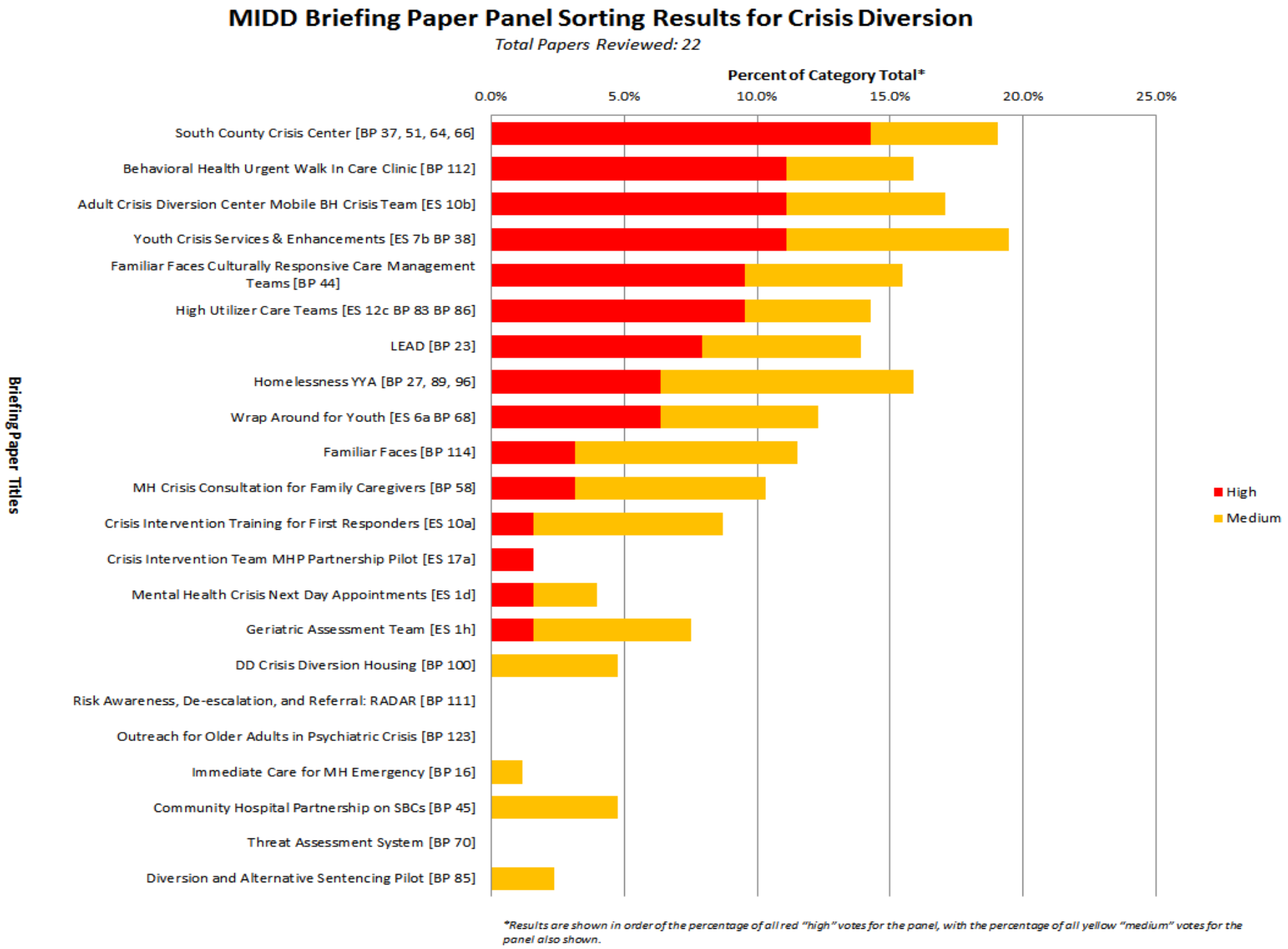
In early March, more than 50 community members, including MIDD Oversight Committee Members, participated on four diverse briefing paper review panels. Briefing papers on new concepts and existing MIDD I strategies were created to answer important analytical and policy questions related to the concepts and strategies. The four panels corresponded to the four overarching MIDD II strategy areas reviewed existing strategies and new concepts in the form of briefing papers. Briefing papers considered by the different review panels are linked below:

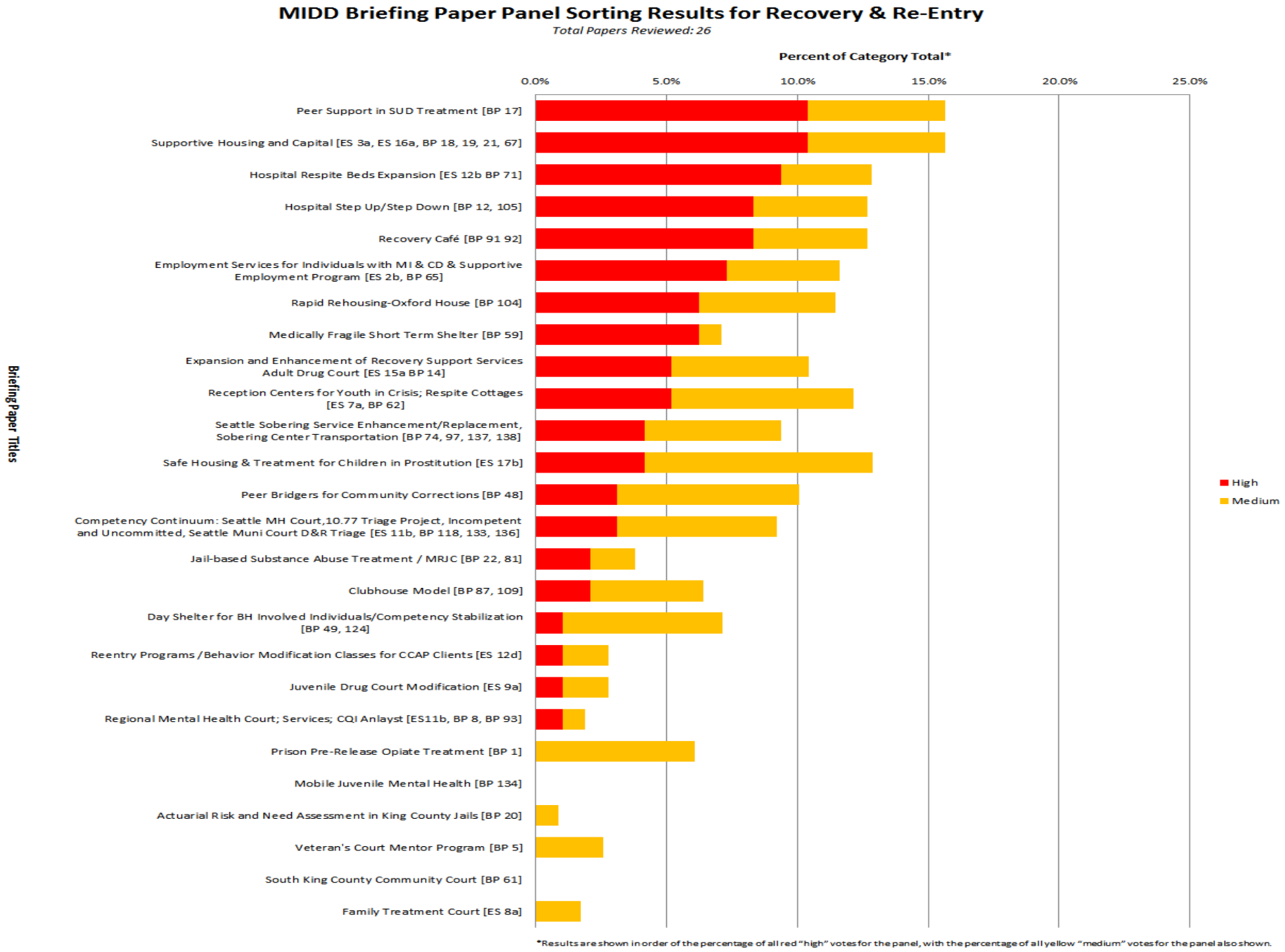
- **Prevention and Early Intervention**
- **Crisis Diversion**
- **Recovery and Re-Entry**
- **System Improvement**

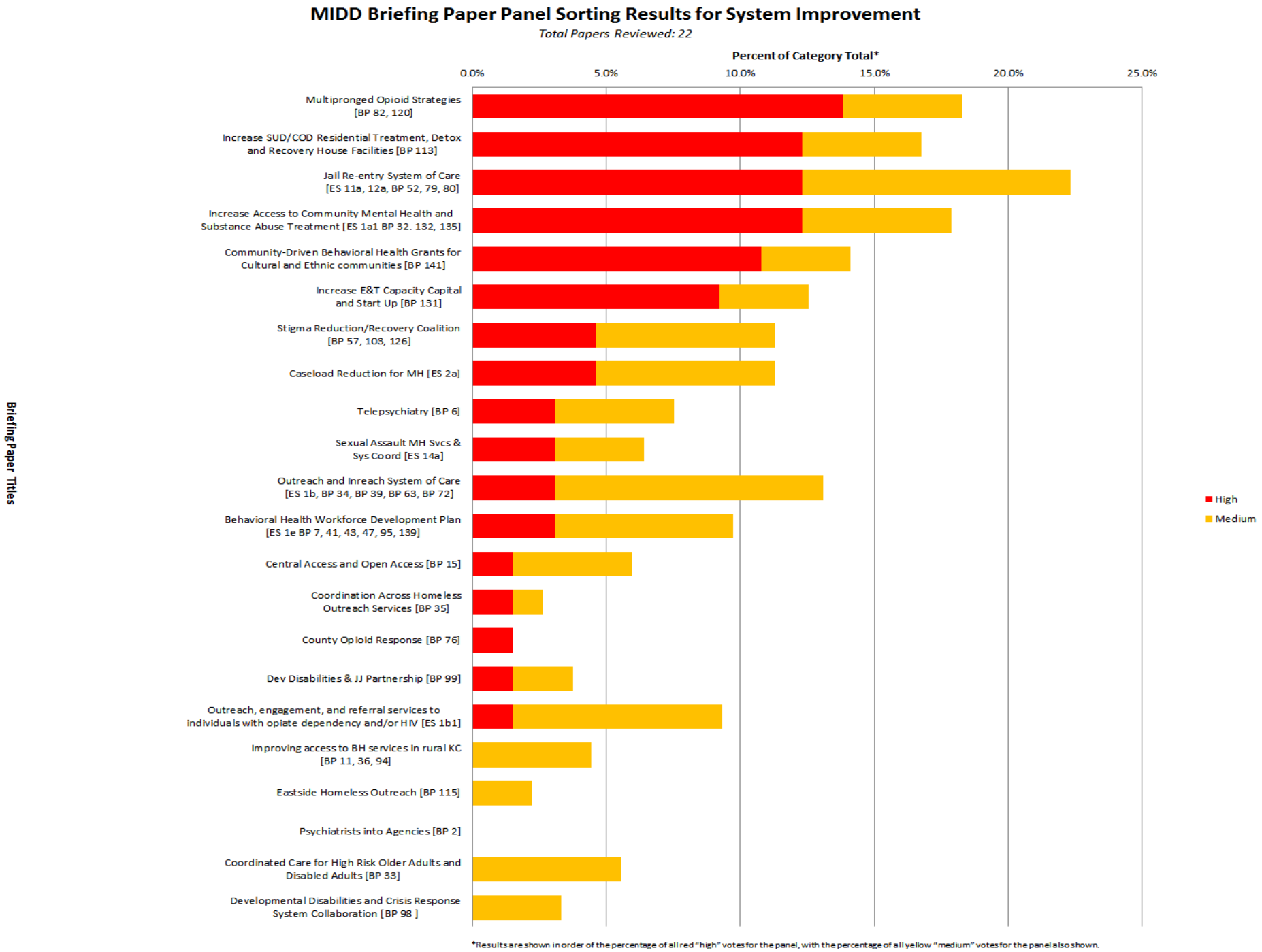
The panels were constructed to bring in a diverse array of lived experiences, skills, knowledge, perspectives, and insights to the sorting process. Each review panel included a mix of community members and MIDD Oversight Committee members or their designees. The work of the panels included deep discussion of each briefing paper and sorting the strategies and concepts into high, medium, and low categories for potential funding consideration. The results are shown in the following graphs in order of the percentage of red "high" votes of all high votes for the panel, with percentage of yellow "medium" votes also shown of all medium votes for the panel.

The work of these review teams, along with the discussions had by the teams in the panel sessions, coupled with the feedback King County has gathered from its robust community engagement process, is informing the next phases of MIDD II planning.


MIDD Briefing Paper Panel Sorting Results for Prevention & Early Intervention
Total Papers Reviewed: 25
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
King County Zero Suicide Initiative [BP 26, 140, 78, 102]
Embedding BH Supports in Opp Youth Reengagement System [BP 106]
Domestic Violence/Mental Health Services and System Coordination [ES 13a]
Collaborative School-based Behavioral Health Services for Middle School and High School Students [ES 4c, 4d, BP 25, 29, 42, 77, 90, 130]
Prevention/Early Intervention MH & SA Services for Adults Age 50+ [ES 1g]
Mobile Medical Program [BP 73]
Parent Partner Family Assistance [ES 1f, BP 55, BP 129]
FIRS [BP 28]
Comprehensive SUD Outpatient Services to Parents in Recovery and Prevention Services for Children of Substance Abuse [ES 4a ES 4b]
MH First Aid [BP 108]
Hoarding Disorder Treatment Program [BP 122]
Aging with Pride: Mental Health Prevention Program for Behavioral Health Needs LGBTQ Midlife and Older Adults [BP 128]
Area Prevention Network [BP 31, 121]
Prevention of Serious MH Problems in Young Children [BP 40]
Expanded Crisis Responses for Youth [BP 60]
Children's Domestic Violence Response Team-Expansion [ES 13b BP 56]
Equity Academy [BP 110]
Early Intervention for Young Adults [BP 46]
Youth Mental Health Alternatives to Secure Detention [BP 116]
211 [BP 24]
Infant Early Child Home Base Mental Health Services [BP 53]
(SBIRT) for substance abuse, depression and/or anxiety in EDs, primary care, and community behavioral health centers [ES 1c]
Juvenile Justice Youth Assessments-expansion [ES 5a}
Eastside Housing Response [BP 30]
CEA Regional Hubs [BP 84]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for Crisis Diversion
Total Papers Reviewed: 22
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
South County Crisis Center [BP 37, 51, 64, 66]
Behavioral Health Urgent Walk In Care Clinic [BP 112]
Adult Crisis Diversion Center Mobile BH Crisis Team [ES 10b]
Youth Crisis Services & Enhancements [ES 7b BP 38]
Familiar Faces Culturally Responsive Care Management Teams [BP 44]
High Utilizer Care Teams [ES 12c BP 83 BP 86]
LEAD [BP 23]
Homelessness YYA [BP 27, 89, 96]
Wrap Around for Youth [ES 6a BP 68]
Familiar Faces [BP 114]
MH Crisis Consultation for Family Caregivers [BP 58]
Crisis Intervention Training for First Responders [ES 10a]
Crisis Intervention Team MHP Partnership Pilot [ES 17a]
Mental Health Crisis Next Day Appointments [ES 1d]
Geriatric Assessment Team [ES 1h]
DD Crisis Diversion Housing [BP 100]
Risk Awareness, De-escalation, and Referral: RADAR [BP 111]
Outreach for Older Adults in Psychiatric Crisis [BP 123]
Immediate Care for MH Emergency [BP 16]
Community Hospital Partnership on SBCs [BP 45]
Threat Assessment System [BP 70]
Diversion and Alternative Sentencing Pilot [BP 85]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for Recovery & Re-Entry
Total Papers Reviewed: 26
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
Peer Support in SUD Treatment [BP 17]
Supportive Housing and Capital [ES 3a, ES 16a, BP 18, 19, 21, 67]
Hospital Respite Beds Expansion [ES 12b BP 71]
Hospital Step Up/Step Down [BP 12, 105]
Recovery Café [BP 91 92]
Employment Services for Individuals with MI & CD & Supportive Employment Program [ES 2b, BP 65]
Rapid Rehousing-Oxford House [BP 104]
Medically Fragile Short Term Shelter [BP 59]
Expansion and Enhancement of Recovery Support Services Adult Drug Court [ES 15a BP 14]
Reception Centers for Youth in Crisis; Respite Cottages [ES 7a, BP 62]
Seattle Sobering Service Enhancement/Replacement, Sobering Center Transportation [BP 74, 97, 137, 138]
Safe Housing & Treatment for Children in Prostitution [ES 17b]
Peer Bridgers for Community Corrections [BP 48]
Competency Continuum: Seattle MH Court,10.77 Triage Project, Incompetent and Uncommitted, Seattle Muni Court D&R Triage [ES 11b, BP 118, 133, 136]
Jail-based Substance Abuse Treatment / MRJC [BP 22, 81]
Clubhouse Model [BP 87, 109]
Day Shelter for BH Involved Individuals/Competency Stabilization [BP 49, 124]
Reentry Programs /Behavior Modification Classes for CCAP Clients [ES 12d]
Juvenile Drug Court Modification [ES 9a]
Regional Mental Health Court; Services; CQI Anlayst [ES11b, BP 8, BP 93]
Prison Pre-Release Opiate Treatment [BP 1]
Mobile Juvenile Mental Health [BP 134]
Actuarial Risk and Need Assessment in King County Jails [BP 20]
Veteran's Court Mentor Program [BP 5]
South King County Community Court [BP 61]
Family Treatment Court [ES 8a]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for System Improvement
Total Papers Reviewed: 22
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
Multipronged Opioid Strategies [BP 82, 120]
Increase SUD/COD Residential Treatment, Detox and Recovery House Facilities [BP 113]
Jail Re-entry System of Care [ES 11a, 12a, BP 52, 79, 80]
Increase Access to Community Mental Health and Substance Abuse Treatment [ES 1a1 BP 32. 132, 135]
Community-Driven Behavioral Health Grants for Cultural and Ethnic communities [BP 141]
Increase E&T Capacity Capital and Start Up [BP 131]
Stigma Reduction/Recovery Coalition [BP 57, 103, 126]
Caseload Reduction for MH [ES 2a]
Telepsychiatry [BP 6]
Sexual Assault MH Svcs & Sys Coord [ES 14a]
Outreach and Inreach System of Care [ES 1b, BP 34, BP 39, BP 63, BP 72]
Behavioral Health Workforce Development Plan [ES 1e BP 7, 41, 43, 47, 95, 139]
Central Access and Open Access [BP 15]
Coordination Across Homeless Outreach Services [BP 35]
County Opioid Response [BP 76]
Dev Disabilities & JJ Partnership [BP 99]
Outreach, engagement, and referral services to individuals with opiate dependency and/or HIV [ES 1b1]
Improving access to BH services in rural KC [BP 11, 36, 94]
Eastside Homeless Outreach [BP 115]
Psychiatrists into Agencies [BP 2]
Coordinated Care for High Risk Older Adults and Disabled Adults [BP 33]
Developmental Disabilities and Crisis Response System Collaboration [BP 98]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.

Appendix E MIDD II Service Improvement Plan
MIDD II PROCESS OVERVIEW
Revised 6.2.16

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

Open Call Timeframe: 9/15-10/31

Existing MIDD Programs* Analysis**

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

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

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

BHRD coordinates analysis of existing programs

PHASE II
Analysis and Collective Review

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

Sept-Dec Briefing Paper Drafting

141 New Concepts Submitted!

New Concepts Address/Identify

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

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

Submission of New Concepts will be electronic

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

Not all submitted concepts will move to Phase II

BHRD screens new concepts for forwarding to Phase II

Key Questions for Briefing Papers**

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

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

Jan & Feb Teams Review

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

Four Briefing Panels Held March 7-10 With Over 50 Reviewers

March - May

You are HERE!

Phase III
MIDD II Service Improvement Plan Recommendations Development
Align MIDD II programs and funding recommendations
County staff drafts recommendations and identifies initial funding levels.
MIDD Oversight Committee reviews recommendations.
Funding recommendations PUBLIC REVIEW AND COMMENT April 22-May 6

May-August

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

- Recommended programs will be included in the MIDD II SIP that is sent to the Executive for review and forwarding to Council
- Transmitted to the King County Council: August 25, 2016
- Changes may be made to the recommendations by the Executive AND/OR the Council

County staff drafts SIP report. MIDD Oversight Committee reviews.
SIP PUBLIC REVIEW AND COMMENT June 16-30

Revised 3.28.16

DRAFT MIDD II FRAMEWORK Revised *4.7.16*		
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.		
OUTCOMES		
Population Indicators	**MIDD and other King County and community initiatives contribute to the overall health and well-being of King County residents that is demonstrated by positive changes in population**	• Emotional health – rated by level of mental distress • Daily functioning - rated by limitations to due to physical, mental or emotional problems • Reduced or eliminated alcohol and substance use • Health rated as 'very good' or 'excellent' • Housing stability • Representation of people with behavioral health conditions within jail, hospitals and emergency departments
MIDD II Strategy Areas	**SAMPLE[i] MIDD II Performance Measures (to be refined after specific programs/services are selected)**	
Prevention and Early Intervention *People get the help they need to stay healthy and keep problems from escalating*	**How much? Service capacity measures** • Increased number of people receiving substance abuse and suicide prevention services • Increased number of people receiving screening for health and behavioral health conditions within behavioral health and primary care settings **How well? Service quality measures** • Increased treatment and trainings in non-traditional settings (day cares, schools, primary care) • Increased primary care providers serving individuals enrolled in Medicaid **Is anyone better off? Individual outcome measures** • Increased use of preventive (outpatient) services • Reduced use of drugs and alcohol in youth & adults • Increased employment and/or attainment of high school diploma and post-secondary credential • Reduced risk factors for behavioral health problems (e.g., social isolation, stress, etc.)	
Crisis Diversion *People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*	**How much? Service capacity measures** • Increased capacity of community alternatives to hospitalization and incarceration (e.g., crisis triage, respite, LEAD, therapeutic courts, etc.) **How well? Service quality measures** • Increased use of community alternatives to hospitalization and incarceration by first responders **Is anyone better off? Individual outcome measures** • Reduced unnecessary hospitalization, emergency department use and incarceration • Decreased length and frequency of crisis events	
Recovery and Reentry *People become healthy and safely reintegrate to community after crisis*	**How much? Service capacity measures** • Increased in affordable, supported, and safe housing • Increased availability of community reentry services from jail and hospitals • Increased capacity of peer supports **How well? Service quality measures** • Increased linkage to employment, vocational, and educational services • Increased linkage of individuals to community reentry services from jail or hospital • Increased housing stability **Is anyone better off? Individual outcome measures** • Increased employment and attainment of high school diploma and post-secondary credential • Improved wellness self-management • Improved social relationships • Improved perception of health and behavioral health issues and disorders • Decreased use of hospitals and jails	

System Improvements *Strengthen the behavioral health system to become more accessible and deliver on outcomes*	**How much? Service capacity measures** • Expanded workforce including increased provider retention • Decreased provider caseloads • Increased culturally diverse workforce • Increased capacity for outreach and engagement • Increased workforce cross-trained in both mental health and substance abuse treatment methods **How well? Service quality measures** • Increased accessibility of behavioral health treatment on demand • Increased accessibility of services via: hours, geographic locations, transportation, mobile services • Increased application of recovery, resiliency, and trauma-informed principles in services and outreach • Right sized treatment for the individual • Increased use of culturally appropriate evidence-based or promising behavioral health practices • Improved care coordination • MIDD is funder of last resort **Is anyone better off? Individual outcome measures** • Improved client experience of care

Please note that this is a living document; the contents of this document are subject to change and modification.

Adopted MIDD I Policy Goals:

1. A reduction in the number of mentally ill and chemically dependent people using costly interventions, such as, jail, emergency rooms, and hospitals.
2. A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.
3. A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
4. Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement.
5. Explicit linkage with, and furthering the work of, other county 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.

These goals may be revised for MIDD II.

King County

Behavioral Health and Recovery Division
King County Department of Community and Human Services

Decision Model: Determining the Need For Requests for Proposals/Competitive Procurement

Principles of Purchasing

King County will apply principles that promote effectiveness, accountability and social justice.

Ethical Behavior and Conduct

The objectives of ethical behavior and conduct are to insure that in its procurement activities, the County will:

- Behave with impartiality, fairness, independence, openness, integrity and professionalism in its dealings with suppliers;
- Advance the interests of the County in all transactions with suppliers;

Open and effective competition

The objectives of open and effective competition are:

- To instill confidence in the County and the public about the integrity and cost effectiveness of public sector procurement;
- To support the most effective and efficient outcomes for the County;
- To ensure that all suppliers wishing to conduct business with the County are given a reasonable opportunity to do so; and
- To ensure that bid documents and contracts reflect the requirements and desired outcome of the County and that all participants are subject to equivalent terms, conditions and requirements.

Open and Effective Competition means:

- Procurement procedures and processes are visible to the County, suppliers, and the public;
- Suppliers have a real opportunity to do business with the County; and
- Competition is sought to provide value for money, to achieve the best possible return from County spend on goods and services;

When is a Competitive Process to Secure a Contract Required?

Purchases over $2,499 for a single purchase of goods or services and/or purchases of over $2,500 in a calendar year to a single vendor or provider require a contract. When the County initiates a contracting process the default procurement stance is that a competitive process to identify the vendor/provider must occur. A competitive bid process shall be utilized when:

A. The County has new funding to purchase services(e.g. new grants, new levies, new allocations from funders);
B. A new program/service is to be implemented;
C. There is a change in requirements or regulations related to services/programs currently under contract with the County requiring a substantial revision in the scope of services; or
D. The funder of programs/services requires competitive procurement process for new funds and/or ongoing funds at a specified frequency.

The following categories of purchases are exempt from the requirement of a competitive bid process:

A. Purchases that are covered by a blanket contract entered into by King County Purchasing.

B. Purchases of services where an there is an existing contract within the Division/Department that purchases the same scope of work:

    1. The purchase adds capacity to the program (e.g. purchases more program slots, or bed days); or
    2. The purchase expands the population to be served (without changing the scope of work);

C. Purchases where there is only one source that can provide the scope of work (A Sole Source Waiver must be sought and authorized from King County Purchasing):

    1. The County has been told by a funder to hire a particular (sub)contractor; or
    2. There is only one expert/specialty organization in the region that can deliver the scope of work.

Methods Utilized for Competitive Bid Processes

The competitive bid processes below are solicited by the County. The responses to these solicitations are evaluated against the County's criteria/requirements for the service/program and awards are made for responses that best meet the County's needs/specifications.

1. Requests for Proposals – Prospective bidders complete a proposal to provide services that includes details about: a) their experience providing similar service; b) details on how the agency meets required qualifications; c) a proposal for

how the needed/required services will be provided; and d) a detailed expenditure budget.

2. Requests for Qualifications/Applications – Prospective bidders complete a response detailing their qualifications to provide the needed/required services according to the County specifications and funding.
3. Letters of Intent – A response to a request for a letter of intent that describes the responder's interest, qualifications, and a description of their plan to provide services according to the County's specifications and funding.

Special Purchasing Issues

Divisions/Departments have been delegated the authority to competitively procure and purchase services that are designed to address the needs of the County's citizens (e.g. treatment, supportive services, prevention services, etc.). King County Purchasing may be utilized for the purchase of services if the Division/Department wishes to.

Goods and Consultant Services purchased for King County Divisions/Departments can be competitively procured by the Divisions/Departments if the total expenditure for the consultation will be less than $25,000. For consultation purchase/contracts that exceed $25,000 the competitive procurement process must be directed and run by King County Purchasing.

Criteria for Using King County Procurement for the Competitive Bid Process

King County Procurement buyers should be utilized when:

- There is a need for broad community distribution of the Request for Proposals;
- There will be a large number of potential bidders;
- Regions within King County may be competing with each other;
- The award will go to multiple recipients and will exceed $500,000 each recipient.

Criteria for the Department Running the Competitive Bid Process

The Department may run the competitive bid process when:

- The competitive bid is being distributed to the Department's existing provider network;
- The project is similar to projects that are already in existence in the department;
- The awards are for discreet or small projects.

Appendix H
MIDD II Service Improvement Plan

Initiative Descriptions – Preliminary Implementation Information

*Please note that the Initiative Description documents that are included in this appendix 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 stakeholder 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 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 level 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 will be submitted to the Council in 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

MIDD II Initiative Title: Law Enforcement Assisted Diversion (LEAD) **(NEW)**

MIDD II Number: CD-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Drug use, mental illness and homelessness often generate behaviors that fuel repeated involvement with the criminal justice system, impede an individual's recovery, and foster legitimate community public safety/order concerns.[1]

The Law Enforcement Assisted Diversion (LEAD) program diverts individuals who are engaged in low-level drug crime, prostitution, and other collateral crime due to drug involvement, from the justice system, bypassing prosecution and jail time, to directly connect drug-involved individuals to case managers who can provide immediate assessment and crisis response, and long term wrap-around services to address the cycling of individuals with behavioral issues through the criminal justice system.

LEAD intercepts the individual and divert the behavioral problem at the point of law enforcement response, to channel drug-involved individuals into a community-based intervention whenever possible and appropriate. LEAD is based in the principles of harm reduction,[2] which focuses on the prevention of harms to individuals and communities that are related to drug usage/dependency in individuals who are unable or unwilling to stop. LEAD is a community policing effort, addressing low-level drug crimes with socioeconomic and health impacts, and providing law enforcement with credible alternatives to booking people into jail.

1. Program Description

◊ *A. Service Components/Design (Brief)*

All LEAD participants receive case management, which supports fulfilment of basic needs, and may include housing stability, job attainment or income stabilization, enrollment in drug and alcohol treatment, and coordination of all criminal justice

[1] King County's Familiar Faces project found that nearly all individuals with four or more bookings into the County's jails in a year have a behavioral health indicator of drug dependency or mental illness, and at least one other acute or chronic medical condition. More than half (likely undercounted) were homeless. *Familiar Faces: Current State – Analysis of Population*, September 28, 2015

[2] Harm reduction interventions are designed to meet individuals where they currently are in their lives and their motivation to change, in order to tailor strategies to meet their specific needs and to minimize the specific harms to themselves and their community. "Harm reduction strategies can be effective in reducing harm, increasing the quality of life and decreasing high-risk behaviors." Marlatt, G. Alan; Larimer, Mary E.; Witkiewitz, K., Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors

involvement and prosecution to support and not compromise LEAD intervention plans. In general, LEAD pursues the goals of the individual participant, as identified by the case manager and the participant in an Individual Intervention Plan.

Case managers provide street-based outreach and engagement, as well as immediate response to unscheduled needs wherever possible. Case managers use motivational interviewing techniques, and establish a low- or no-barrier atmosphere that ensures participants are not shamed and can readily re-engage when they have struggled or are struggling.

The second component of LEAD is the coordination of all prosecution and contact participants may have with the criminal justice system for other cases that may not be eligible for diversion. The prosecution coordination component of LEAD supports prosecutors to make discretionary decisions about whether to file charges, recommend pre-trial detention or release conditions, reduce charges, recommend incarceration after conviction, and/or dismiss charges, in a way that supports the intervention plan designed for the particular participant, in order to maximize community health and safety.

Another component of the LEAD program is engagement with the community and addressing neighborhoods' concerns with criminal activity and public safety. This takes the form of ongoing education and dialogue with community leaders about the LEAD approach, coordination of information between neighborhood leaders and the operational workgroup regarding LEAD participants and neighborhood hotspots and concerns. It also generates community-based social contact referrals to LEAD that can be validated by law enforcement as appropriate referrals. Through LEAD, community-generated pressure for traditional enforcement can be transformed into participation in alternative health-based responses.

Specific strategies of the LEAD program include:

- effective training of and engagement with front-line law enforcement officers (officers and sergeants) to enlist their active participation in this approach, to familiarize them with harm reduction principles, and to tap into their experience and knowledge of the street-involved population;
- coordination by prosecutors of LEAD participants' filed criminal cases with the Individual Intervention Plan established by LEAD case managers, wherever possible;
- ongoing community outreach and engagement;
- provision of case management in a harm reduction/Housing First framework;
- assistance in removing legal obstacles to improved life circumstances; and
- coordination with public defenders to receive defense-initiated social contact referrals and ensure defenders integrate LEAD into defense planning for resolution of filed cases as appropriate.

◊ *B. Goals*

As described above, the primary objectives of LEAD are to reduce recidivism and criminal justice costs, and to increase positive psychosocial, housing and quality-of-life outcomes for participants.

◊ *C. Expected Numbers of Individuals Served*

The increased level of financial participation by MIDD will support the delivery of the LEAD program for approximately 500 participants. Potential service recipients would be located in currently funded areas[3] as well as other communities that have expressed interest in becoming partners in the delivery of LEAD. There is a particular interest among LEAD's policy coordinating group in exploring opportunities to expand LEAD into South and East King County jurisdictions that presently make comparatively high use of King County Jail facilities for individuals with frequent bookings,[4] as part of a countywide strategy to increase access to the program and decrease the unnecessary use of jail.

Of note, the current LEAD case management level of care may need to be enhanced for some individuals who are referred to the program. Through other demonstration efforts, more intensive levels of care will become available to address higher needs. Over time, it is the goal to have agencies contracted by BHRD provide this intensive care as part of the LEAD service mix.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- reduced jail, hospital, and emergency department use
- reduced substance use
- improved daily functioning

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive (outpatient) services
- increased use of alternatives to incarceration by first responders
- increased capacity of community alternatives to incarceration
- reduced behavioral health risk factors
- reduced unnecessary incarceration

[3] LEAD launched as a pilot in Seattle's Belltown neighborhood and King County's Skyway neighborhood in 2011, funded entirely by grants from private foundations. In 2014, with support from the City of Seattle, and at the request of other downtown Seattle neighborhoods, the program was expanded to include the rest of downtown Seattle. LEAD received $800,000 in one-time funding from MIDD I in 2016. The City of Seattle plans to expand LEAD to its East precinct (Capitol Hill) in 2016, and, since other Seattle neighborhoods have requested LEAD, the City Council has requested a plan for how to scale up citywide. The Sound Cities Association has also entered discussions regarding expanding LEAD to other King County cities.

[4] This refers to individuals who meet the Familiar Faces threshold of four or more bookings into the County's jails in a year.

Specifically, the LEAD program will help reduce criminal justice involvement and costs for county residents with behavioral issues, leading to positive outcomes and a reduction of harm to the individual participant and to the community, and increasing efficiencies in program costs and uses of funds. Participating neighborhoods should also experience improved neighborhood-based outcomes, with corresponding reduction in demand for traditional incarceration-based responses, if the program is taken to scale and sustained over time, and an increased level of satisfaction with public response to behavioral health-driven law violations compared to current levels of satisfaction.

Outcomes for participants:

- reduction/mitigation/elimination of drug use/abuse
- increased stability in treatment, employment, and other quality of life measures
- reduction or elimination of criminal behavior to support addictions

Outcomes for local government:

- law enforcement, prosecutors, defenders are able to identify LEAD participants to plan and coordinate services
- address basic needs and behavioral health issues and halt repeated cycling through the criminal justice system
- decreased arrests, court filings, jail utilization and prison admissions
- decreased recidivism
- decreased justice system costs
- increased efficiencies with decreased costs per participant

Outcomes for communities/neighborhoods:

- reductions in low-level drug activity and street crime to support addictions
- improvement in perceptions of public safety/order and increased satisfaction
- participation in community efforts to positively impact neighborhoods

Specific outcomes and measures for LEAD, especially identification of what will be evaluated as part of MIDD II, are subject to further definition.

◊ *E. Provided by: Contractor*

Prosecution services will be provided by the King County Prosecuting Attorney's Office (KCPAO) and municipal attorneys including the Seattle City Attorney's Office as well as those representing any future cities that may participate in future expansions of LEAD to South and East King County.

Funding for community engagement, project management including accountability to MIDD and other oversight bodies, and stakeholder coordination would be directed to the Public Defender Association (PDA).

Funding for case management will be contracted to PDA through King County BHRD, which will provide program oversight of and contract monitoring for the MIDD-funded portion of LEAD, including ensuring that other funding sources including Medicaid are

maximized. (See 3.A below for the expected long-term approach to case management contracting.)

2. Spending Plan

This spending plan shows estimated amounts and expected categories for MIDD II's recommended contribution to LEAD.

It is designed to invest in expansion of LEAD to other jurisdictions, and/or other Seattle neighborhoods, as part of a countywide strategy. Each additional jurisdiction will be expected to secure or contribute funding for increased case management, project management, community engagement, client legal services, law enforcement overtime, and training costs when LEAD expands into its area, alongside the MIDD II investment.

All expenses shown are provisional and may be adjusted depending on the timing of expansion of LEAD into other communities within Seattle and/or throughout the County.

Year	Activity	Amount
2017	Case management	$1,091,625
2017	Prosecution costs	$512,500
2017	MIDD portion of project management, stakeholder coordination and community engagement	$292,125
2017	1.0 FTE County (BHRD) program oversight and planning to enhance integration with other initiatives and to focus on expansion to suburban cities in King County	$153,750
2017 Annual Expenditure		**$2,050,000**
2018	Case management	$1,120,007
2018	Prosecution costs	$525,825
2018	MIDD portion of project management, stakeholder coordination and community engagement	$299,720
2018	1.0 FTE County (BHRD) program oversight and planning to enhance integration with other initiatives and to focus on expansion to suburban cities in King County	$157,748
2018 Annual Expenditure		**$2,103,300**
Biennial Expenditure		**$4,153,300**

3. Implementation Schedule

◊ *A. Procurement of Providers*

County funds will be granted to Public Defender Association (PDA) to support its existing role in project management, stakeholder coordination and community engagement for LEAD, including its role in working with the multisystem LEAD Policy Coordinating Group, the consensus-based governing body of LEAD that includes PDA, prosecutors, law enforcement, the King County Executive's Office, and municipal funders.

Funding for LEAD case management will administered by the through a Memorandum of Agreement between PDA and King County BHRD, which will provide program oversight of and contract monitoring for the MIDD-funded portion of LEAD.

It is the long-term goal for LEAD that King County BHRD oversee the contract for case management services and oversee the social services aspect of LEAD, including behavioral health, primary care and housing. This will occur when BHRD-administered "on demand" referral portals are available featuring harm reduction and trauma-informed care approaches.

If new King County cities wish to launch LEAD, an RFP would be developed by BHRD staff in conjunction with the Policy Coordinating Group in order to identify case management providers appropriate to those new cities.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

As the initiative is already operating, services are expected to continue uninterrupted in the current service areas.

Expansion to other communities throughout King County is expected to occur gradually between 2017 and 2022 when:

- specific jurisdictions come forward with interest and additional funding;
- agreements and law enforcement/prosecution training is completed; and
- contracted case management provider(s) are identified for South King County as applicable.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth and Young Adult Homelessness Services (CD-2)

MIDD II Initiative Title: Youth and Young Adult Homelessness Services **(NEW)**

MIDD II Number: CD-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "explicit linkage with, and furthering the work of, other King County and community initiatives."

This program is a coordinated approach to supporting youth and young adults experiencing homelessness. It provides mobile behavioral health team(s) to young adult housing programs as featured in the All Home Comprehensive Plan to Prevent and End Youth and Young Adult (YYA) Homelessness.

This approach is also consistent with the principles of King County's plans for behavioral health integration and health and human services transformation, which call for reduced fragmentation across systems, increased flexibility of services and coordination of care, and strong emphasis on prevention, recovery and elimination of disparities for marginalized populations.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Mental health and/or chemical dependency professionals will be embedded within an existing agency or agencies providing housing in Seattle, East King County, and/or South King County and shared across all young adult (YA) housing programs, including transitional housing, rapid rehousing, and permanent housing. If more than one team is created, each team would serve an identified geographic region.

These staff will provide on-site, timely mental health and chemical dependency screenings and assessment, brief intervention, and connection to ongoing behavioral health services. Because these team(s) will be based at existing housing programs, the "home base" programs will have stronger capacity to provide intensive on-site behavioral health supports.

This will create more appropriate supports within existing housing programs for young adults with ongoing mental health or substance abuse needs. It is anticipated that these programs will be able to stabilize more young people, and support them moving to other programs in the continuum as their service needs change.

◊ *B. Goals*

This initiative focuses on mobile behavioral health team(s) based in young adult housing programs, as a priority element of a coordinated approach that will support youth and

young adults experiencing homeless with acute behavioral health needs and/or a history of trauma in achieving and succeeding in safe and stable housing.[1] Improving behavioral health services to this population will help ensure that their homelessness is a brief and one-time experience.

◊ *C. Expected Numbers of Individuals Served*

It is not yet known how many individuals may be served by this program. As the program is further developed by King County DCHS Community Services Division's housing and community development section in consultation with All Home and King County BHRD to match appropriated funding levels, the expected number of people to be served will be more clearly identified.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use
- housing stability

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use
- increased housing stability

Outcomes specific to the mobile behavioral health team(s) programming may include:

- Fewer young people will be exited from YA housing programs due to a program's inability to meet their mental health or substance abuse needs.
- When YA do experience crisis, they will receive timely support from a crisis response team with YA-specific training.
- More young people in YA housing programs will be connected to needed ongoing behavioral health care treatment.
- YA will attain safe and stable housing.
- YA attaining housing will remain in safe and stable housing for at least one year after transition from program.

Initiative-specific outcomes are subject to further refinement as programming is defined.

[1] In addition to the mobile behavioral health team(s) described in this document, this coordinated approach could include wraparound services for homeless youth & young adults (YYA), enhanced crisis response for young adults (YA) in housing programs as well as trauma-specific therapy and supports for homeless youth and young adults, or other programming, if future funding permits.

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to community providers and managed by existing staff within King County DCHS' Community Services Division in coordination with King County BHRD.

2. Spending Plan

The spending plan outlined here is limited to the recommended funding level. As such, these expenditure plans may be adjusted as program design continues.

Year	Activity	Amount
2017	Mobile behavioral health team(s) based at young adult housing programs (approximately 3.0 contracted FTE total, organized into 1-2 teams)	$300,000
2017 Annual Expenditure		**$300,000**
2018	Mobile behavioral health team(s) based at young adult housing programs (approximately 3.0 contracted FTE total, organized into 1-2 teams)	$307,800
2018 Annual Expenditure		**$307,800**
Biennial Expenditure		**$607,800**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposals (RFP) process will result in the selection of one or more provider(s) for these services.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning for this initiative will occur primarily in first quarter 2017, to align plans with final funding levels. Providers will be identified via the RFP process in second quarter 2017, with services to begin in third quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

MIDD II Initiative Title: South County Crisis Diversion Services/Center **(NEW)**

MIDD II Number: CD-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MID policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This program relates to the current MIDD I strategy Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team in the availability of in-the-community crisis response and the accessibility of a facility-based crisis diversion program. The program would provide south King County first responders with a therapeutic community-based alternative to jail and hospital settings when engaging with adult individuals in behavioral health crisis.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The South County Crisis Center (SCCC) is envisioned provide crisis services the southern region of King County serving individuals in behavioral health crisis who are coming into contact with first responders, as well as those individuals in South King County who may need a location for preventative and pre-crisis support and/or outreach. This allows for potential co-location and coordination of many crisis receiving and stabilization services accessible 24 hours a day, seven days per week (24/7), including but not limited to: on-site respite/crisis diversion and mobile crisis teams.

◊ *B. Goals*

The goals of the programs at the SCCC would be to meet the individual where they are, rather than expecting the individual to be ready for services, housing, etc. The recovery aspect would be indicated in the expectation that the SCCC will work with individuals on a repeat basis in order to work on motivation for treatment, while also focusing their efforts on addressing what is important for the individual. Without basic needs being met, individuals will likely be moving from crisis to crisis, rather than moving down a path of recovery. By setting the focus on identifying and addressing the most pressing needs – such as obtaining identification, obtaining health benefits, completing housing applications, etc. – the facility will be able to take the extra steps to ensure an individual has access to services and the support they need to help them maintain stabilization.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 1500 individuals annually when fully operational.

◊ *D. Outcomes and Performance Measures*

The expected outcomes for eligible individuals in South King County are:

- Reduced incarcerations and jail lengths of stay;
- Reduced emergency department utilization;
- Reduced psychiatric hospitalizations;
- Increased referrals and linkages to treatment;
- Increased access to health benefits/entitlements and primary care; and
- Increased diversion access and system response for criminal justice stakeholders, thus reducing the number of people with behavioral health conditions in our South King County jails.

◊ *E. Provided by: Contractor*

2. Spending Plan

The spending plan outlined here is limited to the pilot funding level. As such, implementation may include only some of the program elements listed above. The timing and/or amounts of some expenditures shown below may depend on when and how the facility is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

Year	Activity	Amount
2017 only	South King County Crisis Diversion Facility/Services capital investment and/or startup costs	$1,500,000
2017 Annual Expenditure		**$1,500,000**
2018	South King County Crisis Diversion Facility programs, services, and operations	$1,539,000
2018 Annual Expenditure		**$1,539,000**
Biennial Expenditure		**$3,039,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Planning for this new initiative is expected to be completed during the second quarter 2017. The RFP will be released in the third quarter 2017.

◊ *B. Contracting of Services*

The contract is expected to begin during the third quarter 2017.

◊ *C. Services Start date (s)*

The anticipated start date will likely be in 2018, depending on timeline for planning and procuring a contractor. In addition, depending on the extent of renovations or construction needed, implementation for the project could be delayed beyond a year from award.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

MIDD II Initiative Title: Multipronged Opioid Strategies **(NEW)**

MIDD II Number: CD-7

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

There are an estimated 23,000 people who use drugs by injection in King County.[1] Of clients seen at Public Health – Seattle and King County's Needle Exchange Program, 89 percent report having used heroin in the last three months, and 47 percent of these heroin users report being "hooked on prescription-type opiates" before they started using heroin.[2] Accelerating opiate use has been documented by increased treatment admits, increased heroin overdose deaths, an increase in heroin evidence tested by the State Crime Lab, and increased use of prescription-type opioids by 10th grade students.[3] Heroin involved overdose deaths in King County increased from 49 individuals in 2009 to 156 individuals in 2014, the highest number ever recorded.[4] The volume of syringes exchanged in King County in 2015 topped seven million, almost a four-fold increase in the last ten years, and an increase of 18 percent compared to 2014.

While capacity for Medication Assisted Treatment (MAT) has increased in King County, it has not kept pace with need: the number of treatment admissions for heroin in King County doubled between 2010 and 2014 and increased 32 percent from 2013 (2,187 admits) to 2014 (2,886).[4]

This initiative aims to address this trend by supporting the forthcoming recommendations of the Heroin and Prescription Opioid Addiction Task Force, jointly convened by King County Executive Dow Constantine and the mayors of Seattle, Auburn, and Renton.[5] Specifically, recommended interventions in as many as five categories may emerge from the work of the Task Force:

1. Expanded treatment on demand for office-based medication assisted treatment;
2. Primary prevention efforts including targeted educational campaigns;

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[1] Thiede H and Buskin S, *Updated men who have sex with men (MSM) and people who inject drugs (PWID) population estimates for King County*, HIV/AIDS Epidemiology Unit, Public Health – Seattle & King County and the Infectious Disease Assessment Unit, Washington State Department of Health, HIV/AIDS Epidemiology Report 2014, Volume 83, p59-62, http://www.kingcounty.gov/healthservices/health/communicable/hiv/epi/reports.aspx.
[2] Hanrahan M, Kummer K, Thiede H, unpublished results of a comprehensive intercept survey conducted at PHSKC needle exchange sites in June 2015.
[3] Banta-Green C, *Heroin Trends Across WA State*, ADAI Info Brief, UW Alcohol & Drug Abuse Institute, June 2013, http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2013-02.pdf.
[4] Banta-Green C et al, Drug Abuse Trends in the Seattle-King County Area: 2014, Alcohol & Drug Abuse Institute, University of Washington, June 2015, http://adai.washington.edu/pubs/cewg/Drug%20Trends_2014_final.pdf.
[5] http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/heroin-opiates-task-force.aspx. Task Force recommendations will be completed by September 30.

3. Increased access to overdose reversal drug naloxone to prevent fatalities and problem escalation;
4. Engagement services to link clients of Public Health Seattle-King County's (PHSKC) needle exchange to needed treatment services (as funded under MIDD I), and potential enhancement and/or expansion to serve more clients and/or address more complex needs.
5. Staffing support for a supervised consumption area[6] in King County.

Such approaches will assure equity in access to limited treatment resources, while also ensuring that residents whose heroin use is chaotically and expensively impacting other publicly funded resources (such as emergency medical care, psychiatric hospitalizations, criminal courts and incarceration facilities) have access to less expensive and responsive treatment services.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Although Task Force recommendations are not yet known, potential services could be implemented in five categories being considered by the Task Force and may include the following. Examples of potential interventions are described for each category.

- Category 1: Expanded treatment on demand for office-based MAT.
  - Offer multiple frequent induction points including needle exchange, jails, and detoxification facilities, community health centers, and behavioral health providers, including centralized coordination of service availability.

- Category 2: Primary prevention efforts, possibly including targeted educational campaigns.
  - Pilot educational campaigns to pediatric and adolescent medical providers regarding opioid prescribing and educating families on the role of opioids in medical treatment.
  - Other primary prevention efforts may emerge but have not yet been defined.

- Category 3: Increased access to overdose reversal drug naloxone to prevent fatalities and problem escalation.
  - Recipients of publicly funded treatment for opioid use disorder or needle exchange services, and those in their social and familial networks, may be enrolled in an overdose education and take-home-Naloxone program.

- Category 4: Continuation of MIDD I-funded engagement services to link clients of PHSKC's needle exchange to needed treatment services.
  - 1.0 FTE social worker at PHSKC's needle exchange.

- Category 5: Staffing support for a supervised consumption site in King County.
  - Services will include MAT with buprenorphine, and will be staffed in part by a nurse care manager.

[6] Such programs are often referred to as "safe injection facilities."

◊ *B. Goals*

Broad goals of this initiative include reduced heroin or opioid-linked overdose fatalities, and an improved continuum of health care services, treatment, and supports for opioid users in King County.

◊ *C. Expected Numbers of Individuals Served*

The 1.0 FTE social worker at PHSKC under category 4 serves 700 clients per year, refers 300 clients per year to MAT, and successfully places 200 clients in treatment.

Targets for the number of individuals to be served by categories 1, 2, 3, and 5 of this initiative – or other categories to be determined – will be set once Task Force recommendations are finalized. As the initiative's varied approaches are likely to yield interventions across the continuum of care, some potential interventions may come into contact with many people, while others may have a more focused impact on a smaller number of participants.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- reduced/eliminated substance use
- reduced jail, hospital, and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive services
- reduction of crisis events
- improved wellness and social relationships
- reduced hospitalization, emergency department use, and incarceration
- improved wellness self-management

Six anticipated outcomes are anticipated, all of which are either currently tracked or can be tracked:

1. Decrease in opioid related deaths in King County.
2. Increase access and utilization of MAT.
3. Increase ancillary service utilization, such as harm reduction housing and/or injector health utilization.
4. Quantifying prevention activities geared specifically to prevention activities of first initiation.
5. Reduction of emergency medical services via hospital or ambulance.
6. Reduction in post-release opioid deaths and post-release emergency department/hospital care related to opioid overdose in King County.

◊ *E. Provided by: County and/or Contractor*

Some funding for this project would support County clinical staff at PHSKC, while many other aspects would likely be contracted to community providers.

2. Spending Plan

Aside from needle exchange services, expenditures per service category will be determined after Task Force recommendations are finalized. Expected categories may also change.

Year	Activity	Amount
2017	Task Force-recommended service enhancements to address opiate addiction	$1,417,000
2017	Continuation of 1.0 FTE needle exchange social worker to engage clients with treatment	$83,000
2017 Annual Expenditure		**$1,500,000**
2018	Task Force-recommended service enhancements to address opiate addiction	$1,453,842
2018	Continuation of 1.0 FTE needle exchange social worker to engage clients with treatment	$85,158
2018 Annual Expenditure		**$1,539,000**
Biennial Expenditure		**$3,039,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Request for Interest (RFI) and/or Request for Proposals (RFP) process will result in the identification of providers for services under categories 1, 2, and 3.

Category 4 funding will likely continue to be distributed to PHSKC via a Memorandum of Understanding (MOU).

It is not yet known whether category 5 funding will be distributed via MOU or RFP.

◊ *B. Contracting of Services*

See 3.A above.

◊ *C. Services Start date (s)*

Category 4 funding for PHSKC needle exchange social worker(s) will be implemented January 1, 2017.

King County work to define the various other aspects of this initiative will begin in fall 2016, once Task Force recommendations are released, with stakeholder engagement to occur in first quarter 2017 when a final funding level is known. RFI and RFP processes, as applicable, will be completed in second quarter 2017, with services to be launched in third quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

MIDD II Initiative Title: Behavioral Health Urgent Care Walk-In Clinic **(NEW)**

MIDD II Number: CD-9

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "reduce the number, length, and frequency of behavioral health crisis events."

In communities where Behavioral Health Urgent Care Walk-In Clinics (BHUCCs) exist, people have rapid access to behavioral health services and supports, including peer specialists, to avert the need for more intensive crisis response by law enforcement, involuntary detention authorities, EDs, and inpatient hospitals. BHUCCs are available to intervene earlier, and to offer alternatives that prevent future destabilization. They promote hope and recovery, and offer skills to promote resilience. BHUCCs are an innovative system improvement and operate in coordination with all other components of a community's continuum of crisis services.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The King County BHUCC[1] is envisioned to serve adults who are experiencing a behavioral health crisis and is in need of immediate assistance. The Clinic would be as centrally located as possible and accessible via public transportation. Individuals may self-refer by coming directly to the Clinic during established business hours including evenings. Other referral avenues may be developed. No appointments would be necessary.

As funding permits, services available at the King County BHUCC may include:

- Help with coping skills and crisis resolution planning;
- Support from peer recovery specialists who bring hope to others on their recovery journeys;
- Access to crisis psychiatry as necessary;
- Crisis stabilization services, as needed, for up to 30 days;
- Intake/referral for crisis residential services;
- Substance use disorder screening and referral;
- Family education and support;
- Referral to community services for needs beyond the immediate crisis;
- Coordination of care with an individual's current providers, as permitted by the client; and

[1] The King County Behavioral Health Urgent Care Clinic (BHUCC) for adults experiencing behavioral health crises will be closely modeled after the Mental Health Crisis Alliance's Urgent Care Clinic, which has been in operation in St. Paul, Minnesota for over four years (http://mentalhealthcrisisalliance.org).

- Crisis phone support

Services are voluntary and meant to be short-term.

◊ *B. Goals*

The goals of the King County BHUCC are to offer urgent care services to individuals experiencing a behavioral crisis to help them avoid involuntary detention, hospital emergency department (ED) visits, psychiatric inpatient stays, or involvement with law enforcement.

◊ *C. Expected Numbers of Individuals Served*

It is not yet known how many individuals may be served by this program, as the BHUCC's service scope is scaled to available funding.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use

Specific BHUCC initial outcomes may include:

- Decrease in emergency room use for behavioral health crises
- Decrease in involuntary detentions
- Decrease in psychiatric hospital admissions
- Decrease in calls to law enforcement and/or fire departments by persons experiencing behavioral health crises
- Increase in timely access to crisis assessments
- Increase in access to peer crisis services
- Increase in number of successful linkages to treatment and other supports post crisis episodes

These measures will be further defined in consultation with crisis service experts.

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to community providers, potentially in tandem with Next Day Appointment services as described further below. County staff will provide program management and oversight.

2. Spending Plan

The spending plan outlined here is limited to the pilot funding level. As such, implementation may include only some of the detailed program elements listed above. The timing and/or amounts of some expenditures shown below may depend on when and how the clinic is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

Dates	Activity	Funding
2017 only	Urgent Care Walk-In Clinic capital investment and startup costs	$425,000
2017 only	0.5 TLT County program design, siting, public awareness, and launch support	$75,000
2017 Annual Expenditure		**$500,000**
2018 Annual Expenditure	Urgent Care Walk-In Clinic operations and services	$497,610
2018 Annual Expenditure	0.1 FTE County program management and monitoring	$15,390
2018 Annual Expenditure		**$513,000**
Biennial Expenditure		**$1,013,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposals (RFP) process hosted by King County BHRD will result in the selection of one or more Behavioral Health Urgent Care Walk-In pilot provider(s). Procurement for this initiative may be paired with Next Day Appointments, a closely related part of the crisis continuum that is also funded in part by MIDD.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning for this initiative will occur primarily in second quarter 2017, to align plans with final funding levels. Providers will be identified via the RFP process in third quarter 2017, with services to begin after a site is identified, secured, and readied, and staff are in place to implement the program model.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

MIDD II Initiative Title: Family Interventions Restorative Services (FIRS) **(NEW)**

MIDD II Number: CD-13

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

When law enforcement has probable cause of domestic violence in a home involving a youth, they must make an arrest if the suspected perpetrator is 16 years of age or older. (This state law is slated to change on July 1, 2016 so that parents can determine if the youth should be detained.) Arrested youth are then transported to the King County Youth Service Center and booked into detention. Younger youth may be transported to Spruce Street Inn.

With the FIRS Program, eligible youth involved in a domestic violence situation may avoid detention and have the opportunity to engage in a range of services. Youth are provided a place to stay in a 24/7 non-secure facility run by a contracted community services provider. Youth meet with a specialized FIRS Juvenile Probation Officer (JPC) who provides an assessment, designs a FIRS Agreement, and assigns youth to appropriate services, including Step-Up, evidence-based therapy, or the 180 Program. Youth may also agree to complete community service or engage with other services. In addition to enhancing access to existing services, FIRS expands the capacity of Step-Up, a "nationally recognized adolescent family violence intervention program designed to address youth violence toward family members" run by the King County Department of Judicial Administration (DJA). Step-Up provides safety plans for all FIRS families. The Step-Up curriculum provides 20 sessions of group counseling for parents and youth, which will be provided if FIRS screeners determine Step-Up is the appropriate treatment.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Family Intervention and Restorative Services (FIRS) program is an alternative to court involvement that provides services for King County youth who are violent towards a family member (often their mother). The initial King County Superior Court pilot of the FIRS program is currently active with temporary support from the City of Seattle and MIDD fund balance funding. The concept includes two components:

1. A non-detention 24/7 Respite and Reception Center (FIRS Center) staffed by a contract community services organization
2. Improved access to evidence-based and best practices interventions for families, including expansion of the Step-Up Program

◊ *B. Goals*

Goals for this initiative include:

- Improve prompt access to services for families experiencing youth domestic violence;
- Reduce detention and filings; and
- Reduce future domestic violence and other criminal incidents.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected serve more than 300 individuals annually-though figures may be adjusted due to the impact of the change in state law.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative include:

- Increased access to culturally appropriate recovery services;
- Increased linkage to behavioral health treatment; and
- Decreased admissions to detention.

◊ *E. Provided by: Both County and Contractor*

2. Spending Plan

Year	Activity	Amount
2017	24/7 non-secure facility for King County youth who are violent towards a family member and evidence-based and best practices interventions for families continue.	$ 717,500
2017 Annual Expenditure		**$ 717,500**
2018	24/7 non-secure facility for King County youth who are violent towards a family member and evidence-based and best practices interventions for families continue.	$ 736,155
2018 Annual Expenditure		**$ 736,155**
Biennial Expenditure		**$ 1,453,655**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The initial King County Superior Court pilot of the FIRS program is currently active with temporary support from the City of Seattle and MIDD fund balance funding. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

MIDD II Initiative Title: Involuntary Treatment Triage **(NEW)**

MIDD II Number: CD-14

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This funding will enable Harborview Medical Center (HMC) to provide local triage evaluations for individuals with severe and persistent mental illness who have been charged with a serious misdemeanor offense and are found not competent to assist in their own defense and not able to be restored to competency to stand trial.

This will enable Designated Mental Health Professionals (DMHPs), dispatched from King County Crisis and Commitment Services (CCS), who currently provide these evaluations, to respond more efficiently to a significant volume of initial referrals for involuntary treatment evaluation services under RCW 71.05 (the civil Involuntary Treatment Act). This triage project also ensures full compliance with the process outlined in RCW 10.77, as HMC can evaluate each person for a 90-day civil commitment, unlike DMHPs who may only evaluate for an initial 72-hour detention.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The HMC evaluator (who is a licensed clinical social worker) receives the court order to evaluate the person in jail within a 72-hour window.

If the person is deemed to not meet the threshold for civil commitment, the HMC evaluator develops a safe plan for release in coordination with outside providers and release planners, and petitions the judge for release of the person to the community.

If the person is determined to meet the legal threshold for civil commitment under Chapter 71.05 RCW (the Involuntary Treatment Act),[1] the evaluator (along with a provider) will file a petition for a 90-day more restrictive order. In coordination with the County and local Evaluation and Treatment (E&T) facilities, the person is placed in the appropriate local E&T for inpatient psychiatric treatment.

[1] Mental Illness and Involuntary Treatment Act statute: http://app.leg.wa.gov/RCW/default.aspx?cite=71.05.

◊ *B. Goals*

This initiative will ensure that incarcerated individuals with mental illness who may not be competent and not restorable receive the appropriate level of care - locally. Specifically, if these individuals do not require hospitalization, they will be connected with appropriate outpatient services to address their primary and mental healthcare needs. This initiative provides a more robust continuum and coordination of care with a more thorough assessment of the individuals' needs and strong linkage to services either from jail or once discharged from the E&T. By keeping individuals in local treatment facilities (vs. WSH) for the initial treatment, there is a decrease in the number of patients being placed on long term court orders and in turn a decrease in placements to WSH. Lastly, this triage project effectively avoids the unnecessary use of emergency departments, by providing the initial evaluation in the jail.

◊ *C. Expected Numbers of Individuals Served*

Based on the unfunded RCW 10.77 evaluation volume currently handled by King County's DMHPs, it is estimated that between 200 to 250 individuals per year would receive evaluations through this program once funded.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- reduced jail, hospital, and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- reduced unnecessary hospital and emergency department use

In addition to diverting more individuals with mental illness from unnecessary ED and psychiatric hospitalizations, this process provides a more efficient, safe, cost effective process as well as improved resource utilization, with local evaluations provided in the jail.

The triage process ensures that persons who are already connected with outpatient providers are reconnected with these services. Additionally, if these individuals are not acute or not deemed dangerous/gravely disabled, this process creates a safe plan for direct release from the jail.

As a result of interventions by an evaluator or care manager targeting the individuals most frequently coming into contact with law enforcement and crisis systems, this initiative may also result in a reduction in referrals to DMHPs and eventually a decline in the law enforcement contacts with these individuals

◊ *E. Provided by: Contractor*

All evaluation services offered under this initiative will be contracted to current 10.77 Triage Project partner Harborview Medical Center.

2. Spending Plan

The spending plan outlined here would create the capacity to provide 200 to 250 evaluations per year.

Year	Activity	Amount
2017	0.2 FTE Psychiatric nurse practitioner (co-petitioner)	$37,000
2017	1.0 FTE Licensed social worker (primary evaluator)	$92,000
2017	0.2 FTE administrative support (processing and filing petitions, tracking court dates and plan/outcomes)	$10,500
2017	0.1 FTE supervisor	$10,500
2017 Annual Expenditure		**$150,000**
2018	0.2 FTE Psychiatric nurse practitioner (co-petitioner)	$37,000
2018	1.0 FTE Licensed social worker (primary evaluator)	$92,000
2018	0.2 FTE administrative support (processing and filing petitions, tracking court dates and plan/outcomes)	$10,500
2018	0.1 FTE supervisor	$10,500
2018 Annual Expenditure		**$153,900**
Biennial Expenditure		**$303,900**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The service would most appropriately be procured from existing triage project partner Harborview Medical Center, which has been performing evaluations via this workgroup since 2013 to the degree such services have been feasible without dedicated funding.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning and measures for this initiative will occur primarily in first quarter 2017, to align plans with final funding levels. MIDD-funded services could begin as soon as second quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

MIDD II Initiative Title: Youth Behavioral Health Alternatives to Secure Detention **(NEW)**

MIDD II Number: CD-16

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This program is envisioned to provide community based treatment beds for youth who are being held in detention. These treatment beds would divert youth from detention and address a serious gap in the current behavioral health system. Program treatment services will stabilize the youth and family.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This program will be developed collaboratively with stakeholders and communities. The final program design and services may include other elements than what is reflected in this document.

It is currently envisioned that this initiative would create a community placement specialized alternative to secure detention beds for children and youth who are detained in juvenile detention and who have mental health, substance use disorder (SUD) related or other behavioral health needs. The youth utilizing the beds would be supported with a full continuum of therapeutic behavioral health services that includes one on one therapy, family counseling, group counseling, case aide support, vocational training, behavioral support, social skills training, and medication management. It also includes all services included in the Medicaid continuum of care for youth (whatever is medically necessary to treat or ameliorate the condition).

In addition, this proposal would include a complementary less restrictive program where the family would be able to provide the housing for the child/youth as long as the counseling, assessment, case aide support and other interventions would be available to support the family.

◊ *B. Goals*

The goal of this initiative is to provide youth with behavioral health treatment needs in juvenile detention with community based treatment beds in order to safely return youth to their homes with comprehensive supports to the family to prevent further involvement with the juvenile justice system.

◊ *C. Expected Numbers of Individuals Served*

Depending on the length of stay 16 to 32 youth will be served per year.

◊ *D. Outcomes and Performance Measures*
This initiative is expected to provide the following outcomes:

- Improved health and well-being for youth;
- Reduced days incarcerated;
- Increased connection to community services; and
- Improved connections to family and natural supports.

◊ *E. Provided by: Contractor(s)*

2. Spending Plan

Year	Activity	Amount
2017	Complete planning, develop and issue Request for Statement of Interest/Request for Proposal, Select recipients, complete contracts, and services begin.	$ 1,000,000
2017 Annual Expenditure		**$1,000,000**
2018	Alternatives to Secure Detention programs, services, and operations	$
2018 Annual Expenditure		**$1,026,000**
Biennial Expenditure		**$ 1,026,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Planning for this new initiative is expected to be completed during the first and second quarter of 2017. The RFP will be released in the third quarter 2017.

◊ *B. Contracting of Services*

The contract is expected to begin during the third quarter 2017.

◊ *C. Services Start date (s)*

The anticipated start date will likely be in the third quarter 2017, depending on timeline for planning and procuring a contractor.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

MIDD II Initiative Title: Zero Suicide Initiative Pilot **(NEW)**

MIDD II Number: PRI-6

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "reduce the number, length, and frequency of behavioral health crisis events."

Zero Suicide[1] is built on the foundational understanding that suicide deaths for individuals receiving services in health and behavioral health systems are preventable. The Zero Suicide Initiative is the beginning of a comprehensive suicide prevention strategy/plan for King County, and will be a new approach for suicide prevention for the region.

Suicide is a major public health problem. In Washington State, suicide is the eighth leading cause of death overall and the second leading cause of death among young people ages 15-35. In King County, there are roughly 250 deaths by suicide every year. For every suicide, it is estimated that 25 attempts are made, some requiring expensive emergency room and hospital visits. For every suicide death, it is estimated that six friends and family members of the deceased will struggle with this particularly devastating and complicated form of grief for the rest of their lives.[2]

Zero Suicide will involve a multi-stage project where the public health and behavioral health systems serving adults with serious mental illnesses will be supported in adopting a specific set of strategies, tools and training to transform these systems to eliminate patient safety failures and to close gaps in depression and suicide care. Zero Suicide a key concept in healthcare that is contained in the 2012 National Strategy for Suicide Prevention.[3]

The programmatic approach of Zero Suicide is based on the understanding that individuals at risk of suicide often fall through cracks in a fragmented, and sometimes distracted, health care systems. A systematic approach to quality improvement in these settings is both available and necessary. The challenge and implementation of a Zero Suicide Initiative cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and to close the gaps.

[1] http://zerosuicide.sprc.org/about
[2] http://www.doh.wa.gov/Portals/1/Documents/5500/IV-SUI2013.pdf
[3] http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Zero Suicide Initiative is designed with three phases and additional trainings to the community, as funding permits:

- Phase 1: King County behavioral health and health care system – provider and county system (DCHS and Public Health) and trainings/development;
- Phase 2: Hospital and Healthcare systems participating in Screening, Brief Intervention and Referral to Treatment (SBIRT), to the degree funding permits;
- Phase 3: Remaining Hospital, Behavioral Health and Healthcare systems, to the degree funding permits.

Zero Suicide approach implementation includes the following components, each of which will be carried out as much as feasible given funding limitations:

1. Identify sources of data that can be improved and analyzed to assess, as fully as possible, the extent of suicidal behavior occurring within King County's public behavioral health care system and primary care system and, to put into place a reporting system on suicidal behavior.
2. Analyze provider contracts to recommend changes to incentivize Zero Suicide approaches within contracted agencies.
3. Determine a Zero Suicide implementation provider agency and work to determine and select the first cohort of the provider agencies, who are determined to be ready based on a base-line assessment, to begin work via Zero Suicide grants.
4. Provide intensive training and technical assistance to the first cohort of contracted provider agencies to implement a Zero Suicide approach.
5. Establish a Zero Suicide learning collaborative comprised of implementation teams from each agency. Each team will develop a strategic plan for their work over the next two years and a cross-agency learning collaborative will be established.
6. Provide technical assistance to each agency. Many training opportunities for agency staff will be provided to the learning collaborative of participating contracted agencies over the two-year period.
7. Continued rollout to additional cohorts of contracted providers annually, and then expand to phase 2 and 3 sites as funding permits.

The Zero Suicide Initiative may also include many of the following components, subject to available funding. Prioritization of these components will be determined in consultation with suicide prevention partners:

8. Lethal means restriction training, including exploration of options for means restrictions programming implementation (e.g. implementation of recommendations from the Washington State Safer Homes Task Force);
9. Suicide attempt follow up care program when released from Emergency Department or inpatient settings (including development of a model-based emerging best practice);
10. Universal and proper implementation of suicide risk screening at Emergency Departments (coupled with brief interventions, discharge planning and follow up); and

11. Programming for families/friends who have lost someone to suicide.
12. Universal gatekeeper suicide prevention training.
13. A social marketing/media outreach plan.
14. Partnership with Mental Health First Aid training for stigma reduction.

The MIDD II allocation described in this implementation plan is a pilot award amount. Therefore, the Zero Suicide initiative may be scaled, and phases reduced, in consultation with partners to design and implement a pilot within appropriated budget levels. Rollout to hospital settings via Phase 2 and 3 may be slowed or likewise scaled in accordance with partner input. The spending plan in section 2 below therefore represents expenditures for the appropriated amount only, commensurate with the implementation of a pilot.

◊ *B. Goals*

Through this initiative's training and technical assistance efforts, the following seven elements of suicide prevention care for health and behavioral systems would gradually be adopted by behavioral health and physical health care providers, and become a new best practice standard for publicly funded care in King County[4].

- Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
- Train – Develop a competent, confident, and caring workforce. Train all staff commensurate with their potential role in suicide prevention.
- Identify – Systematically identify and assess (screening and assessment) suicide risk among people receiving care.
- Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet their needs. Include collaborative safety planning and restriction of lethal means.
- Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- Transition – Provide continuous contact and support, especially after acute care. Utilize peers who are in behavioral health recovery who also experience suicidal behaviors to help support those who are at-risk.
- Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Additional goals include effective implementation of Suicide Prevention components across King County.

◊ *C. Expected Numbers of Individuals Served*

Each annual provider cohort is expected to include several agencies, each of which will identify implementation teams to pioneer Zero Suicide approaches within their organizations. The number of potential clients who could benefit from the resulting

[4] Adapted from the Zero Suicide Toolkit at http://zerosuicide.sprc.org/toolkit

enhanced services provided by these teams is indeterminate and likely to vary by agency. Additional individuals reached by suicide prevention trainings will vary depending on funding allocation.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital, and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships

Zero Suicide initial outcomes may include:

- reduced suicide rates among clients served by participating providers;
- increased numbers of clinical and support staff who are trained in how to prevent suicide commensurate with their role in the agency;
- measureable systems-based improvements in suicide care; and/or
- fewer emergency room visits and inpatient stays in psychiatric hospitals for agency clients.

The lethal means and screening training aspects of the initiative, along with services for survivors or families, could include such measures as:

- the number of individuals trained or served; and/or
- changes in participant attitude, knowledge, and behavior.

These measures will be further defined in consultation with suicide prevention partners.

◊ *E. Provided by: Contractor*

The training and services will be contracted to suicide prevention experts and the pilot grants will be contracted to provider agencies. County staff will provide program management and oversight.

2. Spending Plan

The spending plan outlined on the next page is limited to the pilot funding level. As such it reflects only some aspects of the implementation plan described above.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

Year	Activity	Amount
2017 only	Develop Zero Suicide pilot plan, including capacity/ training and technical assistance, and identification of provider to implement pilot (components 1-2)	$250,000
2017	Develop and begin implementation of lethal means restriction training, suicide attempt follow-up, programming for families, and/or universal gatekeeper suicide prevention training (components 8-14)*	$75,000
2017 (partial year)	Begin Zero Suicide approach training and learning collaborative cohorts (components 3-7)	$100,000
2017	0.50 FTE County program management, including BHRD suicide prevention, Zero Suicide implementation oversight and technical assistance, community/provider engagement and monitoring	$75,000
2017 Annual Expenditure		**$500,000**
2018	Zero Suicide approach training and learning collaborative cohorts (components 3-7)	$307,800
2018	Small-scale implementation of lethal means restriction training, suicide attempt follow-up, and/or programming for families, and/or universal gatekeeper suicide prevention training(components 8-14)*	$128,250
2018	0.50 FTE County program management, including BHRD suicide prevention, Zero Suicide implementation oversight and technical assistance, community/provider engagement and monitoring	$76,950
2018 Annual Expenditure		**$513,000**
Biennial Expenditure		**$1,013,000**

* The relative emphasis of the various program elements among components 8-14 during the pilot, will be determined in consultation with suicide prevention partners during the last quarter of 2016 and early 2017 in accordance with the final funding level.

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Qualifications (RFQ) and/or Request for Proposals (RFP) process hosted by King County BHRD will result in the selection of Zero Suicide pilot provider implementation and training coordinator(s). King County and selected provider will conduct a Request for Interest (RFI) including a provider readiness assessment to determine the first cohort of provider agencies who will participate in implementation of the Zero Suicide model.

RFI(s) for provision of lethal means restriction training, suicide attempt follow-up services, programs for families, and/or universal gatekeeper suicide prevention training may be procured separately and subsequently, based on the programming and budget determination noted above.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Zero Suicide is an existing normed service framework with existing major milestones and deliverables. Component consultation with suicide prevention partners will occur during late 2016 and early 2017, with final pilot design definition to occur in by March 2017. A request for interest (RFI) for Zero Suicide pilot implementation will occur by second quarter 2017. To the degree funding permits, and subject to the results of planning with suicide prevention partners, lethal means restriction training, suicide attempt follow-up, and services for families, will be procured in the first quarter of 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

MIDD II Initiative Title: Mental Health First Aid **(NEW)**

MIDD II Number: PRI-7

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

About one in five Americans experiences a mental illness per year[1] and many are reluctant to seek help or might not know where to turn for care. The symptoms of mental illness can be difficult to detect — even when friends and family of someone who appears to be developing a mental illness can tell that something is amiss, they may not know how to intervene or direct the person to proper treatment – which means that those in need of mental health services do not get them until they require emergency medical intervention. Many people in society remain ignorant or fearful about the signs and symptoms of mental illnesses,[2] although society has a role through responsible community members to help people experiencing these illnesses. If the greater community has a better understanding of psychiatric conditions, then more people will feel both competent and equipped to help people in their communities. If mental illness is destigmatized, more people will feel comfortable asking for and receiving help earlier in the process. This will improve the overall health of the population and promote wellness in the region.

Mental Health First Aid is an 8-hour training course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Mental Health First Aid would be available to a variety of audiences, including: health and human services workers; employers and business leaders; faith community leaders; college and university staff and faculty; law enforcement and public safety officials; veterans and family members; persons with mental illness-substance use disorders and their families; and other caring citizens. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand, and respond to signs of mental illness. It also helps reduce stigma related to behavioral health conditions.

Just as CPR training helps a person with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a person assist someone experiencing a mental health crisis such as contemplating suicide. In both situations, the goal is to help support an individual *until appropriate professional* help arrives. Mental Health First Aid trainees learn a single 5-step strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other supports. Participants are also introduced to risk factors and warning signs for mental health or substance use

[1] Any Mental Illness (AMI) Among Adults. (n.d.). Retrieved December 11, 2015, from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml
[2] Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health. 1999;89(9):1328-33.

problems, engage in experiential activities that build understanding of the impact of illness on individuals and families, and learn about evidence-supported treatment and self-help strategies. Mental Health First Aid is intended for all people and organizations that make up the fabric of a community.[3]

A study of Mental Health First Aid training for the public showed that participants were more able to recognize a mental disorder in vignettes, changed their beliefs about treatment that were more consistent with those of health professionals, were more likely to engage with people with mental health disorders, felt increased confidence to help someone with a psychiatric condition, and were more likely to provide more help to others.[4]

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Mental Health First Aid training initiative service components will include a combination of direct Mental Health First Aid trainings and "train the trainer" courses, with the numbers of each type of training to be determined by community capacity and interest.

The Mental Health First Aid course runs eight hours and may be offered in a variety of formats (Adult & Youth). Most often, it is provided in one day, or in two 4-hour sessions spaced over a short period of time. In addition, offering 5-day train the trainer courses in Mental Health First Aid, thereby increasing training capacity within the County, will also increase the likelihood that people in a number of different communities will learn about Mental Health First Aid.

The specifics of the service components will be created in partnership with individuals in King County currently trained in Mental Health First Aid and others who are interested in becoming Mental Health First Aid trainers, in consultation with the Mental Health First Aid training developers. The service components will be coordinated by King County DCHS' Behavioral Health and Recovery Division, and the specifics of service delivery and implementation will be based on community input, readiness, and demand. At the beginning stages of implementation, currently trained facilitators can conduct a certain number of trainings in their geographic areas and collect required evaluation data.

In addition, current King County providers will be consulted about their willingness and capacity to have staff trained as facilitators. Other entities such as school districts and law enforcement agencies will be surveyed about their interest in hosting or attending these trainings.

[3] Mental Health First Aid Frequently Asked Questions. (n.d.). Retrieved December 11, 2015, from http://www.mentalhealthfirstaid.org/cs/faq/
[4] Kitchener, B. A., & Jorm, A. F. (2002). Mental Health First Aid training for the public: Evaluation of effects knowledge, attitudes and helping behavior. BMC Psychiatry, 2(10), 1-6.

◊ *B. Goals*

Having more people throughout the county who become knowledgeable about psychiatric conditions will ultimately reduce stigma for individuals with these conditions. Giving more people in the community the basic tools to recognize and respond to emergent mental health crises will increase the likelihood of useful interventions from a person' s natural support system during a behavioral health crisis.

◊ *C. Expected Numbers of Individuals Served*

Given current funding levels and national estimates of average costs of Mental Health First Aid training per person, as many as 1,700 people per year could be served if only direct trainings are offered, although this number may vary depending on the focus and target population. Costs are variable, depending on the number of individuals trained, and the numbers of trainings offered.

The potential reach of the MIDD investment could be broadened through the strategic use of "train the trainer" certification courses that could create lasting impact beyond the MIDD funding. However, the higher up-front cost of these trainings ($1,850 to $2,000 per person for a 5-day training) would decrease the total number of trainees funded directly by MIDD.

The relative number of direct trainings versus certification courses that would be offered by through this MIDD initiative will be determined via the community-informed design process outlined above.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level MIDD II outcomes are expected for individuals who receive Mental Health First Aid training:

- improved perception of health and behavioral health issues and disorders

The following individual-level MIDD II outcomes are expected for individuals who are assisted by Mental Health First Aid trainees:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- improved experience of care

Output measures may include the number of trainings offered, the number of training participants, and increases in the number of trained facilitators in King County.

Mental Health First Aid trainings include evaluation components that measure increased knowledge regarding mental illness and increased awareness of resources for individual training participants. These components would be reported and aggregated to determine the impact of the initiative.

Additional expected benefits, to be explored during the implementation phase for possible measurement (if feasible), include:

- Increase in the number of people who would benefit from behavioral health services seeking those services
- Decrease in the number of people who need emergent behavioral health interventions (e.g., reductions in emergency department use due to psychiatric reasons)
- Members of the general population interacting with people with behavioral health conditions (i.e., reduction in stigma)
- Increase in resources directed towards behavioral health services, due to greater recognition of need in the area (e.g., communities would be more willing to permit the building of a behavioral health facility in the neighborhood)

◊ *E. Provided by: Contractor*

Contracting for implementation of Mental Health First Aid training calendar and trainings will be explored in consultation with partners. Most or all trainings are expected to be provided by contractors, although County staff may have a training role as well.

2. Spending Plan

Year	Activity	Amount
2017	Mental Health First Aid trainings to communities and certification courses via contracted providers (direct trainings estimated at $100 per participant, variable; certification courses $1,850-$2,000 per participant)[5]	$170,000
2017	Program management, promotion, trainings delivered by County staff 0.2 County FTE	$30,000
2017 Annual Expenditure		**$200,000**
2018	Mental Health First Aid trainings to communities and certification courses via contracted providers (direct trainings estimated at $100 per participant, variable; certification courses $1,850-$2,000 per participant)[6]	$174,420
2018	Program management, promotion, trainings delivered by County staff 0.2 County FTE	$30,780
2018 Annual Expenditure		**$205,200**
Biennial Expenditure		**$405,200**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Qualifications (RFQ) process hosted by King County BHRD will result in the selection of a provider to coordinate the Mental Health First Aid training calendar and Mental Health First Aid training coordinator(s).

A Request for Information (RFI) process hosted by King County BHRD will result in the identification of provider agencies and individuals who want to be trained as facilitators in Mental Health First Aid.

◊ *B. Contracting of Services*

King County BHRD, through the RFQ, will contract with one entity to coordinate the Mental Health First Aid training calendar county-wide; explore with partners setting up a regional system within training contracts in each region to ensure training capacity and saturation; and BHRD offering some trainings itself.

[5] http://www.mentalhealthfirstaid.org/cs/become-an-instructor/certification-process/
[6] http://www.mentalhealthfirstaid.org/cs/become-an-instructor/certification-process/

The outreach process and plan development will include finalizing the approach for training implementation and design. BHRD staff will work with selected provider agency for the training calendar coordination and identified training coordinator(s) to create a regional training plan that ensures distribution and training across King County.

◊ *C. Services Start date (s)*

With resources dedicated to up-front community outreach, the projected start for trainings is second quarter 2017, with facilitators already trained in Mental Health First Aid to begin trainings as soon as monthly once the RFQ/RFI and contracting processes are complete. Full-scale implementation could be under way by third quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

MIDD II Initiative Title: Rapid Rehousing Oxford House Model **(NEW)**

MIDD II Number: RR-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "explicit linkage with, and furthering the work of, other King County and community initiatives."

The rapid rehousing Oxford House voucher program is an immediate solution for affordable, clean and sober housing option for individuals in recovery who are homeless or at risk of homelessness. The program supports the goals of the All Home Strategic Plan, Behavioral Heath Integration, Health and Human Services Transformation and the Veterans and Human Service Levy.

This program will prevent and decrease homelessness and improve the self-reliance and increase employment among program participants. This program would support the King County's vision for health care, reflecting the triple aim of improved patient care experience, improved health, and reduced cost of health care. As more individuals with substance use disorders receive treatment due to health care reform and system improvement, there will be a greater need for next step housing to bridge the gap between residential treatment and fully independent living.

The initiative pairs a proven residential program with rapid rehousing, a best practice for getting people off the street and out of shelters, while also preventing homelessness.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Specifically, the initiative will provide vouchers for clean and sober housing for individuals in recovery.

This program will serve adults who are newly in recovery – typically having recently completed a drug and alcohol treatment program – and who would be homeless without this assistance. Individuals will receive rental assistance for approximately three months while they secure employment.

◊ *B. Goals*

This initiative creates access to rapid rehousing rental support for individuals for whom such recovery support would enable them to regain stability, but may not have chronic conditions that would qualify them for housing assistance through other traditional sources.

◊ *C. Expected Numbers of Individuals Served*

It is expected that about 333 people in recovery per year will receive vouchers for Oxford housing at the recommended funding level.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- housing stability
- reduced use of jails, hospitals, and emergency departments
- reduced substance use

The following individual-level MIDD II outcome measures are expected for program participants:

- reduced behavioral health risk factors
- improved wellness and social relationships
- increased housing stability
- increased employment
- reduced hospitalization, emergency department use, and incarceration
- reduced use of drugs and alcohol

Outcomes specific to the rapid rehousing Oxford House voucher program may include:

- Increased access to housing and improved housing stability
- Increased access to person centered, culturally appropriate recovery treatment
- Increased access to reentry services from jail or hospital
- Increased application of recovery and resiliency principles in services provided
- Reduction in use of jail and emergency departments for crisis services
- Increased geographic availability of services
- Increased employment and education outcomes
- Reduced barriers to services
- Increase in personal happiness as measured by meaningful life activities

Initiative-specific outcomes are subject to further refinement as programming is defined.

◊ *E. Provided by: Contractor*

All vouchers offered under this initiative will be distributed to community substance use disorders (SUD) treatment providers and managed by existing staff within King County DCHS' Community Services Division's rapid rehousing program, in coordination with King County BHRD.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

2. Spending Plan

Year	Activity	Amount
2017	Approximately 333 rapid rehousing vouchers for use in Oxford House settings	$500,000
2017 Annual Expenditure		**$500,000**
2018	Approximately 333 rapid rehousing vouchers for use in Oxford House settings	$513,000
2018 Annual Expenditure		**$513,000**
Biennial Expenditure		**$1,013,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Qualifications (RFQ) process will result in the selection of participating qualified SUD treatment agencies who will receive these vouchers for their clients to access.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning and outcome measurement determination for this initiative will occur primarily in second quarter 2017. Providers will be identified via the RFQ process in second quarter 2017, with services to begin soon thereafter.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

MIDD II Initiative Title: Behavioral Health Risk Assessment Tool for Adult Detention **(NEW)**

MIDD II Number: RR-7

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Individuals who experience behavioral health issues have increased rates of incarceration.[1] Some jurisdictions in the U.S. have been able to reduce rates of recidivism for individuals who experience behavioral health issues through the complete application of evidence-based practices with fidelity, of which risk and need assessment is foundational.[2] The implementation of the comprehensive risk and needs assessment of incarcerated individuals in King County will guide case management and appropriate services placement, and will position King County Department of Adult and Juvenile Detention (DAJD) and the King County Community Corrections Division (CCD) to partner with providers in an effort to reduce recidivism consistent with national best practices.

The first step in this work is the development and implementation of a validated needs assessment platform in King County.[3] At present, a King county cross-system criminal justice and behavioral health work team[4] is working with the Washington State University Criminal Justice Institute to develop a comprehensive jurisdictional needs assessment tool for King County that, when applied countywide, will not only identify the likelihood of re-offense but will specifically categorize the criminogenic needs of the individual.

This initiative supports implementation of a behavioral health risk assessment instrument in King County's adult correctional facilities.

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[1] Steadman, HJ, Osher, FC, Robbins, PC, Case, B, Samuels S. "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services,* 60, 6, (2009): 761-765.
[2] https://csgjusticecenter.org/nrrc/publications/states-report-reductions-in-recidivism-2/ and https://csgjusticecenter.org/re-entry/publications/reducing-recidivism-states-deliver-results/. Accessed 12/31/15.
[3] King County Recidivism Reduction and Re-entry Strategic Planning, Progress Report I, Submitted by Patty Noble-Desy (July 2015). Available at http://aqua.kingcounty.gov/Council/agendas/LJEM/20151027-LJEM-packet.pdf. Accessed 12/29/15.
[4] KC Performance, Strategy and Budget, KC Dept. of Adult and Juvenile Detention, KC Prosecuting Attorney's Office, KC Dept. of Public Defense, KC Behavioral Health and Recovery Division, KC Jail Health Services, KC Superior Court, KC Drug Diversion Court, KC Sheriff's Office, KC Council Staff, KC Executive's Office, City of Seattle, Northwest Justice, Public, Defender Assoc., WA State Dept. of Corrections, University of Washington, Antioch University

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

1. Program Description

◊ *A. Service Components/Design (Brief)*

The needs assessment will be administered to a subpopulation of individuals who are:

- incarcerated in DAJD adult facilities for at least four days and no more than 180 days;
- who are not subject to Washington State Department of Corrections supervision;
- who will not be transferred to another jail or jurisdiction; and
- who will be releasing to King County.

Following completion of the needs assessment, those who are identified as likely having a substance use[5] or serious mental health disorder[6] will be invited to participate in the development of a Recidivism Reduction and Community Re-entry Plan using Screening, Brief Intervention, and Referral to Treatment (SBIRT)[7] interviewing, and an evidence-based Risk Need Responsivity Simulation Tool[8] developed by George Mason University. This work considers all relevant individual needs information while factoring local recidivism drivers and develops an individualized community re-entry plan designed to measure and reduce recidivism factors.

With signed permission from the individual and after conferring with defense counsel, information obtained from the needs assessment will be shared with any potential service providers in the community or release planning staff in the jail. In some cases, this information may be shared with programs that operate inside the jail.[9]

With a plan developed, referral sources will be better able to direct participants to viable community-based programs that are prepared to address their behavioral health risks and needs and will document their admission to appropriate programs in the community. In the event of a return to custody in King County, the client needs profile and the associated Community Re-entry Plan will be reviewed to determine what did not work well and what can be done differently to achieve a positive outcome.

◊ *B. Goals*

As King County begins to identify and address individuals' behavioral health risks and criminogenic needs consistent with best practices, a reduction in the return to custody among adult individuals with SUDs and/or serious mental illness is expected. This new concept addresses a currently unmet need and represents a critical and necessary initial

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[5] http://www.casacolumbia.org/newsroom/press-releases/2010-behind-bars-II. Accessed 12/29/15.
[6] Aufderheide, Dean H. and Brown, Patrick H. "Crisis in Corrections: The Mentally Ill in America's Prison." Corrections Today, Volume 67, Issue 1, (February 2005): 30 to 33. Cited from http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/ on 12/31/15.
[7] http://www.samhsa.gov/sbirt. Accessed 12/29/15.
[8] https://www.gmuace.org/research_rnr.html. Accessed 12/29/15.
[9] The Prosecuting Attorney's Office and the Department of Public Defense will be parties to a Memorandum of Understanding that assures the purpose and product of this work to be limited to the collection of data for program and resources planning and for use by the participant and any potential service providers they may choose to release their information to, with written and signed documentation, to assist with re-entry and ongoing services in the community.

component in the application of alternatives that can result in overall reduced County expenses. It includes better meeting the behavioral health needs of the participants by providing them a specific and unique plan of action designed to address their behavioral health needs and decrease their likelihood of further criminal justice involvement.

◊ *C. Expected Numbers of Individuals Served*

Approximately 2,460 individuals per year are expected to receive comprehensive actuarial needs assessments after jail booking, as well as referral to needed services upon release.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- reduced jail use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduced unnecessary incarceration

Potential performance measures for this initiative may include the number of in-custody assessments conducted and subsequent linkages to treatment and/or behavioral health and wellness services in the community upon release. Other areas that could be measured may include decreased criminal justice and crisis systems use, timely access to treatment and other needed services, and access to housing if needed.

Likely outcome indicators specific to this initiative include identification of individuals in need of behavioral health interventions, specific and targeted referrals for this population, identified criminogenic needs that can be used to inform jail practices for this population, and an individualized plan to reduce the likelihood of re-offense.

Specific outcomes and measures for this initiative, especially identification of what will be evaluated as part of MIDD II, are subject to further definition. The cross system workgroup referenced above will provide guidance regarding the overarching measures to be used in this initiative as they are finalized, to ensure linkage to MIDD's policy goals as well as any other County priorities.

◊ *E. Provided by: County*

The services planned under this initiative would be provided by County staff within the intake services unit known as Personal Recognizance Investigators (PR screeners), housed within the jail under the leadership of the Community Corrections Division of the Department of Adult and Juvenile Detention (DAJD).

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

2. Spending Plan

Year	Activity	Amount
2017	4.0 FTE intake services staff (3.0 FTE PR investigators plus 1.0 FTE supervisor)	$450,900
2017	Materials, training, and overhead	$20,000
2017 Annual Expenditure		**$470,900**
2018	4.0 FTE intake services staff (3.0 FTE PR investigators plus 1.0 FTE supervisor)	$462,623
2018	Materials, training, and overhead	$20,520
2018 Annual Expenditure		**$483,143**
Biennial Expenditure		**$954,043**

3. Implementation Schedule

◊ *A. Procurement of Providers*

No procurement would be necessary, as this service would be provided by County staff.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Funding will be distributed to DAJD immediately in first quarter 2017 as no procurement process is necessary. Hiring and training of intake section staff could extend into second quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

MIDD II Initiative Title: Recovery Café **(NEW)**

MIDD II Number: RR-9

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The nonprofit Recovery Café provides an alternative therapeutic supportive community for women and men traumatized by homelessness, addiction and other mental health challenges. Operating for over 10 years, Recovery Café has helped thousands of women and men find stability and support on their recovery journey.

MIDD II's annual investment, in combination with operating and capital funding from other sources, would allow a second location in King County to be launched.

The alternative therapeutic model used at Recovery Café provides support, resources and a community of care along the entire continuum of a person's need for recovery assistance. In crisis, newer to recovery, in long-term recovery, after a relapse, during a difficult life change, or mental health transition, Recovery Café is a refuge of care and evidence-based addiction support.

Recovery Café provides a community in which women and men can stabilize in their mental/physical health, housing, relationships, and employment/volunteer service. This community helps women and men fulfill their potential and live meaningful lives. Recovery Café teaches people ways to manage their mental health, maintain sobriety, and build mutually supportive community.

Through its work, Recovery Café prevents individuals from potentially lethal crises, avoiding the need for emergency intervention to stabilize that person, and allowing mental health and addiction support professionals to focus on health maintenance and additional harm reduction.

Recovery Café has been recognized by Washington State and King County experts as an example of how a Recovery Oriented System of Care (ROSC) works.[1]

[1] ROSC is a fairly new approach that the Washington State Division of of Behavioral Health and Recovery and King County have embraced. A ROSC is a more effective approach for addressing substance use disorder (SUD) issues than traditional models, because it meets people where they are on the recovery continuum, engages them for a lifetime of managing their disease, focuses holistically on a person's needs, and empowers them to build a life that realizes their full potential. This person-centered system of care supports a person as they establish a healthy life and recognizes that everyone needs a meaningful sense of membership and belonging in community.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

1. Program Description

◊ *A. Service Components/Design (Brief)*

Recovery Café provides a safe, warm, beautiful, drug-and-alcohol-free space and loving community to anchor members – Recovery Café's most closely held participants – in the sustained recovery needed to gain and maintain access to housing, social and health services, healthy relationships, education and employment. Recovery Café's program is designed to help people maintain recovery, reduce relapse and fulfill their potential. Important elements of this work include:

- A healing milieu including free nutritious meals, activities, computer access, and individualized encouragement.
- Accountability groups called Recovery Circles, where members become known and get to know others.
- Peer-to-peer member empowerment, enrichment and involvement.
- The School of Recovery, an educational program available to members featuring classes that address the underlying causes of addiction, teach coping skills, develop knowledge, learn new skills and build the resources necessary to begin and maintain recovery from substance use disorders.
- Referral Services to help members navigate the complex social services system to gain and maintain housing, healthcare, mental health services, legal assistance, and a base of support including positive and consistent relationships with service providers.
- 12-step meetings held in a dedicated space.

Recovery Café's community support model has the flexibility to meet the needs of people at any stage of recovery from alcohol and substance addiction. Major elements of the program include behavioral interventions, motivational interviewing style, motivational incentives, psychoeducation including relapse prevention and skill building, and significant peer-to-peer support.

◊ *B. Goals*

Recovery Cafe services aim to meet the need for stabilizing community accountability for women and men suffering from the trauma of homelessness, addiction and/or other behavioral health challenges in King County.

The goal of MIDD II's investment in Recovery Café is to seed the launch of a second café in King County beyond downtown Seattle, in partnership with other funds to be secured by Recovery Café, and to provide ongoing support for the operations of this additional site.

◊ *C. Expected Numbers of Individuals Served*

The MIDD investment could support services for 85 to 350 members at any one time – or 300 to 1,000 per year – depending on the amount of other funds that are leveraged. Services would begin in 2018.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced or eliminated substance use
- reduced jail, hospital and emergency department use

The following individual-level MIDD II outcomes are expected for individuals who participate in Recovery Café services:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness self-management
- improved social relationships
- improved experience of care

Based on member surveys in combination with a database tracking participation, Recovery Café tracks these outcomes for its members:

- reduction of mental health symptoms;
- reduction of suicidal behavior;
- reduction of isolation (or increase in perceived social support)
- reduction of substance use disorder symptoms/complications
- reduction in the use of emergency room services, time in jail, and interaction with the legal system
- relapse prevention, and shortened length of relapse
- increase in the development of life skills
- increase in access to meaningful life activities including Recovery Café programming
- increased stability in housing situation
- improvements in physical health

Broadly, this initiative will also result in increased peer support capacity in King County by bringing the Recovery Café model to a new community.

Outcome measures will be defined further by King County BHRD in partnership with Recovery Café, including identifying methods of outcome tracking beyond surveys and attendance.

◊ *E. Provided by: Contractor*

Recovery Café will provide this service via a contract with King County BHRD.

2. Spending Plan

The spending plan outlined here is limited to the MIDD funding level of $250,000 per year. As such, implementation scale and timing will be significantly affected by the

degree to which other funds are leveraged for the second King County Recovery Café site. As a result, the timing and/or amounts of some expenditures shown below may depend on when and how the new location is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

Year	Activity	Amount
2017 only	Capital and/or startup funding for second Recovery Café site in King County	$250,000
2017 Annual Expenditure		**$250,000**
2018 Annual Expenditure	Operational funding for second King County Recovery Café site 1.0 FTE site manager 3.0 FTE café managers 0.5 FTE mental health coordinator	$256,500
2018 Annual Expenditure		**$256,500**
Biennial Expenditure		**$506,500**

3. Implementation Schedule

◊ *A. Procurement of Providers*

No procurement process will be required.

◊ *B. Contracting of Services*

Funding will be disbursed to Recovery Café via a contract that will be specific to the launch of the second site.

◊ *C. Services Start date (s)*

As no procurement process is needed, funds could be disbursed as soon as January 2017. Services at the second Recovery Café site in King County will begin sometime in 2018, after other funding is secured; a site is identified, secured, and readied; and staff are in place to implement the program model.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

MIDD II Initiative Title: Peer Bridgers and Peer Support Pilot **(NEW)**

MIDD II Number: RR-11

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health conditions from costly interventions, such as jail, emergency rooms, and hospitals."

Specifically, through its two program components, the initiative provides:

- transition supports for adult individuals who have been hospitalized in inpatient psychiatric units by supporting peer bridger programs that have been shown to be effective in reducing hospital episodes and lengths of stay; reducing rehospitalization; and increasing Medicaid enrollment; and
- peer specialists strategically deployed to substance use disorder (SUD) service settings where peers' unique experiences and skills can have a significant impact on participants' ability to maintain recovery by supporting them to engage successfully with ongoing treatment services and other supports. These peer services are critical to diverting people from criminal justice and emergency medical settings.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The initiative includes two discrete but related components: MIDD support for the Peer Bridger programs at Navos Mental Health Solutions and Harborview Mental Health and Addiction Services, and a pilot to support the strategic use of peer services in settings serving individuals with elevated or emergent substance use needs and risks.

<u>Peer Bridger Component</u>

The Peer Bridger programs provide transition supports for adult individuals who have been hospitalized at the psychiatric inpatient units at Navos and Harborview.[1] Teams of certified peer specialists work in coordination with the inpatient treatment teams to identify individuals in need of this support, and to develop individualized plans to promote each person's successful transition to the community.

[1] The Peer Bridger Program was originally funded in the spring of 2013 by a grant from the State of Washington Attorney General's Office, Consumer Protection Division, from proceeds associated with a class action lawsuit. Those grant funds were exhausted in December 2015. MIDD fund balance dollars were provided to sustain the current program through 2016.

Peer Bridgers work with individuals for up to 90 days after discharge. Participants are offered:

- concrete support to obtain personal identification documents, medical insurance benefits, housing, treatment services, medications, social supports, transportation, cell phones, and other basic necessities;
- one-to-one and group services during hospitalization;
- support for wellness self-management using evidence-based tools; and
- an authentic personal connection based on personal experience.

If this aspect of the initiative is expanded in future years, peer bridger services could expand to serve additional psychiatric units in King County's other evaluation and treatment facilities and/or community hospitals.

SUD Peer Support Component

SUD peers are people with lived experience who have initiated their recovery journey and are able and willing to assist others who are earlier in the recovery process. They can have a unique role in the provision of recovery support services including access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; and illness management. Peers can also play a key role in helping people engage successfully with formal SUD treatment. Peer support removes barriers to access and is invaluable throughout the continuum of care, prior to treatment, during treatment, and as after-care support.

Approximately 2.0 FTE peer specialists will be deployed to serve in two stand-alone recovery community organizations (RCOs) that have been strong leaders in developing a peer to peer infrastructure in King County. At RCOs, peer positions build connections with recovering people, helping link them to community support and providing emotional assistance to their recovery journey.

Approximately 0.5 FTE peer specialists will be deployed to unique location(s) where effective peer interventions are most likely to prevent, reduce, or shorten emergency system use. This may include such settings as the Dutch Shisler Sobering Center, the Public Health Seattle-King County (PHSKC) needle exchange, current or future detoxification facilities, and/or other environments where SUD peer staff can have an especially significant impact on criminal justice system involvement.

The anticipated expansion of the pilot in future years could establish peer services more broadly in SUD treatment agencies, including outpatient, withdrawal management, and residential settings, in accordance with a broader vision to expand peer support in SUD treatment. The remainder of this document describes expected SUD peer support services and expenditures at the pilot level only.

◊ *B. Goals*

Peer Bridger Component

The primary goal of the Peer Bridger Programs is to promote successful community tenure for the identified population. System goals include: reductions in King County

funded inpatient admissions, readmissions, and hospital days. The program prioritizes services for the most vulnerable of hospitalized individuals:

- people who are not insured and not enrolled in ongoing mental health services; and
- people who are insured and enrolled, but disengaged from their ongoing mental health provider and at high risk of re-hospitalization.

SUD Peer Support Component

The SUD peer support component in its current pilot phase will aim to deploy a small number of peers to assist individuals, with a goal of reducing their recurring use of emergency systems, including the criminal justice system. As would be the case if the pilot were expanded more broadly, these peers will work to facilitate effective linkage and engagement with ongoing treatment services in the recovery community, outpatient treatment services, withdrawal management, and/or residential settings.

◊ *C. Expected Numbers of Individuals Served*

Peer Bridger Component

The Peer Bridger programs at Navos and Harborview currently together serve approximately 200 individuals per year.

SUD Peer Support Component

The number of individuals to be served by the SUD peer support pilot component will depend on the service setting(s) and role(s) selected.

◊ *D. Outcomes and Performance Measures*

Both components of this initiative contribute to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced substance use
- reduced jail, hospital, and emergency department use

The following individual-level MIDD II outcomes are expected for participants in either component:

- increased use of preventive services
- reduced substance use
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness self-management
- reduced hospitalization, emergency department use, and incarceration

Peer Bridger Component

For Peer Bridger program participants, it is expected that the following outcomes will be achieved:

- Reduction in rehospitalizations
- Reduction in length of stay
- Reductions in readmissions
- Increase in enrollment in Medicaid
- Increase in engagement with and participation in behavioral health treatment (mental health and/or substance use disorder services)
- Increase in quality of life (as indicated by stable housing, employment, meaningful activities, social connectedness, sense of well-being, stable physical health, etc.)

SUD Peer Support Component

For SUD peer support pilot participants, many similar outcomes are expected, with a special emphasis on treatment engagement and the added benefit of reduced criminal justice involvement. As specific service settings are selected in alignment with funding levels, outcomes specific to this component will be further defined.

◊ *E. Provided by: Contractor*

Services provided under both components of this program will be provided by contracted agencies.

2. Spending Plan

Year	Activity	Amount
2017	Peer Bridger teams at two inpatient psychiatric facilities	$604,750
2017	Approximately 2.5 FTE peer support specialists deployed to RCOs and other key SUD service settings	$164,000
2017 Annual Expenditure		**$768,750**
2018	Peer Bridger teams at two inpatient psychiatric facilities	$620,474
2018	Approximately 2.5 FTE peer support specialists deployed to RCOs and other key SUD service settings	$168,264
2018 Annual Expenditure		**$788,738**
Biennial Expenditure		**$1,557,488**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Peer Bridger Component

Supports two peer bridger providers Navos and Harborview.

SUD Peer Support Component

At the pilot level of funding for RCOs is likely to continue to be disbursed to the same agencies that were funded under MIDD I.

For the additional services to be added in other SUD settings, either a Request for Proposals (RFP) process hosted by King County BHRD or a Memorandum of Understanding (MOU) (if services will be provided by a County department such as PHSKC) will result in the selection of provider organizations to deliver additional peer services in accordance with the goals and approaches described above.

Additional Procurement Expected if Programs are Expanded in Future Years

If at any point in the future additional peer bridger services are added, or SUD peer services are expanded to outpatient, withdrawal management, or residential settings using MIDD funds, additional procurement processes would be initiated.

◊ *B. Contracting of Services*

See 1.E and 3.A above.

◊ *C. Services Start date (s)*

MIDD II funding for existing peer bridger programs at Navos and Harborview, and for SUD peer services at RCOs, will be implemented January 1, 2017 to ensure continuous services.

King County's work to select high-impact settings for the pilot SUD Peer Support aspect of this initiative will begin in first quarter 2017 once funding levels are known. Procurement processes will be completed in second quarter 2017, with services to be launched in third quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

MIDD II Initiative Title: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities **(NEW)**

MIDD II Number: SI-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "increase culturally appropriate, trauma informed behavioral health services."

By directly empowering communities to design service approaches that meet their felt needs, this initiative will help to address key barriers to behavioral health service participation and recovery among ethnic minority communities. Such barriers include:

- Underutilization and premature termination of treatment despite continued need;
- Disproportionately higher burden from unmet mental health needs;
- Poorer-quality care;
- Mistrust of the behavioral health system resulting from the cultural insensitivity of treating clinicians;
- Lack of culturally appropriate services including bilingual and bicultural staff;
- Collectivist cultural values that may make the individualistic process of psychotherapy foreign;
- Varying conceptions of the nature, causes, and cures of behavioral health conditions;
- Perceptions of stigma and shame; and
- Lack of health insurance coverage.[1]

In King County, as in many ethnic and cultural minority communities nationwide, people are left primarily with behavioral health service options that do not fit their cultural needs, so they remain unserved or underserved. These findings about ethnic communities' preferences around service delivery were confirmed locally via MIDD community engagement, including community conversations, focus groups, and surveys.[2]

This initiative provides a structure and resources for communities to propose projects and receive funding to address community needs using culturally appropriate programs.

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[1] Leong and Kalibatseva (2011). Cross-cultural barriers to mental health services in the United States. Cerebrum 2011 March-April: 5. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3574791/ and U.S. Department of Health and Human Services. (2001). Mental health: culture, race and ethnicity, a supplement to Mental health: A report of the surgeon general. http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf

[2] MIDD review and renewal focus groups in January 2016 whose perspectives surfaced these themes and needs included focus groups specifically for African American, Somali, Hispanic, Asian Pacific Islander, Native American, trans*, and refugee populations. See http://www.kingcounty.gov/~/media/depts/community-human-services/MIDD/documents/160226_FG_Highlights.ashx?la=en. Survey information is summarized at http://www.kingcounty.gov/~/media/depts/community-human-services/MIDD/documents/160226_Community_Engagement_Main_Themes.ashx?la=en.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

1. Program Description

◊ *A. Service Components/Design (Brief)*

King County will provide funding, oversight, and evaluation for small grants designed to support targeted community-initiated behavioral health-related services or programs designed by particular cultural or ethnic communities to address issues of common concern.

This approach will build upon processes employed by King County's Community Service Area (CSA) Community Engagement Grant program,[3] except that it will be organized around particular populations rather than by geographic locations. It will provide MIDD resources to enable local culturally specific grassroots organizations to support implementation of small-scale, local initiative(s) designed by community members to address key felt needs that relate to behavioral health treatment, prevention, recovery, or service access.

Funded projects may include, but are not limited to:
(a) community-initiated engagement efforts, classes, prevention/outreach campaigns, or one-time events related to mental health or substance abuse, and/or
(b) specific behavioral health services requested by a cultural or ethnic community that are expected to meaningfully address its self-identified needs.

◊ *B. Goals*

The goal of this concept is to provide a mechanism for MIDD to invest in locally conceived, community-driven behavioral health services, with a special focus on cultural and ethnic communities. Nearly 30 percent of King County residents are people of color,[4] but culturally specific and accessible resources, along with community-designed and -informed services, are relatively lacking. MIDD's 2015-16 community outreach effort has confirmed the need for an avenue for community self-determination and services focused on the needs of specific groups.

◊ *C. Expected Numbers of Individuals Served*

As the funded programs would be designed by multiple different communities and customized to their particular felt needs, it is not yet known how many individuals will be served. Furthermore, as funded projects change from year to year, the number of people served will vary annually. However, the number of people served will be tracked for each project and aggregated for the initiative as a whole.

◊ *D. Outcomes and Performance Measures*

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[3] Information about the existing Community Engagement Grant program, administered by King County's Department of Natural Resources and Parks, is available at http://www.kingcounty.gov/exec/community-service-areas/engagement-grants.aspx.
[4] 2014 census data, available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/king-county-profile.

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level MIDD II outcome measures are expected for individuals who participate in services funded via this program:

- improved perception of health and behavioral health issues and disorders
- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services and outreach
- increased use of culturally appropriate behavioral health practices

In addition to output targets customized to each funded grant proposal, performance measures across funded programs will focus on the degree to which cultural needs and/or trauma are addressed, in accordance with the recommended policy goal, although culturally appropriate measures of improved health and wellness may also be considered. One or more low-barrier assessment tools can be developed for this initiative, standardized across all funded projects,[5] and translated into multiple languages. These tool(s) can establish the connection between each project and an adopted policy goal, and can provide for a basic evaluation of the degree to which the project has fulfilled the goal.

◊ *E. Provided by: Contractor*

This grant program would be administered by County staff in consultation with stakeholders from each geographic area. All funded programs and services would be delivered by organizations with deep ties to the local communities being served.

[5] These tools may be adapted from questionnaires previously used by King County's Community Organizing Program, with a goal of aligning with one or more MIDD II policy goals once adopted, while ensuring cultural competence and appropriateness.

2. Spending Plan

Year	Activity	Amount
2017	Startup: Outreach, input-gathering, and process design 0.5 County TLT for 6 months[6]	$37,500
2017	Ongoing program management by County staff 0.25 County FTE for 6 months	$18,750
2017	Distributed as community-initiated, time-limited small grants to local culturally specific organizations or projects	$293,750
2017 Annual Expenditure		**$350,000**
2018	Ongoing program management by County staff 0.25 County FTE	$38,475
2018	Distributed as community-initiated, time-limited small grants to local culturally specific organizations or projects	$320,625
2018 Annual Expenditure		**$359,100**
Biennial Expenditure		**$709,100**

* Efforts will be made to distribute funding equitably across communities and populations. However, these efforts will depend on the number and amount of funding requests from each group. Also, as unique community needs may arise in certain areas at times, program procedures will be designed to allow flexibility to shift resources accordingly when necessary.

3. Implementation Schedule

◊ *A. Procurement of Providers*

This initiative will require periodic, low-barrier requests for proposals (RFPs) – no less frequently than annually – to facilitate the selection of time-limited community-driven projects for funding.

The level of complexity and requirements for these proposals will vary depending on the amount of the funding request. Multiple categories will be created in accordance with contracting requirements, in order to ease access for small organizations and small projects. This will include reducing barriers such as insurance and data submission requirement, and technical support as needed. The specifics of these categories are described in section B below.

[6] Some aspects of startup work for this initiative and Behavioral Health Services in Rural King County initiative will be shared, so funding for temporary staffing is divided equally between the two initiatives.

Applicant organizations will be expected to demonstrate that they have leveraged matching contributions.[7] Matching funds may come in the form of funding from other sources or donated time, space, or other in-kind resources. Combining all sources (including in-kind), the match must total at least 25 percent of the MIDD funding request in the first year, and at least 50 percent in the second and/or third years (if applicable).

◊ *B. Contracting of Services*

An annual request for proposals process would be established to provide a predictable timing and process by which communities could request funds. Organizations selected for funding via this community-driven grant initiative would establish contracts or monitoring agreements with King County covering each proposed program or service and its associated time period.

Criteria for limited renewal of the projects will be developed, up to a limit of three years of funding per project or service. Factors to be considered the decision to renew funding for a project or service may include:
(1) the volume of people served;
(2) community feedback about project effectiveness and engagement/organizing work; and
(3) Efforts to enroll project participants in Medicaid, as applicable.

When renewed grants are sought for equivalent or substantively similar projects after the first year, funding will most commonly be renewed partially, at 50 percent to 75 percent of the initial year's amount, depending on the three factors above. The expectation is that other funding sources beyond MIDD will be leveraged to continue the service.

Processes and requirements specific to particular funding levels, based on known procurement mandates and the overarching goals of the initiative, are outlined below.

<u>Requests of $4,999 or Below</u>
Grants of $4,999 per year per organization and below would be awarded two to four times per year, and would be directly funded without formal County contracts, allowing small grassroots organizations or coalitions to receive funds without having to meet costly insurance and fiscal monitoring requirements. Oversight of expenditures of these grants, including organizations' internal controls, would be performed by County program management staff, allowing for funds to be disbursed either via small advance payments combined with reconciliation against actual expenditures or via simple expenditure reimbursement.

<u>Requests of $5,000 to $49,999</u>
Funding requests from $5,000 to $49,999 per year per organization will be procured via formal annual County contracts. Every effort will be made to minimize administrative

[7] Match requirements are part of both the CSA small grant program after which this initiative is modeled, and the Community Organizing Program small grant initiative previously operated by King County DCHS.

burdens associated with these contracts, including reduced fiscal auditing requirements. Contracting requirements specific to particular funding levels are as follows:

(1) For requests of $5,000 to $9,999, simplified contracting will be available, building on existing processes in place for contracting with providers for small special projects.
(2) For requests of $10,000 to $49,999, full contracts will be required, but reduced insurance requirements may be available depending on the type of program or service proposed.

Requests of $50,000 or Above

Any requests of $50,000 or more per year per organization are expected to be rare and would be required to demonstrate a high level of coordination and community engagement involving grassroots groups representing two or more cultural or ethnic communities. Projects at this level of funding would be required to comply with all standard County contracting rules including insurance and financial audit requirements commensurate with the funding level.

◊ *C. Services Start date (s)*

An outreach effort would begin in early 2017 to ensure that communities are aware of the existence of this new funding opportunity and to gather input about the operations and criteria for the initiative. Informed by this engagement work, the first RFP could be issued in spring 2017 with services to begin in July 2017. New grants of $5,000 or more would be launched no less frequently than annually as each RFP cycle is completed, with grants of $4,999 and below issued quarterly or semiannually.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Services in Rural King County (SI-2)

MIDD II Initiative Title: Behavioral Health Services in Rural King County **(NEW)**

MIDD II Number: SI-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Currently, vast sections of King County have no publicly funded behavioral health clinic option.[1] Rural King County residents lack reasonable access to these service sites due to transportation barriers including long distances to behavioral health clinic sites in suburban cities, and very limited bus service in rural areas. In the case of Vashon Island, the only linkage to some aspects of the outpatient service continuum is via ferry.[2]

This initiative's small grant process not only may address access issues common to rural communities nationally, but also concerns identified at a local level. Examples of these may include stigma associated with receiving care;[3] elevated rates of obesity, diabetes, and suicide;[4] and/or high prevalence of adverse childhood experiences which are a strong predictor of anxiety and other mental illnesses.[5]

1. Program Description

◊ *A. Service Components/Design (Brief)*

King County would provide funding, oversight, and evaluation for small grants designed to support targeted community-initiated behavioral health-related services or programs designed by rural communities to address issues of common concern. It would serve especially the seven community service areas (CSAs) in King County that experience a lack of behavioral health services. These CSAs are: Bear Creek/Sammamish, Snoqualmie Valley/Northeast King County, Four Creeks/Tiger Mountain, Greater Maple Valley/Cedar River, Southeast King County, West King County unincorporated areas,[6]

[1] http://kingcounty.maps.arcgis.com/apps/PublicInformation/index.html?appid=eaf2562bfde3437f8519fa90a2eaff0b
[2] "Notes from Group Discussion: Snoqualmie Healthy Community Coalition, Sept 17, 2015, facilitators: Alan Painter and DeAnna Martin," and "Vashon Social Services Network, August 14, 2015," provided by Alan Painter, King County Community Services Area program manager. The unique transportation barriers experienced by Vashon Island residents were also highlighted in a January 2016 Best Starts for Kids focus group.
[3] "Notes from Group Discussion: Snoqualmie Healthy Community Coalition, Sept 17, 2015, facilitators: Alan Painter and DeAnna Martin," and phone consultation with Ross Marzolf, January 2016. Participants in MIDD review and renewal focus groups in both Maple Valley (Southeast King County) and Preston (Snoqualmie Valley) in January 2016 identified stigma reduction campaigns and community education about mental illness as priorities for potential funding.
[4] King County Health Profile, December 2014.
[5] Adverse Childhood Experiences ACES 2013 Report.
[6] The West King County Unincorporated Areas CSA serves unincorporated pockets of West King County that are generally near suburbs where publicly funded behavioral health clinics are located. As a result, funding requests from

and Vashon/Maury Islands. Programs and services in certain rural cities and towns adjoining these CSAs, such as Skykomish, Duvall, Carnation, Snoqualmie, North Bend, Covington, Maple Valley, Black Diamond, and Enumclaw, would also be included.

This approach would build upon or replicate the existing structure of King County's CSA Community Engagement Grant program,[7] providing MIDD resources to enable local grassroots organizations located within any CSAs or identified adjoining rural cities or towns to design specific initiative(s) that address key felt needs that relate to behavioral health treatment, prevention, recovery, or service access.

Funded projects may include, but are not limited to:
(a) community-initiated engagement efforts, classes, prevention/outreach campaigns, or one-time events related to mental health or substance abuse, and/or
(b) specific behavioral health services requested by a rural community that are expected to meaningfully address its self-identified needs.

◊ *B. Goals*

As described above, this program would improve health and wellness primarily by promoting access to services and community self-determination in areas of King County that have very little access to publicly funded behavioral health care.

◊ *C. Expected Numbers of Individuals Served*

As the funded programs would be designed by multiple different communities and customized to their particular felt needs, it is not yet known how many individuals will be served. Furthermore, as funded projects change from year to year, the number of people served will vary annually. However, the number of people served will be tracked for each project and aggregated for the initiative as a whole.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level MIDD II outcome measures are expected for individuals who participate in services funded via this program:

- improved perception of health and behavioral health issues and disorders
- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events

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this CSA will be required to demonstrate that proposed projects are coordinated with any nearby existing providers and avoid duplication of efforts.

[7] Information about the existing Community Engagement Grant program, administered by King County's Department of Natural Resources and Parks, is available at http://www.kingcounty.gov/exec/community-service-areas/engagement-grants.aspx.

- improved wellness and social relationships
- improved experience of care

In addition to output targets customized to each funded grant proposal, performance measures across funded programs will focus on treatment access and/or behavioral health and wellness, in accordance with the recommended policy goal. One or more low-barrier assessment tools can be developed for this initiative and standardized across all funded projects.[8] These tool(s) can establish the connection between each project and the health and wellness policy goal, and can provide for a basic evaluation of the degree to which the project has fulfilled the goal. Areas that could potentially be measured may include wellness self-management, employment, and/or social relationships; decreased system use; timely treatment access; and perceptions of accessibility.

Symptom reduction could be measured using standard scales such as the PHQ-9, GAD-7 or other proven tools that assess common mental health or substance abuse conditions.[9] Referrals to needed community-based services, including housing and entitlement resources, could be a measure of any intervention's effectiveness in delivering holistic assistance in alignment with the established literature regarding service to rural communities.[10]

◊ *E. Provided by: Contractor*

This grant program would be administered by County staff in consultation with stakeholders from each geographic area. All funded programs and services would be delivered by organizations with deep ties to the local communities being served.

[8] These tools will be adapted from questionnaires previously used by King County's Community Organizing Program, in order to ensure alignment with one or more MIDD II policy goals once adopted.
[9] Depending on the interventions designed by local communities, administration of these clinical measures may or may not be appropriate. Alternative measures of effectiveness would need to be developed for communitywide interventions such as primary prevention.
[10] Priester, Clone, Browne, Hock, Iachini, and DeHart. (2015). The Multi-Systems Impact of Barriers to Behavioral Health Services in Rural Communities. Presented January 16, 2015.

2. Spending Plan

Year	Activity	Amount
2017	Startup: Outreach, input-gathering, and process design 0.5 County TLT for 6 months[11]	$37,500
2017	Ongoing program management by County staff 0.25 County FTE for 6 months	$18,750
2017	Distributed as community-initiated, time-limited small grants to local organizations within seven identified geographic areas	$293,750
2017 Annual Expenditure		**$350,000**
2018	Ongoing program management by County staff 0.25 County FTE	$38,475
2018	Distributed as community-initiated, time-limited small grants to local organizations within seven identified geographic areas	$320,625
2018 Annual Expenditure		**$359,100**
Biennial Expenditure		**$709,100**

* Efforts will be made to distribute funding equitably across seven geographic areas, largely in alignment with the established CSAs but including the named adjoining cities and towns. However, these efforts will depend on the number and amount of funding requests from each community. Also, as unique community needs may arise in certain areas at times, program procedures will be designed to allow flexibility to shift resources accordingly when necessary.

3. Implementation Schedule

◊ *A. Procurement of Providers*

This initiative will require periodic, low-barrier requests for proposals (RFPs) – no less frequently than annually – to facilitate the selection of time-limited community-driven projects for funding.

The level of complexity and requirements for these proposals will vary depending on the amount of the funding request. Multiple categories will be created in accordance with contracting requirements, in order to ease access for small organizations and small projects. This will include reducing barriers such as insurance and data submission

[11] Some aspects of startup work for this initiative and the Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities initiative will be shared, so funding for temporary staffing is divided equally between the two initiatives.

requirement, and technical support as needed. The specifics of these categories are described in section B below.

Applicant organizations will be expected to demonstrate that they have leveraged matching contributions.[12] Matching funds may come in the form of funding from other sources or donated time, space, or other in-kind resources. Combining all sources (including in-kind), the match must total at least 25 percent of the MIDD funding request in the first year, and at least 50 percent in the second and/or third years (if applicable).

◊ *B. Contracting of Services*

An annual request for proposals process would be established to provide a predictable timing and process by which communities could request funds. Organizations selected for funding via this community-driven grant initiative would establish contracts or monitoring agreements with King County covering each proposed program or service and its associated time period.

Criteria for limited renewal of the projects will be developed, up to a limit of three years of funding per project or service. Factors to be considered the decision to renew funding for a project or service may include:
(1) the volume of people served;
(2) community feedback about project effectiveness and engagement/organizing work; and
(3) Efforts to enroll project participants in Medicaid, as applicable.

When renewed grants are sought for equivalent or substantively similar projects after the first year, funding will most commonly be renewed partially, at 50 percent to 75 percent of the initial year's amount, depending on the three factors above. The expectation is that other funding sources beyond MIDD will be leveraged to continue the service.

Processes and requirements specific to particular funding levels, based on known procurement mandates and the overarching goals of the initiative, are outlined below.

<u>Requests of $4,999 or Below</u>
Grants of $4,999 per year per organization and below would be awarded two to four times per year, and would be directly funded without formal County contracts, allowing small grassroots organizations or coalitions to receive funds without having to meet costly insurance and fiscal monitoring requirements. Oversight of expenditures of these grants, including organizations' internal controls, would be performed by County program management staff, allowing for funds to be disbursed either via small advance payments combined with reconciliation against actual expenditures or via simple expenditure reimbursement.

<u>Requests of $5,000 to $49,999</u>
Funding requests from $5,000 to $49,999 per year per organization will be procured via formal annual County contracts. Every effort will be made to minimize administrative

[12] Match requirements are part of both the CSA small grant program after which this initiative is modeled, and the Community Organizing Program small grant initiative previously operated by King County DCHS.

burdens associated with these contracts, including reduced fiscal auditing requirements. Contracting requirements specific to particular funding levels are as follows:

(1) For requests of $5,000 to $9,999, simplified contracting will be available, building on existing processes in place for contracting with providers for small special projects.
(2) For requests of $10,000 to $49,999, full contracts will be required, but reduced insurance requirements may be available depending on the type of program or service proposed.

<u>Requests of $50,000 or Above</u>
Any requests of $50,000 or more per year per organization are expected to be rare and would be required to demonstrate a high level of coordination and community engagement involving grassroots groups representing two or more of the identified seven geographic areas. Projects at this level of funding would be required to comply with all standard County contracting rules including insurance and financial audit requirements commensurate with the funding level.

◊ *C. Services Start date (s)*

An outreach effort would begin in early 2017 to ensure that communities are aware of the existence of this new funding opportunity and to gather input about the operations and criteria for the initiative. Informed by this engagement work, the first RFP could be issued in spring 2017 with services to begin in July 2017. New grants of $5,000 or more would be launched no less frequently than annually as each RFP cycle is completed, with grants of $4,999 and below issued quarterly or semiannually.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

MIDD II Initiative Title: Outreach & In Reach System of Care

MIDD II Number: CD-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Community-based outreach and engagement connect individuals in need of services prior to court involvement or as a treatment alternative. Many individuals do not enter into criminal justice system responses, such as specialty courts, when they have health and human service needs and often return to the streets after release from jail still in desperate need of connection to treatment, housing and community.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Existing MIDD I services are provided under Public Health through two agencies: 1) Harborview Medical Center (HMC) in downtown Seattle and 2) the Valley Cities Counseling and Consultation (VCCC) in south and east King County, and known as the Bridges program[1] and through the Seattle Indian Health Board at the Dutch Shisler Service Center and the Chief Seattle Club. All provider agencies target individuals who have a recent history of cycling through hospitals, jails, other crisis facilities, psychiatric hospitals, or residential substance use disorder (SUD) treatment facilities. They work with individuals who do not have or are not eligible for Medicaid, and clients with mental health problems who are not eligible for enrollment in the Behavioral Health Organization (BHO) network that has provided publicly funded mental health services, or who are disconnected from their BHO case manager or program. The services are community-based mental health/SUD-based outreach, engagement and service linkages, including advocacy for individuals with mental health and substance use conditions, mental health assessments and linkage to counseling.

County Administration/Oversight resources, Community-based organizations, and other experts will be engaged to use a collective impact approach, in order to assess current defined results and recommend any needs to redefine any determined results. This will include looking at population currently being served, to be served, accessibility, community need, etc.

Public Health – Seattle and King County (PHSKC), King County Behavioral Health and Recovery Division (BHRD) and Housing & Community Development,; Harborview Medical Center (current provider), Valley Cities Counseling & Consultation (current

[1] http://www.valleycities.org/services/outreach/bridges/.

provider), local homelessness advisory boards (e.g. Eastside Homeless Advisory Committee), All Home, Community-based organizations and other community meeting forums, will be engaged to determine if the current defined scope and parameters of this initiative are properly defined.

PHSKC will continue funding current organizations into early 2017. Component re-design, evaluation, and consultation will happen on a quarterly continuous improvement cycle. A review of utilizer systems will be conducted in early 2017 to ensure that the current agencies are meeting goals and serving the target population.

◊ *B. Goals*

The primary goal of this initiative is to increase availability of outreach, engagement, and case management services for homeless individuals.

Behavioral health professionals engage clients and provide stabilizing services with the goal of making referrals to mental health and SUD treatment providers in order to ensure appropriate ongoing treatment for those individuals who are eligible for services.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals served annually is 675.

◊ *D. Outcomes and Performance Measures*

This initiative will look at a variety of performance measures (including a decrease in hospital and criminal justice involvement, decrease in homelessness, and a reduction in crisis services).

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Community-based outreach and engagement services continue.	$ 307,500
2017 Annual Expenditure		**$ 307,500**
2018	Community-based outreach and engagement services continue.	$ 315,495
2018 Annual Expenditure		**$ 315,495**
Biennial Expenditure		**$ 622,995**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Funding will continue to be distributed to PHSKC via a Memorandum of Understanding (MOU). BHRD currently contracts with Seattle Indian Health Board for services in this

initiative. No RFP is needed unless the review process determines that a program change is needed during the second quarter 2017.

◊ *B. Contracting of Services*

This initiative has already established contracts. The contracts will be assessed for renewal during the second quarter 2017.

◊ *C. Services Start date (s)*

Services continue in first quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

MIDD II Initiative Title: High Utilizer Care Teams

MIDD II Number: CD-5

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The initiative assists people in the midst of crisis by delivering flexible and individualized service beginning in the ED or hospital inpatient unit. This program builds on initial supportive contact to help people reintegrate safely into the community after an immediate crisis, and help them to acquire and engage with stabilizing resources such as housing and community-based care, thereby reducing future emergency system use.[1]

The program focuses on reducing individuals' use of crisis services, including the emergency room, inpatient psychiatry, and inpatient medical care; and enhancing the capacity to link individuals to community services. The initiative serves people who are falling through the cracks of the existing service system, such as people who have no services in place but need intensive outreach to connect to care, or people with mental illness who also have chronic medical conditions.[2]

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative will serve individuals who are frequently seen the emergency department (ED) or psychiatric emergency service (PES) at Harborview Medical Center (HMC). Funding will cover 2.5 FTE full time equivalent (FTE) clinicians who will serve individuals that use the HMC ED or PES four or more times in three months.[3] Due to the intensity of service as well as the complex needs of program individuals, caseloads are kept smaller, so people with eight or more ED or PES visits in six months will be prioritized, because they are most likely to benefit from the services offered by this specialized care team. The program also provides support for clients' basic needs that reduce barriers to participating in the plan of care through a modest fund to address transportation, clothing, rent, and similar expenses.

Newly available data from Washington's Emergency Department Information Exchange (EDIE) will also be used to identify Harborview patients who may not meet the priority

[1] MIDD II Framework Updated 8.27.15. Retrieved from: http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/RenewalPlanningDocuments/150828_MIDD_II_Framework.ashx?la=en.
[2] Harborview Medical Center, December 2015.
[3] Extracted from 2015 Harborview Medical Center Contract, Exhibit IV.

threshold based on HMC data alone, but have a high level of ED use at other King County hospitals.

Most participants are homeless at the outset of the intervention. Along with homelessness, almost all individuals' vulnerability arises from at least two of the following: chronic medical issues, substance use disorders, and serious mental illness.[4]

Service components include a harm reduction approach to substance abuse, motivational strategies to engage individuals in primary healthcare for chronic conditions, active engagement of community supports, outreach during individuals' crises in the ED or during an inpatient admission, and continued engagement of individuals once they return to the community. Broadly, the team assists individuals to find stable housing, improves de-escalation skills to decrease behavioral barriers to care, and helps individuals with co-occurring disorders access needed behavioral health services and connections to primary care for their medical needs.[5]

The most frequent service connections upon discharge are in mental health, substance abuse, and medical clinics. Staff will coordinate with King County; other EDs; and behavioral health, social service, and housing providers, in order to ensure appropriate referrals and linkages to services. The team uses HMC primary care and aftercare clinics to provide urgent and long-term service connections to primary care. HMC's mental health services provide mental health urgent care, while long-term case management comes from a variety of community mental health providers.[6]

◊ *B. Goals*

This initiative's goal is to connect individuals who have frequent crisis visits to EDs or the PES to care providers and treatment systems in the community in order to decrease their need for emergency services.

◊ *C. Expected Numbers of Individuals Served*

The program will have the capacity to serve approximately 100 individuals per year.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- reduced hospital and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors

[4] Harborview Medical Center, December 2015.
[5] ED/PES High Utilizer Case Management Annual Report, MIDD Strategy 12c, King County Contract 5656153 – Exhibit IV (December 2014).
[6] ED/PES High Utilizer Case Management Annual Report, MIDD Strategy 12c, King Co. Contract 5656153 – Exhibit IV (December 2014).

- reduction of crisis events
- reduced unnecessary hospital and emergency department use

Based on past results, specific expected outcomes for the high utilizer care team initiative include:

- reduced ED utilization,[7] [8] [9]
- reduced psychiatric hospitalizations,[10]
- decreased medical hospitalizations,[11] [12]
- increased referrals and linkages to treatment,
- increased access to health benefits/entitlements and primary care, and
- reduced deaths due to behavioral health conditions and/or chronic homelessness.

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to MIDD I provider Harborview Medical Center. The contractor will manage expenditures on basic needs and seek reimbursement from the County up to allowed limits.

2. Spending Plan

Year	Activity	Amount
2017	Approximately 2.5 FTE licensed clinicians	$247,691
2017	Expenditures on basic needs to reduce barriers to participation in care plan	$8,559
2017 Annual Expenditure		**$256,250**
2017	Approximately 2.5 FTE licensed clinicians	$254,131
2017	Expenditures on basic needs to reduce barriers to participation in care plan	$8,781
2018 Annual Expenditure		**$262,913**
Biennial Expenditure		**$519,163**

[7] Seventh MIDD Annual Report, page 3.
[8] Seventh MIDD Annual Report, page 44.
[9] 2014 outcome study, Harborview High Utilizer Program.
[10] Seventh MIDD Annual Report, page 44.
[11] Community Collaboration and Intensive Case Management for Patients with High ED Utilization, Ann Allen LICSW, Brigitte Folz LICSW, Craig Jaffe MD.
[12] 2014 outcome study, Harborview High Utilizer Program.

3. Implementation Schedule

◊ *A. Procurement of Providers*

The service would most appropriately be procured from existing MIDD I provider Harborview Medical Center. Changes to staffing levels would be established via contract revisions.

◊ *B. Contracting of Services*

See 1.E and 3.A. above.

◊ *C. Services Start date (s)*

Service planning and contracting will occur by January 2017, in alignment with final funding levels.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

MIDD II Initiative Title: Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team

MIDD II Number: CD-6

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MID policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The Crisis Solutions Center (CSC), operated by the Downtown Emergency Service Center (DESC), provides King County first responders with alternative options to jail and hospital settings when engaging with individuals, age 18 and older, in behavioral health crisis. The intent of the facility is to stabilize and support individuals in the least restrictive setting possible, while identifying and directly linking them to appropriate and ongoing services in the community. The CSC has three program components intended to stabilize and support an individual in the least restrictive setting possible, while identifying and directly linking that individual to ongoing services in the community.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Adult Crisis Diversion Center strategy (herein referred to as the Crisis Solutions Center or CSC) provides King County first responders with a therapeutic, community-based alternative to jails and hospitals when engaging with adults who are in behavioral health crisis. King County contracts with DESC to provide crisis diversion services in King County at the CSC. DESC has a strong history of engaging with individuals who are homeless, who experience mental health and substance use disorders, and who may be reticent in accepting traditional services. The CSC has three program components; Mobile Crisis Team (MCT), Crisis Diversion Facility (CDF), and Crisis Diversion Interim Services (CDIS). The programs are intended to stabilize and support individuals in the least restrictive setting possible, while identifying and directly linking them to appropriate and ongoing services in the community.

The MCT consists of a team of two mental health clinicians, trained in the field of substance use disorders, who provide crisis outreach and stabilization services in the community 24 hours a day, 7 days per week (24/7). The team responds to requests from first responders in the field to assist with people in a mental health and/or substance use crisis. They intervene with individuals in their own communities, identify immediate needs and resources and, in most cases, relieve the need for any further intervention by first responders. The MCT is available for consultation or direct outreach to any location in King County and may assist individuals in crisis by providing or arranging for transportation.

The CDF is a 16-bed facility for individuals in mental health and/or substance abuse crisis who can be diverted from jails and hospitals, and voluntarily agree to services. The facility accepts individuals 24/7, with a 72-hour maximum length of stay. Individuals receive mental health and physical health screenings upon arrival. Services include crisis and stabilization services, case management, evaluation and psychiatric services, medication management and monitoring, mental health and substance abuse disorder assessments, peer specialist services and linkage to ongoing community-based services.

The CDIS is a 30-bed program co-located with the CDF. After a crisis has resolved at the CDF, individuals may be referred to the CDIS if they are homeless, their shelter situation is dangerous or has the potential to send them into crisis again, or they need additional services prior to discharge to help support stabilization. Individuals can stay at the CDIS for up to 2 weeks. Services include continued stabilization services, intensive case management, peer specialist services, and linkage to community-based services, with a focus on housing and benefits applications.

◊ *B. Goals*

One of the main goals of crisis services is to stabilize individuals in the community. Crisis services also provide post-stabilization activities, including referral and linkage to outpatient services and supports.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals served is 3000 annually.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative are:

- Reduced incarcerations and lengths of stay;
- Reduced emergency department utilization;
- Reduced psychiatric hospitalizations; and
- Increased referrals and linkages to treatment.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Diversion services for people with mental health and substance use disorders experiencing a crisis continue.	$ 4,100,000
2017 Annual Expenditure		**$4,100,000**
2018	Diversion services for people with mental health and substance use disorders experiencing a crisis	$ 4,206,600

	continue.	
2018 Annual Expenditure		**$ 4,206,600**
Biennial Expenditure		**$ 8,306,600**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with DESC to provide services for this initiative. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services will continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

MIDD II Initiative Title: Children's Domestic Violence Response Team (CDVRT)

MIDD II Number: CD-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

CDVRT addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The CDVRT provides a continuum of recovery services to address the needs of the families served. The impacts of domestic violence (DV) vary depending on severity of the violence in the home, age and developmental stage of the child, and the ability of the primary caretaker to meet the child's needs. Children's symptoms range from mild (primary and secondary prevention) to severe impairments in functioning requiring intensive rehabilitation/treatment. Support groups such as "Kids Club" and its concurrent parenting group, are offered for children and non-abusive parents who may not need or want mental health services. For children and families needing a higher level of mental health treatment, child and family therapists use individual, family, and group counseling; Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)[1]; and Parent-Child Interaction Therapy (PCIT)[2].

1. Program Description

◊ *A. Service Components/Design (Brief)*

A team provides mental health and advocacy services to children, ages 0-12 who have experienced DV, and support, advocacy and parent education to their non-violent parent. The team consists of a children's mental health therapist, a children's DV advocate, and other team members as identified by the family (including supportive family members, case workers, teachers, etc.). Children are assessed through a parent and child interview, and use of established screening tools. Children's treatment includes evidence-based Trauma Focused Cognitive Behavioral-Therapy, as well as Kids Club, a tested group therapy intervention for children experiencing DV. Children and families are referred through the DV Protection Order Advocacy program, as well as through other partner agencies.

◊ *B. Goals*

The CDVRT has one primary long-term goal: to help break the generational cycles of violence—to decrease the likelihood that exposure to violence at home will lead to other forms of juvenile and adult violence by children who have been exposed to domestic violence.

[1] http://nctsnet.org/sites/default/files/assets/pdfs/tfcbt_general.pdf
[2] http://www.pcit.org/

The CDVRT's more immediate program goals are: 1) to ensure ongoing physical and emotional safety of children and families impacted by domestic violence; 2) to support emotional healing for children and adults who are victims and survivors of domestic violence.

◊ *C. Expected Numbers of Individuals Served*

Approximately 85 families with 150 children are served annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative are:

- Decrease trauma symptoms exhibited by children.
- Reduce children's externalizing behaviors as observed in school, community, and family settings.
- Reduce children's internalizing behaviors.
- Increase protective/resiliency factors available to children and their supportive parents.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Provide services to children and their supportive parent 1 FTE lead children's mental health clinician 1 FTE children's DV advocate	$281,875
2017 Annual Expenditure		**$281,875**
2018	Provide services to children and their supportive parent 1 FTE lead children's mental health clinician 1 FTE children's DV advocate	$289,204
2018 Annual Expenditure		**$289,204**
Biennial Expenditure		**$571,079**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD contracts with Sound Mental Health for this program under MIDD I, which is anticipated to continue. It is cost effective to utilize existing organizations to develop the integrated model of DV and behavioral health services within community based DV advocacy organizations.

◊ *B. Contracting of Services*

See previous.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

MIDD II Initiative Title: Next Day Crisis Appointments (NDA)

MIDD II Number: CD-10

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The Next Day Appointment (NDA) program helps to divert people experiencing a behavioral health crisis from psychiatric hospitalization – especially those who are not currently enrolled in the King County mental health outpatient treatment system. Over 91 percent of individuals who participate in NDAs would otherwise be considered for psychiatric inpatient care.

The NDA program is designed to provide an urgent crisis response follow-up (within 24 hours) for individuals who are presenting in emergency rooms at local hospitals with a behavioral health crisis, or as a follow-up to the Designated Mental Health Professionals (DMHPs) who have provided an evaluation for involuntary treatment and found the person not eligible for, or could be diverted from detention with follow-up services.

MIDD funding enables the NDA program to provide follow-up services for a brief period after an initial appointment, in order to increase the degree to which participants link to ongoing care.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Individuals served in NDA services present with a behavioral health crisis, either to hospital emergency departments or to crisis outreach mental health professionals. These are adults that typically do not have access to any ongoing mental health services. The crisis clinicians that respond to the individual in the hospital or community setting assess the individual and determine that an inpatient psychiatric hospital stay could be averted if the person had access to outpatient crisis stabilization services with the 24 hours following their crisis assessment. A referral is made to the King County Crisis Clinic and an appointment is made with the NDA service in the geographic area of the person's preference.

Including baseline services made possible by the state and other funding partners, NDA Services include:

- Crisis intervention and stabilization services provided by professional staff trained in crisis management.
- Consultation with an appropriate clinical specialist when such services are necessary to ensure culturally appropriate crisis response.

- Referral to long-term mental health or other care as appropriate.
- Benefits counseling to work with NDA clients to gain entitlements that will enable clients to qualify for ongoing mental health and medical services.
- Psychiatric evaluation and medication management services, when clinically indicated, that include access to medications via prescription or direct provision of medications, or provides access to medication through collaboration with the individual's primary care physician.

MIDD specifically funds an enhancement to NDAs including short-term follow-up services:

- Consumers in crisis are offered additional short-term treatment and stabilization beyond the next day appointment. Potential additional services include:
    - linkage to ongoing services;
    - completion of a Medicaid application process;
    - development of a medication plan;
    - linkage to a primary care provider for those who are not enrolled for ongoing services; and/or
    - referrals to chemical dependency treatment.

As future funding permits, NDA capacity may be expanded to meet demand, as the need for NDAs from the local Emergency Departments far outstrips the current capacity.

◊ *B. Goals*

The Next Day Appointment (NDA) program is a clinic-based, follow-up crisis response program that provides assessment, brief intervention and linkage to ongoing treatment. The goal of the program is to provide crisis stabilization and to divert individuals from psychiatric inpatient care.

◊ *C. Expected Numbers of Individuals Served*

At the recommended level of funding, the NDA program is expected to serve about 1,800 people per year at its five current sites, including state- and MIDD-funded capacity. Of these, most come from hospital emergency departments, while other referrals come from DMHPs, the Crisis Clinic's voluntary hospital authorization team, and other first responder services. MIDD-supported follow-up services will be provided to at least 350 NDA participants per year system wide, based on their needs.[1]

Depending on future funding levels from the state and from MIDD, some MIDD funding under this initiative could potentially be used to expand initial NDA appointment capacity to help meet demand.

[1] Improved methods for counting recipients of the enhanced service will be explored, as even more people may be receiving follow-up services via MIDD than have been counted in recent years.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use

Specific to this initiative, the primary outcome for the NDA program is a direct diversion from an inpatient psychiatric stay. Additional outcomes include a reduction in the use of jails, emergency rooms, and hospitals after the NDA intervention.

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to community providers, potentially in tandem with Behavioral Health Urgent Care Walk-In services.

2. Spending Plan

Year	Activity	Amount
2017	Short-term follow-up services including medication and/or service linkage for at least 350 NDA participants, at 5 sites throughout King County	$307,500
2017 Annual Expenditure		**$307,500**
2018	Short-term follow-up services including medication and/or service linkage for at least 350 NDA participants, at 5 sites throughout King County	$315,495
2018 Annual Expenditure		**$315,495**
Biennial Expenditure		**$622,995**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The county, in collaboration with providers, may determine that it is necessary to re-RFP this body of work, particularly should NDA enhanced services be joined with new

behavioral health urgent care walk-in services for procurement and contracting purposes.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above. Contracts and associated targets may be revised to match with the recommended level of funding.

◊ *C. Services Start date (s)*

MIDD II services can begin immediately in January 2017, with continuous availability of crisis services and short-term follow-up, and no disruption of system capacity.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

MIDD II Initiative Title: Children's Crisis Outreach Response System

MIDD II Number: CD-11

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "reduce the number, length, and frequency of behavioral health crisis events."

The Children's Crisis Outreach Response System (CCORS) supports a countywide crisis response system for King County youth up to age 18 who are currently experiencing a mental health crisis. These services are provided to children, youth, and families where the functioning of the child and/or the family is severely impacted due to family conflict and/or severe emotional or behavioral problems, and where the current living situation is at imminent risk of disruption. CCORS also addresses the needs of children and youth who are being discharged from a psychiatric hospital or juvenile detention center and need intensive short-term services while ongoing supports are being put in place. An enhancement is included to reduce response time when law enforcement is involved, in order to improve de-escalation, follow-through with service linkage, and outcomes for families.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The CCORS program utilizes strength-based, individualized approaches via teams that include Crisis Intervention Specialists (Mental Health Professionals and Children's Mental Health Specialists), Family Advocates, and Parent Partners. Teams meet the referred youth and families in the home and other community locations. CCORS partners with families, as well as other professionals and systems, and uses short-term, evidence-based, crisis intervention strategies. Services are available 24 hours a day, seven days a week, 365 days a year.

The CCORS program has three main components: Crisis Outreach Services and Non-Emergent Outreach; Intensive Stabilization Services (ISS); and, Crisis Stabilization Beds (CSBs) also known as Hospital Diversion Beds.

<u>Crisis Outreach Services and Non-Emergent Outreach</u>

CCORS' Crisis Emergent and Non-Emergent Outreach services are available to children and youth in King County who meet certain crisis service criteria and are not currently receiving services through a contracted mental health agency. Emergent Crisis Response consists of: 1) crisis telephone response available 24 hours a day, seven days a week that includes immediate access to a mental health professional, as well as:

2) an outreach team that, at a minimum, consists of a Children's Mental Health Specialist and a Family Advocate who are trained in crisis management.

Crisis Outreach services provide rapid face-to-face response at the community site of the escalating behavior. Teams develop crisis safety plans with family and youth input. Teams also provide crisis outreach to children/youth not engaged with a contracted mental health agency that have been referred for inpatient hospitalization. Teams provide referrals for voluntary hospitalization or coordination with the Designated Mental Health Professionals (DMHPs) for involuntary hospitalization when needed, while keeping youth in the least restrictive option available that is clinically appropriate.

Intensive Stabilization Services (ISS)

ISS is an intensive service lasting up to 90 days that provides children and youth whose placement is at risk with immediate crisis stabilization. They build on the family's and child/youth's strengths and provide creative and flexible solutions focused on teaching and modeling parenting and problem-solving skills, developing skills necessary to manage behavior within the home/community environment and to prevent out-of-home placement. A variation of this stabilization service is available to those not enrolled in the pubic mental health system services provided by King County who are determined to need and agree to stabilization services upon initial crisis outreach services. They are available for up to eight weeks. This care is coordinated with new or existing community providers, including, but not limited to, other treatment providers, Department of Child and Family Services (DCFS) social workers and school staff.

Crisis Stabilization Beds (CSBs)

Crisis Stabilization Beds (CSBs) are designed for CCORS clients who would likely be hospitalized or experience another out of home placement without the use of a CSB, or are enrolled in RSN contracted mental health services and are in need of a CSB for hospital diversion. Crisis outreach teams facilitate access to these beds.

Enhancement: Expedited Response Time for Law Enforcement-Involved Referrals

In addition, this initiative includes an enhancement to the CCORS program, which aims to reduce the length of crisis events and increase family follow through with safety planning recommendations and treatment by reducing the average time it takes for CCORS to get to the scene of the crisis, thereby increasing CCORS's ability to carry out in-person crisis response in tandem with law enforcement, in order to enable crisis triage while law enforcement is still on the scene. This quicker response will increase family follow-up with mental health treatment resources.

Target response time for law enforcement-involved referrals will be reduced from the current two hours to 30-45 minutes. Although intended to operate countywide as resources permit, the enhancement to provide tandem de-escalation with law enforcement may not be available everywhere due to funding limitations. The gradual establishment of law enforcement agency partnerships, including those with and without

a significant degree of Crisis Intervention Training (CIT) among frontline officers, may determine geographic availability.

◊ *B. Goals*

CCORS's main goals are:

- to provide a single, integrated, county-wide, comprehensive system of crisis outreach response, stabilization intervention, family reunification, and transition to community supports for children and youth; and
- to ensure the safety of children/youth and their families and/or caregivers who are facing crisis situations while helping them stay the least restrictive location via community-based services and supports.

◊ *C. Expected Numbers of Individuals Served*

Historically the CCORS provider has not separately identified a number of clients served specifically due to the MIDD investment, although reports show that more than 1,000 clients per year benefit from CCORS services via blended funding from the partners described in section 2 below. King County BHRD may work with the provider to identify an appropriate number of clients to be served specifically as a result of MIDD II funding.

The proposed enhancement would provide expedited initial outreach within 30 to 45 minutes to approximately 360 families per year who are engaged with law enforcement at the time of referral.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level MIDD II outcome measures are expected for program participants:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use

For this specific initiative, expected outcomes include:

- diversion of children and youth experiencing a behavioral health crisis from inpatient hospitalization, detention, jails, hospital emergency departments, child welfare dependency and/or out of home placements.
- delivery of in-person, community-based emergency services that are responsive to families' needs and available when and where they need them.
- increased de-escalation skills for participating families.

- supportive linkage to ongoing services for families in crisis.
- expedited response to law enforcement involved with families in crisis, including more effective transition to crisis services, improved family follow through with referrals, and more active participation in crisis and stabilization services.

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from a community-based organization with expertise in providing this service. See also 3.A and 3.B below.

2. Spending Plan

As MIDD funding represents only a modest portion of the cost of the current comprehensive countywide program, federal block grant funds, state children's administration/DCFS funds, and state non-Medicaid funds remain essential to the program's full operation. The spending plan below relates solely to the recommended MIDD investment.

This spending plan provides for an expedited response in accordance with the enhancement described above.

Year	Activity	Amount
2017	Child/family teams with 24-hour availability to provide in-person support within two hours to any eligible child/family in crisis in King County, as well as short-term follow-up services and CSB access as needed	$522,750
2017	Enhanced staffing to provide in-person response within 30 to 45 minutes for referrals involving law enforcement	$194,750
2017 Annual Expenditure		**$717,500**
2018	Child/family teams with 24-hour availability to provide in-person support within two hours to any eligible child/family in crisis in King County, as well as short-term follow-up services and CSB access as needed	$536,342
2018	Enhanced staffing to provide in-person response within 30 to 45 minutes for referrals involving law enforcement	$199,814
2018 Annual Expenditure		**$736,155**
Biennial Expenditure		**$1,453,655**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Services will continue to be procured from the current CCORS provider. Competitive bids are not needed at this time, as a provider is already in place.

◊ *B. Contracting of Services*

A contract is in place with the current CCORS provider, the YMCA of Greater Seattle, and is expected to be renewed for the 2017-18 biennium. The enhancement to expedite response time for law enforcement-involved referrals will be added via contract changes.

◊ *C. Services Start date (s)*

MIDD II services can begin immediately in January 2017, with continuous availability of crisis services and no disruption for families served under MIDD I. Staffing expansion to enable enhanced response time for law enforcement-involved referrals would be in place by second quarter 2017, if the enhancement is reflected in final funding levels.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

MIDD II Initiative Title: Parent Partners Family Assistance

MIDD II Number: CD-12

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

This program provides family members and caregivers, youth, and community members (schools, faith organizations, social service and behavioral health agencies, etc.) with information about effectively navigating complex service systems, referrals to services, systems and supports for families, and/or direct support to utilize effective coping skills and strategies in person, via the telephone, or by text. Parent partners and youth peers support families where they need it (e.g., home, school, church, cafes, etc.). The current site for this work is located in an accessible office park in Kent. Some events and services are available at this office. Family social events and community educational offerings are provided throughout the county at parks, libraries, community centers, schools, churches, social service agencies, and other accessible locations.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The existing MIDD funds a free-standing, family-run, family support organization, currently known as Guided Pathways—Support for Youth and Families (GPS). GPS has a staff of three parent partners and one youth peer, in addition to the Executive Director and an administrative/volunteer coordinator. GPS provides parent training and education, 1:1 parent partner support, 1:1 youth peer support, a community referral and education help line, social and wellness activities for families, and advocacy. It also offers continuing education opportunities for peer support specialists employed in King County agencies, and maintains an informative and appealing website that includes a blog, a resource bank, and calendar of activities.

◊ *B. Goals*

The goals are to help families and youth who experience behavioral health challenges to:

- Increase their knowledge and expertise;
- Utilize effective coping skills and strategies to support themselves and/or their children/youth; and
- Effectively navigate complex service system(s).

◊ *C. Expected Numbers of Individuals Served*

This initiative serves at least 400 people annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative are:

- Decreased interpersonal/ family conflict;
- Increased family/youth social connectedness;
- Increased family/youth natural supports;
- Decreased acting-out behavior; and
- Increased empowerment/self-/family-advocacy.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Provide system navigation services, educational and social events, and other supports to youth and families	$420,250
2017 Annual Expenditure		**$420,250**
2018	Provide system navigation services, educational and social events, and other supports to youth and families	$431,177
2018 Annual Expenditure		**$431,177**
Biennial Expenditure		**$851,427**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with Guided Pathways—Support for Youth and Families (GPS) for this body of work. After two unsuccessful procurement processes during MIDD I BHRD worked with a consultant and stakeholders to establish GPS as a Family Support Organization to implement the MIDD I strategy. No RFP is needed for MIDD II.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue in First Quarter 2017.

MIDD Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

MIDD II Initiative Title: Wraparound Services for Youth

MIDD II Number: CD-15

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Families with children or youth who have serious emotional and behavioral disturbances face numerous challenges that traditional services models are unable to address. These children or youth often experience profound difficulties with functioning in school, maintaining relationships with family and peers, coping with their emotions, and controlling their behavior. Sometimes these difficulties strain families to the point that they see no other solution than to place their child outside of their home. When families turn to formal systems for support, they may experience a fragmented process that is driven more by system needs than by the needs of the child, youth and family. This fragmented process further isolates these youth and families as they develop a mistrust of professionals and lose hope in their own recovery.

Families who participate in wraparound often describe it as the only approach that truly worked for them. They report feeling heard, and then begin to develop positive working relationships with professionals and systems, while also increasing their own resilience, self-determination, and overall well-being.[1] Throughout the phases of wraparound, youth and their families learn the skills needed to continue this process, informally creating a sustainable plan of care. This reduces reliance on formal systems, helps families to stay together and avoid the inappropriate use of more costly resources such as inpatient care, foster care, and/or the juvenile justice system.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Wraparound is a team based approach to serving youth with complex needs – typically those involved with two or more child-serving systems – and their families. Wraparound's intensive, strength based and individualized care planning and management supports youth in their community and within their family culture.[2] Wraparound is a proven, effective approach to developing and coordinating plans of care that build on the strengths of the child or youth and family. Resulting plans are individualized and based on the needs and goals identified by the family. Plans address the specific cultural needs of the family, with a goal that services and supports occur in the family's home and community whenever possible. A team of supportive individuals 'wraps' around the family to help them achieve their goals. The team is made up of

[1] Bruns, E. J., Sather, A., Quick, H., Mudd, R, (2014, 2015) King County Wraparound Evaluation.
[2] The National Wraparound Initiative http://nwi.pdx.edu/

professionals as well as 'natural' supports like relatives, neighbors, coaches, or clergy who will continue to be involved with the family for years. High-fidelity wraparound follows the guidelines as set forth in the National Wraparound Initiative.[3] Fidelity monitoring includes tracking outcomes and continuous observation and verification of the skills and practices of facilitators. Fidelity monitoring also supports continuous quality improvement.

The implementation of Wraparound in MIDD II will feature a blended funding and services model that fulfills the terms of a 2013 legal settlement with Washington State (*T.R. vs. Quigley and Teeter*). That settlement requires the provision of Wraparound with Intensive Services (known as WISe) by all regions in the state to Medicaid-eligible children and youth with complex behavioral health needs.[4] In King County, many of these individuals are currently served by MIDD Wraparound. The WISe program, as defined in the settlement agreement, consists of Wraparound, intensive community-based mental health services, and mobile crisis outreach and stabilization services. These services have been available in King County for several years, due in part to MIDD I investments in Wraparound and the Children's Crisis Outreach Response System (CCORS).

While some new Medicaid funds will be provided by the state to deliver WISe, the state's funds do not cover the costs of the providing the services required of the WISe program, nor do those funds support non-Medicaid activities and services that MIDD currently funds through MIDD I funding. MIDD funding also enables Wraparound to be provided to children and families not eligible for Medicaid, or not eligible for WISe services. (Under MIDD I, Wraparound was provided to all families and children who met multiple systems involvement criteria, without regard to family means and without billing participants' private insurance.)

◊ *B. Goals*

Via a collaborative, facilitated process with an emphasis on family voice and choice, Wraparound brings multiple systems and natural supports together with a youth and family. The process and the system participants work together to create effective crisis and safety planning, support children and their families by addressing behaviors or unmet needs to prevent out of home placement, and help youth get back on track developmentally. As implemented in King County, Wraparound further has a specific role in assisting families in avoiding long-term inpatient placement or helping a child rejoin family after a long-term inpatient stay or an institutional placement.

Similarly, the state-funded WISe initiative described in 1.A above, which will be paired with MIDD II Wraparound and also used to support outpatient and crisis programs, is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral needs and to their families. The goal of the program is for eligible youth to live and thrive in their

[3] Walker, J.S. and Bruns, E. J. "Wraparound Implementation Guide 2008-2014," National Wraparound Initiative, Portland, Oregon.
[4] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/childrens-mental-health-lawsuit-and-agreement

homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements.[5]

◊ *C. Expected Numbers of Individuals Served*

During MIDD I, Wraparound served an average of just over 600 clients per year from 2011 through 2015. The MIDD funding level for Wraparound in MIDD II is lower than in MIDD I in anticipation of WISe funding supporting some aspects of Wraparound for Medicaid-eligible program participants. Under this blended funding and services model, at least 490 youth will be served per year, in accordance with the target established by the state WISe program. As funding from other sources including WISe permits, additional youth may be served.

A process to enable access to Wraparound services for children and youth from low- to moderate-income families who are not eligible for Medicaid and WISe will be developed in early 2017. This work will be informed by a workgroup in early 2017 as part of MIDD II implementation planning. The workgroup will specifically address financial and/or system use criteria. The number of non-Medicaid and/or non-WISe children to be served will be assessed via these criteria. Adjustments to program components to increase access while maintaining required fidelity will also be explored.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced/eliminated substance use
- reduced jail, hospital, and emergency department use

The following individual-level MIDD II outcomes are expected for program participants:

- increased use of preventive services
- educational achievement
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships

Specific expected outcomes for the Wraparound program include:[6]

- improved school performance for youth
- improved high school graduation rates for youth
- reduced drug and alcohol use for youth
- improvement in functioning at home, school, and in the community
- reduced juvenile justice involvement for youth
- maintained stability of current placement for youth
- increased community connections

[5] https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/TR.ImplementationPlan.8.1.2014.pdf
[6] Bruns, E. J., Sather, A., Quick, H., Mudd, R, (2014, 2015) King County Wraparound Evaluation.

- increased utilization of natural supports by youth and families
- Decreased emergency room visits for both medical and psychiatric episodes

◊ *E. Provided by: Contractors*

As in MIDD I, referral management and other coordinating activities will be provided by King County, although County personnel expenditures will now be underwritten by WISe. Contracted Wraparound Delivery Teams (WDTs) will be assigned to specific regions of the county, and eligible referrals are assigned to the appropriate team.[7]

[7] In consultation with a workgroup including stakeholders, the current five-region geographical allocation of funds and services will be adjusted for MIDD II to address current variation in caseload sizes and waitlists in different areas of King County.

MIDD Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

2. Spending Plan

Year	Activity	Amount
Program Elements Supported by MIDD II:		
2017	5 regional Wraparound Delivery Teams to ensure countywide capacity including ability to serve some non-Medicaid/non-WISe children (10 contracted FTEs per team, or 50 FTE total: facilitators, parent partners, youth peers, and coaches)	$2,356,219
2017	Flexible funds to meet clients' essential needs, including respite care via behavioral support aides	$565,031
2017	Training, monitoring, evaluation, and quality management	$153,750
2017 Annual Expenditure		**$3,075,000**
2018	5 regional Wraparound Delivery Teams to ensure countywide capacity including ability to serve some non-Medicaid/non-WISe children (10 contracted FTEs per team, or 50 FTE total: facilitators, parent partners, youth peers, and coaches)	$2,417,480
2018	Flexible funds to meet clients' essential needs, including respite care via behavioral support aides	$579,722
2018	Training, monitoring, evaluation, and quality management	$157,748
2018 Annual Expenditure		**$3,154,950**
Biennial Expenditure		**$6,229,950**
Program Elements Supported by Medicaid WISe Funding:[8]		
Annual	Certain Medicaid-/WISe-eligible services per state plan	Supported by WISe case rate
Annual	Assessment survey instrument and implementation	Supported by WISe case rate
Annual	Program management: referral management, coaching, technical assistance, contract compliance 2.0 King County FTE	Supported by WISe case rate

[8] *$2,115 per month per WISe-eligible child (via a case rate) funds some Wraparound services, and other intensive services.*

3. Implementation Schedule

◊ *A. Procurement of Providers*

As described in 1.C above, a workgroup will be convened to revisit both eligibility criteria and regional boundaries as part of planning for MIDD II Wraparound, along with program component adjustments to increase access, starting in first quarter 2017. Changes to these aspects of Wraparound service delivery may result in a new Request for Proposals (RFP), and will at a minimum result in changes to contract terms to reflect the effects of changes to the MIDD contribution level as well as expected revenue from the new WISe case rate funding stream.

◊ *B. Contracting of Services*

See 1.E and 3.A above.

◊ *C. Services Start date (s)*

King County BHRD's work to redefine this initiative will begin in the fourth quarter of 2016, with provider involvement to occur beginning in first quarter 2017 once funding levels are finalized. Implementation of the MIDD II initiative, including an RFP if needed, would be completed during the second quarter of 2017.

(Services at the five MIDD I Wraparound provider agencies will continue uninterrupted at MIDD I levels until this process is completed.)

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

MIDD II Initiative Title: Screening, Brief Intervention and Referral To Treatment-SBIRT (SBIRT)

MIDD II Number: PRI-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in vehicle and other crashes, as well as a heightened risk for other health problems, which may lead to emergency room admissions. SBIRT is a tool to universally screen and identify people with mild to severe substance use disorders (SUD) and/or who have depression or anxiety. Persons identified by SBIRT screening are given a brief intervention (BI) by a medical professional or counselor. The brief intervention (BI) addresses the individual's substance use, depression and/or anxiety and assists with establishing a plan to reduce use in the future. When indicated, patients are referred to specialty care for their substance use disorder, depression or anxiety.

In addition to identifying and intervening with people who have mild SUDs, SBIRT also identifies individuals with moderate to severe SUD and works to connect them (Referral to Treatment) to substance use treatment or options. In cases where there is not a SUD but there is an indication of depression or anxiety, patients are referred to a behavioral health specialist. In cases where SUD and depression and/or anxiety are present, depression/anxiety are handled first because often times the SUD is the self-medication for the depression/anxiety symptoms. SBIRT services connect behavioral and primary health care to effectively meet the needs of individuals.

1. Program Description

◊ *A. Service Components/Design (Brief)*

MIDD SBIRT services have focused on emergency departments (ED) by providing staff support to assist with SBIRT for SUD. Harborview ED, St Francis ED and Highline ED have staff that assist in SBIRT. Universal screening has not been possible with limited staff resources for an ED with 24 hour seven days per week operation.

SBIRT is provided to individuals when a patient shows an indication of use of alcohol or drugs; the SBIRT clinician is alerted and will complete a brief screen for alcohol and or drugs. The tools chosen are the Alcohol Use Disorders Identification Test (AUDIT)[1] and Drug Abuse Screening Test (DAST)[2]. Based on screen results a brief intervention using

[1] Babor TF, Higgins-Biddle JC , Saunders JB, Monteiro MG. *AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd Edition.* World Health Organization. 2001
[2] Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982, 7(4): 363-371.

Motivational Interviewing techniques may be completed. The patient is offered assistance in connecting to further assistance with the behavioral health clinician either for a follow-up brief therapy visit or for a referral for an assessment. "Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence".[3]

◊ *B. Goals*

SBIRT is a universal public health approach to integrate behavioral and primary health care. Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in vehicle and other crashes, as well as a heightened risk for other health problems, which may lead to emergency room admissions. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 2500 individuals annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for SBIRT are:

- Increase in admissions into substance use disorder treatment;
- Increases in admissions to co-occurring disorder treatment;
- Reduction in the average days of alcohol use, binge drinking and use of other drugs;
- Reduction in ED visits and hospital days by participants; and
- Improved mental health including reduction in symptoms of depression and anxiety.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Screening, Brief Intervention and Referral To Treatment in EDs continue. 6.0 FTE Behavioral Health Professionals	$ 717,500
2017 Annual Expenditure		**$ 717,500**

Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007, 32:189-198.

[3] Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*, *23*, 325-334.

2018	Screening, Brief Intervention and Referral To Treatment in EDs continue. 6.0 FTE Behavioral Health Professionals	$736,155
2018 Annual Expenditure		**$ 736,155**
Biennial Expenditure		**$ 1,453,655**

3. Implementation Schedule

◊ *A. Procurement of Providers*

An RFP will be developed and released in the first quarter 2017.

◊ *B. Contracting of Services*

Contracting will be completed with new or continuing providers in the second quarter of 2017.

◊ *C. Services Start date (s)*

Services continue in first quarter 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

MIDD II Initiative Title: Juvenile Justice Youth Behavioral Health Assessments & Improvements

MIDD II Number: PRI-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

A majority of youth entering the juvenile justice (JJ) system have underlying mental health and/or substance use disorder issues that may have caused the behavior which resulted in the initial need for juvenile justice involvement. This program assesses the behavioral health needs of youth and recommends service and treatment options in order to divert youth with mental illness and substance use disorder needs and diagnoses from further justice system involvement.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The MIDD I funds for this initiative provided mental health and substance use disorder screening/assessment services and psychological evaluations serves for King County youth age 12 years or older who have become involved with the juvenile justice system.

The team conducts assessments, makes recommendations to the Court regarding youth needs, including sentencing options and diversion from criminal justice sentencing due to underlying mental health or substance use disorder issues, refers youth to treatment services when a treatment need has been identified; and works to help youth follow-up on the treatment referrals and transition from screening/assessment/evaluation to ongoing treatment services when indicated.

Some of the contracted providers have been unable to keep the positions filled to conduct these services. For MIDD II, in collaboration with the Court, communities, and stakeholders, BHRD will engage in system mapping and promising practice analysis to determine the best way to serve JJ youth with behavioral health needs and their families through integrated behavioral health with these funds.

◊ *B. Goals*

The goal of this program is to serve youth whose involvement with the juvenile justice system is due to behavioral health issues to get them to the right type of service and treatment so that treatment and justice outcomes are improved, including reduced recidivism, reduced alcohol and substance use, and improved behavioral health of the youth and family.

◊ *C. Expected Numbers of Individuals Served*

Dependent upon program recommendations and design.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative are :

- Linkage to treatment services for those youth identified with a treatment need;
- Reduction in future involvement in the juvenile justice system;
- Reduction in use of alcohol and substance use; and
- Improved behavioral health.

◊ *E. Provided by: Both County and Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Juvenile Justice assessments and treatment linkage services. 1.0 FTE - Program Coordinator (Superior Court) 0.8 FTE - Staff Psychologist (Superior Court) 3.5 FTE - Behavioral Health Professionals (contracted agency)	$584,250
2017 Annual Expenditure		**$584,250**
2018	Juvenile Justice assessments and treatment linkage services. 1.0 FTE - Program Coordinator (Superior Court) 0.8 FTE - Staff Psychologist (Superior Court) 3.5 FTE - Behavioral Health Professionals (contracted agency)	$599,441
2018 Annual Expenditure		**$599,441**
Biennial Expenditure		**$1,183,691**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposal and/or Request for Qualifications may be necessary.

◊ *B. Contracting of Services*

Contracts will be completed during the third quarter 2017.

◊ *C. Services Start date (s)*

There is no service interruption; services remain in place into 2017-2018 biennium,

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

MIDD II Initiative Title: Prevention and Early Intervention Behavioral Health for Adults Over 50

MIDD II Number: PRI-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

Screening for depression, anxiety and substance use disorder is provided for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are enrolled in the Mental Health Integration Program (MHIP)[1], a short-term behavioral health intervention based on the Collaborative Care Model. The Collaborative Care Model is a specific model for integrated care developed at the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center to treat common mental health conditions that are persistent in nature and require systematic follow-up. Services take place in primary care clinics that are contracted under Public Health.

MHIP focuses on a defined patient population identified through screening and uses measurement-based practice and treatment to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7). Primary care providers work with behavioral health professionals to provide evidence-based medications and psychosocial treatments supported by regular consultation with a psychiatric specialist and treatment adjustment for patients who are not improving. Treatment lasts on average for six months.

Adults with more severe or complex needs that cannot be adequately treated in primary care are referred to mental health and substance use disorder treatment.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The MIDD Strategy Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+ provides prevention and intervention services for older adults to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses. This MIDD II initiative provides screening for depression, anxiety and substance use disorder for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are be enrolled in the Mental Health Integration Program (MHIP),[2] a short-term behavioral health intervention based on the Collaborative Care Model.

[1] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip
[2] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip

◊ *B. Goals*

The goal of this initiative is to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7) and to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve at least 4000 participants annually.

◊ *D. Outcomes and Performance Measures*

King County can expect continued improvement in depression scores and reductions in visits to the Emergency Department for those who screen positive for depression. Other outcomes include reductions in suicides, anxiety and alcohol and drug abuse among older adults in King County.

E. Provided by: Contractors

2. Spending Plan

Year	Activity	Amount
2017	Continued screening and intervention services for older adults	$484,639
2017 Annual Expenditure		**$484,639**
2018	Continued screening and intervention services for older adults	$497,240
2018 Annual Expenditure		**$497,240**
Biennial Expenditure		**$981,880**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Public Health – Seattle and King County manages this initiative as part of the Mental Health Integration Program (MHIP). No RFP is needed.

◊ *B. Contracting of Services*

See 3.A above.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Older Adult Crisis Intervention/Geriatric Regional Assessment Team (PRI-4)

MIDD II Initiative Title: Older Adult Crisis Intervention/Geriatric Regional Assessment Team (GRAT)

MIDD II Number: PRI-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

GRAT provides a comprehensive assessment, crisis intervention, and referral and linkage to community resources for older adults struggling with mental health and/or chemical dependency issues. By intervening early, GRAT effectively diverts many of the older adults it serves from using other more costly services, such as inpatient psychiatric hospitalization, emergency rooms, skilled nursing facilities, and jail. GRAT also provides consultation, care planning, and education on older adult mental health issues for other community providers.

1. Program Description

◊ *A. Service Components/Design (Brief)*

GRAT provides a specialized outreach crisis and mental health assessment, including a substance use screening, that is age, culturally, and linguistically appropriate for King County residents age 60 years and older who are experiencing a crisis in which mental health or alcohol and/or other drugs are a likely contributing factor and/or exacerbating the situation, and who are not currently enrolled in mental health services under the King County Mental Health Plan.

◊ *B. Goals*

GRAT provides assessment, crisis intervention and referral for older adults throughout King County, and for many, this service diverts them from using more intensive and costly crisis services (hospital emergency room, psychiatric hospitalization, jail, etc.). This program is consistent with the Recovery model, in that it focuses on helping those older adults most in need to improve their wellbeing, get the assistance needed to accomplish this, and to help older adults live as independently as possible.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 340 annually.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative are:

- divert older adults from Emergency Room Visits;
- divert older adults from psychiatric hospital admissions;
- divert older adult people from homelessness;
- divert older adults from criminal justice involvement;
- divert older adults from skilled nursing facility placements; and
- divert older adults from eviction.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued specialized outreach crisis and mental health assessment, including substance use screening, for older adults	$329,025
2017 Annual Expenditure		**$329,025**
2018	Continued specialized outreach crisis and mental health assessment, including substance use screening, for older adults	$337,580
2018 Annual Expenditure		**$337,580**
Biennial Expenditure		**$666,605**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD contracts with EvergreenHealth (EH) for GRAT services under MIDD I. The county may elect to re-RFP this service supported by MIDD II funds. EvergreenHealth also receives funding from other sources that supports the program.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students
(PRI-8)

MIDD II Initiative Title: Collaborative School Based Behavioral Health Services: Middle and High School Students

MIDD II Number: PRI-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

This initiative includes the development and integration of school-based SBIRT (screening brief intervention & referral to treatment)[1] services. School-based SBIRT will include working with all middle schools on the development and implementation of SBIRT services, which includes training and technical assistance in the Global Appraisal of Individual Need - Short Screen (GAIN-SS). The GAIN-SS is a 23-question screening tool that quickly and effectively screens for depression, anxiety, substance abuse, and other behavioral health disorders.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The current MIDD Collaborative School Based Mental Health and Substance Abuse Services strategy invests in prevention/early intervention for school-based services provided in middle schools. These services include: assessments, screenings, brief intervention, referral, case coordination and mental health and behavioral health support groups, including social skills groups, anger management groups, and recovery groups. MIDD School Based Suicide Prevention provides students and schools suicide prevention trainings. Youth are trained on stress management and suicide prevention. Adults are trained on identification of early signs of stress, depression, and suicide ideation, and how to handle these issues in families and in youth-serving organizations. School-based MIDD prevention services will continue and be expanded as part of Best Starts for Kids (BSK).

These previously separate MIDD supported programs are combined into one initiative under MIDD II.

◊ *B. Goals*

The goals of this initiative are:

- Reduce the risk of students developing mental or emotional illness, or using drugs/alcohol;
- Reduce poor school performance, to prevent school dropout, and to decrease other problem behaviors experienced by youth; and

[1] http://www.integration.samhsa.gov/clinical-practice/SBIRT

- To build collaboration between organizations in order to connect middle school-aged students or high school-aged students to needed mental health and substance abuse services in the school and community.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 1000 youth in individual and small group services and 5000 people in large group activities.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative are:

- Increased number of school-community collaborations;
- Improved school performance and attendance;
- Decrease in suspensions and other disciplinary actions;
- Decrease in truancy petitions filed; and
- Increase the number of effective, evidence-based prevention interventions implemented.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	School-Based prevention services continue	$1,579,652
2017 Annual Expenditure		**$1,579,652**
2018	School-Based prevention services continue	$ 1,620,723
2018 Annual Expenditure		**$1,620,723**
Biennial Expenditure		**$ 3,200,375**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A planning period will involve coordinating this MIDD II Initiative with Best Starts for Kids to ensure a comprehensive program is developed across initiatives. A RFP will be released in the second quarter 2017.

◊ *B. Contracting of Services*

Contracts will be completed in the third quarter 2017.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Crisis Intervention Training – First Responders (PRI-8)

MIDD II Initiative Title: Crisis Intervention Training – First Responders

MIDD II Number: PRI-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goals of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

CIT is an intervention primarily focused on increasing the understanding and use of community-based resources to help reduce the reliance on and use of jail and hospitals. The initial strategy goals were to increase diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement, and to reduce the number of people with mental health and substance use disorders using costly interventions such as jail, emergency rooms, and hospitals.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Crisis Intervention Training (CIT) is a model of police-based crisis intervention with community behavioral health care and advocacy partnerships. CIT provides intensive training to law enforcement and other first responders that teaches them to effectively assist and respond to individuals with mental illness or substance use disorders, and better equips them to help individuals access the most appropriate and least restrictive services while preserving public safety.

◊ *B. Goals*

The goals for CIT are to increase safety for first responders, individuals, and the community; increase options and tools when responding to individuals in crisis; and encourage and increase the use of community resources resulting in decreased jail bookings and hospital emergency department admissions.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 600 participants.

◊ *D. Outcomes and Performance Measures*

The outcomes expected are:

- Reduced emergency department utilization;
- Reduced incarcerations;
- Improved linkages to treatment;
- Increased skills related to crisis de-escalation/intervention; and

- Increased knowledge of, and improved perceptions regarding individuals with, behavioral health disorders.

◊ *E. Provided by: Both County and Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Crisis intervention trainings to law enforcement and other first responders continue.	$ 820,000
2017 Annual Expenditure		**$ 820,000**
2018	Crisis intervention trainings to law enforcement and other first responders continue.	$ 841,320
2018 Annual Expenditure		**$ 841,320**
Biennial Expenditure		**$ 1,661,320**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with the Washington State Criminal Justice Training Commission and coordinates the King County Sheriff's Office for CIT services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Trainings continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

MIDD II Initiative Title: Sexual Assault Behavioral Health Services

MIDD II Number: PRI-9

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The sexual assault service delivery system addresses a unique set of needs as compared to broader community mental health treatment. In the sexual assault service system, victims and/or their families are seeking services as a result of the crime and its impact. They may have a variety of specific needs including medical, forensic, crisis response, information, advocacy to assist with legal needs and counseling. Often victims and families may not know the variety of issues and the impacts of the assault.[1]

Community sexual assault programs (CSAPs) are designed to provide holistic services tailored to the sexual assault-specific needs of victims. Because of their experience with and in-depth of knowledge of all aspects of sexual assault, the organizations are equipped to anticipate and respond based on an individualized assessment of needs. CSAPs provide empirically supported services through a trauma-informed lens. This holistic response means that the organization can address the full range of concerns about legal, medical and other systems that may adversely affect mental health outcomes, while also providing brief early interventions to reduce the likelihood of longer term mental health distress. For individuals who develop persisting sexual assault-specific mental health problems, effective evidence-based interventions are provided.

The system coordination component of this initiative aims to support information-sharing, consultation, and expertise dissemination across the domestic violence, sexual assault, and behavioral health systems.

1. Program Description

◊ *A. Service Components/Design (Brief)*

<u>Evidence-based Treatment Services Component</u>

Services currently provided by the CSAPs as part of this initiative include the following:

[1] This contrasts with typical assistance from traditional public mental health settings where clients are eligible for services if they meet access to care criteria related to a mental health disorder, and their unique needs related to the assault may or may not be able to addressed directly in that setting.

- Screening and assessment to identify the mental health and/or substance use disorder (SUD) needs of survivors receiving sexual assault services at the Contractor;
- Evidence-based trauma-focused therapy for those children, teen, and adult survivors of sexual assault who would benefit from the therapy;[2] and
- Referrals to community mental health and SUD treatment agencies for those sexual assault survivors who need more intensive services.

◊ *B. Goals*

This initiative aims to increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County, and increase coordination between programs serving sexual assault survivors who are experiencing mental illness, substance abuse and domestic violence.

◊ *C. Expected Numbers of Individuals Served*

Historically CSAPs have not been able to separately identify a number of clients served specifically due to the MIDD investment, although reports show that approximately 350 clients per year benefit from CSAP services via blended funding. In consultation with providers, King County BHRD will work to identify an appropriate number of clients to be served specifically as a result of MIDD II funding if possible.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning

The following individual-level MIDD II outcomes are expected as a result of this initiative:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services

For this specific initiative, output measures include such counts as the number of individuals screened and the number of referrals to mental health or substance use disorder treatment, among others. As part of output determination for MIDD II referenced in 1.C above, data tracking processes will be established to facilitate identification of outputs and outcomes specific to MIDD-funded clients.

[2] Evidence-based services at King County's CSAPs include trauma-focused cognitive behavioral therapy (TF-CBT), prolonged exposure (PE), prolonged-exposure-adolescent (PE-A), cognitive processing therapy (CPT), parent child interaction therapy (PCIT), and the common elements treatment approach (CETA), and other evidence-based approaches proven effective for post-traumatic stress disorder including interventions specifically for children.

The therapy interventions offered under this initiative have been well-researched and have been demonstrated to result in positive outcomes for victims. Because CSAPs have adopted evidence-based approaches, they use standard measures to track individual symptom reduction outcomes.

This initiative is further expected to impact the following outcomes:

- increased access to mental health and substance use treatment services for sexual assault survivors
- increased resiliency and coping skills among sexual assault survivors served
- consistent screening for mental health and substance abuse needs among sexual assault agencies
- improved ability of mental health and substance abuse providers to serve individuals with sexual assault and behavioral health issues, including an increased knowledge of sexual assault resources.

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from community-based organizations. See also 3.A below.

2. Spending Plan

Year	Activity	Amount
2017	Approximately 5.7 FTE clinicians to provide screening and evidence-based sexual assault therapy	$584,250
2017 Annual Expenditure		**$584,250**
2018	Approximately 5.7 FTE clinicians to provide screening and evidence-based sexual assault therapy	$599,441
2018 Annual Expenditure		**$599,441**
Biennial Expenditure		**$1,183,691**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Clinical services will be procured from agencies with expertise in evidence-based sexual assault therapy.

Although competitive bids are not needed at this time as providers are already in place, reprocurement of either component of the initiative could occur in the future as needed.

◊ *B. Contracting of Services*

Contracts are in place with two CSAPs for evidence-based therapy services. These are expected to continue without need for a competitive bidding process, and will be revised for 2017 to reflect MIDD II funding levels, performance targets, and outcome tracking expectations.

The contract for system coordination encompassing sexual assault and domestic violence is similarly expected to continue at the same agency.

◊ *C. Services Start date (s)*

MIDD II services can begin immediately in January 2017, with no disruption for clients served under MIDD I.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-9)

MIDD II Initiative Title: Domestic Violence Behavioral Health Services and System Coordination

MIDD II Number: PRI-10

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Survivors of domestic violence are at greater risk of developing a variety of mental health disorders, including depression, anxiety and post-traumatic stress disorder. Survivors are often in an environment of on-going trauma, which can prolong and exacerbate their mental health concerns, increase their vulnerability and compromise their safety.

This initiative's model of early, accessible mental health intervention combined with integrated advocacy and other supportive services decreases the risk of mental health concerns and other negative impacts of domestic violence and increases survivor stability and capacity to cope. The initiative also decreases barriers for survivors by identifying areas of concern (screening), providing trauma-informed therapy integrated with advocacy, and facilitating referrals to other appropriate behavioral health support.

The system coordination component of this initiative aims to support information-sharing, consultation, and expertise dissemination across the domestic violence, sexual assault, and behavioral health systems.

1. Program Description

◊ *A. Service Components/Design (Brief)*

<u>Co-Located Mental Health Professional (MHP) Component</u>

This initiative co-locates 3.5 FTE MHPs with expertise in domestic violence (DV) and substance use disorders in community-based domestic violence victim advocacy programs around King County. Of these, 0.5 FTE are expected to be directed specifically to an organization serving marginalized population(s), such as people of color or LGBTQ individuals.

Services provided by co-located mental health professional include the following:

- Screening using an evidence-based instrument
- Assessment
- Brief therapy and mental health support, both individually and in groups
- Referral to mental health and substance use disorder treatment for those DV survivors who need more intensive services

- Consultation to DV advocacy staff and staff of community mental health or substance use treatment agencies

Culturally Appropriate Clinical Services Component

This initiative also funds 1.0 FTE full-time mental health professional at an agency specializing in the provision of services to immigrant and refugee survivors of domestic and sexual violence. This person primarily serves as a clinical consultant and trainer for the agency's team of domestic violence advocates providing direct care – including screening, assessment, brief therapy, and referral as above – to clients in multiple languages.

System Coordination Component

In addition to treatment services, this initiative also supports 0.5 FTE of a full-time systems coordinator/trainer – with the balance of funding coming from MIDD II's sexual assault behavioral health services and system coordination initiative – to coordinate ongoing cross training, policy development, and consultation on domestic violence (DV), sexual assault, and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County. The systems coordinator offers training, consultation, relationship-building, research, policy and practice recommendations, etc. for clinicians and agencies who wish to improve their response to survivors with behavioral health concerns but who lack the time or knowledge to do so.

◊ *B. Goals*

The overall goals of this initiative include the following:

- To promote a reduction in the incidence and severity of substance abuse, mental and emotional disorders in youth and adults.
- To integrate mental health services within community-based domestic violence agencies, including training and consultation for advocacy and other staff, making services more accessible to domestic violence survivors.
- To improve screening, referral, coordination, and collaboration between mental health, substance use disorder, domestic violence, and sexual assault service providers.

◊ *C. Expected Numbers of Individuals Served*

As a result of the planned expansion of system capacity, approximately 750 to 800 clients will be served per year through the clinical components of this initiative.

The system coordination component of this initiative includes training for approximately 1,800 professionals per year, among other services provided.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health

- daily functioning

The following individual-level MIDD II outcomes are expected as a result of this initiative:

- increased use of preventive services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services

For this specific initiative, output measures include such counts as the number of individuals screened and the number of referrals to mental health or substance use disorder treatment, among others.

This initiative is further expected to impact the following outcomes:

- increased access to mental health and substance use treatment services for DV survivors
- the provision of culturally relevant mental health services provided to DV survivors from immigrant and refugee communities in their own language
- increased resiliency and coping skills among DV survivors served
- consistent screening for mental health and substance abuse needs among DV agencies
- improved ability of DV, sexual assault, mental health and substance abuse providers to serve individuals with DV and mental health issues.

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from community-based organizations. See also 3.A below.

2. Spending Plan

This spending plan provides for expanded capacity at agencies that were funded under MIDD I, and creates the potential for added services at a new agency serving marginalized populations.

Year	Activity	Amount
2017	Approximately 3.0 FTE clinicians co-located within DV agencies to provide behavioral health screening, brief therapy, and referral	$307,500
2017	Approximately 1.0 FTE clinician to provide culturally appropriate behavioral health consultation and training within DV agency serving immigrant and refugee survivors[1]	$102,500
2017	Approximately 0.5 additional FTE clinician co-located within a DV agency serving marginalized population(s)	$51,250
2017	1.0 FTE system coordination, training, and consultation[2]	$102,500
2017 Annual Expenditure		**$563,750**
2018	Approximately 3.0 FTE clinicians co-located within DV agencies to provide behavioral health screening, brief therapy, and referral	$315,495
2018	Approximately 1.0 FTE clinician to provide culturally appropriate behavioral health consultation and training within DV agency serving immigrant and refugee survivors	$105,165
2018	Approximately 0.5 additional FTE clinician co-located within a DV agency serving marginalized population(s)	$52,583
2018	1.0 FTE system coordination, training, and consultation	$105,165
2018 Annual Expenditure		**$578,408**
Biennial Expenditure		**$1,142,158**

[1] Under MIDD I, funding for this role was divided between strategies addressing sexual assault and DV. Under a potential MIDD II, although the function of the position is unchanged and is designed to cross between these systems, for administrative purposes it is funded under the DV initiative only at the request of stakeholders.
[2] Under MIDD I, funding for this role was divided between strategies addressing sexual assault and DV. Under a potential MIDD II, although the function of the position is unchanged and is designed to cross between these systems, for administrative purposes it is funded under the DV initiative only at the request of stakeholders.

3. Implementation Schedule

◊ *A. Procurement of Providers*

Clinical services will be procured from agencies with expertise in serving survivors of DV that have the capacity to incorporate a co-located mental health professional. Coordination functions will be procured from an organization with relevant expertise in training, consultation, and/or system coordination.

Competitive bids are not needed at this time for the system coordination portion of this initiative, as a provider is already in place.

Among clinical services funded under this initiative, 4.0 FTE are expected to continue to be contracted to DV providers that were funded under MIDD I (including 1.0 FTE for culturally appropriate services for immigrants and refugees).

A part-time 0.5 FTE position may be contracted to a new agency that serves marginalized population(s). If this approach is selected, a Request for Proposals (RFP) process may occur to identify an agency to provide this additional system capacity.

Reprocurement of any component of the initiative could occur in the future as needed.

◊ *B. Contracting of Services*

Contracts are in place with four DV agencies for co-located MHPs. These are expected to continue without need for a competitive bidding process, and will be revised for 2017 to reflect MIDD II funding levels, performance targets, and outcome tracking expectations. A new contract may be needed if a new agency is selected for the expanded clinical services.

The contract for system coordination encompassing sexual assault and domestic violence is similarly expected to continue at the same agency.

◊ *C. Services Start date (s)*

MIDD II services can begin immediately in January 2017, with no disruption for clients served under MIDD I.

If a new agency is selected for the expanded clinical services for marginalized population(s), services would likely be in place by third quarter 2017 after completion of the RFP process.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

MIDD II Initiative Title: Community Behavioral Health Treatment

MIDD II Number: PRI-11

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The current community need for behavioral health treatment is significant. There is a large unserved population of people who are not on Medicaid, or do not qualify for Medicaid, whose behavioral health needs are only addressed when their need reaches crisis proportions - either in hospital emergency departments, in-patient care, or jails. Over half of the individuals with mental illness who are admitted to psychiatric hospitals do not have Medicaid coverage. Eleven percent of people in King County over the age of 18 suffer from frequent mental distress; most are living in poverty and many live in South King County.[1] Twenty-seven percent of school-aged youth are experiencing depression, many of which are minorities living in South King County;[2] 29 percent of in-school youth in King County report having used some type of illicit drug within the past 30 days. [2] These treatment services decrease disparities across King County so that all residents have the opportunity to achieve their full potential.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative provides mental health (MH) and substance use disorder (SUD) services to those who are not served by Medicaid, including undocumented individuals, incarcerated individuals, people on Medicare, people who are under 220 percent of the federal poverty level and have extremely high co-pays and deductibles in order to access service, people on Medicaid spend down (meaning they have to pay a certain amount of out of pocket expense every six months before Medicaid reimbursement kicks in), and people who are pending Medicaid coverage. In addition, this initiative provides essential services that are part of the treatment continuum not covered by Medicaid such as outreach, transportation, and peer support (SUD specifically).

[1] Behavioral Risk Factor Surveillance System. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014.
http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx
[2] Healthy Youth Survey. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014.
http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx

◊ *B. Goals*

The goals of the strategy are to increase access to and provide services for individuals who are currently ineligible for Medicaid, decrease the number of people with behavioral health issues who are re-incarcerated or re-hospitalized, reduce jail and inpatient utilization, and homelessness.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 3500 people at least annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative include:[3]

- Reduced substance use disorder symptoms;
- Improved psychiatric symptoms and functioning;
- Decreased unnecessary hospitalization;
- Increased housing stability; and
- Improved quality of life.

Youth related outcomes include:

- Increased access to person-centered, culturally appropriate counseling and case management services;
- Reduced risk factors for substance use and mental health disorders;
- Increased retention in school (and employment for older youth); and
- Improvement in life domains: Family Functioning; Peer Relations; Community Attachment; Individual Emotional/Behavior; Academic Achievement and School Readiness.

◊ *E. Provided by: Contractors*

2. Spending Plan

Year	Activity	Amount
2017	Continued mental health and substance use disorder services for people who are not served by Medicaid, and essential services in the care continuum that are not covered by Medicaid	$11,890,000
2017 Annual Expenditure		**$11,890,000**
2018	Continued mental health and substance use disorder services for people who are not served by	$12,199,140

[3] http://www.samhsa.gov/treatment

	Medicaid, and essential services in the care continuum that are not covered by Medicaid	
2018 Annual Expenditure		**$12,199,140**
Biennial Expenditure		**$24,089,140**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health providers currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Supportive Services (RR-1)

MIDD II Initiative Title: Housing Supportive Services

MIDD II Number: RR-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This initiative provides housing support services to chronically homeless adults. Individuals that have previously been unsuccessful in housing due to lack of stability and/or lack of daily living skills become successfully housed with the assistance of housing support specialists. Housing stability reduces use of criminal justice and emergency medical systems.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Housing supportive services includes assistance to help the individual meet the obligations of tenancy, i.e. rent payments, abide by landlord rules, cooperate with neighbors, keep the apartment clean and safe; assistance with learning the daily living skills to live independently, i.e. shopping, cooking, budgeting, cleaning; coordination with behavioral health treatment providers and healthcare providers; and helping individuals get to medical appointments. Housing support services assist individuals in moving from homelessness to housing stability. Services are provided primarily at the individual's housing site and in the surrounding community by housing support specialists.

◊ *B. Goals*

The goal of this initiative is to increase the number of housed individuals with mental illness and chemical dependency who are receiving supportive housing services, leading to increased housing tenure and housing stability. Housing stability is a key determinant in increasing treatment participation and in reducing use of criminal justice and emergency medical systems.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 140 people each year initially with capacity growing over time as new annual awards are included.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative are:

- Reduced incarcerations and lengths of stay;
- Reduced emergency department utilization;
- Reduced psychiatric hospitalizations; and

- Increased referrals and linkages to behavioral health treatment.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued housing supportive services for individuals with behavioral health conditions.	$2,050,000
2017 Annual Expenditure		**$2,050,000**
2018	Continued housing supportive services for individuals with behavioral health conditions.	$2,103,300
2018 Annual Expenditure		**$2,103,300**
Biennial Expenditure		**$4,153,300**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The King County DCHS Housing Finance Program (HFP) administers and oversees funding for housing stability and services programs. MIDD II funding will be allocated to the HFP in January 2017. HFP distributes MIDD Housing Supportive Services as part of the HFP annual Notice of Funding Availability (NOFA) RFP process.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP)
(RR-2)

MIDD II Initiative Title: Behavior Modification Classes at Community Center for Alternative Programs (CCAP)

MIDD II Number: RR-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative is expeced to impact the recommended MIDD policy goal of "Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The Moral Reconation Therapy (MRT) model in this initative uses a positive group dynamic to alter inappropriate thought and behavior amongst domestic violence (DV) offenders. The Moral Reconation Therapy-Domestic Violence (MRT-DV) pilot program adaptation is a cognitive-behavioral program designed to change how DV offenders think (beliefs) and change behavior to one of equality and acceptance. The MRT-DV adaptation takes approximately 55 sessions to complete, which are conducted twice weekly at CCAP. Both the MRT-DV and standard DV education occur within a 60-day court order to CCAP.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative enhances program services offered at CCAP in the areas of behavioral health education and intervention, and addresses criminogenic risk factors specifically associated with DV. Since 2014, MIDD has supported a 1.0 Full Time Equivalent (FTE) clinician from Sound Mental Health (SMH) trained in MRT and the specialized DV version to prepare and facilitate groups for one caseload of 15 men participants who are randomly assigned to the MRT-DV program at CCAP for approximately 60 days. All MRT-DV participants have a substance use disorder, primarily involving alcohol and/or cannabis. Participants are clinically assessed and enrolled in appropriate substance use disorder (SUD) treatment at CCAP per American Society of Addiction Medicine criteria.

◊ *B. Goals*

The program goal is to realize an increase in the scope and effectiveness of the services offered at CCAP and appropriately address the changing service needs of court-ordered participants. Specifically, the MRT-DV pilot was implemented to intervene and provide a holistic array of services including outpatient SUD treatment with court monitoring to promote participant behavior change and recovery, and reduce recidivism and victimization.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 40 participants annually.

◊ *D. Outcomes and Performance Measures*

The County expects reduced recidivism and victimization as a result of the investment in the pilot. The MRT-DV pilot evaluation is examining the following outcomes by comparing change from the year prior to and the year starting with MRT-DV programming at CCAP:

- DV charges;
- King County jail bookings and jail days;
- Municipal jail bookings and days (Enumclaw, Kent, South Correctional Entity, Kirkland);
- Police reports;
- Orders of protection; and
- DV survivor interviews.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Moral Reconation Therapy – Domestic Violence version for CCAP clients 1.0 contracted FTE	$77,900
2017 Annual Expenditure		**$77,900**
2018	Moral Reconation Therapy – Domestic Violence version for CCAP clients 1.0 contracted FTE	$79,925
2018 Annual Expenditure		**$79,925**
Biennial Expenditure		**$157,825**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health provider currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

MIDD II Initiative Title: Housing Capital and Rental (RR-3)

MIDD II Number: RR-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The initiative will provide a dedicated source of capital funding for the creation of housing units specifically set aside for the behavioral health needs population struggling with mental health and substance use disorders (SUDs) who are homeless or being discharged from hospitals, jails, prison, crisis diversion facilities or residential chemical dependency treatment. Dedicated housing for this population decreases homelessness, the need for medical care/hospital stays, and jail time.

It also supports housing stability by investing in rental subsidies for 25 individuals living in existing supportive housing settings.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Supportive housing with services targeted to people with behavioral health conditions will feature, as much as feasible, a Housing First approach. Housing First is a homeless best practice, designed to create a stable environment where households can address their health issues while receiving additional employment and stable housing services.

Capital funding to create housing is paired with service funding to ensure success of those being housed. While the level of service may vary, for most households facing behavioral health conditions, some level of services will be required for success.

Permanent supportive housing is the most service-enriched housing environment. Many individuals and households with persistent mental illness and/or chronic addiction need this high intensity level of services. Although costly, permanent supportive housing is still more cost effective when compared to homelessness and frequent hospitalization and/or incarceration.

A portion of funds under this initiative will also be used to continue approximately 25 rental subsidies in existing supportive housing projects. These were supported by the MIDD I.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

◊ *B. Goals*

The primary focus of this initiative is the creation of housing – to be paired with services through companion MIDD II initiative Housing Supportive Services, Medicaid supported housing funding, and/or other sources – to support extremely low income households with mental illness and/or substance abuse issues.[1] This initiative will serve extremely low income populations below 30% of the area median income struggling with mental illness and/or SUDs who are likely to be predominantly homeless.

In addition to creating new housing, a portion of this initiative supports housing access by providing 25 rental subsidies for individuals in existing supportive housing settings.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals to be served by capital investments from this initiative will vary depending on which projects are funded. However, based on general estimates assuming that MIDD funds will leverage $5 for every $1 in local funds invested, about 25 to 30 units of permanent housing will be created for each year's investment at the recommended level.

The rental subsidies funded through this initiative will serve 25 individuals or families per year.

◊ *D. Outcomes and Performance Measures*

This initiative contributes to population outcomes of the MIDD II Framework, including:

- reduced jail, hospital, and emergency department use
- housing stability

The following individual-level MIDD II outcome measures are expected for program participants:

- reduced behavioral health risk factors
- improved wellness self-management
- reduced unnecessary incarceration, hospital, and emergency department use
- increased housing stability

Likely outcomes from this initiative will include an increase in housing dedicated to people with behavioral health conditions, and decreased costs associated with medical care and incarceration for individuals served by these projects.

[1] A key consideration for this initiative is the connection between housing capital and service funding. Neither service dollars nor capital funds alone can produce the amount of successful supportive housing required to reduce the incidence of homelessness. To be successful any housing dedicated to MIDD populations must include services.

◊ *E. Provided by: Contractor*

As described in 3.A and 3.B below, capital funding will be disbursed to housing developers via RFPs administered by King County. Capital funds from MIDD will be paired with capital investments from other funders, and will be linked to services appropriate to each project's target population.

Rental subsidies are contracted by BHRD to supportive housing provider(s).

2. Spending Plan

This spending plan shows estimated amounts and expected categories for MIDD II's recommended contribution to housing capital and rental subsidies.

Estimated costs below are expected to be adjusted depending on market factors and/or as specific capital project opportunities arise.

Year	Activity	Amount
2017	Capital investments for an annual average of 25 to 30 new permanent supportive housing units for people with behavioral health conditions	$1,660,000
2017	Approximately 25 rental subsidies for people with behavioral health conditions	$240,000
2017 Annual Expenditure		**$1,900,000**
2018	Capital investments for an annual average of 25 to 30 new permanent supportive housing units for people with behavioral health conditions	$1,703,160
2018	Approximately 25 rental subsidies for people with behavioral health conditions	$246,240
2018 Annual Expenditure		**$1,949,400**
Biennial Expenditure		**$3,849,400**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Following existing processes for capital projects, MIDD funding will be allocated to the King County DCHS Housing Finance Program (HFP) immediately in January 2017, with RFPs for project developers to be released in second quarter 2017, reviewed in third quarter 2017, and awarded in fourth quarter 2017 including specific housing set-aside commitments for funded projects.

The HFP and BHRD program staff will review all capital proposals received through the RFP to determine the capacity and experience of the housing developers and service providers, as well as the financial feasibility of each project. The number of proposals received each year will vary, so the number of projects awarded capital MIDD funding will also vary annually.

Awards will be made based on availability of all funding provided from King County as well as the developer's ability to secure any and all additional capital funding from all other sources, such as other state and local funding.

King County DCHS is moving toward a targeted capital affordable housing allocation process. Rather than publishing a general request for proposals, over several years DCHS will shift the request for proposal (RFP) process to one that solicits proposals for specific projects. MIDD funds will be included in this process.

◊ *B. Contracting of Services*

Contract negotiation timing for capital projects will depend on how quickly other funding is secured, including other capital funding and service funding via MIDD and/or other sources. In general, negotiated contracts are in place within six months of award.

Rental subsidy funding will continue to be disbursed by BHRD via contract to supportive housing provider(s).

◊ *C. Services Start date (s)*

Rental subsidies will continue without disruption beginning in January 2017.

Services for clients will begin when housing projects are built, and paired supportive services are in place.

This process will be completed at least annually in order to continue to fund additional units and projects in future years.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing - Adult Drug Court (RR-5)

MIDD II Initiative Title: Housing - Adult Drug Court (ADC)

MIDD II Number: RR-5

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The recovery-oriented, transitional housing units and housing support services provide the opportunity to stably house vulnerable participants while decreasing the use of jail, shelters and other temporary housing options, which supports recovery and improved behavioral health outcomes. This initiative prevents homelessness for a vulnerable population.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative provides recovery-oriented, supportive, transitional housing units and housing support services for ADC participants. The majority of the added units will be single adult units, however some will accommodate families. Financial assistance for move-in costs for up to 25 percent of the single adults and 75 percent of the families who successfully complete the recovery-oriented housing program and transition to permanent housing will be provided. This initiative reduces and prevents homelessness and recidivism in King County by providing safe, supportive and stable housing.

◊ *B. Goals*

The goals of this initiative are to reduce homelessness for those involved in ADC and increase graduation rates of ADC participants. Those who graduate from ADC have more opportunities for employment, health and overall well-being, and stable, safe permanent housing.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve at least 30 people annually.

◊ *D. Outcomes and Performance Measures*

This initiative includes the following outcomes:

- Achievement of greater equity in graduation rates between those who are experiencing homelessness at the start of and those who are not;
- Reduced incidents of homelessness; and
- Improved employment status from ADC start to exit.

◊ *E. Provided by: Contractors*

2. Spending Plan

Year	Activity	Amount
2017	Housing units and housing support services for ADC participants.	$231,136
2017 Annual Expenditure		**$231,136**
2018	Housing units and housing support services for ADC participants.	$237,146
2018 Annual Expenditure		**$237,146**
Biennial Expenditure		**$468,282**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Department of Judicial Administration manages Adult Drug Court and has contracts with housing providers. A RFP will be released in first quarter 2017.

◊ *B. Contracting of Services*

Contracting of services will be completed in second quarter 2017.

◊ *C. Services Start date (s)*

Expanded housing units and housing support services will be available in second quarter 2107.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

MIDD II Initiative Title: Jail Reentry System of Care

MIDD II Number: RR-6

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The MIDD I Re-entry Case Management Services (RCMS) program consists of a small team of re-entry case managers, including a Mental Health Professional (MHP) lead, and provides up to 90 days of re-entry linkage case management services, which begin prior to release from jail (within 45 days) and continues through transition to the community. The RCMS program provides assistance that may include obtaining the following:

- Public entitlements and Apple Health/Medicaid enrollments (includes linkage to state and federal entitlements application);
- Basic needs resources (e.g. clothing, food, hygiene);
- Transportation;
- Identification (ID) upon release from custody;
- Mental health treatment (primarily outpatient);
- Substance Use Disorder (SUD) treatment (both residential and outpatient);
- Primary physical healthcare (including dental care);
- Housing (linking to emergency shelter, transitional and linkage to assessment for permanent supportive housing and low-income public housing);
- Employment; and
- Education and other job training.

1. Program Description

◊ *A. Service Components/Design (Brief)*

A continuum of care better serves individuals with behavioral health conditions who are booked into jail facilities within King County (including misdemeanor jails). This program links closely with all other programs and services the individual is receiving or needing in order to achieve stability in the community.

◊ *B. Goals*

The goal of this initiative is to provide increased access to intensive, short term case management to individuals with mental health and/or chemical dependency disorders who are close to release/discharge and in need of assistance in reintegrating back into the community. This includes providing immediate assistance for more participants in accessing publicly funded benefits (if eligible), housing, rental

assistance, outpatient treatment and other services including education, training, and employment in the community upon release/discharge.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 350 participants annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative are:

- Improved health;
- Improved housing stability;
- Reduced Emergency Department usage;
- Reduced criminal justice involvement; and
- Improved client satisfaction.

◊ *E. Provided by: Contractor-See below*

2. Spending Plan

Year	Activity	Amount
2017	Intensive, short term case management to individuals with behavioral health conditions who are close to release/discharge from jail	$435,625
2017 Annual Expenditure		**$435,625**
2018	Intensive, short term case management to individuals with behavioral health conditions who are close to release/discharge from jail	$446,951
2018 Annual Expenditure		**$446,951**
Biennial Expenditure		**$882,576**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County contracts with South Seattle Community College, New Beginnings, and Sound Mental Health for services. No RFP is required. A planning process in the first quarter of 2017 will determine what improvements and can be made to this initiative to better serve clients under MIDD II.

◊ *B. Contracting of Services*

To be determined, pending first quarter 2017 review.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017. If services are revised, new services are expected to begin in the second or third quarter of 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Re-entry Respite Beds (RR-8)

MIDD II Initiative Title: Hospital Re-entry Respite Beds

MIDD II Number: RR-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Research has shown that people who experience homelessness with health conditions struggle to establish and/or maintain appropriate treatment within the mainstream health care system[1]. Many people experiencing problems are caught up in cycles of crisis and lack the family and other social supports as well as the income and other material resources that might help them break these cycles. The individuals are extremely challenging for behavioral health and medical providers to locate and engage, let alone establish in an ongoing plan of treatment. Their chronic behavioral health and medical conditions worsen, their likelihood of involvement with the criminal justice system escalates, and, in many cases, they begin to cycle in and out of emergency rooms, inpatient hospital stays, and jail.

These dynamics help explain the significantly higher risk of hospital readmission for patients experiencing homelessness that has been established in numerous research studies.[2] This increased risk relates to the scarcity of places in which homeless patients can safely rest and obtain the support they need to fully recuperate. It also relates to behavioral health disorders that can lead to behaviors that complicate or undermine recuperation.[3] Because of this risk, hospitals often delay discharge of homeless patients past the point at which they would discharge a person with housing and other necessary supports for recuperation and thus past the point that is medically indicated.[4] Their experience has shown that when a person's living situation makes it impossible to adequately rest, keep from walking or putting weight on a joint, or keep a surgical site clean, the hospital is much more likely to see the person return for infections or other problems that necessitate readmission.

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[1] Bonin E, Brehove T, Carlson C, Downing M, Hoeft J, Kalinowski A, Solomon-Bame J, Post P. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 50 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2010.
[2] Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.
[3] Thompson, SJ, Bender KA, Lewis CM, Watkins R. *Shelter-based Convalescence for Homeless Adults*. Canadian Journal of Public Health, Vol. 97, Issue 5: 379-383, 2006.
[4] Gundlapalli A, Hanks M, Stevens SM, Geroso AM, Viavant CR, McCall Y, Lang P, Bovos M, Branscomb NT, Ainsworth AD.. *It takes a village: a multidisciplinary model for the acute illness aftercare of individuals experiencing homelessness*. Journal of Health Care for the Poor and Underserved. Vol. 16 Issue 2:257-72, 2005.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Re-entry Respite Beds (RR-8)

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Edward Thomas House Medical Respite Program provides comprehensive recuperative care after an acute hospital stay for people who are living with homelessness, focusing particularly on those with disabling substance use and mental health conditions. The recuperative care is a critical intervention for a segment of the population with high rates of emergency room and hospital utilization as well as involvement in the criminal justice system. In addition to intensive medical and mental health care, patients at Edward Thomas House (ETH) receive intensive case management services to help them transition from their stay to ongoing behavioral health treatment, housing, social services, and primary care. Recovery is promoted by providing a full continuum of services.

◊ *B. Goals*

The program's overarching goal is to improve health outcomes and reduce community costs in the health, human services, and housing arenas. Within that broad goal, it seeks to stabilize the medical and behavioral health conditions of its patients and effectively link them to (1) ongoing substance use and/or mental health services in the community, (2) an ongoing medical home, (3) social services, and (4) stable, appropriate housing. It strives to ensure that patients leave the program with identified case management provided by partnering agencies in the community that will help them make these linkages.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 350 participants annually.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative are:

- Reduction in future hospital utilization for hospitalized patients experiencing homelessness with mental health and/or substance use disorders;
- Successful medical recuperation of hospitalized patients experiencing homelessness with mental health and/or substance use disorders;
- Successful linkage of hospitalized patients experiencing homelessness with mental health and/or substance use disorders to shelter, housing; and behavioral health treatment services provided outside the respite program.

◊ *E. Provided by: Contractor*

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Re-entry Respite Beds (RR-8)

2. Spending Plan

Year	Activity	Amount
2017	Continued comprehensive recuperative care after acute hospital stays for people who are living with homelessness as well as disabling substance use and mental health conditions	$1,025,000
2017 Annual Expenditure		**$1,025,000**
2018	Continued comprehensive recuperative care after acute hospital stays for people who are living with homelessness as well as disabling substance use and mental health conditions	$1,051,650
2018 Annual Expenditure		**$1,051,650**
Biennial Expenditure		**$2,076650**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The Edward Thomas House Medical Respite Program is managed by Harborview Medical Center through a contract with Public Health Seattle and King County. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

MIDD II Initiative Title: Behavioral Health Employment Services and Supported Employment

MIDD II Number: RR-10

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

Helping individuals achieve employment outcomes makes a significant difference not only in the income levels of the individuals being served within the behavioral health system, but also helps them achieve self-sufficiency and improve non-vocational based outcomes such as improved self-esteem, sense of purpose, decreased isolation and meaningful activities that employment often provides.[1]

In a four year pre/post examination of MIDD-funded supported employment, the program demonstrated a significant impact decreased the number and length of stays for hospitalizations, but also the number of jail bookings, and lengths of stays in jail.[2]

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative continues the existing MIDD I Employment Services for Individuals with Mental Illness and Chemical Dependency, also known as "Supported Employment" and offers modified employment services to for people living with mental illness or substance use disorders.

Based on the needs of each individual job seeker within the integrated behavioral health system (formerly the mental health and substance use disorders systems), this program provides a two-tiered model to assist the job seeker to receive either the fidelity-based, intensive, Supported Employment (SE) services or a modified employment model that provides less intensive services for individuals requiring less employment support who can benefit primarily from linkage and referral to external employment service providers. This model allows employment services to be offered to a greater number of individuals while disseminating the principles of the evidence-based Supported Employment model.

◊ *B. Goals*

[1] The Impact of Competitive Employment on Non-vocational Outcomes (Luciano, Bond, & Drake, 2014)
[2] Impact of Supported Employment in Reducing Hospitalizations and Incarcerations, Floyd, 2015

The primary goal of this program is to increase the number of individuals with behavioral health conditions that gain and maintain employment in competitive and integrated jobs in the community that pay at or above minimum wage.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve 800 participants annually.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative include:

- Job placement;
- Job Retention;
- Increased income; and
- Improved quality of life.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued supported employment services at behavioral health provider agencies, with less intensive employment support services also available	$973,750
2017 Annual Expenditure		**$300,000**
2018	Continued supported employment services at behavioral health provider agencies, with less intensive employment support services also available	$999,068
2018 Annual Expenditure		**$999,068**
Biennial Expenditure		**$1,972,818**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health providers currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

MIDD II Initiative Title: Workload Reduction

MIDD II Number: SI-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The reduction of treatment caseloads by increasing the number of qualified staff provides for better treatment services, promoting the achievement of recovery outcomes for clientele, including proactive care that improves overall health and wellness. Additionally, workload reduction results in higher job satisfaction for treatment staff, thereby reducing staff turnover, which is a critical system improvement in the mental health treatment system.

Case management is the primary model of service delivery in public community mental health in the United States (US) and among comparable countries around the world (i.e. Australia, United Kingdom (UK), etc.).[1] Caseload size is highly variable in the US, ranging from caseloads of 10 to 25:1 in intensive case management models such as Assertive Community Treatment (ACT), to 40 to 50:1 in standard outpatient mental health settings.[2] Although King County data also demonstrates great variability in caseloads across agencies and types of service provided, average caseload fits within the ranges reported above with average caseloads of 40:1 (MIDD 4th Annual Evaluation Report, year 3). Studies have suggested that caseloads in excess of 20 to 30 would result in reactive case management, with deficiencies in service planning, support for families and caregivers and liaison with other services.[3] When faced with high caseloads, case managers are more likely to deal with crises and immediate problems[4] with a resulting negative impact on activities such as timely response to client needs, documentation of work, receptiveness to urgent client needs, contact during hospital admissions, home visits and advocacy.[5]

In addition to the impacts cited above, there is evidence that higher caseloads are also associated with increased work-related stress, especially stress associated with workload and professional self-doubt. Higher caseload was also associated with lower case manager personal efficacy. Increased job stress can exacerbate issues of staff burnout and pose problems with

[1] Burgess P, Pirkis J. The currency of case management: benefits and costs. Curr Opin Psychiatry 1999; 12: 195–199.
[2] King, Robert (2009) Caseload management, work-related stress and case manager self-efficacy among Victorian mental health case managers. Australian and New Zealand Journal of Psychiatry, 43(5), pp. 453-459.
[3] Intagliata J. Improving the quality of community care for the chronically clinically mentally disabled: the role of case management. Schizophr Bull 1982; 8: 655–674.
[4] King R, Le Bas J, Spooner D. The impact of caseload on mental health case manager personal efficacy. Psychiatr Serv 2000; 52: 364–368.
[5] King, R., Meadows, G., & LeBas, J. (2004). Compiling a caseload index for mental health case management. Australian and New Zealand Journal of Psychiatry, 38, 455-462.

the recruitment and retention of case managers,[6] in addition to impacting health and safety outcomes and the quality of care provided to clients.[7] These findings support the need for active management of caseloads to minimize risk of overload.

Although not the subject of a formal research study in King County, the issues outlined above have been reflected qualitatively by outpatient mental health provider agencies, as well as individual clinicians throughout King County.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Workload reduction funding distributed among outpatient mental health provider agencies during MIDD I is recommended to continue in MIDD II. In addition, substance use disorder providers are now participating in managed care under the integrated Behavioral Health Organization (BHO) structure, the distribution of MIDD II funds (in addition to the accompanying Medicaid match) will be revisited with the input of providers, guided by the following principles, at a minimum:

- Medicaid-funded outpatient programs will be targeted, to ensure continued Medicaid match.
- Provider agencies will receive appropriations of funds in an equitable manner.
- All mental health and substance abuse outpatient providers will have access to a portion of the funds.[8]
- Small provider agencies will receive no less than a minimum amount that is sufficient to affect the size of their workforce in a measurable way.
- Accountability measures for providers will be consistent across agencies and will be tied clearly to policy goal outcomes. See section D below for more details.

◊ *B. Goals*

Broad goals of this initiative include creating greater provider agency capacity to allow case managers to see clients more regularly to assist them to achieve greater stability and recovery, as well as be more responsive to clients who are in crisis. This would include increased proactive case management, care coordination, family support, outreach, and advocacy, in alignment with the literature on workload impacts described above. A related goal of this initiative is to decrease case manager turnover resulting from high caseloads, thus creating a more stable and effective workforce.

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[6] Evans, S., Huxley, P., Gately, C., Webber, M., Means, A., Pajak, S., et al. (2006). Mental health, burnout, and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry , 188*, 75-80.
[7] Priebe, S., Fakhoury, W., Hoffman, K., & Powell, R. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social Psychiatry Psychiatric Epidemiology , 40*, 223-232.
[8] The distribution of funds in MIDD II between mental health services and substance use disorders services may be influenced in part by Washington Administrative Code requirements that keep typical substance use disorders caseloads lower than mental health caseloads. Despite this consideration, at least some funds will be available to all contracted outpatient providers regardless of service type.

◊ *C. Expected Numbers of Individuals Served*

Under MIDD I, only the number of participating provider agencies was measured. The number of providers expected to participate will increase from 17 to approximately 44. Because this initiative has the potential to have broad impact on all outpatient clients of an agency that receives funding, it is not yet known how many individuals would benefit.

◊ *D. Outcomes and Performance Measures*

Specific measured outcomes and associated provider accountability for funding will be developed by King County BHRD and reviewed by provider agencies.

This initiative contributes to population outcomes of the MIDD II Framework, including:

- emotional health
- daily functioning
- reduced substance use
- reduced jail, hospital and emergency department use

The following individual-level MIDD II outcomes are expected for program participants:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced hospitalization, emergency department use, and incarceration
- improved experience of care

Options for outcome measures to be implemented at both the initiative level and the provider level may include some or all of the following (if feasible), among others:

- Sustainable average caseload size reductions that can reasonably be linked by established research to improved client outcomes (as described at the beginning of this document);
- Measurable reductions in the degree to which front-line staff cite workload as a job stressor and/or a contributor to their decision to seek other work;
- Demonstrated measurable changes in the degree to which services are responsive to client needs; and/or
- Demonstrated measurable changes in the health and wellness of program participants.

Additional output measures may include the number of FTE direct service staff added as a result of the funding provided, and/or retention rates for staff throughout the agency's outpatient program.

◊ *E. Provided by: Contractor*

All funding under this initiative will be distributed among contracted providers who offer a Medicaid-funded outpatient service. As part of forthcoming procedural design, a mechanism will be established to ensure that any new providers who may join the

network in the future will have access to an equitable share of the funds and will deliver the same level of accountability for funds received.

2. Spending Plan

Year	Activity	Amount
2017	Funding to support hiring of additional direct service staff at agencies that offer a Medicaid-funded outpatient behavioral health service (approximately 44 providers, distribution formula to be determined)	$4,100,000 *(plus Medicaid matching funds totaling $4,100,000)*
2017 Annual Expenditure		**$4,100,000**
2018	Funding to support hiring of additional direct service staff at agencies that offer a Medicaid-funded outpatient behavioral health service (approximately 44 providers, distribution formula to be determined)	$4,206,600 *(plus Medicaid matching funds totaling $4,206,000)*
2018 Annual Expenditure		**$4,206,600**
Biennial Expenditure		**$8,306,600**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Interest (RFI) and/or a Request for Qualifications (RFQ) process will result in the identification of a full list of provider agencies that are aware of new accountability requirements and interested in receiving these funds under MIDD II. No competitive bidding process is needed.

◊ *B. Contracting of Services*

Funds will be distributed to all interested and qualified agencies via contract exhibits unique to this initiative containing clear accountability measures defined via the process described above.

◊ *C. Services Start date (s)*

King County BHRD's work to redefine this initiative will begin in fall 2016, with provider involvement to occur beginning in December 2016. Implementation of the MIDD II initiative, with a new funding distribution methodology along with new outcome measures and accountability procedures, could occur as soon as the first quarter of 2017 and will be completed no later than June 2017.

(Funding levels for the 17 MIDD I workload reduction providers will be maintained at MIDD I levels until this process is completed.)

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

MIDD II Initiative Title: Workforce Development

MIDD II Number: SI-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative addresses the recommended MIDD policy goal of "increase culturally appropriate, trauma informed behavioral health services."

The behavioral health workforce is in crisis. The behavioral health system is struggling to find and/or retain trained, licensed, and qualified staff to provide services those in need of services. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Behavioral health integration highlights the need for continuing education. Clients benefit when clinical staff are trained on the full spectrum of behavioral health conditions and how to best intervene. Coordinating services with primary care also requires training and education; this again will facilitate clients receiving optimal services. Integrated care benefits from staff stability, confidence, and knowledge. The current workforce shortage, evolving clinical knowledge, as well as the need to provide culturally appropriate services by staff that are reflective of populations being served will be factors in determining the best training programs to be utilized and disseminated.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The original MIDD strategy responded to the workforce shortage of Chemical Dependency Professionals (CDP) and provided reimbursement for Chemical Dependency Professional Trainees (CDPTs) for: tuition, books for CDP-related classes and testing fees. Due to CDP credential requirements mandating CDP clinical supervision, the agencies were also reimbursed for CDPT specific clinical supervision. CDPs received reimbursement for annual license fees and obtained reimbursed Continuing Education Units (CEU) to maintain their credentials. In addition, this strategy funded Evidence-Based Practices (EBP) training, quality assurance (QA) for EBPs, and a CDP certificate program through the University Of Washington School Of Social Work.

Given the integration of mental health and substance use disorder, the present work shortages, and growing demand, this MIDD II initiative will create a develop a sustained, systems based approach to supporting and developing the behavioral health workforce. In collaboration with the MIDD Oversight Committee and stakeholders, a Behavioral Health Workforce Development Plan (WDP) will be developed that may include:

- Investment into initial credentials for behavioral health professionals, including psychiatric nurse practitioners and psychiatrists;
- CEUs for credentialed staff and ongoing training of EBP and Practice Based Evidence (PBE) for mental health and substance use disorder (SUD) treatment including Medication Assisted Treatment (MAT);

- Increase in the number of dually credentialed, Mental Health Professional (MHP) and CDP, staff;
- Additional training and initiation of Opioid Prescribing Training Program (OPTP) for professionals with prescriptive authority to assist in treatment opioid addiction; and
- Initiation of a train-the-trainer program to build a work force that can train other clinical staff on adopted EDPs and PBEs.

◊ *B. Goals*

The initiatives goals are:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals;
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults;
- Increase the qualified King County behavioral health workforce;
- Increase capacity to provide quality behavioral health services in King County; and
- Increase adoption of evidence-based, best, or promising practices.

◊ *C. Expected Numbers of Individuals Served*

The revised initiative will have a minimum of 700 participants annually, depending on the types of support and services offered.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative include:

- Increased staff retention at agencies and more effective recruitment, which would result in fewer vacancies at agencies;
- Increased collaboration and more uniform quality of care across agencies for clients;
- Improved clinical interventions in the outpatient setting;
- Agencies accepting more complex clients into care due to greater effectiveness and skills of clinical staff;
- Increased job satisfaction at the agency level; and
- Increased quality of care.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Behavioral health workforce development strategies continue	$743,125
2017 Annual Expenditure		**$743,125**
2018	Behavioral health workforce	$762,446

	development strategies continue	
2018 Annual Expenditure		**$762,446**
Biennial Expenditure		**$1,505,571**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The resources will be available for all providers across the county that were awarded a contract with BHRD and provided Medicaid services. The development of a Behavioral Health Workforce Development Plan (WDP) will guide the initiative improvements.

◊ *B. Contracting of Services*

TBD

◊ *C. Services Start date (s)*

Trainings services continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Drug Court (TX-ADC)

MIDD II Initiative Title: Adult Drug Court (ADC)

MIDD II Number: TX-ADC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

ADC is a pre-adjudication program that provides eligible defendants the opportunity to receive drug treatment in lieu of incarceration. If defendants meet the requirements of each of the four phases of the ADC program they graduate from the program and the charges are dismissed.

1. Program Description

◊ *A. Service Components/Design (Brief)*

After opting into the program, defendants come under the court's supervision and are required to attend treatment sessions, undergo random urinalysis, and appear before the judge on a regular basis.

If defendants meet the requirements of each of the four phases of the ADC program they graduate from the program and the charges are dismissed. If defendants fail to make progress they are terminated from the program and sentenced on their original charge. While this is a minimum 12 month program, the average graduate requires 18 months to complete the program.

◊ *B. Goals*

ADC Goals include:

1. Reduce substance use and related criminal activity;
2. Enhance community safety;
3. Reduce reliance on incarceration for non-violent drug dependent offenders;
4. Hold drug dependent offenders accountable for their actions and decisions;
5. Integrate substance abuse treatment with criminal justice case processing;
6. Provide resources and support to assist the drug dependent offender in the acquisition of skills necessary for the maintenance of sobriety;
7. Reduce the impact of drug related cases on criminal justice resources; and
8. Reward positive life changes while maintaining accountability for negative conduct.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves at least 700 people annually.

◊ *D. Outcomes and Performance Measures*

The outcomes for ADC include:

- Diversion of ADC participants with SUDs, with or without concurrent mental illness, from initial or further justice system involvement;
- Reduction of jail days usage; and
- Reduction of the incidence and severity of mental illness and/or drug dependency symptoms.

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	Adult Drug Court participant supervision and services continue.	$ 4,255,000
2017 Annual Expenditure		**$4,255,000**
2018	Adult Drug Court participant supervision and services continue.	$ 4,365,630
2018 Annual Expenditure		**$4,365,630**
Biennial Expenditure		**$ 8,620,630**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Department of Judicial Administration manages Adult Drug Court. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services will continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

MIDD II Initiative Title: Family Treatment Court (FTC)

MIDD II Number: TX-FTC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

FTC is a recovery based child welfare intervention. Parents participate in FTC to receive help in obtaining and maintaining sobriety as well as family services that support a recovery based lifestyle, including mental health treatment when applicable. Many of the court's parents have a history of incarceration and FTC supports their re-entry into mainstream services. It is an improvement to the current way child welfare cases are handled in the dependency court system. It is also a prevention and early intervention program, working with both the parent and the child to prevent future involvement in the criminal and juvenile justice systems and address the health and well-being of child welfare involved families.

1. Program Description

◊ *A. Service Components/Design (Brief)*

FTC promotes the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other service needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan. FTC is organized around the ten key components that define a drug court:

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

◊ *B. Goals*

FTC has four primary goals:

- To ensure that children have safe and permanent homes within permanency planning guidelines or sooner;

- To ensure that families of color have outcomes from dependency cases similar to families not of color;
- To ensure that parents are better able to care for themselves and their children and seek resources to do so; and
- To ensure that the cost to society of dependency cases involving substances is reduced.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve 140 children annually in MIDD II including the expanded court in south King County included.

◊ *D. Outcomes and Performance Measures*

Outcome measures for this initiate include:

- Increase positive child placements at parent exit from FTC;
- Increase number of FTC parents who are enrolled in SUD services;
- Increase number of FTC parents who complete SUD treatment; and
- Reduce severity of SUD symptoms for parents served.

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	FTC supports and services continue.	$ 1,481,000
2017 Annual Expenditure		**$1,481,000**
2018	FTC supports and services continue.	$ 1,519,506
2018 Annual Expenditure		**$1,519,506**
Biennial Expenditure		**$ 3,000,506**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Superior Court manages the Family Treatment Court. No RPPs Needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Drug Court (TX-JDC)

MIDD II Initiative Title: Juvenile Drug Court (JDC)

MIDD II Number: TX-JDC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The JDC program is effective at reducing recidivism and keeping youth engaged in the treatment process. (Bolan, 2007) King County JDC outcome studies have documented significant reductions in recidivism among program participants. Juvenile justice has increasingly become the service delivery point for adolescents with substance use disorder (SUD) and co-occurring problems that lack resources for other assistance. The JDC model provides improved, expanded, yet cost-effective adolescent SUD treatment in a coordinated system of care. The model of care in King County challenges systemic inequities and facilitates dialogue among justice and treatment professionals, families, and the youth themselves. JDC includes services designed for youth with SUD diagnoses and co-occurring Mental Health issues. All service areas of the JDC program have shown overtime to increase protective factors for youth involved in the program and strengthen the participant's transition to participating in pro-social behaviors and activities.

1. Program Description

◊ *A. Service Components/Design (Brief)*

JDC is a therapeutic court that provides services to juvenile charged with criminal offenses and identified as having a SUD diagnosis. JDC was implemented in July, 1999. This court is an alternative to regular juvenile court and is designed to improve the safety and well-being of youth and families involved in the juvenile justice system by providing the juvenile offender access to SUD treatment, judicial monitoring of their sobriety and individualized services to support the entire family [1](NCJFCJ, 2013).

Juvenile justice-involved youth voluntarily enter the program and agree to increased court participation, SUD treatment, co-occurring mental health treatment if necessary and intensive case management in order to have their charges dismissed. Case review hearings initially occur every week and then become less frequent as the youth progresses through the program. Incentives are awarded to recognize the youths' achievements and graduated sanctions are used when a youth violate program rules. Youth typically spend between 12 and 18 months in the program.

Through a collaborative, non-adversarial approach, the JDC integrates SUD, co-occurring mental health treatment and increased accountability into the process. Each youth has a JDC team and a comprehensive service team that reviews his or her

[1] Seen, Heard and Engaged: A process Evaluation for Children in Court Programs (NCJFCJ, p. 2013)

participation and recommends services. This interdisciplinary team is cross-trained and works collaboratively to resolve issues.

◊ *B. Goals*

JDC improves the safety and wellbeing of youth and families involved in the juvenile justice system by providing the youth in the juvenile justice system access to SUD treatment, evidence based/best practice holistic family intervention services, and judicial monitoring of their recovery.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 50 new participants each year.

◊ *D. Outcomes and Performance Measures*

The outcomes for this initiative are:

- Reduce recidivism of youth involved in the juvenile justice system;
- Reduce substance use disorder symptoms;
- Increase access to SUD and mental health services;
- Increase access to therapeutic family interventions; and
- Increase in youth and family engagement.

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	JDC supports and services continue.	$ 1,075,000
2017 Annual Expenditure		**$1,075,000**
2018	JDC supports and services continue.	$ 1,102,950
2018 Annual Expenditure		**$1,102,950**
Biennial Expenditure		**$ 2,177,950**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Superior Court will continue to provide Juvenile Drug Court services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

MIDD II Initiative Title: Regional Mental Health Court (RMHC)

MIDD II Number: TX-RMHC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

RMHC serves individuals experiencing mental illness (and frequently poverty and homelessness), who come into contact with the local criminal justice system. Once in jail, these individuals stay much longer than those with similar charges who are not experiencing mental health disorders. Moreover, these individuals are released to the community with limited behavioral health and social service supports critical to stability in the community.

Mental health court is often an effective strategy for diverting individuals with mental health disorders from further incarceration and engaging these individuals in community-based treatment and supportive services, with regular court monitoring, to address the underlying factors contributing to their criminal justice involvement.[1]

1. Program Description

◊ *A. Service Components/Design (Brief)*

Until 2010, RMHC served individuals who had cases originally filed in District Court or King County Superior Court. In 2010 MIDD funding was used to increase the services available for existing mental health courts and expanded KCDC Mental Health Court to become regional, such that any city in King County could refer court-involved individuals experiencing significant mental illness to the RMHC.

Currently, there are three referral streams through which court-involved individuals can access RMHC. First, court-involved individuals can have cases filed directly into District Court. For tracking purposes, these cases are referred to as "misdemeanor cases." Second, court-involved individuals can be referred to RMHC from any city jurisdiction within King County (referred to as "city cases"). Third, participants can be referred to RMHC from Superior Court when they have committed a felony and plead guilty to a lesser gross misdemeanor or combination of other misdemeanors (referred to as "felony drop-downs").

◊ *B. Goals*

[1] Edgely, Michelle. "Why do mental health courts work? A confluence of treatment, support & adroit judicial supervision." International Journal of Law and Psychiatry, Volume 36, Issue 6, November–December 2014, Pages 572–580.

RMHC program goals are to:

(1) Protect public safety;
(2) Reduce the level of recidivism (considering frequency, offense severity and length of time between episodes) of persons with mental illness with the criminal justice system;
(3) Reduce the use of institutionalization for persons with mental illness who can function successfully within the community with service supports;
(4) Improve the mental health and well-being of persons with mental illness who come in contact with Mental Health Court;
(5) Develop more expeditious case resolution than traditional courts;
(6) Develop more cost-effective / efficient use of resources than traditional courts;
(7) Develop more linkages between the criminal justice system and the mental health system; and
(8) Establish linkages with other community programs that target services to persons with mental illness.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 130 participants annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for RMHC participants are:

- Reduction in jail use;
- Reduction of psychiatric hospitalizations and psychiatric emergency room visits;
- Reduction in substance use disorder symptoms; and
- Improvement in psychosocial function.

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	RMHC supports and services continue.	$3,375,000
2017 Annual Expenditure		**$3,375,000**
2018	RMHC supports and services continue.	$3,462,750
2018 Annual Expenditure		**$3,462,750**
Biennial Expenditure		**$6,837,750**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County District Court will continue to provide Regional Mental Health Court. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD II Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Seattle Mental Health Municipal Court (TX-SMC)

MIDD II Initiative Title: Seattle Mental Health Municipal Court (SMC)

MIDD II Number: TX-SMC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Mental health courts are an essential component of a jail diversion continuum of service and have been shown to be effective in engaging clients in treatment and reducing future jail bookings. In addition to diverting more individuals with mental illness from unnecessary emergency department (ED) and psychiatric hospitalizations, this process provides a more efficient, safe, cost effective process as well as improved resource utilization.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative provides a care manager position in the Seattle Municipal Court. The position serves individuals who have frequent contact with the criminal justice system, and who receive an evaluation for civil commitment. Most or all of these individuals are not engaged in the public mental health system. The care manager provides assertive outreach and engagement for these individuals to offer services, respite supports, assistance with entitlements and other essential needs, with the ultimate goal of reducing contact with the criminal justice system.

◊ *B. Goals*

This initiative provides outreach and linkage services into the community to locate and serve a group of individuals that are committing low level criminal offenses, and are appearing in Seattle Municipal MHC on a frequent basis. The goal is to prevent future criminal justice involvement.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 35 participants annually.

◊ *D. Outcomes and Performance Measures*

Outcomes for this initiative are expected to include:

- Increase in linkages to behavioral health services;
- Reduce severity of behavioral health symptoms; and
- Reduce jail bookings and days for those served.

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Care management for SMC individuals who have frequent contact with the criminal justice system. 1.0 FTE Contracted Care Manager	$ 93,150
2017 Annual Expenditure		**$ 93,150**
2018	Care management for SMC individuals who have frequent contact with the criminal justice system. 1.0 FTE Contracted Care Manager	$ 95,572
2018 Annual Expenditure		**$ 95,572**
Biennial Expenditure		**$ 188,722**

3. Implementation Schedule

◊ *A. Procurement of Providers*

This service was revised in 2016. See description above for more details. A review process in early 2017 will determine if an RFP is needed.

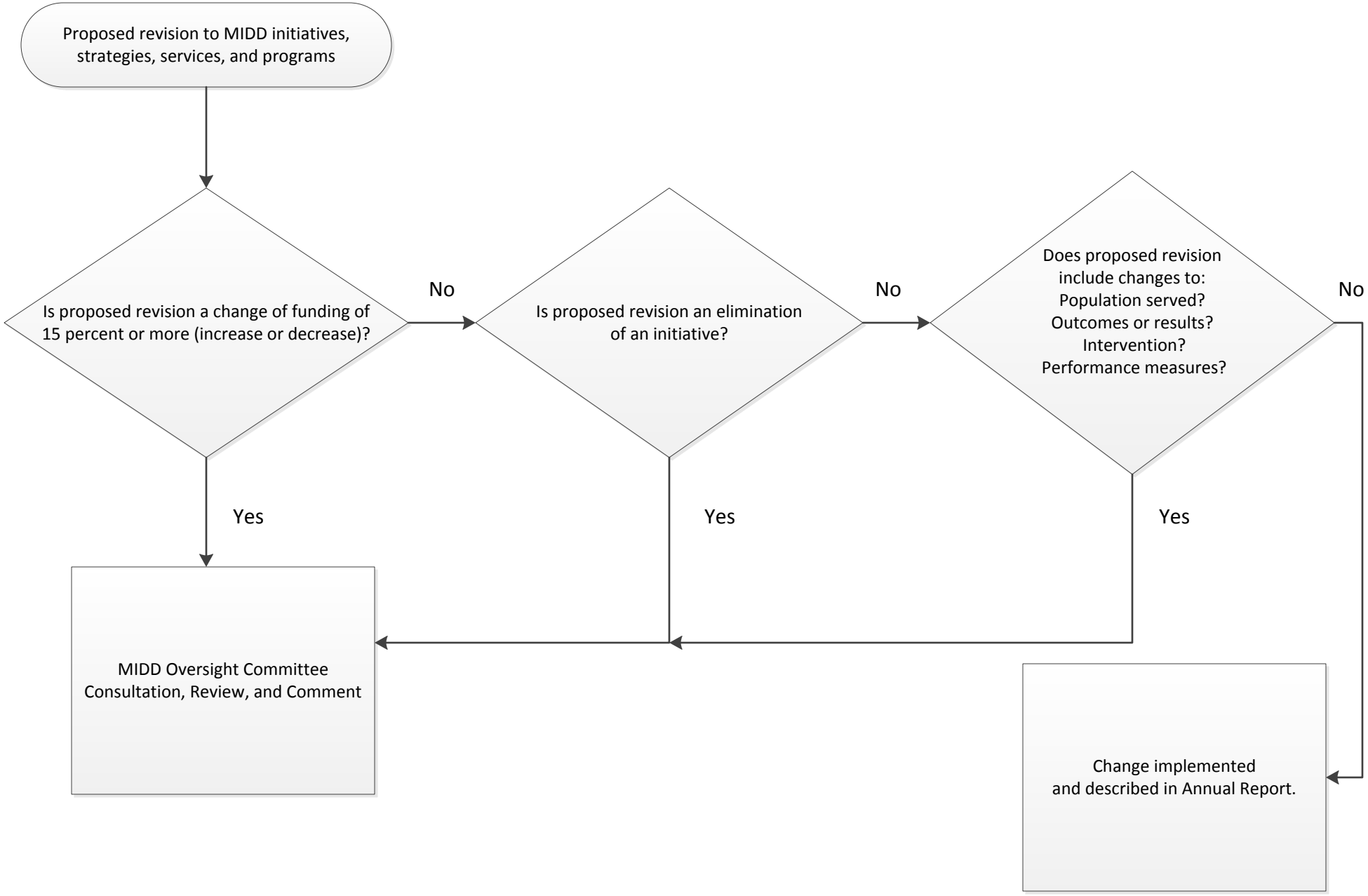
◊ *B. Contracting of Services*

To be determined, pending early 2017 review.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD Initiative Revision Process Flow



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Racial Equity Impact Assessment

What are Racial Equity Impact Assessments?

A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities.

Why are they needed?

REIAs are used to reduce, eliminate and prevent racial discrimination and inequities. The persistence of deep racial disparities and divisions across society is evidence of institutional racism--the routine, often invisible and unintentional, production of inequitable social opportunities and outcomes. When racial equity is not consciously addressed, racial inequality is often unconsciously replicated.

When should it be conducted?

REIAs are best conducted during the decision-making process, prior to enacting new proposals. They are used to inform decisions, much like environmental impact statements, fiscal impact reports and workplace risk assessments.

Where are they in use?

The use of REIAs in the U.S. is relatively new and still somewhat limited, but new interest and initiatives are on the rise. The United Kingdom has been using them with success for nearly a decade.

EXAMPLES OF RACIAL JUSTICE EQUITY IMPACTS

Equity and Social Justice Initiative

King County, WA

The county government is using an Equity Impact Review Tool to intentionally consider the promotion of equity in the development and implementation of key policies, programs and funding decisions.

Race and Social Justice Initiative

Seattle, WA

City Departments are using a set of Racial Equity Analysis questions as filters for policy development and budget making.

Minority Impact Statements

Iowa and Connecticut

Both states have passed legislation which requires the examination of the racial and ethnic impacts of all new sentencing laws prior to passage. Commissions have been created in Illinois and Wisconsin to consider adopting a similar review process. Related measures are being proposed in other states, based on a model developed by the Sentencing Project.

Proposed Racial Equity Impact Policy

St. Paul, MN

If approved by the city council, a Racial Equity Impact Policy would require city staff and developers to compile a "Racial Equity Impact Report" for all development projects that receive a public subsidy of $100,000 or more.

Race Equality Impact Assessments

United Kingdom

Since 2000, all public authorities required to develop and publish race equity plans must assess proposed policies using a Race Equality Impact Assessment, a systematic process for analysis.

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Racial Equity Impact Assessment **GUIDE**

Below are sample questions to use to anticipate, assess and prevent potential adverse consequences of proposed actions on different racial groups.

1. IDENTIFYING STAKEHOLDERS

Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

2. ENGAGING STAKEHOLDERS

Have stakeholders from different racial/ethnic groups—especially those most adversely affected—been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

3. I IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES

Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

4. EXAMINING THE CAUSES

What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

5. CLARIFYING THE PURPOSE

What does the proposal seek to accomplish? Will it reduce disparities or discrimination

6. CONSIDERING ADVERSE IMPACTS

What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

7. ADVANCING EQUITABLE IMPACTS

What positive impacts on equality and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS

Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

9. ENSURING VIABILITY AND SUSTAINABILITY

Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement. Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

10. IDENTIFYING SUCCESS INDICATORS

What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

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MIDD I Comprehensive Historical Assessment Report: Evaluation Recommendations

I. Update and Revise the Evaluation Framework

a. Revise or establish relevant output and outcome measures (see section II below).
b. Involve stakeholders in developing the evaluation framework.
c. Clarify and communicate the purpose of the evaluation and logic of the evaluation framework.

II. Revise Performance Measures, Targets and Outcomes

a. When possible, select valid, reliable, and sensitive outcome measures.
b. Adjust performance targets only when clear evidence exists that the original target was an over- or underestimation of feasible service delivery given available resources.
c. Outcome targets should be based on evidence that supports the expected results.
d. Focus on using clinically and practically meaningful changes in outcomes.
e. The basis for modifying a target, rather than working to improve performance, should be clearly documented when target modifications are requested.

III. Upgrade Data Collection and Infrastructure

a. Invest in data collection infrastructure.
b. Create an online dashboard of selected performance indicators to be updated quarterly.
c. Incorporate client surveys to gather more evaluative feedback from the client perspective on subjects such as service satisfaction and key indicators such as improved quality of life.
d. Seek opportunities for better data sharing, involving more and more reliable data sources, to improve the speed and efficiency of data gathering and analysis.
e. Consider a web-based data submission approach.

IV. Enhance Reporting and Improve Processes

a. Align the MIDD program year with the calendar year, rather than October through September.[1]
b. Replace semi-annual progress reports with digitally available dashboard data.
c. Increase the frequency of performance evaluation availability.
d. Establish guidelines for report creators and editors on the scope of their decision making.
e. Continue to avoid presenting non-causal results in ways that imply causality.
f. Continue to produce one annual report that includes both performance measurement and outcome evaluation.
g. Enhance the quality and frequency of communication regarding evaluation data and reporting, updating the MIDD Oversight Committee and others on substantive findings.

DRAFT MIDD II Spending Plan DRAFT 6.17.16

Initiatives and funding levels are subject to change

MIDD II Number	MIDD II Initiative Title	Initial MIDD II Funding Rec	Economic Adjustment	2017 Funding Level	Economic Adjustment	2018 Funding Level	2017-2018 Biennial Funding Level
CD-01	NEW Law Enforcement Assisted Diversion (LEAD)	2,000,000	50,000	2,050,000	53,300	2,103,300	4,153,300
CD-02	NEW Youth and Young Adult Homelessness Services	300,000	-	300,000	7,800	307,800	607,800
CD-03	Outreach & In reach System of Care	300,000	7,500	307,500	7,995	315,495	622,995
CD-04	NEW South County Crisis Diversion Services/Center	1,500,000	-	1,500,000	39,000	1,539,000	3,039,000
CD-05	High Utilizer Care Teams	250,000	6,250	256,250	6,663	262,913	519,163
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	4,000,000	100,000	4,100,000	106,600	4,206,600	8,306,600
CD-07	NEW Multipronged Opioid Strategies	1,500,000	-	1,500,000	39,000	1,539,000	3,039,000
CD-08	Children's Domestic Violence Response Team	275,000	6,875	281,875	7,329	289,204	571,079
CD-09	NEW Behavioral Health Urgent Care-Walk In Clinic Pilot	500,000	-	500,000	13,000	513,000	1,013,000
CD-10	Next Day Crisis Appointments	300,000	7,500	307,500	7,995	315,495	622,995
CD-11	Children's Crisis Outreach and Response System - CCORS	700,000	17,500	717,500	18,655	736,155	1,453,655
CD-12	Parent Partners Family Assistance	410,000	10,250	420,250	10,927	431,177	851,427
CD-13	NEW Family Intervention Restorative Services - FIRS	700,000	17,500	717,500	18,655	736,155	1,453,655
CD-14	NEW Involuntary Treatment Triage Pilot	150,000	-	150,000	3,900	153,900	303,900
CD-15	Wraparound Services for Youth	3,000,000	75,000	3,075,000	79,950	3,154,950	6,229,950
CD-16	NEW Youth Behavioral Health Alternatives to Secure Detention	1,000,000	-	1,000,000	26,000	1,026,000	2,026,000
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT	700,000	17,500	717,500	18,655	736,155	1,453,655
PRI-02	Juvenile Justice Youth Behavioral Health Assessments	570,000	14,250	584,250	15,191	599,441	1,183,691
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over 50	472,819	11,820	484,639	12,601	497,240	981,880
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	321,000	8,025	329,025	8,555	337,580	666,605

DRAFT MIDD II Spending Plan DRAFT 6.17.16

Initiatives and funding levels are subject to change

MIDD II Number	MIDD II Initiative Title	Initial MIDD II Funding Rec	Economic Adjustment	2017 Funding Level	Economic Adjustment	2018 Funding Level	2017-2018 Biennial Funding Level
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students	1,541,124	35,002	1,576,126	41,538	1,617,664	3,193,790
PRI-06	NEW Zero Suicide Initiative Pilot	500,000	-	500,000	13,000	513,000	1,013,000
PRI-07	NEW Mental Health First Aid	200,000	-	200,000	5,200	205,200	405,200
PRI-08	Crisis Intervention Training - First Responders	800,000	20,000	820,000	21,320	841,320	1,661,320
PRI-09	Sexual Assault Behavioral Health Services	570,000	14,250	584,250	15,191	599,441	1,183,691
PRI-10	Domestic Violence and Behavioral Health Services & System Coordination	550,000	13,750	563,750	14,658	578,408	1,142,158
PRI-11	Community Behavioral Health Treatment	11,600,000	290,000	11,890,000	309,140	12,199,140	24,089,140
RR-01	Housing Supportive Services	2,000,000	50,000	2,050,000	53,300	2,103,300	4,153,300
RR-02	Behavior Modification Classes at CCAP	76,000	1,900	77,900	2,025	79,925	157,825
RR-03	Housing Capital and Rental	1,900,000	-	1,900,000	49,400	1,949,400	3,849,400
RR-04	NEW Rapid Rehousing-Oxford House Model	500,000	-	500,000	13,000	513,000	1,013,000
RR-05	Housing - Adult Drug Court	225,499	5,637	231,136	6,010	237,146	468,282
RR-06	Jail Reentry System of Care	425,000	10,625	435,625	11,326	446,951	882,576
RR-07	NEW Behavioral Health Risk Assessment Tool for Adult Detention	470,900	-	470,900	12,243	483,143	954,043
RR-08	Hospital Re-Entry Respite Beds	1,000,000	25,000	1,025,000	26,650	1,051,650	2,076,650
RR-09	NEW Recovery Café	250,000	-	250,000	6,500	256,500	506,500
RR-10	BH Employment Services & Supported Employment	950,000	23,750	973,750	25,318	999,068	1,972,818
RR-11	NEW Peer Support and Peer Bridgers Pilot	750,000	18,750	768,750	19,988	788,738	1,557,488
SI-01	NEW Community Driven Behavioral Health Grants	350,000	-	350,000	9,100	359,100	709,100
SI-02	NEW Behavioral Health Services In Rural King County	350,000	-	350,000	9,100	359,100	709,100
SI-03	Workload Reduction	4,000,000	100,000	4,100,000	106,600	4,206,600	8,306,600
SI-04	Workforce Development	725,000	18,125	743,125	19,321	762,446	1,505,571
TX-ADC	Adult Drug Court	4,255,000	-	4,255,000	110,630	4,365,630	8,620,630
TX-FTC	Family Treatment Court	1,481,000	-	1,481,000	38,506	1,519,506	3,000,506
TX-JDC	Juvenile Drug Court	1,075,000	-	1,075,000	27,950	1,102,950	2,177,950
TX-RMHC	Regional Mental Health and Veterans Courts	3,375,000	-	3,375,000	87,750	3,462,750	6,837,750
TX-SMC	Seattle Mental Health Municipal Court	93,150	-	93,150	2,422	95,572	188,722

DRAFT MIDD II Spending Plan DRAFT 6.17.16

Initiatives and funding levels are subject to change

MIDD II Number	MIDD II Initiative Title	Initial MIDD II Funding Rec	Economic Adjustment	2017 Funding Level	Economic Adjustment	2018 Funding Level	2017-2018 Biennial Funding Level
ADM	Administration & Evaluation	4,038,379	100,959	4,139,338	107,623	4,246,961	8,386,300
TOTAL		**62,999,871**	**1,077,719**	**64,077,590**	**1,666,576**	**65,744,167**	**129,821,757**
SI-05	Emerging Needs Initiative	650,000					
	Expansion of Rainy Day Reserve	750,000					