Mental Illness and Drug Dependency

Year Two Progress Report
October 1, 2009 — March 31, 2010

King County

Mental Health, Chemical Abuse and Dependency Services Division

As approved by
Mental Illness and Drug Dependency Oversight Committee

August 2010

King County Department of Community and Human Services

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MIDD Year Two Progress Report
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For further information on the current status of MIDD activities, please see the MIDD website at:

www. kingcounty.gov/healthservices/MHSA/MIDDPlan

Alternate formats available
Call 206-263-8663
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Introduction

In accordance with Ordinance 15949, this report provides the Metropolitan King County Council with updates on programs supported with the one-tenth of one percent sales tax revenue for the delivery of Mental Illness and Drug Dependency (MIDD) fund services. The ordinance requires the King County Executive to submit reports every six months, a progress report and annual report. This progress report, covering the time period from October 1, 2009 through March 31, 2010 (Quarter 4-2009 and Quarter 1-2010) includes:

a. performance measurement statistics
b. program utilization statistics
c. request for proposal and expenditure status updates
d. progress reports on evaluation implementation
e. geographic distribution of the sales tax expenditures across the county, including collection of residential ZIP code data for individuals served by programs and strategies
f. updated financial plan.

Background

After several consecutive years of inadequate state funding for local mental health (MH) and substance abuse (SA) programs, access to King County's treatment system was limited for many needy residents. Without access to care, a large number of individuals arrested, jailed, or hospitalized were people with untreated MH and SA issues. In 2005, Washington State passed legislation allowing counties to raise their local sales tax by one-tenth of one percent to augment state funding of MH and chemical dependency (CD) services and therapeutic courts. Two council motions (12320 and 12598) authorized and accepted the MIDD Action Plan for King County, which ultimately outlined 37 unique strategies to address the needs of people with mental illness and/or drug dependency, including treatment, support, and prevention. On November 13, 2007, the sales tax increase was implemented with the passage of Ordinance 15949 and in April 2008 Ordinance 16077 approved the MIDD Oversight Plan and created the MIDD Oversight Committee (OC). On October 6, 2008, Ordinances 16261 and 16262 approved the MIDD Implementation and Evaluation Plans and the first services using MIDD funds began on October 16, 2008.

MIDD Policy Goals

The MIDD Plan was adopted through King County Council Ordinance 15949. The primary vision of the MIDD is to:

> *"Prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems, and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing, and case management services."*

The ordinance identified the following five policy goals:

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

Year Two Progress Report Highlights (October 1, 2009—March 31, 2010)

This year two progress report covers the fourth quarter of 2009 through the first quarter of 2010 (October 1, 2009 - March 31, 2010). This is the first semi-annual progress report for the MIDD; previously, progress was reported quarterly.

- More than 17,000 unique individuals were served by 23 MIDD strategies during the six months covered by this report. Of these, 5,455 received youth suicide prevention training.
- The MIDD funding provided outpatient MH benefits for 2,730 King County residents who were not eligible for Medicaid.
- 1,537 people received CD treatment through outpatient programs and 528 through opiate substitution therapy (OST).
- Of the 24 performance measurements evaluated, 18 (75%) were projected to be at 85 percent of their annual target goal or higher.
- The MIDD programs served clients from Seattle (37%), south King County (33%), east (15%), and north (8%).
- Preliminary findings found a statistically significant reduction in jail use and a trend toward reduction in psychiatric inpatient hospitalizations.
- Request for proposals (RFPs) were requested of community agencies interested in providing services for the following strategies: **1f (Parent Partners Family Assistance)**, **4c (School-Based Mental Health and Substance Abuse Services)**, and **10b (Adult Crisis Diversion).**
- The MIDD funded services continue to reach an ethnically and regionally diverse population.

MIDD Implementation and Evaluation Progress for Q4-2009 and Q1-2010

Thirty-one of the 37 MIDD strategies were implemented during this timeframe. Two strategies were still in the planning phase, **7b (Expansion of Children's Crisis Outreach Response Service System)** and **10b (Adult Crisis Diversion)**; Three strategies are delayed as a result of budget reductions and supplantation, **4a (Services for Parents in Substance Abuse Outpatient Treatment)**, **4b (Prevention Services to Children of Substance Abusers)**, and **7a (Reception Centers for Youth in Crisis)**. One strategy **17a (Crisis Intervention Team/Mental Health Partnership Pilot)** is proceeding with funding the City of Seattle received from the federal justice department. Additionally, the following tasks were accomplished:

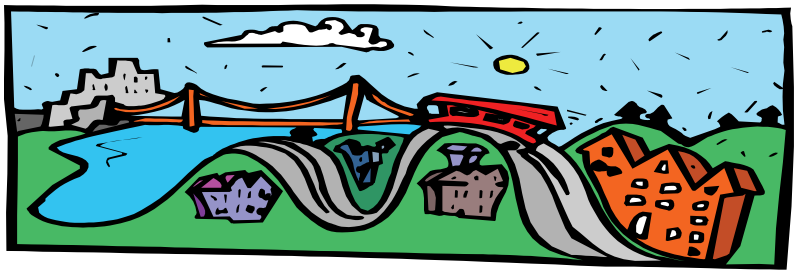
- Updated evaluation matrices for MIDD strategies to meet the most current implementation plans
- Worked with information technology resources to make ongoing modifications to the MIDD database
- Further customized the existing King County MH data system to accept mental illness symptom reduction outcome measures
- Provided ongoing management of custom MIDD data
- Performed continuous quality improvement analysis for specific strategies as needed to address issues of data quality and timeliness
- Provided ongoing consultation and technical assistance to agencies providing MIDD services, especially **5a (Juvenile Justice Youth Assessments)**, **6a (Wraparound)**, and **13a (Domestic Violence and Mental Health Services)**
- Consulted with the Washington State Hospital Association, Washington State Department of Social and Health Services, and other entities on obtaining emergency department utilization data
- Made progress in developing data sharing agreements, including an agreement with Safe Harbors for homelessness and housing data
- Analyzed demographic and service data to monitor performance related to program output goals
- Developed query and report procedures to generate jail and psychiatric hospital utilization figures for outcomes analysis.

MIDD Oversight Committee Activities in Q4-2009 and Q1-2010

From October 1, 2009 through March 31, 2010, the MIDD OC met six times; OC members cumulatively logged 216 hours. Please see Attachment A for the roster of MIDD OC members as of March 31, 2010. During the OC meetings, members were able to monitor implementation and evaluation of the MIDD through briefings and discussion on the following:

- **Supplantation legislation** by the Washington State Legislature allowed 30 percent of the 2010 MIDD revenues, or $21.6 million, to supplant previously county-funded criminal justice, therapeutic courts, MH and CD service programs
- The **MIDD evaluation progress**, including data collection and management efforts, overcoming provider privacy concerns, and selecting appropriate symptom reduction outcome measures
- The importance of **youth suicide prevention** programs throughout King County **(MIDD Strategy 4d)**
- Issues surrounding siting for the new **Crisis Diversion Facility (CDF)** and rebidding the non-awarded components of the RFP for review and award during the first quarter of 2010 (**MIDD Strategy 10b)**
- Securing collaborative funding toward development of the **Safe Housing and Treatment for Children in Prostitution Pilot Project** spearheaded by the City of Seattle, United Way, and many private donors **(MIDD Strategy 17b)**
- Harborview's efforts to link **Psychiatric Emergency Services (PES)** high-utilizer clients with community resources through liaison and intensive case management services funded by the MIDD **(MIDD Strategy 12c)**
- New plans for **collaborative school-based mental health and substance abuse services** that will ensure geographic equity in funding for prevention, early intervention, brief treatment, and referral to treatment for middle school aged youth **(MIDD Strategy 4c)**
- Contracting with the Washington State Criminal Justice Training Commission (WSCJTC) to implement the **Crisis Intervention Training (CIT)** program for police and other first responders **(MIDD Strategy 10a)**
- **Regional Mental Health Court (RMHC)** expansion for clients from municipalities throughout King County **(MIDD Strategy 11b)**
- Efforts to implement the **Peer Support and Parent Partner Family Assistance** program after the RFP was released in early November 2009 produced no successful bidders and materials had to be updated and reissued on March 11, 2010 **(MIDD Strategy 1f)**
- Progress made toward expanding the **Juvenile Justice Assessment Team (JJAT)**, a strategy providing assessments for juvenile justice involved youth **(MIDD Strategy 5a)**
- Discussion regarding options for obtaining **hospital data** for evaluating reductions in Emergency Room (ER) utilization in the MIDD strategies with this element identified as an outcome measure
- The announcement of five providers to deliver **wraparound services** for children and youth involved in multiple service delivery systems **(MIDD Strategy 6a)**

Additionally during this reporting period, the OC watched video presentations and participated in a panel discussion with the objective of **breaking down the stigma of mental illness**. To watch these videos and learn more, visit: http://www.bringchange2mind.org/.



MIDD Request for Proposal Progress for Q4-2009 and Q1-2010

Three RFPs were prepared, released, and reviewed for three MIDD strategies during October 1, 2009 - March 31, 2010.

The RFP for **Strategy 1f (Parent Partner and Youth Peer Support Assistance Program)** was released for one MIDD Family Support Organization to provide peer support, technical assistance, mentoring, training, networking opportunities and resources to families whose child and/or youth experiences emotional or behavioral disturbances, and/or a substance use disorder.

- **Strategy 1f (Parent Partner and Youth Peer Support Assistance Program)**

  11/12/2009 - RFP advertised

  11/18/2009 - RFP pre-proposal conference, 11/23/2009 - RFP Addendum 1 issued

  01/13/2010 - RFP closed; two proposals received, proposals were not responsive, no award

  03/11/2010 - RFP re-advertised

  03/12/2010 - RFP pre-proposal conference, 3/19/2010 - RFP Addendum 1 issued

  04/08/2010 - Responses due; four proposals received

  05/13/2010 - Award notice

The RFP for **Strategy 4c (Collaborative School-Based Mental Health and Substance Abuse Services)** was released; the strategy focuses services toward students attending public and private schools within King County specifically; depending upon the school district and area, either middle school aged students or junior high school aged students. The strategy will invest in MH and SA services with a focus on indicated prevention, early intervention, screening, brief intervention, and referral to treatment. While the scope of school-based MH and SA is broad and inclusive of a number of approaches, this strategy will invest resources in direct services for youth. At the same time, the services that the investment supports should be aligned with school-wide policies and strategies to address a continuum of services from primary prevention through recovery.

- **Strategy 4c (Collaborative School-Based Mental Health and Substance Abuse Services)**

  01/07/2010 - RFP advertised

  01/14/2010 - RFP pre-proposal conference, 01/22/2010 and 02/11/2010 RFP Addendums issued

  02/25/2010 - RFP closed; 26 proposals received

  03/30/2010 - RFP proposals reviewed; 13 recommended for awards

  04/23/2010 - Award notice

The RFP for **Strategy 10b (Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team)** was re-released for proposals. The MIDD Strategy 10b establishes a CDF to which law enforcement and other crisis first responders can refer adults who are in crisis. The facility will evaluate and stabilize individuals in crisis and refer them to community-based services. Respite beds will also be created to provide short-term housing for homeless individuals leaving the center. The Crisis Diversion Interim Services (respite beds) funding was awarded under a separate solicitation on November 4, 2009. Additionally, the strategy includes creation of a mobile crisis team of MH and CD specialists who will provide increased access to crisis response for police, as well as referrals and linkage to the CDF and other community-based services.

- **Strategy 10b (Adult Crisis Diversion Services)**

  11/04/2009 - Award for the Crisis Diversion Interim Services (respite beds) component

  03/11/2010 - RFP revised and re-advertised for crisis facility and mobile crisis team

  03/18/2010 - RFP pre-proposal conference

  03/30/2010, 04/16/2010, 05/07/2010, 06/04/2010 and 06/07/2010 - RFP Addendums issued

  06/08/2010 - Responses due; four proposals received

  07/07/2010 - Award notice

Program Utilization and Performance Measurement Targets Progress

Most MIDD strategies have explicit goals regarding the number of individuals to be served each year. This table shows progress toward these, or other appropriate key targets, for the first half of year two of the MIDD. Strategies not yet implemented, or without data for the reporting period, have been omitted from the table.

Strategy Number	Strategy "Nickname"	Year 2 Target	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
1a-1	MH Treatment	2,400 clients/yr	2,730	(B)	148%	↑
1a-2	CD Treatment	50,000 adult OP units 4,000 youth OP units 70,000 OST units	20,109 adult OP units 1,319 youth OP units 36,008 OST units	(A)	80% 66% 102%	→[3] ↑
1b	Outreach & Engagement	675 clients/yr	1,101	(A)	327%	↑
1c	SA Emergency Room Intervention	7,680 clients/yr	1,588	(A)	41%	↓[4]
1d	MH Crisis Next Day Appts	750 clients/yr with enhanced services	Analysis requires a full year of data			
1e	CD Professionals Training	125 trainees/yr	94 reimbursed Q4-2009 90 reimbursed Q1-2010	Unable to unduplicate across quarters		
1g	Older Adults Prevention MH & SA	2,500 clients/yr	1,406	(A)	112%	↑
1h	Older Adults Crisis & Service Linkage	340 clients/yr	205	(C)	114%	↑
2b	Employment Services MH & CD	920 clients/yr	549	(B)	77%	→[5]
3a	Supportive Housing	140 clients/yr[2]	126	(B)	117%	↑
4d	Suicide Prevention Training	1,500 adults/yr 3,250 youth/yr	524 adults 4,931 youth	(A)	70% 303%	→[6] ↑
5a	Juvenile Justice Youth Assessments	280 CD assessments[2] 200 MH assessments[2]	197 unduplicated youth served	Data collected do not allow projection of original target		
6a	Wraparound	920 youth/yr	minimum of 215	Ramp up and change in reporting requirements preclude projection		
8a	Family Treatment Court Expansion	45 new children/yr	21 new since 10/1/2009	(A)	102%	↑
9a	Juvenile Drug Court Expansion	36 new children/yr	20 new since 10/1/2009	(A)	111%	↑
11a	Increase Jail Liaison Capacity	200 clients/yr	141	(A)	141%	↑
12a	Jail Re-Entry Capacity Increase	300 clients/yr	157	(A)	105%	↑
	CCAP Education Classes	600 clients/yr	252	(A)	84%	→[7]
12c	PES Link to Community Services	75-100 clients/yr	113	(C)	286%	↑
12d	Behavior Modification for CCAP	100 clients/yr	51	(A)	102%	↑
13a	Domestic Violence & MH Services	700-800 clients/yr	319	(A)	91%	↑
13b	Domestic Violence Prevention	85 families/yr	104	(B)	159%	↑
14a	Sexual Assault, MH & CD Services	400 clients/yr	353	(A)	177%	↑
15a	Adult Drug Court Expansion	300 clients/yr[2]	245	(B)	106%	↑
16a	New Housing and Rental Subsidies	50 rental subsidies[2] 250 new units	41 rental subsidies 15 tenants in new units	(B) -	107% -	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Targets to change with adoption of matrix revisions.
[3] Spend-down of other fund sources makes projection difficult.
[4] Not fully implemented; model shifting based on referral types.
[5] Near capacity for mental health; not implemented for chemical dependency yet.
[6] Blended funding makes portion of trainings attributable to MIDD difficult to pull apart.
[7] Data collection barriers may impact projections.

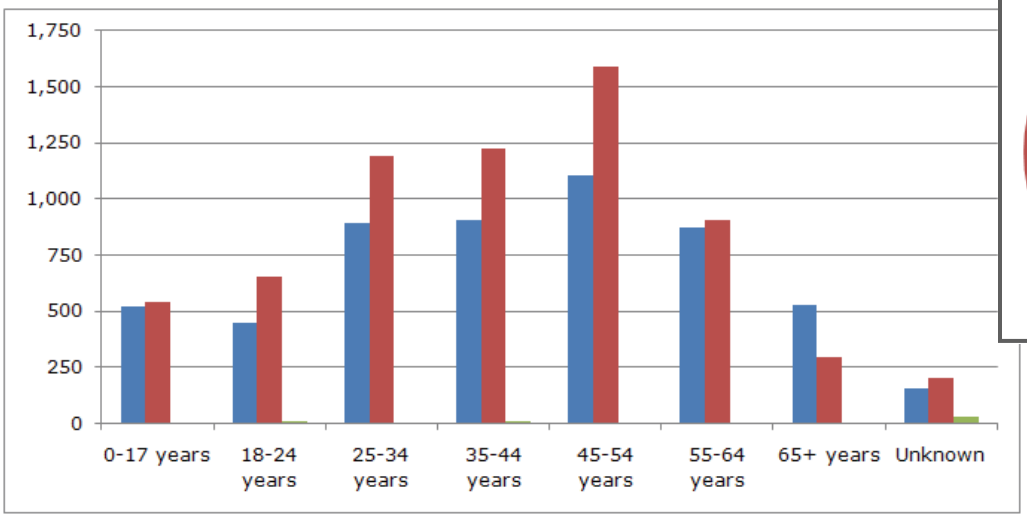
Key to Target Success Rating Symbols	
↑	Projected percentage of annual target is higher than 85%
→	Projected percentage of annual target is 65% to 85%
↓	Projected percentage of annual target is less than 65%

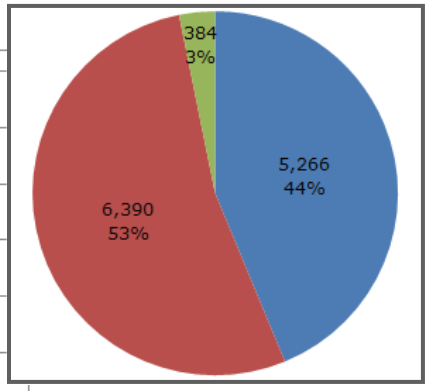
Key to Projection Algorithms	
(A)	Some strategies are expected to serve twice as many clients in a full year as they serve in a 6-month period. The default projection multiplier is 2.0.
(B)	For programs now operating at capacity or with benefits lasting 365 days, the projection multiplier is 1.3, which factors in program turnover.
(C)	For shorter term programs (typically 1-3 months), a multiplier of 1.9 is used for projection. Since July 2009, the number of unduplicated people starting these types of programs has remained fairly stable.

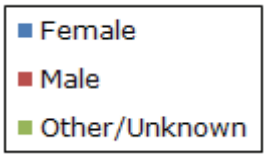
Touched by the MIDD - Demographics for Q4 2009 - Q1 2010

Basic demographic information describing characteristics of the MIDD population were available for 12,043 unduplicated individuals who received services, or were actively enrolled in MIDD programming during this six month reporting period. Database corrections, changes in reporting requirements, and the difficulty of obtaining information for certain data elements were issues impacting the availability of demographic data. The numbers reported for regional distribution of MIDD services (page 8) include the 5,455 individuals who participated in suicide prevention trainings for whom no other demographics are available and who are not included in the 12,043 unduplicated count. Unless noted otherwise, all charts and graphs are based on the demographics sampling of 12,043.

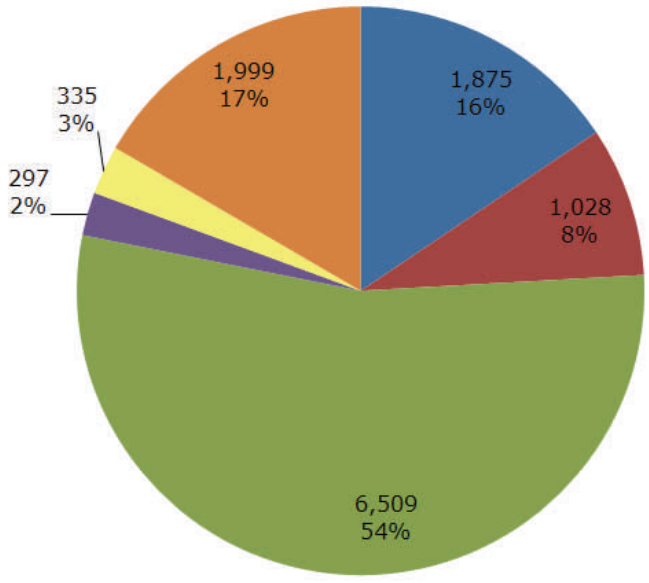
Unduplicated Gender by Age Group and Overall Gender Distribution

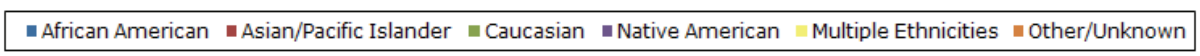






Distribution of Primary Ethnicity





Notes on Ethnicity and Hispanic Origin

Data collection by some MIDD providers allows clients to identify with up to four different ethnicities. Because multiple ethnicities were provided for only 335 people, that information is shown here clustered together as 'Multiple Ethnicities'.

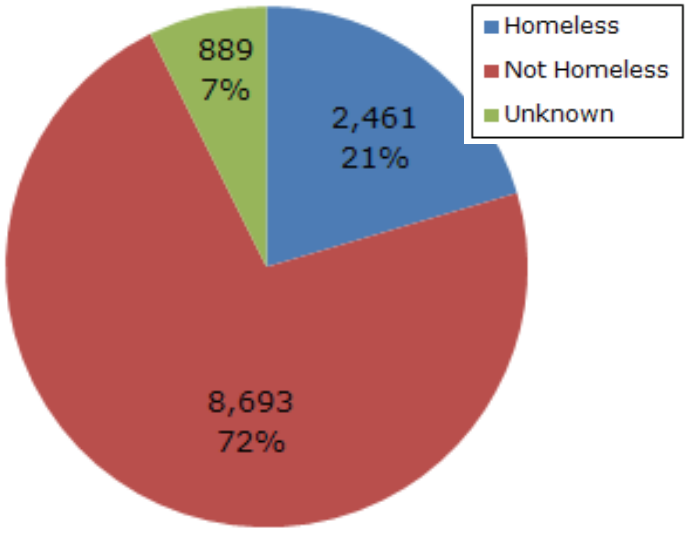
Hispanic origin is a separate data element gathered independently of the ethnicity variables. Of those who indicated their primary race as "Other", 88 percent were of Hispanic origin. Across all programs where this information was reported, 1,129 of 6,555 (17%) were of Hispanic origin.

King County Region by Total Served or Trained

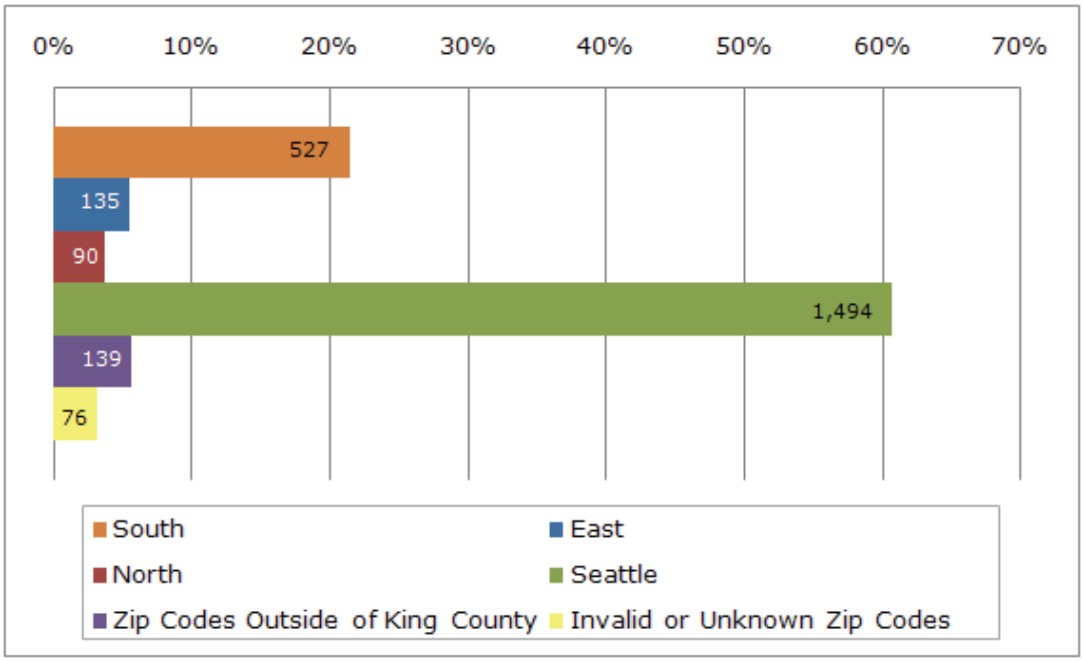
	Frequency	Percent
South	5,696	33%
North	1,482	8%
East	2,554	15%
Seattle	6,475	37%
Zip Codes outside of King County *	625	4%
Invalid or Unknown Zip Codes	666	4%
	17,498	100%

* The most common services provided to those reporting out of county zip codes were screenings at King County hospitals for individuals who met the criteria to be screened. Out of county residents sometimes use hospitals and other health care facilities located within the county. Nearly a quarter of those with zip codes outside of King County were currently homeless and reporting last known address.

Homelessness at Start of MIDD Services



Percent of MIDD Homeless Population (N = 2,461) by King County Region



Strategy Overlaps

A total of 772 people received MIDD services from more than one strategy, or from multiple providers under the same strategy during this reporting period. The most common overlaps in descending order of frequency were:

1a-1 and 1a-2a (N=120)

1a-1 and 2b (N=80)

1b and 1c (N = 76)

1c and 1d (N = 52)

1c and 12c (N = 50)

Additional Demographic Summaries

For the following analyses, the total Ns are the number of individuals for whom the information is known. All instances where the data were missing or reported as unknown or not applicable were subtracted from the total sample of 12,043. Of those served in the first half of the second year of the MIDD, 1,187 of 8,723 (14%) were known to have had previous experience in the U.S. military. Similarly, 1,067 of 7,205 (15%) were known to have required the services of a language interpreter.

Where a primary language was reported (N = 10,662), approximately 80 percent spoke English and nine percent spoke Spanish. Within the remaining 11 percent of cases, 40 distinct languages were documented, including Bosnian, Farsi, Korean, Russian, and Vietnamese.

Some type of disability was noted in roughly 13 percent of the 9,518 cases where data was provided on types of disabilities. Multiple responses are possible. In descending rank order, the top three disability types were: medical or physical (N=515), other - not listed (N=229), and developmental (N=180).

MIDD Implementation Plan

The MIDD Implementation Plan provides an integrated system of prevention and early intervention services, community-based treatment, expanded therapeutic court programs, jail and hospital diversion programs, housing, and housing supportive services. The plan includes new programs, as well as expansion of existing programs and services. These new and expanded services will address the unmet needs of approximately 33,000 individuals in King County each year.

The adopted MIDD Implementation Plan, strategies are grouped into six service areas: 1) Community-Based Care, 2) Programs Targeted to Help Youth, 3) Jail and Hospital Diversion programs, 4) Domestic Violence, Sexual Assault, and Adult Drug Court, 5) Housing Development, and 6) New Strategies. For ease of reporting and consistency with strategy intent, the **Domestic Violence and Sexual Assault Mental Health and Substance Abuse Strategies (13a and 14a)** will be grouped under **Community-Based Care**; **Domestic Violence Prevention Services for Children (13b)** and **Safe Housing and Treatment for Children in Prostitution Pilot (17b)** will be grouped under **Programs Targeted to Help Youth**; and **Adult Drug Diversion (15a) and Housing Development (16a)** will be grouped under the **Jail and Hospital Diversion** service area.

Community-Based Care Strategies

Community-Based Care includes strategies designed to increase access to community MH and SA treatment for uninsured children, adults, and older adults, improve the quality of care by decreasing MH caseloads and providing specialized employment services, and providing supportive services within housing projects serving people with mental illness and CD treatment needs.

Strategies 1a-1 (Mental Health Treatment) and **1a-2 (Chemical Dependency Treatment)** are geared to making treatment services available to those who qualify for standard services clinically, but who do not qualify for Medicaid. Through contracts with 17 outpatient MH treatment providers and 34 drug treatment agencies, King County has been able to provide treatment to individuals who otherwise would not be served. Similarly, survivors of domestic violence and sexual assault now have new MH and substance use treatment options available to them through advocacy agencies serving all regions of the community. Mental health therapists associated with **13a (Domestic Violence and Mental Health Services)** and **14a (Sexual Assault, Mental Health, and Chemical Dependency Services)** have bolstered their offerings of professional services to clients in shelters, transitional housing programs, and through community outreach.

Other MIDD strategies provide resources for early identification of MH and SA problems within distinct sub-populations. **Strategy 1b (Outreach and Engagement)** funds providers who reach out and provide case management to help homeless individuals, intravenous drug users, and high utilizers of the Dutch Shisler Sobering Center and links them to vital MH and CD treatment services. During the reporting period, Strategy 1b had encounters with three times as many people as anticipated based on targets defined in the evaluation matrices. During these encounters, efforts were made to link individuals to ongoing programs tailored to address needs identified in the course of each outreach interaction. Prior to the next annual report, a continuous quality improvement analysis will be performed to understand why the numbers served are so much higher than expected and what, if any, adjustments should be made to current data collection efforts.

Strategy 1c (Substance Abuse Early Intervention Program) funds a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with or at risk for substance use disorders in medical hospitals throughout King County. Analysis of the quarterly narrative reports submitted by Harborview Hospital for Strategy 1c revealed: 1) monthly networking meetings of the screening, brief intervention, and referral to treatment (SBIRT) providers began in October 2009; 2) data handling improvements were implemented; 3) consultation and training sessions at South County hospitals (Highline, St. Francis, and Valley Medical) were successful; and 4) a slight model shift toward providing better follow-up for brief therapy consumers at Harborview has been adopted. Brief therapy is based upon individual motivational interviewing.

The focus for **Strategy 1d (Mental Health Crisis Next Day Appointments)** is enhanced crisis stabilization services for adults. A strategy analysis will be available in the next annual report.

Community-Based Care Strategies (Continued)

Under **Strategy 1e (Chemical Dependency Professional Education and Training)**, staff at county-contracted CD treatment and prevention agencies are reimbursed for expenses, such as tuition and testing fees, incurred while becoming certified or maintaining their credentials as CD professionals (CDPs) or certified prevention professionals. The long-range goal of Strategy 1e is to create and sustain a highly-trained SA treatment workforce to meet increased demand as community members begin to address CD issues impacting their lives.

Through **Strategy 1f (Peer Support and Parent Partner Family Assistance)**, parent partners and youth peer counselors are paired up with youth and families to help them navigate systems such as juvenile justice, child welfare, MH and/or SA treatment. These trained partners empower clients by increasing their knowledge and understanding about services, systems, and supports available. They also help those in need to use effective coping skills and to increase their self-advocacy skills. In November 2009 the RFP for a family support organization was released; no bid was awarded and the RFP was re-bid in March 2010 with an award anticipated for May 2010.

Job Placements and Retention

A primary goal of Strategy 2b, which provides supported employment services, is to help give MH program enrollees who express a desire to work the opportunity to gain mainstream jobs with competitive wages. For the 338 people who enrolled in the program during the fourth quarter of 2008 and the first quarter of 2009, 60 (18%) became employed in a total of 65 job placements. Eighteen of those placements (28%) were known to have lasted at least 90 days in length. This is a much higher success rate for finding jobs in the community than is typically seen for those completing MH programs without a supported employment benefit. Historically in King County, the rate for gaining employment during a benefit period for those receiving publicly-funded MH treatment is less than three percent.

The roll-out for supported employment services within CD treatment agencies has been placed on hold due to MIDD budget shortfalls.

Having meaningful work and the ability to make a living is an important way for people to connect with the world around them. **Strategy 2b (Employment Services for Individuals with Mental Illness and Chemical Dependency)** connects those receiving public MH and/or CD services with competitive employment opportunities and provides them with the skills and supports needed to stay in those jobs. Currently implemented only on the MH side, over 500 people were enrolled in supported employment benefits during the first half of MIDD year two.

Just as supported employment helps keep people in real jobs with real pay, **Strategy 3a (Supported Housing)** is designed to offer supplemental services that enable those dealing with mental illness or substance use issues to stay off the streets and live independently in stable housing. By tailoring service offerings to individual client needs, supported housing programs have proven to be adept at preventing homelessness for typically vulnerable populations. In conjunction with the efforts of the Committee to End Homelessness in King County, a total of 400 MIDD-funded supported housing beds (120 currently operational and 280 new) are slated to be in place before the end of 2010.

For **Strategy 1g (Older Adults Prevention and Early Intervention)**, the focus is on providing MH and substance use screening for those over the age of 50 when they present for primary medical care at low-income health clinics. For those over the age of 55, the Geriatric Regional Assessment Team (GRAT) has been expanded through funding of Strategy 1h (Older Adults Crisis and Service Linkage). The GRAT is a team of specially trained clinicians that responds rapidly, deploying to all regions of King County when crisis referrals involving older adults are made. Through the MIDD expansion, GRAT is continuing to provide 24 hour turnaround response times.

For mental health treatment programs, **Strategy 2a (Workload Reduction for Mental Health**) seeks to reduce workload for case managers in accordance with approved agency plans. By increasing direct services staff, agencies can see clients more often and offer services without long waits.

Strategies with Programs Targeted to Help Youth

Programs targeted to help youth include strategies designed to expand prevention and early intervention, expand assessments for youth in the juvenile justice system, provide comprehensive team-based intensive wraparound services, expand services to youth in crisis, and maintain and expand Family Treatment Court and Juvenile Drug Court.

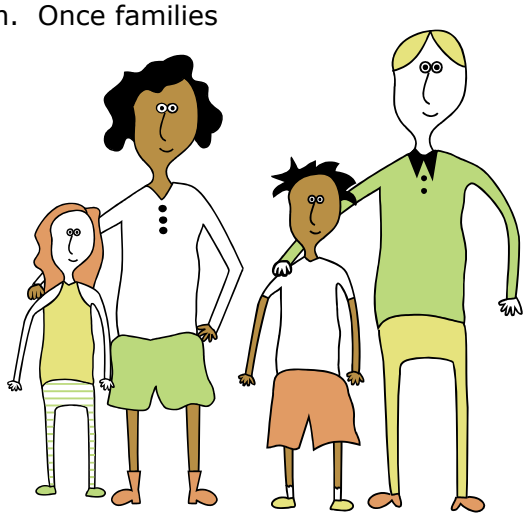
Within the MIDD Plan, strategies placing particular emphasis on prevention include **Strategy 4a (Services for Parents in Substance Abuse Outpatient Treatment)**, **Strategy 4b (Prevention Services to Children of Substance Abusers)**, **Strategy 4c (School-Based Mental Health and Substance Abuse Services)**, **Strategy 4d (Youth Suicide Prevention)**, and **Strategy 13b (Domestic Violence Prevention)**. While the first two of these are still on hold due to budget cutbacks, Strategy 4c made considerable progress toward implementation during this reporting period. In January 2010, an RFP was released to potential bidders and in mid-March, the 27 proposals that were submitted by 14 organizations underwent review.

In addition to suicide prevention trainings, **Strategy 4d (Youth Suicide Prevention)** has been tasked with the objective of evaluating school policies and procedures for intervening with students who are at risk for suicide. As of March 31, 2010, the Youth Suicide Prevention Project had received and reviewed policies from 17 of 19 school districts within King County. Of these, 11 were rated "average" (having a few policies around intervention or post incident) and six were rated "below average" (having no policies that mention suicide prevention). Work is underway to move more districts and individual schools toward "exceptional" crisis response policies that encompass prevention, intervention, and post incident concerns. Technical assistance will be made available to school districts to assist with improving crisis response policies.

For youth coming into contact with the juvenile justice system, **Strategy 5a (Juvenile Justice Youth Assessments)** helps determine which screening services are most appropriate for each individual through a team triage and consultation approach, ensuring delivery of relevant assessments in a timely manner. All youth entering the juvenile justice system are individually screened, assessed, and linked to treatment for MH and SA needs. The JJAT is in the process of developing a RFP to add a children's MH professional and CD professional to the team.

Strategy 8a Family Treatment Court (FTC) provides a formal structure for monitoring treatment compliance of parents identified as chemically dependent who have lost custody of their children due to their substance use. Successful "graduates" of FTC have the opportunity to reunite within families and their children are often the ultimate beneficiaries of the court's expanded supports. The FTC expanded to provide services in south King County at the Norm Maleng Regional Justice Center. Since October 2009, 21 new children have been served through FTC. **Strategy 9a (Juvenile Drug Court)** is an intensive therapeutic treatment court serving on average 50 clients per year in order to provide the highest level of care to those who have committed crimes while diagnosed as chemically dependent. Incorporating aspects of prevention, therapeutic court models have been shown to be very effective in reducing recidivism for these multi-need youth.

The Children's Domestic Violence Response Team funded by **Strategy 13b (Domestic Violence Prevention)** provides another example of a preventive intervention. Once families are engaged in services, children up to 12 years of age can go to Kid's Club, a series of group sessions offering support and information to help children deal with their exposure to domestic violence. Based on a national model, Kid's Club strives to increase feelings of safety while decreasing anxiety and depression in order to interrupt the cycle of violence within families.



For **Strategy 17b (Safe Housing and Treatment for Children in Prostitution Pilot)**, the MIDD made a one-time allocation of funds to the City of Seattle for this pilot project. This funding will enable provision of MH and SA services to prostitution-involved youth housed within a specialized residential program. This City of Seattle program will be doing its own evaluation and the strategy is no longer included in the MIDD outcome analysis. Output data will continue to be collected and reported.

Strategies with Programs Targeted to Help Youth (Continued)

Strategy 6a (Wraparound for Children, Youth, and Families) is a coordinated system of support provided by five treatment providers. Wraparound is available to youth involved in more than one service system and is essential for streamlining individualized care across the service delivery system. To date, more than 300 youth and their families have participated in wraparound.

The Wraparound Process is an intensive, individualized care coordination process for children and youth with serious or complex needs. Wraparound was initially developed in the 1980's as a means for maintaining youth with the most serious emotional and behavioral problems in their home and community. The MIDD wraparound offered to families served by the MH, SA, child welfare, juvenile justice, and special education systems helps to improve outcomes, including maintaining youth in their community.

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

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

Jail and Hospital Diversion Strategies

Jail and hospital diversion strategies are designed to divert people who do not need to be in jail or hospitals through CIT training for law enforcement and other first responders; creating a CDF, expanding MH court, drug diversion court and other post-booking services to get people out of jail and into services quicker; and expand programs that help individuals re-enter the community from jails and hospitals.

Strategy 10a (Crisis Intervention Training for Police and Other First Responders) provides CIT training to local law enforcement and other first responders to respond to MH and CD crises and intervene and divert people form the criminal justice system when appropriate. In partnership with the WSCJTC and the King County Sheriff's Office, the curriculum for the CIT training is underway with monthly trainings scheduled to begin in the fourth quarter of 2010.

In November 2009, the component of **Strategy 10b (Adult Crisis Diversion Services)** will provide respite beds with intensive clinical services, Crisis Diversion Interim Services, for homeless adults exiting the CDF was awarded to Downtown Emergency Services Center. On March 11, 2010, the RFP was re-advertised for the remaining two components, (the CDF and the mobile crisis team), as there was no award made for these two components in the initial RFP round. When fully operational, the CDF will be a place where police can bring low level offenders in lieu of arrest and trained professionals can help stabilize those with mental illness or substance use disorders who are in crisis and connect them to services in the community instead of using the jail as a default mental hospital and sobering center.

Jail and Hospital Diversion Strategies (Continued)

Strategies 11a (Increase Jail Liaison Capacity), **11b (Mental Health Court Expansion)**, **12a1 (Jail Re-Entry Capacity Increase)**, **12a2 (Education Classes at Community Center for Alternative Programs (CCAP))**, **12d (Behavior Modification Classes for CCAP Clients)**, and **15a (Adult Drug Diversion Court)** are post-booking strategies that identify and divert individuals with mental illness into alternative community-based treatment after they have entered the criminal justice system.

Expanding jail liaison services for both work and education release **(Strategy 11a)** and the county jail system **(Strategy 12a1)** has been key to successfully transitioning criminal offenders between their time spent in jail, or under court supervision, to re-entering the community as productive citizens. With resources from the MIDD, liaisons have been able to concentrate efforts on making referrals to: community-based MH treatment, CD treatment, medical services, housing, legal, education or employment, and veteran's programs. These professionals are able to clear barriers to obtaining post-release treatment and support services which are essential in curbing recidivism.

The MIDD Plan embraces the concept that education can make a difference in helping people realize they have something important to contribute to society. With support from **Strategy 12a2**, class offerings have been enhanced to prepare individuals for re-entry into the community upon completion of their court-ordered alternative sentencing. Job preparation and education are key components. In the current reporting period, 60 individuals took either Life Skills to Work or General Education Development (GED) courses and five received their GED diplomas. Another 184 CCAP participants attended at least one class focused on breaking the cycle of domestic violence.

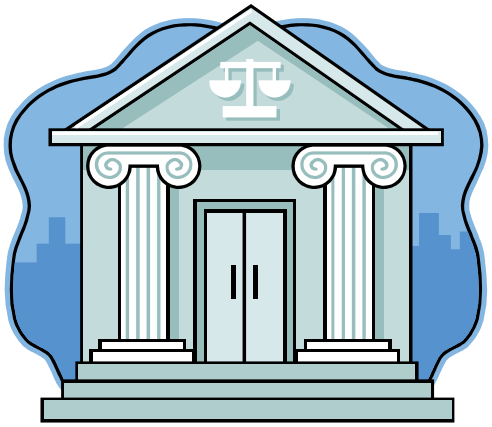
At the same time, groups of individuals in the criminal justice system are now able to take evidence-based therapeutic classes based on cognitive behavioral therapy under **Strategy 12d (Behavior Modification Classes for CCAP)**. Classes offered include Rational Emotive Behavioral Therapy, Cognitive Behavioral Therapy and Moral Reconation Therapy; 51 people participated in behavior modification classes.

Assertive case management is the core methodology behind the success of **Strategy 12c (Psychiatric Emergency Services or PES Link to Community Services)**. While the PES at Harborview is a long-standing program providing a critical safety net for disadvantaged patients with severe mental illness and SA, both acute and chronic, the MIDD-funded portion of the program targets a designated high utilizer caseload. Individuals who meet the high utilizer criteria (for example, four emergency department visits in a six month period, homeless, alienated from traditional resources, etc.) receive intensive engagement attention and advocacy until they are successfully linked to the resources they need. Principles of this intervention include: respectful and compassionate care, relationship building out in the field (going under the freeway ramps, if needed), concrete provision of resources such as food vouchers and bus tickets, and a harm reduction approach to CD. By employing this non-judgmental approach to helping substance users reduce the negative impact of drugs and alcohol in their lives, case managers are able to address the complex relationships people develop with drugs and alcohol. At the start of this reporting period, Strategy 12c was operating at full capacity with cases turning over for most clients in about three months. For the first 18 clients served, Harborview has been able to show dramatic reductions in ER usage and associated medical costs. [Note: Raw individual-level information on medical hospital utilization is not currently available for the MIDD evaluation.]

Strategy 17a (Crisis Intervention Team/Mental Health Partnership Pilot), designed to have MH professionals assist Seattle police responding to MH crises, is proceeding through federal justice funding the City of Seattle received.

Jail and Hospital Diversion Strategies (Continued)

Other MIDD strategies were designed to divert individuals from jails and hospitals by filling identified gaps in the service delivery system. **Strategy 12b (Hospital Re-Entry Respite Beds)** and **Strategy 16a (New Housing Units and Rental Subsidies)** are both good examples. Without a short-term medical care facility in place, homeless persons with mental illness and/or CD are too often released to the streets upon discharge from hospitals, contributing to a cycle of high hospital utilization. Likewise, shortages in available affordable housing contribute to long-term homelessness, an exacerbating factor in over-utilization of often inappropriate systems such as jails and hospitals for a population already at serious disadvantage due to their diagnoses. **Strategy 12b** has plans to provide a safe facility and medical recovery services for 350 to 500 people per year and one goal of **Strategy 16a** is to make 250 new beds available for those with mental illness or substance use issues.



Therapeutic Courts

The MIDD expansion of two specialty courts, **Strategy 11b (Mental Health Court)** and **Strategy 15a (Adult Drug Court),** will increase the availability of these important therapeutic courts by increasing caseload capacities to 115 and 250 clients per year, respectively. Funding from the MIDD has allowed the Mental Health Court to expand and become the King County Regional Mental Health Court (RMHC), collaborating with the 39 cities in King County to make this unique client-centered court option available to adult misdemeanants regardless of where the crime was committed. The RMHC, which began accepting new cases in January 2010, is able to go out "on the road" with facilities in Issaquah and Kent, Washington to reach those in outlying and rural areas.

While centrally located in downtown Seattle, over half of the Adult Drug Court (ADC) caseload for Q4-2009 through Q1-2010 reported zip codes outside of the downtown core, including 75 (31% of the 245 served) from south King County. The MIDD resources have allowed ADC participants to take an unlimited number of life skills classes, enroll in wraparound services specially designed for those 18 to 24 years of age, and to connect with housing resources instrumental in their effort to turn their lives around. See the inset on page 17 for more preliminary outcome findings.

Expenditure Status Update

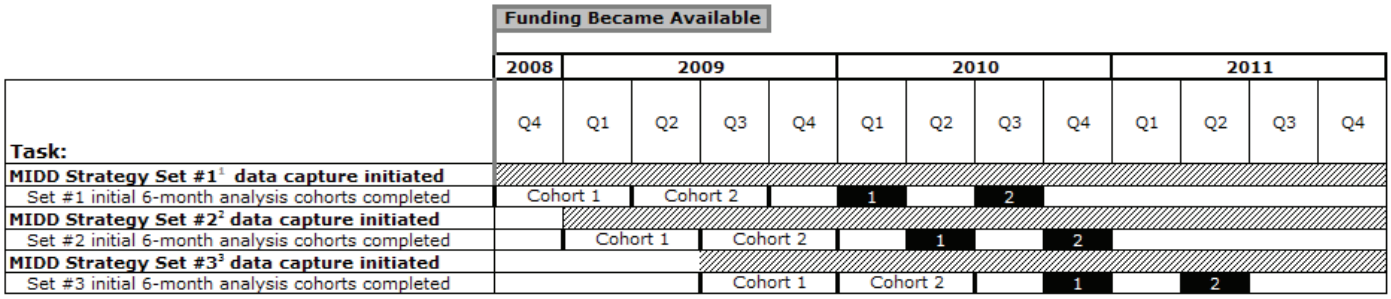
As of June 30, 2010, $14,711,271 in MIDD funds had been expended in 2010. The detailed MIDD Financial Status Report for January 1 through June 30, 2010 is included on pages 18 and 19. Expenditures were reimbursed for 27 of the 31 strategies implemented, with the remaining four strategies being implemented, but not requesting reimbursement to date.

Please note that the amount of spending alone does not sufficiently measure the progress of MIDD programming toward meeting its goals. The majority of the MIDD programs are paid on a reimbursement basis, where contracted agencies have to spend the funds and submit reimbursement requests to the county before any funds are released and noted on the county's books. Therefore, it is necessary to review the amount of funding expended to date, along with the year-end projection in order to get a more accurate picture of MIDD progress.

Lastly, 2010 marked the beginning of supplantation to support qualifying King County general fund programs. Approximately 30 percent ($13,047,322) of the MIDD fund was supplanted in 2010; the financial status report for MIDD Supplantation is included on page 20.

Outcomes for MIDD Strategy Set #1 - Cohort #1

As indicated in the Second Annual Report: First Year Implementation and Evaluation Summary (February 2010), most outcome data are now available for Set #1 - Cohort #1. The first analysis set includes individual-level data for the following strategies: 1a-1, 1a-2, 1d, 1h, 2b (MH), 12c, 15a, and 16a which began service delivery in October 2008. The first cohort refers to all clients who began receiving services during Q4-2008 and Q1-2009. See below for an illustration excerpted from the updated MIDD evaluation timeline.

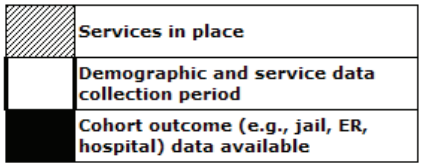


[1]Set #1 includes individual-level data for the following strategies: 1a-1, 1a-2, 1d, 1h, 2b (MH),12-c, 15a, 16a

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

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

Note: Set #4 is under development. Additional cohorts will be added to the timeline above, following the same pattern as illustrated.



In accordance with the evaluation matrices (see Attachment B for versions with proposed revisions), each of these strategies is aligned with its own set of outcome measures as shown below.

			Outcome Measures					
Strategy	**Strategy Nickname**	**N in Cohort #1**	**Jail**	**Psychiatric Hospitalizations**	**MH Treatment Link**	**CD Treatment Link**	**Symptom Reduction**	**Other**
1a-1	MH Treatment	980	X	X			X	X
1a-2a (OP)	CD Treatment - Outpatient	789	X					
1a-2b (OST)	CD Treatment - Opiate Substitution	142	X					
2b	Employment Services MH & CD	338						X
1d	MH Crisis Next Day Aoots	697		X	X			X
1h	Older Adults Crisis & Service Linkage	125		X	X	X		X
12c	PES Link to Community Services	29	X	X	X	X		
15a	Adult Drug Court Expansion	93	X					
16a	New Housing and Rental Subsidies	9	X	X				
Total in Analysis		3,202	2,042	1,840	851	154	N/A	N/A

For jail and psychiatric inpatient hospital utilization, analysis involves comparing numbers from the one year period prior to an individual's MIDD start date with numbers for the year following their start date. Linkages to treatment are measured during the year after a MIDD-funded authorization only. Results across strategies have been aggregated and are presented by outcome type on page 16. Outcome findings for **Strategy 2b (Supported Employment)** which highlight job placement and retention were presented on page 10. Note that "Other" outcomes in the table above can involve looking at program level data at two time points, rather than at the individual level. Results for strategies with these types of outcomes are shown on page 17.

For adult symptom reduction, composite scores will be calculated from Problem Severity Summary (PSS) subscales such as dangerous behavior, self-care, depressive symptoms, and anxiety symptoms. Those composites will then be compared *within individuals* at three distinct points in time: intake, six months, and one year. Note that providers were not required to start reporting PSS scores until January 1, 2010, so these outcomes cannot be measured before February 1, 2011. Symptom reduction in children will utilize Children's Functional Assessment Rating Scale scores which are required as of April 1, 2010.

Jail Utilization

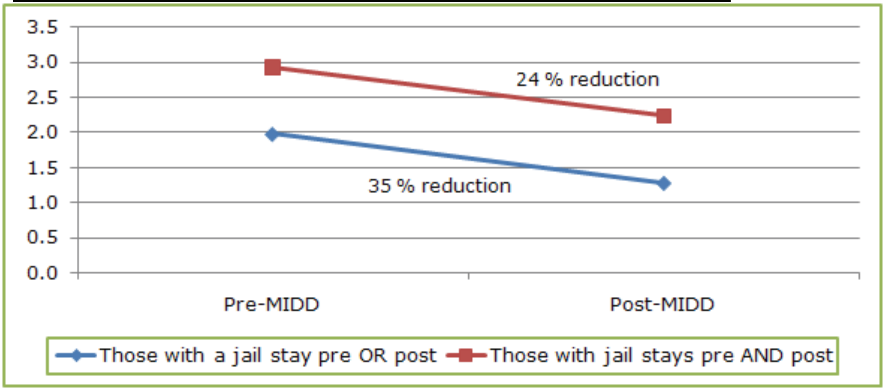
The first group eligible for measurement of jail outcomes is comprised of 2,042 individuals who began services during Q4-2008 and Q1-2009. Altogether, 312 consumers had at least one jail stay in a county-run correctional facility in the one year period prior to the start of MIDD funding (pre) and 241 had one or more jail bookings during their first year of the MIDD (post). Only 174 had jail bookings in both pre and post periods. See the grid below for an illustration of the relationship between pre and post jail bookings.

		Post Jail Bookings	
		Yes	No
Pre Jail Bookings	Yes	174 (8.5%)	138(6.8%)
	No	67 (3.3%)	1,663 (81.4%)

For those with at least one jail booking (N=379), the average number of jail stays during the pre period was 1.98, compared to 1.28 post-MIDD ($p < .001$). Days in jail also dropped, on average, from 42 days to 35.

Looking more closely at those jailed in *both* the pre and post periods (N=174), the average reduction in bookings was from 2.93 to 2.24, but the number of days in jail actually increased 12 percent (from 59 days to 66). This is consistent with the Criminal Justice Initiative evaluation finding for King County criminal justice programs, as individuals often receive longer sentences if they do return before a judge. The reduction in bookings was a statistically significant difference, but the increase in days was not. In the next annual report, analyses will explore jail use by each strategy with outcome data available.

Average Number of Jail Bookings from Pre to Post



Psychiatric Inpatient Hospitalizations

The combined cohort for whom psychiatric hospital usage was examined totaled 1,840 (see grid on page 15 for strategies included in cohort). Of those, only two people had Western State Hospital (WSH) admissions in the year prior to MIDD implementation. In the post period, five others accounted for seven admissions to WSH. Other psychiatric inpatient hospitalizations within King County were documented for 149 individuals in the pre period and 118 post. Forty-six people (2.5%) were hospitalized in both the pre and post timeframe.

Altogether, 12 percent of the cohort (N=221) had some type of psychiatric inpatient admission. The average number of hospitalization episodes and days pre-MIDD were 1.24 and 16.87, respectively, in contrast to 1.02 episodes and 14.41 days post-MIDD. Neither of these reductions was statistically significant. In general, those with hospitalizations, both pre and post tended to have more episodes and longer stays than the groups hospitalized in either one time period or the other.

Linkage to Mental Health and/or Chemical Dependency Treatment

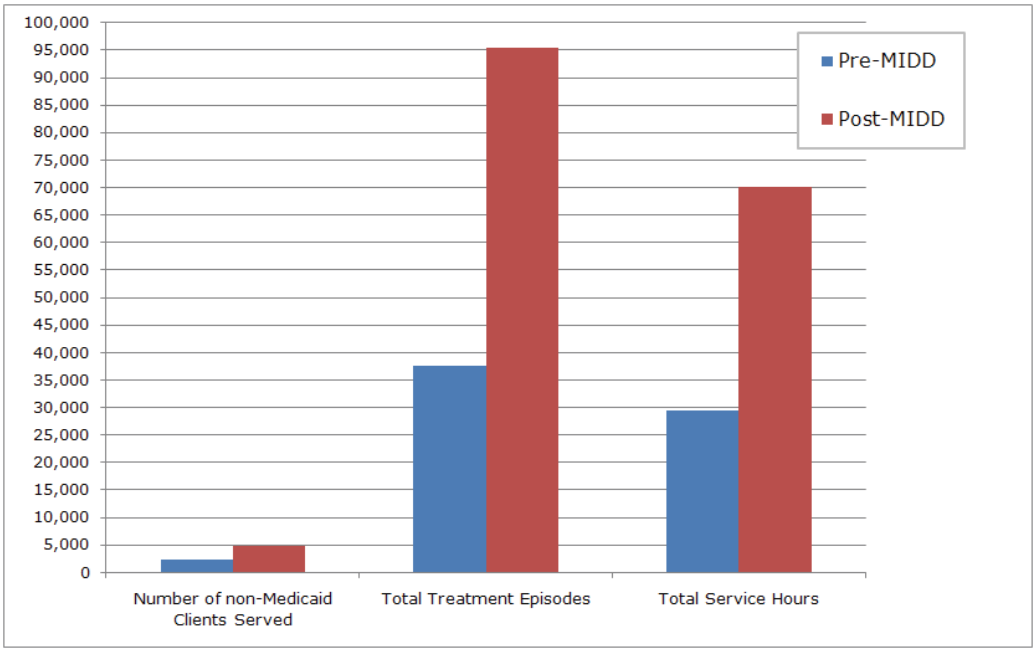
Confirmed linkages to MH benefit programs beyond the MIDD-funded entry point were made for at least 222 of the 851 (26%) enrolled in the first cohort for **1d (Mental Health Crisis Stabilization)**, **1h (Older Adults Crisis and Service Linkage)**, and **12c (Psychiatric Emergency Services Link to Community Services).** The number of subsequent formal MH programs to which individuals were linked ranged from one additional (N=162) to five (N=1).

Nine of the 29 individuals (31%) in Cohort #1 from 12c were linked to a total of 18 CD treatment programs. One other CD linkage was indicated for a person in 1h. Closely tracking completed referrals to treatment in conjunction with linkages made will be a part of ongoing evaluation efforts. For example, of those referred to CD treatment, how many were entered into the TARGET statewide CD treatment data system?

Strategy Level Outcome Findings to Date

1a-1 Mental Health Treatment

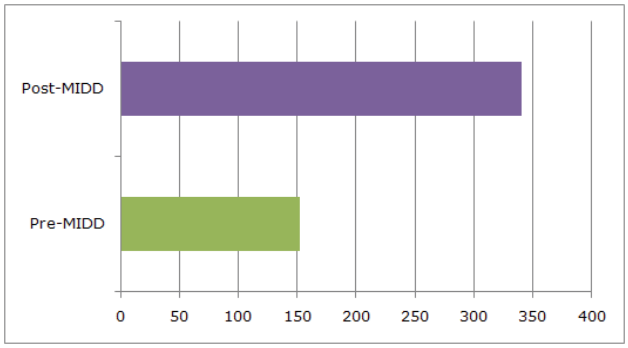
For Strategy 1a-1, the short-term output objective was to increase the number of non-Medicaid eligible clients served in outpatient settings. In the year prior to the MIDD, 2,406 non-Medicaid clients were served, compared to 4,828 in the year after funding began, a two-fold increase. Total treatment episodes increased from 37,526 to 95,442 and service hours went from 29,407 up to 70,124.



1h - Older Adults Crisis and Service Linkage

The number of clients served by the GRAT under Strategy 1h more than doubled from the year before MIDD to after (from 152 up to 341).

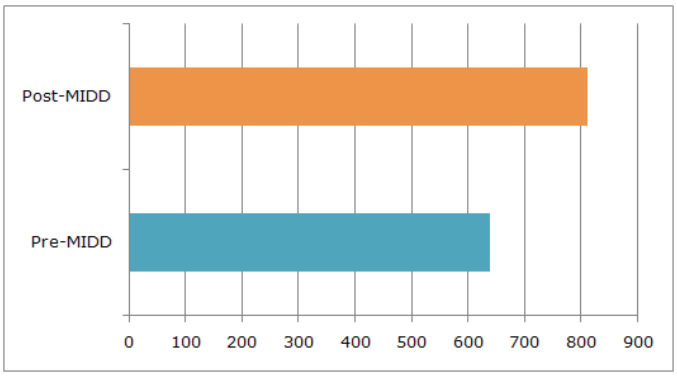
Number of Older Adults Served



1d - Mental Health Crisis Next Day Appointments

The number of people receiving "enhanced" services under the mental health crisis program increased by 27 percent (from 638 in the pre-period to 812 post).

Number of Clients with Enhanced Services



15a - Adult Drug Court: Expansion of Recovery Support Services

While Adult Drug Court is an ongoing therapeutic court intervention, MIDD expansion has provided enhancements such as employability classes, wraparound services for transition-aged youth (18 to 24 years old), and housing case management. Teasing out the impact of the MIDD expansion will require careful analysis of service delivery in conjunction with exit reasons and dispositions and will be presented in the next annual report.

Generally speaking, however, exit information was available for 49 drug court participants from the first outcomes cohort (N=93). The graduation rate for this group was 63 percent (31 of 49). Six participants (12%) opted out and ten (20%) were terminated from the program for noncompliance issues. All but ten percent of those exiting the program for any reason were successfully housed: 19 in permanent housing, two with permanent housing secured, and 23 temporarily or transitionally housed.

MIDD Financial Status Report through Q2-2010

This financial status report is provided for the first half of calendar year 2010 (January 1 - June 30, 2010).

Mental Illness and Drug Dependency Fund - Part I

	Strategy	Spending Plan 2010	Year-End Projection 2010	ARMS Report - End of June 2010
1a-1	Increase access to community mental health treatment	8,520,000	8,520,000	$ 3,137,256
1a-2	Increase access to community substance abuse treatment	2,623,225	2,623,225	$ 542,272
1b	Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities	495,000	495,000	$ 27,508
1c	Emergency room substance abuse early intervention program	717,000	717,000	$ 222,153
1d	Mental health crisis next day appointments and stabilization services	225,000	225,000	$ 88,086
1e	Chemical dependency professional education and training	555,000	555,000	$ 134,353
1f	Peer support and parent partner family assistance	375,000	375,000	$ 891
1g	Prevention and early intervention mental health and substance abuse services for older adults	450,000	450,000	$ -
1h	Expand availability of crisis intervention and linkage to on-going services for older adults	315,000	315,000	$ 131,250
2a	Worklaod reduction for mental health	4,000,000	4,000,000	$ 1,505,107
2b	Employment services for individuals with mental illness and chemical dependency	1,000,000	1,000,000	$ 237,350
3a	Supportive Services for Housing Projects	2,000,000	2,000,000	$ 2,000,000
4a	Services to parents participating in substance abuse outpatient treatment programs	-	-	
4b	Prevention Services - Children of substance abusers	-	-	
4c	Collaborative school based mental health and substance abuse services	1,235,000	1,235,000	
4d	School Based Suicide Prevention	200,000	200,000	$ 50,051
5a	Increase capacity for social and psychological assessments for juvenile justice youth	176,938	176,938	$ -
6a	Wraparound family, professional and natural support services for emotionally disturbed youth	3,200,000	3,200,000	$ 881,401
7a	Reception Centers for Youth in Crisis	-	-	$ -
7b	Expanded crisis outreach and stabilization services for children and youth	500,000	500,000	$ -
8a	Expand Family Treatment Court & Support to parents	123,926	123,926	$ 31,250
9a	Expand Juvenile Drug Court Treatment	237,766	237,766	$ -
10a	Crisis Intervention Training	763,747	763,747	
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	4,600,000	4,600,000	$ 213
11a	Increase capacity for jail liaison program	80,000	80,000	$ 31,286
11b	Increase services available for new or existing mental health court programs	1,295,000	1,295,000	$ 84,239
12a	Increase jail re-entry program capacity	320,000	320,000	$ 79,332
12b	Hospital Re-Entry Respite Beds	508,500	508,500	$ -
12c	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community based services upon discharge from Emergency Room	200,000	200,000	$ 83,335
12d	Behavioral Modification Classes for Community Center for Alternative Program clients	75,000	75,000	$ 31,250
13a	Domestic Violence and mental health services	250,000	250,000	$ 122,924
13b	Domestic Violence prevention	224,000	224,000	$ 74,672
14a	Sexual assault and mental health and chemical dependency services	400,000	400,000	$ 133,510
15a	Drug Court Expansion of Recovery Support Services	103,778	103,778	$ -
16a	Housing Projects	-	-	$ -
17a	Crisis Intervention Team/MH Partnership Pilot	-	-	
17b	Safe Housing, MH & CD treatment for youth prostitution pilot	100,000	100,000	$ -
	MIDD Administration	$ 2,439,171	$ 2,439,171	$ 454,581
	Personnel			$ 377,288
	Other Costs			$ 77,293
	Total MIDD Operating Dollars	$ 38,308,051	$ 38,308,051	$ 10,084,269
	Percentage of Appropriation		100.00%	26%

MIDD Financial Status Report (Continued)

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units for County FTEs)	Spending Plan 2010	Year-End Projection 2010	ARMS Report - End of June 2010
	DJA			
15a	Drug Court Expansion of Recovery Support Services	141,222	141,222	$ 52,743
	PAO			
9a	Expand Juvenile Drug Court Treatment	40,272	40,272	$ 75
	Superior Court			
5a	Increase capacity for social and psychological assessments for juvenile justice youth	186,887	186,887	$ 92,613
8a	Expand family treatment court services and support to parents	223,409	223,409	$ 102,933
9a	Expand Juvenile Drug Court Treatment	276,725	276,725	$ 196,417
	Sheriff - Pre-Booking Diversion			
10a	Sheriff - Crisis Intervention Training Program	186,746	186,746	$ 35,092
	Dept Office of Public Defender			
8a	Family Treatment Court Expansion	84,932	84,932	$ -
9a	Juvenile Drug Court Expansion	41,146	41,146	$ 20,034
	Total Other MIDD Funds	$ 1,181,339	$ 1,181,339	$ 499,907
	Percentage of Appropriation		100.00%	42%
	Total MIDD Funds	$ 39,489,390	$ 39,489,390	$ 10,584,176

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	Spending Plan 2010	Year-End Projection 2010	ARMS Report - End of June 2010
Revenue			
MIDD TAX	43,210,000	42,730,382	19,576,005.45
Streamlined Mitigation			351,090.27
Investment Interest - Gross	290,000	232,235	136,462.85
Cash Management Svcs Fee			(766.02)
Invest Service Fee - Pool			(4,616.13)
Total Revenues	$ 43,500,000	$ 42,962,617	$ 20,058,176
Total MIDD Funds	$ 39,489,390	$ 39,489,390	$ 10,584,176
Total MIDD Supplantation	$ 13,047,322	$ 13,047,322	$ 4,127,095
Total Expenditures	$ 52,536,712	$ 52,536,712	$ 14,711,271
Expenditures Over Revenues	$ (9,036,712)	$ 9,574,095	$ 5,346,906

MIDD Financial Status Report (Continued)

Mental Illness and Drug Dependency Fund - Supplantation

Strategy	Spending Plan 2010	Year-End Projection 2010	ARMS Report - End of June 2010
Other MIDD Funds			
DJA	**$ 1,269,249**	**$ 1,269,249**	**$ 297,237**
Adult Drug Court Base	1,269,249	1,269,249	$ 297,237
PAO	**$ 858,865**	**$ 858,865**	**$ 870**
Adult Drug Court Base	538,045	538,045	$ 522
Juvenile Drug Court Base	121,778	121,778	$ -
Mental Health Court Base	199,042	199,042	$ 348
Superior Court	**$ 227,976**	**$ 227,976**	**$ 107,835**
Adult Drug Court Base	162,651	162,651	$ 82,158
Juv Drug Court Base	32,663	32,663	$ 12,838
Family Trmt Court Base	32,662	32,662	$ 12,838
Dept Office of Public Defender	**$ 1,278,144**	**$ 1,278,144**	**$ 565,945**
Adult Drug Court Base	752,270	752,270	$ 390,719
Juv Drug Court Base	25,906	25,906	$ 12,414
MH Court Base	330,102	330,102	$ 162,812
Family Treatment Court Base	169,866	169,866	$ -
Dept District Court	**$ 629,857**	**$ 629,857**	**$ 268,182**
Mental Health Court Base	629,857	629,857	$ 268,182
Dept Adult and Juvenile Detention (DAJD)	**$ 406,000**	**$ 406,000**	**$ 84,886**
CCAP	100,000	100,000	$ 12,516
Juv MH Treatment	306,000	306,000	$ 72,370
Dept Jail Health Services	**$ 3,115,024**	**$ 3,115,024**	**$ 1,274,212**
Psychiatric Services	3,115,024	3,115,024	$ 1,274,212
DCHS Community Services Division	**$ 362,000**	**$ 362,000**	**$ -**
Sexual Assault	362,000	362,000	$ -
Total Other MIDD Funds	**$ 8,147,115**	**$ 8,147,115**	**$ 2,599,166**
Percentage of Appropriation		**100.00%**	**32%**
MH & SA MIDD Supplantation	**$ 4,900,207**	**$ 4,900,207**	**$ 1,527,929**
SA Administration	399,738	399,738	$ -
SA Criminal Justice Initiative	988,500	988,500	$ 309,135
SA Contracts	121,757	121,757	$ 8,782
SA Housing Voucher Program	602,615	602,615	$ 246,918
SA ESP	593,806	593,806	$ 157,154
SA CCAP	472,981	472,981	$ 220,598
MH Co-Occurring Disorders Tier	800,000	800,000	$ 322,260
MH Recovery	207,204	207,204	$ 98,239
MH Juvenile Justice Liaison	90,000	90,000	$ 30,000
MH Crisis Triage Unit	263,606	263,606	$ 107,463
MH Functional Fam Therapy	272,000	272,000	$ -
MH Mental Health Court Liaison	88,000	88,000	$ 27,380
Total Other MH/SA MIDD Supplantation Funds	**$ 4,900,207**	**$ 4,900,207**	**$ 1,527,929**
Percentage of Appropriation		**100.00%**	**31%**
Total MIDD Supplantation	**$ 13,047,322**	**$ 13,047,322**	**$ 4,127,095**
Percentage of Appropriation		**100.00%**	**32%**

Attachment A: MIDD Oversight Committee Membership Roster*
Year Two Progress Report

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

Susan Rahr, Sheriff (Co-Chair)
King County Sheriff's Office
Representing: Sheriff's Office

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

Rhonda Berry, Assistant Deputy County Executive
Representing: County Executive

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

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

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

Catherine Cornwall, Senior Policy Analyst
Representing: City of Seattle

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

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

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

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

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

Helen Halpert, Assistant Presiding Judge, King County Superior Court
Representing: Superior Court

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

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

David Hocraffer, King County Public Defender
Representing: Public Defense

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

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

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

Barbara Linde, Presiding Judge, King County District Court
Representing: District Court

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

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

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

Mario Paredes, Executive Director, Consejo Counseling and Referral Service
Representing: Provider of culturally specific mental health services in King County

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

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

Hikari Tamura, Director, King County Department of Adult and Juvenile Detention
Representing: Adult and Juvenile Detention

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

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

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

*As of March 22, 2010

Attachment B: Proposed MIDD Evaluation Plan Matrix Revisions with Introduction Year Two Progress Report

The MIDD Evaluation Plan and evaluation matrices for each individual strategy were developed by MHCADSD program evaluation staff from individual implementation strategies with early drafts dating back to May of 2008. These evaluation matrices, originally published on September 2, 2008, were revised as strategy implementation plans were altered, budgets changed, and/or certain data elements were deemed infeasible or not relevant for given target populations. In addition to these content revisions (summarized on the next page), uniform formatting was applied with the stylistic revisions outlined below:

1) One page per strategy
2) Page margins = 1 inch on top, bottom, left, and right
3) Header = Arial font, 14 point, bold, right-justified (Strategy number plus letter)
4) Footer = Arial font, 10 point, left-justified ("Content revised {date} (Previous draft published {date}")
5) Column headers = Arial font, 10 point, bold, left-justified, centered vertically
6) All column contents = Arial font, 10 point, align left, no hanging indents
7) In **Sub-Strategy** column, bold strategy number/letter, title capitalization, and use "Target Population" (vs. Target Pop)
8) Eliminate [Note * if applicable] from **Intervention(s)/Objectives** column heading and the generic explanation of * in footnote, calling out all promising and evidence-based practices with new footnotes where applicable
9) Use periods in **Intervention(s)/Objectives** column only
10) Capitalize "Target Numbers" in **Intervention(s)/Objectives** column heading
11) Include goal numbers in **Intervention(s)/Objectives** column rather than under **Performance Measures**
12) **Performance Measures** numbered as "1.", "2.", etc., single-spaced with first letter capitalized under two sub-headings:
    - "Short-term measures" – Typically *output* (or process) measures or *what is done (and how)*
    - "Longer-term measures" – Typically *outcome* measures or *the effects of what is done*
13) Double space before "Longer-term measures"
14) Remove goal numbers under **Performance Measures** (see #11 above)
15) Combine "bookings **and** days" (jail) or "admissions **and** days" (psychiatric hospital) under single measures
16) Subsume ER cost reduction measure under reduction of ER utilization ("Reduce # of ER visits for those served")
17) Number **Type of Measure** to match **Performance Measures** and align by row
18) Align **Data Sources** with **Type of Measure**
19) Remove "(s)" and capitalize "Sources" in **Data Sources** column heading
20) Eliminate [Note any existing evaluation activity] from **Data Sources** column heading and order primary data sources consistently

The following grid provides a summary of the revisions made to the content of several evaluation matrices. Types of changes, reasons for making these changes, and the strategies impacted are included here:

Type of Change	Reason for Change	Strategies Impacted by Change										
Alter unit of measurement	Service units more accurate measure than clients per year	1a-2										
Remove detox measure	Reducing detox admissions may be counterproductive to CD treatment goals	1c										
Remove psychiatric hospital measure	Not a mental health strategy or not a relevant measure for target population	1a-2	1c	1g	4c							
Remove jail measure	Not a relevant measure for target population	1h										
Remove ER measure	Not a relevant measure for target population	4c										
Remove public assistance measure	Individual level data unavailable	2b										
Remove hospitalization costs measure	Individual level data unavailable	12b										
Remove housing measure	Not directly related to specific strategy objectives	2b	11a	12a								
Remove outcomes directly linked to individuals	Infrastructure strategy or not directly attributable to individuals	1e	2a	4d	10a							
Replace "self-report" with actual measures	Better measurement options available	1g										
Replace vague measures with more concrete deliverables	Measures impractical or could not be standardized across MIDD strategies	4a	4b	4d	5a	6a	7a	8a	9a	13a	13b	14a

All major data sources referenced in the evaluation matrices which follow are defined in alphabetical order in the grid below:

Data Source	Definition
Agency report	Monthly, quarterly, or semi-annual narrative reports provided to King County as required in contract
Assessments.com	A company providing automated assessment solutions for public and private organizations [Source for GAIN data - Global Appraisal of Individual Needs]
CLIP	Children's Long-Term Inpatient Program
Contract report	Reports provided to King County by contracted agencies as required in contract
DCFS data	Washington State Division of Children and Family Services information on out-of-home placements and/or placement disruptions
ER data	Emergency Room usage information
Fidelity monitoring	Monitoring of a representative sample to determine how closely a set of procedures were implemented as they were supposed to have been
Integrated DB	MHCADSD Integrated Data Project (High Utilizer Integrated Database) - In development as of 7/12/2010
Jail data	Jail bookings and days from King County Correctional Facility (KCCF) and Regional Justice Center (RJC), plus select municipalities within the county
Juvenile Justice data	Youth detention admissions to King County Juvenile Detention
MHCADSD	Mental Health, Chemical Abuse and Dependency Services Division of King County's Department of Community and Human Services
MIDD Tools	Excel spreadsheets or other means of transferring custom program and/or client data for upload to the MIDD database
MIS (php96)	MHCADSD Management Information System (MIS)
Pre/Post survey	Survey of trainees before and after training provided
Safe Harbors	Regional Homeless Management Information System
School data	School attendance, suspensions, detentions, and performance (grades) information
Sobering Center	Dutch Shisler Sobering Support Center data system
TARGET	King County download from State of Washington data system for publicly funded substance abuse treatment
TBD	To Be Determined…
Training evaluations	For example, retrospective pre/posts of training curriculum knowledge and/or awareness on representative sample of those trained
Western State data	Inpatient psychiatric hospitalizations at State of Washington facility

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1a-1 – Increase Access to Mental Health (MH) Outpatient Services for People Not On Medicaid Target Population: Individuals who have received MH services but have lost Medicaid eligibility or those who meet clinical and financial criteria for MH services but are not Medicaid eligible	1. Provide expanded access to outpatient MH services ~~to~~ for 2,400 additional persons not eligible for or who lose Medicaid coverage, yet meet income standards for public MH services ~~(goal is 2400 additional non-Medicaid eligible clients per year).~~	Short-term measure: 1. Increase # of non-Medicaid eligible clients served in MH outpatient treatment ~~2. Reduce severity of MH symptoms of clients served~~ Longer-term measures: 2. Reduce severity of MH symptoms for those served 3. Reduce # of jail bookings and days for those served 4. Reduce # of psychiatric hospital admissions and days for those served 5. Reduce # of emergency room (ER) ~~admissions~~ visits for those served	1. Output ~~2. Outcome~~ 2. Outcome 3. Outcome 4. Outcome 5. Outcome	Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Management Information System (MIS) (php96) MIS (php96) Jail data ~~Hospital data~~ Western State data and MIS (php96) ER data❶
1a-2 – Increase Access to Chemical Dependency (CD) Outpatient Services for People Not On Medicaid Target Population: Low-income individuals who are not Medicaid, ADATSA, or GAU eligible who need CD services	1. Provide expanded access to chemical dependency treatment to individuals not eligible or covered by Medicaid, ADATSA, or GAU benefits but who are low-income (have 80% of state median income or less, adjusted for family size). Services to include 70,000 units of opiate substitution treatment (OST), 50,000 units of adult ~~and~~ outpatient treatment and 4,000 units of youth outpatient treatment per year.* ~~(Goal is additional 461 individuals in OST and 400 in outpatient substance abuse disorder treatment per year.)~~	Short-term measure: 1. Increase # of non-Medicaid eligible clients admitted to outpatient substance abuse treatment and OST ~~2. Reduce severity of CD symptoms of clients served~~ Longer-term measures: 2. Reduce severity of CD symptoms for those served 3. Reduce # of jail bookings and days for those served ~~4. Reduce # of psychiatric hospital admissions and days for those served~~ 4. Reduce # of ER ~~admissions~~ visits for those served	1. Output ~~2. Outcome~~ 2. Outcome 3. Outcome ~~4. Outcome~~ 4. Outcome	~~MIS~~ TARGET ~~TBD (eg survey)~~ TARGET❷ Jail data ~~Hospital data~~ ER data❶

❶ Data sharing agreement(s) needed
❷ Database revisions needed
* Outpatient service units include hours for assessments, individual therapy, group therapy, case management, and urinalysis testing for youth. OST units are days when individuals receive medications such as methadone.

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1b – Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities Target Population: Homeless adults being discharged from jails, hospital ERs, crisis facilities and in-patient psychiatric and chemical dependency facilities	~~1. Intervention to be defined. Intent is to fill gaps identified in the high utilizer service system, once other programs dedicated to this population are implemented.~~ 1. Provide mental health and substance abuse stabilization, engagement, screening, and assessment services to homeless individuals. 2. Provide referrals and confirm linkages for 675 homeless individuals per year. 3. Provide mental health, substance abuse, and/or case management services to 350 homeless individuals per year.	Short-term measures: 1. Hire 5.6 FTEs to provide outreach services 2. Increase # of mental health, substance abuse, and/or case management services provided to homeless individuals per year 3. ~~Link~~ Increase # of referrals for homeless individuals to needed ~~community~~ outpatient MH and substance abuse treatment and housing ~~2. Increase # of individuals in shelters being placed in: a) services and b) permanent housing~~ Longer-term measures: 4. Increase # of linkages to outpatient MH treatment for those referred 5. Increase # of linkages to outpatient substance abuse treatment for those referred 6. Increase # of linkages to permanent housing placements for those referred 7. Reduce # of jail bookings and days for those served 8. Reduce # of psychiatric hospital admissions and days for those served 9. Reduce # of days in Sobering Center for those served 10. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Output 3. Output ~~2. Outcome~~ 4.Outcome 5.Outcome 6.Outcome 7. Outcome 8. Outcome 9. Outcome 10.Outcome	Contract report MIDD Tools MIDD Tools ~~TBD when specifics of intervention are defined~~ MIS (php96) TARGET Integrated DB or Safe Harbors❶ Jail data ~~Hospital data~~ Western State data and MIS (php96) Sobering data ER data❶

❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1c - Emergency Room Substance Abuse ~~and~~ Early Intervention Program Target Population: At-risk substance abusers, including high utilizers of hospital ERs	1. Continue lapsed federal grant funding for SBIRT✪ program at Harborview ~~(~~with 5 current FTE substance abuse (SA) professionals~~)~~. 2. Create 1 new program in South King County ~~(hire 4 new FTE CD professionals)~~ with chemical dependency professionals (CDPs) at Auburn General Hospital, Highline Medical Center, St. Francis Hospital, and Valley Medical Center. 3. Serve a total of 7,680 ~~clients/yr~~ clients per year.	Short-term measures: 1. ~~Expansion of~~ Fund existing program at Harborview 2. Hire 4 ~~new~~ FTE ~~SA professionals~~ CDPs for ~~3. Create 1~~ new program in South King County 3. ~~SA services to 7,680 cts/yr~~ Increase # of screening, brief intervention, referrals, and/or brief therapy services for patients presenting in emergency rooms throughout King County Longer-term measures: 4. Increase # of linkages to outpatient substance abuse treatment for those referred 5. Reduce # of jail bookings and days for those served 6. Reduce # of days in Sobering Center for those served 7. Reduce # of ER ~~admissions~~ visits for those served ~~8/9. Reduce # of psychiatric hospital admissions and days for those served~~ ~~10. Reduce # of detox admissions for those served~~ ~~11. Reduce ER costs for those served~~	1. Output 2. Output 3. Output 4.Outcome 5. Outcome 6. Outcome 7. Outcome ~~8/9.Outcome~~ ~~10.Outcome~~ ~~11. Outcome~~	~~MIS~~ Contract report ~~MIS~~ Contract report ~~MIS~~ MIDD Tools MIDD Tools and TARGET Jail data Sobering data ER data❶ ~~Hospital data~~ ~~MIS~~ ~~ER/Hospital data~~

✪SBIRT (Screening, Brief Intervention, Referral and Treatment) is an evidence-based practice.
❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1d - Mental Health Crisis Next Day Appointments (NDAs) and Stabilization Services Target Population: Adults in crisis and at risk for inpatient psychiatric admission	1. Increase ~~access for~~ NDA~~s~~ capacity to provide ~~them~~ enhanced services for 750 of the approximate 1,300 clients receiving NDAs annually. ~~2. Provide expanded~~ Enhanced crisis stabilization services may include any of the following: a. Benefits counseling to help clients gain entitlements that will enable them to qualify for ongoing mental health and medical services; b. Brief, intensive, short term treatment to resolve crises, including motivational interviewing to promote treatment engagement for individuals who are in need of substance use treatment; c. Psychiatric medication evaluations that includes access to medications; d. Consultation with clients' primary care physicians regarding ongoing access to needed psychiatric medications for individuals who are not eligible for ongoing public mental health services; and e. Linkage to on-going care.	Short-term measure: 1. Provide ~~expanded~~ enhanced NDA services as measured by mix of services provided to clients Longer-term measures: 2. Increase # of linkages to outpatient MH treatment for those referred 3. Reduce # of psychiatric hospital admissions and days for those served 4. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Outcome 3. Outcome 4. Outcome	MIS (php96) MIS (php96) ~~Hospital data~~ Western State data and MIS (php96) ER data❶

❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1c - Emergency Room Substance Abuse ~~and~~ Early Intervention Program Target Population: At-risk substance abusers, including high utilizers of hospital ERs	1. Continue lapsed federal grant funding for SBIRT✪ program at Harborview ~~(~~with 5 current FTE substance abuse (SA) professionals~~)~~. 2. Create 1 new program in South King County ~~(hire 4 new FTE CD professionals)~~ with chemical dependency professionals (CDPs) at Auburn General Hospital, Highline Medical Center, St. Francis Hospital, and Valley Medical Center. 3. Serve a total of 7,680 ~~clients/yr~~ clients per year.	Short-term measures: 1. ~~Expansion of~~ Fund existing program at Harborview 2. Hire 4 ~~new~~ FTE ~~SA professionals~~ CDPs for ~~3. Create 1~~ new program in South King County 3. ~~SA services to 7,680 cts/yr~~ Increase # of screening, brief intervention, referrals, and/or brief therapy services for patients presenting in emergency rooms throughout King County Longer-term measures: 4. Increase # of linkages to outpatient substance abuse treatment for those referred 5. Reduce # of jail bookings and days for those served 6. Reduce # of days in Sobering Center for those served 7. Reduce # of ER ~~admissions~~ visits for those served ~~8/9. Reduce # of psychiatric hospital admissions and days for those served~~ ~~10. Reduce # of detox admissions for those served~~ ~~11. Reduce ER costs for those served~~	1. Output 2. Output 3. Output 4.Outcome 5. Outcome 6. Outcome 7. Outcome ~~8/9.Outcome~~ ~~10.Outcome~~ ~~11. Outcome~~	~~MIS~~ Contract report ~~MIS~~ Contract report ~~MIS~~ MIDD Tools MIDD Tools and TARGET Jail data Sobering data ER data❶ ~~Hospital data~~ ~~MIS~~ ~~ER/Hospital data~~

✪SBIRT (Screening, Brief Intervention, Referral and Treatment) is an evidence-based practice.
❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1d - Mental Health Crisis Next Day Appointments (NDAs) and Stabilization Services Target Population: Adults in crisis and at risk for inpatient psychiatric admission	1. Increase ~~access for~~ NDA~~s~~ capacity to provide ~~them~~ enhanced services for 750 of the approximate 1,300 clients receiving NDAs annually. ~~2. Provide expanded~~ Enhanced crisis stabilization services may include any of the following: a. Benefits counseling to help clients gain entitlements that will enable them to qualify for ongoing mental health and medical services; b. Brief, intensive, short term treatment to resolve crises, including motivational interviewing to promote treatment engagement for individuals who are in need of substance use treatment; c. Psychiatric medication evaluations that includes access to medications; d. Consultation with clients' primary care physicians regarding ongoing access to needed psychiatric medications for individuals who are not eligible for ongoing public mental health services; and e. Linkage to on-going care.	Short-term measure: 1. Provide ~~expanded~~ enhanced NDA services as measured by mix of services provided to clients Longer-term measures: 2. Increase # of linkages to outpatient MH treatment for those referred 3. Reduce # of psychiatric hospital admissions and days for those served 4. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Outcome 3. Outcome 4. Outcome	MIS (php96) MIS (php96) ~~Hospital data~~ Western State data and MIS (php96) ER data❶

❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1e – Chemical Dependency Professional (CDP) Education and Workforce Development Target Population: Staff (CDPTs)❶ at King County contracted treatment and prevention agencies training to become CDPs❷ and/or CPPs❸ or seeking recertification	1. Provide tuition, ~~and~~ book stipends, and test reimbursement to agency staff in training to become certified chemical dependency professionals. Reimburse recertification fees, clinical supervision, and cultural competency consultation. 2. Increase # of ~~certified CD treatment professionals (CDPs) by~~ trainees participating in this program by 125 annually. ~~3. Test 45 CDPTs at each test cycle.~~ 3. Provide support to deliver evidenced-based treatment and prevention practices and assure these practices are delivered with fidelity.	Short-term measures: 1. Hire 1 FTE science-to-service/ workforce development coordinator 2. Increase # of certified CDPs and CPPs in the King County substance abuse treatment and prevention delivery system 3. Develop workforce development training plan for CD service providers Longer-term measures: 4. Increase # of ~~certification programs~~ county-sponsored clinical supervisions and cultural competency consultations 5. Increase # of evidence-based treatment and prevention trainings provided 6. Increase # of CDPs and CPPs trained in evidence-based practices ~~5.Increase # clients receiving CD services~~ 7. Assess wider impacts for individuals and agencies (including increased staff recruitment/retention and increased job satisfaction)	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output ~~5.Outcome~~ 7. Outcome	MHCADSD ~~WA State Divisions of Alcohol & Substance Abuse (DASA) data~~ Contract report Contract report ~~DASA data~~ Contract report ~~Agency data~~ Contract report Contract report ~~MIS~~ Agency semi-annual narrative report

❶ Chemical dependency professional trainees
❷ Chemical dependency professionals
❸ Certified prevention professionals

Content revised 7/9/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1f - ~~Peer Support and Parent Partners Family Assistance~~ Parent Partner and Youth Peer Support Assistance Program⌖ Target Populations: 1) Families whose children ~~and/or youth~~ receive services from the public mental health or substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports for their children/youth 2) Youth who receive services from the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports	~~1. Hire 1 FTE MHCADSD Parent Partner Specialist.~~ 1. Provide ~~up to 40 part-time~~ parent partners/youth peer counselors ~~who will serve 100 individuals each~~ ~~to provide outreach and engagement and assist families to~~ that will empower families and youth by assisting them to 1) increase their knowledge and expertise about services, systems and supports for families, 2) utilize effective coping skills and strategies to support children/youth, and 3) effectively navigate the complex child-serving systems, including juvenile justice, child welfare, and mental health and substance abuse treatment. 2. Provide education, training and advocacy to parents and youth involved in the different child-serving systems in an amount to be determined (TBD) in contract. 3. Provide information and resources to families and youth regarding services and supports available throughout King County.	Short-term measures: 1. Hire 1.0 FTE parent partner specialist ~~hired~~ ~~2. A sufficient # of contracts are secured with network parent/youth organizations to provide up to 40 parent partners and/or youth peer mentors~~ 2. Fund a free-standing Family Support Organization (FSO) in King County 3. Hire parent partners and youth peer mentors to operate and staff the FSO 4. Increase ~~in~~ # of families and youth receiving parent partner/peer counseling services 5. Increase ~~in~~ # of parent partner/peer counseling service hours provided 6. Increase # of parents/youth engaged in ~~the Networks of S~~ support groups and other activities of the FSO 7. Increase # of education and training events held annually Longer-term measures: ~~8. Reduce # of psychiatric hospital admissions and days for those served~~ ~~9. Reduce # of detention admits for youth within those families served~~ ~~10. Reduce # of out-of-home placements and/or placement disruptions for families and youth served~~ 8. Increase parent/caregiver knowledge of service systems and how to access resources 9. Increase family empowerment and advocacy skills for parents/caregivers and youth 10. Increase protective factors for families and youth served 11. Decrease risk factors for families and youth served 12. Increase family connections to natural supports	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output ~~8. Outcome~~ ~~9. Outcome~~ ~~10.Outcome~~ 8. Outcome 9. Outcome 10.Outcome 11.Outcome 12.Outcome	MHCADSD MHCADSD MHCADSD MIS (php96)❶ MIS (php96)❶ ~~Agency data~~ Contract report ~~Agency data~~ Contract report ~~Hospital data~~ ~~Juvenile Justice data~~ ~~(TBD) DCFS data~~ MIDD Tools MIDD Tools MIDD Tools MIDD Tools MIDD Tools

⌖ The Parent Partner and Youth Peer Support Assistance Program is based upon a "promising" practice model.
❶ Database revisions needed

Content revised 7/15/2010 (Previous draft amended 5/20/2009)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1g - Prevention and Early Intervention Mental Health and Substance Abuse Services for ~~Older~~ Adults Age 50+ Target Population: Adults age ~~55~~ 50 years and older who are low-income, have limited or no medical insurance, and are at risk of mental health problems and/or alcohol or drug abuse	~~1. Hire 10 FTEs behavioral health specialists/staff to provide prevention and early intervention services by integrating staff into safety net primary care clinics.~~ 1. Increase capacity to provide integrated behavioral health care to at least 2,500 individuals at 21 safety net primary care clinics. 2. ~~This includes~~ Provide on-site prevention and early intervention services that include screening clients for depression, anxiety, and/ or alcohol/drug abuse, identifying treatment needs, and connecting ~~adults~~ those in need to appropriate interventions.	Short-term measures: 1. Hire 7.4 ~~10~~ FTE~~s hired~~ behavioral health specialists/staff 2. ~~Improved~~ Increase access to MH and substance abuse screening and services 3. Provide MH and substance abuse prevention and early intervention services ~~for 2,500 to 4,000 cts/yr~~ in primary care clinics Longer-term measures: 4. Increase # of individuals screened for MH and substance abuse issues using the GAIN-SS 5. Reduce ~~self-report of depression for those served~~ severity of MH symptoms* for those served 6. Increase # of linkages to outpatient MH treatment for those referred 7. Increase # of linkages to outpatient substance abuse treatment for those referred 8. Reduce # of ER ~~admissions~~ visits for those served ~~4. Reduce # of psychiatric hospital admissions and days for those served~~ ~~6. Reduce self-report of substance abuse for those served~~ ~~7. Reduce self-report of suicidal ideation for those served~~ ~~8. Reduce ER and hospital costs for those served~~	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome ~~4. Outcome~~ ~~6. Outcome~~ ~~7. Outcome~~ ~~8. Outcome~~	~~Agency data~~ Contract report ~~Agency data~~ Contract report ~~MIS~~ MIDD Tools MIDD Tools ~~TBD (e.g., survey)~~ MIDD Tools MIS (php96) TARGET ER data❶ ~~Hospital data~~ ~~TBD (e.g., survey)~~ ~~TBD (e.g., survey)~~ ~~Hospital data~~

* Depression measured by PHQ-9 and anxiety measured by GAD-7 at two different time periods.
❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1h - Expand the Availability of Crisis Intervention and Linkages to On-going Services for Older Adults Target Population: Adults age 55 and older experiencing a crisis in which MH or substance abuse is a contributing factor	1. Expand the capacity of the Geriatric Regional Assessment Team (GRAT)⌖ ~~by~~ to provide ~~ing 1 FTE geriatric MH outreach specialist, 1 FTE geriatric CD outreach specialist, 1 geriatric CD trainee, and 1 .6 FTE nurse~~(services to 340 ~~3,400 cts/yr).~~total clients per year. 2. In response to requests from police and other first responders, provide crisis intervention, functional assessments, referrals, and linkages to services.	Short-term measures: 1. Hire 1 FTE geriatric MH specialist, 1 FTE geriatric CD specialist, 1 geriatric CD trainee, and 1.6 FTE nurse ~~2. Crisis intervention and linkages to services for an additional new 3,400 cts/yr~~ 2. Increase # of older adults receiving crisis interventions~~.~~ services 3. Increase # of older adults receiving functional assessments 4. Increase # of older adults receiving referrals to outpatient MH and substance abuse treatment ~~5. # of linkages made to services~~ Longer-term measures: 5. Increase # of linkages to outpatient MH treatment for those referred 6. Increase # of linkages to outpatient substance abuse treatment for those referred 7. Reduce # of psychiatric hospital admissions and days for those served 8. Reduce # of ER ~~admissions~~ visits for those served ~~8. Reduce # of jail bookings and days for those served~~	1. Output ~~2. Output~~ 2. Output 3. Output 4. Output ~~5. Output~~ 5. Outcome 6. Outcome 7. Outcome 8. Outcome ~~8. Outcome~~	~~Agency data~~ Contract report ~~MIS~~ ~~Agency data~~ MIS (php96) ~~Agency data~~ MIS (php96) ~~Agency data~~ MIS (php96) ~~Agency data~~ MIS (php96) TARGET ~~Hospital data~~ Western State data and MIS (php96) ER data❶ ~~Jail data~~

⌖GRAT is recognized by Substance Abuse & Mental Health Services Administration (SAMHSA) as a "promising" practice model.
❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft published 9/2/2008)

Sub-Strategy	Intervention(s)/Objectives – including Target Numbers	Performance Measures	Type of Measure	Data Sources
2a – ~~Caseload~~ Workload Reduction for Mental Health Target Populations: 1) Contracted MH agencies and MH case managers 2) Consumers receiving outpatient services through King County Regional Support Network (KCRSN)	~~1. Develop strategy for addressing definition of case manager, calculation of caseload size and severity of case mix.~~ 1. Develop and implement agency-specific plans for reducing workloads that address~~es~~ variations ~~between agencies~~ in agency size, case mix, and workload allocation among agency staff. 2. Increase payment rates for MH providers in order to increase number of ~~case managers/ supervisors~~ direct services staff, ~~and~~ reduce caseloads, and increase frequency and quantity of services to consumers. ~~Specific goals for # of additions by type of staff will be set in above strategy.~~	Short-term measures: 1. Develop and implement plans that address~~es~~ variation between agencies in size, case mix, and workload allocation among agency staff 2. ~~Receive and~~ Increase # of approved individual agency~~'s~~ Workload Reduction Plans 3. Increase # of direct services staff as specified in above plans 4. Decrease case management and ~~CM/~~direct services staff workload by amount specified in plans Longer-term measures: 5. Increase services provided as specified in plans 6. Increase % of ~~persons~~ clients served within seven days of hospital discharge or jail release 7. Increase case manager job satisfaction as a result of reduced ~~case~~ workload 8. Reduce case manager turnover rates ~~Longer-term measures:~~ ~~6/7. Reduce # of jail bookings and days for adults served~~ ~~8. Reduce juvenile justice involvement for youth served~~ ~~9/10. Reduce # of psychiatric admissions and days for those served~~ ~~11. Reduce # of emergency room admissions for those served~~ ~~12. Reduce # of out of home placements for children~~	1. Output 2. Output 3. Output 4. Output 5. Outcome 6. Outcome 7.Outcome 8.Outcome ~~6/7.Outcome~~ ~~8. Outcome~~ ~~9/10.Outcome~~ ~~11. Outcome~~ ~~10.Outcome~~	MHCADSD MHCADSD ~~Agency data~~ Contract report ~~Agency data~~ Contract report MIS (php96) MIS (php96) Survey ~~Agency data~~ Contract report ~~Jail data~~ ~~JJ data~~ ~~Hospital data~~ ~~ER data~~ ~~Division of Children and Family Services (DCFS) data~~

Content revised 4/8/2010 (Previous draft amended 5/20/2009)

Strategy 2 - Improve Quality of Care				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
2b - Employment Services✪ for Individuals with Mental Illness and Chemical Dependency Target Population: Individuals receiving public mental health and/or chemical dependency services who need supported employment to obtain competitive employment	1. Provide ~~23 vocational specialists (each provider serves ~40 clients/yr) to provider fidelity-based~~ supported employment services ~~(~~such as trial work experience, job placement, and on-the-job retention ~~services~~ support~~)~~ to 920 clients per year. ~~2. Provide public assistance benefits counseling~~ 2. Provide training in vocational services to MH providers ~~first, then~~ and CD providers.	Short-term measure: 1.~~ Provide employment services to 920 clients/yr~~ Hire 23 vocational specialists (each serving ~40 clients per year) 2. Increase # of community providers trained in supported employment services Longer-term measures: 3. Increase # of enrolled MH and CD clients who receive vocational assessments 4. ~~Change in~~ Increase # ~~number~~ of enrolled MH ~~&~~ and CD clients who ~~become employed~~ receive job placements 5. Increase # ~~Number/~~ or rate of ~~individuals who become~~ employed clients who are retained in employment for at least 90 days ~~4. Decrease reliance on public assistance~~ ~~Longer-term measures:~~ ~~5. Increase housing stability (retention)~~	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome ~~4. Outcome~~ ~~5. Outcome~~	~~MIS~~ Contract report MHCADSD Contract report ~~MIS~~ Contract report ~~MIS~~ Contract report ~~Department of Social and Health Services (DSHS)~~ ~~MIS~~

✪ Supported employment services adhere to an evidence-based service model.

Content revised 7/9/2010 (Previous draft published 9/2/2008)

Strategy 3 – Increase Access to Housing				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
3a – Supportive Services for Housing Projects⌖ Target Populations: 1) ~~Persons~~ People in the public MH and CD treatment system who are homeless~~;~~ or have not been able to attain housing stability~~;~~ 2) People who are exiting jails, ~~and~~ hospitals, sobering services~~;~~ or have been seen at a crisis diversion facility and who are homeless or have not been able to attain housing stability	1. Expand on-site supportive housing services by adding housing support specialists to serve ~~an estimated 400~~ ~~140~~ 400 individuals in addition to current capacity. 2. Supportive housing services shall include housing case management, group activities, and/or general support (such as life skills assistance) hours, depending on the provider agency.	Short-term measures: 1. Increase # of housing providers accepting this target population 2. Increase # of individuals ~~served~~ receiving supportive housing services 3. Increase # of supportive housing service hours provided Longer-term measures: 4. Increase # of individuals served who remain in housing ~~stability of those served~~ for at least one year ~~4. Increase treatment participation of those served~~ 5. Increase # of linkages to outpatient MH treatment for those served 6. Increase # of linkages to outpatient substance abuse treatment for those served 7. Reduce # of jail bookings and days for those served 8. Reduce # of psychiatric hospital admissions and days for those served 9. Reduce # of days in Sobering Center for those served 10. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Output 3. Output 4. Outcome ~~4. Outcome~~ 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10.Outcome	~~Agency data~~ MHCADSD ~~Agency data~~ MIDD Tools MIDD Tools ~~MIS~~ MIDD Tools ~~MIS~~ MIS (php96) TARGET Jail data ~~Hospital data~~ Western State data and MIS (php96) Sobering data ER data❶

⌖Supportive Housing Services are based upon a "promising" practice model.
❶ Data sharing agreement(s) needed

Content revised 4/29/2010 (Previous draft amended 5/20/2009)

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
4a –Services ~~to~~ for Parents ~~Participating~~ in Substance Abuse Outpatient Treatment ~~Programs~~ Target Population: Custodial parents (and their children) participating in outpatient substance abuse treatment	1. Implement two evidence based programs (such as "Families Facing the Future"✪) to help parents in recovery become more effective parents by using relapse prevention and refusal skills in drug use situations and reduce the risk that their children will abuse drugs or alcohol. 2. ~~(~~Serve 400 parents per year~~)~~.	Short-term measures: 1. ~~Serve 400 parents per year~~ Contract with service provider to hire program staff 2. Increase parent prevention services at outpatient ~~SA~~ substance abuse treatment programs Longer-term measures: 3. ~~Improve parenting skills of those served~~ Reduce severity of CD symptoms for parents served 4. ~~Increased family communication~~ Reduce reported problem behaviors in children of parents served 5. ~~Increased positive family structure~~ Reduce reported substance use in ~~substance abuse by~~ children of parents served ~~Longer-term measures:~~ 6. Improve school attendance and performance in children of parents served ~~7. Reduce risk factors for substance abuse & other problem behaviors by children of parents served~~ ~~8. Increase protective factors for pro-social behavior by children of parents served~~	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome ~~7. Outcome~~ ~~8. Outcome~~	~~Agency data~~ Contract report ~~Agency data~~ MIDD Tools ~~TBD from contract with service provider~~ TARGET ~~TBD~~ MIDD Tools ~~TBD~~ MIDD Tools ~~TBD~~ School data❶ ~~TBD~~ ~~TBD~~

✪"Families Facing the Future" is an evidence-based program.
❶ Data sharing agreement(s) needed

Content Revised 7/12/2009 (Previous draft published 9/2/2008)

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
4b – Prevention Services to Children of Substance Abusers Target Population: Children of substance abusers and their parents~~/~~, guardians~~/~~, or kinship caregivers	1. Implement evidence-based educational/support programming✪ for children of substance abusers to reduce risk of future substance abuse and increase protective factors. 2. ~~(~~Serve 400 children per year~~)~~.	Short-term measures: 1. Contract with service provider ~~for evidence-based programs~~ to hire program staff 2. Increase ~~# children served (goal 400 per year)~~ services for children of substance abusers ~~3. Increase # activities provided by King County region~~ ~~4. Improve individual and family functioning of those served~~ Longer-term measures: 3. Improve school attendance and performance in ~~of~~ children served ~~Longer-term measures:~~ 4. Reduce ~~JJ involvement~~ # of detention admissions for ~~of~~ children served 5. Reduce reported substance abuse ~~of~~ in children served ~~6. Improve school performance of children served~~ ~~7. Improve health outcomes of children served~~ 6. Reduce risk factors for ~~substance abuse and other problem behaviors of~~ children served 7. Increase protective factors for ~~pro-social behavior of~~ children served	1. Output 2. Output ~~3. Output~~ ~~4. Outcome~~ 3.Outcome 4.Outcome 5.Outcome ~~6. Outcome~~ ~~7. Outcome~~ 6. Outcome 7. Outcome	~~Agency data~~ Contract report ~~Agency data~~ MIDD Tools ~~Agency data~~ ~~TBD from contract with service provider~~ ~~TBD (eg~~ School data~~)~~ ❶ Juvenile Justice data ~~TBD~~ MIDD Tools ~~TBD (eg School data)~~ ~~TBD~~ ~~TBD~~ MIDD Tools ~~TBD~~ MIDD Tools

✪ Programs implemented will be evidence-based.
❶ Data sharing agreement(s) needed

Content Revised 7/9/2010 (Previous draft published 9/2/2008)

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
4c – Collaborative School-~~District~~ Based Mental Health and Substance Abuse Services Target Pop: Children and youth enrolled in King County schools ~~who are~~ identified by the school as at-risk for ~~future school drop out~~ or experiencing early indicators of MH and/or substance abuse concerns.	1. Fund up to19 ~~competitive grant awards to~~ school-based health programs in partnership with mental health, chemical dependency and youth service providers to provide a continuum of mental health and substance abuse prevention services in schools for 2,268 individuals per year. 2. Review and/or develop or modify school policies and procedures to address appropriate steps for intervening with students who are at risk for suicide, including MH and/or substance abuse issues, as follows: - # of schools with current safety plans - # of schools with effective suicide prevention policies (see Strategy 4d) - List of schools and total hours spent in consultation to help schools develop or modify their policies to be more effective	Short-term measures: ~~1. 19 Grants are~~ Funded programs in school districts ~~across~~ throughout King County 2. Hire clinicians/credentialed professionals for each program 3. Increase # of youth and their families receiving MH and/or CD screening, early intervention, and referral to treatment services through on-site school-based programs Longer-term measures: 4. Improved school performance (grades) ~~for~~ in youth served ~~4. Improved school attendance for youth served~~ 5. Reduce # of school suspensions and detentions in youth served 6. Increase protective factors for youth served 7. Reduce risk factors for youth served 8. ~~Decrease in~~ Reduce # of truancy petitions filed for youth served ~~Long-term measures:~~ 9. ~~Decrease in JJ involvement for youth served~~ Reduce # of detention admissions for those served ~~6. Decrease use of psychiatric hospitalization for youth served~~ ~~7. Decrease use of emergency medical system for youth served~~	1. Output 2. Outcome 3. Outcome 4.Outcome ~~4.Outcome~~ 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome ~~6. Outcome~~ ~~7. Outcome~~	MHCADSD Contract report ~~Agency/School data~~ Contract report School data❶ ~~School data~~ School data❶ MIDD Tools MIDD Tools School~~/JJ~~ and Juvenile Justice data ~~JJ~~ Juvenile Justice data ~~Hospital data~~ ~~ER data~~

❶ Data sharing agreement(s) needed

Content Revised 6/4/2010 (Previous draft published 9/2/2008)

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
4d – School-Based Suicide Prevention Target Population: King County public, private and alternative school students, ~~including alternative schools students,~~ age 12-19 years, school staff and administrators, and the students' parents and guardians	1. Fund staff to provide suicide awareness and prevention training to ~~children~~ youth, school administrators, teachers and parents to include: • 130 suicide awareness presentations for 3,250 students per year • ~~12~~ 40 adult presentations with ~~200~~ 1,500 participants per year including: - Teacher training - Parent education 2. Review and/or develop~~ing~~ or modify school policies and procedures to address appropriate steps for intervening with students who are at risk for suicide as follows: - # of schools with current suicide prevention policies TBD - # of schools with effective suicide prevention policies (as noted by the Crisis Response Plan Document Review) TBD - List of schools and total hours spent in consultation to help schools develop or modify their policies to be more effective TBD	Short-term measures: 1. Hire 3 FTE~~s~~ educators to provide suicide awareness and prevention training~~s to children, administrators, teachers, and parents~~ 2. Increase # of suicide awareness trainings for students 3. Increase # of ~~teacher~~ adult trainings ~~4. Increase # of parent education trainings~~ 4. Increase # of schools with current suicide prevention policies ~~and procedures addressing appropriate steps for intervening with students who are at-risk for suicide~~ 5. Increase # of schools with effective suicide prevention policies 6. Increase hours of consultation to help schools develop or modify policies to be more effective ~~6. Increased awareness of the warning signs and symptoms of suicide for students, teachers, and parents~~ ~~7. Increase # of at-risk youth referred and linked to treatment~~ Longer-term measures: 7. Demonstrate effectiveness of youth and adult curriculum delivery for increasing knowledge and/or awareness of youth suicide prevention resources and issues ~~8. Decrease # of suicides and suicide attempts of youth served~~ ~~9. Decreased suicidal ideation among youth served~~ ~~10. Decreased depression and/or depressive symptoms among youth served~~ ~~11. Increased help seeking behavior among target population~~ ~~12. Decreased risk factors for suicide among target population~~ ~~13. Increased protective factors for suicide prevention among target population~~	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output ~~6. Outcome~~ 7. Outcome ~~8. Outcome~~ ~~9. Outcome~~ ~~10. Outcome~~ ~~11.Outcome~~ ~~12.Outcome~~ ~~13.Outcome~~	~~Agency data~~ Contract report ~~Agency data~~ Contract report Contract report ~~Agency data~~ ~~Agency data~~ Contract report Contract report Contract report ~~TBD – pre/post survey~~ Training evaluations ~~???????~~ ~~Healthy Youth Survey~~ ~~Healthy Youth Survey~~ ~~Healthy Youth Survey~~ ~~Healthy Youth Survey~~ ~~Healthy Youth Survey~~

Content revised 5/3/2010 (Previous draft amended 5/20/2009)

Strategy 5 - Expand Assessments for Youth in the Juvenile Justice System				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
5a – Increase Capacity for Social and Psychological Assessments for Juvenile Justice Youth Target Population: Youth aged 12 years or older who have become involved with the juvenile justice (JJ) system (including non-offender youth involved with the Becca truancy process)	1. Hire administrative and clinical staff to enhance and expand the capacity for social and psychological assessments, substance abuse assessment, and other specialty evaluations (~~i.e.~~e.g., psychiatric, forensic, neurological, etc.) for juvenile justice involved youth. 2. Screening and assessment of up to 1,230 youth per year including the following: a. 75 psychiatric consultations b. 200 psychological evaluations or consultations c. 140 additional mental health assessments d. 165 additional chemical dependency evaluations (Global Appraisal of Individual Needs – Initial or GAIN-I)	Short-term measures: 1. ~~1 FTE CDP hired to provide an additional 280 GAIN assessments per year~~ Hire 1 FTE program coordinator 2. ~~1 FTE MH Liaison hired to provide an additional 200 MH assessments per year~~ Hire up to 3 assessment professionals (i.e., psychologist, mental health professional and chemical dependency professional) Longer-term measures: 3. Increase # of youth involved in JJ completing a GAIN assessment 4. Increase # of youth involved in JJ completing a MH assessment or specialty evaluation 5. ~~Increase # of JJ involved youth linked to CD treatment~~ Increase # of linkages to outpatient MH treatment for those referred 6. ~~Increase # of JJ involved youth linked to MH treatment~~ Increase # of linkages to outpatient substance abuse treatment for those referred ~~Long-term measures:~~ 7. ~~Reduction in recidivism rates~~ Reduce # of detention admissions for youth linked to CD and/or MH treatment ~~7. Increase # of JJ involved youth receiving a psychiatric evaluation~~ ~~Longer-term measures:~~ ~~9. Reduction is substance use for youth served~~ ~~10. Increased retention in CD & MH treatment for youth referred~~	1. Output 2. Output 3. ~~Output~~ Outcome 4. ~~Output~~ Outcome 5. ~~Output~~ Outcome 6. ~~Output~~ Outcome 7.Outcome ~~7. Output~~ ~~9. Outcome~~ ~~10.Outcome~~	~~MHCADSD~~ Contract report ~~MHCADSD~~ Contract report ~~MHCADSD~~ Assessments.com ~~Agency data~~ MIDD Tools ~~Agency data /MIS~~ MIS (php96) ~~Agency data /Target data~~ TARGET ~~JJ~~ Juvenile Justice data ~~TBD – JJ or Agency data~~ ~~TBD~~ ~~TBD~~

Note: Performance measures 9 and 10 were removed in an unpublished draft revision dated 3/17/2009.

Content revised 5/19/2010 (Previous draft published 9/2/2008)

Strategy 6 - Expand Wraparound Services for Youth				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
6a - Wraparound Family, Professional, and Natural Support Services for Emotionally Disturbed Youth Target Population: Emotionally and/or behaviorally disturbed children and/or youth (up to the age of 21) and their families who receive services from two or more of the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, developmental disabilities and/or special education programs, and who would benefit from high fidelity wraparound	~~1. 40 additional wraparound facilitators and 5 wraparound supervisors/ coaches.~~ ~~2. Provide wraparound orientation to community on a quarterly basis.~~ ~~3. Flexible funding available to individual child and family teams.~~ 1. Expand wraparound services by developing five new wraparound teams consisting of 1 coach, 6 facilitators, and 2 parent partners each. 2. Provide wraparound services to an additional 920 youth and families per year.	Short-term measures: 1.~~ Provide wraparound to an additional 920 youth and families per year~~ Hire 1 FTE wraparound coordinator 2. ~~# of trainings provided annually~~ Increase wraparound service delivery Longer-term measures: 3. Improve~~d~~ school attendance and performance ~~for~~ among youth served 4. Reduce~~d drug and alcohol~~ reported substance use for youth served 5. Improve~~ment in~~ functioning at home, school, and community for youth served 6. Increase~~d~~ community connections and utilization of natural supports by youth and families served 7. Maintain stability of ~~current placement~~ living situation for youth served ~~Longer-term measures:~~ 8. Reduce~~d juvenile justice involvement~~ # of detention admissions for youth served ~~9. Improved high school graduation rates for youth served~~	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7.Outcome 8.Outcome ~~9.Outcome~~	~~MIS~~ MHCADSD ~~MHCADSD~~ Contract report ~~School data/survey~~ MIDD Tools ~~TBD – survey~~ MIDD Tools ~~TBD – survey~~ MIDD Tools ~~TBD - survey~~ Fidelity monitoring ~~Agency/DCFS data~~ MIDD Tools ~~JJ~~ Juvenile Justice data ~~TBD~~

Content revised 4/7/2010 (Previous draft published 9/2/2008)

Strategy 7 - Expand Services for Youth in Crisis				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
7a - Reception Centers for Youth in Crisis Target Population: Youth who have been arrested, are ineligible for detention, and do not have a readily available parent or guardian and are experiencing a MH and/or substance abuse crisis	1. Conduct a comprehensive needs assessment to ~~determine most appropriate interventions to provide police officers with more options when interacting with~~ identify alternatives to arrest for runaways and minor youth who ~~may be~~ are experiencing mental health and/or substance abuse problems and who come to the attention of law enforcement personnel. 2. Create a coordinated response/entry system for the target population that allows law enforcement and other first responders to link youth to the appropriate services in a timely manner. 3. Develop an enhanced array of services for the target population as deemed appropriate by the needs assessment.	Short-term measures: 1. Complete a needs assessment in conjunction with Strategy 7b to determine appropriate strategies to meet goals 2. Implement~~ation of~~ strategies as identified through needs assessment Longer-term measures: 3. Reduce # of detention admissions ~~in juvenile detention facilities~~ for ~~youth~~ those served 4. Reduce # of psychiatric hospital admissions and days for ~~youth~~ those served 5. Reduce # of ER ~~admissions~~ visits for ~~youth~~ those served ~~6. Decrease homelessness for youth served~~ ~~7. Reduction in risk factors for delinquency for youth served~~ ~~8. Increased protective factors for pro-social behavior for youth served~~	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome ~~6. Outcome~~ ~~7. Outcome~~ ~~8. Outcome~~	MHCADSD MHCADSD ~~JJ~~ Juvenile Justice data ~~TBD~~ CLIP data and MIS (php96) ~~ER/Hospital data~~ ER data❶ ~~TBD~~ ~~TBD~~ ~~TBD~~

❶ Data sharing agreement(s) needed

Content revised 8/5/2010 (Previous draft published 9/2/2008)

Strategy 7 - Expand Services for Youth in Crisis				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
7b - Expanded Crisis Outreach and Stabilization for Children, Youth, and Families Target Populations: 1) Children and youth aged 3-17 who are currently in King County and who are experiencing a mental health crisis ~~This includes children, youth, and families where the functioning of the child and/or 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 2) Children and youth being discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement	1. Conduct a needs assessment in conjunction with the needs assessment for sub-strategy 7a to determine additional capacity and resources needed to develop the full continuum of crisis options within the Children's Crisis Outreach Response System (CCORS) program. 2. Expand current ~~Children's Crisis Outreach Response System (~~CCORS~~)~~ program to provide crisis outreach and stabilization to additional youth and families, including those involved in the JJ system and/or at risk for placement in juvenile detention due to emotional and behavioral problems.	Short-term measures: 1. ~~Conduct~~ Complete a needs assessment in conjunction with strategy 7a to determine appropriate strategies to meet goals ~~additional capacity and resource needed to develop the full continuum of crisis options within the CCORS program~~ 2. Increase # of youth in King County receiving crisis stabilization within the home environment 3. Maintain # of youth who remain in current living placement for ~~youth~~ those served Longer-term measures: 4. Reduce # of detention admissions for youth served 5. Reduce # of psychiatric hospital admissions and days for youth served 6. Reduce # of requests for placement in child welfare system for youth served 7. Reduce # of ER ~~admissions~~ visits for youth served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	MHCADSD MIS (php96) ~~Agency data~~ MIDD Tools ~~JJ~~ Juvenile Justice data ~~Hospital data/MIS~~ CLIP data and MIS (php96) ~~Agency data/DCFS data~~ MIDD Tools ER data❶

❶ Data sharing agreement(s) needed

Content revised 8/5/2010 (Previous draft published 9/2/2008)

Strategy 8 - Expand Family Treatment Court				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
8a - Expand Family Treatment Court (FTC) Services and Support to Parents Target Population: Parents in the child welfare system who are identified as being chemically dependent and who have had their child(ren) removed due to their substance use	1. Sustain and expand capacity of the ~~Family Treatment Court (~~FTC~~)~~ model to benefit up to 45 additional children per year. 2. Enroll up to 15 additional FTC families per year in FTC wraparound services.	Short-term measure: 1. Hire 3.5 FTE staff to expand family treatment court capacity ~~to serve up to 45 additional children per year~~ ~~2. Eligibility/enrollment completed quickly (timeframe TBD)~~ Longer-term measures: 2. Reduce # of days between 72-hour hearing and acceptance hearing dates 3. Increase # of FTC parents who are enrolled in CD services 4. Increase # of FTC parents ~~served~~ who ~~are compliant with/~~complete CD treatment 5. Increase # of FTC families enrolled in ~~wraparound~~ FTC wraparound services 6. ~~Decrease in substance use~~ Reduce severity of CD symptoms for parents served 7. Reduce # of jail bookings and days for parents served ~~5. Parents/children received needed services~~ ~~6. Parents are compliant with court orders~~ ~~7. Decreased placement disruptions~~ ~~8. Earlier determination of alternative placement options~~ ~~9. Increase in after care plan/connection to services~~ ~~Longer-term measures:~~ ~~11. Increased family reunification rates~~ ~~12. Decrease subsequent out-of-home placements and/or Child Protection Services (CPS) involvement~~ ~~13. Reduction in juvenile justice system involvement for children served through FTC~~ ~~14. Reduction in substance abuse for children served through FTC~~ ~~15. Reduction of risk factors for substance abuse and other problem behaviors of children served~~ ~~16. Increased protective factors for pro-social behavior of children served~~	1. Output ~~2. Output~~ 2. Outcome ~~3. Output~~ 3. Outcome ~~4. Output~~ 4. Outcome 5. Outcome 6. Outcome 7. Outcome ~~5. Output~~ ~~6. Outcome~~ ~~7. Outcome~~ ~~8. Outcome~~ ~~9. Outcome~~ ~~11.Outcome~~ ~~12.Outcome~~ ~~13.Outcome~~ ~~14.Outcome~~ ~~15.Outcome~~ ~~16.Outcome~~	~~Superior Court~~ Contract report ~~TBD~~ MIDD Tools ~~TARGET~~ MIDD Tools ~~TARGET~~ MIDD Tools ~~VCCC MIS~~ MIDD Tools ~~TBD~~ TARGET❶ Jail data ~~TBD~~ ~~Superior Court~~ ~~Superior Court/DCFS~~ ~~TBD~~ ~~TBD~~ ~~DCFS data~~ ~~DCFS data~~ ~~JJ data~~ ~~TARGET/Survey~~ ~~TBD~~ ~~TBD~~

❶ Database revisions needed

Note: Evaluation plan eliminated numerous performance measures in an unpublished draft revision dated 3/26/2009.

Content revised 7/9/2010 (Previous draft amended 5/20/2009)

Strategy 9 - Expand Juvenile Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
9a - Expand Juvenile Drug Court (JDC) Treatment Target Population: Youth involved in the JJ system who are identified as having substance abuse issues or are diagnosed chemically dependent	1. Maintain and expand capacity of the Juvenile Drug Court ~~(JDC)~~ model to enroll up to 36 additional youth per year.	Short-term measures: 1. Hire 5.5 FTE staff to expand juvenile drug court capacity~~ to serve an additional 36 chemically dependent youth per year~~ Longer-term measures: 2. Increase # of JDC youth ~~involved in JDC~~ linked to ~~drug/alcohol~~ substance abuse treatment 3. Increase # of JDC youth ~~involved in JDC~~ completing ~~drug/alcohol~~ substance abuse treatment ~~4. Reduce # of days spent in detention for youth involved in juvenile drug court~~ ~~Longer-term measures:~~ 4. Reduce # of detention admissions ~~juvenile recidivism rates~~ for youth completing juvenile drug court 5. Reduce substance abuse~~/dependency~~ and severity of CD symptoms for JDC youth ~~involved in drug court~~ served ~~6. Reduce risk factors for substance abuse and other problem behaviors of youth served~~ ~~7. Increase protective factors for prosocial behavior of youth serve~~	1. Output ~~2. Output~~ 2. Outcome 3. Outcome 4. Outcome 5. Outcome ~~6. Outcome~~ ~~7. Outcome~~	~~Superior Court~~ Contract report ~~Superior Court or TARGET data~~ MIDD Tools TARGET ~~data~~ ~~JJ data~~ ~~JJ~~ Juvenile Justice data ~~TBD~~ Assessments.com and MIDD Tools ~~TBD~~ ~~TBD~~

Content revised 7/12/2010 (Previous draft amended 5/20/2009)

Strategy 10 - Pre-Booking Diversion				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
10a - Crisis Intervention Training Program for King County Sheriff, Police, Jail Staff, and Other First Responders Target Population: King County (KC) Sheriff, police, firefighters, emergency medical technicians, ambulance drivers, jail staff, and other first responders *and* clients	1. Crisis intervention training (CIT) for KC Sheriff, police, firefighters, emergency medical technicians, ambulance drivers, jail staff, and other first responders including the following: a. ~~2.~~ ~~Provide~~ 40-hour CIT training to ~~480~~ 375 police and other first responders per year, and b. ~~3.~~ ~~Provide~~ One-day CIT training to ~~1,200~~ 1,000 other officers and other first responders.	Short-term measures: 1. Contract with the Washington State Criminal Justice Training Commission (WSCJTC) to provide trainings 2. Hire 1 FTE police sergeant ~~educator/consultant II or III~~ 3. Hire 1 FTE administrative/fiscal specialist ~~II~~ ~~3. Provide 40-hr CIT training to 480 police and other first responders per year~~ ~~4. Provide one-day CIT training to 1,200 other officers and other first responders per year~~ 4. Increase # of KC Sheriff, police, jail staff, and other first responders ~~given~~ attending training Longer-term measures: 5. Self-report of training effectiveness/ skills learned 6. Increase support for treatment services for individuals with MH and/or CD needs among CIT trainees 7. Increase CIT trainee knowledge of ~~individuals with~~ MH and/or CD illnesses 8. Reduce CIT trainees~~'~~ stigma toward individuals with MH and/or CD illnesses ~~Long-term measures:~~ ~~10. Increased use of diversion options for those served~~ ~~11. Reduce # of jail bookings for those served~~ ~~12. Reduce # of days in jail for those served~~ ~~13. Reduce # of ER admissions for those served~~ ~~14. Reduce # of psychiatric hospital admissions for those served~~ ~~15. Reduce # of psychiatric hospital days for those served~~	1. Output 2. Output 3. Output ~~3. Output~~ ~~4. Output~~ 4. Output 5. Outcome 6. Outcome 7. Outcome 8. Outcome ~~10.Outcome~~ ~~11.Outcome~~ ~~12.Outcome~~ ~~13.Outcome~~ ~~14.Outcome~~ ~~15.Outcome~~	MHCADSD ~~Agency data~~ Contract report ~~Agency data~~ Contract report ~~Agency data~~ ~~Agency data~~ ~~Agency data~~ Contract report Training evaluations ~~CIT p~~ Pre/post survey ~~CIT p~~ Pre/post survey ~~CIT p~~ Pre/post survey ~~TBD~~ ~~Jail data~~ ~~Jail data~~ ~~ER data~~ ~~Hospital data~~ ~~Hospital data~~

Content revised 7/12/2010 (Previous draft published 9/2/2008)

Strategy 10 - Pre-Booking Diversion				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
10b- Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team Target Populations: 1) Adults in crisis in the community who might otherwise be arrested for minor crimes and taken to jail or to a hospital emergency department 2) Individuals who have been seen in emergency departments or at jail booking and who are ready for discharge but still in crisis and in need of services ~~Target population will be refined during the planning process~~ Note: Exclusionary criteria for admission will include criminal charge or criminal history criteria and medical/behavioral criteria, as recommended by target population workgroups	~~1. Increase number of respite beds~~ 1. Create a Crisis Diversion ~~Center~~ Facility (CDF) ~~for~~ where police and crisis responders may divert adults in crisis. 2. Create a Crisis Diversion Interim Services (CDIS), a respite program for consumers to transfer to after a crisis has resolved at the CDF and their shelter situation may be dangerous or have the potential to send him/her into crisis again. 3. Create a Mobile Crisis Team (MCT) of MH and CD specialists to evaluate, refer and link clients to services. 4. Serve at least 3,000 adults per year when all strategy components are implemented	Short-term measures: 1. Contract with community agencies to provide: a CDF, a CDIS program, and a MCT 2. Increase # of respite beds available to adults in crisis 3. Increase # of referrals for individuals to needed outpatient MH and substance abuse treatment services ~~1. Serve ~3,600 adults/year (xx # depends on when different components implemented)~~ ~~2. Successfully link xx% of those seen by 10b services to MH and/or CD services (benchmark to be determined during contracting)~~ ~~3. Increase # of respite beds~~ ~~4. Mobile crisis team of MH & CD specialists is created~~ ~~5. Crisis diversion center for police and crisis responders is created~~ Longer-term measures: 4. Increase # of linkages to outpatient MH treatment for those referred 5. Increase # of linkages to outpatient substance abuse treatment for those referred 6. Reduce # of jail bookings and days for those served 7. Reduce # of psychiatric hospital admissions and days for those served 8. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Output 3. Output ~~1. Output~~ ~~2. Outcome~~ ~~3. Output~~ ~~4. Output~~ ~~5. Output~~ 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8.Outcome	MHCADSD Contract reports MIDD Tools ~~MIS~~ ~~MIS and TARGET data~~ ~~MHCADSD~~ ~~MHCADSD~~ ~~MHCADSD~~ MIS (php96) TARGET Jail data ~~Hospital data~~ Western State data and MIS (php96) ER data❶

❶ Data sharing agreement(s) needed

Content revised 7/9/2010 (Previous draft published 9/2/2008)

Strategy 11 - Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
11a - Increase Capacity of Jail Liaison Program Target Pop: King County Work Release (WER) inmates who are residents of King County or likely to be homeless within King County upon release from custody, and who are assessed as needing mental health services, chemical dependency treatment, other human services, or housing upon release	1. ~~One additional~~ Increase jail liaison capacity to handle increased mental health ~~courts~~ caseloads ~~as designed under MIDD~~. 2. Provide liaison~~s~~ ~~linked~~ services to 200 additional inmates per year who are within 10-45 days from release. Liaison services to include referrals to: community-based MH, CD, ~~medical services and~~ housing, legal, education or employment, and Veteran's programs.	Short-term measures: ~~1. Serve 360 additional clients via liaison~~ 1. Hire 1 FTE jail liaison at WER ~~2. Assist target population in applying for DSHS benefits when they are within 45 days of discharge~~ ~~3. Refer veterans to Veterans Reintegration Services~~ 2. Increase # of referrals to needed outpatient MH and substance abuse treatment, housing, and community resources for those served Longer-term measures: 3. Increase # of linkages to outpatient MH treatment for those referred 4. Increase # of linkages to outpatient substance abuse treatment for those referred 5. Increase # of linkages to permanent housing placements for those referred 4. ~~Successfully link xx% of those seen by liaison to MH and/or CD services (benchmark to be determined through contracting)~~ ~~5. Improve rates of target population being placed in housing (temporary or permanent) upon discharge~~ ~~Longer-term measures:~~ 6. Reduce # of jail bookings and days for those served	 ~~1. Output~~ 1. Output ~~2. Outcome~~ ~~3. Outcome~~ 2. Output 3. Outcome 4. Outcome 5. Outcome ~~4. Outcome~~ ~~5. Outcome~~ 6. Outcome	 ~~CJ liaison Excel~~ Contract report ~~CJ liaison Excel~~ ~~TBD~~ MIDD Tools MIS (php96) TARGET Integrated DB or Safe Harbors❶ ~~MIS and TARGET~~ ~~TBD~~ Jail data

❶ Data sharing agreement(s) needed

Content revised 5/5/2010 (Previous draft published 9/2/2008)

Strategy 11 - Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
11b - Increase Services Available for New or Existing Mental Health Court (MHC) Programs Target Population: 1) Adult misdemeanants with serious mental illness who opt-in to the mental health court and those who are unable to opt-in because of their lack of legal competency 2) Access to participate will ~~also~~ be developed for individuals in court jurisdictions in all parts of King County	~~1. Add court liaison/monitor and peer support specialist to existing mental health court and/or develop new municipal mental health courts.~~ ~~2. Other components may include increases in dedicated service capacity for mental health and co-occurring disorder treatment, housing, and access to community treatment providers.~~ Strategy is on hold and will be rewritten. 1. Expand MHC programs to serve ~~250~~ 115 additional clients per year (over ~~300/~~ 200 per yr current capacity). 2. Make MHC services available to any misdemeanor offender in King County who is mentally ill, regardless of where the offense is committed.	Short-term measures: ~~1. Serve 250 additional clients/year (over 300/yr current capacity)~~ ~~2. Successfully engage 90% of those seen to MH and/or CD services~~ 1. Hire regional MHC staff 2. Increase # of MHC clients referred from King County municipalities for screening 3. Increase # of referrals to needed outpatient MH treatment Longer-term measures: 4. Increase # of linkages to outpatient MH treatment for those referred 5. Reduce severity of MH symptoms for those linked to outpatient MH treatment 6. Increase # of clients with housing at exit 7. Increase # of clients with employment at exit 8. Reduce # of jail bookings and days for those served	~~1. Output~~ ~~2. Outcome~~ 1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	~~Data from courts - TBD~~ ~~MIS and TARGET combined with data from courts – TBD~~ Contract report Contract report MIS (php96) or MIDD Tools MIS (php96) MIS (php96) and MIDD Tools MIDD Tools MIDD Tools Jail data

Content revised 7/12/2010 (Previous draft amended 5/20/2009)

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
12a1 - Increase Jail Re-Entry Program Capacity Target Population: King County jail inmates who are residents of King County or likely to be homeless within King County upon release from custody, and who are assessed as needing mental health services, chemical dependency treatment, other human services, or housing upon release	~~1. Add four re-entry case managers~~ 1. Increase jail re-entry capacity to handle increased mental health caseloads. 2. Provide re-entry case management services to ~~1,440~~ 300 additional clients ~~served~~ per year ~~(over current capacity of 900/yr)~~. Case management services to include referrals to: community-based MH, CD, housing, legal, education or employment, and Veteran's programs.	Short-term measures: 1. ~~Add four~~ Hire 3 re-entry case managers ~~1. Serve 1,440 additional clients served (over current capacity of 900/yr)~~ ~~2. Successfully link xx% of those seen by liaison to MH and/or CD services~~ 2. Increase # of referrals to needed outpatient MH and substance abuse treatment, housing, and community resources for those served Longer-term measures: 3. Increase # of linkages to outpatient MH treatment for those referred 4. Increase # of linkages to outpatient substance abuse treatment for those referred 5. Increase # of linkages to permanent housing placements for those referred 6. Reduce # of jail bookings and days for those served by liaison ~~4. House xx% of homeless individuals served~~	1. Output ~~2. Outcome~~ 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome ~~4. Outcome~~	Contract report ~~CCAP Excel~~ ~~MIS and/or TARGET data~~ MIS (php96) MIS (php96) TARGET Integrated DB or Safe Harbors❶ Jail data ~~CCAP Excel~~
12a2 - Increase Community Corrections Re-Entry Program Capacity Target Population: Adult defendants and offenders participating in Community Corrections Department (CCD) programs who are in need of life skills training, domestic violence education, and/or other education services	1. Provide classes to 600 CCD participants per year. Classes to include: Life-Skills-to-Work, General Educational Development (GED) preparation, and domestic violence education at Community Center for Alternative Programs (CCAP) facilities.	Short-term measure: 1. Subcontract to provide classes for CCD participants Longer-term measures: 2. Increase # of CCD participants taking classes 3. Reduce # of jail bookings and days for those served by liaison	1. Output 2. Outcome 3. Outcome	Contract report MIDD Tools Jail data

❶ Data sharing agreement(s) needed

Content revised 7/21/2010 (Previous draft published 9/2/2008)

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
12b - Hospital Re-Entry Respite Beds Target Population: Homeless persons with mental illness and/or chemical dependency who require short-term medical care upon discharge from hospitals	1. Create hospital re-entry respite beds. 2. Serve 350-500 clients per year.	Short-term measures: 1. Increase # of re-entry respite beds available to King County residents Longer-term measures: 2. Reduce # of jail bookings and days for those served 3. Reduce # of psychiatric hospital admissions and days for those served 4. Reduce # of ER ~~admissions~~ visits for those served ~~5. Reduce hospitalization costs for those served~~	1. Output 2. Outcome 3. Outcome 4. Outcome ~~5. Outcome~~	MHCADSD Jail data ~~Hospital Records~~ Western State data and MIS (php96) ER data❶ ~~Hospital Records~~

❶ Data sharing agreement(s) needed

Content revised 5/6/2010 (Previous draft published 9/2/2008)

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
12c - Increase Capacity for Harborview's Psychiatric Emergency Services (PES) to Link Individuals to Community-Based Services upon Discharge from the Emergency Room Target pop: Adults who are frequent users of the Harborview Medical Center's PES	~~1. Hire 2 MH/CD staff and 1 program assistant.~~ 1. ~~Build~~ Increase Harborview's capacity to link individuals to community-based services upon discharge from the ER. 2. Serve ~~750-1000 cts/yr.~~ 75-100 clients per year through intensive case management program.	Short-term measures: 1. Hire 2 MH/CD staff and 1 program assistant ~~serving 750-1000 cts/yr~~ 2. Increase # of referrals to needed outpatient MH and substance abuse treatment, housing, and community resources for those served Longer-term measures: 3. Increase # of linkages ~~made~~ to ~~services~~ outpatient MH treatment for those referred 4. Increase # of linkages to outpatient substance abuse treatment for those referred 5. Increase # of linkages to permanent housing placements for those referred 6. Reduce # of jail bookings and days for those served 7. Reduce # of psychiatric hospital admissions and days for those served 8. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	~~Agency data~~ Contract report ~~Agency data~~ MIS (php96) ~~Agency data~~ MIS (php96) TARGET Integrated DB or Safe Harbors❶ Jail data ~~Hospital data~~ Western State data and MIS (php96) ER data❶

❶ Data sharing agreement(s) needed

Content revised 5/6/2010 (Previous draft published 9/2/2008)

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
~~**12d** - Urinalysis Supervision for CCAP Clients~~ ~~Target Pop: CCAP clients who are mandated by Superior Court or District Court to report to CCAP and participate in treatment~~ ~~As of 5/20/2009:~~ **12d** – Behavior Modification Classes for Community Center for Alternative Programs (CCAP) Clients Target Population: CCAP clients who have been mandated by Superior Court or District Court to report daily to CCAP and participate in treatment of general population classes.	~~1. Hire urinalysis technician(s) to provide on-site analyses for both male and female clients of CCAP. Urinalyses will be done for those who are ordered by the court to have one or more urine samples taken and analyzed each month.~~ ~~Currently being negotiated with CCAP.~~ 1. Provide behavior modification outpatient treatment✪ to CCAP clients, including: a. Rational emotive behavioral therapy, b. Moral reconation therapy, c. Cognitive behavioral therapy, and d. Dialectical behavioral therapy. 2. Serve 100 participants per year.	~~Short-term measures:~~ ~~1. New urinalysis technician(s) provide 2,700 UAs/yr – no change in current capacity~~ ~~2. Increase "efficiency" in CCAP operations~~ ~~3. Decreased CCAP staff time dedicated to this service~~ ~~4. Assure gender-specific staff is available for the collection of urine samples~~ ~~TBD~~ Short-term measures: 1. Subcontract to provide behavior modification classes at CCAP 2. Increase # of clients participating in behavior modification classes Longer-term measures: 3. Reduce severity of MH symptoms for those served 4. Reduce severity of CD symptoms for those served 5. Reduce # of jail bookings and days for those served	~~1. Output~~ ~~2. Output~~ ~~3. Output~~ ~~4. Output~~ ~~TBD~~ 1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome	~~TBD - e.g., CCAP reports~~ ~~TBD - e.g., CCAP reports~~ ~~TBD - e.g., CCAP reports~~ ~~TBD - e.g., CCAP reports~~ ~~TBD~~ Contract report MIS (php96) MIS (php96) MIS (php96) Jail data

✪All behavior modification therapies provided are evidence-based practices.

Content revised 5/6/2010 (Previous draft amended 5/20/2009)

Strategy 13 – Domestic Violence Prevention				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
13a – Domestic Violence (DV)/Mental Health Services and System Coordination Target Populations: 1) DV survivors who are experiencing mental health and substance abuse concerns but have been unable to access mental health or substance abuse services due to barriers 2) Providers at sexual assault, mental health, substance abuse, and DV agencies who work with DV survivors and participate in ~~the~~ cross program coordination and ~~cross~~ training ~~of programs~~	1. ~~3~~ Provide mental health ~~professionals (MHPs) will be added to~~ services, including culturally-specific services, at community-based DV agencies. ~~2. A .5 MHP will be housed at an agency serving immigrant and refugee survivors of DV.~~ 2. ~~MHPs will~~ Provide assessment and MH treatment to 700-800 DV survivors per year. Treatment includes brief therapy and MH support through group and/or individual sessions. 3. ~~MHPs will~~ Provide assessment and referrals to community MH and CD agencies for those DV survivors who need more intensive services. 4. ~~MHPs will~~ Offer cross-issue consultation to DV advocacy staff and staff of community MH ~~or~~ and CD agencies. 5. ~~A .5 Systems Coordinator/Trainer will~~ Coordinate ongoing cross training, policy development, and consultation on DV issues between MH, CD, and DV county agencies, training up to 200 counselors/advocates per year.	Short-term measures: 1. Hire 3 mental health professionals (MHPs) within community-based DV agencies 2. Hire .5 FTE MHP housed at culturally-specific provider of ~~sexual assault~~ DV advocacy services 3. Hire .5 FTE Systems Coordinator/Trainer ~~4. Interpreters hired~~ ~~5. 175-200 clients served per year~~ ~~6. 200 counselors/advocates trained per yr~~ 4. Increase ~~access to~~ # of DV survivors screened for, provided, and referred to MH/CD treatment services ~~for DV survivors~~ 5. Increase # of DV survivors from immigrant and refugee communities provided culturally-relevant MH services ~~provided to DV survivors from immigrant and refugee communities~~ in their own language ~~9. Consistent screening for DV among participating MH and CD agencies~~ ~~10. Consistent screening for MH and CD needs~~ ~~11. Increased referrals to DV providers~~ Long-term measures: 6. ~~Development of new~~ Increase # of policies in DV agencies that are responsive to survivors' MH and ~~CD~~ substance abuse concerns and ~~13. I~~ increase~~d~~ coordination and collaboration between MH, substance abuse, DV, and sexual assault service providers 7. Increase # of cross-agency trainings 8. Decreased ~~trauma symptoms and~~ depression ~~among DV survivors~~ for those served 9. Increased ~~resiliency and~~ coping skills ~~among DV survivors~~ for those served	1. Output 2. Output 3. Output ~~4. Output~~ ~~5. Output~~ ~~6. Output~~ 4. Output 5. Output ~~9. Output~~ ~~10. Output~~ ~~11. Output~~ 6. Output ~~13. Output~~ 7. Outcome 8.Outcome 9.Outcome	~~Agency data~~ Contract reports ~~Agency data~~ Contract reports ~~Agency data~~ Contract reports ~~Agency data~~ ~~MIS~~ ~~MHCADSD~~ ~~MIS~~ Contract reports and MIDD Tools ~~Agency data~~ MIDD Tools ~~Agency data~~ ~~Agency data~~ ~~Agency data~~ ~~TBD~~ Contract report ~~TBD~~ Contract report ~~TBD (e.g., survey)~~ MIDD Tools ~~TBD (e.g., survey)~~ MIDD Tools

Content revised 5/6/2010 (Previous draft published 9/2/2008)

Strategy 13 – Domestic Violence Prevention				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
13b – Provide Early Intervention for Children Experiencing Domestic Violence (DV) and for their Supportive Parent Target Population: Children who have experienced DV and their supportive parents	1. ~~A DV response team will~~ Provide MH and advocacy services to children (ages 0-12) in 85 families who have experienced DV. 2. Staff a DV response team ~~will~~ to provide support, advocacy, and parent education to the non-violent parent. 3. Provide children's ~~therapy~~ MH services✪ ~~will~~ that include trauma-focused cognitive behavioral therapy, intensive in-home services, ~~as well as~~ and Kids Club, a group therapy intervention for children experiencing DV. 4. Serve families ~~will be~~ referred through the DV Protection Order Advocacy program, as well as through partner agencies. ~~(goal is to serve approx 85 families with 150 children)~~	Short-term measures: 1. Hire 1 lead clinician ~~will be added~~ at Sound Mental Health 2. Hire 2 FTE DV Advocates ~~will be added~~ at ~~the~~ subcontractor agencies ~~3. DV services to approx 150 children~~ 3. Increase # of DV early intervention service hours delivered to families Longer-term measures: ~~4. Decrease children's trauma symptoms for children receiving TF-CBT~~ 5. Reduce severity of MH symptoms* for children served ~~children's externalizing behaviors~~ ~~6. Reduce children's internalizing behaviors~~ 6. Increase # of children/families successfully completing MH treatment 7. Increase protective/resiliency factors available to children and their supportive parents 8. Reduce children's negative beliefs related to DV, including that the violence is their fault, and/or that violence is an appropriate way to solve problems 9. Improve social and relationship skills so that children may access needed social supports in the future 10. Support and strengthen the relationship between children and their supportive parents 11. Increase supportive parents' understanding of the impact of DV on their children and ways to help	1. Output 2. Output 3. Output ~~4. Outcome~~ 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10.Outcome 11.Outcome	~~Agency reporting~~ Contract report ~~Agency reporting~~ Contract report ~~Agency reporting~~ MIDD Tools ~~Pre-post trauma survey~~ ~~Pre-post PC-17~~ MIDD Tools ~~Pre-post PC-17~~ MIDD Tools TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey)

✪Components of this intervention are based upon evidence-based practices.
* Changes in internalizing and externalizing behaviors are measured by PSC-17 at two different time periods.

Content revised 5/7/2010 (Previous draft published 9/2/2008)

Strategy 14 – Expand Access to Mental Health Services for Survivors of Sexual Assault				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
14a – Sexual Assault Services Target Populations: 1) Adult, youth, and child survivors of sexual assault who are experiencing mental health and substance abuse concerns 2) Providers at sexual assault, mental health, substance abuse, and domestic violence (DV) agencies who work with sexual assault survivors and participate in ~~the~~ cross program coordination and ~~cross~~ training ~~of programs~~	1. Expand the capacity of Community Sexual Assault programs (CSAPs) and culturally specific providers of sexual assault advocacy services to provide evidenced-based MH services to 400 adult, youth, and child survivors per year. 2. Provide services to women and children from immigrant and refugee communities by housing a MH provider specializing in evidenced-based trauma-focused therapy at an agency serving these communities. 3. Offer consultation and cross-systems coordination as specified under Strategy 13a.	Short-term measures: 1. Hire 4 ~~FTEs to work at~~ mental health professionals (MHPs) within CSAP provider agencies 2. Hire .5 FTE ~~as a MH provider to be~~ MHP housed at a culturally-specific provider of sexual assault services 3. Hire .5 FTE Systems Coordinator/ Trainer ~~4. Interpreters hired~~ ~~5. Provide therapy and case management services to 400 adult, youth, and child survivors.~~ 4. Increase ~~access to~~ # of sexual abuse survivors screened for, provided, and referred to MH/CD treatment services ~~for adult, youth, and child survivors~~ 5. Increase # of sexual assault survivors from immigrant and refugee communities provided culturally-relevant MH services ~~provided to sexual assault survivors from immigrant and refugee communities~~ in their own language Longer-term measures: 6. Increase~~d~~ coordination between CSAPs, culturally specific providers of sexual assault advocacy services, public MH, substance abuse, and DV service providers ~~Long-term measures:~~ 7. ~~Reduction in trauma~~ Decrease negative symptoms for ~~those~~ adults served ~~, youth, and child survivors receiving services~~ 8. Increase~~d resiliency and~~ coping skills ~~among sexual assault survivors~~ for those served	1. Output 2. Output 3. Output ~~4. Output~~ ~~5. Output~~ 4. Output 5. Output 6. Output 7. Outcome 8. Outcome	~~Agency data~~ Contract reports ~~Agency data~~ Contract report ~~Agency data~~ Contract report ~~Agency data~~ ~~MIS~~ ~~Service records~~ Contract reports and MIDD Tools ~~Agency data~~ MIDD Tools ~~TBD (e.g., qualitative data)~~ Contract report ~~TBD (e.g., survey)~~ MIDD Tools ~~TBD (e.g., survey)~~ MIDD Tools

Content revised 5/17/2010 (Previous draft published 9/2/2008)

Strategy 15 Adult Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
15a – ~~Increase Services Available to Drug Court Clients~~ Adult Drug Court (ADC) Expansion of Recovery Support Services Target Population: King County Adult Drug Court participants	~~1. Increase # of clients served to 450~~ 1. ~~Provide~~ Expand and enhance services to ~~Drug Court~~ 250* ADC clients per year, which may include providing any of the following: a. Employment services per strategy 2b b. Access to CHOICES ~~program~~ classes for individuals with learning or attention disabilities c. Expanded evidence-based treatment ~~(e.g., Wraparound, Multi-Systemic Therapy (MST))~~ for transition age youth (ages 18-24) ~~(1.0 FTE)~~ d. Expanded services for women with co-occurring disorder (COD) and/or trauma, including ~~(1.0 FTE)~~ ~~and~~ suboxone ~~funding for suboxone for this population~~ if needed, and e. Housing case management. ~~(1.5 FTE)~~	Short-term measures: 1. Hire 1.5 FTE housing case management positions and secure contracts for other service delivery 2. Increase # of ~~drug~~ clients with learning or attention disabilities accessing the CHOICES program ~~(of those eligible)~~ 3. Increase # of transition age youth receiving evidence-based treatment services ~~available for ages 18-24.~~ 4. Increase # of women receiving services ~~available~~ for ~~women with~~ COD and/or trauma~~.~~ 5. Increase # of women receiving suboxone treatment 6. Increase # of clients participating in housing case management Long-term measures 7. Reduce substance use for those served 8. Increase # of clients with housing at exit 9. Increase # of clients with employment at exit 10. Reduce # of jail bookings and days for those served** ~~10. Increase the rates of program completion/attrition~~	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome 9. Outcome 10.Outcome ~~10.Outcome~~	~~MHCADSD~~ Contract report ~~MHCADSD~~ MIDD Tools ~~MHCADSD~~ MIDD Tools ~~MHCADSD~~ MIDD Tools ~~MHCADSD~~ MIDD Tools MIDD Tools TARGET❶ ~~and drug court (Monitor) databse~~ MIDD Tools MIDD Tools Jail data ~~Court (Monitor) database~~

* New target of 250 (reduced from 450) was set in contracts dated 5/11/2010.

**Because drug and mental health courts employ incarceration as a programmatic sanction, we expect reductions in jail utilization to be modest during the first year (prior to participants' court "graduation"), with more pronounced reductions occurring in the second year.

❶ Database revisions needed

Content revised 7/9/2010 (Previous draft published 9/2/2008)

Strategy 16 – Increase Housing Available for Individuals with Mental Illness and/or Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
16a – Housing Development Target Population: Individuals with mental illness and/or chemical dependency who are homeless or being discharged from hospitals, jails, prisons, crisis diversion facilities, or residential chemical dependency treatment	1. ~~Provide additional funds to supplement existing fund sources, which will allow new housing projects to complete their capital budgets and begin construction sooner than would otherwise be possible.~~ Provide supplemental funding to expedite construction of new housing projects for MIDD target population. 2. Create 250 new housing units dedicated for the MIDD target population. 3. Provide 5-year rental subsidies to serve ~~50~~ 40 clients per year.	Short-term measures: 1. Increase # of residential units created 2. Increase # of rental subsidies disbursed Longer-term measures: 3. Increase # of people in target population housed 4. Increase ~~length of time spent in~~ # of individuals in target population who are able to remain in housing for at least one year 5. Reduce # of jail bookings and days for those served 6. Reduce # of psychiatric hospital admissions and days for those served 7. Reduce # of ER ~~admissions~~ visits for those served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	MHCADSD MHCADSD MHCADSD ~~MHCADSD~~ Contract report Jail data ~~Hospital data~~ Western State data and MIS (php96) ER data❶

❶ Data sharing agreement(s) needed

Content revised 7/30/2010 (Previous draft amended 5/20/2009)

Strategy 17 – City of Seattle Pilot Projects				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
17a – Seattle Police Crisis Intervention Response Team (CIRT)	Pilot project is proceeding through funding from a federal justice grant the Seattle Police Department received. Strategy will not be included in the MIDD Evaluation.	N/A		
17b – Safe Housing and Mental Health and Chemical Dependency Treatment for Children in Prostitution Pilot (24 months)	Pilot project is proceeding through funding the City of Seattle received from local, MIDD, state and private resources. The City of Seattle is conducting the evaluation for the project.	N/A		

❶ Data sharing agreement(s) needed

Content drafted 5/18/2010