Year Three
Progress Report

Mental Illness and Drug Dependency

Implementation and Evaluation Progress for October 1, 2010 — March 31, 2011

King County

Mental Health, Chemical Abuse and Dependency Services Division

As approved by
Mental Illness and Drug Dependency Oversight Committee

August 2011

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MIDD Year Three Progress Report
October 1, 2010—March 31, 2011

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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 twice yearly: a progress report and an annual report. This progress report, covering the time period from October 1, 2010 to March 31, 2011 includes required elements listed at right:

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, many individuals being 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. The Metropolitan King County Council passed two motions (12320 and 12598) respectively authorizing and accepting 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. In April 2008, Council passed Ordinance 16077 that approved the MIDD Oversight Plan and created the MIDD Oversight Committee (OC). The MIDD Implementation and Evaluation Plans were adopted through passage of Ordinances 16261 and 16262 on October 6, 2008, 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 Ten-Year Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.

Year Three Progress Report Highlights

This progress report covers the fourth quarter of 2010 (Q4-2010) through the first quarter of 2011 (Q1-2011) or October 1, 2010 to March 31, 2011, which is the first half of MIDD Year Three. This is the second semi-annual progress report for the MIDD. Highlights for this time period include:

- Only three of 37 MIDD strategies remain on hold due to budget constraints. All others have moved into planning, secured other funding, or are now serving their intended targets.
- Currently 27 of 29 strategies with MIDD Year Three performance targets are on track to meet at least 85 percent of their annual target for one or more measures.
- 42 percent of adults in outpatient MH treatment (1a-1) impaired by severe/extreme depression or anxiety symptoms at baseline showed improvement after one year or at exit.
- In a sample of older adults treated in primary care settings (1g), 68 percent had a reduction in their scores measuring depression and 65 percent had reduced anxiety symptoms.
- Data on age, race, ethnicity, and King County geographic region were collected for 19,561 unique individuals receiving MIDD services.
- One request for proposal (RFP) was released by a MIDD partner to choose an operator of the Hospital Re-Entry Program (Strategy 12b).
- A subcommittee of the MIDD OC made new recommendations for strategy prioritization.
- From January to June 2011, MIDD revenues were $21.1 million and expenditures were $16.9 million, including supplantation.

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

MIDD Implementation Progress

Of the 37 MIDD strategies, only three remained on hold due to budgetary cutbacks:

4a - Services for Parents in Substance Abuse Outpatient Treatment
4b - Prevention Services to Children of Substance Abusers
7a - Reception Centers for Youth in Crisis.

Four other strategies progressed beyond the RFP or planning stages into contract negotiations, further consultation, siting, construction, and/or staffing, but had not served clients in this reporting period:

1f - Parent Partners Family Assistance
7b - Expand Youth Crisis Services
10b - Adult Crisis Diversion
12b - Hospital Re-Entry Respite Beds (Recuperative Care).

Two strategies proceeded with implementation. The City of Seattle received federal justice department funding for 17a and 2010 MIDD funds were combined with multiple non-MIDD sources to start 17b:

17a - Crisis Intervention Team/Mental Health Partnership Pilot
17b - Safe Housing and Treatment for Youth Prostitution.

Three strategies began serving clients in October 2010, or had their first reportable client-level data:

4c - School District Based Mental Health & Substance Abuse Services
10a - Crisis Intervention Team Training for Law Enforcement & Other First Responders
11b - Mental Health Court Expansion.

All other strategies continued providing services with at least partial MIDD funding. Updates and information on these programs are provided throughout this report.

MIDD Oversight Committee Activities

The MIDD OC met on October 28, 2010, December 2, 2010, and on March 24, 2011. Members of the committee cumulatively contributed 90.3 hours during these meetings. A new prioritization subcommittee also met in January, February, and March 2011, contributing over 200 additional work group hours. Please see Attachment A for the roster of MIDD OC members as of March 2011. During these meetings, OC members monitored implementation and evaluation of the MIDD while receiving updates on:

- Further state budget cuts and how the MIDD may be impacted by new **supplantation legislation** passed by the Washington State Legislature allowing 50 percent of 2011 MIDD revenues to replace lost funding for criminal justice and MH/CD programs, and no limit for therapeutic courts
- **Crisis Diversion Services** (Strategy 10b), including information about:
  - Downtown Emergency Service Center's letter of intent to lease a property in Seattle's Jackson Place neighborhood
  - The City of Seattle's approval for use of the site and improvements to existing facilities
  - Washington State Department of Health and Division of Behavioral Health and Recovery licensing requirements
  - Community meetings and plans to hire and train 85 new staff members
- **Adult Drug Court** (Strategy 15a) expansion services such as "wraparound" for those aged 18 to 25, housing case management, and classes for those with learning disabilities
- A 2011 budget proviso requiring the Department of Community and Human Services to work collaboratively with other groups to submit a report on **Family Treatment Court** (Strategy 8a) to the King County Council about the program, its costs, number served, and blended funding
- Public commentary expressing the importance of MIDD's continued efforts to implement **Parent Partners Family Assistance** (Strategy 1f), which will provide family and peer support services
- A mandate to review **MIDD OC membership**, per Ordinance 16077, evaluating the structure, membership, and responsibilities of the OC and reporting back to Council in June 2011.

During five OC prioritization subcommittee workgroup sessions, a total of 13 OC members met with several County staff to develop a framework for **prioritizing MIDD strategy funding**. Formation of the subcommittee was prompted in part by:

1. Continuing reduced sales tax revenues
2. Concerns about state budget cuts to mental health and substance abuse funding, and
3. The potential for increased use of MIDD revenues for supplantation in response to these cuts.

With actual 2010 revenues well below projections ($41 million rather than $58 million), the OC Co-Chairs requested a review of the previous 2009 prioritization tool and rating process. Rather than re-assigning numerical scores to each strategy, the subcommittee made these **key recommendations**:

- Identify core services, or the basic assessment, prevention, intervention and treatment services without which people would be at greater risk for going to jail/juvenile detention and hospitals (NOTE: Core does not include expansions or programs with other primary funding)
- Preserve a continuum of services across key dimensions
- Seek individual strategy efficiencies
- Examine the impact of across-the-board cuts
- Ensure maintenance of equity and social justice priorities without disproportionate impacts on disadvantaged communities/geographical areas
- Look at program effectiveness, based on achievement of performance measurement targets and on available outcomes
- Maintain MIDD-supported services to at-risk populations who would otherwise not be served
- Place priority on strategies that highly leverage other funding sources.

MIDD Requests for Proposals (RFPs)

In December 2010, Public Health - Seattle & King County released an RFP for the operator of the **medical respite program** (MIDD Strategy 12b) in partnership with many other funders, including:

- ✓ American Recovery & Reinvestment Act
- ✓ Harborview Medical Center
- ✓ Valley Medical Center
- ✓ University of Washington Medical Center
- ✓ Virginia Mason Medical Center
- ✓ HUD & HRSA grant funds
- ✓ Swedish Health Services
- ✓ Evergreen Healthcare
- ✓ St. Francis Hospital
- ✓ United Way of King County

Harborview Medical Center's Pioneer Square Clinic was selected as the successful applicant in March 2011 (see Page 17 for more information).

While not an RFP, contract negotiations with the YMCA to expand the existing **Children's Crisis Outreach Response System (CCORS)**, were conducted to implement Strategy 7b in this time frame. CCORS serves youth both during and after crises, with 24/7 availability. In January 2011, King County proposed that MIDD expansion of CCORS include:

1. Increased capacity to respond to the growing number of referrals (up from 594 in 2006 when their program began, to 914 in 2009 and 984 in 2010)
2. New capacity to provide in-home behavioral support specialists to maintain safety and assist families in implementing behavioral interventions and skill building
3. Development of a marketing plan targeted at reaching youth and families who may need CCORS services to reduce their emergency room use and the need for police intervention.

MIDD Evaluation Efforts

Evaluation of the MIDD Plan is carried out by staff in the Systems Performance Evaluation unit of the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) within King County's Department of Community and Human Services (DCHS). In this reporting period, the evaluation team:

- Hired a new dedicated Information Systems Senior Analyst responsible for MIDD database design, development, improvement, and maintenance
- Filled the MIDD Assistant Evaluator position, transferring responsibility for daily data management, technical assistance to MIDD providers, and querying of multiple data sources to the new staff
- Shifted the focus of the MIDD Evaluator position away from managing the flow of data toward the in-depth analysis and reporting required at this stage of the project
- Further adjusted evaluation matrices for select MIDD strategies to meet the most current implementation plans (see Attachment B)
- Obtained and converted to a usable format, jail use information from the following municipalities:

  - Auburn
  - Enumclaw
  - Kent
  - Kirkland
  - Issaquah
  - Renton

- Consulted with the MHCADSD Statistician and other DCHS information technology resources to refine sophisticated matching algorithms and computer programs that link individuals served by the MIDD with their outcomes measures from external data sources such as jail records
- Performed continuous quality improvement analysis for specific strategies as needed to address issues of data quality and timeliness
- Began drafting an Institutional Review Board (IRB) application for submission to the University of Washington Human Subjects Review Committee in an effort to obtain emergency department utilization data from Harborview Medical Center in Seattle
- Continued to monitor performance across all MIDD strategies related to program output goals
- Began analyzing symptom reduction outcomes for individuals in relevant MIDD strategies.

Community-Based Care Strategies

Strategies in this category are designed primarily to increase access to community mental health (MH) and substance abuse (SA) treatment for uninsured children, adults, and older adults. Improving the quality of care by decreasing MH caseloads and by offering specialized employment services or support services within housing programs are other goals of strategies focused on community-based care.

Program Utilization and Performance Measurement Targets for Community-Based Care Strategies

Performance targets, such as the number of individuals to be served each year, numbers of service units to be provided, or other relevant measures are outlined in the MIDD Evaluation Plan matrices. Based on information drawn from the original MIDD Implementation Plan, these one-page per strategy documents allow for simplified tracking of modifications to evaluation measures as revisions are submitted for Council approval through the MIDD reporting process. The table below shows current targets from the evaluation matrices for each Community-Based Care strategy, progress toward achieving these goals during the first half of MIDD Year Three, projection against annual targets, adjustments (where indicated), and success ratings.

Strategy Number	Strategy "Nickname"	Year 3 Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
1a-1	MH Treatment	2,400 clients/yr	2634 clients	(B)	143%	↑
1a-2	CD Treatment	50,000 adult OP units 4,000 youth OP units 70,000 OST units	8,398 adult OP units 2,510 youth OP units 30,949 OST units	(A)	33%[2] 126% 88%	↓ ↑
1b	Outreach & Engagement	675 clients/yr	1129 clients	(A)	335%[3]	↑
1c	SA Emergency Room Intervention	6,400 screens/yr with 8 FTE[4] 4,340 brief interventions/yr **Adjust for 3/2011 start of 1 FTE**	1,659 screens 2,006 brief interventions	(A)	61% 98% (Adjusted)	↓ ↑
1d	MH Crisis Next Day Appts	750 clients/yr with enhanced services	361 clients (enhanced)	(A)	96%	↑
1e	CD Professionals Training	125 trainees/yr	193 unduplicated trainees	(B)	119%	↑
1f	Parent Partners Family Assistance	4,000 clients/yr				
1g	Older Adults Prevention MH & SA	2,500 clients/yr (7.4 FTE) **Adjust to 2,196 clients/yr (6.5 FTE)**	1,719 clients	(B)	102% (Adjusted)	↑
1h	Older Adults Crisis & Service Linkage	340 clients/yr (4.6 FTE) **Adjust to 258 clients/yr (3.5 FTE)**	219 clients	(C)	161% (Adjusted)	↑
2a	MH Workload Reduction	16 agencies participating	16 agencies participating	-	100%	↑
2b	Employment Services MH & CD	920 clients/yr (23 FTE) **Adjust to 700 clients/yr (17.5 FTE)**	552 clients	(B)	102% (Adjusted)	↑
3a	Supportive Housing	400 clients/yr[5] **Note: Beds increased from 398 to 413 during this reporting period**	424 clients	(B)	138%	↑
13a	Domestic Violence & MH Services	700-800 clients/yr **Adjust to 560-640 clients per year[6]**	307	(A)	110% (Adjusted)	↑
14a	Sexual Assault, MH & CD Services	170 clients/yr[4]	192 clients	(A)	226%	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Providers were instructed to spend down expiring state funding for the adult outpatient population during this time period.
[3] Blended funds allow more clients to be served than the portion attributable to MIDD only, on which the performance measurement targets are based.
[4] Revised targets accepted by Council in motion of acceptance on 5/9/2011.
[5] Working targets from Proposed MIDD Evaluation Plan Matrix Revisions transmitted to Council on 10/1/2010.
[6] Strategy is operating at 80% of original funding plan.

Note: Strategies "grayed out" in grid not implemented or had no data collected within the reporting period.

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.

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%

Strategy 1a-1 Mental Health Treatment

The MIDD makes treatment services available to those who qualify for standard services clinically, but who do not meet stringent financial qualifications for Medicaid. Through contracts with 17 outpatient MH treatment providers, King County has been able to provide treatment to individuals who otherwise might "fall through the gap." Operating at full capacity, Strategy 1a-1 is projected to serve over 3,400 unique individuals in MIDD Year Three through benefits which typically last for an entire year from their start date.

Strategy 1a-2 Chemical Dependency Treatment

Of the 1,198 unduplicated individuals receiving outpatient substance abuse treatment services through MIDD expenditures in this reporting period, 116 were under the age of 18 on October 1, 2010. The number of adult treatment units purchased was below target as providers were instructed to first use all available state funds prior to their expiration date. While there were only 53 new MIDD-funded adult outpatient starts in Q1-2011, this number is expected to climb as other fund sources have been exhausted. The number of MIDD clients receiving daily medications such as methadone for treatment of opiate addictions has remained fairly constant since the beginning of the MIDD, averaging about 850 per year.

Strategy 1c Emergency Room Substance Abuse Intervention

Cited as a model program in President Obama's 2011 National Drug Control Strategy, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program funded by the MIDD in four area hospitals seeks to intervene with clients *before* their substance use becomes more problematic.

In November 2010, Harborview Medical Center (HMC) added an additional half-time Brief Therapist so that position is now staffed at 1.5 Full-Time Equivalent (FTE). Their 3.5 FTE SBIRT screeners refer appropriate clients to these specialists who are "instrumental in prodding clients to closely examine their substance use."

During March 2011, Valley Medical Center in Renton, WA hired a qualified Chemical Dependency Professional (CDP) who screened 72 patients in his first month on the job, indicating a high level of need for these services here. Further south at St. Francis Hospital in Federal Way, SBIRT services were expanded beyond the emergency room to other units, including intensive and progressive care. An SBIRT trainer from HMC has worked to ensure that all participating hospitals, including Highline Medical Center, adhere to the evidence-based model. This trainer provided 69 hours of one-on-one coaching, featuring both role-play practice and shadowing with immediate feedback, in this reporting period alone.

Strategy 1b Outreach & Engagement

Reaching out to homeless individuals and those with the most chronic CD issues, Strategy 1b provides ongoing case management while seeking to engage clients in needed MH and substance abuse treatment. The number of people for whom the MIDD is able to track outcomes is much higher than the strategy's performance target figure, due to blended funded. As it would be difficult to separate out a sample attributable to only the MIDD portion of overall funding, one of the three providers of these services reports identifying information for all persons served.

One of the three Strategy 1b providers reported that three of their four MIDD-funded staff are now authorized to engage incarcerated homeless clients in jail prior to their release. They found that this practice helped clients remain in services over a longer period of time once they returned to the community. Another notable achievement of the program was the significant number of successful housing placements during the year; 38 of their clients moved into permanent housing. A major challenge of working with homeless clients is developing therapeutic relationships based on trust. Harm reduction approaches which "meet clients where they are", remove shame, and offer alternatives to abstinence help engage this group.

Strategy 1d
MH Crisis Next Day Appts

Psychiatric medication evaluations for up to 750 clients per year are one of the enhancements MIDD has brought to delivery of the existing Adult Crisis Stabilization program, also known as Mental Health Crisis Next Day Appointments. These medical services, while necessary, are often costly due to requirements that they be performed only by those with specific credentials: licensed physician or osteopath (typically board eligible in psychiatry) or registered psychiatric nurse with at least two years of experience treating mentally ill persons who is also an Advanced Registered Nurse Practitioner (ARNP) with prescriptive authority.

Strategy 1e
CD Professionals Training

Throughout this reporting period, the MIDD continued to reimburse eligible chemical dependency professionals (CDPs) and trainees for expenses incurred in the course of their professional development.

Additionally, Strategy 1e laid the groundwork to increase the substance abuse treatment community's adoption of evidence-based practices by developing "Motivational Interviewing" trainings to be delivered in cooperation with The Northwest Frontier Addiction Technology Transfer Center. A workforce development plan is now in place to increase local capacity to deliver recovery-orientated care.

Strategy 1g
Older Adults Prevention MH & SA

Screening of individuals over the age of 50 for depression, anxiety, and substance use issues in primary health care settings is only the beginning for Strategy 1g. Of the 1,719 people screened in the time span covered by this report, only 601 (35%) had scores below the thresholds for concern. Of the other 1,118 whose scores indicated a need for further exploration of their mental health and/or substance use needs, 70 percent (779) were engaged in the short-term treatment services funded directly through the strategy and/or were referred out to specialists.

There are currently 25 "safety net" clinics participating in this effort to integrate behavioral health care into primary care settings. They are operated by seven different agencies, including Harborview Medical Center, Sea Mar and Country Doctor Community Health Centers, Healthpoint, Neighborcare, International Community Health Services, and Public Health - Seattle & King County. Reducing the severity of mental health symptoms experienced by older adults who engage in services is one of the key goals of this intervention. Thus far, 68 percent of those with two or more scores on a measure of depression showed a reduction in symptoms, along with 65 percent of those with anxiety scores at two different points in time. Please see Page 23 for more results from the initial analysis of symptom measures used to screen and monitor patient progress in these community health settings.

Strategy 1f
Parent Partners Family Assistance

The MIDD Strategy 1f, Peer Support and Parent Partner Family Assistance, seeks to improve the lives of children, youth and families by providing alternative services and supports in the community. It is designed to empower families and youth by assisting them to: increase their knowledge and expertise about services, systems and supports for families; utilize effective coping skills and strategies to support children/ youth; and effectively navigate complex service systems.

The Parent Support Specialist funded by this strategy has been involved in facilitating the King County Parent Partner Network, supporting the parent partner staff involved in the implementation of MIDD Strategy 6a (Wraparound), attending Community Resource Teams, and offering training and technical assistance to a variety of family serving organizations.

After two RFP processes in which the County was unable to successfully award a contract, the MHCADSD MIDD Strategy 1f design team reconvened to develop a new plan of action. During this reporting period they sought consultation and technical assistance from the National Federation of Families for Children's Mental Health about how other communities have successfully overcome similar barriers to those encountered implementing this strategy. A revised action plan will be developed in the second half of 2011.

Strategy 1h Older Adults Crisis & Service Linkage

Adults over the age of 55 who are experiencing a crisis in which mental illness or substance abuse appears to be a contributing factor are often referred to the Geriatric Regional Assessment Team (GRAT). This team provides crisis intervention, functional assessments, referrals, and linkages to services in response to requests from police and other first responders. Because of their expansion under the MIDD, GRAT is able to respond to referrals within a day of receipt. In the six month period beginning October 1, 2010, they had 253 mental health referrals and 23 chemical dependency referrals, which led to 232 program admissions for 219 unduplicated individuals.

Strategy 2a MH Workload Reduction

A total of 16 mental health agencies continue to participate in the workload reduction initiative which is closely tied to the Mental Health Recovery Plan of King County first enacted through ordinance in November of 2005. Providing supplemental funding to increase the number of direct services staff and reduce caseloads can increase the frequency and quality of services provided to consumers of behavioral health care.

The total number of staff funded through workload reduction increased by 13 (from 132 to 145) during the first half of MIDD Year Three. At the same time, seven agencies cut staffing by a total of more than 75 positions due to state budget cuts. On average, Strategy 2a currently funds 16 percent of total staffing systemwide.

Strategy 2b Employment Services MH & CD

The MIDD supported employment (SE) strategy currently provides funding for 17.5 FTE MH agency staff who work directly with mentally ill clients and potential employers in the community developing job opportunities and helping individuals on their caseload maintain competitive job placements. Agencies with SE programs are expected to adhere to the evidence-based model developed at Dartmouth College, as measured through fidelity reviews conducted annually. Principles of the SE model include:

- Eligibility is based on consumer choice
- SE is closely integrated with MH treatment
- Jobs must pay at least minimum wage
- Job search starts promptly after interest is expressed
- Individual supports are continuous
- Consumer preferences drive job search
- Benefits planning is integrated.

Strategy 3a Supportive Housing

In January 2011, MIDD funding was awarded to provide supportive services to the 15 "Clean and Sober" units within the Kerner-Scott House run by Seattle's Downtown Emergency Services Center. These new units have raised the total number of MIDD units offering intensive support services from 398 to 413, and four more new projects will be added throughout calendar year 2011.

Each year approximately $2 million from the MIDD Fund is combined with funds from other sources to make support services available within housing programs. These contracts are competitively awarded to agencies who apply for 5-year grants.

Strategies 13a & 14a MH & CD Services for Domestic Violence and Sexual Assault Clients

Both direct MH and CD services for survivors and systems coordination of the chemical dependency, mental health, domestic violence (DV), and sexual assault treatment networks receive MIDD funding. In addition to screening DV and sexual assault survivors for potential MH or substance use disorders and providing counseling services for those in need, Strategies 13a and 14a each contribute 0.5 FTE to facilitate networking and integration of services. A sampling of highlights from activity reports submitted by the systems coordinator includes:

Oct. 2010: Delivered training on strategies for working with chemically-addicted survivors of DV

Nov. & Dec. 2010: Coordinated meetings between Family Treatment Court and specific DV agencies

Jan. 2011: Gave inter-disciplinary communication presentation at Triple Play chapter meeting.

Strategies with Programs to Help Youth

The MIDD strategies that include programs to help youth have been designed primarily to expand prevention and early intervention, expand assessments for youth in the juvenile justice system, provide comprehensive team-based services through Wraparound, help more youth who are in crisis, and maintain and expand both Family Treatment Court and Juvenile Drug Court.

Program Utilization and Performance Measurement Targets for Strategies with Programs to Help Youth

As indicated on Page 6 of this report, numbers to be served each year through any given strategy are outlined in the MIDD Evaluation Plan matrices. Under Strategy 5a (Juvenile Justice Youth Assessments), target numbers from the original MIDD Implementation Plan were modified on May 19, 2010, but further revisions (to be determined) were recommended in the MIDD Third Annual Report. Proposed target revisions for Strategy 5a were finalized on July 1, 2011. Also, targets for Strategy 8a (Family Treatment Court) were revised when the program reached its full newly-expanded capacity. The table below shows *current* targets from the evaluation matrices for each youth-focused strategy, including those proposed and/or adopted AFTER the data collection period for this report (from October 1, 2010 to March 31, 2011). Please see Attachment C for evaluation matrices modified since their last formal publication in the MIDD Year Two Progress Report (August 2010). Also, note that targets will need to be set for Strategy 7b before the end of MIDD Year Three.

Strategy Number	Strategy "Nickname"	Year 3 Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
4a	Parents in Recovery SA Services	400 parents/yr				
4b	Prevention - Children of SA	400 children/yr				
4c	School-Based MH & SA Services	2,268 youth/yr (19 programs)[2] **Adjust to 1,550 youth/yr (13 programs)**	1,276 unduplicated youth (excluding groups)	(D)	123% (Adjusted)	↑
4d	Suicide Prevention Training	1,500 adults/yr 3,250 youth/yr	706 adults 5,432 youth	(D)	71% 250%[3]	→ ↑
5a	Juvenile Justice Youth Assessments	Coordinate 500 assessments/yr[4] Perform 140 MH assessments Perform 165 CD assessments **Adjust for 1/2011 start for two FTE**	268 coordinations 79 MH assessments 112 CD assessments	(A)	107% (Unadjusted) 150%[3] 187%[3] (Adjusted)	↑
6a	Wraparound	920 youth/yr **Adjust to 763 youth/yr** (10 fewer facilitators for first half of 2011)	733 (estimated) based on 293 enrolled and average 1.5 siblings each where known	(B)	125% (Adjusted)	↑
7a	Youth Reception Centers	TBD				
7b	Expand Youth Crisis Services	COMING SOON				
8a	Family Treatment Court Expansion	No more than 90 children/yr	79 children	(B)[5]	114%	↑
9a	Juvenile Drug Court Expansion	36 new youth/yr (up to 5.5 FTE)	20 new since 10/1/2010	(A)	111%	↑
13b	Domestic Violence Prevention	85 families/yr	117 unduplicated families	(B)	179%	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Working targets from Proposed MIDD Evaluation Plan Matrix Revisions transmitted to Council on 10/1/2010.
[3] Blended funds allow more clients to be served than the portion attributable to MIDD only, on which the performance measurement targets are based.
[4] New targets proposed on 7/1/2011.
[5] Program has now reached capacity.

Note: Strategies "grayed out" in grid not implemented or had no data collected within the reporting period.

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.
(D)	School-based programs serve fewer students during the summer months, so the projection multiplier is 1.5.

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%

Strategies 4a & 4b Substance Abuse Services for Parents and Children

Both of these strategies remain on hold due to funding constraints. They are designed to help families impacted by the effects of substance use through skill-building opportunities and other evidence-based prevention practices. By targeting parents who have committed to recovery from their chemical addictions, Strategy 4a hopes to reduce the likelihood that their children will become drug users through evidence-based interventions. Strategy 4b is designed to target children of substance abusers directly by delivering a curriculum-based, family oriented preventive intervention.

Strategy 4c School-Based MH & SA Services

After nearly two years in planning and procurement phases, the school-based mental health and substance abuse services strategy was able to start serving clients and collecting data in October 2011. Original targets for the number of youth to be served were based on funding 19 programs, but since the actual number of projects funded was only 13, adjustments will be made as progress is monitored.

These school-based programs got off to a strong start during the 2010-2011 school year, serving 1,276 unduplicated youth in individual sessions. These figures are especially remarkable when one considers that a mechanism was not initially in place to capture the number of these primarily middle-school aged youth who were also served in group activities. Excerpts from narrative reports submitted by provider staff offer a glimpse into the impact of prevention services:

- Schools are "allowing use of my service as an alternative to suspension."
- "Our counselor worked with several students who had felt hope [was] gone and were suicidal."
- "Difficult to stick to BRIEF intervention…" as students have "...established a rapport with me and [are] not comfortable with change."
- "The Latino girls group wants to form a team to support current students who are embarrassed by observable disabilities."

Strategy 4d School-Based Suicide Prevention

Through funds from Strategy 4c, the Youth Suicide Prevention Project (YSPP) facilitates trainings for school personnel throughout King County. These trainings differ from those offered by the same provider to adult groups for MIDD Strategy 4d. In the fourth quarter of 2010, trainers offered three trainings with a total of 53 certificated participants under the Applied Suicide Intervention Skills Training (ASIST) curriculum and four trainings with 39 people who completed all modules under the SafeTALK curriculum, which teaches participants to recognize and actively engage youth contemplating suicide in order to link them with needed help. In the first quarter of 2011, ASIST classes drew 63 participants and SafeTALK was delivered to 60 people. The YSPP continues to enhance their marketing efforts for both of these curricula.

The Crisis Clinic's Teen Link program, which combines MIDD funds with other fund sources to reach even more students with their anti-suicide message, reported delivery of 220 presentations in the first half of MIDD Year Three when their MIDD goal was only 130. The number of adult presentations offered by YSPP for Strategy 4d was 19 in this reporting period, almost half of their goal of 40 for the third year of full MIDD funding.

The YSPP's offerings of technical assistance* to area school districts to improve their Crisis Response Plans have met a great deal of resistance. Despite multiple efforts and outreach, only four districts have accepted YSPP's help.

*NOTE: In MIDD Year Two, YSPP reviewed policies from 17 of King County's 19 school districts, rating 11 "average" and six "below average."

Strategy 5a Juvenile Justice Youth Assessments

The Juvenile Justice Assessment Team (JJAT) became fully staffed in December 2010, with the addition of one contracted children's mental health liaison and one chemical dependency professional with demonstrated competency in working with young Latino and African American offenders. Both of these positions were filled through an RFP process initiated in MIDD Year Two. The new staff join a triage coordinator and the team's clinical psychologist in offering youth (both in custody and in the community) the professional screening, assessment and referrals to services that can best address trauma and meet their individualized needs.

Strategy 6a Wraparound Services

Original implementation plans for providing wraparound services to emotionally disturbed youth called for developing five new teams consisting of one coach, six facilitators, and two parent partners each. Funding reductions of 32 percent in 2010 led to a delay in fully implementing Strategy 6a. The evaluation matrix for this strategy was recently revised to clarify that the number of youth to be served is inclusive of siblings of identified clients or other young members of families being served (see Attachment C). Counting these "collateral" youth began in October 2010, but the data are only available for new enrollees and are not available for those who have continued from earlier enrollment in the wraparound program. In March 2011, work began to develop new data collection tools to enrich program evaluation for this strategy. Tracking of living arrangements, school performance, substance abuse and other progress indicators will occur every six months.

Strategy 7a Youth Reception Centers

Providing a facility to serve as a triage and central coordination point for youth in crisis is one MIDD strategy that remains on hold, with no planning being done at this time.

When funding is restored, a needs assessment will be conducted to provide the direction for ensuring a coordinated response to youth crises.

Strategy 7b Expand Youth Crisis Services

After nearly two years of delay caused by budget cutbacks, the expansion of the Children's Crisis Outreach Response System (CCORS) was recently funded and service delivery began in April 2011.

A key component of the CCORS expansion involves making available in-home behavioral support specialists who have the flexibility to go into clients' homes on a frequent (daily, if needed) basis to implement specific behavioral interventions until families are able to successfully utilize new skills on their own. This work may entail providing extra support in a client's home for up to eight hours at a time during the day or even overnight when assisting families in maintaining youth safety.

Another feature of expanding CCORS' capacity involves having the YMCA (service provider) partner with King County MHCADSD to develop a marketing/communication plan that reaches out to youth and families in need of CCORS services. Developing resource materials, advertising, and public service announcements are some of the suggested means for information dissemination. This work is important to make families aware of the services being offered, for them to feel comfortable about accessing them, and to divert those in crisis away from a police response or an unnecessary emergency room visit.

Strategy 8a Family Treatment Court

The Family Treatment Court (FTC), which helps parents who are recovering from chemical dependencies to reunite with children removed from their home because of parental substance use, reached its newly expanded capacity at the end of MIDD Year Two. Between November 2010 and March 2011, only nine parent slots opened up and those were quickly filled by eight new parents with a total of 17 children in the child welfare system. Of the 52 parents actively participating in FTC in the first half of MIDD Year Three, 17 were enrolled in special MIDD-funded wraparound services. Those exiting the program for any reason spent an average of 385 days in services. As of March 31, 2011, 43 parents still in services had averaged 336 days from their start, indicating that problems faced by these families take time to solve.

Strategy 9a Juvenile Drug Court

The capacity of the Juvenile Drug Court (JDC) has been expanded under the MIDD to help more juvenile justice system-involved youth overcome substance misuse issues or chemical dependencies. With MIDD funding for five FTEs, including four juvenile probation counselors and one treatment liaison, the JDC now serves more youth from South King County (based on zip code), at just over half of all JDC participants in the reporting period.

When individuals choose to enter JDC, they waive their right to a trial. If they complete the program successfully (between nine and 24 months in duration), the charges against them will be dismissed. Those who opt-out early or fail to comply with the strict program requirements have their guilt or innocence decided by the JDC judge. Once engaged in JDC, youth are closely supervised by probation counselors who ensure they participate in a variety of customized treatment options for their substance abuse disorders, attend frequent court hearings, and are tested at least twice weekly for any drug use.

In the JDC system, participants can reach various levels of success prior to actual graduation. Each phase is characterized as follows:

Phase I:	Minimum 90 days of engagement, 30 consecutive days confirmed sobriety, 20 percent of restitution paid
Phase II:	Minimum 90 days of engagement, 60 consecutive days confirmed sobriety, 66 percent of restitution paid
Phase III:	Minimum 90 days of engagement, 90 consecutive days confirmed sobriety, restitution is paid in full.

In all phases, progress must be achieved in the Drug/Alcohol domain, and four additional domains identified as impacting risk from the Washington State Risk Assessment Tool as follows: Family, Peers, School/Vocation or Pro-Social Activities, and Mental Health.

Strategy 13b Domestic Violence Prevention

MIDD support for the Children's Domestic Violence Response Team (CDVRT) has continued to allow delivery of prevention services to over 100 unduplicated families in each of the MIDD's first three years. For the six months included in this report, narrative reports from the CDVRT provide a glimpse into the work they do when not directly screening or serving children in family, group, or individual therapy sessions:

<u>October 2010</u>
- Held two team meetings with all CDVRT members from three provider agencies
- Continued to explore referrals and resource translations for Spanish-speaking families
- Discussed ongoing safety issues when batterers and survivors are served by the same agency

<u>November 2010</u>
- CDVRT met three times with team discussions of families recently referred for services
- Kid's Club (group sessions for children coping with DV issues) was working to recruit eligible families
- Members shared self-care tips for mental health therapists doing this emotionally investing work

<u>December 2010</u>
- Helped families to cope with budget cuts to funding for parents' individual therapy

<u>January 2011</u>
- Explored and agreed to policy for ensuring family safety while dealing with battering parents

<u>February 2011</u>
- Referrals increased, necessitating potential development of waiting lists
- All team members attended a full day of training on DV resources and family violence treatment

<u>March 2011</u>
- Discussed ways to stay connected with families not formally engaged in ongoing therapy.

Jail and Hospital Diversion Strategies

Diverting individuals with mental health or substance use issues toward appropriate treatment in the community and away from costly incarcerations or hospitalizations is the primary goal of the MIDD strategies grouped in the diversion category. These strategies include programs that range from education and training to therapeutic court options, jail and hospital re-entry assistance, intensive case management services, and even rental subsidies.

Program Utilization and Performance Measurement Targets for Jail and Hospital Diversion Strategies

This report marks the first in which data were available for Strategy 10a (Crisis Intervention Training) and early indicators suggest that targets for the number to be trained each year may have been set too high. These targets will be re-examined in relation to program capacity and logistical issues for possible revision before MIDD Year Four. The target for Strategy 11b (Mental Health Court Expansion) has been adjusted for Year Three as only one of the two MIDD-funded positions (one liaison and one peer support specialist) was filled during the reporting period. Also, because the award for these contracted expansion positions went to a new provider agency in calendar year 2011, the target success rating is calculated for only six months without any projection to the full year. The 11b performance evaluation is based on the number screened by the liaison, not the number opting in to MH Court. Under Strategy 12a (Community Center for Alternative Programs Education Classes), some data were submitted after the data due date and will be included in the MIDD Fourth Annual Report.

Strategy Number	Strategy "Nickname"	Year 3 Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
10a	Crisis Intervention Team Training	375 trainees/yr (40-hr)[2] 1,000 trainees/yr (1-day)[2]	125 trainees (40-hr) 119 trainees (1-day)	(A)	67% 24%	➡⬇
10b	Adult Crisis Diversion	3,000 adults/yr[2]				
11a	Increase Jail Liaison Capacity	200 clients/yr	101 clients	(A)	101%	⬆
11b	MH Court Expansion	115 clients/yr (2 FTE)[2] **30 clients in 6 months (1 FTE)**	62 referred from municipalities 45 screened by MIDD liaison 16 opted in over 6 months	-	-	150% (Adjusted) ⬆
12a	Jail Re-Entry Capacity Increase	300 clients/yr (3 FTE) **Adjust to 200 clients/yr (2 FTE)**	121 clients	(A)	121%	⬆
	CCAP Education Classes	600 clients/yr	68 clients in 3 months	Multiply by 4	45%	⬇
12b	Hospital Re-Entry Respite Beds	350-500 clients/yr[2]	**COMING SOON**			
12c	PES Link to Community Services	75-100 clients/yr	79 clients	(C)	200%	⬆
12d	Behavior Modification for CCAP	100 clients/yr	89 clients	(B)	116%	⬆
15a	Adult Drug Court Expansion	250 clients/yr[2]	224 clients	(B)	116%	⬆
16a	New Housing and Rental Subsidies	40 rental subsidies/yr[2] 250 new units capitally funded	42 rental subsidies 25 tenants in new units	(B) -	137% -	⬆
17a	Crisis Intervention/MH Partnership					
17b	Safe Housing - Child Prostitution					

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.

[2] Working targets from Proposed MIDD Evaluation Plan Matrix Revisions transmitted to Council on 10/1/2010.

Note: Strategies "grayed out" in grid not implemented or had no data collected within the reporting period.

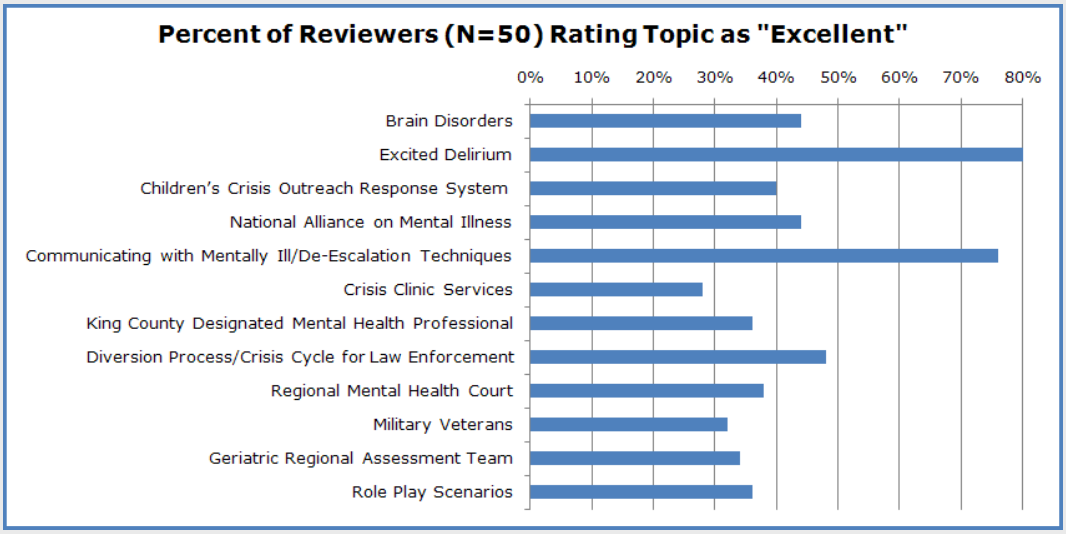
Key to Projection Algorithms	
(A)	Some strategies are expected to serve twice as many clients in a full year as they serve in a 6-month period. The default projection multiplier is 2.0.
(B)	For programs now operating at capacity or with benefits lasting 365 days, the projection multiplier is 1.3, which 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.

⬆	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%

Strategy 10a Crisis Intervention Team Training

Following months of planning and curriculum development, MIDD Strategy 10a staff, with offices at the Washington State Criminal Justice Training Commission (WSCJTC) in Burien, WA, offered their first Crisis Intervention Team (CIT) training in October 2010. Over the next six months, they hosted six 40-hour trainings with 125 total participants and six "in-service" (8-hour) trainings with another 119 participants.

The graphic below shows topics covered in the full week-long training and the percentage of reviewers giving each topic the highest possible rating:



Deputy Joe Winters of the Metro Transit Police, a unit of the King County Sheriff's Office, endorses the CIT training with these thoughts:

"Cutting edge training in dealing with mentally ill (MI) persons."

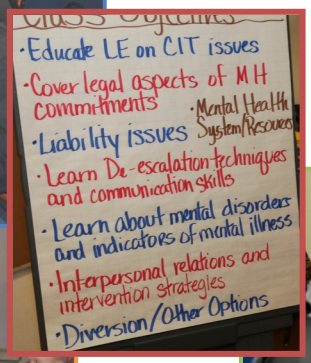
"Access to immediate tools that help with a fast and efficient way of dealing with the MI."

"CIT helps law enforcement (LE) to personalize what the MI are going through."

"Perfect way of bringing LE and the mental health professionals together ."

Online evaluations completed after each course provided additional information about aspects of each training that most contributed to participant learning. Respondent feedback included the following:

- "Learning about the various agencies available to assist and the methods of connecting with them was most helpful. I had no idea that Crisis Clinic could access so many resources, had never even heard of Mental Health Court, and did not know about CCORS or GRAT either."
- "Communicating with the mentally ill and the excited delirium classes will be the most useful for my work on patrol."
- "The role play scenarios were helpful in bringing everything together."



Crisis Intervention Team trainings began in October 2010. Photos courtesy of WSCJTC.

Strategy 10b
Adult Crisis Diversion

The Adult Crisis Diversion strategy consists of three linked programs: a Crisis Diversion Facility (CDF) where police and other first responders may refer adults in crisis for short-term evaluation, crisis intervention and referral to appropriate community-based services; a Crisis Diversion Interim Services Facility (CDIS) which will serve as a place where people leaving the CDF who are homeless may receive up to two weeks of further stabilization and linkage to housing and services; and a Mobile Crisis Team that will respond to police and other first responder requests for on-site evaluation and crisis resolution as well as linkage to the CDF.

Downtown Emergency Services Center (DESC) was selected as the provider of all three programs through a RFP process, and chose a site for these programs in Seattle. A legal challenge to the City of Seattle's land-use designation for the selected site has delayed implementation of these programs.

Meanwhile, the Mobile Crisis Team program is set to begin operations in August 2011. While the team does not have a CDF to which they can take people in crisis, they will be able to respond to calls for assistance and take individuals, when appropriate, to a crisis respite program in downtown Seattle managed by DESC.

Strategy 11a
Increase Jail Liaison Capacity

Jail liaisons work with incarcerated individuals prior to their release from jail, to connect them with services shown to prevent recidivism. Funding from MIDD has allowed more than 200 people court-ordered to Work and Education Release (WER) to receive customized linkage assistance each year, including help accessing mental health treatment and disability benefits, if appropriate.

Strategy 11b
MH Court Expansion

Through MIDD-supported expansion, therapeutic mental health court referrals can now be accepted from any city court within King County. Processing these additional referrals for consideration by the regional court system is a complicated undertaking, made possible in part by court liaison staff from contracted provider agencies. Among other duties, these liaisons are responsible for facilitating initial assessment of client eligibility against clinical criteria. Between October 1, 2010 and March 31, 2011, the court liaison funded by MIDD screened 45 of 70 total referrals for 62 unique individuals. (NOTE: Some regional mental health court candidates were referred by up to three different cities.)

Strategy 12a
Jail Re-Entry Capacity Increase and CCAP Education Classes

Like jail liaisons, re-entry case managers work with those in custody serving court ordered time prior to their release from jail, connecting them to essential services that will increase the likelihood of their successful transition back into the community. Capacity increase through the MIDD Plan has allowed more inmates in the South region of the county to receive re-entry case management.

In some cases, individuals are ordered by a judge to serve their time in community alternative programming, rather than in jail. For those supervised by the Community Center for Alternative Programs (CCAP), MIDD has expanded class offerings and educational opportunities. Working toward a high school equivalency degree or engaging in other pre-employment activities can give people involved with the criminal justice system a chance to develop skills that lessen the likelihood they will break the law in the future.

MIDD also funds gender-specific classes at CCAP aimed at preventing domestic violence.

Strategy 12b Hospital Re-Entry Respite Beds

The new respite facility for individuals leaving hospital care is set to open before the end of MIDD's third year of service delivery. Located in Seattle Housing Authority's Jefferson Terrace complex, medical respite beds will be available for homeless individuals needing additional recuperative care upon release from area hospitals. The MIDD's role in this project involves providing mental health and/or substance abuse treatment services when clinically indicated.

During the fourth quarter of 2010, renovation plans were completed, construction documents were submitted to the City of Seattle and the permitting process began in mid-November. An RFP for the program operator was issued by Public Health - Seattle & King County (PHSKC) on December 30, 2010 and the award was announced in late March 2011. The selection of Harborview Medical Center's Pioneer Square Clinic to operate this facility was the result of a competitive process. Harborview is described by PHSKC as "an organization with deep commitment and exceptional experience and expertise in meeting the care needs of homeless individuals." Please see Page 5 for a list of other key funders for this project.

The MIDD Evaluation Team is working to create data collection tools that will allow tracking of long-term jail and hospital utilization by medical respite care participants.

Strategy 12c PES Link to Community Services

The Psychiatric Emergency Services (PES) program operated by Harborview Medical Center was expanded with MIDD support to allow more assertive outreach and case management for high-utilizer clients. By providing concrete resources such as bus tickets and food vouchers, workers develop relationships with those most difficult to engage in ongoing treatment for their psychiatric disorders or other issues. With annual capacity to serve up to 100 of these very challenging individuals, the program provided enhanced services to 79 participants in the six-month period of this progress report. The ultimate program goal is to reduce use of area emergency departments and crisis services.

Strategy 12d Behavior Modification for CCAP

Through the MIDD, people in the criminal justice system who are court ordered to supervision by the Community Center for Alternative Programs (CCAP) have the opportunity to participate in therapeutic behavior modification classes contracted for delivery by a local mental health agency. Typically administered in twice weekly sessions at three hours per session, the length of time clients spend learning to change their behaviors depends largely on their sentence duration, although some are able to continue treatment after release from CCAP.

In the current reporting period, 89 qualified individuals received at least one Strategy 12d service. Efforts are under way to improve data collection to capture information about the exact number of sessions attended by each participant.

Strategy 15a Adult Drug Court

Housing case management continues to play a key role in the expansion of recovery support services for those in Adult Drug Court (ADC). When not working directly with their clients, these case managers accomplished a great deal during Q4-2010 and Q1-2011, including:

- Conducting site visits at William Booth Center (shelter and transitional housing for men), Dorothy Day House (a permanent supportive housing program for homeless women), Sacred Heart Shelter (for homeless families), and Youthcare's "Passages" (transitional housing for 18-21 year old single adults)
- Attending a Washington State Association of Drug Court Professionals conference
- Presenting their progress, challenges, and future goals at the MIDD OC meeting in October 2010
- Finalizing a policy and procedures manual
- Meeting with multiple housing providers to review referral procedures and staff changes
- Participating in an RFP process to obtain 15 transitional set-aside units for Drug Court.

The MIDD expansion of ADC also funds classes for participants with learning disabilities (CHOICES) and wraparound services for transition aged youth (18 to 24 years old).

Strategy 16a New Housing and Rental Subsidies

The MIDD evaluation effort continues to track individuals housed in units created through capital expenditures made during MIDD Year One. For the majority, demographic information is collected through Strategy 3a, which attaches support services to most of the housing units that were developed with capital funding. Resident information is gathered through other means for the 25 units without MIDD-funded support services.

Strategy 16a also funds 40 rental subsidies for individuals in outpatient treatment for psychiatric disabilities at various community mental health agencies within the King County Regional Support Network. Thus far in MIDD Year Three, 42 different people have maintained their housing placements with this rental assistance.

Strategy 17a Crisis Intervention / MH Partnership

The City of Seattle received a grant in 2010 from the Federal Bureau of Justice Assistance to implement this pilot project. There are currently no MIDD funds associated with Strategy 17a.

The Seattle Police Department reported for the first quarter of 2011 that a mental health professional (MHP) hired in November 2010 completed his training and began casework and field response in January 2011. Partnered with Crisis Intervention Response Team (CIRT) officers, the MHP investigates cases routed to the team by patrol officers, performs outreach, and responds to in-progress calls involving mental illness. In his first three months, the MHP was assigned 78 cases, over half of which were cleared without an arrest being made or a resulting jail booking.

Strategy 17b Safe Housing (Child Prostitution)

YouthCare operates a continuum of services to address the needs of the population targeted by this MIDD strategy, prostituted youth with unmet mental health or chemical dependency treatment needs. The Bridge, a residential recovery housing project, has been open for over a year. Eighteen youth have been served there since March 2010, with a capacity to serve six at a time. Additional youth have been served in emergency shelter beds and in juvenile detention by two community outreach workers.

The Bridge program model consists of comprehensive on-site treatment, education and pre-employment services provided within a structured, therapeutic milieu. Average length of stay at The Bridge is just over three months, with some youth staying considerably longer. Program staff indicate that they have been successful in engaging youth to remain in residence for sufficient time to involve them in treatment and school. The program has been challenged with obtaining access to prescriber services, and with developing appropriate, alternative plans for youth whose needs could not be met in a community-based setting like The Bridge.

Training and consultation in the application of Trauma Focused Cognitive Behavioral Therapy has been provided by Harborview's Sexual Assault Center to YouthCare staff. In addition, YouthCare staff have provided numerous trainings for the treatment provider network about the needs of commercially, sexually exploited children and youth (CSEC). A strong partnership based on a shared philosophy has developed between YouthCare, the Seattle Police Department Victims Unit, the King County Prosecuting Attorney's Office, and Juvenile Court.

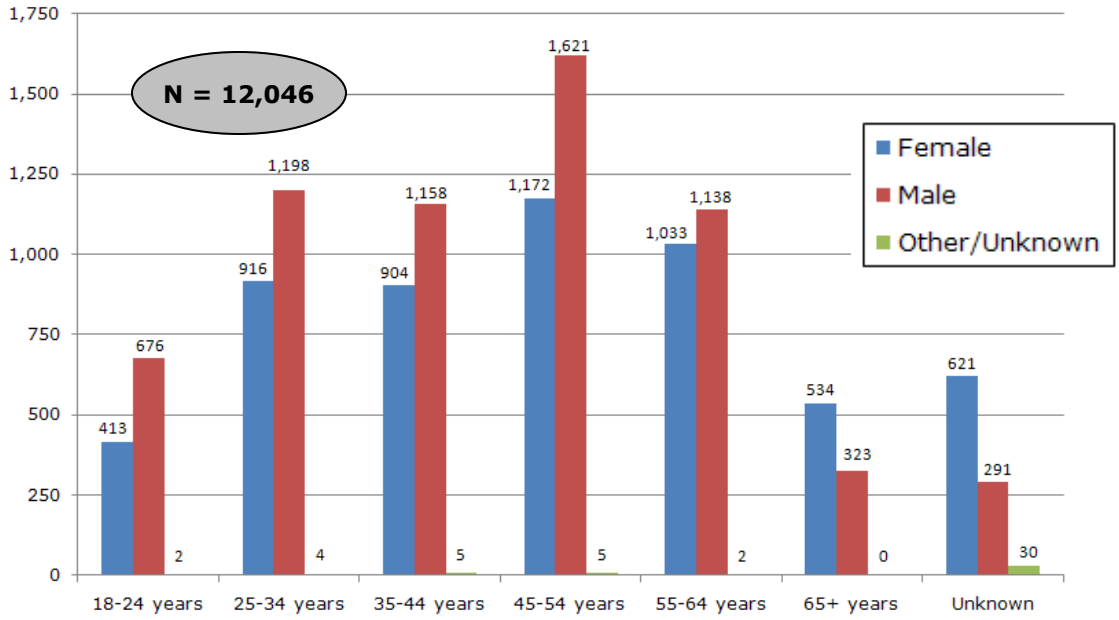
The MIDD made a one-time allocation of funds in 2010 to the City of Seattle for the provision of mental health and chemical dependency services associated with this project. This information on implementation progress and the number of youth served by the program has been provided by the City of Seattle Human Services Department.

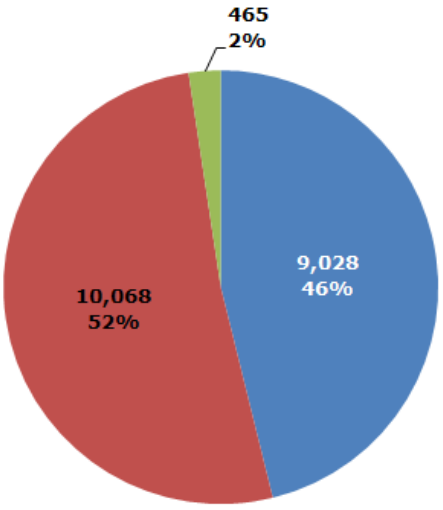
Preliminary qualitative outcomes indicate that the MHP has helped to resolve ongoing problems seen by patrol officers, has used de-escalation techniques when called to cases involving mentally ill persons, and has increased the intervention options available to the CIRT with the ability to conduct assessments in the field. MIDD evaluators are unable to track individuals served by CIRT.

Demographics for Q4-2010 and Q1-2011

Demographic information was collected for 19,561 unduplicated* individuals who received at least one MIDD service between October 1, 2010 and March 31, 2011. Data describing race, ethnicity, age, and geographic region of King County (based on client zip codes) are now available for all new clients, including those attending suicide prevention trainings (Strategy 4d) or participating in school-based prevention programs (Strategy 4c). Given the disproportionate number of youth served in Strategies 4c and 4d (N=6,571), distributions of gender by age group are presented separately for adults (N=12,046) and youth (N=7,515). Other demographic elements such as homeless status, disabilities, and military service are not universally available due to the variety of sources from which these data are drawn.

Unduplicated Gender by Age Group for Adults Receiving MIDD Services

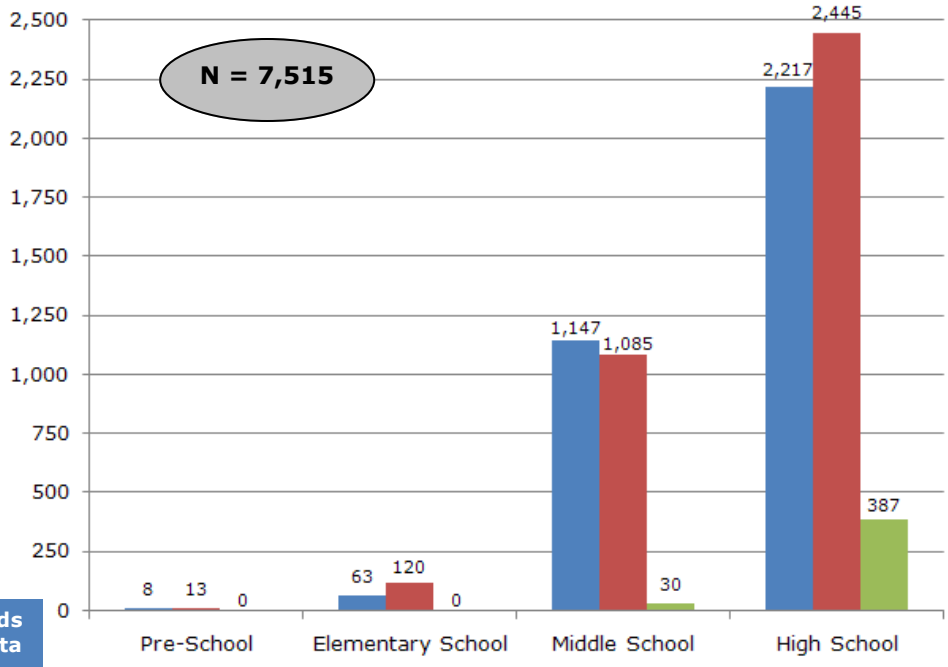




Overall Gender Distribution

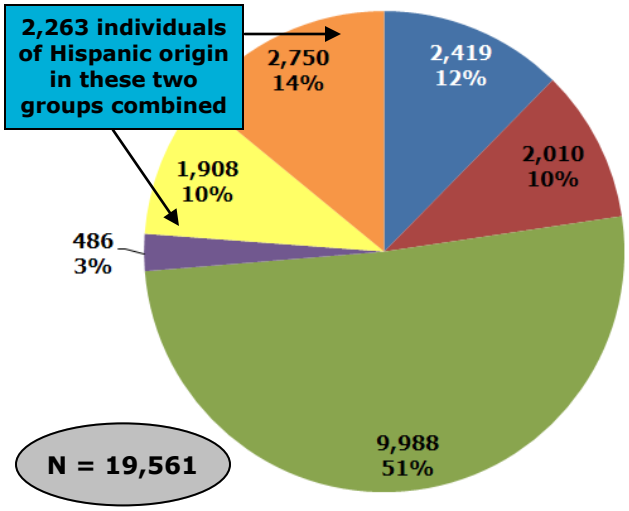
N = 19,561

Gender by School Age Group for Youth Receiving MIDD Services



*** NOTE: Individuals with duplicate records over 26 different strategies and three data sources are counted only once.**

Distribution of Primary Race



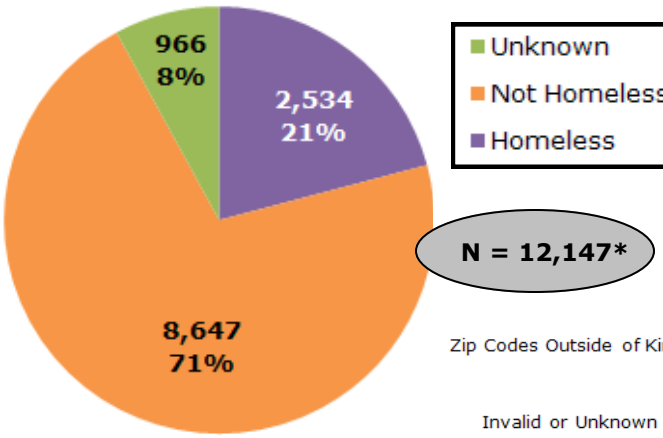
Comparing MIDD Race Data with County Census Data

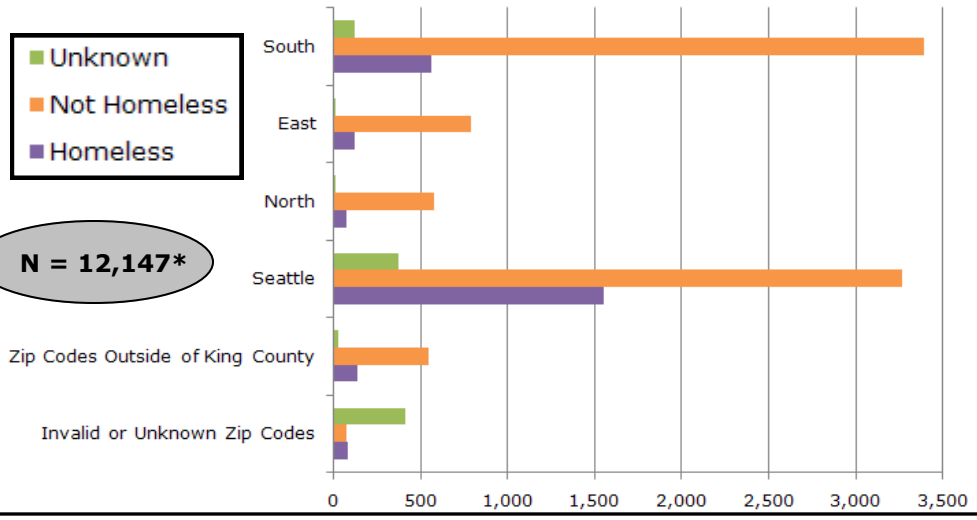
	Race Distribution for Persons Served by MIDD in Reporting Period	King County Race Estimates based on 2005-2009 Census Data
African American/Black	12%	6%
Asian/Pacific Islander	10%	13%
Caucasian/White	51%	73%
Native American	3%	1%
Multiple Races	10%	7%
Other/Unknown	14%	0%
	100%	100%

Data collection by some MIDD providers allows clients to identify with up to four different races. A total of 582 people, excluding Strategy 4d, chose more than one race. For Strategy 4d, the reporting categories have "Multiple" and "Other" combined and those 1,326 people have been included here under "Multiple Races" for a total of 1,908. The category named "Other/Unknown" above includes 870 people from Strategy 4d for whom no race was indicated.

Hispanic origin is a separate data element gathered independently of race. Altogether, 3,220 said they were Hispanic, including 22 percent of those choosing more than one race and 67 percent of those in the "Other/Unknown" category. None of the other race categories indicated Hispanic ethnicity higher than four percent.

Homeless Status at Start of MIDD Services and Number in Each King County Region





*** NOTE:** Data not available for 4c or 4d.

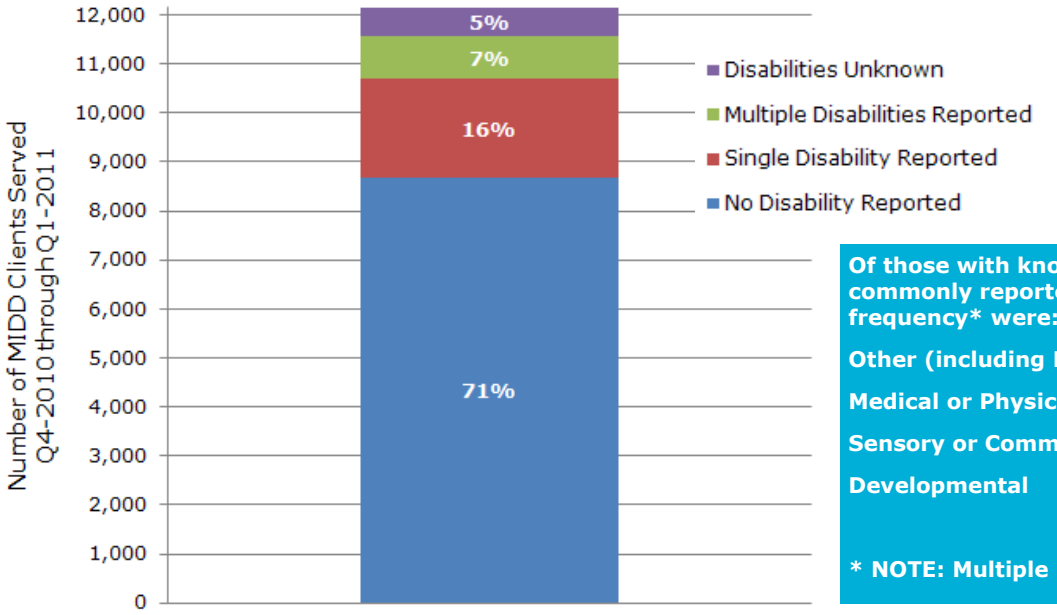
Percent in Each King County Region Comparison for MIDD vs. General Population

	Served by MIDD		2010 King County Cities Census*	
	Number of Individuals	Percent	Number of Individuals	Percent
South	6,712	34%	557,093	34%
North	1,770	9%	103,155	6%
East	3,136	16%	378,252	23%
Seattle	6,659	34%	608,660	37%
Zip Codes outside of King County	709	4%	-	-
Invalid or Unknown Zip Codes	575	3%	-	-
	19,561	100%	1,647,160	100%

* Census numbers adjusted to include annexations after March 31, 2010.

Documented Disabilities Among MIDD Clients Served in Current Reporting Period

In the first half of MIDD's third year of program delivery, nearly 2,800 people with documented and reported disabilities received at least one MIDD service.



N = 12,147

Of those with known disabilities, the most commonly reported, in descending order of frequency* were:

Other (including Psychiatric Disorders)	**1,126**
Medical or Physical	**973**
Sensory or Communication	**345**
Developmental	**251**

*** NOTE: Multiple Responses Possible.**

U.S. Military Veterans and their Families

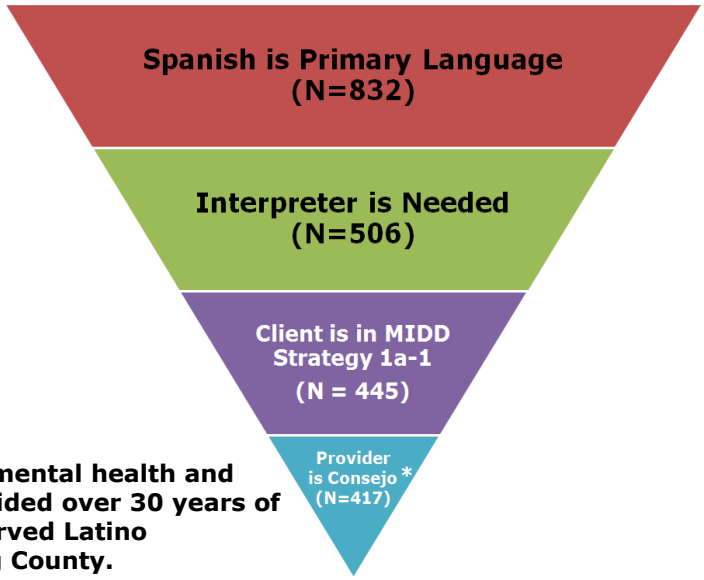
At least 542 MIDD clients in this reporting period were known to have served previously in the U.S. military. Of those, 26 percent were homeless at the start of their MIDD benefit. A total of 87 veterans (16%) were seen in more than one MIDD strategy. Strategies documenting the most encounters with unduplicated U.S. military veterans in descending order of frequency were:

1c	SA Emergency Room Intervention	170
1a-1	MH Treatment	111
3a	Supportive Housing	69
1g	Older Adults Prevention MH & SA	57
1a-2	CD Treatment	55
1b	Outreach & Engagement	44

While data for the new "Family Military Status" are still trickling in slowly, at least 35 children and 58 spouses of those with military service records participated in at least one MIDD program between October 1, 2010 and March 31, 2011.

Primary Languages and Interpretation Services

In the 10,771 instances where client primary language was provided, 8,918 (83%) spoke English. Altogether, 46 different languages were documented among the 1,853 non-English speakers. The most common languages were Spanish (N=832), Vietnamese (N=233), and Russian (N=125). Interpreter services were needed for 1,057 (57%) clients whose primary language was not English. The graphic below provides an example of MIDD service delivery optimization to meet the needs of clients who do not list English as their primary language:



***NOTE: Consejo Counseling and Referral Service is a mental health and chemical dependency treatment agency that has provided over 30 years of culturally-competent services to growing yet underserved Latino communities. They have eight offices throughout King County.**

Preliminary Symptom Reduction Outcomes

Strategy 1a-1

Mental health outpatient treatment providers were required in January 2010 to begin reporting symptom reduction measures for all adults beginning outpatient benefits with MIDD Strategy 1a-1 funds. In April 2010, similar measures became mandatory for children in MIDD-funded outpatient services. This report provides information on the measures adopted in 2009 and initial findings from data collected so far.

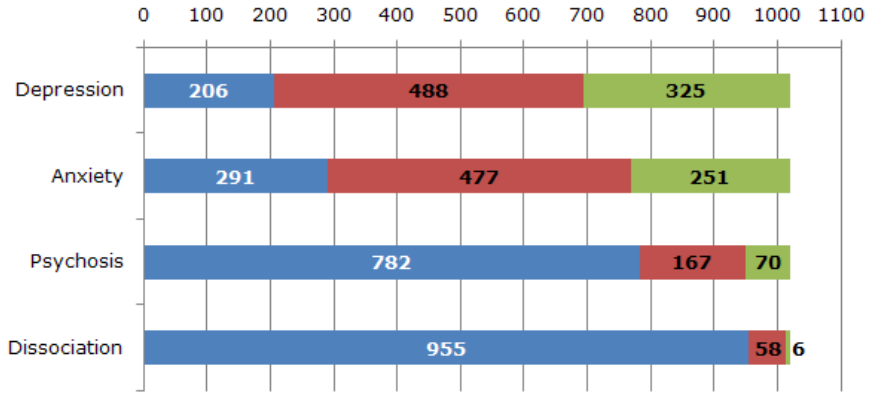
The Problem Severity Summary (PSS)

The PSS was adopted to measure mental illness symptom changes over time in adults. The PSS is an inventory used to assess the functioning level for adults in a number of life domains. Scores on the clinician-rated instrument are assigned to each dimension using the anchors shown below (left):

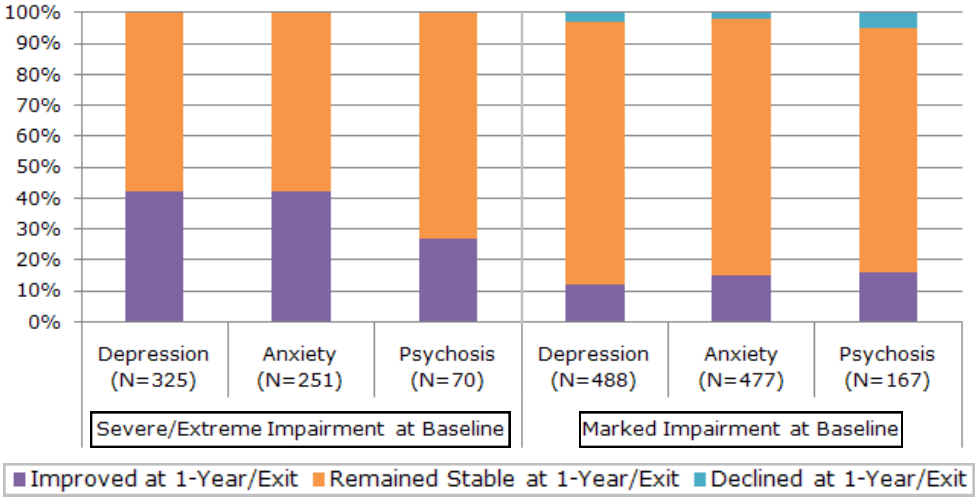
Score	Definition
0	Above average: Area of strength relative to average
1	Average: Functions as well as most people
2	Slight impairment: Limited impairment or disruption in functioning
3	Marked impairment: Obvious impairment, inadequate functioning
4	Severe impairment: Significant disruption/failures in functioning
5	Extreme impairment: Out of control, unacceptable

The PSS assesses 14 dimensions: dangerous behavior, socio-legal, negative social behavior, self-care, community living, social withdrawal, response to stress, sustained attention, physical impairment, health status, and symptoms of depression, anxiety, psychosis (thought disorders), and dissociation (unreality). The PSS also notes cognitive impairment. Of particular interest for the purposes of MIDD evaluation are measures over time for each of the four "symptom" dimensions. The windows for submission of PSS scores are: 1) *Baseline = within 30 days of a benefit start,* 2) *Progress = six months after start, and* 3) *Annual = one year after start or at exit.* (NOTE: Exits prior to six months are submitted as exit scores.)

A total of 1,082 outcome-eligible adults enrolled in Strategy 1a-1 had baseline PSS data. Since only 332 had updates at the six-month mark, analyses were restricted to the 1,019 cases where BOTH baseline and one-year or exit data were available. The incidence for each of the four symptom measures by level of impairments at baseline is shown at right.



Of those with severe/extreme anxiety or depression at baseline, 42 percent improved (reduced symptoms) after one year in treatment or by exit. Just over 12 percent with initial marked impairment improved. See below.



The Children's Functional Assessment Rating Scale (CFARS)

CFARS is a clinician-rated tool used for standardizing impressions from assessment of cognitive, social, and role functioning in children/youth. It includes measures for 16 domains, including depression and anxiety. Ratings are assigned using a 9-point scale where 1 is "no problem" and 9 is a "severe problem." CFARS data will be analyzed in the Fourth Annual Report.

Reduction of Depression and Anxiety for Older Adults in Primary Care Settings

Strategy 1g

Symptom severity for those engaged in relatively brief mental health treatment through MIDD Strategy 1g is measured using two different instruments: PHQ-9 and GAD-7. The PHQ-9 (part of the Patient Health Questionnaire) assesses depression symptoms, while the GAD-7 (Generalized Anxiety Disorder) provides an index to gauge patient anxiety levels. Both instruments have cut points of 5, 10, and 15 to indicate mild, moderate, and severe levels. Symptom reduction is analyzed by comparing changes in instrument scores *within individuals* over time.

Questions from the PHQ-9 assess patient mood, sleeping patterns, energy, appetite, concentration, and thoughts of suicide, among others. The GAD-7 includes questions about feeling worried, nervous, restless, annoyed, or afraid. For all clients served by Strategy 1g prior to April 1, 2011, a total of 1,721 unique individuals had service data (beyond initial screening).

Among the 1,096 individuals for whom two or more PHQ-9 scores were available, 740 (68%) had a reduction in depression symptoms. The average change in PHQ-9 varied by level of initial depression as shown below. On average, those with improved scores had more program contacts (10.17 vs. 7.74) and more total service minutes (397 vs. 284). All differences were found to be statistically significant.

Initial PHQ-9 Level (Scores)	N	Average Change to Lowest Subsequent Score
Below Threshold (0-4)	46	+2.76
Mild (5-9)	119	+0.09
Moderate (10-14)	262	-2.29
Moderately Severe (15-19)	307	-4.71
Most Severe (20-27)	362	-6.64
Analysis of variance, F=47.2, p = .000		

For the anxiety measures, only 742 people had two or more GAD-7 scores. Of those, 483 (65%) showed symptom improvement. Like the depression findings, higher initial scores were associated with greater average reductions over time. For the 323 people with "severe" anxiety at initial assessment, their average improvement was over five points compared to only half a point for those with "mild" anxiety at screening. Those with decreased anxiety did not differ significantly from those with increased anxiety in program contacts and total service minutes.

Outcomes for Domestic Violence and Sexual Assault Survivors

Strategy 13a

Domestic violence survivors working with MIDD-funded mental health therapists become eligible for outcome measurement after they have been seen in at least three separate months. Using a five-point scale, clinicians are asked to rate their clients' stress management, decision making, and self-care. If clients are able to provide their own ratings, they are also asked about life enjoyment and the value of services provided by their mental health therapist.

In this reporting period, outcomes were reported for 243 individuals: 192 clinician-rated, 39 self-rated, and 12 unknown. Those rating themselves were much more likely than their therapists to "strongly agree" with the statement "With the additional support of a therapist, I (my client) can manage the stress in my (her) life better" as shown below (left):

	Clinician Rated	Self Rated
Strongly Disagree	0	0
Disagree	0	0
Agree	132 (69%)	14 (36%)
Strongly Agree	19 (10%)	24 (62%)
Undecided	41 (21%)	1 (2%)
Total	192 (100%)	39 (100%)

Analyses were conducted to explore the relationships between differential clinician/client ratings and the number of days between start and rating, months with service hours, total service hours, and average service hours per month, but no statistically significant differences were found. Where managing stress was rated "strongly agree" (N=43), average time to rating was 199 days (SD=133), and average months with services was 7.72 (SD=3.65).

Strategy 14a

For the survivors of sexual assault included in the MIDD evaluation, adult and child outcomes are tracked separately. If a client does not attend at least two sessions, outcome achievement is coded "not eligible." Successful outcomes are coded for those achieving two or more of the following:

Children/Youth
Able to engage positively with others
Increased emotional stability
Expresses increased sense of safety
Shows positive behavior change
Met treatment goals/milestones
Adults
Increased understanding of experience
Develops skills for coping
Negative symptoms reduced/alleviated
Met treatment goals

When analyzed, outcomes were available for 54 children and 26 adults. Positive overall outcomes were achieved by almost all young clients (89%) and adults (88%). Negative symptoms were reduced for 17 adults (65%).

Jail Utilization Contextual Analysis

As reported in the MIDD Third Annual Report, jail utilization for a sample of MIDD service recipients with at least one jail booking decreased by just over 23 percent during the year following service initiation. The average number of jail bookings for this group of people in the year prior to their MIDD start was 1.95, dropping to 1.50 during their first year of MIDD services. Their average number of days in jail dropped from 44.27 to 33.88 days.

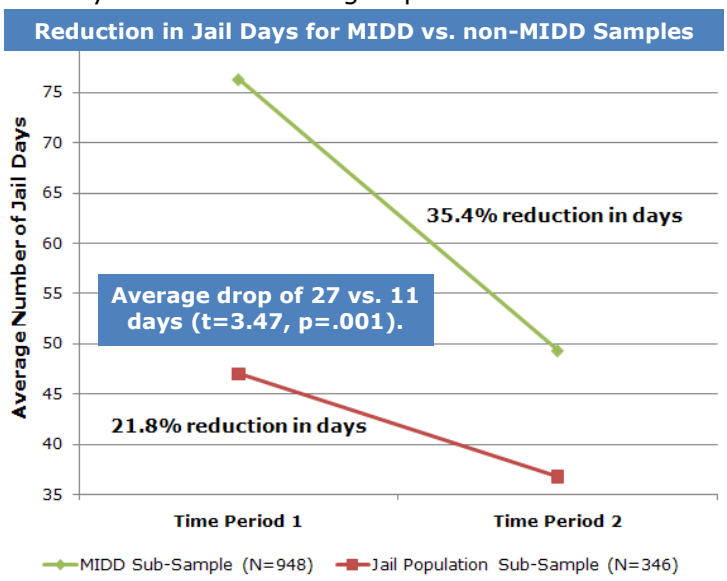
In June 2011, further analyses were conducted as a result of two key criminal justice system changes that occurred during roughly the same time period covered by the initial jail outcomes analysis:

1) Beginning in October 2008, the King County Prosecuting Attorney Office (PAO) changed its Filing and Disposition Standards, which led to a reduction in the number of cases charged as felonies (NOTE: Rather than being arrested and booked, many defendants received a summons to appear in court. Also, convictions for misdemeanors typically result in lighter sentences than felony convictions.)
2) During 2009, the Seattle Police Department's third shift bookings declined dramatically.

These new analyses examined whether the reductions in jail bookings and days for the MIDD population were greater than reductions in the jail population as a whole during the initial outcomes time period. The table below shows jail* bookings and jail days over the four year period ending September 30, 2010, and shows the percent change from one year to the next. These data include people who participated in the MIDD and those who did not. The largest decrease for jail bookings was 10.2 percent in the year prior to the MIDD (2007 to 2008), but for jail days the most substantial decrease was more recent at 13.1 percent (2009 to 2010). The overall decline in bookings/days from end September, 2008 to 2009 (under 8%) is much lower than the percent decline reported for the initial MIDD outcomes sample (over 23%).

	Jail Bookings		Jail Days		Days per Booking	
Time Period	Sum	Percent Change	Sum	Percent Change	Average	Percent Change
October 1, 2006 - September 30, 2007	54,870	N/A	1,074,946	N/A	19.6	N/A
October 1, 2007 - September 30, 2008	49,270	-10.2	995,471	-7.4	20.2	+3.1
October 1, 2008 - September 30, 2009	45,552	-7.5	919,390	-7.6	20.2	0
October 1, 2009 - September 30, 2010	43,297	-4.9	799,336	-13.1	18.5	-8.41

To further put the initial jail findings from the MIDD evaluation into perspective, a random "jail only" sample was drawn. To be eligible for the comparison group, a person had to have at least one jail booking in either 2007 or 2008, or both, and not be included in the MIDD sample. Since the MIDD group with jail use in the year prior to the MIDD was much more extreme than the random "jail only" group (average of 1.95 "pre" bookings vs. 0.97), comparisons were further limited to only those from each group with *two or more bookings* prior to the MIDD or in 2007. The graphic at right illustrates how average reductions in jail days differed for these two "extreme" groups.



While criminal justice system changes occurring in conjunction with MIDD start-up likely contributed to across-the-board reductions in jail bookings/ days, the statistically significant rate of decline *within individuals* for the MIDD sample cannot be dismissed. Because days spent in jail *after* a MIDD service start date may be the result of MIDD participation (therapeutic court interventions or clearing of unrelated outstanding warrants), these new analyses confirm that jail use reductions observed for the MIDD sample were substantial when compared to both overall jail utilization trends and a "jail only" sample.

* Data include King County Jail (Seattle Division), Norm Maleng Regional Justice Center (in Kent, WA), and Juvenile Detention only.

MIDD Financial Status Report

This financial status report is provided for the first half of calendar year 2011 or January 1, 2011 through June 30, 2011. During this period, total MIDD tax revenues were just over $21 million and total expenditures, including supplantation, were nearly $17 million. Parts I and II show budgeted and actual spending by strategy. Also included in the financial report are summary revenues/expenditures and detailed supplantation spending. Please see the bottom of Page 26 for additional information.

Mental Illness and Drug Dependency Fund - Part I

	Strategy	Revised Adopted Budget 2011	Actual June 2011
1a-1	Increase Access to Community Mental Health Treatment	8,519,105	2,829,916
1a-2	Increase Access to Community Substance Abuse Treatment	2,623,225	93,151
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	495,000	28,625
1c	Emergency Room Substance Abuse Early Intervention Program	717,000	254,984
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	225,000	91,670
1e	Chemical Dependency Professional Education and Training	679,994	185,262
1f	Parent Partner and Youth Peer Support Assistance Program	375,000	291
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	450,000	-
1h	Expand Availability of Crisis Intervention and Linkage to	315,000	131,250
2a	Workload Reduction for Mental Health	4,000,000	1,552,677
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	1,000,000	303,971
3a	Supportive Services for Housing Projects	2,000,000	1,742,129
4a	Services for Parents in Substance Abuse Outpatient Treatment	-	-
4b	Prevention Services to Children of Substance Abusers	-	-
4c	Collaborative School-Based Mental Health and Substance Abuse Services	1,236,701	454,225
4d	School-Based Suicide Prevention	200,000	50,000
5a	Expand Assessments for Youth in the Juvenile Justice System	176,938	58,330
6a	Wraparound Services for Emotionally Disturbed Youth	4,500,000	931,893
7a	Reception Centers for Youth in Crisis	-	-
7b	Expansion of Children's Crisis Outreach Response Service System	500,000	207,805
8a	Expand Family Treatment Court Services and Support to Parents	81,250	31,250
9a	Expand Juvenile Drug Court Treatment	[See Part II]	-
10a	Crisis Intervention Team Training for Law Enforcement & Other First Responders	763,747	109,249
10b	Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	6,100,000	234,095
11a	Increase Jail Liaison Capacity	80,000	31,285
11b	Increase Services for New or Existing Mental Health Court Programs	545,282	91,480
12a	Jail Re-Entry Program Capacity Increase / Education Classes at Community Center for Alternative Programs	320,000	78,879
12b	Hospital Re-Entry Respite Beds	508,500	-
12c	Increase Harborview's PES Capacity to Link Individuals to Community Services upon ER Discharge	200,000	83,330
12d	Behavior Modification Classes for CCAP Clients	75,000	31,250
13a	Domestic Violence and Mental Health Services	250,000	129,906
13b	Domestic Violence Prevention	224,000	74,672
14a	Sexual Assault, Mental Health, and Chemical Dependency Services	400,000	134,317
15a	Drug Court: Expansion of Recovery Support Services	103,778	-
16a	New Housing Units and Rental Subsidies	-	-
17a	Crisis Intervention Team/Mental Health Partnership Pilot	-	-
17b	Safe Housing and Treatment for Children in Prostitution Pilot	-	-
	Sexual Assault Supplantation	362,000	362,000
	MH Non-Medicaid Mitigation	-	492,923
	MIDD Administration		
	Personnel	2,783,057	457,709
	Other Costs		365,212
	Total MIDD Operating Dollars	**$ 40,809,577**	**$ 11,623,737**
	Percentage of Appropriation		**28.48%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units for County FTEs)	Revised Adopted Budget 2011	Actual June 2011
	Department of Judicial Administration		
15a	Drug Court: Expansion of Recovery Support Services	126,453	55,268
	Prosecuting Attorney's Office		
9a	Expand Juvenile Drug Court Treatment	42,954	66
11b	Mental Health Court Expansion	220,445	14,329
	Superior Court		
5a	Expand Assessments for Youth in the Juvenile Justice System	209,791	102,373
8a	Family Treatment Court Expansion	308,829	125,259
9a	Expand Juvenile Drug Court Treatment	541,074	246,983
	Sheriff		
10a	Crisis Intervention Training for First Responders	36,615	-
10a	Sheriff MIDD	127,860	32,982
	Office of the Public Defender		
8a	Family Treatment Court Expansion	98,414	44,340
9a	Expand Juvenile Drug Court Treatment	39,998	19,503
11b	Mental Health Court Expansion	304,851	145,932
	District Court		
11b	Mental Health Court Expansion	321,354	147,579
	Total Other MIDD Funds	**$ 2,378,638**	**$ 934,614**
	Percentage of Appropriation		**39.29%**
	Total All MIDD Funds	**$ 43,188,215**	**$ 12,558,351**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

Revenue	Adopted Budget 2011	Actual June 2011
MIDD TAX	42,206,316	20,720,976
Streamlined Mitigation		338,701
Investment Interest - Gross	138,806	72,499
Cash Management Svcs Fee		(1,088)
Invest Service Fee - Pool		3,721
Immaterial Prior Year Correction		25,298
Total Revenues	**$ 42,345,122**	**$ 21,160,106**

Total MIDD Funds	$ 43,188,215	$ 12,558,351
Total MIDD Supplantation	$ 13,098,117	$ 4,291,654
Total Expenditures	**$ 56,286,332**	**$ 16,850,005**

Expenditures Over Revenues	**$ (13,941,210)**	**$ 4,310,101**

Mental Illness and Drug Dependency Expenditure Status Update

The MIDD sales tax is strongly influenced by changes in the economy; as consumer spending declines, the MIDD fund declines. Only three of 37 MIDD strategies remain on hold due to budget constraints. All others have moved into planning, secured other funding, or are now serving their intended targets. Several strategies are serving clients, but are not yet showing expenditures in this report. This may be due to several factors, including strategies that receive state funds expending those funds before they expend MIDD funds, billing delays, and delays in posting expenditures in the accounting system at the time the financial report was generated.

Mental Illness and Drug Dependency Fund - Supplantation

Program Description	Revised Adopted Budget 2011	Actual June 2011
Department of Judicial Administration	**$ 1,339,134**	**$ 264,225**
Adult Drug Court Base	1,339,134	$ 264,225
Prosecuting Attorney's Office	**$ 886,247**	**$ 56,120**
Adult Drug Court Base	551,579	$ 36,036
Juvenile Drug Court Base	121,778	$ -
Mental Health Court Base	212,890	$ 20,084
Superior Court	**$ 239,631**	**$ 108,142**
Adult Drug Court Base	171,713	$ 82,429
Juvenile Drug Court Base	33,959	$ 12,857
Family Treatment Court Base	33,959	$ 12,857
Office of the Public Defender	**$ 1,354,133**	**$ 642,979**
Adult Drug Court Base	834,429	$ 398,460
Juvenile Drug Court Base	24,758	$ 11,883
Mental Health Court Base	346,107	$ 166,126
Family Treatment Court Base	148,839	$ 66,510
District Court	**$ 643,478**	**$ 276,275**
Mental Health Court Base	643,478	$ 276,275
Dept Adult and Juvenile Detention (DAJD)	**$ 406,000**	**$ -**
CCAP	100,000	$ -
Juvenile Mental Health Treatment	306,000	$ -
Jail Health Services	**$ 3,250,372**	**$ 1,507,790**
Psychiatric Services	3,250,372	$ 1,507,790
Total Other MIDD Funds	**$ 8,118,995**	**$ 2,855,533**
Percentage of Appropriation		**35.17%**
SA Administration	399,738	-
SA Criminal Justice Initiative	983,906	248,629
SA Contracts	121,757	5,269
SA Housing Voucher Program (increased by $106,375)	708,990	279,406
SA ESP	560,595	100,505
SA CCAP	472,981	248,581
MH Co-Occurring Disorders Tier	800,000	257,789
MH Recovery (decreased by $106,375)	217,549	81,631
MH Juvenile Justice Liaison	90,000	37,500
MH Crisis Triage Unit	263,606	119,143
MH Functional Family Therapy	272,000	28,864
MH Mental Health Court Liaison	88,000	28,804
Total Other MH/SA MIDD Supplantation Funds	**$ 4,979,122**	**1,436,122**
Percentage of Appropriation		**28.84%**
Total MIDD Supplantation Dollars	**$ 13,098,117**	**$ 4,291,654**
Percentage of Appropriation		**32.77%**

Attachment A: MIDD Oversight Committee Roster

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

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

Christine Lindquist, National Alliance on Mental Illness (NAMI) member
Representing: NAMI in King County

Rhonda Berry, Assistant 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

Chelene Whiteaker, Director, Advocacy and Policy, Washington State Hospital Association
Representing: Washington State Hospital Association/King County Hospitals

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

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

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

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

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

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

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

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

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

Ann McGettigan, Executive Director, Seattle Counseling Center
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

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

Linda Madsen, Healthcare Consultant for Community Health Council of Seattle and King County
Representing: Council of Community Clinics

Dwight Thompson, Mayor Pro Tem 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 3/31/2011

Attachment B: Full Listing of MIDD Strategies

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

Attachment C:

Proposed MIDD Evaluation Plan Matrix Modifications for Select Strategies

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 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 with chemical dependency professionals (CDPs) at Auburn General Hospital (on hold), Highline Medical Center, St. Francis Hospital, and Valley Medical Center. ~~3. Serve a total of 7,680 clients per year.~~ 3. Conduct 6,400 screens and 4,340 brief interventions per year with 8 FTE.	Short-term measures: 1. Fund existing program at Harborview 2. Hire 4 FTE CDPs for new program in South King County 3. 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 visits for those served	1. Output 2. Output 3. Output 4.Outcome 5. Outcome 6. Outcome 7. Outcome	Contract report Contract report MIDD Tools MIDD Tools and TARGET Jail data Sobering data ER data❶

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

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-Based Mental Health and Substance Abuse Services Target Pop: Children and youth enrolled in King County schools identified by the school as at-risk for or experiencing early indicators of MH and/or substance abuse concerns.	1. Fund up to19 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. Fund programs in school districts 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~~ ~~5. Reduce # of school suspensions and detentions in youth served~~ 4. Increase protective factors for youth served 5. Reduce risk factors for youth served 6. Reduce # of truancy petitions filed for youth served 7. Reduce # of detention admissions for those served 8. Reduce severity of CD and MH symptoms in youth served	1. Output ~~2. Outcome~~ 2. Output ~~3. Outcome~~ 3. Output ~~4.Outcome~~ ~~5. Outcome~~ 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	MHCADSD Contract report Contract report ~~School data~~ ❶ ~~School data~~ ❶ MIDD Tools MIDD Tools School ❶ and Juvenile Justice data Juvenile Justice data GAIN Tools

❶ Data sharing agreement(s) needed

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 (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)~~ a. Coordinate/triage 500 assessment referrals per year b. Provide 200 psychological services per year c. Conduct 140 mental health assessments per year d. Conduct 165 chemical dependency evaluations (Global Appraisal of Individual Needs – Initial or GAIN-I) per year e. Provide up to 10 psychiatric evaluations per year (as needed)	Short-term measures: 1. Hire 1 FTE program coordinator 2. 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 linkages to outpatient MH treatment for those referred 6. Increase # of linkages to outpatient substance abuse treatment for those referred 7. Reduce # of detention admissions for youth linked to CD and/or MH treatment	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7.Outcome	Contract report Contract report Assessments.com MIDD Tools MIS (php96) TARGET Juvenile Justice data

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. 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 (including siblings of "identified" youth and/or other young members of families served).	Short-term measures: 1. Hire 1 FTE wraparound coordinator 2. Increase wraparound service delivery Longer-term measures: 3. Improve school attendance and performance among youth served 4. Reduce reported substance use for youth served 5. Improve functioning at home, school, and community for youth served 6. Increase community connections and utilization of natural supports by youth and families served 7. Maintain stability of living situation for youth served 8. Reduce # of detention admissions for youth served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7.Outcome 8.Outcome	MHCADSD Contract report MIDD Tools MIDD Tools MIDD Tools Fidelity monitoring MIDD Tools Juvenile Justice data

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 FTC model to ~~benefit up to 45 additional~~ serve no more than 60 children at any given time and no more than 90 children per year. 2. Enroll up to 15 ~~additional~~ FTC families ~~per year~~ at any given time in FTC wraparound services.	Short-term measure: 1. Hire 3.5 FTE staff to expand family treatment court capacity Longer-term measures: ~~2. Reduce # of days between 72-hour hearing and acceptance hearing dates~~ 2. Increase positive child placements at parent exit from FTC 3. Increase # of FTC parents who are enrolled in CD services 4. Increase # of FTC parents who complete CD treatment 5. ~~Increase~~ Maintain # of FTC families enrolled in FTC wraparound services 6. Reduce severity of CD symptoms for parents served 7. Reduce # of jail bookings and days for parents served	1. Output ~~2. Outcome~~ 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Contract report ~~MIDD Tools~~ MIDD Tools MIDD Tools TARGET MIDD Tools TARGET❶ Jail data

❶ Database revisions ~~needed~~ completed 7/1/2011

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

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 cross program coordination and training	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~~ 170 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 mental health professionals (MHPs) within CSAP provider agencies 2. Hire .5 FTE MHP housed at a culturally-specific provider of sexual assault services 3. Hire .5 FTE Systems Coordinator/ Trainer 4. Increase # of sexual abuse survivors screened for, provided, and referred to MH/CD treatment services 5. Increase # of sexual assault survivors from immigrant and refugee communities provided culturally-relevant MH services in their own language Longer-term measures: 6. Increase coordination between CSAPs, culturally specific providers of sexual assault advocacy services, public MH, substance abuse, and DV service providers 7. Decrease negative symptoms for adults served 8. Increase coping skills for those served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome	Contract reports Contract report Contract report Contract reports and MIDD Tools MIDD Tools Contract report MIDD Tools MIDD Tools