Attachment A

King County

Mental Illness and Drug Dependency Service Improvement Plan

As Required by Ordinance 17998

November 1, 2016

Acknowledgments

The completion of this Service Improvement Plan would not have been possible without the hard work and dedication of a number of individuals.

The Executive wishes to acknowledge the staff of the Department of Community and Human Services, particularly those of the Behavioral Health and Recovery Division, for their contributions of time and expertise. Thank you to all of the County staff from all agencies and departments who assisted with developing this plan.

Very special thanks are also extended to the Mental Illness and Drug Dependency Oversight Committee members and the Committee's co-chairs, King County Superior Court Judge Johanna Bender and Merril Cousin, Executive Director of the Coalition Ending Gender Based Violence, for their tireless leadership, vision and hard work over the last 18 months.

Additional thanks to the numerous cities, organizations and individuals who hosted meetings, held community conversations, facilitated group discussions, and contributed time, insight and expertise to this Service Improvement Plan and the Mental Illness and Drug Dependency planning process. Without the work of all of these organizations and individuals, and the hundreds of community members that participated in the Mental Illness and Drug Dependency review and renewal process, this report and its recommendations would not reflect the broad, and truly county-wide, perspective it contains.

Contents

I. Executive Summary

Much has changed locally, at the state level, and nationally in the realm of mental health and chemical dependency in the eleven years since the Washington State Legislature passed the Omnibus Mental Health and Substance Abuse Act in 2005 to enhance the state's chemical dependency[1] and mental health treatment services, and in the nine years since King County subsequently authorized the one-tenth of one percent sales and use tax to fund new mental health, chemical dependency, or therapeutic court services enabled by the Legislature. From the integration of the formerly separate mental health and chemical dependency services systems into one behavioral health system, to the economic downturn and uptick, to the enactment of the Affordable Care Act, to changes in state laws, King County's Mental Illness and Drug Dependency (MIDD) has become more than a revenue source. The MIDD has become a platform for cross system engagement and improvement, collaboration and policy dialogue.

In accordance with Ordinance 17998, this Service Improvement Plan makes operational, programmatic, funding and policy recommendations for the MIDD service period of 2017-2025 (referred to in this document as "MIDD 2") should the King County Council extend the sales tax sunset date. The recommendations reflect the current and evolving behavioral health needs of King County's citizens, the reality of a challenged behavioral health workforce, and a growing understanding of equity and social justice in the provision of behavioral health services.

King County embraced the opportunity to review and learn from the 2008-2016 MIDD service period (referred to in this document as "MIDD 1") and plan for robust, forward-looking MIDD sales tax supported initiatives, services, and programs for the 2017-2025 service period. This MIDD Service Improvement Plan represents the collaborative efforts over a nearly two-year period from a wide range of internal and external stakeholders including representatives from communities, provider agencies, consumers, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, Council staff, and many others to thoughtfully plan for a renewed MIDD sales tax.

This blueprint for MIDD builds on the success of the first MIDD which was a groundbreaking partnership between health and human services, criminal justice, King County government and community providers, and sets forth a path to overcome the few challenges of the first MIDD service period. The recommended initiatives, policies and processes that comprise MIDD 2 and are reflected in this Service Improvement Plan are:

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

[1] This term is used in its historic context to describe the State Legislature's actions. This term is replaced by "substance use disorder" in subsequent sections of this report.

Successful MIDD 1 programs are proposed to continue into MIDD 2, though some will be merged or retooled during the implementation planning and/or request for proposal (RFP) process.

21 new proposed initiatives are recommended for MIDD 2, bringing the total number of initiatives to 52.

MIDD 2 reflects the integrated behavioral health system, "busting silos" so that services are person-centered, not program-centered. MIDD 2 was intentionally developed in collaboration with initiatives like Best Starts for Kids so that services and funding can be braided to achieve maximum impact.

The proposed MIDD 2 initiatives prioritize:

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

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

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

Community voices and priorities significantly influenced the development of the proposed MIDD 2 funding and programmatic recommendations.

MIDD 2 planning was conducted in a clear and straightforward way, involving the Oversight Committee at each step**.** As guided by the Oversight Committee, the county turned to citizens and community partners across the region for input and guidance in developing the MIDD 2 recommendations. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas, including a focus group with individuals in the King County Jail. Between in person meetings, an electronic survey and other electronic feedback, close to 1,200 citizens and community members provided direct input into the development of the MIDD 2 recommendations.

MIDD 2 continues the County's work to transform the approach to health and human services by **improving health and well-being and creating conditions that allow residents of King County to achieve their full potential.**

MIDD 2 is organized by the MIDD 2 Framework into four strategy areas that reflect a continuum from prevention to crisis services, linked to outcomes. The MIDD 2 Framework is an accountability structure driven by the results policymakers and stakeholders want to see in the community as the result of investment of MIDD funds; the indicators that the county will use to signal that it's headed down the right path to get there; and the actions the county and its partners will take to create the change stakeholders want to see.

A major component of the MIDD 2 Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area. Each of the proposed MIDD 2 initiatives is included in one of the four MIDD 2 Strategy Areas.

MIDD 2 Strategy Area Name	Purpose
Prevention and Early Intervention	*People get the help they need to stay healthy and keep problems from escalating*
Crisis Diversion	*People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*
Recovery and Reentry	*People become healthy and safely reintegrate to community after crisis*
System Improvements	*Strengthen the behavioral health system to become more accessible and deliver on outcomes*

The MIDD 2 Framework is a living document that will be further updated over the life of MIDD 2 to reflect specific programmatic and services once they are determined by the Executive and Council in 2016. The framework will continue to be updated over the life of MIDD 2 as a companion to the MIDD policy goals.

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

Aligning MIDD 2 and Best Starts for Kids (BSK) has been a primary focus of the Department of Community and Human Services (DCHS). From holding joint Community Conversations, to collaborating on strategies and initiatives, to jointly reviewing MIDD 2 concepts and briefing papers, MIDD 2 planning and recommendations development has been a synergistic endeavor with BSK. This strong partnership will continue throughout the life of each of these initiatives, through planned joint meetings of the MIDD Oversight Committee and the Children and Youth Advisory Board and shared approaches to accomplishing the work of each initiative. Operationally, MIDD 2 and BSK are working to coordinate approaches to evaluation, contracting and reporting among other aspects.

Summary of DRAFT MIDD 2 Service Improvement Plan Recommendations

Recommendations that require legislation are noted with ""*

Area of Recommendation	SIP Recommendations
MIDD Fund Financial Policies Recommendations	1. Revise MIDD Fund reserve policy to be 60 days of expenditure. 2. Allocate funds to the Rainy Day Reserve to fully fund the reserve within the current biennium. 3. When reserve levels are met, prioritize use of undesignated fund balance as follows: A. Allocate funds for provider economic adjustments for the next biennium B. Allocate funds to the Emerging Issues initiative to $650,000 annually.
Adding, Deleting, or Modifying MIDD Initiatives, Strategies, Services, and Programs or Initiatives	1. Use updated MIDD 1 revision processes for modifying or adjusting MIDD initiatives, strategies, services and programs. 2. Utilize Emerging Issues initiative to support emerging services and programs for up to two years.
Proposed Schedule for Reporting	1. Revise data collection periods to January to January fiscal/calendar year. * 2. Revise annual report due date to the Council to August.* 3. Launch web data dashboard.
Recommended Modifications to the MIDD Oversight Committee	1. Maintain role as advisory body to the Executive and Council.* 2. Revise membership to reflect changed organizations, boards or entities.* 3. Add five new member seats.* 4. Convene Consumers and Communities Ad Hoc Work Group. 5. Initiate an array of operational improvements. 6. Change the name of the MIDD Oversight Committee to the MIDD Advisory Committee.*

Recommended Additional Seats to MIDD Oversight Committee

Please note that the net increase of seats is five after realigning existing seats to reflect organizational changes.

See report pages 54-59 for details

Focus or Population	Specific Entity
Consumers & Communities – 2	From Consumers and Communities Ad Hoc Work

Representatives	Group
Recovery	Washington Recovery Alliance
Education	Puget Sound Educational Services District
Philanthropy	Many Minds Collaborative
Managed Care	Medicaid Managed Care Plans
Grassroots Organization Representing Cultural Population(s)	To be determined

Highlighted Recommended Improvements to the MIDD Oversight Committee

Convene Consumers and Communities Ad Hoc Work Group – 2 Representatives from Ad Hoc Work Group Elected to MIDD Oversight Committee

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

- Transgender
- Youth
- Immigrant/refugee
- Black/African American
- Asian/API
- Hispanic
- Rural
- Faith
- Former justice involved
- Peers

This recommendation reflects several key principles of community engagement, including the "nothing about us, without us" concept, where the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy. The ad hoc work group invites communities identified as needing a voice in MIDD while not creating an unwieldy Oversight Committee of 50 or more that would not be feasible to operate. A notable component of the Consumers and Communities Ad Hoc Work Group is that its members will be reimbursed for expenses incurred. Two Consumers and Communities Ad Hoc Work Group members would be recommended to serve as full members of the MIDD Oversight Committee, subject to the existing appointment and confirmation process. One of the two Consumers and Communities Ad Hoc Work Group members elected to participate on the Oversight Committee will be a consumer.

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

Change the Name of the Oversight Committee - reflective of the established duties and functions of the Committee that are recommended to continue for MIDD 2, it is recommended that the name of the Committee be amended to reflect its duties as an advisory body: The MIDD Advisory Committee.

Next Steps & Conclusion

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

Ordinance 17998 called for the transmittal of MIDD Service Improvement Plan (SIP) in December of 2016. In order to support the King County Council's desire for expanded review and input of the MIDD 2

SIP, the SIP report called for by Ordinance 17998 is submitted three months earlier than required. The impact of this changed timeline is that two elements of the MIDD 2 – Implementation and Evaluation Plans---require further development. Additionally, the policy goals that were established for MIDD 1 are recommended to be revised, which impacts implementation and evaluation planning outcomes. Developing Implementation and Evaluation Plans will be conducted in collaboration with the MIDD Advisory Committee[2] and providers.

Three specific next steps are necessary for MIDD 2 - completion of the MIDD 2 Implementation and Evaluation Plans and a process to change the name of the MIDD. Each step will be developed collaboratively with the MIDD Oversight Committee and other stakeholders. The Executive recommends transmitting MIDD 2 Implementation and Evaluation Plans to the Council in mid-2017 for review and acceptance, similar to the sequencing of MIDD 1. Additional planning is needed for most of the new initiatives contained in the proposed MIDD 2, many of them requiring community engagement components.

Through the course of MIDD 1 review and MIDD 2 planning, the County received feedback that the name of the MIDD---the Mental Illness and Drug Dependency sales tax and programs—is outdated, negative, disrespectful and stigmatizing. In essence, the name of the MIDD is not itself recovery based and may be counterproductive to wellness. It is recommended that the name of the MIDD be changed to something that more meaningfully and positively reflects the hope of recovery. Changing the name of the MIDD will require revision to the King County Code and other adopted legislation. Executive staff will work with the Code Reviser, the Prosecutor's Office and Council staff on this issue.

In keeping with the established process and timeline for the development of the Mental Illness and Drug Dependency Service Improvement Plan, this document reflects Executive priorities for the programming and funding of Mental Illness and Drug Dependency revenues. In addition to including Executive priorities for the spending of MIDD revenue, adjustments to certain proposed MIDD initiatives have occurred due to or more of the following factors:

1. Updated Office of Financial Analysis (OEFA) MIDD sales tax projections
2. Revised Medicaid assumptions
3. Staged implementation assumptions of select initiatives[3]

Please see Appendix H, Initiative Descriptions and Appendix M, Spending Plan for detailed funding and programmatic recommendations.

[2] Proposed legislation to revise the name of the MIDD Oversight Committee to the MIDD Advisory Committee has been transmitted to the King County Council. Therefore, the term "MIDD Advisory Committee" is used in this document when referencing potential prospective acts by the current MIDD Oversight Committee, assuming King County Council approval of legislation that formally changes the name of the Committee from "Oversight" to "Advisory." A discussion of the proposed name change occurs on page 60 of this document.

[3] Staged Implementation is discussed on page 43 of this report.

II. MIDD 1 and Key Environmental Changes

History of MIDD 1

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

(1)(a) A county legislative authority may authorize, fix, and impose a sales and use tax in accordance with the terms of this chapter.

(b) If a county with a population over eight hundred thousand has not imposed the tax authorized under this subsection by January 1, 2011, any city with a population over thirty thousand located in that county may authorize, fix, and impose the sales and use tax in accordance with the terms of this chapter. The county must provide a credit against its tax for the full amount of tax imposed under this subsection (1)(b) by any city located in that county if the county imposes the tax after January 1, 2011.

(2) The tax authorized in this section is in addition to any other taxes authorized by law and must be collected from those persons who are taxable by the state under chapters 82.08 and 82.12 RCW upon the occurrence of any taxable event within the county for a county's tax and within a city for a city's tax. The rate of tax equals one-tenth of one percent of the selling price in the case of a sales tax, or value of the article used, in the case of a use tax.

(3) Moneys collected under this section must be used solely for the purpose of providing for the operation or delivery of chemical dependency or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services. For the purposes of this section, "programs and services" includes, but is not limited to, treatment services, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service.

(4) All moneys collected under this section must be used solely for the purpose of providing new or expanded programs and services as provided in this section, except as follows:
(a) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposed the tax authorized under this section prior to January 1, 2012, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding in calendar years 2011-2012; up to forty percent may be used to supplant existing funding in calendar year 2013; up to thirty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016;
(b) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposes the tax authorized under this section after December

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

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

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

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

> *The expiration of the tax is established to enable progress toward meeting the county's policy goals outcomes, and to enable evaluations of the programs funded with the sales tax revenue to take place and for the county to deliberate on the success of meeting policy goals and outcomes.*[4]

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

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

MIDD Adopted Policy Goals

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

Policy Goal 2: *A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.*

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

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

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

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

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

MIDD 1 was organized based on the Sequential Intercept Model, providing a framework to determine what services were needed under MIDD 1 to help prevent incarceration, hospitalization and homelessness. It is included as Appendix A to this report.

MIDD 1 Implementation: Oversight, Implementation and Evaluation Plans: Ordinance 15949 called for key foundational planning documents necessary to the successful and transparent implementation of the MIDD. The legislation called on the Departments of Community and Human Services, Adult and Juvenile Detention, and Public Health; the Offices of the Public Defender and Prosecuting Attorney; and Superior and District Courts to develop and submit to the Council MIDD oversight, implementation and evaluation plans.

The MIDD Oversight Plan, adopted by Ordinance 16077, established the MIDD Oversight Committee. It set the role and duties of the Oversight Committee, and established the composition of the Oversight Committee. As described in legislation, the Oversight Committee is responsible for the ongoing oversight of the MIDD services and programs funded with the sales tax revenue. It acts as an advisory body to the Executive and the Council, reviewing and making recommendations on the implementation and effectiveness of the sales tax programs in meeting the five established policy goals. It reviews and comments on all required reports and on emerging and evolving priorities for use of the MIDD funds. Ordinance 16077 states that the Oversight Committee "should promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers, and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts."[5] Ultimately, the Oversight Committee's purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative.

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

The MIDD 1 Implementation Plan was adopted via Ordinance 16261 on October 6, 2008. Per Ordinance 15949, the MIDD Implementation Plan was developed in collaboration with the Oversight Committee. The Implementation Plan described the implementation of the programs and services outlined in the MIDD Action Plan. As required, it included a discussion of needed resources (staff, information and provider), milestones for implementation of programs and a spending plan. It also addressed expansion of Adult Drug Court and mental health and substance abuse services for survivors of domestic violence and sexual assault.

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

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

MIDD 1 Service Areas and Programming

MIDD 1 Service Area	MIDD Programs and Strategies
Community-Based Care	• Increase access to community mental health and substance abuse treatment for uninsured children, adults and older adults • Improve the quality of care by decreasing mental health caseloads and providing specialized employment services • Provide supportive services for housing projects serving people with mental illness and chemical dependency treatment needs
Programs Targeted to Help Youth	• Expand prevention and early intervention programs • Expand assessments for youth in the juvenile justice system • Provide comprehensive team-based, intensive "wraparound" services • Expand services for youth in crisis • Maintain and expand Family Treatment Court and Juvenile Drug Court
Jail and Hospital Diversion	• Divert people who do not need to be in jail or hospital through crisis intervention training for police and other first responders and by creating a crisis diversion facility • Expand mental health courts and other post-booking services to get people out of jail and into services faster • Expand programs that help individuals re-enter the community from jails and hospitals
Domestic Violence and Sexual Assault and Adult Drug Court	• Address the mental health needs of children who have been exposed to domestic violence • Increase access to coordinated, early intervention mental health and substance abuse services for survivors of domestic violence • Increase access to treatment services for victims of sexual assault • Enhance services available through the King County Adult Drug Diversion Court
Housing Development	• Support capital projects and rental subsidies for people with mental illness and chemical dependency

The Implementation Plan for the 2008-2016 MIDD service period contained information on each individual program, called a "strategy," including the following:

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

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

The adopted MIDD Implementation Plan included two additional programs added by the Council that were not in the Executive's transmitted plan: Crisis Intervention Team / Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project.

The Implementation Plan outlined the steps and timeline for creation of the comprehensive programming that became MIDD programs. The Implementation Plan summarized the collaborative work of many entities over a two-year period to organize and develop the work that eventually became the MIDD. The document states that the Implementation Plan is "a product of a comprehensive, multi-jurisdictional plan to help youth and adults who are at risk for or suffer from mental illness or substance abuse."[6]

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

The MIDD Evaluation Plan identified a framework for evaluating most of the programs (strategies) in the MIDD Implementation Plan except the two added by the Council Crisis Intervention Team / Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project. The Evaluation Plan stated that evaluation would be accomplished "by measuring what is done (output), how it is done (process), and the effects of what is done (outcome)."[7]

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

- 2015: 20 percent
- 2016: 10 percent
- 2017: 0 percent (the King County MIDD 1 expires in January 2017; should MIDD be renewed, the 2017-2018 budget would reflect zero supplantation).

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

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

Replacement of lost Federal funds is permitted.

MIDD in 2016: MIDD serves thousands of people annually[8], providing services to those who otherwise would not receive services. MIDD funding provides:

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

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

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

Key Changed Conditions Impacting MIDD

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

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

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

the former Regional Support Networks (RSNs). The BHO services include inpatient and outpatient treatment, involuntary treatment and crisis services, services in jail, and services funded by federal block grants. King County Behavioral Health and Recovery Division will serve as the BHO for the King County region.

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

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

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

Please also see pages 66-69 for additional discussion of Behavioral Health Integration.

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

Since January 1, 2014, when Washington State took advantage of Medicaid expansion under the ACA, King County has seen a significant increase in the number of people enrolled in Medicaid. As of June 1, 2016, approximately 165,000 individuals have become newly eligible for Medicaid services in King County; of those, about 10,000 had accessed outpatient mental health services from the King County RSN. As of June 1, 2016, there are approximately 405,000 Medicaid-covered individuals in King County.

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

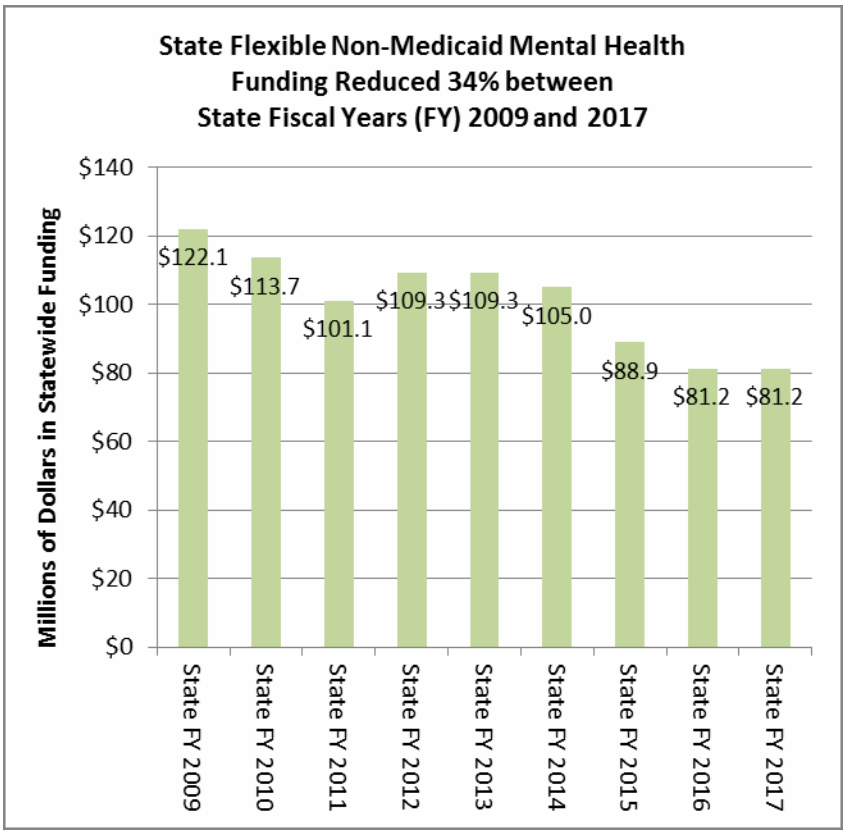
King County BHO to raise outpatient case rates paid to providers. Unfortunately, the system is experiencing a bow wave: the behavioral health system is struggling to find and/or retain trained, licensed and qualified staff to provide services to this expanded population. Providers statewide report difficulty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

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

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

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

Table 1



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

Another aspect to resource scarcity is the ongoing structural deficit of King County's General Fund. For the upcoming 2017-2018 biennium, the General Fund is facing a $50 million deficit. About 75 percent of the General Fund is used to support the county's criminal justice system, including the jail, the courts, prosecution and defense, and the Sheriff's Office. Due to the $50 million General Fund deficit, the County is exploring all options to have other funding sources, like the MIDD sales tax, support programs that would relieve pressure on the General Fund. However, the ability to use MIDD revenue to support previously existing programs is limited by a supplantation restriction in the state MIDD statute, which requires MIDD funding be used on "new or expanded programs or services." One exception to the supplantation restriction in the MIDD statute is therapeutic court activities (e.g. Mental Health Court or Drug Court). Therapeutic courts were originally funded by the General Fund before being funded by the first MIDD. The MIDD 2 spending plan that is included with this report reflects the continued support of King County's four existing therapeutic courts by the MIDD.

High Treatment Need: Severe resource scarcity has coexisted with a very high prevalence of treatment need in Washington as compared to other states. Analysis of data from the federal Substance Abuse and

Mental Health Administration (SAMHSA) 2010-11 Mental Health Surveillance Survey found that Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (seven percent).[9]

Population Growth: The population of King County grew by an estimated 22 percent between 2000 and 2015 – almost 380,000 people. Meanwhile, the state's population increased by approximately 22 percent as well – or nearly 1.3 million.[10] Even this one factor alone – the addition of so many more residents – would have placed more pressure on an overstretched community behavioral health treatment system.

Emergency System Use: More and more people are seeking psychiatric care via hospital emergency departments (EDs) – in 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of 2007 psychiatric ED visits, 41 percent result in a hospital admission, over two and a half times the rate of ED visits for other conditions,[11] and between 2001 and 2006 the average duration of such visits was 42 percent longer than for non-psychiatric issues.[12] The growth in these figures may result from the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally, that began as part of deinstitutionalization in the 1960s and has continued until very recently.[13]

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

Court Rulings

Psychiatric Boarding: On August 7, 2014, the Washington State Supreme Court ruled that hospital boarding of involuntarily detained individuals in mental health crisis, absent medical need, is unconstitutional. Psychiatric boarding or "boarding" became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available,

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

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

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

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

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

individuals were detained and waiting in less than optimal settings such as hospital EDs until a psychiatric bed became available.

Psychiatric boarding hurts patients and drives resources away from community-based and preventive care. Studies show that prolonged waits in EDs for psychiatric patients are associated with lower quality mental health care.[14] This has been a nationwide problem that had been affecting Washington and King County since at least 2009.

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, the Court emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of bed capacity.[15]

State and local partners, including the Community Alternatives to Boarding Task Force[16], are developing system innovations and deploying new resources strategically to improve access to care. Local flexible resources like MIDD play a key part in expanding treatment capacity in King County.

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

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

Other Change Drivers

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

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

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

[16] See www.kingcounty.gov/cabtf for more information about the Community Alternatives to Boarding Task Force, including its June 2016 final report to King County Council in response to Motion 14225.

The workforce crisis crosses all levels of care, as insufficient recruitment and retention of qualified behavioral health workers is presenting significant problems for community providers and hospitals, and the problem is getting worse. It is a concern of providers and public behavioral health systems both nationally and in Washington State, where it has been a focus of attention for the Adult Behavioral Health System Task Force's Workforce Development Workgroup[17], the Washington Community Mental Health Council[18] and the Washington State Hospital Association.[19]

A confluence of competing factors is contributing to the behavioral health workforce crisis. Studies of the situation in Washington have found that there is now a greater awareness of behavioral health needs among human service providers, faith communities, medical, and housing providers; an aging population coping with chronic conditions including mental health and substance abuse issues; and greater attention to the behavioral health needs of veterans. Also, there is increasing need for workers with multiple credentials in order to serve clients who have multiple behavioral health treatment needs or who are receiving care in integrated care settings. At the same time, many longtime behavioral health professionals are retiring or nearing retirement, and fewer younger workers are seeking a career in human services, leading to significant competition in the labor market.[20]

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

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

Evolving Values and Approaches to Care: The factors below reflect new directions or policies taken by King County in the provision of behavioral health services since 2007 when the MIDD was first

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

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

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

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

authorized. In addition, each element echoes a MIDD Oversight Committee-identified guiding principle for the development of MIDD 2.

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

The initial MIDD was based on the concept of decriminalization of mental health and substance use following the National GAINS Center Sequential Intercept model. Building on the model and following emerging practices, King County embraces a recovery-oriented framework for all individuals served in its behavioral health system. This practice enables King County to better address the needs of individuals with complex behavioral and other health conditions who are incarcerated, or at risk of incarceration, throughout King County. It is well documented that individuals with complex behavioral health conditions are overrepresented in criminal justice settings nationally. Reentry and transition from hospital or jail planning can work well when behavioral health and criminal justice systems collaborate to support recovery.[21]

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

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

Most individuals seeking public behavioral health and other public services have histories of physical and sexual abuse and other types of trauma-inducing experiences.[22] These experiences often lead to mental

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

[22] "NCTIC's Current Framework." National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint. Substance Abuse and Mental Health Services Administration, 26 Oct. 2015. Web. 21 June 2016. Also supported by Lu, Weili, Mueser, Kim T., Rosenberg, Stanley D., Jankowski, Mary Kay. Correlates of Adverse Childhood Experiences Among Adults with Severe Mood Disorders. Psychiatric Services. 2008 (59)"1018-1026.

health and co-occurring disorders such as chronic health conditions, substance abuse, as well as contact with the criminal justice system.

Providing services under a trauma-informed framework can result in better outcomes than "treatment as usual." A variety of studies have revealed that programs utilizing a trauma-informed model are associated with a decrease in psychiatric symptoms and substance use. Some programs have shown an improvement in daily functioning and a decrease in trauma symptoms, substance use and mental health symptoms.[23, 24] Trauma-informed care may lead to decreased utilization of crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed services.[25]

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

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

In October of 2014 Executive Constantine signed an Executive Order calling for advancing equity and social justice in King County, along with the development of a countywide Equity and Social Justice Strategic Plan. Planning of MIDD 2 is driven in large part by the County's commitment to enacting its Equity and Social Justice Agenda.

MIDD 1 Comprehensive Historical Review and Assessment Report Findings

As noted, Ordinance 17998 called for two major MIDD related work products to be submitted to the

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

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

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

Council: this **Service Improvement Plan** and the **Comprehensive Historical Review and Assessment Report.** The latter is an extensive examination and assessment of MIDD 1 strategies, programs, and services and was submitted to the Council on June 30. It included recommendations on improvements to MIDD performance measures, evaluation data gathering and a review of MIDD evaluation processes. The Comprehensive Historical Review and Assessment Report contained the following findings on MIDD 1:

1. **Aggregating results from all relevant strategies, MIDD is recognized as SUCCESSFUL and EFFECTIVE in meeting the established policy goals.**

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

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

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

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

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

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

The Comprehensive Historical Review and Assessment Report also identified a number of recommendations to improve evaluations of MIDD 2. The potential renewal of MIDD presents a tremendous opportunity to examine MIDD and its evaluation. Informed by an independent assessment

of the MIDD Evaluation by King County's Office of Performance, Strategy, and Budget (PSB), as well as other internal assessments and stakeholder feedback, a range of improvements to the MIDD evaluation approach were recommended. The 22 potential changes to the MIDD 2 evaluation fall into these four broad categories:

- Updating and revising the evaluation framework
- Revising performance measures, targets, and outcomes
- Upgrading data collection and infrastructure
- Enhancing reporting and improving processes.

III. Key Components of MIDD 2

Overview

The 2016 MIDD Service Improvement Plan represents the collaborative efforts over a nearly two-year period from a wide range of internal and external stakeholders, including representatives from communities, provider agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, Council staff, and many others. The product of this work is the MIDD 2 Service Improvement Plan which is a comprehensive, multi-jurisdictional proposal to help people living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement. It builds on the success of the first MIDD which was a groundbreaking partnership between health and human services, criminal justice and King County government and community providers, and sets forth a path to overcome the few challenges of MIDD 1.

The recommended initiatives, policies and processes that comprise MIDD 2 are:

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

Differences between MIDD 1 and Proposed MIDD 2

MIDD 1	Proposed MIDD 2
• **Organized into five service areas that are a mix of services and populations**	• **Organized into four strategy areas corresponding to the behavioral health continuum of care**
• **Constructed to support two separate systems: mental health and substance use**	• **Based on an integrated system of behavioral health services**
• **Envisioned to support expansion of existing therapeutic courts**	• **Supports entirety of therapeutic courts**

Development of Proposed MIDD 2 Recommendations

The MIDD 2 planning process was co-created by the MIDD Oversight Committee. It was intentionally crafted to be transparent and provide ample opportunities for review and input. Hundreds of citizens and community members engaged in the various elements of the MIDD 2 planning process, from completing a survey, to submitting a new concept, to participating in a community conversation or focus group. Regular updates were provided on MIDD 2 planning to provider networks, jurisdictional coalitions, elected officials, Council and Executive staff and internal county stakeholders. A website was launched so that all relevant MIDD 2 planning documents and updates could be easily accessed. Below highlights some of more notable elements of MIDD 2 planning.

Oversight Committee Guidance and Input: The MIDD Oversight Committee performed a critically important role in MIDD 2 planning. In March 2015, the MIDD Oversight Committee established Values

and Guiding Principles to inform all aspects of MIDD 1 review work and MIDD 2 renewal planning activities. County staff and Oversight Committee members relied on these values and guiding principles as benchmarks as well as used them as checks and balances throughout MIDD 2 planning. The Values and Guiding Principle informed everything about MIDD 2 from the development of outreach and communications plans, to recommendations contained in this report. The values and guiding principles served as cues for the transparent and collaborative approach the County executed for the review of planning for, and implementation of, a potential MIDD 2.

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

MIDD Oversight Committee members and/or the MIDD Renewal Strategy Team[26] reviewed and provided feedback on the recommendations contained within this report. Additionally, the Oversight Committee has reviewed and provided feedback on major MIDD review and renewal planning documents, including the MIDD 2 Framework which is the basis of recommended revisions to the MIDD policy goals and a key driver of recommended revisions to the potential MIDD 2 evaluation approach. The MIDD 2 Framework is discussed in detail later in this section of the report.

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

[26] The Oversight Committee appointed a MIDD Renewal Strategy Team comprised of eight Oversight Committee members, representing an array of populations and stakeholders and including staff from the county's executive and legislative branches, to facilitate a higher degree of collaboration and input from the Oversight Committee. The Strategy Team provided guidance and expertise for MIDD 1 review and MIDD 2 planning activities to BHRD staff. Intended to augment Oversight Committee feedback and input, the MIDD Oversight Committee Strategy Team provided in-depth reviews of MIDD 1 review and MIDD 2 planning activities and documents. The Strategy Team facilitated analysis, identified issues, offered subject matter expertise, and helped to problem-solve with county staff charged with completing the tasks required by Ordinance 17998.

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

Citizen and Community Input: King County conducted its MIDD renewal planning work with an unprecedented level of transparency and community engagement. The Department of Community and Human Services (DCHS) planned and collaboratively developed the deliverables required by Council by sharing information and involving internal and external partners and communities. In order to develop responsive and relevant MIDD 2 initiatives, King County turned to residents and community partners across the region for input and guidance. Informed by the MIDD Oversight Committee's Values and Guiding Principles, King County staff conducted a robust outreach and engagement process around MIDD renewal. From September 2015 through February 2016, King County invited citizens and communities to participate in five regional Community Conversations on MIDD.[27] Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas, including a focus group with individuals in the King County Jail. The purpose of these engagement efforts was to hear ideas about services and programs for people living with mental illness and substance use disorders from those who need, use or engage with our county systems. The conversations were intentionally designed so that community members had a role in informing the County's decisions around its investments for children and youth and investments for mental health and substance use disorder services and programs. Focus groups ranged in size from as few as four to over 100 participants. Groups included, in order of meeting:

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

MIDD staff also conducted an electronic survey between September 2015 and February 2016. Over 360 respondents took the time to answer key questions about MIDD. Summaries and themes from these groups are available on the MIDD renewal website, along with the MIDD survey data.

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

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

Three Phased MIDD Renewal Process: In addition to the vigorous community engagement work, a structured three phased review and renewal process was established in collaboration with the MIDD Oversight Committee. This process enabled the widest possible access to MIDD 2 funding and facilitated a coordinated analysis of new concepts and existing MIDD 1 programming. The process included:

I. **PHASE I -** Interested parties submitted New Concepts to the County between September 15, 2015 and October 31, 2015. After initial screening of the concept forms to ensure fitness under the RCW, they were forwarded to Phase 2. Only a handful of concepts were not moved forward out of the 141 received.

II. **PHASE II -** County staff drafted over 90 briefing papers in consultation with behavioral health partners, providers and subject matter experts. Briefing papers provided answers to important analytical questions. The process specifically involved review of the papers by concept submitters and every effort was made by DCHS to reflect feedback from concept submitters whenever possible while striving to provide objective analysis.[28]

    The second step of Phase 2 were panel reviews of existing strategy and new concept briefing papers, with the panels sorting the strategies and concepts into high, medium and low categories for potential funding consideration. Four panels, corresponding to the four MIDD 2 strategy areas, convened in March 2016. Over 50 individuals participated on the review panel teams. The panels were intentionally constructed to bring in a diverse array of lived experiences, skills, knowledge, perspectives and insights to the sorting process. Each review panel team had a mix of community members and MIDD Oversight Committee members or their designees. Guiding factors provided to the review panels to use as they conducted their reviews of the briefing papers included questions on community needs, equity and social justice, integration, and recovery and reentry. See Appendix D for the briefing paper panel sorting results. Briefing papers can be found on the MIDD website: http://www.kingcounty.gov/MIDDrenewal.

III. **PHASE III –** County staff aligned MIDD 2 programmatic recommendations, developing the recommendations and identifying funding levels. County staff assessed all existing MIDD 1 programs and potential new concepts for fit, value and ability to help the County achieve MIDD policy goals. The initial recommendations were released to the MIDD Oversight Committee and for public review and a two week public comment period on April 22, 2016. Over 200 public comments were received. County staff made revisions to the draft MIDD 2 funding and programmatic recommendations in May, with revised recommendations released on May 20. Two Oversight Committee meetings (April and May) were dedicated to the review of and feedback on the draft funding and programmatic recommendations.

Please see Appendix E for the detailed MIDD 2 process overview.

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

MIDD 1 Policy Goals & Proposed Modifications

MIDD 1's adopted policy goals are the foundational expression of what policymakers expected the MIDD to achieve, or work towards achieving. The policy goals provided the essential framing for all elements of the MIDD, including the MIDD 1 Implementation and Evaluation Plans. The primary focus of the MIDD 1 evaluation was to determine progress of MIDD-supported programs toward meeting the five policy goals.

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

MIDD 2007 Adopted Policy Goals

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

Policy Goal 2: A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency;

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

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

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

Calling for proposed modifications to the MIDD policy goals through Ordinance 17998[29], the Council recognized that the behavioral health and criminal justice environments have changed since 2007 when the MIDD 1 policy goals were established via Ordinance 15949 and that refined policy goals may be necessary for MIDD 2. As required, the requested modifications to the adopted MIDD policy goals were submitted to the Council in the Comprehensive Historical Assessment Report submitted to the Council on June 30, 2016.

Because of the fundamental role of the MIDD policy goals for the implementation of MIDD 2, this Service Improvement Plan includes the proposed modifications to the goals that were recommended in the Comprehensive Historical Assessment Report submitted to the Council on June 30. They are also included in this report because the Proposed MIDD 2 Initiative Descriptions reference the 2007 policy goals AND the proposed modified goals.

Person-Centered Language and Goals: Revised MIDD policy goals reflect a person-centered language approach. Person-centered language strives to avoid dehumanizing terms for individuals and groups

[29] Ordinance 17998, lines 103-104

that demean or create barriers to inclusion. For example, instead of saying, "the mentally ill," person-centered language would say "individuals with mental illness." This approach also aligns with RCW 44.04.280, based on 2004 HB 2663, which directed state statue to avoid non-person first language.[30]

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

RECOMMENDED REVISIONS TO MIDD POLICY GOALS	
2007 Policy Goal	**Recommended Revised Policy Goal**
1. A reduction in the number of mentally ill and chemically dependent people using costly interventions, such as, jail, emergency rooms, and hospitals	1. Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals.
2. A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency	2. Reduce the number, length, and frequency of behavioral health crisis events.
3. A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.	3. Increase culturally-appropriate, trauma-informed behavioral health services.
4. Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement.	4. Improve health and wellness of individuals living with behavioral health conditions.
5. Explicit linkage with, and furthering the work of, other Council directed efforts including, the Adult and Juvenile Justice Operational Master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.	5. Explicit linkage with, and furthering the work of, other King County and community initiatives.

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

Recommended Policy Goal 2 addresses the emergency medical system use aim of the 2007 policy goal 1 by addressing reduction of behavioral health crises. It further recognizes that return on investment in

[30] http://app.leg.wa.gov/RCW/default.aspx?cite=44.04.280

this area can be achieved either by reducing how often people are in crisis, or helping people in crisis stabilize more quickly.

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

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

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

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

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

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

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

In light of these factors, the recommended policy goal revisions clearly highlight the fundamental intentions of MIDD 2 while at the same time recognizing its limitations. These proposed revised MIDD policy goals focus primarily on **expected results for MIDD program participants and improvements in access to services**.

MIDD 2 Framework

MIDD 2 is rooted in the County's work to transform the approach to health and human services by improving health and well-being and creating conditions that allow residents of King County to achieve their full potential. This is reflected throughout the planning and development of MIDD 2 recommendations and summarized in the MIDD 2 Framework.

The MIDD 2 Framework is an accountability framework driven by the results policymakers and stakeholders want to see in the community as the result of investment of MIDD funds; the indicators that the county will use to signal that it's headed down the right path to get there; and the actions the county and its partners will take to create the change stakeholders want to see. To inform this framework, DCHS drew upon the principles of results-based accountability practices among other elements, including the Sequential Intercept Model.[31] The MIDD 2 Framework is shown in Appendix F.

The MIDD 2 Framework identifies and organizes the central components of MIDD 2. It identifies the MIDD 2 approach at four different levels:

1) What will happen as a result of MIDD services
2) The theory of change driving the result of MIDD
3) Key strategies and outcomes intended to achieve MIDD's 2 result
4) Sample performance measures used to demonstrate progress toward outcomes.

MIDD 2 Framework Highlights
***MIDD Result**: People living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement.* ***MIDD Theory of Change**: When people who are living with, or who are at risk of, behavioral health disorders utilize culturally-relevant prevention and early intervention, crisis diversion, community reentry, treatment, and recovery services, and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.*

The MIDD 2 Framework shows the outcomes of MIDD 2 as divided into two areas: population and individual outcomes. Each level of outcomes has associated indicators and measures. There are two very important caveats associated with MIDD outcomes and indicators.

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

2. Performance measures and indicators for MIDD 2 will be identified after the funding and

[31] The Sequential Intercept Model is discussed on page 63.

programmatic decisions are made by the Executive and Council. The measures and indicators must be developed in partnership with providers and other stakeholders.

3. The MIDD 2 Evaluation Framework will include performance measures and indicators necessary to gather and report on population and individual outcomes and progress toward policy goals.

A major component of the MIDD 2 Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area. Each proposed MIDD 2 initiative is included in one of the four MIDD 2 Strategy Areas.

MIDD 2 Strategy Area Name	Purpose
Prevention and Early Intervention	*People get the help they need to stay healthy and keep problems from escalating*
Crisis Diversion	*People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*
Recovery and Reentry	*People become healthy and safely reintegrate to community after crisis*
System Improvements	*Strengthen the behavioral health system to become more accessible and deliver on outcomes*

Each of the framework's four strategy areas includes sample performance measures for individuals along with outcomes and indicators for the wider population. They are noted as "sample" because they represent examples of the types of information to be sought in evaluation of MIDD 2 strategy areas and programming. Indicators reflected in the framework will change based on final MIDD 2 programming decisions and community and stakeholder feedback. Subsequent updates to the MIDD 2 Framework will be shared with the MIDD Oversight Committee for their review and feedback.

As discussed in the MIDD Renewal Progress Report that was submitted to the Council in November 2015, and the Comprehensive Historical Review and Assessment Report submitted to the Council in June 2016, King County Behavioral Health and Recovery Division, in consultation with the MIDD Oversight Committee, developed the MIDD 2 Framework as a tool to succinctly summarize the MIDD 2 approach, activities, policies and outcomes. Updates to the MIDD 2 Framework have been made based on stakeholder input and further clarifying the intent of sections that address potential performance measures.

The MIDD 2 Framework is a living document that will be further updated over the life of the MIDD 2 to reflect specific programmatic and services once they are determined by the Executive and Council in 2016. The Framework will continue to be updated over the life of MIDD 2 as a companion to the MIDD policy goals.

IV. Proposed MIDD 2 Initiatives

MIDD 2 planning work was carefully conducted in clear and straightforward ways. From establishing the MIDD 2 Framework that simply and explicitly explains the purpose and outcomes of MIDD, to developing the review and renewal processes that prioritized the voices of communities, every step of the process that has resulted in the recommendations proposed in this Service Improvement Plan has been transparently shared with stakeholders.

The terms "initiative" and "MIDD initiative" describe individual programs and services supported by the MIDD sales tax.

The Proposed MIDD 2 initiatives prioritize:

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

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

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

Aligning MIDD 2 and Best Starts for Kids (BSK) has been a primary focus of DCHS. From holding joint Community Conversations, to collaborating on strategies and initiatives, to jointly reviewing MIDD 2 concepts and briefing papers, MIDD 2 planning and recommendations development has been a synergistic endeavor with BSK. This strong partnership will continue throughout the life of each of these initiatives, through planned joint meetings of the MIDD Oversight Committee and the Children and Youth Advisory Board and shared approaches to accomplishing the work of each initiative. Operationally, MIDD 2 and BSK are working to coordinate approaches to evaluation, contracting and reporting among other aspects.

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

Leveraging Medicaid to a greater extent is an underlying consideration of the proposed MIDD 2, with some MIDD funding replaced by expected Medicaid dollars. BHRD has concluded that King County and its partner providers can better leverage Medicaid funds, and in doing so, free up MIDD funds for other uses. The proposed MIDD 2 recommendations assume an estimated $3.4 million in Medicaid funds replace MIDD revenue. These assumptions impact not only providers, but also BHRD as well. BHRD is developing technical assistance and support for providers to ensure that they have the tools, training

and support to process Medicaid billing. Because getting the Medicaid assumptions accurate is critically important, BHRD engaged a consulting firm to analyze the Medicaid assumptions.

Successful MIDD 1 programs are proposed to continue into MIDD 2, though some are merged or will be retooled during the implementation planning or request for proposal (RFP) process. Existing MIDD programs received strong support from stakeholders; those programs that were initially slated for marginal reductions launched effective public comment campaigns to restore funds.

Twenty one new proposed initiatives are recommended for MIDD 2, bringing the total number of initiatives to 52. Please note that most newly proposed initiatives, along with existing MIDD 1 initiatives, have other sources of support. Very few MIDD 1 or MIDD 2 initiatives are solely supported by MIDD funds. The following are the new initiatives included in the proposed MIDD 2 funding and programmatic allocations.

1. Law Enforcement Assisted Diversion (LEAD)
2. South County Crisis Diversion
3. Alternatives to Incarceration for Youth
4. Family Intervention Restorative Services (FIRS)
5. Community Driven Behavioral Health Grants
6. Behavioral Health Services in Rural King County
7. Multipronged Opioid Response
8. Behavioral Health Urgent Care Walk In
9. Mental Health First Aid
10. Zero Suicide Pilot
11. Recovery Café
12. Peer Bridgers/Peer Support
13. Rapid Rehousing-Oxford House Model
14. Emerging Issues Initiative
15. Youth and Young Adult Homelessness Services
16. Young Adult Crisis Facility
17. Jail-Based Substance Use Disorder Treatment
18. Deputy Prosecuting Attorney for Familiar Faces
19. Involuntary Treatment Triage Pilot
20. Behavioral Health Risk Assessment Tool for Adult Detention

In addition to these items, one time funds to study the concept of creating a new therapeutic court called "Community Court" is included in the Executive's proposed use of MIDD funds.

Please see Appendix H, Initiative Descriptions and Appendix M, Spending Plan for detailed funding and programmatic recommendations.

Therapeutic courts[32] are proposed to be fully supported by MIDD due to the continued constriction of the County's General Fund. While expanding treatment courts was included under MIDD, treatment

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

courts were funded by MIDD as authorized by supplantation[33] starting in 2009. State law was modified to enable sales tax revenue to be used to support the cost of the judicial officer and support staff of a therapeutic court without being considered as supplantation.

The MIDD 2 funding and programmatic proposal includes a recommended expansion of the Family Treatment Court to south King County due to demand. No other expansions of the courts are recommended, due in large part to strong and consistent feedback from stakeholders who were not supportive of expanding "deep end" criminal justice costs.

The MIDD resource is finite, and while the MIDD Fund has benefitted from a robust regional economy experiencing increasing projected sales tax growth, not all of the suggested MIDD 2 concepts were able to be funded, despite increased revenue. The MIDD's new concept process yielded about $180 million in requests for the estimated $63 million of available MIDD funds. The collaboratively designed MIDD 2 review and renewal process balanced the needs for objectivity, analysis, transparency and community feedback. While most of the feedback on the MIDD review and renewal process has been positive, as with any process where funding recommendations are involved, there has been some expected frustration articulated. The dissatisfaction with the process has largely been from entities whose particular suggestions were not recommended for funding or were recommended to be funded at a lower level.

A survey of the MIDD 2 review and renewal process will occur in early 2017 to inform future similar endeavors.

Economic Adjustments for Providers are included in MIDD 2 to be funded by fund balance as recommended in the MIDD Fund Financial Policies section on page 44. This is a major difference between MIDD 2 and MIDD 1, as MIDD 1 did not provide for adjustments to allocations based on inflation. In most years, but not all, county agencies operating MIDD programs received inflationary adjustments while community providers did not. Consequently, partner agencies have been managing the erosion of MIDD funds while being expected to provide a constant level of services, resulting in provider subsidy of MIDD programs. MIDD 2 seeks to address this inequity by providing economic adjustments to providers. Should future MIDD 2 revenues decline, the county will need to explore the impact of continued economic adjustments on the MIDD 2 services and initiatives.

Supporting and improving the behavioral health system is a vital component of the proposed MIDD 2 funding and programmatic recommendations. As discussed in an earlier section of this report the community behavioral health workforce is in crisis. These challenges negatively impact the publicly-funded behavioral health care system when trained, licensed and qualified staff are difficult to find and/or retain in community provider organizations. Without the people qualified to provide the services, the system is crippled. The proposed MIDD 2 funding and programmatic recommendations maintains the important MIDD 1 initiative, Workload Reduction (formerly "Caseload Reduction") and expands the Workforce Development initiative (formerly "Chemical Dependency Professional Education and Training"). While maintained and expanded respectively, each of these initiatives is planned to be

[33] See page 16 for a discussion of supplantation and MIDD.

revised and restructured in 2017 in part due to the integration of substance use and mental health services.

MIDD Operations and Management

As with MIDD 1, DCHS will continue to have overall responsibility for the management and implementation of MIDD 2, including managing the budget; behavioral health systems and programmatic development; oversight of the request for proposal (RFP), memorandum of agreement (MOU), and contracting processes; and evaluation of MIDD.

The great majority of services provided through the MIDD will be contracted out to community agencies, though not all MIDD initiatives will be subject to an RFP process. For example, MIDD 1 services that are provided under an MOU with another King County department and will continue into MIDD 2 will not be RFPd, (but will have a revised MOU). MIDD 2 will use the same approach used for MIDD 1 to determine whether proposed MIDD 2 initiatives will engage in a competitive RFP process. Please see Appendix G for the decision model BHRD will continue to use to determine the need for competitive procurement.

Because of MIDD and BHRD's commitment to equity and social justice and community engagement, many of the initiatives proposed in the MIDD 2 funding and programmatic recommendations (both new and existing under MIDD 1) will involve intentional partnering with communities, particularly around services and RFP development. For example, the revisions needed for the Workload Reduction initiative to include substance use providers will be developed with a workgroup of providers and other stakeholders. A new initiative such as the Youth Behavioral Health Alternatives to Secure Detention requires deliberate and planned community engagement to ensure that the determined approach is truly responsive to community needs.

Not only does MIDD 2 propose funding and programmatic recommendations, the next iteration of MIDD will include a number of internal operating and process improvements designed to enhance transparency, streamline processes, promote collaboration, share information, and make progress on overcoming challenges.

V. Responses to Ordinance 17998

Ordinance 17998 called for the MIDD 2 Service Improvement Plan (SIP) to be submitted to the King County Council in December 2016. In order to support the King County Council's desire for expanded review and input of the MIDD 2 SIP, the SIP report called for by Ordinance 17998 is submitted *three months earlier than required*.

One impact of this changed timeline is that two elements of the MIDD 2 SIP called for by Ordinance 17998 –Implementation[34] and Evaluation information[35] -- are included at *high levels* in this SIP. This is due to the fact that these two elements require further development that needs to occur in collaboration with the MIDD Oversight Committee and providers. The shortened time line impacted BHRD's ability to conduct thoughtful implementation planning in partnership with providers and others.

During the Briefing Paper Review Panels, a number of themes around implementation of MIDD 2 were articulated repeatedly by dozens of community members who participated. Thoughtful implementation planning must:

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

Developing a MIDD 2 Implementation Plan requires the County to collaborate with providers, consumers and communities which takes time and resources.

Additionally, policy goals that were established for MIDD 1 were recommended to be revised as per the MIDD Comprehensive Historical Assessment Report, and have not been reviewed, discussed, amended or finalized by the Council. The MIDD 1 policy goals played a major role in developing implementation and evaluation outcomes; they are foundational to the entire MIDD 1 evaluation approach. Having MIDD 2 policy goals will enable the county to efficiently and effectively develop meaningful, collaborative implementation and evaluation plans. Finally, adoption of the King County 2017-2018 biennial budget in mid-November will have a significant impact on the final programmatic and funding array for the MIDD 2 and final budgetary decisions which would need to be reflected in the MIDD 2 Implementation and Evaluation Plans.

It is therefore the recommendation of the Executive that the MIDD 2 Implementation and Evaluation Plans be submitted in mid-2017 for review and acceptance by the Council. This approach is similar to the sequencing of MIDD 1 Implementation and Evaluation plans. This timeline allows for BHRD to conduct an intentional implementation and evaluation planning process in collaboration with communities, consumers and the MIDD Oversight Committee; align with BSK and other county endeavors; and thoughtfully enact recommendations related to MIDD evaluation contained in the Comprehensive

[34] Ordinance 17998, lines 119-120

[35] Ordinance 17998, lines 127-128

Historical Assessment Report.

Appendices Table

Ordinance Component	Appendix Name	Appendix Number
A detailed description of each proposed strategy, service and program to be funded from the MIDD sales tax beginning in 2017, including strategy goals, outcomes, expected number of individuals to be served and whether the services are provided by the county or by a contracted provider (lines 115-118) *Explanation of how each recommended MIDD strategy, service and program supports the adopted and/or recommended MIDD policy goals (lines 119-120)* *An initial list of performance measures, outcomes, and/or evaluation data for each proposed strategy, service and program that will inform annual reporting to the executive, the council, the MIDD oversight committee, and the public regarding the investment of MIDD sales tax funds (lines 127-130)*	**MIDD 2 Initiative Descriptions**	**H**
A schedule for the implementation of the strategies, programs and services outlined in the MIDD service improvement plan (lines 121-122)) ***Also referenced in Initiative Description documents.*	**MIDD 2 Implementation Schedule**	**N**
A spending plan for each strategy, program and service outlined in the MIDD service improvement plan, including recommended 2017-2018 biennial budget levels for each proposed strategy, service and program (lines 123-126) ***Also referenced in Initiative Description documents.*	**MIDD 2 Spending Plan**	**M**
The proposed MIDD Service Improvement Plan strategies, services and programs shall: *Demonstrate that they are based on evidence related to successful outcomes for chemical dependency or mental health treatment programs and services;* *Demonstrate that they are based on best or promising practices for chemical dependency or mental health treatment programs and services and that they incorporate the goals and principles of recovery and resilience within a trauma informed framework, as specified by K.C.C, chapter 2.43 and King County's adopted behavioral health system principles set out in Ordinance 17553 (lines 145-151)*	**MIDD 2 Outcomes and Basis Crosswalk**	**J**

Please note that the Initiative Description documents that are included in this Plan as Appendix H provide *initial* implementation and evaluation information. The information in these documents is preliminary and subject to revision based on revised policy goals, the adopted budget and community

feedback that might occur during the upcoming implementation planning work or as a result of changed funding levels that may occur during the County's budget adoption process.

Please note that in most instances, information for the proposed MIDD 2 initiatives is very preliminary due to the need to conduct detailed implementation planning in collaboration with stakeholders and communities. Additionally, most existing MIDD 1 initiatives that are recommended to continue into MIDD 2 will also undergo some form of operational updating to increase efficiency, effectiveness and meet revised policy goals. All initiatives will be included and detailed in a MIDD 2 Implementation Plan that is recommended to be submitted to the Council in 2017.

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

The spending plan (Attachment M) reflects the four strategy areas of the MIDD Framework (Prevention and Early Intervention, Crisis Diversion, Recovery and Reentry and System Improvements).[36] Therapeutic courts and MIDD administration and evaluation are included as separate categories so that those important costs can be seen and tracked separately.

Finally, in keeping with the established process and timeline for the development of the Mental Illness and Drug Dependency Service Improvement Plan, this document reflects Executive priorities for the programming and funding of Mental Illness and Drug Dependency revenues. In addition to including Executive priorities for the spending of MIDD revenue, adjustments to certain proposed MIDD initiatives have occurred due to one or more of the following factors:

1. Updated Office of Financial Analysis (OEFA) MIDD sales tax projections
2. Revised Medicaid assumptions
3. Staged implementation assumptions of select initiatives.

Learning from the experience of MIDD 1, the County recognizes that it is not always possible to begin spending on a MIDD initiative, program or service as soon as budget authority is granted. Requests for Proposals, Qualifications or Information (RFP, RFQ, RFI) are often needed, and communities and stakeholders may wish to be involved in developing the details of services and or locations, all of which take time to thoughtfully address. Given the fact that some new initiatives require time to launch, the spending plan (Attachment M) assumes the staged implementation of some new initiatives. Staged implementation of initiatives allows for the efficient deployment of unspent funds for other needs such as addressing the revised Medicaid assumptions, building of the Rainy Day Reserve and funding other identified priorities.

Please see Appendix H, Initiative Descriptions and Appendix M, Spending Plan for detailed funding and programmatic recommendations.

[36] The MIDD Framework is described on page 35.

MIDD Fund Financial Policies Recommendations

Ordinance Component	SIP Recommendations
Recommend MIDD fund balance reserve policies for the fund, taking into consideration the county's existing fund balance and reserve policies (lines 170-171)	1. Revise MIDD Fund reserve policy to be 60 days of expenditure, placed in a reserve titled "Rainy Day Reserve." 2. Allocate funds to the Rainy Day Reserve to fully fund the reserve within the current biennium. 3. When reserve levels are met, prioritize use of MIDD funding as follows: A. Allocate funds for provider economic adjustments for the next biennium. B. Reserve funds for the Emerging Issues initiative to $650,000 annually.

Reserve Policies: In 2007 when the MIDD 1 Fund was created, a Rate Stabilization Reserve[37] of 5.25% of expected revenues was established. Since then, the County has refined and standardized its reserve policies (Motion 14110). Page 21 of the Comprehensive Financial Management Policies[38] states, "the majority of operating funds, including Enterprise Funds and Special Revenue Funds, should maintain a Rainy Day Reserve equal to 30-60 days of expenditures."

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

The effect of this recommendation will be an increase in the level of reserves.

Rainy Day Reserve: In order to achieve the level of reserves that the 60 day policy calls for, it is recommended that funds be allocated to the Rainy Day Reserve to fund the reserve within the current biennium. The County may elect to allocate additional funds to the reserve when feasible.

As a result of the 2008 economic downturn, MIDD 1 was forced to cut funding to strategies, services and programs due to deeply reduced sales tax revenue. Establishing and maintaining the Rainy Day Reserve will help the county preserve services as long as possible during the next economic decline.

Use of Undesignated Fund Balance: When required financial reserves are fully funded, any remaining

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

[38] http://www.kingcounty.gov/~/media/exec/PSB/documents/CompFinMngmtPoliciesDoc.ashx?la=en

fund balance is considered "undesignated fund balance." Undesignated fund balance can be utilized and generated when the MIDD Fund has under expended budget and/or collected higher than planned for revenue. When an undesignated fund balance exists for the MIDD fund, it is recommended that the funds be allocated in the following order:

1. Allocate funds for provider economic adjustments for following biennia. This ensures future adjustments can occur without reducing services or funding for existing initiatives;

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

Over the course of MIDD 1, the MIDD Oversight Committee utilized subcommittees and work groups to inform its financial recommendations to the Council and Executive. Most recently in 2015 and in 2016, the MIDD Oversight Committee created an ad hoc work group to generate recommendations for potential use of MIDD fund balance for the Council and Executive to consider during supplemental budget processes. It is recommended that the county continue to utilize MIDD Advisory Committee[39] work groups/subcommittees when fund balance remains after applying it as outlined above.[40]

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

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

The MIDD 2 initiative revision processes outlined below will ensure that revisions of MIDD-funded initiatives, strategies, services and programs are communicated clearly to MIDD providers, policymakers and the MIDD Oversight Committee. The processes also specify how and when the MIDD Oversight Committee is to be engaged in recommended changes. The modifications to the MIDD 1 strategy revision process, along with other improvements to the operations of the MIDD Oversight Committee, provide the means to transparently share information and develop recommendations regarding changes or additions to MIDD initiatives, strategies, services and programs.

[39] Proposed legislation to revise the name of the MIDD Oversight Committee to the MIDD Advisory Committee has been transmitted to the King County Council. Therefore, the term "MIDD Advisory Committee" is used in this document when referencing potential prospective acts by the current MIDD Oversight Committee, assuming King County Council approval of legislation that formally changes the name of the Committee from "Oversight" to "Advisory". A discussion of the proposed name change occurs on page 60 of this document.

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

MIDD 1 Strategy Modification Process: In March of 2009, a process to modify strategies, services and programs was established for MIDD 1. It was reviewed and discussed by the MIDD Oversight Committee in March 2009. The process outlined when revisions were to be brought before the Oversight Committee for review and discussion and when revisions could occur at the discretion of the division. Three thresholds were identified that triggered when strategy revisions were to be brought to the MIDD Oversight Committee for consultation, review and comment. They were:

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

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

In the instances when the threshold criteria for MIDD Oversight Committee review were not met (i.e., the change was less than 15 percent in funding, a strategy was not eliminated, nor a change to resources, processes, FTE, etc.), the change was made and reflected in the annual and quarterly reports. This process was used frequently in the first few years of MIDD 1 as strategies were evolving. For example, in 2010, a project with the University Of Washington School Of Social Work was piloted to allow students pursuing Masters' degrees to jointly earn their chemical dependency professional certificate. Over time, as strategies matured, fewer modifications were required, and the process for modifying strategies was used less. Each annual report continues to include strategy revisions.

Recommended MIDD 2 Processes for Modifying Initiatives, Strategies, Services and Programs: Building on the MIDD 1 revision approach, MIDD 2 will use the same approach to revisions process with some modification to one of the thresholds for clarity. The third type of threshold modification that would trigger a review by the MIDD Advisory Committee will be revised as shown below.

MIDD Strategy Revision Process

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

Revisions to MIDD 2 initiatives, strategies, services and programs will be brought to the MIDD Advisory Committee for consultation, review and comment when revisions meet one of three thresholds:

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

Similar to the revision process for MIDD 1, in the instances when the threshold criteria for MIDD Oversight Committee review are not met in MIDD 2 (i.e., the change was less than 15 percent in funding, a strategy was not eliminated, nor changes to population served, intervention, outcomes, performance measures, etc.), the change will be made and reflected in the annual reports. Please see Appendix I for the MIDD 2 Initiative Revisions Process Flow Chart.

In addition to the formalized process above, BHRD staff will provide regular updates on all changes to MIDD 2 initiatives to the MIDD Advisory Committee at least two times per year at Advisory Committee meetings. Additionally, BHRD staff and leadership will receive trainings on the revision process to ensure it is used appropriately.

New MIDD Initiatives: Given that MIDD is a limited resource that is proposed to be fully programmed, including the allocation of fund balances to reserves, it is not recommended that new, ongoing initiatives, strategies, services and programs be added to the MIDD during the biennium. Should it be determined by BHRD and PSB that MIDD revenues greatly outpace projections for a sustained period, and that economic adjustments can continue for existing initiative providers, BHRD in collaboration with the MIDD Advisory Committee, may elect to initiate a new initiative process. Such a process would follow a similar approach and methodology to the MIDD 1 Fund Balance Work Group (FBWG) and MIDD 2 New Concepts processes. The MIDD 1 FBWG, comprised of MIDD Oversight Committee members and county staff, reviewed financial and programmatic information and made recommendations to the Oversight Committee regarding services and funding. The New Concepts process for MIDD 2 was a structured, time-limited invitation to suggest new ideas for MIDD 2 funding.

Emerging Issues: MIDD 2 is proposed to include an Emerging Issues initiative whereby certain developing programs or services can seek to be funded for up to two years by the MIDD 2. As was done for certain MIDD 1 strategies, it is recommended that the MIDD Advisory Committee, in partnership with BHRD, develop criteria and processes for recommending to the Executive and the Council how to utilize Emerging Issues funds. Among other criteria to be included:

- Allowable under RCW 82.14.460
- Furthers the MIDD's continuum of care
- Based on best or promising practices

- Reflects a recovery oriented system of care
- Demonstrates financial sustainability outside of MIDD revenues.

The section below details the Emerging Issues approach.

Emerging Issues Initiative & Protocols

The MIDD initiative revision processes outlined above specify how revisions to MIDD funded initiatives, strategies, services and programs occur and how and when the MIDD Advisory Committee is to be engaged in recommended changes. This section outlines protocols for utilization of the recommended Emerging Issues initiative of MIDD 2.

The Emerging Issues initiative provides a flexible source of MIDD funds for certain items to be funded for a short term. The Emerging Issues initiative is not intended to be used as an ongoing source of funds for new MIDD 2 initiatives, programs or services, because MIDD is a limited resource that is fully programmed, including the programming of fund balances.

As noted, MIDD is a limited resource that is proposed to be fully programmed, including the allocation of fund balances to reserves. Following the recommendation outlined above for new initiatives, no new, ongoing initiatives, strategies, services and programs should be added to the MIDD during the biennium, including services and programs supported by Emerging Issues funding to be added to the MIDD. Should it be determined by BHRD and PSB that MIDD revenues greatly outpace projections for a sustained period, and that economic adjustments can continue for existing initiative providers, BHRD in collaboration with the MIDD Advisory Committee, may elect to initiate a new initiative process. Such a process would follow a similar approach and methodology to the MIDD 1 Fund Balance Work Group (FBWG) and MIDD 2 New Concepts processes.[41]

The Emerging Issues initiative is modeled in part on the New Strategy reserve that was established early in MIDD 1 via Ordinance 16261. The purpose of the reserve was to support new strategies not provided for in the then current MIDD plan that would meet the established policy goals. Ordinance 16261 stated,

> *The council recognizes that the needs of the county's residents may change over time and that new and innovative mental health, substance abuse and therapeutic court programs and services are continually being developed and implemented across the country. Therefore, it is the policy of the county that the county's mental illness and drug dependency shall maintain flexibility to respond to the changing needs of the county's population as well as to accommodate new mental health, substance abuse and therapeutic court strategies and programs.*[42]

Ordinance 16261 tasked the MIDD Oversight Committee with proposing a new strategies process and schedule. The new strategies process approach was reviewed at the February 2009 MIDD Oversight Committee meeting and was included in the subsequent MIDD Annual Report that was transmitted to

[41] See page 31 for details of the Three Phased Renewal Process.

[42] Ordinance 16261, lines 68-74

the Council. The new strategy process was never launched due to the economic downturn. MIDD strategies were reduced when sales tax revenues declined sharply.

Emerging Issues Policies and Protocols: The following outline the key components of the proposed MIDD Emerging Issues initiative.[43]

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

B. The Emerging Issues initiative funds would be appropriated periodically during the biennial budget period. .

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

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

E. How and whether programs supported by Emerging Issues funds are evaluated will be included in the MIDD 2 evaluation framework that is planned to be transmitted to the Council in 2017.

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

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

Proposed Schedule for Reporting

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

[43] Because the Emerging Issues Initiative process and timeline will be developed in partnership with the MIDD Advisory Committee, an Initiative Description is not included in Appendix H. It will be detailed in the forthcoming MIDD Implementation Plan.

Reporting on the progress of MIDD toward meeting the established policy goals is a vital aspect of MIDD that must continue with MIDD 2. Reporting is the chief mechanism to share the growth and evolution of MIDD or highlight its challenges. The recommendations included in this section are based on internal and external stakeholder feedback and are intended to streamline and make more efficient the reporting processes for providers and the county.

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

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

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

2. **Revise data collection periods to January to January fiscal/calendar year.** The current data collection period for MIDD 1 strategies is October 1-September 30 each year, with the MIDD annual report due to the Council on April 1.[44] The MIDD 1 data collection timeline was established to enable the preparation and analysis of data to meet the April 1 timeline. As experienced over eight years of MIDD 1 evaluation work, it requires several months to gather, clean, prepare and analyze data for MIDD evaluations. This is due in part to the sheer quantity of data, in part due to the quality of data, and in part to the methodology that providers use to submit their data.[45]

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

3. **Launch web data dashboard.** This recommendation also stems from MIDD Oversight Committee and stakeholder feedback to have more readily accessible and updated MIDD data available. It is also related to recommendations to improve data infrastructure from the PSB Evaluation Assessment Report that was a component of the MIDD 1 Comprehensive Historical Review and Assessment Report.[46] This recommendation also aligns with Best Starts for Kids which is considering a similar dashboard.

Fulfilling this recommendation will take time and resources, due in part because collaboration with

[44] Ordinance 15949

[45] Recommendations on improving the MIDD 2 evaluation approach were included in the Comprehensive Historical MIDD 1 Report that was submitted to the Council on June 30.

[46] See recommendation III A-E in the MIDD 1 Comprehensive Historical Review and Assessment Report.

internal county stakeholders (such as IT) and external (such as providers) is vital.

All annual reports for MIDD 2 will contain the following information:

- performance measurement statistics and updated performance measurement targets
- service and program utilization statistics
- request for proposal, revenue, and expenditure status updates
- an updated financial plan showing current year revenue and expenditure
- projections, along with adopted and actual expenditure, revenue and reserves identified
- recommendations on program and/or process changes to the initiatives and the rationale for the recommendations.

Recommended Modifications to the MIDD Oversight Committee

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

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

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

> *The purpose of the oversight committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative. The committee reviews and comments on quarterly, annual and evaluation reports as required in Ordinance 15949. It also reviews and comments on emerging and evolving priorities for the use of the mental illness and drug dependency sales tax revenue. The oversight committee members bring knowledge, expertise and the perspective necessary to successfully review and provide input on the development, implementation and evaluation of the tax funded programs.*
>
> *The oversight committee should: promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers and*

stakeholders on sales tax funded programs; and coordinate and share information with other related efforts and groups.

Recognizing that King County is the countywide provider of mental health and substance abuse services, the committee should work to ensure that access to mental health and chemical dependency services is available to those who are most in need throughout the county, regardless of jurisdiction[47].

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

The MIDD 1 Oversight Committee is comprised of the following entities as required by Ordinance 16077. King County government seats are noted with "*".

MIDD Oversight Committee Members

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

[47] Ordinance 16077, lines 34-51.

26. The city of Bellevue;
27. Labor representing a bona fide labor organization;
28. *The Office of the Public Defender;
29. The National Alliance on Mental Illness; and
30. A representative from a public defender agency that the county contracts with to provide services.

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

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

Maintain role as advisory body to the Executive and Council.
The members of MIDD Oversight Committee provide essential advice and input to King County policymakers on matters involving the MIDD. Each member brings their individual and systems wide experience and knowledge to the MIDD Oversight Committee table to inform discussions and develop recommendations for policymakers. This crucial role is proposed to continue into MIDD 2.

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

While the ordinance-established role of the Advisory Committee is not proposed to be changed, *how* the Advisory Committee functions and *what else it can accomplish* within its role and with its unique array of leaders from the behavioral health, physical health and criminal justice systems will evolve with MIDD 2. Based on strong feedback from Oversight Committee members, particularly those who participated in the MIDD 2 planning work on MIDD 2 Briefing Paper Review Panels, the Advisory Committee is envisioned to leverage its position to move systems forward and collaboratively resolve issues. System stakeholders can utilize MIDD to work collectively to explore and align solutions to complex problems. Specific areas and tasks that the Advisory Committee will engage on during MIDD 2 include:

- Engaging in intentional and deep systems discussions that inform, initiate, innovate and enhance outcomes for those served
- Creating a "well connectedness" of systems
- Emphasizing community engagement and two-way information sharing
- Building trust and credibility, particularly in communities of color or other marginalized communities
- Developing a deeper understanding of MIDD 2 initiatives, data and evaluation approaches.

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

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

MIDD Oversight Committee Seat	Recommend Revision to MIDD Advisory Committee	Basis of Change
• Two Seats for King County Behavioral Health Board	Consolidate 2 Behavioral Health Board seats into one MIDD Oversight Net change: -1	On April 1, 2016, King County's mental health and substance use disorder services systems were integrated into one seamless, managed care treatment system as required by state legislation (2SSB 6312). The formerly separate King County Mental Health Advisory Board and the King County Alcoholism and Substance Abuse Administrative Board were merged into one Behavioral Health and Recovery Board.[48]
A representative from a public defender agency that the county contracts with to provide services	Eliminate seat for this entity; Public Defense is represented by existing Office of Public Defense seat Net change: -1	In 2013, King County established the Department of Public Defense (DPD) as a charter-created department within county government and transitioned from a public defense system in which the county contracted with four defender organizations to provide defense services. Defense services are provided by DPD and the county no longer holds contracts with defender agencies.

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

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

[48] Ordinance 18170 passed in 2015 amended the MIDD Oversight Committee to include two members of the Behavioral Health Board rather than one seat for the eliminated Mental Health Advisory Board and the Alcohol and Substance Abuse Administrative Board; the number of seats were not amended.

seats are King County government seats (11 out of 30); with the addition of more seats, the ratio of community to government seats would be even greater than the current 2:1 community to government seats.

Among the changes proposed to be made to the MIDD Oversight Committee are technical changes that reflect organizational name changes by member organizations that in turn require updating the King County Code established member list including:

- Suburban Cities Association is now Sound Cities Association
- Committee to End Homelessness is now All Home
- Office of the public defender is now Department of Public Defense

Add five new seats to the Committee.

Throughout the course of MIDD 2 planning, Oversight Committee members recognized and articulated the need to have additional perspectives represented on the committee. From the Committee's establishment of Values and Guiding Principles in March 2015 to its explicit feedback on the roles and composition of the committee in January and March of 2016, members have been exceedingly clear about the need to have MIDD 2 intentionally informed by the voices and experiences of consumers, youth, immigrants and refugees, the faith community, and specific cultural populations.

The recommended additions to the MIDD Oversight Committee are also driven by the County's Equity and Social Justice Agenda which finds that race, place and income impact quality of life for residents of King County and people of color, and those who have limited English proficiency and/or low-incomes persistently face inequities in key educational, economic and health outcomes. These inequities are driven by an array of factors including the tax system, unequal access to the determinants of equity,[49] subtle but pervasive individual bias, and institutional and structural racism and sexism. These factors, while invisible to some, have profound and tangible impacts for others, particularly those who also may be living with behavioral health conditions and experiencing criminal justice involvement.

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

Recommended Additional Seats to MIDD Advisory Committee

Focus or Population	Specific Entity
Consumers & Communities – 2 Representatives	From Consumers and Communities Ad Hoc Work Group
Recovery	Washington Recovery Alliance
Education	Puget Sound Educational Services District
Philanthropy	Many Minds Collaborative

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

Managed Care	Medicaid Managed Care Plans
Grassroots Organization Representing Cultural Population(s)	To be determined

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

A. *Convene Consumers and Communities Ad Hoc Work Group – 2 Representatives from Ad Hoc Work Group Appointed to MIDD* Advisory *Committee*

After much discussion with subject matter experts (including specific feedback during the community engagement process), individual MIDD Oversight Committee members, and building off of the learnings from recent efforts that included consumers and communities, the County recommends establishing a Consumers and Communities Ad Hoc Work Group of the MIDD Advisory Committee. The work group would be comprised of individuals with lived experience of the behavioral health system (consumers) and individuals who are a part of communities with marginalized identities or experiences, including but not limited to:

- Transgender (Trans)
- Youth
- Immigrant/Refugee
- African American
- Asian/Pacific Islander
- Hispanic
- Rural
- Faith
- Previous justice system involvement
- Peers.

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

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

Given the number of communities identified as needing a voice in MIDD, and because there are many diverse lived experiences involved with behavioral health, an additional 12 up to a maximum

of 20 consumer and community positions to the MIDD Advisory Committee would be required. An Oversight Committee of 50 or more would not be feasible to operate as the Committee has operated, and more so given the operational improvements planned; therefore, the recommendation to convene a Consumers and Communities Ad Hoc Work Group balances the need to enable a greater number of experiences and perspectives to be brought forward to the Advisory Committee with efficiency and effectiveness of operation.

One of the chief barriers to ongoing and meaningful consumer and community participation is the expectation that individuals will donate their time to participate and advise. Unlike separately elected or other city or county officials, or executive directors of behavioral health provider organizations whose jobs include participation with MIDD, community members' time has not been considered for compensation. A notable component of the Consumers and Communities Ad Hoc Work Group is that work group members will be reimbursed for expenses associated with their participation. This is reflective of the County and MIDD 2's commitment to enacting principles of equity and social justice.

It is currently envisioned that the Ad Hoc Work Group will have between 12 and a maximum of20 members, with at least half to be people with lived experience as a consumer of behavioral health services. The Ad Hoc Work Group members will be given extra support and preparation to help them fulfill their duties. The charter of the work group, along with other processes including identifying members of the work group, will be developed by BHRD in collaboration with the MIDD Advisory Committee. It is expected that the work group will begin meeting at the beginning of the second quarter of 2017.

Two Consumers and Communities Ad Hoc Work Group members would be recommended to serve as full members of the MIDD Advisory Committee, subject to the existing appointment and confirmation process.

B. *Recovery*

Recovery from mental health and/or substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to achieve their full potential.[50] The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. "Fundamentally, recovery is not a practice; it is a culture. It is not as much what you do, but how you do it. Recovery focuses on values and meaning more than on behaviors."[51]

In 2013 Ordinance 17553, King County established that the principles of recovery are foundational to behavioral health services, thus adding a recovery seat to the MIDD Oversight Committee further enacts the vision of recovery as outlined in Ordinance 17553. Bringing the perspective of recovery to the MIDD Advisory Committee will further embed recovery into the work of the MIDD and help

[50] https://www.mentalhealth.gov/basics/recovery/index.html

[51] King County Recovery and Resiliency Oriented Behavioral Health Services Plan 2012-2017, pg. 10; attachment A to Ordinance 17553

ensure that recommendations from the MIDD Advisory Committee are infused with recovery principles such as trauma-informed care.

Oversight Committee feedback stated that coalitions and alliances representing a group of entities should be considered when possible, rather than individual entities. This would enable broader involvement than one individual or entity. In keeping with that charge, it is recommended that the recovery seat be established for the Washington Recovery Alliance.[52] The Washington Recovery Alliance is a group of organizations and individual from across Washington State that educates, promotes and advocates for recovery issues.

C. *Education*

Bringing a representative of the education domain to the MIDD Advisory Committee provides another connection to children, youth and families served by MIDD and the other systems represented by MIDD Advisory Committee members. Early identification of social, emotional and behavioral problems in children often happen in schools. Schools are critical in linking youth and families with crisis support, respite care, case management, counseling and behavioral health interventions. Schools are directly connected to MIDD via prevention, intervention, treatment and crisis services, so creating a seat for the education domain is a natural evolution of MIDD.

D. *Philanthropy*

King County has become proficient at braiding funds to create a system of care; between state, federal and local resources a continuum of care from early intervention/prevention to crisis services has been created and is demonstrated through MIDD 2. Despite the County's best efforts, gaps remain. The philanthropic community has become an important community partner to advance the public behavioral health system. The Many Minds Collaborative is partnering with King County to research, assess and document the public mental health landscape in King County. That work has grown into early catalytic investments in proven behavioral health programs. Their investments demonstrate commitment to improving the behavioral health system and rationale for participation in the MIDD Advisory Committee.

E. *Managed Care*

As King County is moving toward addressing the question of what form "full" integration of behavioral and physical health care will take, it is clear that whatever the answer, Managed Care Organizations (MCOs) operating in King County will have some kind of role. In recognition of the future role that MCOs may have with full integration[53], it is recommended that a seat on the Advisory Committee be held by the MCOs. Following the approach that the King County Accountable Community of Health Interim Leadership Council outlined in its charter,

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

[52] https://washingtonrecoveryalliance.org

[53] A more in-depth discussion of integration of behavioral and physical health care takes place on pages 66-69 of this report.

decision making.[54]

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

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

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

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

Type of Improvement	Details
1. Alignment & Collaboration	• Co-convene an annual King County Boards and Commissions Summit with Children and Youth Advisory Board, Veterans and Human Services Levy boards, Behavioral Health Advisory Board and others to jointly engage in planning, data sharing and review, and to coordinate and align work • Explore development of Executive Committee of board co-chairs to ensure ongoing alignment of respective committee work and outcomes
2. Training & Education	• Hold annual Advisory Committee retreat to develop annual work plan, create cohesion and shared understanding of role and objectives • Develop and implement training program that may include such matters as: ○ Trauma and trauma-informed care ○ Anti-racism

[54] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/~/media/exec/HHStransformation/ACH-Charter.ashx , page 4.

	○ Cultural sensitivity ○ Evaluations and data ○ The involuntary court process ○ How treatment courts work & their outcomes. • Conduct new member orientation for each new committee member within two months of appointment and one annual refresher meeting for existing members • Members representing coalitions or groups will be asked to make an annual presentation on their group and how information is shared and gathered
3. Operational & Logistical	• Utilize Advisory Committee workgroups and/or subcommittees to inform the design and development of key MIDD 2 deliverables such as Implementation Plan, RFPs, and Evaluation Framework • Create evaluation subcommittee to work with MIDD evaluation team on MIDD data and analysis • Hold at least one Advisory Committee meeting per quarter in the community, at times and locations that enable wider community participation, with interpretation and childcare available

Change the Name of the Oversight Committee.

Reflective of the established duties and functions of the Committee that are recommended to continue to MIDD 2, it is recommended that the name of the Committee be amended to reflect its duties as an advisory body: The MIDD Advisory Committee.

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

Executive staff have consulted with the Prosecutor's Office on this matter and no potential legal issues were raised. Legislation to effectuate this, and other changes proposed for the Committee, has been transmitted to the King County Council for consideration.

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

Evidence Related to Successful Outcomes-Practice Basis-Goals and Principles of Recovery and Resiliency

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

Outcomes and Accountability: One way to help assure policymakers and the public that results are achievable is to identify programs that have been shown to be effective. Delivering on outcomes is a major consideration of MIDD 2 funding and programmatic recommendations. This section, accompanied by the data and information in Appendix J, responds to the requirements of Ordinance 17998 related to demonstrating practice categories (i.e., promising, best or evidence-based practice) and how those practice categories are reflected in the recommended MIDD 2 initiatives. Programs recommended to be supported by MIDD funds are expected to show evidence that they advance the MIDD policy goals.

During the Oversight Committee's development of MIDD Values and Guiding Principles and through the course of Community Conversations and other community input, the concept of including "emerging practices" as a basis for MIDD 2 arose. *Emerging Practices* are those not based on research results "but for which anecdotal evidence and professional wisdom exists. These include practices that practitioners have tried and claimed effectiveness. Emerging practices also include new technologies that have not yet been researched."[55] Subject matter experts and community engagement participants communicated that research is often conducted with mainstream participants and results may not be valid or reliable for communities of color or other marginalized groups.

Based on this feedback, the category of Emerging Practices is added to the array of practice considerations for MIDD 2 concepts. It was determined important to include Emerging Practices in the consideration of MIDD programming due to limitations of research-based practices for marginalized communities. Additional information on the use of Evidence-Based Practices is included in a discussion of Equity and Social Justice on page 64 of this report. Consequently, for purposes of responding to the requirements of Ordinance 17998, "emerging practices are included in the category of "promising practices" in Appendix J.

The established categories of practices used as the basis of MIDD 2 recommendations are described below:

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

[55] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc

researched."[56]

- *Promising Practices* are those developed based on theory or research, but for which an insufficient amount of research results "have determined the effectiveness of the practice. If a study uses a weak design resulting evidence is categorized as promising."[57]

- *Best Practice*s are those that have "been shown by research and experience to produce optimal results and that [are] established or proposed as a standard suitable for widespread adoption."[58]

- *Evidence-Based Practices* are those for which research has been used "to determine the effectiveness of the practice. The research utilizes scientifically-based rigorous research designs (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research)."[59]

Basis of the practice informed the determination of outcomes. The following approaches were used to determine if recommended MIDD 2 programs had evidence of successful outcomes:

- Staff examined data from MIDD evaluations related to the five MIDD policy goals (for most MIDD 1 programs recommended to continue in MIDD 2 where data was available):
    - MIDD 1 policy goals of reduced jail use (goals 1 and 2) were used to identify successful outcomes for criminal justice when there were statistically significant reductions of jail bookings or jail days.
    - MIDD 1 policy goals of symptom reduction, reduced use of emergency departments and psychiatric hospital use (goals 1 and 3) were used to identify behavioral health outcomes.
- Behavioral health outcomes that "improve health and wellness of individuals living with behavioral health conditions (proposed MIDD 2 policy goal) were also considered for MIDD 2 programmatic recommendations. These outcomes include:
    - Increased treatment access
    - Improved quality of life (stable housing, improved social functioning, coping skills, self-determination and well-being)
- For new initiatives recommended for MIDD 2, existing evidence (studies, research findings, data) of expected outcomes based on similar programs were analyzed by subject matter experts during the development of briefing papers.

Incorporating the Goals of Recovery and Resiliency within a Trauma-Informed Care Framework: Building on research, practice and the lived experiences of individuals in recovery from mental and/or substance use disorders, the MIDD will use the following working definition of recovery developed by the Substance Abuse Mental Health Services Administration (SAMHSA): A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. "Recovery" means a process in which an individual achieves management of the individual's

[56] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc
[57] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc
[58] http://www.merriam-webster.com/dictionary/best%20practice
[59] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc

symptoms and regains or develops sufficient skills and autonomy to enable the individual to live, work and participate fully in the community. "Resiliency" means an innate capacity that empowers people across the life span to successfully meet life's challenges with a sense of self-determination, mastery and hope. "Trauma-informed framework" means an approach to engage an individual with a history of trauma that recognizes the presence of trauma symptoms and acknowledges the impact that trauma has had on the individual's life.

Overarchingly, the proposed MIDD 2 initiatives promote and support people in all phases of their recovery, analogous to the behavioral health continuum of care reflected in the MIDD 2 Framework. The proposed MIDD 2 initiatives work together and with the broader health and human services and criminal justice systems to provide opportunities for people involved with the behavioral health system to realize their full potential.

The Sequential Intercept Model in MIDD 2

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

The strategies that made up MIDD 1 were first developed by several community workgroups using the Sequential Intercept Model as a framework to determine what services needed to be provided for which people at what locations in order to help prevent incarceration, hospitalization and homelessness. This model is in use today by a number of communities across the nation as an action blueprint for planning system change in the way that communities address the problem of people with mental illness in their criminal justice systems.

King County further adapted the organizing principles of this model to include people who may have no mental illness but who are at risk for criminal justice involvement due to substance use, and to include diversion from emergency medical services as another priority. These principles remain in place for MIDD 2 and the initiatives recommended to be funded by MIDD 2.

The recognition that the greatest opportunities for diversion exist when individuals are still in the community, and that diversion options decrease as individuals move through the criminal justice system, is reflected throughout MIDD 2. While MIDD 1 articulated the importance of prevention services, early assessment and intervention, and comprehensive and integrated community-based services, MIDD 2 furthers this understanding by grounding the MIDD 2 initiatives in the continuum of care as reflected by the MIDD 2 Framework. As with MIDD 1, MIDD 2 is devoting considerable resources to supporting a community services system that will serve to divert many individuals from the criminal justice and emergency medical systems while also providing the infrastructure needed to help people who have entered these systems rejoin the community in a safe and effective manner.

Through the MIDD programs, individuals with behavioral health needs will be linked to services designed to help them become stable and productive, and prevent unnecessary incarceration and hospitalization. The MIDD 2 Strategy Areas reflecting the behavioral health continuum of care are:

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

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

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

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

Together, the MIDD 2 initiatives will result in improved quality of life for people with mental illness and chemical dependency and their families throughout King County. The Sequential Intercept Model is shown in Appendix A.

Equity & Social Justice in the Implementation of MIDD 2 Programs

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

Equity and Social Justice is a key initiative in King County recognizing that numerous communities within King County face inequities in key educational, economic and health outcomes. Key drivers of such inequities include race and ethnicity, poverty, geographic location, gender and sexual identity, immigration status, limited English proficiency, and physical disability. The County's Equity and Social Justice Initiative is critical to the implementation of the Service Improvement Plan for MIDD 2. Moreover, guided by the Values and Guiding Principles for MIDD developed by the MIDD Oversight Committee that emphasized equity and social justice, the planning and development of MIDD 2 was conducted with a deep focus on equity and social justice.[60]

Below is a list of several key principles that MIDD 2 considers in the procurement, contracting, training, and/or implementation of programs supported by MIDD 2. Appendix K includes an equity tool that will be used as help guide and inform system improvement/system change processes related to MIDD 2.

Culturally Responsive and Informed: The U.S. Department of Health and Human Services (HHS) Office of Minority Health has released *The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care,*[61] which provides some guideposts for providers of behavioral health services to align with the populations they serve and ensure that services are culturally responsive and informed. In the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities,*[62] several strategies directly relate to the provision of care management teams, including *reduce disparities*

[60] See Appendix C for more information on MIDD 2 planning community engagement efforts.
[61] https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards.
[62] U.S. Department of Health and Human Services. *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care***.** Washington, D.C.: U.S. Department of Health and Human Services, (April 2011).

(strategy I.B.[63]) in access to primary care services and care coordination, which focuses on migrant workers, people experiencing homelessness and residents of public housing. Using such models as community-based health teams (e.g. health home model) are recommended to establish agreements with primary care providers and other health care providers to improve care coordination. Another HHS Action Plan strategy (2.C.3[64]) calls for an increase in the diversity and cultural competency of clinicians, including behavioral health workers. This guidance provides an opportunity for King County to implement MIDD 2 with a heightened emphasis on serving the County's most marginalized populations, and align with national best practices on care coordination and treatment services that are culturally responsive and informed.

It is the intent of King County that services provided under MIDD 2 be **culturally responsive** and **culturally specific**. Enacting this intention requires the willingness of both providers and King County to acknowledge historical and cultural trauma as sources of substance use and other behavioral health conditions and the willingness to do business differently to serve people in culturally responsive and specific manners. MIDD-supported direct services should address individual level discrimination that those served encounter in their daily lives by recognizing institutional and structural racism, classism, and ableism.

Community-based agencies providing culturally specific and culturally responsive behavioral health, primary care and reentry support services will be sought to provide these services under MIDD 2. Addressing trauma as a result of both interpersonal violence and childhood experiences as well as historical and cultural trauma will be critical for serving the individuals served by publicly-funded behavioral health services. MIDD 2 providers should explore and implement the use of alternative interventions which are culturally informed, such as substance use disorder treatment for historically disempowered communities,[65] which may yield more meaningful treatment outcomes for marginalized populations.

King County will encourage organizations receiving MIDD 2 funds to provide technical assistance and/or sub-contract with smaller community groups and organizations to increase participation by community groups and organizations that may have difficulty meeting the County's contracting requirements. In addition, when possible, King County will utilize flexible contracting approaches to reduce barriers that make it more difficult for small organizations to participate.

Evidence-Based Practices and Equity: It is expected that whenever possible, evidence-based practices (EBPs) are to be embedded in the service continuum of MIDD 2. Because most mental health/substance use disorder treatment EBPs are researched on predominantly mainstream/White populations, it is important to have a critical and continuous improvement lens to these behavioral health services to ensure that services are not perpetuating marginalization and negatively impacting those individuals being served, furthering their disenfranchisement. It is necessary that whenever possible, MIDD 2 use anti-oppressive practices to complement recovery oriented and person-centered approaches.

Harm Reduction: Where possible, MIDD 2 initiatives should employ a harm reduction model. Harm

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

reduction activities "meet people where they are," enabling individuals to access better health and human potential outcomes, irrespective of whether the individual engages in substance use. Harm reduction is a grass-roots and "user-driven" set of compassionate and pragmatic approaches to reducing substance-related harm and improving quality of life.[66]

While there is no universal definition or formula for harm reduction given the multiple different interventions and policies designed to serve an individual in need of behavioral health services, there are key principles for harm reduction that MIDD 2 initiatives are encouraged to demonstrate such as:

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

Harm reduction is linked to equity and social justice because provision of services should be nonjudgmental, non-coercive and recognize the realities of poverty, class, racism, social isolation, past trauma, sex-based discriminations and all other social inequalities that affect an individual's vulnerability to, and capacity for, effectively changing behavior.[67]

Serving Individuals Who Have Contact with the Criminal Justice System: Though the County is actively working to address overrepresentation of individuals from non-white racial and ethnic groups, disproportionality currently exists in the County's justice system. When providing MIDD 2 services to people involved with the justice system, there is a need to ensure that an anti-oppressive practice lens is applied to the behavioral health services provided to non-white and other marginalized groups. MIDD 2 should provide or leverage the provision of culturally responsive and specific services and reentry opportunities.

Integration with the County's Policy and Planning Work

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

The MIDD 2 Framework explicitly conveys the expected linkage between MIDD 2 and other county and community initiatives. MIDD 2 is grounded in a collaborative approach to information sharing, evaluation, aligning of services and braiding of funds.

As with MIDD 1, the proposed MIDD 2 initiatives are expected to individually and as a whole advance/integrate with the County's planning and policy initiatives. For example, the proposed Youth Behavioral Health Alternatives to Secure Detention initiative is intended to link to and further the work

[66] Collins, Clifasefi et al. 2011; Marlatt, 1998

[67] http://harmreduction.org/about-us/principles-of-harm-reduction/.

of the Juvenile Justice Equity Steering Committee. School-based services supported by MIDD 2 will align with BSK work. The proposed Multipronged Opioid initiative is planned to support recommendations from the Heroin and Prescription Opiate Addiction Task Force. Proposed initiatives involving housing supports and resources for capital and rental assistance further the goals of the All Home[68] strategic plan. Elements of the County's Equity and Social Justice[69] strategic plan are reflected throughout the MIDD 2, from how the MIDD 2 recommendations were determined, to the recommended revised composition of the Advisory Committee.

The MIDD 2 Implementation Plan that will be submitted to the Council in 2017 after adoption of the 2017-2018 MIDD 2 budget will include how each initiative will link to the County's policy and planning work.

Affordable Care Act and Behavioral Health Integration Opportunities

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

Medicaid Expansion: One of the main goals of the Affordable Care Act (ACA) is to increase access to health care coverage for individuals. As a Medicaid expansion state, more individuals than ever are covered by Medicaid in Washington and in King County, allowing them to access and receive Medicaid-covered physical, mental health and substance use disorder services. As such, Medicaid can now pay for more traditional outpatient and inpatient mental health and substance use disorder treatment services for a larger number of covered children, youth and adults. The increase in Medicaid-eligible individuals and subsequent increase in Medicaid funding, allows King County to continue to direct MIDD 2 funding toward services that are not covered by Medicaid and/or individuals who remain uninsured to help build a robust continuum of care.

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

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

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

available to clients in need.

MIDD 2 will support and leverage opportunities provided under the ACA and through implementation of ESSB 6312 in a variety of ways, including

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

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

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

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

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

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

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

As the state moves forward with plans to fully integrate physical and behavioral health care, King County has significant decisions to make related to what the financial infrastructure for fully integrated managed care will be and what the optimal role of the county is in that model. King County is considering a number of potential options and working with community stakeholders and partners to identify the best path forward. The decisions King County makes regarding its future role in fully integrated managed care will significantly impact how and what programs are implemented under the MIDD and could require a complete retooling of the MIDD 2 programming before it expires at the end of 2025.

Earlier this year, the Health Care Authority and the Department of Social and Health Services jointly issued a letter to counties identifying three potential timelines for moving to fully integrated managed care. Those options include a start date of: July 1, 2017; July 1, 2018; or January 1, 2020. King County is

considering the 2018 and the 2020 options and will make recommendations in late 2016 or early 2017 to the King County Executive and Council regarding the recommended path forward and the optimal timeline for implementation based on the magnitude of change required and community readiness.

The implications of this decision for MIDD 2 could be significant regardless of what option King County chooses. For example, if King County selects an option that includes Managed Care Organizations (MCOs) having primary risk and responsibility for the full continuum of physical and behavioral health care for Medicaid eligible individuals through a single managed care contract with the state, the role of King County in the administration and delivery of behavioral health services related to Medicaid would shift to one of primary monitoring/oversight and assurance. This would require revisiting MIDD 2 investments in light of the county's revised role for behavioral health.

Research shows that fully integrated physical and behavioral health care achieves better outcomes for clients. As King County works to determine the optimal path to full integration for the region, the focus will be on keeping clients at the center of planning and ensuring a system care that provides the best experience, improves outcomes and reduces overall costs to the system. Once the decisions about the fully integrated managed care infrastructure and timeline for implementation are known, King County will need to revisit all MIDD 2 supported programs to evaluate them in relationship to the system transformation that will occur.

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

VI. **Next Steps**

This section acknowledges three specific next steps necessary for MIDD 2: completion of the MIDD 2 Implementation and Evaluation Plans and a process to change the name of the MIDD. Each component will be developed collaboratively with the MIDD Advisory Committee and other stakeholders.

MIDD 2 Implementation Plan

Additional planning is needed for most of the new initiatives contained in the proposed MIDD 2, many of them requiring community engagement components. For each MIDD 2 initiative, the MIDD 2 Implementation Plan that will be transmitted to the Council in 2017 will include[70]:

- Description of the initiative/program/services
- How the initiative advances the MIDD 2 policy goals
- Goal of the initiative
- Outcomes and performance measures
- Expected number of individuals served
- Provided by contractor or county
- Spending plan (based on adopted budget)
- Implementation schedule (for new initiatives)
- Procurement and contracting details
- Services start date (new)
- What community engagement will occur and when
- Other relevant information as directed by the Council or requested by stakeholders.

The MIDD Oversight Committee was deeply involved in the development and review of MIDD 1 implementation plan documents. Similarly, it is expected that the Advisory Committee will play a significant role with the implementation planning for MIDD 2 that will occur in 2017.

MIDD 2 Evaluation Plan

The MIDD 1 Evaluation Plan adopted by the Council in 2008 served as the blueprint for conducting the evaluation and assessment of MIDD. The MIDD 1 Evaluation Plan was developed in conjunction with the MIDD 1 Implementation Plan, after the individual MIDD 1 strategies were established in the Council adopted MIDD Action Plan. The MIDD 1 Implementation Plan specified how each MIDD 1 strategy would be executed and individual MIDD strategy implementation information was used to develop an evaluation approach for each program supported by MIDD funds. MIDD policy goals and strategies were linked to the results, which in turn provided a structure for identifying performance indicators, targets and data sources, and for collecting and reporting results.[71]

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

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

A detailed MIDD 2 Evaluation Plan will be transmitted to the Council in 2017. In order to complete an Evaluation Plan for MIDD 2, final MIDD 2 funding and programmatic decisions are needed, which are expected with adoption of the County's 2017-2018 biennial budget. Further, it is necessary to develop a MIDD 2 Evaluation Plan that is built on the recommendations contained in the MIDD Comprehensive Historical Assessment Report, which includes stakeholder involvement in the development of the MIDD 2 Evaluation Plan. See Appendix L for the MIDD evaluation recommendations. To the extent possible, DCHS will align its approach to MIDD 2 evaluation planning with evaluation planning for BSK. The MIDD 2 Evaluation Plan will contain most, if not all, of the same elements as called for in the MIDD 1 Evaluation Plan:

Requirements of the MIDD 1 Evaluation Plan

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

As with BSK, the MIDD 2 Evaluation Plan will include the overarching principles, framing questions and approaches that will guide the evaluation and performance measurement of MIDD 2. As MIDD 2 initiatives are refined and programs are selected over the remainder of 2016, the MIDD evaluation framework will be developed, particularly with respect to initiative-level performance metrics and targets. The structure for MIDD 2 evaluation and performance measurement will be based on the MIDD 2 Framework (Appendix F).

Much has changed in the eight years since the MIDD 1 Evaluation Plan was completed, including behavioral health integration and technological advances. Yet, the purpose for evaluating MIDD 2 remains the same: providing the public and policy makers with the tools to evaluate the effectiveness of the MIDD strategies in meeting the established MIDD policy goals, as well as to ensure transparency and accountability.

Changing the Name of the MIDD

Through the course of MIDD 1 review and MIDD 2 planning, the county received feedback that the name of the MIDD---the Mental Illness and Drug Dependency sales tax and programs—is outdated, negative, disrespectful and stigmatizing. In essence, the name of the MIDD is not itself recovery-based and may be counterproductive to wellness.

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

Advisory Committee leadership will be critically important.

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

VII. **Conclusion**

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

The groundbreaking MIDD 1 provided a strong foundation on which to plan and build MIDD 2, taking the very best of what worked and retooling where needed to address challenges so that the MIDD is positioned to help the County's behavioral health and criminal justice systems to serve more people and achieve more notable outcomes.

The proposed MIDD 2 programmatic and funding recommendations are a holistic approach to the continuum of behavioral health services, grounded in the principles of equity and social justice and recovery and resiliency. The proposed initiatives were deliberately and intentionally developed with input from a wide array of stakeholders and communities; they were subject to wide public review and comment, which yielded meaningful changes to the proposals. The services, programs and systems supported by MIDD 2 initiatives are interwoven and interdependent.

Recommended improvements to the composition of the MIDD Advisory Committee are intended to bring greater depth and breadth of subject matter expertise and knowledge and experiences to the review of MIDD initiatives and outcomes, while operational improvements are intended to make full use of the capabilities of the committee. Revised fund balance and reserve policies are intended to strengthen the MIDD Fund's financial position and provide clarity around use of fund balance. MIDD 2 is deeply aligned with BSK and other initiatives.

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

While it has been demonstrated that MIDD 1-supported programs have resulted in reduced jail bookings and shorter hospital stays, individuals with mental health and substance use conditions continue to end up in jails and emergency services because other options are not available – to them or to first

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

As documented in this and other reports, the world of behavioral health care is rapidly evolving. Actions such as state mandated behavioral health integration, court rulings, along with the implementation of the Affordable Care Act, require King County and its behavioral health and criminal justice partners to continue the historical collaboration initiated by the development of MIDD 1 over eight years ago to make further meaningful systems improvements. The MIDD planning processes have taken into account the changing landscape of behavioral health, while continuing to build on the strong foundation of MIDD 1. County staff are prepared to lead the work necessary to re-envision and re-tool MIDD programs to achieve even greater impact and outcomes.

VIII. Appendices Contents

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

Mark R. Munetz, M.D.
Patricia A. Griffin, Ph.D.

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

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

The Sequential Intercept Model: ideals and description

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

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

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

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

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

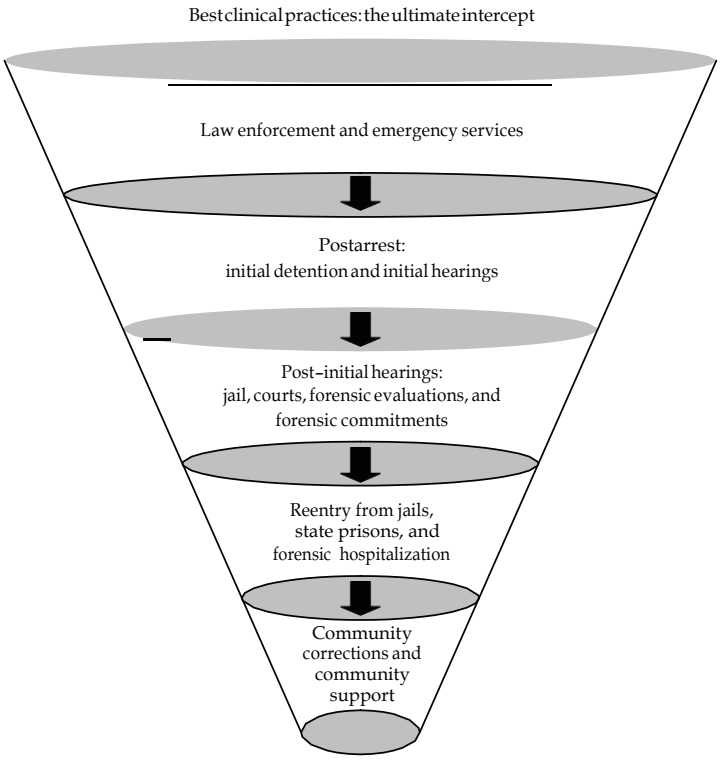
In contrast to the six critical intervention points identified in Landsberg's conceptual roadmap (3), we have specified the following five intercept points to more closely reflect the flow of individuals through the criminal justice system and the interactive nature of mental health and criminal justice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

- Law enforcement and emergency services
- Initial detention and initial hearings
- Jail, courts, forensic evaluations, and forensic commitments
- Reentry from jails, state prisons, and forensic hospitalization
- Community corrections and community support services

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

Figure 1

The Sequential Intercept Model viewed as a series of filters



An accessible mental health system: the ultimate intercept

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

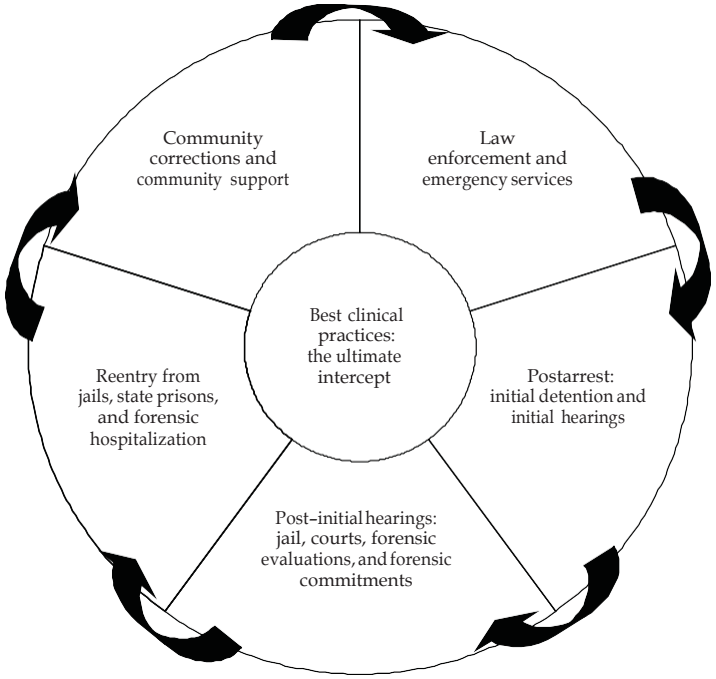
In addition to accessible and comprehensive services, it is increasingly clear that clinicians and treatment systems need to use treatment interventions for which there is evidence of efficacy and effectiveness (7,8). In many systems, evidence-based treatments are not delivered consistently (9). Examples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

Intercept 1: law enforcement and emergency services

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

Figure 2

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



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

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

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

Intercept 2: initial hearings and initial detention

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

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

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

Examples of programs that intercept at the initial detention or initial

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

Intercept 3: jails and courts

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

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

Intercept 4: reentry from jails, prisons, and hospitals

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

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

Intercept 5: community corrections and community support services

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

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

Discussion

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

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

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

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

Conclusions

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

Acknowledgments

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2016 MIDD Oversight Committee Membership Roster
As of April 2016

Johanna Bender, Judge, King County Superior Court, (Co-Chair)
Representing: Superior Court

Merril Cousin, Executive Director, Coalition Ending Gender Based Violence (Co-Chair)
Representing: Domestic violence prevention services

Dave Asher, Kirkland City Council
Councilmember, City of Kirkland
Representing: Sound Cities Association (formerly Suburban Cities Association)

Rhonda Berry, Chief of Operations
Representing: King County Executive

Jeanette Blankenship, Fiscal and Policy Analyst
Representing: City of Seattle

Susan Craighead, Presiding Judge, King County Superior Court
Representing: Superior Court

Claudia D'Allegri, Vice President of Behavioral Health, SeaMar Community Health Centers
Representing: Community Health Council

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

Lea Ennis, Director, Juvenile Court, King County Superior Court
Representing: King County Systems Integration Initiative

Ashley Fontaine, Director, National Alliance on Mental Illness (NAMI)
Representing: NAMI in King County

Pat Godfrey, Member, King County Alcoholism and Substance Abuse Administrative Board
Representing: King County Alcoholism and Substance Abuse Administrative Board

Shirley Havenga, Chief Executive Officer
Community Psychiatric Clinic
Representing: Provider of mental health and chemical dependency services

Patty Hayes, Director Public Health–Seattle & King County
Representing: Public Health Department

William Hayes, Director, King County Department of Adult and Juvenile Detention
Representing: Department of Adult and Juvenile Detention

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

Darcy Jaffe, Chief Nurse Officer and Senior Associate Administrator
Representing: Harborview Medical Center

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

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

Jeanne Kohl-Welles, Councilmember, Metropolitan King County Council
Representing: King County Council

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

Mark Putnam, Director, All Home (formerly Committee to End Homelessness)
Representing: All Home

Adrienne Quinn, Director, King County Department of Community and Human Services (DCHS)
Representing: King County DCHS

Lynne Robinson, Councilmember, City of Bellevue
Representing: City of Bellevue

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 survivor services in King County

Donna Tucker, Chief Judge, King County District Court

John Urquhart, Sheriff, King County Sheriff's Office
Representing: Sheriff's Office

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

Lorinda Youngcourt, Director, King County Department of Public Defense
Representing: Public Defense

Mental Illness and Drug Dependency (MIDD) 2
Community Conversations & Focus Group Themes

County staff conducted a robust outreach and engagement process around MIDD 2 planning. From September through December 2016, King County invited communities to participate in five regional Community Conversations on MIDD[1]. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas.

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

MIDD 2 Planning Community Conversations September – December 2016		
MIDD Strategy Area Table	**What's working?**	**What's not working or needed?**
Prevention & Early Intervention	• Wraparound • Peer Mentors/Counselors • School-based Services • Trauma Informed Care • Suicide Prevention	• Family/In-home Support • Youth-Young Adult Support • Culturally Diverse Resources • Crisis Line Texting • Provider Trainings
Crisis Diversion	• Mental Health First Aid Training • Police De-escalation Training • Crisis Clinic • Crisis Solution Services • Children's Crisis Outreach Response System/Geriatric Regional Assessment Team	• Waiting for Services • Mental Health Aftercare for Young Adults • Mobile Van for Mental Health • Respite Housing/ Crisis beds • Culturally Sensitive Services
Recovery & Reentry	• Non-Medicaid services • Wraparound • Recovery Café • Peer/Mentoring Support • Clubhouses	• Non-Medicaid Services, more needed • Restorative Justice • Recovery House/Oxford House • Treatment on Demand • Recovery High Schools
System Improvement	• Harm Reduction Programs • Specialty Population Behavioral Health Services • MIDD Mental Health/Substance Use Disorder funds • Staff Trainings • Behavioral Health/Physical Health Integration	• High Staff Turnover and Burnout • Caregiver/Parent Resources are lacking • Lack of services in south and rural county areas • Culturally Competent Services • Facility-based Mental Health/Substance Use Disorder services limit access

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

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

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

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

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

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

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

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

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

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

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

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

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

MIDD SURVEY: TOP AREAS OF NEED OR SERVICE GAPS

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

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

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

MIDD 2 Briefing Paper Review Panel Sorting

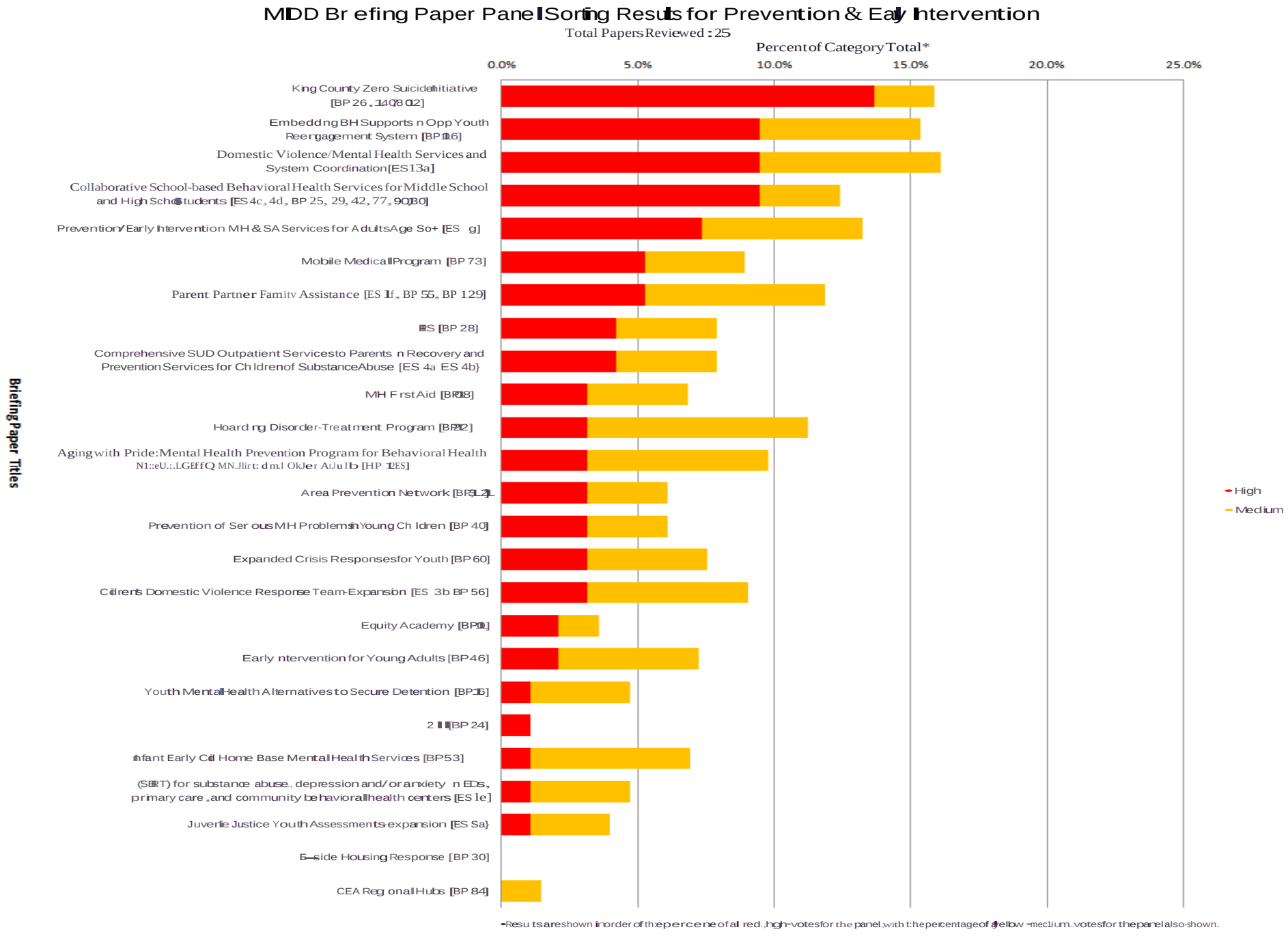
Briefing Paper Review Panel Information

In early March, more than 50 community members, including MIDD Oversight Committee Members, participated on four diverse briefing paper review panels. Briefing papers on new concepts and existing MIDD 1 strategies were created to answer important analytical and policy questions related to the concepts and strategies. The four panels corresponded to the four overarching MIDD 2 strategy areas reviewed existing strategies and new concepts in the form of briefing papers. Briefing papers considered by the different review panels are linked below:

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

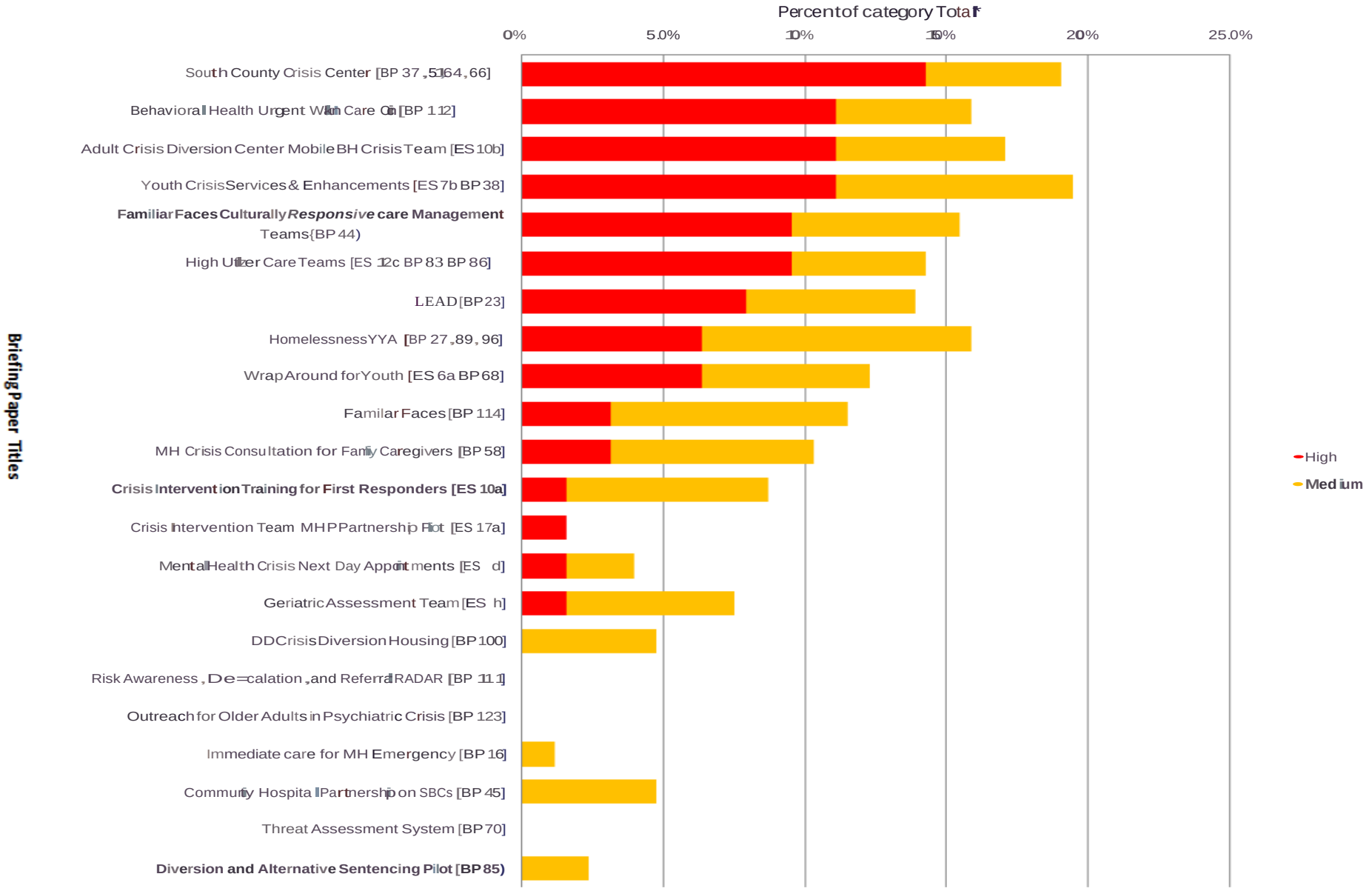
The panels were constructed to bring in a diverse array of lived experiences, skills, knowledge, perspectives, and insights to the sorting process. Each review panel included a mix of community members and MIDD Oversight Committee members or their designees. The work of the panels included deep discussion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

The work of these review teams, along with the discussions had by the teams in the panel sessions, coupled with the feedback King County has gathered from its robust community engagement process, is informing the next phases of MIDD 2 planning.

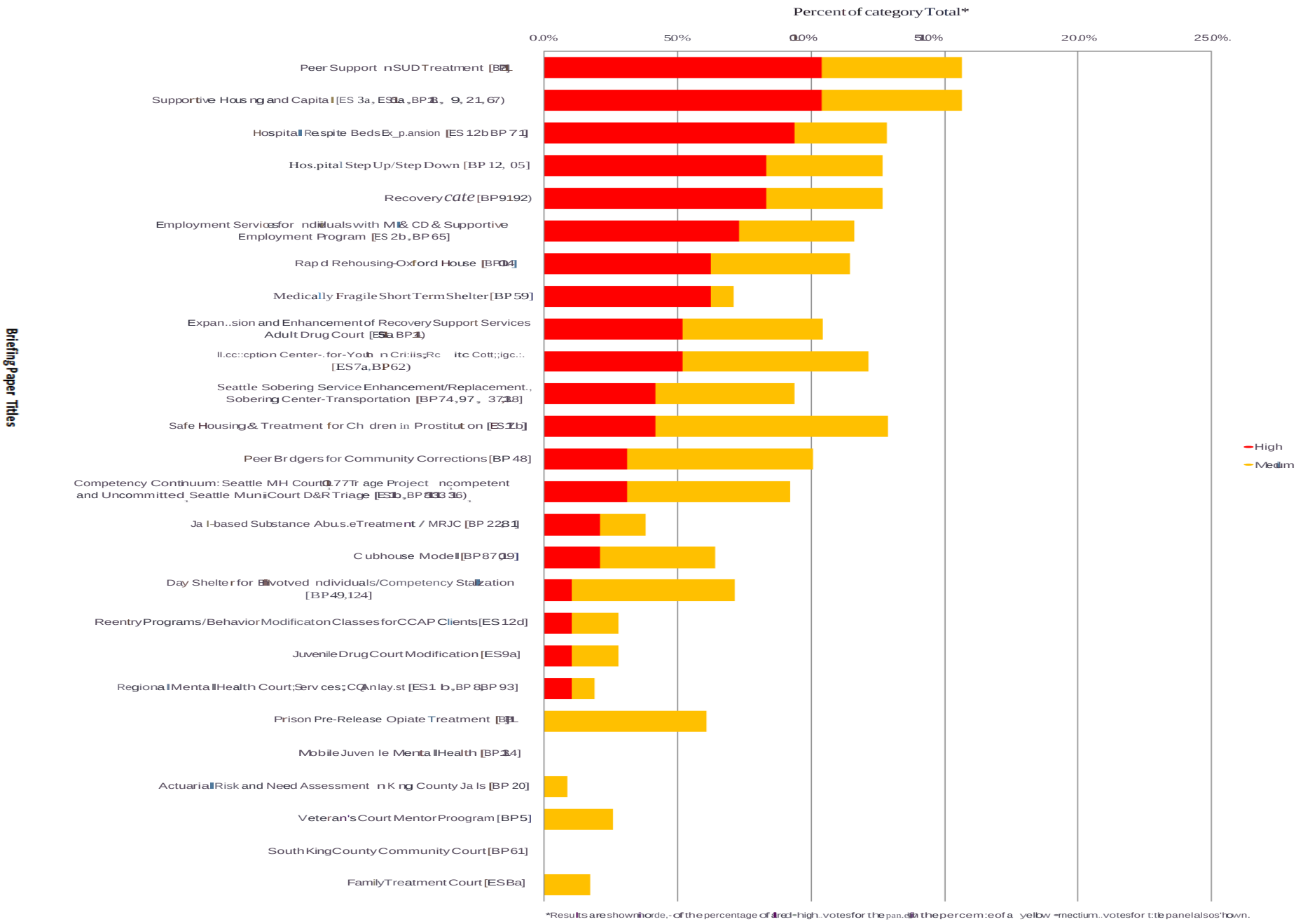

MIDD Briefing Paper Panel Sorting Results for Prevention & Early Intervention
Total Papers Reviewed : 25
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
King County Zero Suicide Initiative [BP 26, 140, 80, 102]
Embedding BH Supports in Opp Youth Reengagement System [BP 106]
Domestic Violence/Mental Health Services and System Coordination [ES 13a]
Collaborative School-based Behavioral Health Services for Middle School and High School Students [ES 4c, 4d, BP 25, 29, 42, 77, 90, 130]
Prevention/Early Intervention MH & SA Services for Adults Age 50+ [ES 9]
Mobile Medical Program [BP 73]
Parent Partner Family Assistance [ES 1f, BP 55, BP 129]
IRS [BP 28]
Comprehensive SUD Outpatient Services to Parents in Recovery and Prevention Services for Children of Substance Abuse [ES 4a, ES 4b]
MH First Aid [BP 118]
Hoarding Disorder-Treatment Program [BP 132]
Aging with Pride: Mental Health Prevention Program for Behavioral Health
Area Prevention Network [BP 121]
Prevention of Serious MH Problems in Young Children [BP 40]
Expanded Crisis Responses for Youth [BP 60]
Children's Domestic Violence Response Team-Expansion [ES 3b, BP 56]
Equity Academy [BP 101]
Early Intervention for Young Adults [BP 46]
Youth Mental Health Alternatives to Secure Detention [BP 116]
2 1 1 [BP 24]
Infant Early Child Home Base Mental Health Services [BP 53]
(SBIRT) for substance abuse, depression and/or anxiety in EDs, primary care, and community behavioral health centers [ES 1e]
Juvenile Justice Youth Assessments-expansion [ES 5a]
E-side Housing Response [BP 30]
CEA Regional Hubs [BP 84]
High
Medium
*Results are shown in order of the percent of all red, high votes for the panel, with the percentage of yellow medium votes for the panel also shown.

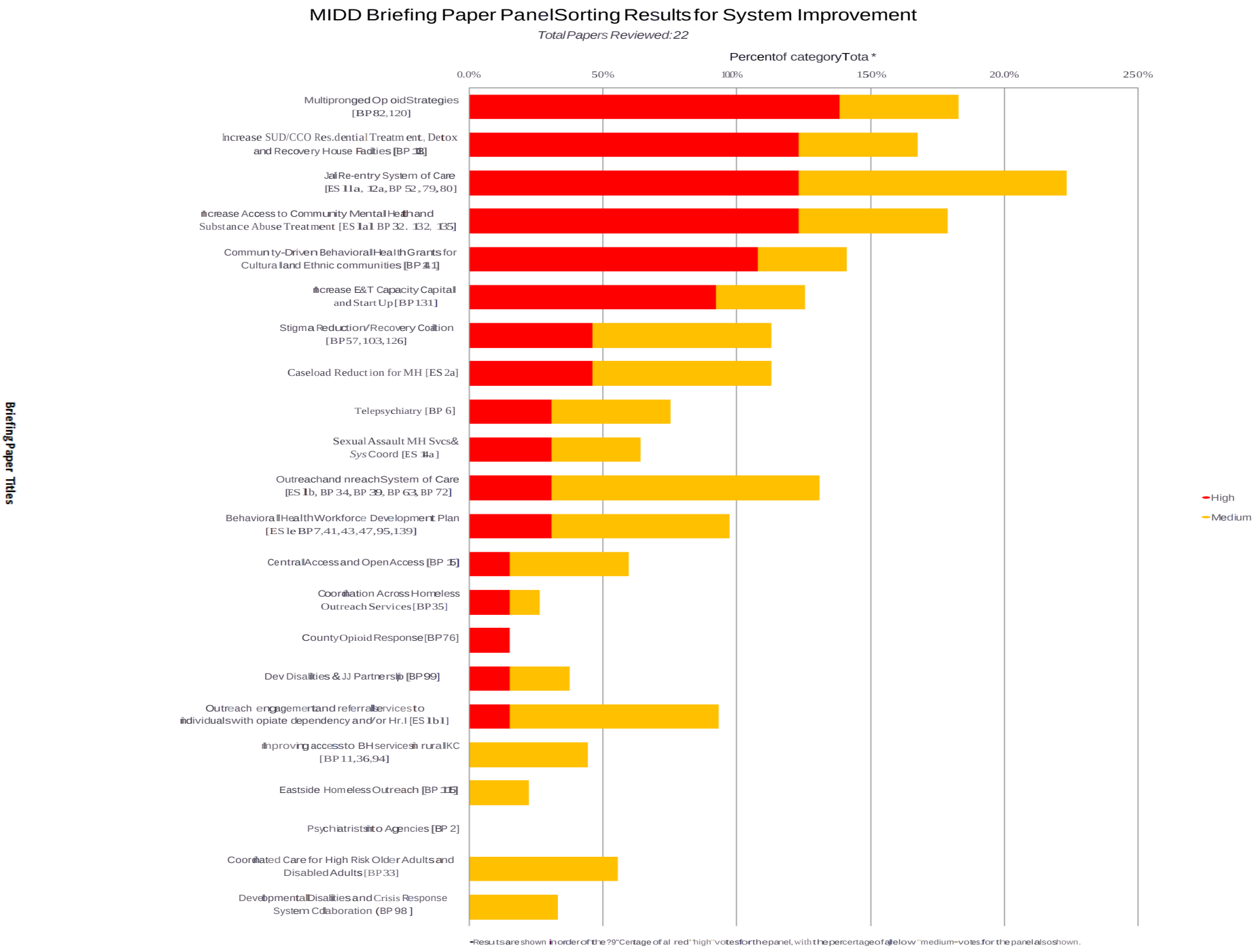
MIDD Briefing Paper Panel Sorting Results for Crisis Diversion

Toto/ Papers Reviewed: 22



•Results are shown in order of the percentage of all red "high ,,votes for the pone/, with the percentage of oily yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for Recovery & Re-Entry
Total Papers Reviewed: 26
Percent of category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
Peer Support in SUD Treatment [BP 4]
Supportive Housing and Capital [ES 3a, ES 3b, BP 3, 9, 21, 67)
Hospital Respite Beds Expansion [ES 12b BP 71]
Hospital Step Up/Step Down [BP 12, 05]
Recovery Cafe [BP 9192]
Employment Services for Individuals with MH & CD & Supportive Employment Program [ES 2b, BP 65]
Rapid Rehousing-Oxford House [BP 04]
Medically Fragile Short Term Shelter [BP 59]
Expansion and Enhancement of Recovery Support Services Adult Drug Court [ES 9a BP 4]
Intercept Center-for-Youth in Crisis; Rectic Cottages [ES 7a, BP 62]
Seattle Sobering Service Enhancement/Replacement, Sobering Center-Transportation [BP 74, 97, 37, 38]
Safe Housing & Treatment for Children in Prostitution [ES 12b]
Peer Bridgers for Community Corrections [BP 48]
Competency Continuum: Seattle MH Court, Triage Project Incompetent and Uncommitted, Seattle Muni Court D&R Triage [ES 1b, BP 33, 36),
Jail-based Substance Abuse Treatment / MRJC [BP 22, 31]
Clubhouse Model [BP 87, 09]
Day Shelter for Involved Individuals/Competency Stabilization [BP 49, 124]
Reentry Programs/Behavior Modificaton Classes for CCAP Clients [ES 12d]
Juvenile Drug Court Modification [ES 9a]
Regional Mental Health Court; Services; CD Analyst [ES 1 b, BP 8 BP 93]
Prison Pre-Release Opiate Treatment [BP 1]
Mobile Juvenile Mental Health [BP 14]
Actuarial Risk and Need Assessment in King County Jails [BP 20]
Veteran's Court Mentor Proogram [BP 5]
South King County Community Court [BP 61]
Family Treatment Court [ES 8a]
High
Medium
*Results are shown in order, of the percentage of red-high votes for the panel, to the percent of a yellow-medium votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for System Improvement
Total Papers Reviewed: 22
Percent of category Total *
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
Multipronged Opioid Strategies [BP 82, 120]
Increase SUD/CCO Residential Treatment, Detox and Recovery House Facilities [BP 138]
Jail Re-entry System of Care [ES 11a, 12a, BP 52, 79, 80]
Increase Access to Community Mental Health and Substance Abuse Treatment [ES 1a1 BP 32, 132, 135]
Community-Driven Behavioral Health Grants for Cultural and Ethnic communities [BP 141]
Increase E&T Capacity Capital and Start Up [BP 131]
Stigma Reduction/Recovery Coalition [BP 57, 103, 126]
Caseload Reduction for MH [ES 2a]
Telepsychiatry [BP 6]
Sexual Assault MH Svcs & Sys Coord [ES 14a]
Outreach and Inreach System of Care [ES 1b, BP 34, BP 39, BP 63, BP 72]
Behavioral Health Workforce Development Plan [ES 1e BP 7, 41, 43, 47, 95, 139]
Central Access and Open Access [BP 15]
Coordination Across Homeless Outreach Services [BP 35]
County Opioid Response [BP 76]
Dev Disabilities & JJ Partnership [BP 99]
Outreach engagement and referral services to individuals with opiate dependency and/or Hr. I [ES 1b1]
Improving access to BH services in rural KC [BP 11, 36, 94]
Eastside Homeless Outreach [BP 116]
Psychiatrists in to Agencies [BP 2]
Coordinated Care for High Risk Older Adults and Disabled Adults [BP 33]
Developmental Disabilities and Crisis Response System Collaboration (BP 98)
High
Medium
* Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.

Appendix E MIDD 2 Service Improvement Plan
MIDD 2 PROCESS OVERVIEW
Revised 8.16.16

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

Open Call Timeframe: 9/15-10/31

PHASE II
Analysis and Collective Review

Existing MIDD Programs* Analysis**

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

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

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

BHRD coordinates analysis of existing programs

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

Sept-Dec Briefing Paper Drafting

141 New Concepts Submitted!

New Concepts Address/Identify

- What is the specific need that concept addresses?
- How does the concept address need?
- What results/outcomes would the program have?
- What partnering entities are necessary for this concept to be successful?
- Of the four strategy areas in the MIDD 2 Framework, what strategy area does this concept fall under?

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

Submission of New Concepts will be electronic

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

Not all submitted concepts will move to Phase II

BHRD screens new concepts for forwarding to Phase II

Key Questions for Briefing Papers**

- What is the estimated resource need ($, # and type of positions, technology)?
- How long will it take to fully implement?
- What are the barriers or challenges to success for this program/concept? How would barriers be overcome?
- Does this program/ concept positively address disproportionality or enhance cultural competency and if so, how?
- Is it client centered?
- What populations does it serve?
- What MIDD 2 Framework Strategy Area does this program/concept fall under?
- What measureable outcomes are there for this program?
- Plus requirements from Ordinance 17998.

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

Jan & Feb Teams Review

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

March - May

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

Phase III
MIDD 2 Service Improvement Plan Recommendations Development
Align MIDD 2 programs and funding recommendations
County staff drafts recommendations and identifies initial funding levels.
MIDD Oversight Committee reviews recommendations.
Funding recommendations PUBLIC REVIEW AND COMMENT April 22-May 6

May-August

Final Phase: Drafting and Review of MIDD 2 Service Improvement Plan (SIS)

- Recommended programs will be included in the MIDD 2 SIP that is sent to the Executive for review and forwarding to Council
- Transmitted to the King County Council: August 25, 2016
- Changes may be made to the recommendations by the Executive AND/OR the Council

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

<table>
<tr><td colspan="3">MIDD 2 FRAMEWORK Revised 8.10.16</td></tr>
<tr><td colspan="3">MIDD RESULT
People living with, or at risk of behavioral health conditions, are healthy, have satisfying social relationships, and avoid criminal justice involvement.</td></tr>
<tr><td colspan="3">MIDD THEORY OF CHANGE
When people who are living with or who are at risk of behavioral health conditions utilize culturally relevant prevention and early intervention, crisis diversion, community reentry, treatment, and recovery services, and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.</td></tr>
<tr><td colspan="3">OUTCOMES</td></tr>
<tr><td>Population Indicators</td><td>MIDD and other King County and community initiatives contribute to the overall health and well-being of King County residents that is demonstrated by positive changes in population</td><td>• Emotional health – rated by level of mental distress
• Daily functioning - rated by limitations to due to physical, mental or emotional problems
• Reduced or eliminated alcohol and substance use
• Health rated as ‘very good’ or ‘excellent’
• Housing stability
• Representation of people with behavioral health conditions within jail, hospitals and emergency departments</td></tr>
<tr><td>MIDD 2 Strategy Areas</td><td colspan="2">SAMPLE[i] MIDD 2 Performance Measures (to be refined after specific programs/services are selected)</td></tr>
<tr><td>Prevention and Early Intervention

People get the help they need to stay healthy and keep problems from escalating</td><td colspan="2"><u>How much?</u> Service capacity measures
• Increased number of people receiving substance abuse and suicide prevention services
• Increased number of people receiving screening for health and behavioral health conditions within behavioral health and primary care settings

<u>How well?</u> Service quality measures
• Increased treatment and trainings in non-traditional settings (day cares, schools, primary care)
• Increased primary care providers serving individuals enrolled in Medicaid

<u>Is anyone better off?</u> Individual outcome measures
• Increased use of preventive (outpatient) services
• Reduced use of drugs and alcohol in youth & adults
• Increased employment and/or attainment of high school diploma and post-secondary credential
• Reduced risk factors for behavioral health problems (e.g., social isolation, stress, etc.)</td></tr>
<tr><td>Crisis Diversion

People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration</td><td colspan="2"><u>How much?</u> Service capacity measures
• Increased capacity of community alternatives to hospitalization and incarceration (e.g., crisis triage, respite, LEAD, therapeutic courts, etc.)

<u>How well?</u> Service quality measures
• Increased use of community alternatives to hospitalization and incarceration by first responders

<u>Is anyone better off?</u> Individual outcome measures
• Reduced unnecessary hospitalization, emergency department use and incarceration
• Decreased length and frequency of crisis events</td></tr>
<tr><td>Recovery and Reentry

People become healthy and safely reintegrate to community after crisis</td><td colspan="2"><u>How much?</u> Service capacity measures
• Increased in affordable, supported, and safe housing
• Increased availability of community reentry services from jail and hospitals
• Increased capacity of peer supports

<u>How well?</u> Service quality measures
• Increased linkage to employment, vocational, and educational services
• Increased linkage of individuals to community reentry services from jail or hospital
• Increased housing stability

<u>Is anyone better off?</u> Individual outcome measures
• Increased employment and attainment of high school diploma and post-secondary credential
• Improved wellness self-management
• Improved social relationships
• Improved perception of health and behavioral health issues and disorders
• Decreased use of hospitals and jails</td></tr>
</table>

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

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

Adopted MIDD 1 Policy Goals:

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

These goals may be revised for the MIDD Service Period 2017-2025

King County

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

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

Principles of Purchasing

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

Ethical Behavior and Conduct

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

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

Open and effective competition

The objectives of open and effective competition are:

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

Open and Effective Competition means:

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

When is a Competitive Process to Secure a Contract Required?

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

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

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

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

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

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

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

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

Methods Utilized for Competitive Bid Processes

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

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

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

Special Purchasing Issues

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

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

Criteria for Using King County Procurement for the Competitive Bid Process

King County Procurement buyers should be utilized when:

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

Criteria for the Department Running the Competitive Bid Process

The Department may run the competitive bid process when:

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

Appendix H
MIDD 2 Service Improvement Plan

Initiative Descriptions – Preliminary Implementation Information

*Please note that the Initiative Description documents that are included in this appendix provide **initial** implementation and evaluation information. The information in these documents is **preliminary** and **subject to revision** based on revised policy goals, the adopted budget, and stakeholder and community feedback that might occur during the upcoming implementation planning work or as a result of changed funding levels that may occur during the County's budget adoption process.*

Please note that in most instances, information for new MIDD 2 initiatives is very preliminary due to the need to conduct detailed implementation planning in collaboration with stakeholders and communities. Additionally most existing MIDD 1 initiatives that are recommended to continue into MIDD 2 will also undergo some level of operational updating to increase efficiency, effectiveness, and meet revised policy goals. All initiatives will be included & detailed in a MIDD 2 Implementation Plan that will be submitted to the Council in 2017.

Contents

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

MIDD 2 Initiative Title: Law Enforcement Assisted Diversion (LEAD) **(NEW)**

MIDD 2 Number: CD-1

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

How does the program advance the recommended MIDD policy goals?

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

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

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

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

1. Program Description

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

All LEAD participants receive case management, which supports fulfilment of basic needs, and may include housing stability, job attainment or income stabilization, enrollment in drug and alcohol treatment, and coordination of all criminal justice involvement and prosecution to support and not compromise LEAD intervention plans. In

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

general, LEAD pursues the goals of the individual participant, as identified by the case manager and the participant in an Individual Intervention Plan.

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

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

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

Specific strategies of the LEAD program include:

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduced unnecessary incarceration
- reduced substance use
- increased stability in treatment, employment, or other quality of life measures

[3] LEAD launched as a pilot in Seattle's Belltown neighborhood and King County's Skyway neighborhood in 2011, funded entirely by grants from private foundations. In 2014, with support from the City of Seattle, and at the request of other downtown Seattle neighborhoods, the program was expanded to include the rest of downtown Seattle. LEAD received $800,000 in one-time funding from MIDD 1 in 2016. The City of Seattle plans to expand LEAD to its East precinct (Capitol Hill) in 2016, and, since other Seattle neighborhoods have requested LEAD, the City Council has requested a plan for how to scale up citywide. The Sound Cities Association has also entered discussions regarding expanding LEAD to other King County cities.

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

Specific outcomes and measures for LEAD, especially identification of what will be evaluated as part of MIDD 2, are subject to further definition.

◊ *E. Provided by: Contractor*

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

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

Funding for case management will be contracted to PDA through King County BHRD, which will provide program oversight of and contract monitoring for the MIDD-funded portion of LEAD, including ensuring that other funding sources including Medicaid are maximized. (See 3.A below for the expected long-term approach to case management contracting.)

2. Spending Plan

This spending plan shows estimated amounts and expected categories for MIDD 2's recommended contribution to LEAD.

It is designed to invest in expansion of LEAD to other jurisdictions, and/or other Seattle neighborhoods, as part of a countywide strategy. Each additional jurisdiction will be expected to secure or contribute funding for increased case management, project management, community engagement, client legal services, law enforcement overtime, and training costs when LEAD expands into its area, alongside the MIDD 2 investment.

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

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

Year	Activity	Amount
2017	Case management, prosecution costs, project management, stakeholder coordination, community engagement, and planning to enhance integration and expand to suburban cities	$1,537,500
2017 Annual Expenditure		**$1,537,500**
2018	Case management, prosecution costs, project management, stakeholder coordination, community engagement, and planning to enhance integration and expand to suburban cities	$2,052,000
2018 Annual Expenditure		**$2,052,000**
Biennial Expenditure		**$3,589,500**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

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

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

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

◊ *B. Contracting of Services*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

◊ *C. Services Start date (s)*

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

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

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

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

MIDD 2 Initiative Title: Youth and Young Adult Homelessness Services **(NEW)**

MIDD 2 Number: CD-2

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

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

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

◊ *B. Goals*

This initiative focuses on mobile behavioral health team(s) based in young adult housing programs, as a priority element of a coordinated approach that will support youth and young adults experiencing homeless with acute behavioral health needs and/or a history

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

of trauma in achieving and succeeding in safe and stable housing.[1] Improving behavioral health services to this population will help ensure that their homelessness is a brief and one-time experience.

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

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

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

2. Spending Plan

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

Year	Activity	Amount
2017	Mobile behavioral health team(s) based at young adult housing programs	$300,000
2017 Annual Expenditure		**$300,000**
2018	Mobile behavioral health team(s) based at young adult housing programs	$307,800
2018 Annual Expenditure		**$307,800**
Biennial Expenditure		**$607,800**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

MIDD 2 Initiative Title: South County Crisis Diversion Services/Center **(NEW)**

MIDD 2 Number: CD-4

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

How does the program advance the recommended MIDD policy goals?

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

This program relates to the current MIDD 1 strategy Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team in the availability of in-the-community crisis response and the accessibility of a facility-based crisis diversion program. The program would provide south King County first responders with a therapeutic community-based alternative to jail and hospital settings when engaging with adult individuals in behavioral health crisis.

1. Program Description

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

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 1,500 individuals annually when fully operational.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

2. Spending Plan

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

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

Year	Activity	Amount
2017 only	South King County Crisis Diversion Facility/Services capital investment and/or startup costs	$500,000
2017 Annual Expenditure		**$500,000**
2018	South King County Crisis Diversion Facility programs, services, and operations	$1,539,000
2018 Annual Expenditure		**$1,539,000**
Biennial Expenditure		**$2,039,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

The anticipated start of services will likely be in 2018, depending on timeline for planning and procuring a contractor. In addition, depending on the extent of renovations or construction needed, implementation for the project could be extended.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

MIDD 2 Initiative Title: Multipronged Opioid Strategies **(NEW)**

MIDD 2 Number: CD-7

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

How does the program advance the recommended MIDD policy goals?

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

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

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

This initiative aims to address the trend by supporting the recommendations (due end of September 2016) of the Heroin and Prescription Opioid Addiction Task Force, jointly convened by the King County Executive and the mayors of Seattle, Auburn, and Renton.[5] Specifically, recommended interventions in as many as five categories may emerge from the work of the Task Force:

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

3. Increased access to overdose reversal drug naloxone to prevent fatalities and problem escalation;
4. Engagement services to link clients of Public Health Seattle-King County's (PHSKC) needle exchange to needed treatment services (as funded under MIDD 1), and potential enhancement and/or expansion to serve more clients and/or address more complex needs.
5. Staffing support for a supervised consumption area[6] in King County.

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

1. Program Description

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

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

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

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

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

- Category 4: Continuation of MIDD 1-funded engagement services to link clients of PHSKC's needle exchange to needed treatment services.
  - Social work staff at PHSKC's needle exchange.

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

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

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

2. Spending Plan

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

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a

staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

Year	Activity	Amount
2017	Task Force-recommended service enhancements to address opiate addiction	$667,000
2017	Continuation of needle exchange social work staff to engage clients with treatment	$83,000
2017 Annual Expenditure		**$750,000**
2018	Task Force-recommended service enhancements to address opiate addiction	$1,456,000
2018	Continuation of needle exchange social work staff to engage clients with treatment	$83,000
2018 Annual Expenditure		**$1,539,000**
Biennial Expenditure		**$2,289,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

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

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

◊ *B. Contracting of Services*

See 3.A above.

◊ *C. Services Start date (s)*

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

King County work to define the various other aspects of this initiative will begin in fall 2016, once Task Force recommendations are released, with stakeholder engagement to occur in first quarter 2017 when a final funding level is known. RFI and RFP processes, as applicable, will be completed in second quarter 2017, with services to be launched via a staged approach between third quarter 2017 and first quarter 2018.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

MIDD 2 Initiative Title: Behavioral Health Urgent Care Walk-In Clinic **(NEW)**

MIDD 2 Number: CD-9

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

How does the program advance the recommended MIDD policy goals?

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

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

1. Program Description

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

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

- Crisis phone support

Services are voluntary and meant to be short-term.

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

2. Spending Plan

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

Dates	Activity	Funding
2017 only	Urgent Care Walk-In Clinic capital investment, startup costs, program design, siting, and public awareness	$250,000
2017 Annual Expenditure		**$250,000**
2018 Annual Expenditure	Urgent Care Walk-In Clinic operations and services	$256,500
2018 Annual Expenditure		**$256,500**
Biennial Expenditure		**$506,500**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

MIDD 2 Initiative Title: Family Interventions Restorative Services (FIRS) **(NEW)**

MIDD 2 Number: CD-13

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

◊ *B. Goals*

Goals for this initiative include:

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

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- reduced substance use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary incarceration
- reduced substance use
- improved wellness and social relationships
- reduced behavioral health risk factors
- increased access to culturally appropriate recovery services

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

2. Spending Plan

Year	Activity	Amount
2017	24/7 non-secure facility for King County youth who are violent towards a family member and evidence-based and best practices interventions for families continue.	$ 1,087,688
2017 Annual Expenditure		**$ 1,087,688**
2018	24/7 non-secure facility for King County youth who are violent towards a family member and evidence-based and best practices interventions for families continue.	$ 1,115,967
2018 Annual Expenditure		**$ 1,115,967**
Biennial Expenditure		**$ 2,203,655**

NOTE: This spending plan assumes $500,000 will be contributed by the City of Seattle to support 2017-18 FIRS expenditures totaling $2.7 million. The City's actual contribution will be finalized during their budget process, with a final budget expected to be adopted in November 2016.

3. Implementation Schedule

◊ *A. Procurement of Providers*

The initial King County Superior Court pilot of the FIRS program is currently active with temporary support from the City of Seattle and MIDD fund balance funding. An RFP may be issued for expansion.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

MIDD 2 Initiative Title: Involuntary Treatment Triage **(NEW)**

MIDD 2 Number: CD-14

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

Based on the unfunded RCW 10.77 evaluation volume currently handled by King County's DMHPs, it is estimated that between 200 and 250 individuals per year may receive evaluations through this program once funded. In coordination with court partners, efforts will also be made to reduce the number of evaluations that are needed.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

2. Spending Plan

This spending plan would create the capacity to provide 200 to 250 evaluations per year.

Year	Activity	Amount
2017	Competency triage evaluation services	$150,000
2017 Annual Expenditure		**$150,000**
2018	Competency triage evaluation services	$153,900
2018 Annual Expenditure		**$153,900**
Biennial Expenditure		**$303,900**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

MIDD 2 Initiative Title: Youth Behavioral Health Alternatives to Secure Detention **(NEW)**

MIDD 2 Number: CD-16

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

How does the program advance the recommended MIDD policy goals?

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

This program is envisioned to provide community based treatment beds for youth who are involved in the justice system, prioritizing those youth who may be held in detention. These treatment beds address a serious gap in the current behavioral health system. Program treatment services will be offered to stabilize the youth and family, with the intention of diversion from further justice system involvement related to behavioral health conditions.

1. Program Description

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

This program must be developed collaboratively with stakeholders and communities. The final program design and services may include differ and/or contain elements than what is reflected in this initial description of the initiative.

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

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

◊ *B. Goals*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures- outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- improved daily functioning
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary incarceration
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduced behavioral health risk factors
- Increased connection to community services

◊ *E. Provided by: Contractor(s)*

2. Spending Plan

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

Year	Activity	Amount
2017	Complete planning, develop and issue Request for Statement of Interest/Request for Proposal, select recipients, complete contracts, and services begin.	$ 250,000
2017 Annual Expenditure		**$250,000**
2018	Alternatives to Secure Detention programs, services, and operations	$1,026,000
2018 Annual Expenditure		**$1,026,000**
Biennial Expenditure		**$ 1,276,000**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Young Adult Crisis Facility (CD-17)

MIDD 2 Initiative Title: Young Adult Crisis Facility **(NEW)**

MIDD 2 Number: CD-17

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

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "Reduce the number, length, and frequency of behavioral health crisis events".

The young adult homeless system has seen a dramatic increase in transition aged youth with serious behavioral health needs. In recent months, there have been two suicides, and several attempted suicides by young, homeless people who are experiencing their first psychotic break. There have been multiple other incidents of high needs young people in homeless housing or shelter situations that were not intended or suited to serve youth with these high needs.

This program will provide community based treatment beds to stabilize these transition-aged youth, or to house youth in crisis on a transitional basis, including those who are exiting from involuntary commitment facilities. Initially, the focus will be on young people who are in homeless housing or shelter situations, but will be expanded to be available to a broader group of transitioned-aged youth to avert more significant crises. Although transition-aged youth are legally considered adults, existing adult facilities are not developmentally appropriate to serve this age group. The treatment beds supported by this funding will address a serious gap in the current behavioral health and housing systems for these transition aged youth. Program treatment services will be offered to stabilize individuals and mitigate further trauma for an already vulnerable population.

1. Program Description

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

This program must be developed collaboratively with stakeholders and communities. The final program design and services may include differ and/or contain elements than what is reflected in this initial description of the initiative.

The model will provide temporary housing for young people who are currently homeless and need an appropriate placement, with a focus on 24/7 services that have the capacity to address suicidal ideation and co-occurring disorders. Lengths of stay are anticipated to be between 3 and 18 months, with most young people staying about a year. The young adult crisis facility will focus on mental health services, medication management, and identifying and treating substance use disorders. It would have capacity for 12-15 young people, using existing facilities if possible that could be repurposed or consolidating certain providers' existing homeless youth programs to create space.

◊ *B. Goals*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Young Adult Crisis Facility (CD-17)

The goal of this initiative is to provide youth in crisis with behavioral health treatment needs with community based treatment beds that reduce crisis events and emergency system contacts.

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures- outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved emotional health
- improved daily functioning
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services

◊ *E. Provided by: Contractor(s)*

2. Spending Plan

Year	Activity	Amount
2017	Complete site identification, acquisition and any necessary rehabilitation. Complete program design and contracting process. Begin providing services.	$ 705,825
2017 Annual Expenditure		**$705,825**
2018	Provide programs, services, and operations	$724,175
2018 Annual Expenditure		**$724,175**
Biennial Expenditure		**$ 1,430,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

If approved, planning for this new initiative is expected to occur during the fourth quarter of 2016.

◊ *B. Contracting of Services*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Young Adult Crisis Facility (CD-17)

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

◊ *C. Services Start date (s)*

The anticipated start date for the facility and its core services to be operational is targeted for the first quarter 2017, depending on how quickly planning, procurement, site identification and rehabilitation can occur.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

MIDD 2 Initiative Title: Zero Suicide Initiative Pilot **(NEW)**

MIDD 2 Number: PRI-6

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

How does the program advance the recommended MIDD policy goals?

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

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

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

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

1. Program Description

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

The Zero Suicide Initiative is designed envisioning three phases as funding permits:

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

Additional community trainings may be included as funding allows.

Zero Suicide approach implementation includes the following components:

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

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

The Zero Suicide Initiative may also include many of the following components. Prioritization of these components will be determined in consultation with suicide prevention partners and other stakeholders:

8. Lethal means restriction training, including exploration of options for means restrictions programming implementation (e.g. implementation of recommendations from the Washington State Safer Homes Task Force);
9. Suicide attempt follow up care program when released from Emergency Department or inpatient settings (including development of a model-based emerging best practice);
10. Universal and proper implementation of suicide risk screening at Emergency Departments (coupled with brief interventions, discharge planning and follow up); and
11. Programming for families/friends who have lost someone to suicide.
12. Universal gatekeeper suicide prevention training.
13. A social marketing/media outreach plan.
14. Partnership with Mental Health First Aid training for stigma reduction.

Stakeholders and partners will be consulted to design and implement the pilot.

◊ *B. Goals*

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

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

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

◊ *C. Expected Numbers of Individuals Served*

Each annual provider cohort is expected to include several agencies, each of which will identify implementation teams to pioneer Zero Suicide approaches within their organizations. The number of potential clients who could benefit from the resulting enhanced services provided by these teams is indeterminate and likely to vary by agency. Additional individuals reached by suicide prevention trainings will vary depending on funding allocation.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved perception of health and behavioral health issues and disorders

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

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

2. Spending Plan

This spending plan reflects the pilot funding level. Some activities may be staged later or may not occur.

Year	Activity	Amount
2017	Develop & implement Zero Suicide pilot; begin training and learning collaborative cohorts Implement technical assistance; community engagement and monitoring activities	$500,000
2017 Annual Expenditure		**$500,000**
2018	Continue implementation and services	$513,000
2018 Annual Expenditure		**$513,000**
Biennial Expenditure		**$1,013,000**

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

The proposed MIDD 2 allocation for Zero Suicide is a pilot award amount; the initiative may be scaled, and phases reduced or increased according to available funding. Rollout to hospital settings via Phase 2 and 3 may be impacted due to available funding, or scaled in accordance with partner input.

3. Implementation Schedule

◊ *A. Procurement of Providers*

Request for Proposals (RFP) will be conducted. Request for Qualifications (RFQ) and/or Request for Information (RFI) may be conducted.

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

A request for interest (RFI) for Zero Suicide pilot implementation will occur by second quarter 2017. Services & training will occur in the third quarter.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

MIDD 2 Initiative Title: Mental Health First Aid **(NEW)**

MIDD 2 Number: PRI-7

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

How does the program advance the recommended MIDD policy goals?

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

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

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

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

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

individuals and families, and learn about evidence-supported treatment and self-help strategies. Mental Health First Aid is intended for all people and organizations that make up the fabric of a community.[3]

1. Program Description

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

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

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

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

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

Given current funding levels and national estimates of average costs of Mental Health First Aid training per person, as many as 2,000 people per year could be served if only direct

[3] Mental Health First Aid Frequently Asked Questions. (n.d.). Retrieved December 11, 2015, from http://www.mentalhealthfirstaid.org/cs/faq/

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

trainings are offered, although this number may vary depending on the focus and target population. Costs are variable, depending on the number of individuals trained, and the numbers of trainings offered.

The potential reach of the MIDD investment could be broadened through the strategic use of "train the trainer" certification courses that could create lasting impact beyond the MIDD funding. However, the higher up-front cost of these trainings[4] would decrease the total number of trainees funded directly by MIDD.

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved perception of health and behavioral health issues and disorders

◊ *E. Provided by: Contractor*

Contracting for implementation of Mental Health First Aid training calendar and trainings will be explored in consultation with partners. Most or all trainings are expected to be provided by contractors.

2. Spending Plan

Year	Activity	Amount
2017	Mental Health First Aid trainings to communities and certification courses	$200,000
2017 Annual Expenditure		**$200,000**
2018	Mental Health First Aid trainings to communities and certification courses	$205,200
2018 Annual Expenditure		**$205,200**
Biennial Expenditure		**$405,200**

3. Implementation Schedule

[4] $1,850 to $2,000 per person for a 5-day training. http://www.mentalhealthfirstaid.org/cs/become-an-instructor/certification-process/

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

◊ *A. Procurement of Providers*

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

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

◊ *B. Contracting of Services*

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

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

MIDD 2 Initiative Title: Rapid Rehousing Oxford House Model **(NEW)**

MIDD 2 Number: RR-4

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

How does the program advance the recommended MIDD policy goals?

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

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

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

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

1. Program Description

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

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

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

◊ *B. Goals*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

2. Spending Plan

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

MIDD 2 Initiative Title: Behavioral Health Risk Assessment Tool for Adult Detention **(NEW)**

MIDD 2 Number: RR-7

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

How does the program advance the recommended MIDD policy goals?

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

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

1. Program Description

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

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

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

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

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

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

◊ *B. Goals*

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

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

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

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: County*

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

2. Spending Plan

Year	Activity	Amount
2017	Intake services staff to implement behavioral health risk assessment; materials and training	$470,900
2017 Annual Expenditure		**$470,900**
2018	Intake services staff to implement behavioral health risk assessment; materials and training	$483,143
2018 Annual Expenditure		**$483,143**
Biennial Expenditure		**$954,043**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

MIDD 2 Initiative Title: Recovery Café **(NEW)**

MIDD 2 Number: RR-9

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

How does the program advance the recommended MIDD policy goals?

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

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

MIDD 2's annual investment, in combination with operating and capital funding from other sources, would allow a second location in King County to be launched.

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

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

1. Program Description

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

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

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

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

◊ *B. Goals*

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

The goal of MIDD 2's investment in Recovery Café is to seed the launch of a second café in King County beyond downtown Seattle, in partnership with other funds to be secured by Recovery Café, and to provide ongoing support for the operations of this additional site.

◊ *C. Expected Numbers of Individuals Served*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

2. Spending Plan

The spending plan outlined here is limited to the MIDD funding level. As such, implementation scale and timing will be significantly affected by the degree to which other funds are leveraged for the second King County Recovery Café site. As a result, the timing and/or amounts of some expenditures shown below may depend on when and how the new location is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

Year	Activity	Amount
2017 only	Capital and/or startup funding for second Recovery Café site in King County	$348,717
2017 Annual Expenditure		**$348,717**
2018 Annual Expenditure	Operational funding for second King County Recovery Café site (site management and mental health coordination)	$357,783
2018 Annual Expenditure		**$357,783**
Biennial Expenditure		**$706,500**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

3. Implementation Schedule

◊ *A. Procurement of Providers*

No procurement process will be required.

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

MIDD 2 Initiative Title: Peer Bridgers and Peer Support Pilot **(NEW)**

MIDD 2 Number: RR-11

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

<u>Peer Bridger Component</u>

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

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

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

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

SUD Peer Support Component

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

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

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

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

◊ *B. Goals*

Peer Bridger Component

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

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

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

SUD Peer Support Component

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

◊ *C. Expected Numbers of Individuals Served*

Peer Bridger Component

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

SUD Peer Support Component

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

Both components of this initiative contribute to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced substance use
- reduced behavioral health risk factors
- reduction of crisis events
- reduced hospitalization, emergency department use, and incarceration

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

◊ *E. Provided by: Contractor*

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

2. Spending Plan

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

3. Implementation Schedule

◊ *A. Procurement of Providers*

Peer Bridger Component

This funding supports two peer bridger providers: Navos and Harborview Medical Center.

SUD Peer Support Component

At the pilot level of funding for RCOs is likely to continue to be disbursed to the same agencies that were funded under MIDD 1.

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

Additional Procurement Expected if Programs are Expanded in Future Years

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

◊ *B. Contracting of Services*

See 1.E and 3.A above.

◊ *C. Services Start date (s)*

MIDD 2 funding for existing peer bridger programs at Navos and Harborview, and for SUD peer services at RCOs, will be implemented January 1, 2017 to ensure continuous services.

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail-Based Substance Abuse Treatment (RR-12)

MIDD 2 Initiative Title: Jail-Based Substance Abuse Treatment **(NEW)**

MIDD 2 Number: RR-12

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

How does the program advance the recommended MIDD policy goals?

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

This initiative will expand substance use disorder (SUD) treatment at the King County Maleng Regional Justice Center (MRJC). Persons are often arrested and incarcerated for behaviors either directly or indirectly related to substance abuse. The National Center on Addiction and Substance Abuse (CASA) at Columbia University published a study in 2010 showing that 65 percent of all incarcerated persons in the United States meet medical criteria for a substance use disorder (SUD), yet only 11 percent receive any treatment. Initial withdrawal management (detoxification) is provided at King County correctional facilities. While in jail, the nature of the controlled setting and limited "competing demands" offer an opportunity to initiate evidence-based SUD treatment. This initiative will provide contracted counselors to deliver SUD treatment and include the implementation of a modified therapeutic community (TC).

1. Program Description

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

Jail-Based Substance Abuse Treatment will provide a modified, variable length of stay and evidence-based model of care at the Maleng Regional Justice Center. A provider will be selected with demonstrated skill and expertise in employing fidelity adherent, evidence-based practices and documented experience to train corrections and treatment staff in the implementation of a modified therapeutic community (TC). The provider will also provide a continuum of services including screening, assessment, and a variable length of outpatient SUD treatment and criminogenic interventions at the MRJC. Jail Health will serve in a consultation role specific to integrated behavioral health and medication needs.

◊ *B. Goals*

This initiative seeks to reduce recidivism among populations with reoccurring incarcerations in King County jails by addressing clinical and behavioral factors of individuals that contribute to continued involvement in the criminal justice system. This program includes coordinating continuing outpatient treatment which will include a release plan and hand-off to community-based SUD providers.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 200-300 individuals annually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail-Based Substance Abuse Treatment (RR-12)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- reduced unnecessary incarceration
- increased use of preventive (outpatient) services
- increased housing stability

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Jail-based SUD and Therapeutic Community services	$444,225
2017 Annual Expenditure		**$444,225**
2018	Jail-based SUD and Therapeutic Community services	$455,775
2018 Annual Expenditure		**$455,775**
Biennial Expenditure		**$900,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Through a competitive Request for Proposals (RFP) process, a provider will be selected with demonstrated skill and expertise in employing fidelity adherent, evidence-based practices and documented experience to train corrections and treatment staff in the implementation of a modified therapeutic community (TC). The RFP will be released in the first quarter of 2017.

◊ *B. Contracting of Services*

Contracting is expected to be completed in the second quarter of 2017.

◊ *C. Services Start date (s)*

Services are expected to begin in the third quarter of 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Deputy Prosecuting Attorney for Familiar Faces (RR-13)

MIDD 2 Initiative Title: Deputy Prosecuting Attorney for Familiar Faces

MIDD 2 Number: RR-13

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

How does the program advance the recommended MIDD policy goals?

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

The dedicated deputy prosecuting attorney (DPA) for King County's Familiar Faces will support the work of specialized programs that provide mental health and substance use disorder treatment, primary health care, life skills development, and/or assistance with care transitions, for individuals referred to as "Familiar Faces" who have been booked in the King County jail four or more times within a 12-month period. Among the Familiar Faces population,[1] 94 percent have one or more behavioral health conditions,[2] and 93 percent have at least one acute medical condition. The dedicated DPA will work with Familiar Faces care management and/or care transition teams – including the Familiar Faces Intensive Care Management Team[3] (FF-ICMT).

The dedicated DPA will provide needed prosecutorial authority and discretion about legal cases for the FF-ICMT and/or other Familiar Faces care management and transition teams. As part of the FF team, the DPA will consult and collaborate with FF-ICMT, defense, law enforcement, and the community on individual cases. DPA participation on the FF team helps to divert some individuals from further criminal justice contact, and works to reduce costly criminal justice involvement via harm reduction alternatives that support preferred long-term outcomes for participants and communities.

1. Program Description

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

The dedicated DPA funded by this initiative will coordinate closely and frequently with the Familiar Faces Intensive Care Management Team (FF-ICMT) and/or other Familiar Faces care management and transition teams to track any new bookings, pending cases/charges, pre-existing criminal history, and any post-adjudication hearings and requirements involving all active program participants. The dedicated DPA would also serve as a liaison between program steering committee(s) and law enforcement regarding the changing status of pending cases, outstanding warrants, or court hearings. The DPA would seek steering committee and law enforcement input to determine

[1] King County Health and Human Services Transformation: The Familiar Faces Initiative, June 2016.
[2] In addition to individuals booked in the King County jail who have a history of mental health and/or substance abuse treatment, King County Jail Health Services uses certain "flags" to identify people who have a recent history of mood, psychosis, or trauma diagnosis or psychiatric medications, or who have a recent history of substance use disorder diagnosis, detoxification service use or withdrawal risk, or treatment referral.
[3] http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/Familiar-Faces-ICMT.aspx.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Deputy Prosecuting Attorney for Familiar Faces (RR-13)

dismissals, detention, or transfer to an appropriate therapeutic court, and would track, monitor, and negotiate all cases associated with program participants.

◊ *B. Goals*

The addition of a dedicated DPA would increase the effectiveness of Familiar Faces care management and care transition teams in reducing criminal justice involvement and promoting wellness and stability for a portion of the sentinel Familiar Faces population.

◊ *C. Expected Numbers of Individuals Served*

The FF-ICMT that will benefit immediately from the services of this dedicated DPA would serve about 60 adults meeting Familiar Faces criteria at any given time. As additional relevant Familiar Faces programs are launched, this DPA is likely to assist many more people.[4]

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced representation of people with behavioral health conditions within jails, hospitals, and emergency departments
- housing stability

Individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants who benefit from services provided by the dedicated DPA may include:

- decreased use of jails, hospitals, and emergency departments
- improved housing stability
- reduced criminal justice involvement
- reduced avoidable emergency department use

◊ *E. Provided by: County*

[4] The total Familiar Faces population in King County averages over 1,200 people per year, although only a portion of this group will be served via care management or care transition programs. A similar dedicated DPA for the Law Enforcement Assisted Diversion (LEAD) program serves about 350 people.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Deputy Prosecuting Attorney for Familiar Faces (RR-13)

2. Spending Plan

Year	Activity	Amount
2017 partial year	Dedicated deputy prosecuting attorney (DPA) for Familiar Faces, including its flexible care management and care transition teams	$47,091
2017 Annual Expenditure		**$47,091**
2018	Dedicated DPA for Familiar Faces, including its flexible care management and care transition teams	$145,511
2018 Annual Expenditure		**$145,511**
Biennial Expenditure		**$192,602**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Funding for the Familiar Faces DPA would be directed to the King County Prosecuting Attorney's office via a Memorandum of Agreement (MOA).

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

MIDD 2 funding for the Familiar Faces DPA will begin in third quarter 2017 when private grant funding expires.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities (SI-1)

MIDD 2 Initiative Title: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities **(NEW)**

MIDD 2 Number: SI-1

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

How does the program advance the recommended MIDD policy goals?

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

By directly empowering communities to design service approaches that meet their needs, this initiative seeks to overcome barriers to behavioral health service participation and recovery that ethnic and cultural communities experience. Such barriers include:

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

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

1. Program Description

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

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

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

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities (SI-1)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of culturally appropriate behavioral health practices
- improved perception of health and behavioral health issues and disorders
- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- improved wellness and social relationships

◊ *E. Provided by: Contractor*

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

2. Spending Plan

Year	Activity	Amount
2017	Startup (partial year of outreach, input-gathering, process design, and program management),[5] and partial year of community-initiated, time-limited small grants to local culturally specific organizations or projects	$350,000
2017 Annual Expenditure		**$350,000**
2018	Community-initiated, time-limited small grants to local culturally specific organizations or projects, and program management	$359,100
2018 Annual Expenditure		**$359,100**
Biennial Expenditure		**$709,100**

* Efforts will be made to distribute funding equitably across communities and populations. However, these efforts will depend on the number and amount of funding requests from each group. Also, as unique community needs may arise among certain

[5] Some aspects of startup work for this initiative and Behavioral Health Services in Rural King County initiative will be shared, so funding for outreach, input-gathering, and process design is divided between the two initiatives.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

communities at times, program procedures will be designed to allow flexibility to shift resources accordingly when necessary.

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

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

Applicant organizations will be expected to demonstrate that they have leveraged matching contributions.[6] Matching funds may come in the form of funding from other sources or donated time, space, or other in-kind resources. Combining all sources (including in-kind), the match must total at least 25 percent of the MIDD funding request in the first year, and at least 50 percent in the second and/or third years (if applicable).

◊ *B. Contracting of Services*

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

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

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

Requests of $5,000 to $49,999
Funding requests from $5,000 to $49,999 per year per organization will be procured via formal annual County contracts. Every effort will be made to minimize administrative burdens associated with these contracts, including reduced fiscal auditing requirements. Contracting requirements specific to particular funding levels are as follows:

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

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

◊ *C. Services Start date (s)*

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

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

MIDD 2 Initiative Title: Behavioral Health Services in Rural King County **(NEW)**

MIDD 2 Number: SI-2

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

It would serve especially the seven community service areas (CSAs) in King County that experience a lack of behavioral health services. These CSAs are: Bear Creek/Sammamish, Snoqualmie Valley/Northeast King County, Four Creeks/Tiger Mountain, Greater Maple Valley/Cedar River, Southeast King County, West King County

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

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

unincorporated areas,[6] and Vashon/Maury Islands. Programs and services in certain rural cities and towns adjoining these CSAs, such as Skykomish, Duvall, Carnation, Snoqualmie, North Bend, Covington, Maple Valley, Black Diamond, and Enumclaw, would also be included.

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

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

[6] The West King County Unincorporated Areas CSA serves unincorporated pockets of West King County that are generally near suburbs where publicly funded behavioral health clinics are located. As a result, funding requests from this CSA will be required to demonstrate that proposed projects are coordinated with any nearby existing providers and avoid duplication of efforts.
[7] Information about the existing Community Engagement Grant program, administered by King County's Department of Natural Resources and Parks, is available at http://www.kingcounty.gov/exec/community-service-areas/engagement-grants.aspx.

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved perception of health and behavioral health issues and disorders
- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- improved wellness and social relationships
- improved experience of care

◊ *E. Provided by: Contractor*

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

2. Spending Plan

Year	Activity	Amount
2017	Startup (partial year of outreach, input-gathering, process design, and program management),[8] and partial year of community-initiated, time-limited small grants to local organizations within seven identified geographic areas	$350,000
2017 Annual Expenditure		**$350,000**
2018	Community-initiated, time-limited small grants to local organizations within seven identified geographic areas, and program management	$359,100
2018 Annual Expenditure		**$359,100**
Biennial Expenditure		**$709,100**

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

[8] Some aspects of startup work for this initiative and the Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities initiative will be shared, so funding for outreach, input-gathering, and process design is divided between the two initiatives.

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

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

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

Applicant organizations will be expected to demonstrate that they have leveraged matching contributions.[9] Matching funds may come in the form of funding from other sources or donated time, space, or other in-kind resources. Combining all sources (including in-kind), the match must total at least 25 percent of the MIDD funding request in the first year, and at least 50 percent in the second and/or third years (if applicable).

◊ *B. Contracting of Services*

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

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

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

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

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

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

Requests of $4,999 or Below

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

Requests of $5,000 to $49,999

Funding requests from $5,000 to $49,999 per year per organization will be procured via formal annual County contracts. Every effort will be made to minimize administrative burdens associated with these contracts, including reduced fiscal auditing requirements. Contracting requirements specific to particular funding levels are as follows:

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

Requests of $50,000 or Above

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

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Court Planning (TX-CCPL)

MIDD 2 Initiative Title: Community Court Planning **(NEW)**

MIDD 2 Number: TX-CCPL

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

How does the program advance the recommended MIDD policy goals?

This initiative aims to impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals" by exploring the possible development of a new King County Community Court.

1. Program Description

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

This initiative funds the study and preliminary planning of a potential new King County therapeutic Community Court. This court is envisioned to serve individuals with low-level, misdemeanor offenses who have frequent contact with the criminal justice system. Implementation of the Community Court funded by MIDD revenue may be considered in 2018.

◊ *B. Goals*

To Be Determined.

◊ *C. Expected Numbers of Individuals Served*

Not applicable for this initiative.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative may contribute to the population outcome of reduced jail use identified in the MIDD 2 Framework.

Individual-level outcome measures are not applicable to this initiative.

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Court Planning (TX-CCPL)

2. Spending Plan

Year	Activity	Amount
2017	Consultant study	$100,000
2017 Annual Expenditure		**$100,000**
2018	None identified to date	$0
2018 Annual Expenditure		**$0**
Biennial Expenditure		**$100,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposal (RFP) for a consultant to conduct the planning process will be released the first quarter of 2017.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Not applicable for this initiative.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

MIDD 2 Initiative Title: Outreach & In Reach System of Care

MIDD 2 Number: CD-3

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

How does the program advance the recommended MIDD policy goals?

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

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

1. Program Description

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

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

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

Public Health – Seattle and King County (PHSKC), King County Behavioral Health and Recovery Division (BHRD) and Housing & Community Development,; Harborview Medical Center (current provider), Valley Cities Counseling & Consultation (current provider), local homelessness advisory boards (e.g. Eastside Homeless Advisory Committee), All Home,

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

Community-based organizations and other community meeting forums, will be engaged to determine if the current defined scope and parameters of this initiative are properly defined.

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

◊ *B. Goals*

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

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

◊ *C. Expected Numbers of Individuals Served*

The number of individuals served annually is 675.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary incarceration
- improved wellness self-management
- reduction of crisis events

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Community-based outreach and engagement services continue.	$410,000
2017 Annual Expenditure		**$410,000**
2018	Community-based outreach and engagement services continue.	$420,660
2018 Annual Expenditure		**$420,660**
Biennial Expenditure		**$830,660**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Funding will continue to be distributed to PHSKC via a Memorandum of Understanding (MOU). BHRD currently contracts with Seattle Indian Health Board for services in this initiative. No RFP is needed unless the review process determines that a program change is needed during the second quarter 2017.

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

Services continue in first quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

MIDD 2 Initiative Title: High Utilizer Care Teams

MIDD 2 Number: CD-5

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

How does the program advance the recommended MIDD policy goals?

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

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

The program focuses on reducing individuals' use of crisis services, including the emergency room, inpatient psychiatry, and inpatient medical care; and enhancing the capacity to link individuals to community services. The initiative serves people who are falling through the cracks of the existing service system, such as people who have no services in place but need intensive outreach to connect to care, or people with mental illness who also have chronic medical conditions.[1]

1. Program Description

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

This initiative will serve individuals who are frequently seen the emergency department (ED) or psychiatric emergency service (PES) at Harborview Medical Center (HMC). Funding will cover clinicians who will serve individuals that use the HMC ED or PES four or more times in three months.[2] Due to the intensity of service as well as the complex needs of program individuals, caseloads are kept smaller, so people with eight or more ED or PES visits in six months will be prioritized, because they are most likely to benefit from the services offered by this specialized care team. The program also provides support for clients' basic needs that reduce barriers to participating in the plan of care through a modest fund to address transportation, clothing, rent, and similar expenses.

Newly available data from Washington's Emergency Department Information Exchange (EDIE) will also be used to identify Harborview patients who may not meet the priority threshold based on HMC data alone, but have a high level of ED use at other King County hospitals.

[1] Harborview Medical Center, December 2015.
[2] Extracted from 2015 Harborview Medical Center Contract, Exhibit IV.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

Most participants are homeless at the outset of the intervention. Along with homelessness, almost all individuals' vulnerability arises from at least two of the following: chronic medical issues, substance use disorders, and serious mental illness.[3]

Service components include a harm reduction approach to substance abuse, motivational strategies to engage individuals in primary healthcare for chronic conditions, active engagement of community supports, outreach during individuals' crises in the ED or during an inpatient admission, and continued engagement of individuals once they return to the community. Broadly, the team assists individuals to find stable housing, improves de-escalation skills to decrease behavioral barriers to care, and helps individuals with co-occurring disorders access needed behavioral health services and connections to primary care for their medical needs.[4]

The most frequent service connections upon discharge are in mental health, substance abuse, and medical clinics. Staff will coordinate with King County; other EDs; and behavioral health, social service, and housing providers, in order to ensure appropriate referrals and linkages to services. The team uses HMC primary care and aftercare clinics to provide urgent and long-term service connections to primary care. HMC's mental health services provide mental health urgent care, while long-term case management comes from a variety of community mental health providers.[5]

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

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

2. Spending Plan

Year	Activity	Amount
2017	High utilizer care team services, with support for basic needs to reduce barriers to care plan participation	$256,250
2017 Annual Expenditure		**$256,250**
2017	High utilizer care team services, with support for basic needs to reduce barriers to care plan participation	$262,913
2018 Annual Expenditure		**$262,913**
Biennial Expenditure		**$519,163**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

See 1.E and 3.A. above.

◊ *C. Services Start date (s)*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

MIDD 2 Initiative Title: Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team

MIDD 2 Number: CD-6

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

How does the program advance the recommended MIDD policy goals?

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

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

1. Program Description

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

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

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

The number of individuals served is 3000 annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

2. Spending Plan

Year	Activity	Amount
2017	Diversion services for people with mental health and substance use disorders experiencing a crisis program management, and stakeholder coordination continue.	$5,125,000
2017 Annual Expenditure		**$5,125,000**
2018	Diversion services for people with mental health and substance use disorders experiencing a crisis, program management, and stakeholder coordination continue.	$5,208,569
2018 Annual Expenditure		**$5,208,569**
Biennial Expenditure		**$10,333,569**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services will continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

MIDD 2 Initiative Title: Children's Domestic Violence Response Team (CDVRT)

MIDD 2 Number: CD-8

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

How does the program advance the recommended MIDD policy goals?

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

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

1. Program Description

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

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

◊ *B. Goals*

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

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

◊ *C. Expected Numbers of Individuals Served*

Approximately 85 families with 150 children are served annually.

◊ *D. Draft Outcomes and Performance Measures - - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Provide CDVRT services to children and their supportive parent	$281,875
2017 Annual Expenditure		**$281,875**
2018	Provide CDVRT services to children and their supportive parent	$289,204
2018 Annual Expenditure		**$289,204**
Biennial Expenditure		**$571,079**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD contracts with Sound Mental Health for this program under MIDD 1, which is anticipated to continue. It is cost effective to utilize existing organizations to develop the integrated model of DV and behavioral health services within community based DV advocacy organizations.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

◊ *B. Contracting of Services*

See previous.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

MIDD 2 Initiative Title: Next Day Crisis Appointments (NDA)

MIDD 2 Number: CD-10

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

How does the program advance the recommended MIDD policy goals?

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

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

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

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

1. Program Description

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

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

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

- Crisis intervention and stabilization services provided by professional staff trained in crisis management.
- Consultation with an appropriate clinical specialist when such services are necessary to ensure culturally appropriate crisis response.
- Referral to long-term mental health or other care as appropriate.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

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

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

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

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

2. Spending Plan

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

3. Implementation Schedule

◊ *A. Procurement of Providers*

The county, in collaboration with providers, may determine that it is necessary to re-RFP this body of work, particularly should NDA enhanced services be joined with new behavioral health urgent care walk-in services for procurement and contracting purposes.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

◊ *B. Contracting of Services*

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

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with continuous availability of crisis services and short-term follow-up, and no disruption of system capacity.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

MIDD 2 Initiative Title: Children's Crisis Outreach Response System

MIDD 2 Number: CD-11

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

How does the program advance the recommended MIDD policy goals?

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

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

1. Program Description

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

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

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

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

CCORS' Crisis Emergent and Non-Emergent Outreach services are available to children and youth in King County who meet certain crisis service criteria and are not currently receiving services through a contracted mental health agency. Emergent Crisis Response consists of: 1) crisis telephone response available 24 hours a day, seven days a week that includes immediate access to a mental health professional, as well as: 2) an outreach team that, at a minimum, consists of a Children's Mental Health Specialist and a Family Advocate who are trained in crisis management.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

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

Intensive Stabilization Services (ISS)

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

Crisis Stabilization Beds (CSBs)

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

Potential Future Service Improvements

As part of broader efforts to improve crisis response countywide, CCORS and King County will explore potential ways to deliver crisis services for transition-age young adults up to age 21, and/or to serve previously homeless youth in behavioral health crisis.

◊ *B. Goals*

CCORS's main goals are:

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

◊ *C. Expected Numbers of Individuals Served*

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

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

2. Spending Plan

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

Year	Activity	Amount
2017	Child/family teams with 24-hour availability to provide in-person support within two hours to any eligible child/family in crisis in King County, as well as short-term follow-up services and CSB access as needed	$563,750
2017 Annual Expenditure		**$563,750**
2018	Child/family teams with 24-hour availability to provide in-person support within two hours to any eligible child/family in crisis in King County, as well as short-term follow-up services and CSB access as needed	$578,408
2018 Annual Expenditure		**$578,408**
Biennial Expenditure		**$1,142,158**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

A contract is in place with the current CCORS provider, the YMCA of Greater Seattle, and is expected to be renewed for the 2017-18 biennium.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with continuous availability of crisis services and no disruption for families served under MIDD I.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

MIDD 2 Initiative Title: Parent Partners Family Assistance

MIDD 2 Number: CD-12

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

How does the program advance the recommended MIDD policy goals?

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

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

1. Program Description

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

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

◊ *B. Goals*

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

◊ *C. Expected Numbers of Individuals Served*

This initiative serves at least 400 people annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- improved wellness self-management
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	System navigation services, educational and social events, other supports to youth and families, program management, and stakeholder coordination continue.	$420,250
2017 Annual Expenditure		**$420,250**
2018	System navigation services, educational and social events, other supports to youth and families, program management, and stakeholder coordination continue.	$431,177
2018 Annual Expenditure		**$431,177**
Biennial Expenditure		**$851,427**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with Guided Pathways—Support for Youth and Families (GPS) for this body of work. After two unsuccessful procurement processes during MIDD I BHRD worked with a consultant and stakeholders to establish GPS as a Family Support Organization to implement the MIDD 1 strategy. No RFP is needed for MIDD 2.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue in First Quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

MIDD 2 Initiative Title: Wraparound Services for Youth

MIDD 2 Number: CD-15

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

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

The implementation of Wraparound in MIDD 2 will feature a blended funding and services model that fulfills the terms of a 2013 legal settlement with Washington State (*T.R. vs. Quigley and Teeter*). That settlement requires the provision of Wraparound with Intensive Services (known as WISe) by all regions in the state to Medicaid-eligible children and youth with complex behavioral health needs.[4] In King County, many of these individuals are currently served by MIDD Wraparound. The WISe program, as defined in the settlement agreement, consists of Wraparound, intensive community-based mental health services, and mobile crisis outreach and stabilization services. These services have been available in King County for several years, due in part to MIDD 1 investments in Wraparound and the Children's Crisis Outreach Response System (CCORS).

While some new Medicaid funds will be provided by the state to deliver WISe, the state's funds do not cover the costs of providing the delivery team and services required of the WISe program, nor do those funds support non-Medicaid activities and services that MIDD currently funds through MIDD 1 funding. MIDD funding also enables Wraparound to be provided to children and families not eligible for Medicaid, or not eligible for WISe services. (Under MIDD 1, Wraparound was provided to all families and children who met multiple systems involvement criteria, without regard to family means and without billing participants' private insurance.)

◊ *B. Goals*

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

Similarly, the state-funded WISe initiative described in 1.A above, which will be paired with MIDD 2 Wraparound and also used to support outpatient and crisis programs, is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral needs and to their families. The goal of the program is for eligible youth to live and thrive in their

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

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

◊ *C. Expected Numbers of Individuals Served*

During MIDD 1, Wraparound served an average of just over 600 clients per year from 2011 through 2015, with a maximum capacity of 450 youth at any given time. The MIDD funding level for Wraparound in MIDD 2 is lower than in MIDD 1 in anticipation of WISe funding supporting some aspects of Wraparound for Medicaid-eligible program participants. Under this blended funding and services model, at least 490 youth will be served per quarter, in accordance with the target established by the state. As funding from other sources including WISe permits, additional youth may be served.

A process to enable access to Wraparound services for children and youth from low- to moderate-income families who are not eligible for Medicaid and WISe will be developed in early 2017. This work will be informed by a workgroup in early 2017 as part of MIDD 2 implementation planning. The workgroup will specifically address financial and/or system use criteria. The number of non-Medicaid and/or non-WISe children to be served will be assessed via these criteria. Adjustments to program components to increase access while maintaining required fidelity will also be explored.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractors*

As in MIDD 1, referral management and other coordinating activities will be provided by King County, although County personnel expenditures will now be underwritten by the WISe Medicaid case rate revenues. Contracted Wraparound Delivery Teams (WDTs)

[5] https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/TR.ImplementationPlan.8.1.2014.pdf

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

will be assigned to specific regions of the county, and eligible referrals are assigned to the appropriate team.[6]

2. Spending Plan

Year	Activity	Amount
Program Elements Supported by MIDD 2:		
2017	Five regional Wraparound Delivery Teams to ensure countywide capacity including ability to serve some non-Medicaid/non-WISe children; flexible funds to meet clients' essential needs, including respite care via behavioral support aides; and training, monitoring, evaluation, and quality management	$3,075,000
2017 Annual Expenditure		**$3,075,000**
2018	Five regional Wraparound Delivery Teams to ensure countywide capacity including ability to serve some non-Medicaid/non-WISe children; flexible funds to meet clients' essential needs, including respite care via behavioral support aides; and training, monitoring, evaluation, and quality management	$3,154,950
2018 Annual Expenditure		**$3,154,950**
Biennial Expenditure		**$6,229,950**
Program Elements Supported by Medicaid WISe Funding:[7]		
Annual	Certain Medicaid-/WISe-eligible services per state plan	Supported by WISe case rate
Annual	Assessment survey instrument and implementation	Supported by WISe case rate
Annual	Program management: referral management, coaching, technical assistance, contract compliance	Supported by WISe case rate

[6] In consultation with a workgroup including stakeholders, the current five-region geographical allocation of funds and services will be adjusted for MIDD 2 to address current variation in caseload sizes and waitlists in different areas of King County.
[7] $2,156 per month per WISe-eligible child (via a case rate) funds some Wraparound services, and other intensive services. In King County, about $1,400 per child per month of this WISe case rate is expected to support Wraparound directly.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

3. Implementation Schedule

◊ *A. Procurement of Providers*

As described in 1.C above, a workgroup will be convened to revisit both eligibility criteria and regional boundaries as part of planning for MIDD 2 Wraparound, along with program component adjustments to increase access, starting in first quarter 2017. Changes to these aspects of Wraparound service delivery may result in a new Request for Proposals (RFP), and will at a minimum result in changes to contract terms to reflect the effects of changes to the MIDD contribution level as well as expected revenue from the new WISe case rate funding stream.

◊ *B. Contracting of Services*

See 1.E and 3.A above.

◊ *C. Services Start date (s)*

King County BHRD's work to redefine this initiative will begin in the fourth quarter of 2016, with provider involvement to occur beginning in first quarter 2017 once funding levels are finalized. Implementation of the MIDD 2 initiative, including an RFP if needed, would be completed during the second quarter of 2017.

(Services at the five MIDD 1 Wraparound provider agencies will continue uninterrupted at MIDD 1 levels until this process is completed.)

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

MIDD 2 Initiative Title: Screening, Brief Intervention and Referral To Treatment-SBIRT (SBIRT)

MIDD 2 Number: PRI-1

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

How does the program advance the recommended MIDD policy goals?

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

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

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

1. Program Description

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

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

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

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

◊ *B. Goals*

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

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 2500 individuals annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced hospital, and emergency department use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

◊ *E. Provided by: Contractor*

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

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

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

2. Spending Plan

Year	Activity	Amount
2017	Screening, Brief Intervention and Referral To Treatment in EDs continue.	$ 717,500
2017 Annual Expenditure		**$ 717,500**
2018	Screening, Brief Intervention and Referral To Treatment in EDs continue.	$736,155
2018 Annual Expenditure		**$ 736,155**
Biennial Expenditure		**$ 1,453,655**

3. Implementation Schedule

◊ *A. Procurement of Providers*

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

◊ *B. Contracting of Services*

Contracting will be completed with new or continuing providers in the second quarter of 2017.

◊ *C. Services Start date (s)*

Services continue in first quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

MIDD 2 Initiative Title: Juvenile Justice Youth Behavioral Health Assessments & Improvements

MIDD 2 Number: PRI-2

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

How does the program advance the recommended MIDD policy goals?

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

A majority of youth entering the juvenile justice (JJ) system have underlying mental health and/or substance use disorder issues that may have caused the behavior which resulted in the initial need for juvenile justice involvement. This program assesses the behavioral health needs of youth and recommends service and treatment options in order to divert youth with mental illness and substance use disorder needs and diagnoses from further justice system involvement.

1. Program Description

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

The MIDD 1 funds for this initiative provided mental health and substance use disorder screening/assessment services and psychological evaluations serves for King County youth age 12 years or older who have become involved with the juvenile justice system.

The team conducts assessments, makes recommendations to the Court regarding youth needs, including sentencing options and diversion from criminal justice sentencing due to underlying mental health or substance use disorder issues, refers youth to treatment services when a treatment need has been identified; and works to help youth follow-up on the treatment referrals and transition from screening/assessment/evaluation to ongoing treatment services when indicated.

Some of the contracted providers have been unable to keep the positions filled to conduct these services. For MIDD 2, in collaboration with the Court, communities, and stakeholders, BHRD will engage in system mapping and promising practice analysis to determine the best way to serve JJ youth with behavioral health needs and their families through integrated behavioral health with these funds.

◊ *B. Goals*

The goal of this program is to serve youth whose involvement with the juvenile justice system is due to behavioral health issues to get them to the right type of service and treatment so that treatment and justice outcomes are improved, including reduced recidivism, reduced alcohol and substance use, and improved behavioral health of the youth and family.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

◊ *C. Expected Numbers of Individuals Served*

Dependent upon program recommendations and design.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

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

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

2. Spending Plan

Year	Activity	Amount
2017	Juvenile Justice assessments and treatment linkage services continue.	$584,250
2017 Annual Expenditure		**$584,250**
2018	Juvenile Justice assessments and treatment linkage services continue.	$599,441
2018 Annual Expenditure		**$599,441**
Biennial Expenditure		**$1,183,691**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposal and/or Request for Qualifications may be necessary.

◊ *B. Contracting of Services*

Contracts will be completed during the third quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

◊ *C. Services Start date (s)*

There is no service interruption; services remain in place into the 2017-2018 biennium.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

MIDD 2 Initiative Title: Prevention and Early Intervention Behavioral Health for Adults Over 50

MIDD 2 Number: PRI-3

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

How does the program advance the recommended MIDD policy goals?

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

Screening for depression, anxiety and substance use disorder is provided for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are enrolled in the Mental Health Integration Program (MHIP)[1], a short-term behavioral health intervention based on the Collaborative Care Model. The Collaborative Care Model is a specific model for integrated care developed at the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center to treat common mental health conditions that are persistent in nature and require systematic follow-up. Services take place in primary care clinics that are contracted under Public Health.

MHIP focuses on a defined patient population identified through screening and uses measurement-based practice and treatment to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7). Primary care providers work with behavioral health professionals to provide evidence-based medications and psychosocial treatments supported by regular consultation with a psychiatric specialist and treatment adjustment for patients who are not improving. Treatment lasts on average for six months.

Adults with more severe or complex needs that cannot be adequately treated in primary care are referred to mental health and substance use disorder treatment.

1. Program Description

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

The MIDD Strategy Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+ provides prevention and intervention services for older adults to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses. This MIDD 2 initiative provides screening for depression, anxiety and substance use disorder for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are be enrolled in the Mental Health Integration Program (MHIP),[2] a short-term behavioral health intervention based on the Collaborative Care Model.

[1] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip
[2] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

◊ *B. Goals*

The goal of this initiative is to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7) and to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve at least 4,000 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced emergency department use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary emergency department use

E. Provided by: Contractors

2. Spending Plan

Year	Activity	Amount
2017	Continued screening and intervention services for older adults	$484,639
2017 Annual Expenditure		**$484,639**
2018	Continued screening and intervention services for older adults	$497,240
2018 Annual Expenditure		**$497,240**
Biennial Expenditure		**$981,880**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Public Health – Seattle and King County manages this initiative as part of the Mental Health Integration Program (MHIP). No RFP is needed.

◊ *B. Contracting of Services*

See 3.A above.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Older Adult Crisis Intervention/Geriatric Regional Assessment Team (PRI-4)

MIDD 2 Initiative Title: Older Adult Crisis Intervention/Geriatric Regional Assessment Team (GRAT)

MIDD 2 Number: PRI-4

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

How does the program advance the recommended MIDD policy goals?

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

GRAT provides a comprehensive assessment, crisis intervention, and referral and linkage to community resources for older adults struggling with mental health and/or chemical dependency issues. By intervening early, GRAT effectively diverts many of the older adults it serves from using other more costly services, such as inpatient psychiatric hospitalization, emergency rooms, skilled nursing facilities, and jail. GRAT also provides consultation, care planning, and education on older adult mental health issues for other community providers.

1. Program Description

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

GRAT provides a specialized outreach crisis and mental health assessment, including a substance use screening, that is age, culturally, and linguistically appropriate for King County residents age 60 years and older who are experiencing a crisis in which mental health or alcohol and/or other drugs are a likely contributing factor and/or exacerbating the situation, and who are not currently enrolled in mental health services under the King County Mental Health Plan.

◊ *B. Goals*

GRAT provides assessment, crisis intervention and referral for older adults throughout King County, and for many, this service diverts them from using more intensive and costly crisis services (hospital emergency room, psychiatric hospitalization, jail, etc.). This program is consistent with the Recovery model, in that it focuses on helping those older adults most in need to improve their wellbeing, get the assistance needed to accomplish this, and to help older adults live as independently as possible.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 340 annually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Older Adult Crisis Intervention/Geriatric Regional Assessment Team (PRI-4)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced hospital and emergency department use
- reduced substance use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- reduction of crisis events
- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued specialized outreach crisis and mental health assessment, including substance use screening, for older adults	$329,025
2017 Annual Expenditure		**$329,025**
2018	Continued specialized outreach crisis and mental health assessment, including substance use screening, for older adults	$337,580
2018 Annual Expenditure		**$337,580**
Biennial Expenditure		**$666,605**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD contracts with EvergreenHealth (EH) for GRAT services under MIDD 1. The county may elect to re-RFP this service supported by MIDD 2 funds. EvergreenHealth also receives funding from other sources that supports the program.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students (PRI-5)

MIDD 2 Initiative Title: Collaborative School Based Behavioral Health Services: Middle and High School Students

MIDD 2 Number: PRI-5

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

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

This initiative includes the development and integration of school-based SBIRT (screening brief intervention & referral to treatment)[1] services. School-based SBIRT will include working with all middle schools on the development and implementation of SBIRT services, which includes training and technical assistance in the Global Appraisal of Individual Need - Short Screen (GAIN-SS). The GAIN-SS is a 23-question screening tool that quickly and effectively screens for depression, anxiety, substance abuse, and other behavioral health disorders.

1. Program Description

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

The current MIDD Collaborative School Based Mental Health and Substance Abuse Services strategy invests in prevention/early intervention for school-based services provided in middle schools. These services include: assessments, screenings, brief intervention, referral, case coordination and mental health and behavioral health support groups, including social skills groups, anger management groups, and recovery groups. MIDD School Based Suicide Prevention provides students and schools suicide prevention trainings. Youth are trained on stress management and suicide prevention. Adults are trained on identification of early signs of stress, depression, and suicide ideation, and how to handle these issues in families and in youth-serving organizations. School-based MIDD prevention services will continue and be expanded as part of Best Starts for Kids (BSK).

These previously separate MIDD supported programs are combined into one initiative under MIDD 2.

◊ *B. Goals*

The goals of this initiative are:

- Reduce the risk of students developing mental or emotional illness, or using drugs/alcohol;
- Reduce poor school performance, to prevent school dropout, and to decrease other problem behaviors experienced by youth; and

[1] http://www.integration.samhsa.gov/clinical-practice/SBIRT

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students (PRI-5)

- To build collaboration between organizations in order to connect middle school-aged students or high school-aged students to needed mental health and substance abuse services in the school and community.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 1,000 youth in individual and small group services and 5,000 people in large group activities.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced substance use
- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- educational achievement
- improved wellness and social relationships
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	School-Based prevention services, program management, and stakeholder coordination continue.	$1,579,652
2017 Annual Expenditure		**$1,579,652**
2018	School-Based prevention services, program management, and stakeholder coordination continue.	$1,607,552
2018 Annual Expenditure		**$1,607,552**
Biennial Expenditure		**$3,187,204**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students (PRI-5)

3. Implementation Schedule

◊ *A. Procurement of Providers*

A planning period will involve coordinating this MIDD 2 Initiative with Best Starts for Kids to ensure a comprehensive program is developed across initiatives. A RFP will be released in the second quarter 2017.

◊ *B. Contracting of Services*

Contracts will be completed in the third quarter 2017.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Crisis Intervention Training – First Responders (PRI-8)

MIDD 2 Initiative Title: Crisis Intervention Training – First Responders

MIDD 2 Number: PRI-8

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

How does the program advance the recommended MIDD policy goals?

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

CIT is an intervention primarily focused on increasing the understanding and use of community-based resources to help reduce the reliance on and use of jail and hospitals. The initial strategy goals were to increase diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement, and to reduce the number of people with mental health and substance use disorders using costly interventions such as jail, emergency rooms, and hospitals.

1. Program Description

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

Crisis Intervention Training (CIT) is a model of police-based crisis intervention with community behavioral health care and advocacy partnerships. CIT provides intensive training to law enforcement and other first responders that teaches them to effectively assist and respond to individuals with mental illness or substance use disorders, and better equips them to help individuals access the most appropriate and least restrictive services while preserving public safety.

◊ *B. Goals*

The goals for CIT are to increase safety for first responders, individuals, and the community; increase options and tools when responding to individuals in crisis; and encourage and increase the use of community resources resulting in decreased jail bookings and hospital emergency department admissions.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 600 participants.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Crisis Intervention Training – First Responders (PRI-8)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased skills related to crisis de-escalation/intervention
- improved perception of health and behavioral health issues and disorders

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

2. Spending Plan

Year	Activity	Amount
2017	Crisis intervention trainings to law enforcement and other first responders continue.	$ 820,000
2017 Annual Expenditure		**$ 820,000**
2018	Crisis intervention trainings to law enforcement and other first responders continue.	$ 841,320
2018 Annual Expenditure		**$ 841,320**
Biennial Expenditure		**$ 1,661,320**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with the Washington State Criminal Justice Training Commission and coordinates the King County Sheriff's Office for CIT services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Trainings continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

MIDD 2 Initiative Title: Sexual Assault Behavioral Health Services

MIDD 2 Number: PRI-9

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

How does the program advance the recommended MIDD policy goals?

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

The sexual assault service delivery system addresses a unique set of needs as compared to broader community mental health treatment. In the sexual assault service system, victims and/or their families are seeking services as a result of the crime and its impact. They may have a variety of specific needs including medical, forensic, crisis response, information, advocacy to assist with legal needs and counseling. Often victims and families may not know the variety of issues and the impacts of the assault.[1]

Community sexual assault programs (CSAPs) are designed to provide holistic services tailored to the sexual assault-specific needs of victims. Because of their experience with and in-depth of knowledge of all aspects of sexual assault, the organizations are equipped to anticipate and respond based on an individualized assessment of needs. CSAPs provide empirically supported services through a trauma-informed lens. This holistic response means that the organization can address the full range of concerns about legal, medical and other systems that may adversely affect mental health outcomes, while also providing brief early interventions to reduce the likelihood of longer term mental health distress. For individuals who develop persisting sexual assault-specific mental health problems, effective evidence-based interventions are provided.

1. Program Description

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

Services currently provided by the CSAPs as part of this initiative include the following:

- Screening and assessment to identify the mental health and/or substance use disorder (SUD) needs of survivors receiving sexual assault services at the Contractor;
- Evidence-based trauma-focused therapy for those children, teen, and adult survivors of sexual assault who would benefit from the therapy;[2] and

[1] This contrasts with typical assistance from traditional public mental health settings where clients are eligible for services if they meet access to care criteria related to a mental health disorder, and their unique needs related to the assault may or may not be able to addressed directly in that setting.
[2] Evidence-based services at King County's CSAPs include trauma-focused cognitive behavioral therapy (TF-CBT), prolonged exposure (PE), prolonged-exposure-adolescent (PE-A), cognitive processing therapy (CPT), parent child interaction therapy (PCIT), and the common elements treatment approach (CETA), and other evidence-based approaches proven effective for post-traumatic stress disorder including interventions specifically for children.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

- Referrals to community mental health and SUD treatment agencies for those sexual assault survivors who need more intensive services.

◊ *B. Goals*

This initiative aims to increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County.

◊ *C. Expected Numbers of Individuals Served*

Historically CSAPs have not been able to separately identify a number of clients served specifically due to the MIDD 1nvestment, although reports show that approximately 350 clients per year benefit from CSAP services via blended funding. In consultation with providers, King County BHRD will work to identify an appropriate number of clients to be served specifically as a result of MIDD 2 funding if possible.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from community-based organizations. See also 3.A below.

2. Spending Plan

Year	Activity	Amount
2017	Screening and evidence-based sexual assault therapy	$584,250
2017 Annual Expenditure		**$584,250**
2018	Screening and evidence-based sexual assault therapy	$599,441
2018 Annual Expenditure		**$599,441**
Biennial Expenditure		**$1,183,691**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Clinical services will be procured from agencies with expertise in evidence-based sexual assault therapy.

◊ *B. Contracting of Services*

Contracts are in place with two CSAPs for evidence-based therapy services. These are expected to continue without need for a competitive bidding process, and will be revised for 2017 to reflect MIDD 2 funding levels, performance targets, and outcome tracking expectations.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with no disruption for clients served under MIDD 1.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

MIDD 2 Initiative Title: Domestic Violence Behavioral Health Services and System Coordination

MIDD 2 Number: PRI-10

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

How does the program advance the recommended MIDD policy goals?

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

Survivors of domestic violence are at greater risk of developing a variety of mental health disorders, including depression, anxiety and post-traumatic stress disorder. Survivors are often in an environment of on-going trauma, which can prolong and exacerbate their mental health concerns, increase their vulnerability and compromise their safety.

This initiative's model of early, accessible mental health intervention combined with integrated advocacy and other supportive services decreases the risk of mental health concerns and other negative impacts of domestic violence and increases survivor stability and capacity to cope. The initiative also decreases barriers for survivors by identifying areas of concern (screening), providing trauma-informed therapy integrated with advocacy, and facilitating referrals to other appropriate behavioral health support.

The system coordination component of this initiative aims to support information-sharing, consultation, and expertise dissemination across the domestic violence, sexual assault, and behavioral health systems.

1. Program Description

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

Co-Located Mental Health Professional (MHP) Component

This initiative co-locates MHPs with expertise in domestic violence (DV) and substance use disorders in community-based domestic violence victim advocacy programs around King County. Of these, some staff are expected to serve in an organization serving marginalized population(s), such as people of color or LGBTQ individuals.

Services provided by co-located mental health professional include the following:

- Screening using an evidence-based instrument
- Assessment
- Brief therapy and mental health support, both individually and in groups
- Referral to mental health and substance use disorder treatment for those DV survivors who need more intensive services
- Consultation to DV advocacy staff and staff of community mental health or substance use treatment agencies

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

Culturally Appropriate Clinical Services Component

This initiative also funds clinical consultation and training for a team of domestic violence advocates providing direct care – including screening, assessment, brief therapy, and referral as above – to clients in multiple languages, at an agency specializing in the provision of services to immigrant and refugee survivors of domestic and sexual violence.

System Coordination Component

In addition to treatment services, this initiative also supports ongoing cross training, policy development, and consultation on domestic violence (DV), sexual assault, and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County. The systems coordinator offers training, consultation, relationship-building, research, policy and practice recommendations, etc. for clinicians and agencies who wish to improve their response to survivors with behavioral health concerns but who lack the time or knowledge to do so.

◊ *B. Goals*

The overall goals of this initiative include the following:

- To promote a reduction in the incidence and severity of substance abuse, mental and emotional disorders in youth and adults.
- To integrate mental health services within community-based domestic violence agencies, including training and consultation for advocacy and other staff, making services more accessible to domestic violence survivors.
- To improve screening, referral, coordination, and collaboration between mental health, substance use disorder, domestic violence, and sexual assault service providers.

◊ *C. Expected Numbers of Individuals Served*

Approximately 750 to 800 clients will be served per year through the clinical components of this initiative.

The system coordination component of this initiative includes training for approximately 1,800 professionals per year, among other services provided.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive services

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

- reduced behavioral health risk factors
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from community-based organizations. See also 3.A below.

2. Spending Plan

This spending plan provides for expanded capacity at agencies that were funded under MIDD 1, and creates the potential for added services at a new agency serving marginalized populations.

Year	Activity	Amount
2017	Behavioral health screening, brief therapy, and referral co-located within DV agencies, including services for marginalized populations; culturally appropriate behavioral health consultation within agency serving immigrant and refugee survivors; and system coordination, training, and consultation[1]	$563,750
2017 Annual Expenditure		**$563,750**
2018	Behavioral health screening, brief therapy, and referral co-located within DV agencies, including services for marginalized populations; culturally appropriate behavioral health consultation within agency serving immigrant and refugee survivors; and system coordination, training, and consultation	$578,408
2018 Annual Expenditure		**$578,408**
Biennial Expenditure		**$1,142,158**

[1] Under MIDD 1, funding for this role was divided between strategies addressing sexual assault and DV. Under a potential MIDD 2, although the function of the position is unchanged and is designed to cross between these systems, for administrative purposes it is funded under the DV initiative only at the request of stakeholders.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Clinical services will be procured from agencies with expertise in serving survivors of DV that have the capacity to incorporate a co-located mental health professional. Coordination functions will be procured from an organization with relevant expertise in training, consultation, and/or system coordination.

Competitive bids are not needed at this time for the system coordination portion of this initiative, as a provider is already in place.

Among clinical services funded under this initiative, most are expected to continue to be contracted to DV providers that were funded under MIDD 1 (including culturally appropriate services for immigrants and refugees).

Some funds may be contracted to a new agency that serves marginalized population(s). If this approach is selected, a Request for Proposals (RFP) process may occur to identify an agency to provide this additional system capacity.

◊ *B. Contracting of Services*

Contracts are in place with four DV agencies for co-located MHPs. These are expected to continue without need for a competitive bidding process, and will be revised for 2017 to reflect MIDD 2 funding levels, performance targets, and outcome tracking expectations. A new contract may be needed if a new agency is selected for the expanded clinical services.

The contract for system coordination encompassing sexual assault and domestic violence is similarly expected to continue at the same agency.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with no disruption for clients served under MIDD 1.

If a new agency is selected for the expanded clinical services for marginalized population(s), services would likely be in place by third quarter 2017 after completion of the RFP process.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

MIDD 2 Initiative Title: Community Behavioral Health Treatment

MIDD 2 Number: PRI-11

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

How does the program advance the recommended MIDD policy goals?

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

The current community need for behavioral health treatment is significant. There is a large unserved population of people who are not on Medicaid, or do not qualify for Medicaid, whose behavioral health needs are only addressed when their need reaches crisis proportions - either in hospital emergency departments, in-patient care, or jails. Over half of the individuals with mental illness who are admitted to psychiatric hospitals do not have Medicaid coverage. Eleven percent of people in King County over the age of 18 suffer from frequent mental distress; most are living in poverty and many live in South King County.[1] Twenty-seven percent of school-aged youth are experiencing depression, many of which are minorities living in South King County;[2] 29 percent of in-school youth in King County report having used some type of illicit drug within the past 30 days. [2] These treatment services decrease disparities across King County so that all residents have the opportunity to achieve their full potential.

1. Program Description

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

This initiative provides mental health (MH) and substance use disorder (SUD) services to those who are not served by Medicaid, including undocumented individuals, incarcerated individuals, people on Medicare, people who are under 220 percent of the federal poverty level and have extremely high co-pays and deductibles in order to access service, people on Medicaid spend down (meaning they have to pay a certain amount of out of pocket expense every six months before Medicaid reimbursement kicks in), and people who are pending Medicaid coverage. In addition, this initiative provides essential services that are part of the treatment continuum not covered by Medicaid such as outreach, transportation, and peer support (SUD specifically).

[1] Behavioral Risk Factor Surveillance System. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014.
http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx
[2] Healthy Youth Survey. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014.
http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

◊ *B. Goals*

The goals of the strategy are to increase access to and provide services for individuals who are currently ineligible for Medicaid, decrease the number of people with behavioral health issues who are re-incarcerated or re-hospitalized, reduce jail and inpatient utilization, and homelessness.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 3500 people at least annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduction of crisis events
- reduced unnecessary jail, hospital and emergency department use

◊ *E. Provided by: Contractors*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

2. Spending Plan

Year	Activity	Amount
2017	Continued mental health and substance use disorder services for people who are not served by Medicaid, essential services in the care continuum that are not covered by Medicaid, and program management.	$11,890,000
2017 Annual Expenditure		**$11,890,000**
2018	Continued mental health and substance use disorder services for people who are not served by Medicaid, essential services in the care continuum that are not covered by Medicaid, and program management.	$12,199,140
2018 Annual Expenditure		**$12,199,140**
Biennial Expenditure		**$24,089,140**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health providers currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Supportive Services (RR-1)

MIDD 2 Initiative Title: Housing Supportive Services

MIDD 2 Number: RR-1

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

How does the program advance the recommended MIDD policy goals?

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

This initiative provides housing support services to chronically homeless adults. Individuals that have previously been unsuccessful in housing due to lack of stability and/or lack of daily living skills become successfully housed with the assistance of housing support specialists. Housing stability reduces use of criminal justice and emergency medical systems.

1. Program Description

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

Housing supportive services includes assistance to help the individual meet the obligations of tenancy, i.e. rent payments, abide by landlord rules, cooperate with neighbors, keep the apartment clean and safe; assistance with learning the daily living skills to live independently, i.e. shopping, cooking, budgeting, cleaning; coordination with behavioral health treatment providers and healthcare providers; and helping individuals get to medical appointments. Housing support services assist individuals in moving from homelessness to housing stability. Services are provided primarily at the individual's housing site and in the surrounding community by housing support specialists.

◊ *B. Goals*

The goal of this initiative is to increase the number of housed individuals with mental illness and chemical dependency who are receiving supportive housing services, leading to increased housing tenure and housing stability. Housing stability is a key determinant in increasing treatment participation and in reducing use of criminal justice and emergency medical systems.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 140 people each year initially with capacity growing over time as new annual awards are included.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved wellness self-management
- reduction of crisis events
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary jail, hospital and emergency department use

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued housing supportive services for individuals with behavioral health conditions.	$2,050,000
2017 Annual Expenditure		**$2,050,000**
2018	Continued housing supportive services for individuals with behavioral health conditions.	$2,096,712
2018 Annual Expenditure		**$2,096,712**
Biennial Expenditure		**$4,146,712**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The King County DCHS Housing Finance Program (HFP) administers and oversees funding for housing stability and services programs. MIDD 2 funding will be allocated to the HFP in January 2017. HFP distributes MIDD Housing Supportive Services as part of the HFP annual Notice of Funding Availability (NOFA) RFP process.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP)
(RR-2)

MIDD 2 Initiative Title: Behavior Modification Classes at Community Center for Alternative Programs (CCAP)

MIDD 2 Number: RR-2

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

How does the program advance the recommended MIDD policy goals?

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

The Moral Reconation Therapy (MRT) model in this initative uses a positive group dynamic to alter inappropriate thought and behavior amongst domestic violence (DV) offenders. The Moral Reconation Therapy-Domestic Violence (MRT-DV) pilot program adaptation is a cognitive-behavioral program designed to change how DV offenders think (beliefs) and change behavior to one of equality and acceptance. The MRT-DV adaptation takes approximately 55 sessions to complete, which are conducted twice weekly at CCAP. Both the MRT-DV and standard DV education occur within a 60-day court order to CCAP.

1. Program Description

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

This initiative enhances program services offered at CCAP in the areas of behavioral health education and intervention, and addresses criminogenic risk factors specifically associated with DV. Since 2014, MIDD has supported a clinician from Sound Mental Health (SMH) trained in MRT and the specialized DV version to prepare and facilitate groups for one caseload of 15 men participants who are randomly assigned to the MRT-DV program at CCAP for approximately 60 days. All MRT-DV participants have a substance use disorder, primarily involving alcohol and/or cannabis. Participants are clinically assessed and enrolled in appropriate substance use disorder (SUD) treatment at CCAP per American Society of Addiction Medicine criteria.

◊ *B. Goals*

The program goal is to realize an increase in the scope and effectiveness of the services offered at CCAP and appropriately address the changing service needs of court-ordered participants. Specifically, the MRT-DV pilot was implemented to intervene and provide a holistic array of services including outpatient SUD treatment with court monitoring to promote participant behavior change and recovery, and reduce recidivism and victimization.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP)
(RR-2)

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 40 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- reduced unnecessary incarceration

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Moral Reconation Therapy – Domestic Violence version for CCAP clients	$77,900
2017 Annual Expenditure		**$77,900**
2018	Moral Reconation Therapy – Domestic Violence version for CCAP clients	$79,925
2018 Annual Expenditure		**$79,925**
Biennial Expenditure		**$157,825**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health provider currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP)
(RR-2)

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

MIDD 2 Initiative Title: Housing Capital and Rental

MIDD 2 Number: RR-3

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

How does the program advance the recommended MIDD policy goals?

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

The initiative will provide a dedicated source of capital funding for the creation of housing units specifically set aside for the behavioral health needs population struggling with mental health and substance use disorders (SUDs) who are homeless or being discharged from hospitals, jails, prison, crisis diversion facilities or residential chemical dependency treatment. Dedicated housing for this population decreases homelessness, the need for medical care/hospital stays, and jail time.

It also supports housing stability by investing in rental subsidies individuals living in existing supportive housing settings.

1. Program Description

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

Supportive housing with services targeted to people with behavioral health conditions will feature, as much as feasible, a Housing First approach. Housing First is a homeless best practice, designed to create a stable environment where households can address their health issues while receiving additional employment and stable housing services.

Capital funding to create housing is paired with service funding to ensure success of those being housed. While the level of service may vary, for most households facing behavioral health conditions, some level of services will be required for success.

Permanent supportive housing is the most service-enriched housing environment. Many individuals and households with persistent mental illness and/or chronic addiction need this high intensity level of services. Although costly, permanent supportive housing is still more cost effective when compared to homelessness and frequent hospitalization and/or incarceration.

A portion of funds under this initiative will also be used to continue rental subsidies in existing supportive housing projects. These were supported by MIDD 1.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

◊ *B. Goals*

The primary focus of this initiative is the creation of housing – to be paired with services through companion MIDD 2 initiative Housing Supportive Services, Medicaid supported housing funding, and/or other sources – to support extremely low income households with mental illness and/or substance abuse issues.[1] This initiative will serve extremely low income populations below 30 percent of the area median income struggling with mental illness and/or SUDs who are likely to be predominantly homeless.

In addition to creating new housing, a portion of this initiative supports housing access by providing rental subsidies for individuals in existing supportive housing settings.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals to be served by capital investments from this initiative will vary depending on which projects are funded. The number of ongoing rental subsidies to be provided will be determined based on available funding for this purpose, as well as market factors.[2]

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced behavioral health risk factors
- improved wellness self-management
- reduced unnecessary incarceration, hospital, and emergency department use
- increased housing stability

◊ *E. Provided by: Contractor*

As described in 3.A and 3.B below, capital funding will be disbursed to housing developers via RFPs administered by King County. Capital funds from MIDD will be paired with capital investments from other funders, and will be linked to services appropriate to each project's target population.

Rental subsidies are contracted by BHRD to supportive housing provider(s).

[1] A key consideration for this initiative is the connection between housing capital and service funding. Neither service dollars nor capital funds alone can produce the amount of successful supportive housing required to reduce the incidence of homelessness. To be successful any housing dedicated to MIDD populations must include services.
[2] During MIDD 1, 25 rental subsidies were provided for supportive housing.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

2. Spending Plan

This spending plan shows estimated amounts and expected categories for MIDD 2's recommended contribution to housing capital and rental subsidies.

Estimated costs below are expected to be adjusted depending on market factors and/or as specific capital project opportunities arise.

Year	Activity	Amount
2017	Capital investments for new permanent supportive housing units for people with behavioral health conditions; and rental subsidies for people with behavioral health conditions	$2,393,584
2017 Annual Expenditure		**$2,393,584**
2018	Capital investments for new permanent supportive housing units for people with behavioral health conditions; and rental subsidies for people with behavioral health conditions	$2,455,816
2018 Annual Expenditure		**$2,455,816**
Biennial Expenditure		**$4,849,400**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Following existing processes for capital projects, MIDD funding under this initiative for capital projects will be allocated to the King County DCHS Housing Finance Program (HFP) immediately in January 2017, with RFPs for project developers to be released in second quarter 2017, reviewed in third quarter 2017, and awarded in fourth quarter 2017 including specific housing set-aside commitments for funded projects.

The HFP and BHRD program staff will review all capital proposals received through the RFP to determine the capacity and experience of the housing developers and service providers, as well as the financial feasibility of each project. The number of proposals received each year will vary, so the number of projects awarded capital MIDD funding will also vary annually.

Awards will be made based on availability of all funding provided from King County as well as the developer's ability to secure any and all additional capital funding from all other sources, such as other state and local funding.

King County DCHS is moving toward a targeted capital affordable housing allocation process. Rather than publishing a general request for proposals, over several years

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

DCHS will shift the request for proposal (RFP) process to one that solicits proposals for specific projects. MIDD funds will be included in this process.

◊ *B. Contracting of Services*

Contract negotiation timing for capital projects will depend on how quickly other funding is secured, including other capital funding and service funding via MIDD and/or other sources. In general, negotiated contracts are in place within six months of award.

Rental subsidy funding will continue to be disbursed by BHRD via contract to supportive housing provider(s).

◊ *C. Services Start date (s)*

Rental subsidies will continue without disruption beginning in January 2017.

Services for clients will begin when housing projects are built, and paired supportive services are in place.

This process will be completed at least annually in order to continue to fund additional units and projects in future years.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing - Adult Drug Court (RR-5)

MIDD 2 Initiative Title: Housing - Adult Drug Court (ADC)

MIDD 2 Number: RR-5

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

How does the program advance the recommended MIDD policy goals?

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

The recovery-oriented, transitional housing units and housing support services provide the opportunity to stably house vulnerable participants while decreasing the use of jail, shelters and other temporary housing options, which supports recovery and improved behavioral health outcomes. This initiative prevents homelessness for a vulnerable population.

1. Program Description

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

This initiative provides recovery-oriented, supportive, transitional housing units and housing support services for ADC participants. The majority of the added units will be single adult units, however some will accommodate families. Financial assistance for move-in costs for up to 25 percent of the single adults and 75 percent of the families who successfully complete the recovery-oriented housing program and transition to permanent housing will be provided. This initiative reduces and prevents homelessness and recidivism in King County by providing safe, supportive and stable housing.

◊ *B. Goals*

The goals of this initiative are to reduce homelessness for those involved in ADC and increase graduation rates of ADC participants. Those who graduate from ADC have more opportunities for employment, health and overall well-being, and stable, safe permanent housing.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve at least 30 people annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use
- housing stability

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing - Adult Drug Court (RR-5)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- reduced unnecessary incarceration
- Achievement of greater equity in ADC graduation rates between those who are experiencing homelessness at ADC start and those who are stably housed

◊ *E. Provided by: Contractors*

2. Spending Plan

Year	Activity	Amount
2017	Housing units and housing support services for ADC participants.	$231,136
2017 Annual Expenditure		**$231,136**
2018	Housing units and housing support services for ADC participants.	$237,146
2018 Annual Expenditure		**$237,146**
Biennial Expenditure		**$468,282**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Department of Judicial Administration manages Adult Drug Court and has contracts with housing providers. A RFP will be released in first quarter 2017.

◊ *B. Contracting of Services*

Contracting of services will be completed in second quarter 2017.

◊ *C. Services Start date (s)*

Expanded housing units and housing support services will be available in second quarter 2107.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

MIDD 2 Initiative Title: Jail Reentry System of Care

MIDD 2 Number: RR-6

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

How does the program advance the recommended MIDD policy goals?

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

The MIDD 1 Reentry Case Management Services (RCMS) program consists of a small team of reentry case managers, including a Mental Health Professional (MHP) lead, and provides up to 90 days of reentry linkage case management services, which begin prior to release from jail (within 45 days) and continues through transition to the community. The RCMS program provides assistance that may include obtaining the following:

- Public entitlements and Apple Health/Medicaid enrollments (includes linkage to state and federal entitlements application);
- Basic needs resources (e.g. clothing, food, hygiene);
- Transportation;
- Identification (ID) upon release from custody;
- Mental health treatment (primarily outpatient);
- Substance Use Disorder (SUD) treatment (both residential and outpatient);
- Primary physical healthcare (including dental care);
- Housing (linking to emergency shelter, transitional and linkage to assessment for permanent supportive housing and low-income public housing);
- Employment; and
- Education and other job training.

1. Program Description

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

A continuum of care better serves individuals with behavioral health conditions who are booked into jail facilities within King County (including misdemeanor jails). This program links closely with all other programs and services the individual is receiving or needing in order to achieve stability in the community.

◊ *B. Goals*

The goal of this initiative is to provide increased access to intensive, short term case management to individuals with mental health and/or chemical dependency disorders who are close to release/discharge and in need of assistance in reintegrating back into the community. This includes providing immediate assistance for more participants in accessing publicly funded benefits (if eligible), housing, rental

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

assistance, outpatient treatment and other services including education, training, and employment in the community upon release/discharge.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 350 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail and emergency department use
- improved emotional health
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- improved wellness self-management
- increased use of preventive (outpatient) services
- reduced unnecessary jail and emergency department use

◊ *E. Provided by: Contractor-See below*

2. Spending Plan

Year	Activity	Amount
2017	Intensive, short term case management to individuals with behavioral health conditions who are close to release/discharge from jail	$435,625
2017 Annual Expenditure		**$435,625**
2018	Intensive, short term case management to individuals with behavioral health conditions who are close to release/discharge from jail	$446,951
2018 Annual Expenditure		**$446,951**
Biennial Expenditure		**$882,576**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County contracts with South Seattle Community College, New Beginnings, and Sound Mental Health for services. No RFP is required. A planning process in the first quarter of 2017 will determine what improvements and can be made to this initiative to better serve clients under MIDD 2.

◊ *B. Contracting of Services*

To be determined, pending first quarter 2017 review.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017. If services are revised, new services are expected to begin in the second or third quarter of 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Reentry Respite Beds (RR-8)

MIDD 2 Initiative Title: Hospital Reentry Respite Beds

MIDD 2 Number: RR-8

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

How does the program advance the recommended MIDD policy goals?

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

Research has shown that people who experience homelessness with health conditions struggle to establish and/or maintain appropriate treatment within the mainstream health care system[1]. Many people experiencing problems are caught up in cycles of crisis and lack the family and other social supports as well as the income and other material resources that might help them break these cycles. The individuals are extremely challenging for behavioral health and medical providers to locate and engage, let alone establish in an ongoing plan of treatment. Their chronic behavioral health and medical conditions worsen, their likelihood of involvement with the criminal justice system escalates, and, in many cases, they begin to cycle in and out of emergency rooms, inpatient hospital stays, and jail.

These dynamics help explain the significantly higher risk of hospital readmission for patients experiencing homelessness that has been established in numerous research studies.[2] This increased risk relates to the scarcity of places in which homeless patients can safely rest and obtain the support they need to fully recuperate. It also relates to behavioral health disorders that can lead to behaviors that complicate or undermine recuperation.[3] Because of this risk, hospitals often delay discharge of homeless patients past the point at which they would discharge a person with housing and other necessary supports for recuperation and thus past the point that is medically indicated.[4] Their experience has shown that when a person's living situation makes it impossible to adequately rest, keep from walking or putting weight on a joint, or keep a surgical site clean, the hospital is much more likely to see the person return for infections or other problems that necessitate readmission.

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[1] Bonin E, Brehove T, Carlson C, Downing M, Hoeft J, Kalinowski A, Solomon-Bame J, Post P. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 50 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2010.
[2] Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.
[3] Thompson, SJ, Bender KA, Lewis CM, Watkins R. *Shelter-based Convalescence for Homeless Adults*. Canadian Journal of Public Health, Vol. 97, Issue 5: 379-383, 2006.
[4] Gundlapalli A, Hanks M, Stevens SM, Geroso AM, Viavant CR, McCall Y, Lang P, Bovos M, Branscomb NT, Ainsworth AD.. *It takes a village: a multidisciplinary model for the acute illness aftercare of individuals experiencing homelessness*. Journal of Health Care for the Poor and Underserved. Vol. 16 Issue 2:257-72, 2005.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Reentry Respite Beds (RR-8)

1. Program Description

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

The Edward Thomas House Medical Respite Program provides comprehensive recuperative care after an acute hospital stay for people who are living with homelessness, focusing particularly on those with disabling substance use and mental health conditions. The recuperative care is a critical intervention for a segment of the population with high rates of emergency room and hospital utilization as well as involvement in the criminal justice system. In addition to intensive medical and mental health care, patients at Edward Thomas House (ETH) receive intensive case management services to help them transition from their stay to ongoing behavioral health treatment, housing, social services, and primary care. Recovery is promoted by providing a full continuum of services.

◊ *B. Goals*

The program's overarching goal is to improve health outcomes and reduce community costs in the health, human services, and housing arenas. Within that broad goal, it seeks to stabilize the medical and behavioral health conditions of its patients and effectively link them to (1) ongoing substance use and/or mental health services in the community, (2) an ongoing medical home, (3) social services, and (4) stable, appropriate housing. It strives to ensure that patients leave the program with identified case management provided by partnering agencies in the community that will help them make these linkages.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 350 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced emergency department use
- improved emotional health
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- increased use of preventive (outpatient) services
- reduced unnecessary emergency department use

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Reentry Respite Beds (RR-8)

2. Spending Plan

Year	Activity	Amount
2017	Continued comprehensive recuperative care after acute hospital stays for people who are living with homelessness as well as disabling substance use and mental health conditions	$928,650
2017 Annual Expenditure		**$928,650**
2018	Continued comprehensive recuperative care after acute hospital stays for people who are living with homelessness as well as disabling substance use and mental health conditions	$952,795
2018 Annual Expenditure		**$952,795**
Biennial Expenditure		**$1,881,445**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The Edward Thomas House Medical Respite Program is managed by Harborview Medical Center through a contract with Public Health Seattle and King County. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

MIDD 2 Initiative Title: Behavioral Health Employment Services and Supported Employment

MIDD 2 Number: RR-10

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

How does the program advance the recommended MIDD policy goals?

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

Helping individuals achieve employment outcomes makes a significant difference not only in the income levels of the individuals being served within the behavioral health system, but also helps them achieve self-sufficiency and improve non-vocational based outcomes such as improved self-esteem, sense of purpose, decreased isolation and meaningful activities that employment often provides.[1]

In a four year pre/post examination of MIDD-funded supported employment, the program demonstrated a significant impact decreased the number and length of stays for hospitalizations, but also the number of jail bookings, and lengths of stays in jail.[2]

1. Program Description

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

This initiative continues the existing MIDD 1 Employment Services for Individuals with Mental Illness and Chemical Dependency, also known as "Supported Employment" and offers modified employment services to for people living with mental illness or substance use disorders.

Based on the needs of each individual job seeker within the integrated behavioral health system (formerly the mental health and substance use disorders systems), this program provides a two-tiered model to assist the job seeker to receive either the fidelity-based, intensive, Supported Employment (SE) services or a modified employment model that provides less intensive services for individuals requiring less employment support who can benefit primarily from linkage and referral to external employment service providers. This model allows employment services to be offered to a greater number of individuals while disseminating the principles of the evidence-based Supported Employment model.

[1] The Impact of Competitive Employment on Non-vocational Outcomes (Luciano, Bond, & Drake, 2014)
[2] Impact of Supported Employment in Reducing Hospitalizations and Incarcerations, Floyd, 2015

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

◊ *B. Goals*

The primary goal of this program is to increase the number of individuals with behavioral health conditions that gain and maintain employment in competitive and integrated jobs in the community that pay at or above minimum wage.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve 800 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased job placement
- Improved job retention
- increased income

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued supported employment services at behavioral health provider agencies, with less intensive employment support services also available	$973,750
2017 Annual Expenditure		**$973,750**
2018	Continued supported employment services at behavioral health provider agencies, with less intensive employment support services also available	$999,068
2018 Annual Expenditure		**$999,068**
Biennial Expenditure		**$1,972,818**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health providers currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

MIDD 2 Initiative Title: Workload Reduction

MIDD 2 Number: SI-3

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

How does the program advance the recommended MIDD policy goals?

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

The reduction of treatment caseloads by increasing the number of qualified staff provides for better treatment services, promoting the achievement of recovery outcomes for clientele, including proactive care that improves overall health and wellness. Additionally, workload reduction results in higher job satisfaction for treatment staff, thereby reducing staff turnover, which is a critical system improvement in the mental health treatment system.

Studies have suggested that higher caseloads may result in reactive case management, with deficiencies in service planning, support for families and caregivers and liaison with other services.[1] When faced with high caseloads, case managers are more likely to deal with crises and immediate problems[2] with a resulting negative impact on activities such as timely response to client needs, documentation of work, receptiveness to urgent client needs, contact during hospital admissions, home visits and advocacy.[3]

In addition to the impacts cited above, there is evidence that higher caseloads are also associated with increased work-related stress, especially stress associated with workload and professional self-doubt. Higher caseload was also associated with lower case manager personal efficacy. Increased job stress can exacerbate issues of staff burnout and pose problems with the recruitment and retention of case managers,[4] in addition to impacting health and safety outcomes and the quality of care provided to clients.[5] These findings support the need for active management of caseloads to minimize risk of overload.

Although not the subject of a formal research study in King County, the issues outlined above have been reflected qualitatively by outpatient mental health provider agencies, as well as individual clinicians throughout King County.

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[1] Intagliata J. Improving the quality of community care for the chronically clinically mentally disabled: the role of case management. Schizophr Bull 1982; 8: 655–674.
[2] King R, Le Bas J, Spooner D. The impact of caseload on mental health case manager personal efficacy. Psychiatr Serv 2000; 52: 364–368.
[3] King, R., Meadows, G., & LeBas, J. (2004). Compiling a caseload index for mental health case management. Australian and New Zealand Journal of Psychiatry, 38, 455-462.
[4] Evans, S., Huxley, P., Gately, C., Webber, M., Means, A., Pajak, S., et al. (2006). Mental health, burnout, and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry , 188*, 75-80.
[5] Priebe, S., Fakhoury, W., Hoffman, K., & Powell, R. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social Psychiatry Psychiatric Epidemiology , 40*, 223-232.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

1. Program Description

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

Workload reduction funding distributed among outpatient mental health provider agencies during MIDD 1 is recommended to continue in MIDD 2. In addition, substance use disorder providers are now participating in managed care under the integrated Behavioral Health Organization (BHO) structure, the distribution of MIDD 2 funds (in addition to the accompanying Medicaid match) will be revisited with the input of providers, guided by the following principles, at a minimum:

- Medicaid-funded outpatient programs will be targeted, to ensure continued Medicaid match.
- Provider agencies will receive appropriations of funds in an equitable manner.
- All mental health and substance abuse outpatient providers will have access to a portion of the funds.[6]
- Small provider agencies will receive no less than a minimum amount that is sufficient to affect the size of their workforce in a measurable way.
- Accountability measures for providers will be consistent across agencies and will be tied clearly to policy goal outcomes. See section D below for more details.

◊ *B. Goals*

Broad goals of this initiative include creating greater provider agency capacity to allow case managers to see clients more regularly to assist them to achieve greater stability and recovery, as well as be more responsive to clients who are in crisis. This would include increased proactive case management, care coordination, family support, outreach, and advocacy, in alignment with the literature on workload impacts described above. A related goal of this initiative is to decrease case manager turnover resulting from high caseloads, thus creating a more stable and effective workforce.

◊ *C. Expected Numbers of Individuals Served*

Under MIDD 1, only the number of participating provider agencies was measured. The number of providers expected to participate will increase from 17 to approximately 44. Because this initiative has the potential to have broad impact on all outpatient clients of an agency that receives funding, it is not yet known how many individuals would benefit.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

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

[6] The distribution of funds in MIDD 2 between mental health services and substance use disorders services may be influenced in part by Washington Administrative Code requirements that keep typical substance use disorders caseloads lower than mental health caseloads. Despite this consideration, at least some funds will be available to all contracted outpatient providers regardless of service type.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved experience of care
- reductions in the degree to which front-line staff cite workload as a job stressor and/or a contributor to their decision to seek other work

◊ *E. Provided by: Contractor*

All funding under this initiative will be distributed among contracted providers who offer a Medicaid-funded outpatient service. As part of forthcoming procedural design, a mechanism will be established to ensure that any new providers who may join the network in the future will have access to an equitable share of the funds and will deliver the same level of accountability for funds received.

2. Spending Plan

Year	Activity	Amount
2017	Funding to support hiring of additional direct service staff at agencies that offer a Medicaid-funded outpatient behavioral health service (approximately 44 providers, distribution formula to be determined)	$4,100,000 *(plus Medicaid matching funds totaling $4,100,000)*
2017 Annual Expenditure		**$4,100,000**
2018	Funding to support hiring of additional direct service staff at agencies that offer a Medicaid-funded outpatient behavioral health service (approximately 44 providers, distribution formula to be determined)	$4,206,600 *(plus Medicaid matching funds totaling $4,206,000)*
2018 Annual Expenditure		**$4,206,600**
Biennial Expenditure		**$8,306,600**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Interest (RFI) and/or a Request for Qualifications (RFQ) process will result in the identification of a full list of provider agencies that are aware of new accountability requirements and interested in receiving these funds under MIDD 2. No competitive bidding process is needed.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

◊ *B. Contracting of Services*

Funds will be distributed to all interested and qualified agencies via contract exhibits unique to this initiative containing clear accountability measures defined via the process described above.

◊ *C. Services Start date (s)*

King County BHRD's work to redefine this initiative, includingprovider involvement, will begin in the first quarter 2017. Implementation of the MIDD 2 initiative, with a new funding distribution methodology along with new outcome measures and accountability procedures, could occur as soon as the first quarter 2017 and will be completed no later than the second quarter 2017.

(Funding levels for the 17 MIDD 1 workload reduction providers will be maintained at MIDD 1 levels until this process is completed.)

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

MIDD 2 Initiative Title: Workforce Development

MIDD 2 Number: SI-4

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

How does the program advance the recommended MIDD policy goals?

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

The behavioral health workforce is in crisis. The behavioral health system is struggling to find and/or retain trained, licensed, and qualified staff to provide services those in need of services. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Behavioral health integration highlights the need for continuing education. Clients benefit when clinical staff are trained on the full spectrum of behavioral health conditions and how to best intervene. Coordinating services with primary care also requires training and education; this again will facilitate clients receiving optimal services. Integrated care benefits from staff stability, confidence, and knowledge. The current workforce shortage, evolving clinical knowledge, as well as the need to provide culturally appropriate services by staff that are reflective of populations being served will be factors in determining the best training programs to be utilized and disseminated.

1. Program Description

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

The original MIDD 1 strategy responded to the workforce shortage of Chemical Dependency Professionals (CDP) and provided reimbursement for Chemical Dependency Professional Trainees (CDPTs) for: tuition, books for CDP-related classes and testing fees. Due to CDP credential requirements mandating CDP clinical supervision, the agencies were also reimbursed for CDPT specific clinical supervision. CDPs received reimbursement for annual license fees and obtained reimbursed Continuing Education Units (CEU) to maintain their credentials. In addition, this strategy funded Evidence-Based Practices (EBP) training, quality assurance (QA) for EBPs, Certified Prevention Professional (CPP) credentials, and a CDP certificate program through the University Of Washington School Of Social Work.

Given the integration of mental health and substance use disorder, the present work shortages, and growing demand, this MIDD 2 initiative will create a develop a sustained, systems based approach to supporting and developing the behavioral health workforce. In collaboration with the MIDD Oversight Committee and stakeholders, a Behavioral Health Workforce Development Plan (WDP) will be developed that may include:

- Investment into initial credentials for behavioral health professionals, including psychiatric nurse practitioners and psychiatrists;
- CEUs for credentialed staff and ongoing training of EBP and Practice Based Evidence (PBE) for mental health and substance use disorder (SUD) treatment including Medication Assisted Treatment (MAT);

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

- Increase in the number of dually credentialed, Mental Health Professional (MHP) and CDP, staff;
- Additional training and initiation of Opioid Prescribing Training Program (OPTP) for professionals with prescriptive authority to assist in treatment opioid addiction; and
- Initiation of a train-the-trainer program to build a work force that can train other clinical staff on adopted EDPs and PBEs.

◊ *B. Goals*

The initiatives goals are:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals;
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults;
- Increase the qualified King County behavioral health workforce;
- Increase capacity to provide quality behavioral health services in King County; and
- Increase adoption of evidence-based, best, or promising practices.

◊ *C. Expected Numbers of Individuals Served*

The revised initiative will have a minimum of 700 participants annually, depending on the types of support and services offered.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased staff retention at agencies and more effective recruitment, which would result in fewer vacancies at agencies
- improved clinical interventions in the outpatient setting

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

2. Spending Plan

Year	Activity	Amount
2017	Behavioral health workforce development , project management and stakeholder coordination activities continue	$743,125
2017 Annual Expenditure		**$743,125**
2018	Behavioral health workforce development, project management and stakeholder coordination activities continue	$762,446
2018 Annual Expenditure		**$762,446**
Biennial Expenditure		**$1,505,571**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The resources will be available for all providers across the county that were awarded a contract with BHRD and provided Medicaid services. The development of a Behavioral Health Workforce Development Plan (WDP) during the fourth quarter 2016 will guide the initiative improvements.

◊ *B. Contracting of Services*

To be determined.

◊ *C. Services Start date (s)*

Trainings services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Drug Court (TX-ADC)

MIDD 2 Initiative Title: Adult Drug Court (ADC)

MIDD 2 Number: TX-ADC

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

How does the program advance the recommended MIDD policy goals?

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

ADC is a pre-adjudication program that provides eligible defendants the opportunity to receive drug treatment in lieu of incarceration. If defendants meet the requirements of each of the four phases of the ADC program they graduate from the program and the charges are dismissed.

1. Program Description

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

After opting into the program, defendants come under the court's supervision and are required to attend treatment sessions, undergo random urinalysis, and appear before the judge on a regular basis.

If defendants meet the requirements of each of the four phases of the ADC program they graduate from the program and the charges are dismissed. If defendants fail to make progress they are terminated from the program and sentenced on their original charge. While this is a minimum 12 month program, the average graduate requires 18 months to complete the program.

◊ *B. Goals*

ADC Goals include:

1. Reduce substance use and related criminal activity;
2. Enhance community safety;
3. Reduce reliance on incarceration for non-violent drug dependent offenders;
4. Hold drug dependent offenders accountable for their actions and decisions;
5. Integrate substance abuse treatment with criminal justice case processing;
6. Provide resources and support to assist the drug dependent offender in the acquisition of skills necessary for the maintenance of sobriety;
7. Reduce the impact of drug related cases on criminal justice resources; and
8. Reward positive life changes while maintaining accountability for negative conduct.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves at least 700 people annually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Drug Court (TX-ADC)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- improved wellness self-management
- reduced unnecessary incarceration

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	Adult Drug Court participant supervision and services continue.	$4,165,351
2017 Annual Expenditure		**$4,165,351**
2018	Adult Drug Court participant supervision and services continue.	$4,273,649
2018 Annual Expenditure		**$4,273,649**
Biennial Expenditure		**$8,439,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Department of Judicial Administration manages Adult Drug Court. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services will continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

MIDD 2 Initiative Title: Family Treatment Court (FTC)

MIDD 2 Number: TX-FTC

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

How does the program advance the recommended MIDD policy goals?

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

FTC is a recovery based child welfare intervention. Parents participate in FTC to receive help in obtaining and maintaining sobriety as well as family services that support a recovery based lifestyle, including mental health treatment when applicable. Many of the court's parents have a history of incarceration and FTC supports their reentry into mainstream services. It is an improvement to the current way child welfare cases are handled in the dependency court system. It is also a prevention and early intervention program, working with both the parent and the child to prevent future involvement in the criminal and juvenile justice systems and address the health and well-being of child welfare involved families.

1. Program Description

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

FTC promotes the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other service needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan. FTC is organized around the ten key components that define a drug court:

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

◊ *B. Goals*

FTC has four primary goals:

- To ensure that children have safe and permanent homes within permanency planning guidelines or sooner;

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

- To ensure that families of color have outcomes from dependency cases similar to families not of color;
- To ensure that parents are better able to care for themselves and their children and seek resources to do so; and
- To ensure that the cost to society of dependency cases involving substances is reduced.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve 140 children annually in MIDD 2 including the expanded court in south King County included.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased use of preventive (outpatient) services
- increase positive child placements at parent exit from FTC

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	FTC supports and services continue.	$1,435,340
2017 Annual Expenditure		**$1,435,340**
2018	FTC supports and services continue.	$1,472,660
2018 Annual Expenditure		**$1,472,660**
Biennial Expenditure		**$2,908,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Superior Court manages the Family Treatment Court. No RPPs Needed.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Drug Court (TX-JDC)

MIDD 2 Initiative Title: Juvenile Drug Court (JDC)

MIDD 2 Number: TX-JDC

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

How does the program advance the recommended MIDD policy goals?

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

The JDC program is effective at reducing recidivism and keeping youth engaged in the treatment process. (Bolan, 2007) King County JDC outcome studies have documented significant reductions in recidivism among program participants. Juvenile justice has increasingly become the service delivery point for adolescents with substance use disorder (SUD) and co-occurring problems that lack resources for other assistance. The JDC model provides improved, expanded, yet cost-effective adolescent SUD treatment in a coordinated system of care. The model of care in King County challenges systemic inequities and facilitates dialogue among justice and treatment professionals, families, and the youth themselves. JDC includes services designed for youth with SUD diagnoses and co-occurring Mental Health issues. All service areas of the JDC program have shown overtime to increase protective factors for youth involved in the program and strengthen the participant's transition to participating in pro-social behaviors and activities.

1. Program Description

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

JDC is a therapeutic court that provides services to juvenile charged with criminal offenses and identified as having a SUD diagnosis. JDC was implemented in July, 1999. This court is an alternative to regular juvenile court and is designed to improve the safety and well-being of youth and families involved in the juvenile justice system by providing the juvenile offender access to SUD treatment, judicial monitoring of their sobriety and individualized services to support the entire family [1](NCJFCJ, 2013).

Juvenile justice-involved youth voluntarily enter the program and agree to increased court participation, SUD treatment, co-occurring mental health treatment if necessary and intensive case management in order to have their charges dismissed. Case review hearings initially occur every week and then become less frequent as the youth progresses through the program. Incentives are awarded to recognize the youths' achievements and graduated sanctions are used when a youth violate program rules. Youth typically spend between 12 and 18 months in the program.

Through a collaborative, non-adversarial approach, the JDC integrates SUD, co-occurring mental health treatment and increased accountability into the process. Each youth has a JDC team and a comprehensive service team that reviews his or her

[1] Seen, Heard and Engaged: A process Evaluation for Children in Court Programs (NCJFCJ, p. 2013)

participation and recommends services. This interdisciplinary team is cross-trained and works collaboratively to resolve issues.

◊ *B. Goals*

JDC improves the safety and wellbeing of youth and families involved in the juvenile justice system by providing the youth in the juvenile justice system access to SUD treatment, evidence based/best practice holistic family intervention services, and judicial monitoring of their recovery.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 50 new participants each year.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- reduced substance use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased use of preventive (outpatient) services
- reduced unnecessary incarceration

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	JDC supports and services continue.	$1,099,211
2017 Annual Expenditure		**$1,099,211**
2018	JDC supports and services continue.	$1,127,789
2018 Annual Expenditure		**$1,127,789**
Biennial Expenditure		**$2,227,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Superior Court will continue to provide Juvenile Drug Court services. No RFP is needed.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Drug Court (TX-JDC)

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

MIDD 2 Initiative Title: Regional Mental Health Court (RMHC)

MIDD 2 Number: TX-RMHC

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

How does the program advance the recommended MIDD policy goals?

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

RMHC serves individuals experiencing mental illness (and frequently poverty and homelessness), who come into contact with the local criminal justice system. Once in jail, these individuals stay much longer than those with similar charges who are not experiencing mental health disorders. Moreover, these individuals are released to the community with limited behavioral health and social service supports critical to stability in the community.

Mental health court is often an effective strategy for diverting individuals with mental health disorders from further incarceration and engaging these individuals in community-based treatment and supportive services, with regular court monitoring, to address the underlying factors contributing to their criminal justice involvement.[1]

1. Program Description

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

Until 2010, RMHC served individuals who had cases originally filed in District Court or King County Superior Court. In 2010 MIDD funding was used to increase the services available for existing mental health courts and expanded KCDC Mental Health Court to become regional, such that any city in King County could refer court-involved individuals experiencing significant mental illness to the RMHC.

Currently, there are three referral streams through which court-involved individuals can access RMHC. First, court-involved individuals can have cases filed directly into District Court. For tracking purposes, these cases are referred to as "misdemeanor cases." Second, court-involved individuals can be referred to RMHC from any city jurisdiction within King County (referred to as "city cases"). Third, participants can be referred to RMHC from Superior Court when they have committed a felony and plead guilty to a lesser gross misdemeanor or combination of other misdemeanors (referred to as "felony drop-downs").

[1] Edgely, Michelle. "Why do mental health courts work? A confluence of treatment, support & adroit judicial supervision." International Journal of Law and Psychiatry, Volume 36, Issue 6, November–December 2014, Pages 572–580.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

◊ *B. Goals*

RMHC program goals are to:
(1) Protect public safety;
(2) Reduce the level of recidivism (considering frequency, offense severity and length of time between episodes) of persons with mental illness with the criminal justice system;
(3) Reduce the use of institutionalization for persons with mental illness who can function successfully within the community with service supports;
(4) Improve the mental health and well-being of persons with mental illness who come in contact with Mental Health Court;
(5) Develop more expeditious case resolution than traditional courts;
(6) Develop more cost-effective / efficient use of resources than traditional courts;
(7) Develop more linkages between the criminal justice system and the mental health system; and
(8) Establish linkages with other community programs that target services to persons with mental illness.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 130 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:
- reduced jail, hospital, and emergency department use
- reduced substance use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:
- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased use of preventive (outpatient) services
- reduced unnecessary jail, hospital and emergency department use

◊ *E. Provided by: County*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

2. Spending Plan

Year	Activity	Amount
2017	RMHC supports and services continue.	$3,865,746
2017 Annual Expenditure		**$3,865,746**
2018	RMHC supports and services continue.	$3,966,254
2018 Annual Expenditure		**$3,966,254**
Biennial Expenditure		**$7,832,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County District Court will continue to provide Regional Mental Health Court. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Seattle Mental Health Municipal Court (TX-SMC)

MIDD 2 Initiative Title: Seattle Mental Health Municipal Court (SMC)

MIDD 2 Number: TX-SMC

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

How does the program advance the recommended MIDD policy goals?

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

Mental health courts are an essential component of a jail diversion continuum of service and have been shown to be effective in engaging clients in treatment and reducing future jail bookings. In addition to diverting more individuals with mental illness from unnecessary emergency department (ED) and psychiatric hospitalizations, this process provides a more efficient, safe, cost effective process as well as improved resource utilization.

1. Program Description

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

This initiative provides a care manager position in the Seattle Municipal Court. The position serves individuals who have frequent contact with the criminal justice system, and who receive an evaluation for civil commitment. Most or all of these individuals are not engaged in the public mental health system. The care manager provides assertive outreach and engagement for these individuals to offer services, respite supports, assistance with entitlements and other essential needs, with the ultimate goal of reducing contact with the criminal justice system.

◊ *B. Goals*

This initiative provides outreach and linkage services into the community to locate and serve a group of individuals that are committing low level criminal offenses, and are appearing in Seattle Municipal MHC on a frequent basis. The goal is to prevent future criminal justice involvement.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 35 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Seattle Mental Health Municipal Court (TX-SMC)

- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- improved wellness and social relationships
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary incarceration

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Care management for SMC individuals who have frequent contact with the criminal justice system.	$ 93,150
2017 Annual Expenditure		**$ 93,150**
2018	Care management for SMC individuals who have frequent contact with the criminal justice system.	$ 95,572
2018 Annual Expenditure		**$ 95,572**
Biennial Expenditure		**$ 188,722**

3. Implementation Schedule

◊ *A. Procurement of Providers*

This service was revised in 2016. See description above for more details. A review process in early 2017 will determine if an RFP is needed.

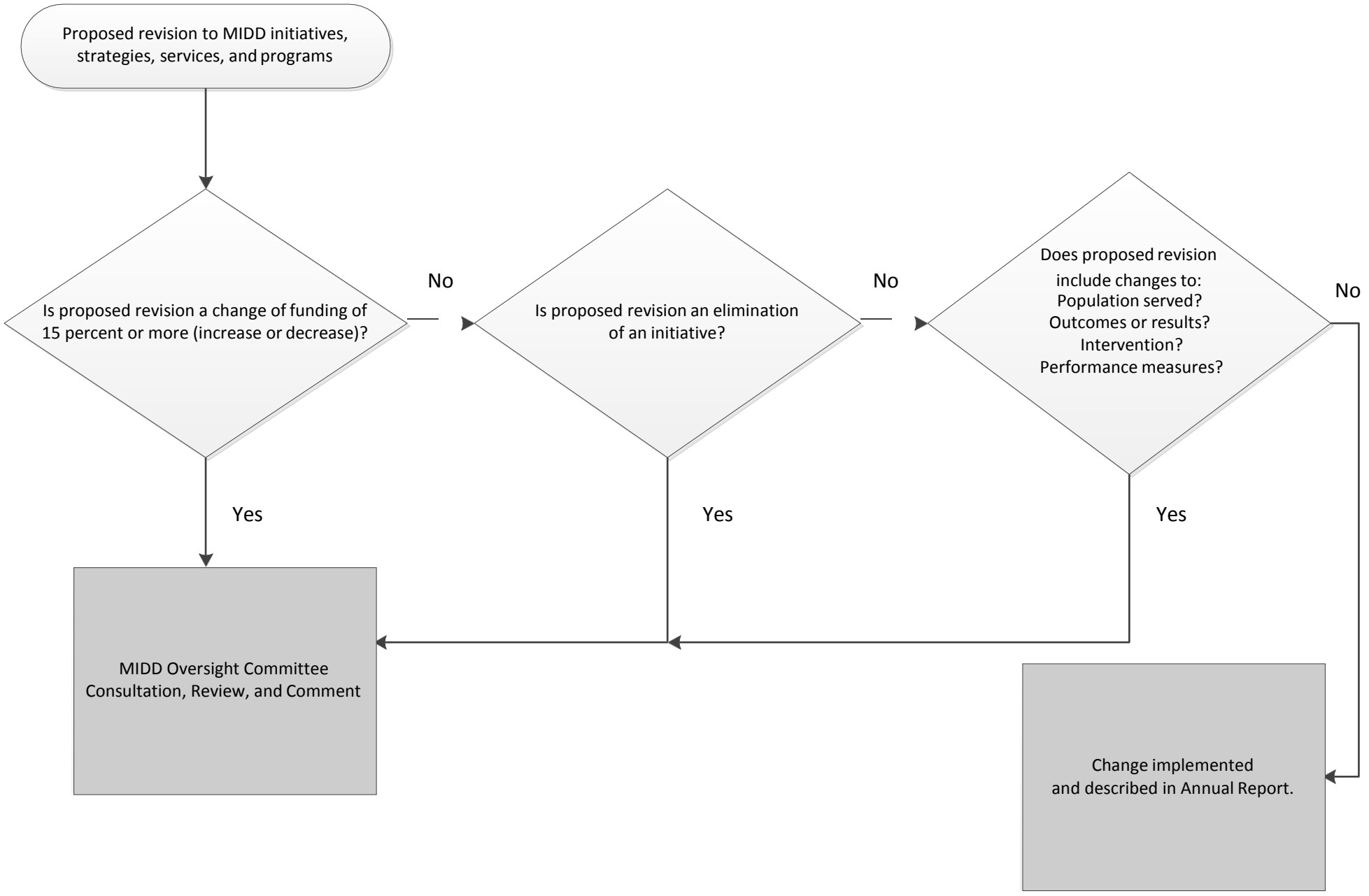
◊ *B. Contracting of Services*

To be determined, pending early 2017 review.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD Initiative Revision Process Flow



MIDD 2 Initiative Outcomes and Basis Crosswalk

The assessment of whether an initiative is considered a “best” or “promising practice” is based on findings included in published research, studies, or other reports of program efficacy as reviewed and/or assessed by Behavioral Health Division Staff. For something to be considered an “evidence-based practice”, it has been subject to scientifically based rigorous research designs, (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research). Please note that "emerging practices" are included in the category of "promising practices".

MIDD 1 Policy Goals were used to identify successful outcomes where results are available. Behavioral Health outcomes also includes increased treatment access and improved quality of life, which are linked to the proposed MIDD 2 Policy Goal of "Improve health and wellness of individuals living with behavioral health conditions."

MIDD 2 EXISTING INITIATIVES

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-03	Outreach & In reach System of Care			X	X		Jail Use Reduction
CD-05	High Utilizer Care Teams		X			X	ED Use Reduction
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	X				X	ED Use Reduction
CD-08	Children's Domestic Violence Response Team			X		X	Symptom Reduction
CD-10	Next Day Crisis Appointments	X				X	ED Use Reduction
CD-11	Children's Crisis Outreach and Response System - CCORS			X		X	Improved Quality of Life
CD-12	Parent Partners Family Assistance	X				X	Improved Quality of Life

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-15	Wraparound Services for Youth		X			X	Symptom Reduction
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT			X		X	ED Use Reduction
PRI-02	Juvenile Justice Youth Behavioral Health Assessments		X		X		Jail Use Reduction
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over 50			X		X	Symptom Reduction
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	X				X	Psychiatric Hospital Use Reduction; ED Use Reduction
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students			X		X	Improved Quality of Life
PRI-08	Crisis Intervention Training - First Responders		X		X		Research supports identified positive person level outcomes.
PRI-09	Sexual Assault Behavioral Health Services	X		X		X	Improved Quality of Life
PRI-10	Domestic Violence Behavioral Health Services & System Coordination	X				X	Symptom Reduction
PRI-11	Community Behavioral Health Treatment		X			X	Symptom Reduction; ED Use Reduction

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
RR-01	Housing Supportive Services			X	X		Jail Use Reduction
RR-02	Behavior Modification Classes at CCAP			X	X		Jail Use Reduction
RR-03	Housing Capital and Rental			X		X	Psychiatric Hospital Use Reduction
RR-05	Housing Vouchers for Adult Drug Court			X	X		Jail Use Reduction
RR-06	Jail Reentry System of Care			X	X		Jail Use Reduction
RR-08	Hospital Re-Entry Respite Beds	X				X	ED Use Reduction
RR-10	BH Employment Services & Supported Employment			X		X	Improved Quality of Life
SI-03	Workload Reduction	X				X	Research supports identified positive person level outcomes.
SI-04	Workforce Development		X			X	Research supports identified positive person level outcomes.
TX-ADC	Adult Drug Court		X			X	Symptom Reduction
TX-FTC	Family Treatment Court	X				X	Symptom Reduction; Increased Treatment Access
TX-JDC	Juvenile Drug Court		X		X		Jail Use Reduction

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
TX-MHC	Regional Mental Health Court	X			X		Jail Use Reduction
TX-SMC	Seattle Mental Health Municipal Court	X			X		Jail Use Reduction

MIDD 2 Outcomes and Basis Crosswalk

The assessment of whether an initiative is considered a “best” or “promising practice” is based on findings included in published research, studies, or other reports of program efficacy as reviewed and/or assessed by Behavioral Health Division Staff. For something to be considered an “evidence-based practice”, it has been subject to scientifically based rigorous research designs, (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research). Please note that "emerging practices" are included in the category of "promising practices".

MIDD 1 Policy Goals were used to identify successful outcomes where results are available. Behavioral Health outcomes also includes increased treatment access and improved quality of life, which are linked to the proposed MIDD 2 Policy Goal of "Improve health and wellness of individuals living with behavioral health conditions."

MIDD 2 NEW INITIATIVES

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-01	Law Enforcement Assisted Diversion (LEAD)	X			X		Criminal Justice System Involvement Reduction
CD-02	Youth and Young Adult Homelessness Services	X				x	Improved Quality of Life
CD-04	South County Crisis Diversion Services/Center	X				X	ED Use Reduction
CD-07	Multipronged Opioid Strategies		X			X	Improved Quality of Life
CD-09	Behavioral Health Urgent Care-Walk In Clinic Pilot		X			X	Psychiatric Hospitalization Use Reduction

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-13	Family Intervention Restorative Services - FIRS	X			X		Criminal Justice System Involvement Reduction
CD-14	Involuntary Treatment Triage	X				X	Increased Treatment Access
CD-16	Youth Behavioral Health Alternatives to Secure Detention	X				X	Improved Quality of Life
CD-17	Young Adult Crisis Facility	X				X	Improved Quality of Life
PRI-06	Zero Suicide Initiative Pilot			X		X	Improved Quality of Life
PRI-07	Mental Health First Aid			X		X	Improved Quality of Life
RR-04	Rapid Rehousing-Oxford House Model			X		X	Improved Quality of Life
RR-07	Behavioral Health Risk Assessment Tool for Adult Detention			X	X		Criminal Justice System Involvement Reduction
RR-09	Recovery Café	X				X	Improved Quality of Life
RR-11	Peer Support and Peer Bridger	X				X	Psychiatric Hospitalization Use Reduction
RR-12	Jail-Based Substance Abuse Treatment	X			X		Criminal Justice System Involvement Reduction
RR-13	Deputy Prosecuting Attorney for Familiar Faces	X			X		Criminal Justice System Involvement Reduction
SI-01	Community Driven Behavioral Health Grants	X				X	Improved Quality of Life

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
SI-02	Behavioral Health Services In Rural King County	X				X	Improved Quality of Life
TX-CCPL	Community Court Planning	X			X		Criminal Justice System Involvement Reduction

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THE CENTER FOR RACIAL JUSTICE INNOVATION

Racial Equity Impact Assessment

What are Racial Equity Impact Assessments?

A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities.

Why are they needed?

REIAs are used to reduce, eliminate and prevent racial discrimination and inequities. The persistence of deep racial disparities and divisions across society is evidence of institutional racism--the routine, often invisible and unintentional, production of inequitable social opportunities and outcomes. When racial equity is not consciously addressed, racial inequality is often unconsciously replicated.

When should it be conducted?

REIAs are best conducted during the decision-making process, prior to enacting new proposals. They are used to inform decisions, much like environmental impact statements, fiscal impact reports and workplace risk assessments.

Where are they in use?

The use of REIAs in the U.S. is relatively new and still somewhat limited, but new interest and initiatives are on the rise. The United Kingdom has been using them with success for nearly a decade.

EXAMPLES OF RACIAL JUSTICE EQUITY IMPACTS

Equity and Social Justice Initiative
King County, WA

The county government is using an Equity Impact Review Tool to intentionally consider the promotion of equity in the development and implementation of key policies, programs and funding decisions.

Race and Social Justice Initiative
Seattle, WA

City Departments are using a set of Racial Equity Analysis questions as filters for policy development and budget making.

Minority Impact Statements
Iowa and Connecticut

Both states have passed legislation which requires the examination of the racial and ethnic impacts of all new sentencing laws prior to passage. Commissions have been created in Illinois and Wisconsin to consider adopting a similar review process. Related measures are being proposed in other states, based on a model developed by the Sentencing Project.

Proposed Racial Equity Impact Policy
St. Paul, MN

If approved by the city council, a Racial Equity Impact Policy would require city staff and developers to compile a "Racial Equity Impact Report" for all development projects that receive a public subsidy of $100,000 or more.

Race Equality Impact Assessments
United Kingdom

Since 2000, all public authorities required to develop and publish race equity plans must assess proposed policies using a Race Equality Impact Assessment, a systematic process for analysis.

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Racial Equity Impact Assessment GUIDE

Below are sample questions to use to anticipate, assess and prevent potential adverse consequences of proposed actions on different racial groups.

1. IDENTIFYING STAKEHOLDERS

Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

2. ENGAGING STAKEHOLDERS

Have stakeholders from different racial/ethnic groups – especially those most adversely affected – been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

3. I IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES

Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

4. EXAMINING THE CAUSES

What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

5. CLARIFYING THE PURPOSE

What does the proposal seek to accomplish? Will it reduce disparities or discrimination

6. CONSIDERING ADVERSE IMPACTS

What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

7. ADVANCING EQUITABLE IMPACTS

What positive impacts on equality and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS

Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

9. ENSURING VIABILITY AND SUSTAINABILITY

Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement. Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

10. IDENTIFYING SUCCESS INDICATORS

What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

MIDD 1 Comprehensive Historical Assessment Report: Evaluation Recommendations

I. Update and Revise the Evaluation Framework

a. Revise or establish relevant output and outcome measures (see section II below).
b. Involve stakeholders in developing the evaluation framework.
c. Clarify and communicate the purpose of the evaluation and logic of the evaluation framework.

II. Revise Performance Measures, Targets and Outcomes

a. When possible, select valid, reliable, and sensitive outcome measures.
b. Adjust performance targets only when clear evidence exists that the original target was an over- or underestimation of feasible service delivery given available resources.
c. Outcome targets should be based on evidence that supports the expected results.
d. Focus on using clinically and practically meaningful changes in outcomes.
e. The basis for modifying a target, rather than working to improve performance, should be clearly documented when target modifications are requested.

III. Upgrade Data Collection and Infrastructure

a. Invest in data collection infrastructure.
b. Create an online dashboard of selected performance indicators to be updated quarterly.
c. Incorporate client surveys to gather more evaluative feedback from the client perspective on subjects such as service satisfaction and key indicators such as improved quality of life.
d. Seek opportunities for better data sharing, involving more and more reliable data sources, to improve the speed and efficiency of data gathering and analysis.
e. Consider a web-based data submission approach.

IV. Enhance Reporting and Improve Processes

a. Align the MIDD program year with the calendar year, rather than October through September.[1]
b. Replace semi-annual progress reports with digitally available dashboard data.
c. Increase the frequency of performance evaluation availability.
d. Establish guidelines for report creators and editors on the scope of their decision making.
e. Continue to avoid presenting non-causal results in ways that imply causality.
f. Continue to produce one annual report that includes both performance measurement and outcome evaluation.
g. Enhance the quality and frequency of communication regarding evaluation data and reporting, updating the MIDD Oversight Committee and others on substantive findings.
h. Develop and deploy a continuous quality improvement process for MIDD programs and services based in part in evaluation.
i. To the extent possible, align MIDD evaluation approach with Best Starts for Kids initiative evaluation approach to ensure consistency.

These recommendations chart a path to enhance the MIDD evaluation approach and provide clearer data and findings to the public and policy makers. The recommendations work together to position a potential MIDD 2 to better demonstrate return on investment.

Appendix M-MIDD Service Improvement Plan
MIDD 2 Spending Plan

MIDD 2 Initiative Number	MIDD 2 Initiative Title	2017 Funding Level	2018 Funding Level	2017-2018 Biennial Funding Level	Planned Staged Implementation
CD-01	NEW Law Enforcement Assisted Diversion (LEAD)	1,537,500	2,052,000	3,589,500	Yes-assumes 75% spending in year one
CD-02	NEW Youth and Young Adult Homelessness Services	300,000	307,800	607,800	NO
CD-03	Outreach & In reach System of Care	410,000	420,660	830,660	NO
CD-04	NEW South County Crisis Diversion Services/Center	500,000	1,539,000	2,039,000	Yes-assumes 33% spending in year one
CD-05	High Utilizer Care Teams	256,250	262,913	519,163	NO
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	5,125,000	5,208,569	10,333,569	NO
CD-07	NEW Multipronged Opioid Strategies	750,000	1,539,000	2,289,000	Yes-assumes 50% spending in year one
CD-08	Children's Domestic Violence Response Team	281,875	289,204	571,079	NO
CD-09	NEW Behavioral Health Urgent Care-Walk In Clinic Pilot	250,000	256,500	506,500	NO
CD-10	Next Day Crisis Appointments	307,500	315,495	622,995	NO
CD-11	Children's Crisis Outreach and Response System - CCORS	563,750	578,408	1,142,158	NO
CD-12	Parent Partners Family Assistance	420,250	431,177	851,427	NO
CD-13	NEW Family Intervention Restorative Services - FIRS	1,087,688	1,115,967	2,203,655	NO
CD-14	NEW Involuntary Treatment Triage Pilot	150,000	153,900	303,900	NO
CD-15	Wraparound Services for Youth	3,075,000	3,154,950	6,229,950	NO
CD-16	NEW Youth Behavioral Health Alternatives to Secure Detention	250,000	1,026,000	1,276,000	Yes-assumes 25% spending in year one
CD-17	NEW Young Adult Crisis Facility	705,825	724,175	1,430,000	NO
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT	717,500	736,155	1,453,655	NO
PRI-02	Juvenile Justice Youth Behavioral Health Assessments	584,250	599,441	1,183,691	NO
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over50	484,639	497,240	981,880	NO

Appendix M-MIDD Service Improvement Plan
MIDD 2 Spending Plan

MIDD 2 Initiative Number	MIDD 2 Initiative Title	2017 Funding Level	2018 Funding Level	2017-2018 Biennial Funding Level	Planned Staged Implementation
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	329,025	337,580	666,605	NO
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students	1,579,652	1,607,552	3,187,204	NO
PRI-06	NEW Zero Suicide Initiative Pilot	500,000	513,000	1,013,000	NO
PRI-07	NEW Mental Health First Aid	200,000	205,200	405,200	NO
PRI-08	Crisis Intervention Training - First Responders	820,000	841,320	1,661,320	NO
PRI-09	Sexual Assault Behavioral Health Services	584,250	599,441	1,183,691	NO
PRI-10	Domestic Violence and Behavioral Health Services & System Coordination	563,750	578,408	1,142,158	NO
PRI-11	Community Behavioral Health Treatment	11,890,000	12,199,140	24,089,140	NO
RR-01	Housing Supportive Services	2,050,000	2,096,712	4,146,712	NO
RR-02	Behavior Modification Classes at CCAP	77,900	79,925	157,825	NO
RR-03	Housing Capital and Rental	2,393,584	2,455,816	4,849,400	NO
RR-04	NEW Rapid Rehousing-Oxford House Model	500,000	513,000	1,013,000	NO
RR-05	Housing - Adult Drug Court	231,136	237,146	468,282	NO
RR-06	Jail Reentry System of Care	435,625	446,951	882,576	NO
RR-07	NEW Behavioral Health Risk Assessment Tool for Adult Detention	470,900	483,143	954,043	NO
RR-08	Hospital Re-Entry Respite Beds	928,650	952,795	1,881,445	NO
RR-09	NEW Recovery Café	348,717	357,783	706,500	NO
RR-10	BH Employment Services & Supported Employment	973,750	999,068	1,972,818	NO
RR-11	NEW Peer Support and Peer Bridgers Pilot	768,750	788,738	1,557,488	NO
RR-12	NEW Jail-based SUD Treatment	444,225	455,775	900,000	NO
RR-13	NEW Deputy Prosecuting Attorney for Familiar Faces	47,091	145,511	192,602	NO
SI-01	NEW Community Driven Behavioral Health Grants	350,000	359,100	709,100	NO
SI-02	NEW Behavioral Health Services In Rural King County	350,000	359,100	709,100	NO
SI-03	Workload Reduction	4,100,000	4,206,600	8,306,600	NO
SI-04	Workforce Development	743,125	762,446	1,505,571	NO

Appendix M-MIDD Service Improvement Plan
MIDD 2 Spending Plan

MIDD 2 Initiative Number	MIDD 2 Initiative Title	2017 Funding Level	2018 Funding Level	2017-2018 Biennial Funding Level	Planned Staged Implementation
SI-05	NEW Emerging Needs Initiative	650,000	666,900	1,316,900	NO
TX-ADC	Adult Drug Court	4,165,351	4,273,649	8,439,000	NO
TX-FTC	Family Treatment Court	1,435,340	1,472,660	2,908,000	NO
TX-JDC	Juvenile Drug Court	1,099,211	1,127,789	2,227,000	NO
TX-RMHC	Regional Mental Health and Veterans Courts	3,865,746	3,966,254	7,832,000	NO
TX-SMC	Seattle Mental Health Municipal Court	93,150	95,572	188,722	NO
TX-CCPL	NEW Community Court Planning	100,000	-	100,000	NO
ADM	Administration & Evaluation	4,139,338	4,246,961	8,386,300	NO
TOTAL		**64,985,295**	**69,639,587**	**134,624,881**	

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT	Fourth Quarter 2016	First Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
PRI-02	Juvenile Justice Youth Behavioral Health Assessments	First Quarter 2017	Third Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over 50	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	First Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students	Second Quarter 2017	Second Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
PRI-06	NEW Zero Suicide Initiative Pilot	First Quarter 2017	Second Quarter 2017	Second Quarter 2017	
PRI-07	NEW Mental Health First Aid	First Quarter 2017	First Quarter 2017	Second Quarter 2017	
PRI-08	Crisis Intervention Training - First Responders	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
PRI-09	Sexual Assault Behavioral Health Services and System Coordination	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
PRI-10	Domestic Violence and Behavioral Health Services & System Coordination	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
PRI-11	Community Behavioral Health Treatment	Fourth Quarter 2016	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-01	NEW Law Enforcement Assisted Diversion (LEAD)	Not Applicable	Not Applicable	First Quarter 2017	Existing Program Received one-time MIDD Fund Balance support in 2016
CD-02	NEW Youth and Young Adult Homelessness Services	First Quarter 2017	Second Quarter 2017	Third Quarter 2017	
CD-03	Outreach & In reach System of Care	First Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Programming included, Initiative to be reviewed in early 2017
CD-04	NEW South County Crisis Diversion Services/Center	Second Quarter 2017	Third Quarter 2017	First Quarter 2018	Site Development may impact timeline
CD-05	High Utilizer Care Teams	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
CD-07	NEW Multipronged Opioid Strategies	First Quarter 2017	Second Quarter 2017	First Quarter 2017	Existing MIDD 1 Program (Needle Exchange) included, Initiative to be revised in early 2017
CD-08	Children's Domestic Violence Response Team	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-09	NEW Behavioral Health Urgent Care-Walk In Clinic Pilot	Second Quarter 2017	Third Quarter 2017	Third Quarter 2017	
CD-10	Next Day Crisis Appointments	Second Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program
CD-11	Children's Crisis Outreach and Response System - CCORS	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-12	Parent Partners Family Assistance	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-13	NEW Family Intervention Restorative Services - FIRS	Not Applicable	Not Applicable	First Quarter 2017	Existing Program Received one-time MIDD Fund Balance support in 2016
CD-14	NEW Involuntary Treatment Triage Pilot	First Quarter 2017	Not Applicable	First Quarter 2017	

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
CD-15	Wraparound Services for Youth	Fourth Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program, Initiative to be revised in early 2017
CD-16	NEW Youth Behavioral Health Alternatives to Secure Detention	Third Quarter 2017	Third Quarter 2017	Third Quarter 2017	
CD-17	NEW Young Adult Crisis Facility	Fourth Quarter 2016	First Quarter 2017	First Quarter 2017	Site Development may impact timeline
RR-01	Housing Supportive Services	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-02	Behavior Modification Classes at CCAP	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-03	Housing Capital and Rental	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-04	NEW Rapid Rehousing-Oxford House Model	Second Quarter 2017	Second Quarter 2017	Second Quarter 2017	
RR-05	Housing Vouchers for Adult Drug Court	First Quarter 2017	First Quarter 2017	Second Quarter 2017	Existing MIDD 1 Program
RR-06	Jail Reentry System of Care	First Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program, Initiative to be revised in early 2017
RR-07	NEW Behavioral Health Risk Assessment Tool for Adult Detention	Not Applicable	Not Applicable	First Quarter 2017	

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
RR-08	Hospital Re-Entry Respite Beds	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-09	NEW Recovery Café	Not Applicable	Not Applicable	First Quarter 2018	Site Development may impact timeline
RR-10	BH Employment Services & Supported Employment	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-11	NEW Peer Support and Peer Bridgers Pilot	Not Applicable	Not Applicable	First Quarter 2017	Peer Bridger (PB) - Existing Program received one-time MIDD Fund Balance support in 2016
RR-12	NEW Jail-Based Substance Abuse Treatment	First Quarter 2017	Second Quarter 2017	Third Quarter 2017	
RR-13	NEW Deputy Prosecuting Attorney for Familiar Faces	Not Applicable	Not Applicable	Third Quarter 2017	
SI-01	NEW Community Driven Behavioral Health Grants	Third Quarter 2017	Varies	Third Quarter 2017	
SI-02	NEW Behavioral Health Services In Rural King County	Third Quarter 2017	Varies	Third Quarter 2017	
SI-03	Workload Reduction	First Quarter 2017	Not Applicable	First Quarter 2017	Existing MIDD 1 Program

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
SI-04	Workforce Development	Fourth Quarter 2016	Varies	First Quarter 2017	Existing MIDD 1 Program Contracts with Trainers will vary depending on training program
TX-ADC	Adult Drug Court	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-FTC	Family Treatment Court	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-JDC	Juvenile Drug Court	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-RMHC	Regional Mental Health and Veterans Courts	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-SMC	Seattle Mental Health Municipal Court	First Quarter 2017	First Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
TX-CCPL	NEW Community Court Planning	First Quarter 2017	First Quarter 2017	Not Applicable	

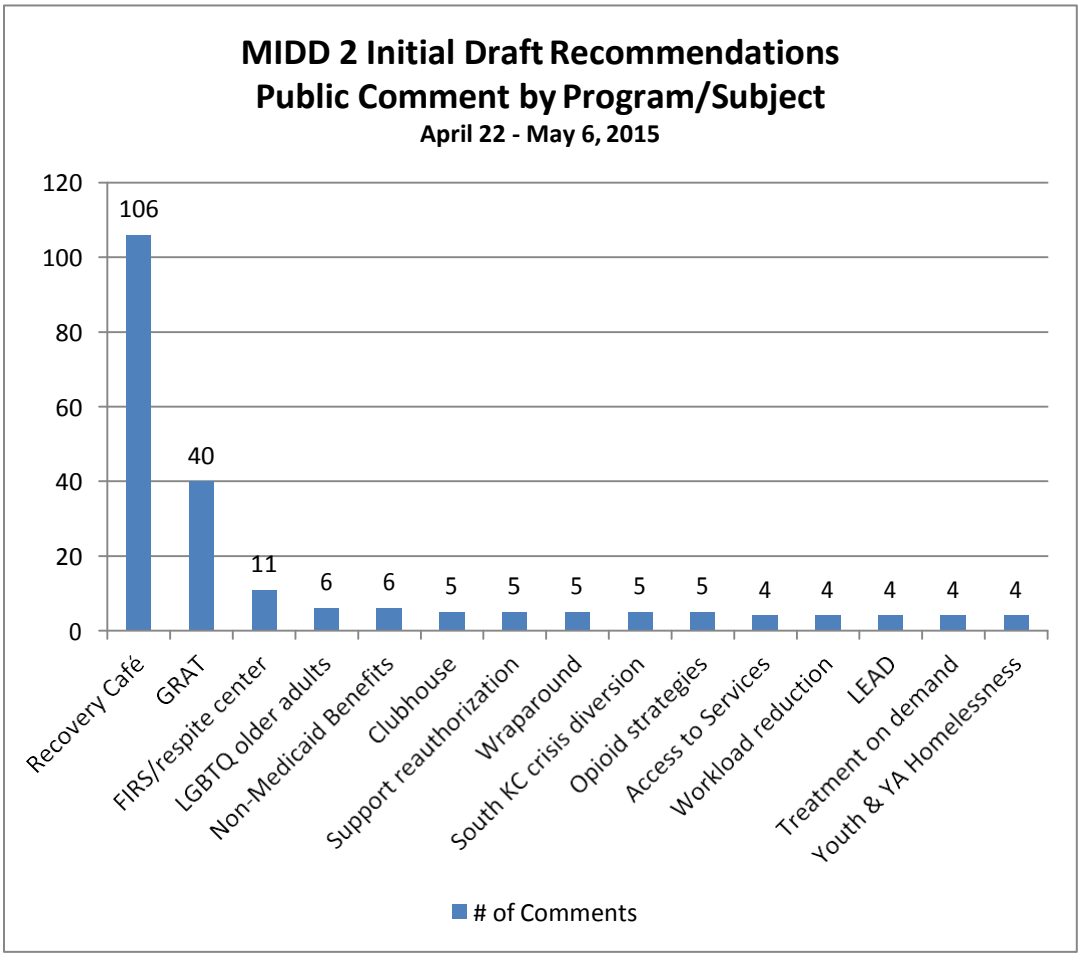
MIDD 2 Initial Programmatic and Funding Recommendations

Public Comment Summary: April 22 – May 6, 2016

A total of 205 comments on the initial draft MIDD 2 programmatic and funding recommendations were received by King County. The comments were provided online April 22 – May 6 through a survey portal, via email, or in person at the MIDD Oversight Committee meeting on April 29.

The vast majority of comments endorsed or supported particular programs that appeared the recommendations, in some cases advocating for additional funding. Notably, over half of commenters (106 total) expressed gratitude for Recovery Café's inclusion in the funding recommendations. Nearly 20 percent of public comment participants (40 total) advocated for funding of the Geriatric Regional Assessment Team (GRAT). About five percent of respondents (11 total) supported the Family Intervention and Restorative Services (FIRS) including its respite center feature.

When comments referenced multiple subjects, they were counted under each subject discussed. Programs or subjects supported by four or more commenters are shown in the chart below.



Public Comment on Initial Draft MIDD 2 Funding and Programmatic Recommendations (April/May 2016)

Name: Judge Lisa Napoli O'Toole

Organization: King County District Court

Comment: I am a Judge in King County District Court, East Division. I am writing to urge King County to allocate MIDD funding to combat the drastic increase in heroin addiction that we see here in King County District Court. The number of defendants that we see in District Court who are heroin addicts is truly staggering. Each and every week here in Redmond I see dozens of defendants who are heroin addicts. One of the remarkable things about this is that not only do I see defendants charged with crimes that one might expect of a heroin addict, such as Driving Under the Influence (of heroin) or Possession of Drug Paraphernalia, but I also see defendants charged with other crimes such as theft and assault, including domestic violence. So very often the genesis of the criminal activity is the addiction. Many of the people in the criminal justice system who are heroin addicts are indigent and without stable housing. Without stable housing it is nearly impossible for these individuals to participate in, and be successful in, substance use disorder treatment. I urge King County to use MIDD funding to prevent further needless deaths due to heroin overdoses and to combat increasing risks to public safety. Ideally, a criminal justice diversion program in District Court would help defendants to address legal issues while engaging in treatment arranged through the program and while living in stable housing arranged through the diversion program. I realize that such a diversion program would be an expensive proposition, however. At a minimum, I urge King County to use MIDD funding to develop programs that will provide treatment and housing options for defendants in the District and Municipal courts.

Name: Merina Hanson

Organization: City of Kent

Comment: Many thanks to King County DCHS staff for the amount of time and effort spent on the MIDD II draft and programmatic recommendations. On behalf of the residents of the City of Kent, we appreciate and support the inclusion of the vast majority of the Initiatives, including:

- upstream prevention and diversion activities;
- treatment on demand;
- community driven behavior health services (We support the concept of cultural communities being able to initiate programs that address their unique needs.);
- new Zero Suicide Initiative Pilot;
- Crisis Intervention Training for first responders (Kent Police Department prioritized this for their officers and it has been very valuable.);
- new Multipronged Opioid Strategies (Treatment options should be available and accessible throughout the County.);
- new Youth Mental Health Alternative to Secure Detention;
- new Involuntary Treatment Triage (System improvements to the involuntary commitment process are critical and our jails are not funded or equipped to properly serve individuals with severe and persistent mental illness.);
- new Recovery Café ; and

- new South County Crisis Diversion Services/Center (Recognizing that siting may be a challenge and close coordination with the community will be required.)

Points of concern include:

- any assumptions related to leveraged Medicaid to replace MIDD funding (Recognizing that County staff is certainly mindful of this, and simply urging extreme caution moving forward.);
- new Youth and Young Adult Homelessness (Urging increased investment and close coordination with Best Start for Kid's Youth and Youth Adult and Families Homelessness Initiative.);
- clarity of where MIDD II Initiative Titles are best placed within the MIDD II Framework Strategies;
- clarity of the differentiation between the Next Day Appointments and New Urgent Care-Walk In; and
- Housing Capital and Rental, New Rapid Rehousing-Oxford House Model, Housing Vouchers for Adult Drug Court (Urging close coordination with All Home and consideration of the variety of other funding sources available for housing capital.)

Name: Steve Chon

Organization: Asian Counseling and Referral Service

Comment: I am a clinical supervisor at Asian Counseling and Referral Service. I also worked as a case manager before I became a supervisor. As I worked with client who suffer from chronic mental health issues directly and indirectly, I can't say more how MIDD helped clients who do not have means to get the service from public agencies such as ours. I personally witnesses clients with chronic mental health issues who find a job, get tx from a doctor and a counselor, and even get housing. I strongly believe in second chance and opportunities in life. I wish our clients continue to get their second chance and opportunity in their life.

Name: Janet Garrow

Organization: King County District Court

Comment: I am serving in my 17th year as a judge in the King County District Court on the Eastside. While I have always seen defendants who have alcohol or drug addictions, the significant increase in the number of misdemeanant offenders with a severe substance use disorders is astonishing. Last week I was on after-hours search warrant duty for King County. Most of the search warrant calls were for drivers who were committing serious driving offenses on freeways and were under the influence of drugs, typically heroin. For example, a driver was going the wrong way on Highway 520, a driver was involved in an accident on I-90, and another driver was speeding on I-5 at 80 mph and weaving in and out of traffic. While I am a strong proponent of early intervention measures to prevent and treat substance use disorders outside of the criminal justice system, the fact of the matter is that we have many people in the criminal justice system who are in serious need of treatment and housing. I see many people on the Eastside, of all ages, who are homeless and drug-addicted. It is truly a tragedy.
I know from experience that unless the person has some kind of stable housing it is highly unlikely she/he will be able to effectively engage in substance use disorder treatment. I have defendants ask me NOT to release them from jail until they can be released into an inpatient treatment program. They know that even one day on the street will, in all likelihood, will lead to heroin use. Many of the adult offenders in the criminal justice system in the District and Municipal courts serve their jail sentences in municipal jails such as SCORE, Kirkland and Issaquah. These facilities are ill-equipped to handle offenders

with substance use disorders. Finding treatment placements for these offenders is a daily challenge for our court system. While I am glad to hear there is a proposal to increase treatment options at the Maleng Regional Justice Center jail, that enhancement does virtually nothing for most of the offenders in our District and Municipal Courts. I strongly urge King County to use MIDD funding to develop programs that will provide treatment and housing options for adult offenders in the District and Municipal courts. Most, if not all these offenders, are indigent. Without enhanced services for this population, we will continue to see an increase in loss of life due to substance abuse and serious risks to public safety. Thank you for your consideration of these comments.

Name: James Hopkins

Organization: Member of Recovery Cafe

Comment: Mr. Hopkins shared his life story, how he began to drink at age 9 and to smoke weed and use drugs beginning at age 13. When he first came to Recovery Café, he was homeless, struggling with addiction, hearing voices and hallucinating. Now he has permanent housing, in September he will have been sober for four years, he is employed full-time and he is looking for additional part-time work. He is no longer at risk for Type II diabetes because of changes in his lifestyle. All this is because of Recovery Café. Recovery Café makes him feel like he belongs and can be his genuine, authentic self, and he commends King County for including Recovery Cafe in MIDD II and supporting Recovery Café becoming available to more people in King County.

Name: George Dicks

Organization: Harborview

Comment: Geriatric specialist at Harborview, also representing the aging with pride component of the older adult people in the system. Early intervention and prevention programs are important, given the prevalence of depression in older adults, especially in communities of color. We have well-established evidence-based programs that through sheltering and socialization enhance wellness and fitness, reducing the severity and prevalence of depression in older adults. He urged the Oversight Committee to keep in mind the high cost of depression in respect to its effects on multiple aspects of health and he asked for continued funding that supports the mental health of older adults. He noted especially the expansion in South King County that will help communities of color especially. Mr. Dicks also voiced his support of GRAT. All older adult programs will affect all of us, even in this room.

Name: Jim Marshall

Organization: Retired from Harborview Medical Center

Comment: Jim Marshall, a licensed independent clinical social worker and Chemical Dependency Professional (CDP), recently retired from Harborview Medical Center after 27 years of witnessing the effects of mental illness and substance abuse on people. Mr. Marshall encouraged the Oversight Committee to support for LBGTQ people in particular because of the disproportionate rates of depression in that population: 40 percent say they have considered suicide, with higher rates among minority populations, due to stigma, victimization, and in many cases criminalization. Mr. Marshall

respectfully requested funding for comprehensive, evidence-based mental health and substance use disorder training programs.

Name: Kathleen Sullivan

Organization: Generations with Pride

Comment: Kathleen Sullivan, Director of a new organization called Generations with Pride that is working to reduce isolation and increase accessibility for the aging Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) population in King County. Ms. Sullivan voiced gratitude for the support that is being shown for this important population: as the UW SSW study has shown, there are clear disparities in care for this group within the older adult population in our County, and this group is expected to double. Research has shown that a lifetime of victimization and internalized stigma leads to greater mental health needs of LGBTQ. Isolation and feelings of loneliness increase likelihood of early death of all older adults, but especially LGBTQ older adults.

Name: Judy Strong

Organization: Evergreen Health Geriatric Regional Assessment Team

Comment: Ms. Strong spoke from two pages or prepared comment. She noted that GRAT is one of only two MIDD II recommendations directed to the geriatric population, and that the current recommendation drafted by the Oversight Committee is to cut GRAT's funding. GRAT receives referrals from first responders and other entities, responding to first-responder referrals within 24 hours and all others within three business days. They do assessments for cognitive functioning She shared stories of individuals and families helped by GRAT: one of an elderly woman showing up a school every day, school called police and police called GRAT; another of a 90-year old man experiencing increased difficulty caring for his wife, who called police who in turn called GRAT, who worked with the entire family to set up appropriate care for the elder in need of care; and another story of a woman in her 60s with known mental illness, living in her car in a church, where the church called GRAT, and GRAT arranged the client to go to the hospital. GRAT is not a program-based service but a person-based service that connects people with services, arranges hospitalizations, provides education to families – going everywhere in King County. No one else is providing this service, and it is crucial to the crisis prevention network. Ms. Strong asked the Oversight Committee to restore to current levels GRAT funding in its recommendations.

Name: Anne Lee

Organization: TeamChild

Comment: We are very pleased to see the MIDD II recommendations that emphasize investments in mental health and behavioral supports for youth who are involved in the justice system. Investments that are targeted to diverting children out of the justice system and into supports that show better evidence for health and well being will have a positive impact on reducing the racial disparities in the justice system. New concepts like the Family Intervention Restorative Services and the dedicated funding for alternatives to detention are excellent approaches. As the strategies are developed, we hope that they include flexibility so that supports can be tailored for the individual needs of children who are in conflict with the law. There is opportunity to achieve a tailored approach that provides meaningful,

timely and lasting support to children and families. CORS, behavioral assessments, and wrap around services have potential for such alignment. We believe that they can be better aligned to ensure that youth are getting services when they need them. We also hope to see clear directives around supports that actually meet the needs of underserved children, including children of color and children with disabilities. Racial disparities persist in all of our public systems - education, health care, child welfare, and juvenile justice. MIDD II investments can make a difference, but there needs to be clear direction about improving outcomes for these groups. Finally, missing in the recommendations are a system of ensuring that people who are marginalized and not able to access the system are able to. Legal aid and other advocates are a critical service that could ensure that the systems we create to support people are actually serving those most in need. Advocacy can also play a role in ensuring that individuals are able to transition into state and federally funded programs for longer term support than those services provided by the county. A portion of MIDD II should be dedicated to helping adults and children with access to the MIDD and other behavioral health services.

Name: Kim Hendrickson

Organization: City of Shoreline

Comment: Public Comment Kim Hendrickson, City of Shoreline May 6, 2016
I am writing to urge the reconsideration of the City of Shoreline Police Department's request for a RADAR Outreach Coordinator. This request was not one of the programs recommended by the MIDD Oversight Committee. I believe it should be. I was brought on this year, by the City of Shoreline, to help its police department respond to individuals with behavioral health issues. It's been a troubling experience. Deputies encounter people, every shift, who have untreated or poorly managed mental illness. They are asked to respond to situations, every day, involving people who are visibly suffering and without the ability to help themselves. What they tell me, to an officer, is that there is very little they can do in these critical situations. ITA criteria is high. The mobile crisis team is useful but response time is long and their ability to respond is limited. The crisis diversion center is an option but the distance is significant—and many people in need of help will not willingly be taken. There is no one with the time and training, within the department, to provide counseling, give professional advice, or conduct follow up visits—and/or connect people to needed treatment and services. A single Outreach Coordinator assisting deputies in Shoreline will not help all people in all situations. But if this person is a social worker, or other type of MHP, it will give Shoreline police a person to call who can counsel individuals in need of care, and link them to resources and services. One of the central purposes of MIDD dollars is to divert people from jails and emergency services, and provide them access to care. I urge the MIDD Committee to understand the importance of the Outreach Coordinator in this context, and to reconsider our application. Thank you for your consideration. Kim Hendrickson

Name: Anita Khandelwal

Organization: DPD

Comment: I first want to thank BHRD for its extraordinary work. The MIDD II process has felt thorough and transparent and I truly believe that our community will be healthier as a result of the programming that is eventually implemented. In going through the MIDD process, it seems like there are two implicit

but core principles underlying the recommendations and I thought it might make sense to articulate them and apply them explicitly going forward.

1) any organization or program funded by MIDD II should first look to Medicaid to see if federal dollars can pay for the programming. All programming that could be paid for by Medicaid should be. MIDD II funds should only be used to pay for programming that Medicaid will not pay for;

2) all programs should provide trauma-informed care and should apply principles of harm reduction. This is important because consistency across the continuum of care will more likely result in successful outcomes for individuals. Mixed messages about expectations regarding, for example, abstinence may confuse and frustrate recipients of service;

Regarding specific programming, I want to particularly applaud the creation of a Crisis Diversion Center in South King County and funding for respite beds and mobile behavioral health crisis teams. Given the explosion in the volume of Involuntary Treatment Act cases, it is critical that the County fund programs that could divert individuals away from that system. I also want to applaud LEAD expansion, which will help keep low-level offenders out of the system and accessing services that they need. Finally, I note that while the draft recommends funding FIRS, it fails to provide enough money for the residential component of the program. The full benefits of the program cannot be realized without adequate funding for the residential component of the program. Thank you again for your work!

Name: Paul Daniels

Organization: King County Superior Court

Comment: I am writing regarding the FIRS program and the recommendations to fund it. Family Intervention and Restorative Services represents a paradigm shift in the response to family violence that significantly reduces the number of youth being presented to King County's Juvenile Detention. FIRS is also a departure from formal court processing that allows for an immediate response to families in crisis. It will be necessary to re-address the funding proposals in order to maintain FIRS under MIDD II. Without additional funding, the model will revert to once again booking youth into detention for family violence incidents.

Name: Cecilia Camino

Organization: Superior Court

Comment: The goal of the Family Intervention and Restorative Services (FIRS) is to provide interventions and services to youth and families that are designed to: 1) decrease violence in the home, 2) decrease further police contact and detentions, and 3) minimize court involvement. The FIRS process allows youth an opportunity to divert their legal matter out of the formal juvenile court and detention system while connecting the youth and family with needed services. As a Juvenile Probation Counselor who works directly with this population, I can personally attest to the positive impact this program has had with youth and families involved in family violence. We are able to intervene and provide alternatives to court process immediately, while putting in place direct services more quickly and effectively. The current proposal includes the addition of a non-secure respite center for youth who would normally be detained. Funding this important piece of the program will be key, as it will eliminate the need for

detention in these cases, while allowing families needed respite time and an increased opportunity to engage youth and families in needed services.

Name: Lauren Davis

Organization: Washington Recovery Alliance

Comment: This is a terrific and important set of recommendations. It represents an inclusive process and a tremendous body of work by the BHRD division. Thank you! I think it would be incredibly strategic to invest a small amount of money ($50-75K) to hire a young professional to organize activities for a King County Recovery Coalition, as described in the briefing paper. As proposed, this coalition would operate under the oversight of the Washington Recovery Alliance (WRA), which is a statewide network of behavioral health recovery coalitions. The WRA has the ideas and expertise, but not the time to carry out a planned stigma reduction campaign. Proposed activities include training a speakers bureau of people in recovery and affected families to speak at public meetings, to help ease concerns of neighbors when treated facilities are being sited. The WRA also seeks to host public recovery events and to create a social marketing campaign to reduce stigma. Stigma presents an obstacle to the fulfillment of nearly every strategy proposed in MIDD 2. For example, stigma creates road blocks to the creation and siting of new treatment facilities and it prevents individuals in distress from seeking care. It also isolates families and friends who are supporting a loved one in crisis. We would be remiss not to dedicate a small portion of funds toward its eradication.

Name: Jeremy Crowe

Organization: King County Superior Court

Comment: Family Intervention and Restorative Services (FIRS) represents a example of a needed and appropriate shifting of our focus to assessing needs/services up front and a path of prevention/decreasing recidivism vs. the previous long-standing approach: waiting for more criminal referrals to pile up and what can be a slow and lengthy court process to get to court supervision and services (while the youth/family and surrounding community, in the mean-time, can often continue to struggle immensely). FIRS attacks the number one driver of youth in detention - domestic violence/assault - one of the most intense, complex and difficult to intervene in issues in our community. It needs more funding to allow its full vision to be realized, including "Z-hall" at juvenile detention, a non-secure respite/shelter "unit" for youth involved in DV incidents at home. This will be a staffed/supervised place that promotes entry into an outside-of-court intervention process where they can access support and services in lieu of secure detention and in lieu of initiating the formal court and charging/filing process. FIRS puts a large dent in the number of kids sitting in detention for DV/assault-related referrals and connects youth and families with timely and often immediate support, assessments, safety planning and services. It has shown positive results in it's first 4 months and we continue to assess how best to serve youth and families embroiled in intense conflict in their homes. This team approach combines immediate staffing, risk/violence assessments, negotiating, family/team meetings and truly tailored/matching service referrals, sometimes within hours of the DV incident occurring. Only funding a promising new program and approach like FIRS for a short period of time and/or only funding part of what it demands in order to truly flourish doesn't make much sense. We are moving towards a more informed, family-empowering and healthy approach to domestic violence in our community FIRS is and can continue to be a part of this shift towards something that makes more sense

and is more effective for our families and communities. But it simply can't develop or even stick around if it is not fully/appropriately funded.

Name: Susan Craighead

Organization: King County Superior Court

Comment: I wish to comment wearing two different "hats." First, as a member of the Juvenile Justice Equity Steering Committee, I am pleased to see the focus on youth and alternatives to secure detention. However, the recommendations themselves are insufficiently detailed for members of the Steering Committee to be able to evaluate their merits versus the merits of other ideas. It is difficult to discern how well the existing programs or the new programs will serve highly marginalized populations. I suspect the Committee will be pleased to see the recommendation for Community Driven Mental Health Grants, but would ask why this strategy is not embedded in all of the recommendations. Different parts of our community may need services from small, community based organizations that can be more culturally sensitive. It is important not to relegate cultural sensitivity to a $300k program. The Steering Committee will need more information (perhaps a visit by Kelli Carroll at our next meeting) and time to present comments on behalf of the Steering Committee as a whole. Speaking as the Presiding Judge, I want to express my gratitude on behalf of the Court for the generosity that these recommendations demonstrate for the criminal and juvenile justice systems. My comments need to be taken in this light. First, it appears that FIRS was funded at 50% of the actual cost; the $700k allocated will pay for the professional staff and evidence-based services, but not a home for FIRS. Without an additional $700k (which could come partly from sources other than MIDD) the youth would have to go back to staying in detention for the "cooling off" period before they can return home. Second, with regard to the Mental Health Alternatives to Secure Detention: we are very supportive of this idea, but we would encourage you to add runaways to the list of youth who might be suitable for these beds. Most of those who arrested on warrants and placed in detention suffer from PTSD; without a safe temporary place to put them, DSHS places them in hotels or the next available foster placement, which may not be appropriate and will cause them to run again. The funding recommended for Family Treatment Court does not allow it to be expanded to South King County. Superior Court obtained a grant to allow us to expand because our cases increasingly come from South King County. The grant requires matching funds from MIDD. Without those dollars, we will have to return grant money. For everyone's information, Family Treatment Court is not a diversion from the criminal justice system. Rather, it enables families in the dependency system to reunite rather than have children grow in foster care. FTC offers the best chance for family reunification and beneficiaries are young children who get to be raised by their biological parents. Superior Court is happy to work with MIDD staff to see if there are other ways to raise money for some of these objectives, such as grant funding or contributions from our city partners. We welcome these discussions. Thanks very much to the entire MIDD staff and DCHS for the hard work that has gone into this list of recommendations

Name: David Coffey

Organization: Recovery Cafe

Comment: I applaud King County for including Recovery Cafe in MIDD II. Everyday here at the Cafe I see people transforming their lives- staying drug and alcohol free and stabilizing their mental health to embrace a life of wellness. Thank you King County for investing in this incredible program.

Name: Leesa Manion

Organization: Prosecuting Attorney's Office

Comment: Please consider adding additional funding to the FIRS concept to allow this innovative and effective program to operate at full capacity as a non-secure, pre-booking, pre-filing juvenile diversion program for youth, many of whom, are struggling with chemical dependency and mental health challenges that cause them to lash out physically against parents or siblings. The $700,000 allocated in the Draft MIDD II Funding and Programmatic Recommendations is not enough to adequately serve the 400 or more youth a year that FIRS can effectively divert out of the criminal justice system.

Name: Patricia Sayed

Organization: None

Comment: One purpose of the mission team of my faith community, of which I am a member, is to research organizations which may need help in maintaining their programs for the homeless, addicted and those with mental health problems. With this in mind, I want the King County Council to know why I definitely think the Recovery Cafe should be included in your funding decisions. First, the work of the Cafe saves the county money by reducing the number of 911 calls, emergency room visits, and police interventions because they give people meals, support, friendship, and other opportunities for healing and safety. Their many classes offer people dealing with homelessness, addiction, and other mental health challenges opportunities to learn anger management, yoga, meditation, and others for stress reduction and emotion regulation. Thank you for considering my comments, Patricia Sayed

Name: Dan McDougall-Treacy

Organization: Valley Cities

Comment: Please reconsider the planned 33% reduction in funding for Wraparound. I know the impending availability of Medicaid funding presents an apparent opportunity to shift funds elsewhere. BUT: the Medicaid reimbursement elsewhere in the state has not been able to cover costs; the state requires King to drastically increase the number of Medicaid youth receiving wraparound in the future. Over the lifespan of the MIDD II funding, the service level for all Wraparound youth will gradually degrade.

Name: Lea Ennis

Organization: King Co. Superior Court

Comment: We are very concerned about the lack of funding for the FIRS respite center. We will be opening this non-secure, residential option for youth involved with family violence case in July of 2016. Without the full funding requested in our proposal we will have to shut down the residential component and revert to booking youth into detention. The respite center provides a mechanism for youth to receive services without spending time in secure detention and entering the juvenile justice system. It is also a resource for law enforcement since some youth do not meet the detention intake criteria.

Name: Teresa Perillo

Organization: Recovery Cafe

Comment: We are grateful to be able to be part of the MIDD program, we believe it has been very helpful for our members that we serve!

Name: Stephen DeChiaro

Organization: Recovery Cafe

Comment: I support the initial draft MIDDII program for Recovery Cafe.

Name: Derek Franklin

Organization: Mercer Island Youth & Family Services

Comment: MIYFS recently partnered with the U.W. Center for the Study of Health and Risk Behaviors to create a novel, on-line individualized normative feedback tool for high school aged youth. This tool allows youth to take a short on-line survey that provides them immediate feedback on their drug and alcohol (and potentially mental health) risk in relation to risks of their peers (normative feedback let's youth know if, for example, drinking 5 beers a weekend is "normal" or not among peer their age--it is not normative behavior in King County but many youth think it is). MIYFS funded the first phase of this study. It needs approximately $50K for the next phase. Once completed it can be implemented to youth across the county for almost no cost, except for local schools or human service organizations helping upload local normative data into the system so local youth can see how they compare not only to peers across the county, but to peers in their own school. This is prevention tool that has been studied at UW--its efficacy can be best explained by Dr. Jason Kilmer. It is an extremely cost effective prevention tool that borrows from Motivational Interviewing and SBIRT. Youth who take the quick survey are given feedback about their substance use issues, where to get help, linked to educational videos, etc.

Name: Carrie Rubenstein

Organization: Swedish Medical Center

Comment: I am a family physician and Geriatrician in Seattle. The services funded by this program/budget are critical for many of our vulnerable elder populations. Please continue this important funding.

Name: Anne Nelsen

Organization: None

Comment: I first volunteered (and became a donor) at the Recovery Cafe two years ago. My charge was to be a Minister of Presence, a concept quite foreign to me at the time, though not now. It is to be present, to be "there," in whatever capacity is needed. It is an extraordinary charge, but one that I see fulfilled by staff and volunteers at the Cafe every day I am there. To be there, to meet needs, to listen, to support, to care, to grieve when necessary, to challenge, to celebrate, to love unconditionally. To walk into the Cafe is to walk into an embracing warmth like no other: a safe place, a nurturing place, a place of fresh starts and healing. To me, the Cafe is the most remarkable place I have encountered in decades of volunteering. I see a motivated, profoundly caring staff, volunteers who are drawn into the experience ever more powerfully, members who are thriving and caring for each other. This incredibly innovative organization is most worthy of public support. It is not magic, but it is possibly as close to that as is humanly possible.

Name: Officer Sam Cook #6325

Organization: Seattle Police Department

Comment: I just want to say that I really support the work and good people at the Recovery Café. I strongly encourage a continued partnership between them and the MIDD.

Name: Dorothy Trueblood

Organization: Valley Cities BHO

Comment: I have always been thankful that MIDD covered families with private or no insurance and for those who have two systems that did not necessarily include mental health. With decreased funding, those things would be gone, which would likely increase the cost in other areas, such as criminal, ER visits, etc.

Name: David Bales

Organization: Washington State Criminal Justice Training Commission

Comment: I am supportive of continued funding for Law Enforcement and first responder Crisis Intervention training. First responders are the only service consistently available to respond to incidents

of people in mental health crisis in the community, where they are, during the crisis- and 24 hours a day, seven days a week. The opportunity to leverage virtually ALL of the other identified programs and interventions starts with having first responders who understand the concepts of CIT as well as the resources that are available. We see all around the country the results of first responders not having this training, knowledge and skill. We are ahead of the curve in King County but we are also in the midst of a hiring spike that the police profession hasn't seen in over 30 years- a significant number of officers are retiring and we MUST train the new ones. I strongly support full continued funding for CIT training for first responders. The need is not diminishing.

Name: Lily Anderson

Organization: King County Step-Up Program

Comment: The addition of a Respite Center component to the Family Intervention Restorative Services program at Juvenile Court is a sensible and purposeful way to significantly reduce the number of youth in detention and the criminal justice system. It will provide more opportunity and time for youth and families to safety plan, learn family violence prevention skills and engage in restorative process to begin re-building relationships. Parents and youth will gain strategies to prevent further violence in the home. If our court, county and community is committed to keeping these youth out of the criminal justice system, this is an attainable and meaningful way to make it happen.

Name: Ruby Takushi

Organization: Recovery Cafe

Comment: I am on the board and staff at Recovery Cafe. Everyday I see the crucial role the Cafe plays in providing recovery support to men and women in our community struggling to heal from homelessness, trauma, mental illness, and addiction.

Name: Elizabeth Trautman

Organization: YouthCare

Comment: Thank you for the opportunity to comment on Programmatic Recommendations for MIDD II Funding. YouthCare is appreciative of the inclusive community process and deep thought that went into forming these recommendations, and are supportive of both the program categories, and the specific strategies and recommendations within each category. In particular, we are supportive of the following interventions that we feel will greatly benefit the homeless, unstably housed, and system-involved young people we serve.

- PRI-VII – Mental Health First Aid – we hope that youth providers can access this training, as our staff can serve as first responders to youth who are decompensating.
- CD-II – Youth and Young Adult Homelessness Services – We believe this strategy provides the necessary supports to ensure we can safely provide housing services to youth with acute behavioral health needs.

- CD-VII – Multipronged Opioid Strategies – we are hopeful that these strategies also consider the needs of homeless youth and young adults.
- CD-IX – Behavioral Health Urgent Care Walkin Clinic Pilot – This proposed pilot meets a huge need in our community, and we hope our young adult clients might access these services.
- CD-XVII – Youth Mental Health ASD This list isn't intended to be exhaustive, as we see many positive elements in the proposed funding list, and look forward to ensuring that our community's homeless youth, young adults, and their families have the behavioral health supports they need to successfully move beyond homelessness into thriving adulthood.

Name: Rachelle Wright

Organization: CIT-King CO Program, WSCJTC

Comment: I like that some of the current programs are still being considered for MIDD II. Please look at continuing the CIT training for first responders as we have just begun the process of implementation of Corrections and Fire/EMS into the training program. With the implementation of new users to the training courses, it has also increased our training need across the county, and we will work as hard as we can to meet that need. We are also looking at new ways to develop sustainability with first responders so that the training continues and collaboration with resources like the MHP, DMHP, hospitals, courts, etc. continues and is strong across the county. We also value the resources available in King County and find the communication and education on resources such as GRAT, CCORS, and King County Mental Health Court have brought a lot of light to available resources many first responders did not know even existed. As a result with more of our training, it has caused a rise in their need to support the referrals from first responders. Please support those crisis resources as they are extremely valuable partners. During MIDD II I would like to expand implementation of training to also include security and other first responders (e.g. Emergency room personnel), transit security, and more to continue to grow the program even further.

Name: Mary Taylor

Organization: King County Step Up Program

Comment: The draft recommendations do not provide the full funding for FIRS. FIRS is a respite center model - a non-secure 24/7 receiving facility that eliminates the need for detention bookings on the majority of family violence cases. The approach represents an entirely new way of doing business, keeping kids out of detention and providing services at the time of crisis. I have been involved in the planning of FIRS since the spring of 2014 as the supervisor of the step up program. Having a physical location to temporarily house the teens, while connecting the family to services and developing safety plans, is the most critical element of the proposal. Without full funding, King County will miss a valuable opportunity supported by the community and juvenile justice professionals, to truly make a difference in an immediate way in the lives of youth and their families.

Name: Kelly Ebels

Organization: None

Comment: Great to see some really helpful and innovative programs being funded. I have heard from several participants in the LEAD program about how positive their experience is and their motivation to

stick with the program. I hope it continues to expand. I see new funding for the Recovery Cafe. I am very pleased to see this. I am a volunteer, supporter, and fan of the Recovery Cafe. I have heard countless stories of struggle and have heard and seen improvement in people's lives through the supportive services offered at the Recovery Cafe. This organization offers crucial support for people struggling with trauma, mental illness, addiction, poverty, and homelessness. The Recovery Cafe uses resources, including volunteers, more effectively than any organization I have ever been involved with. They will stretch this funding far. For this reason, I would like to see their work better funded by the county. I hope that revisions to the MIDD budget will include an increase in funding of their efforts. For example, I see that $800k is budgeted for a peer support pilot. While I have no doubt that this is important work, I wonder why this pilot is receiving significantly more funding than the Recovery Cafe, an organization that already incorporates peer support into all of their programming. The day-to-day engagement with people from the community by the Recovery Cafe significantly responds to the needs identified not only in the recovery and reentry strategy area, but also in the strategy areas of crisis diversion and prevention and intervention. This is a key program that deserves significant support. Please consider increasing funding for the Recovery Cafe in revisions to the budget. Thank you again for funding important community programs and organizations like the Recovery Cafe to invest in improving the lives of people in our community.

Name: Killian Noe

Organization: Recovery Cafe

Comment: We need Recovery Cafe's throughout the city providing support to those seeking to attain and maintain stability in recovery from substance use disorder and other mental health challengers.

Name: David Boyle

Organization: None

Comment: I have been involved with The Recovery Café as a volunteer for over 10 years. I have witnessed the success the Café has had in helping those dealing with drug dependency and mental illness to recover stability and a sense of meaning in their lives. I fully support the Café receiving MIDD funds, and I respectfully request that the MIDD program consider increasing the proposed funding for the Café to provide it with the support necessary to open and operate a Café in South King County.

Name: Amy Worthington

Organization: Recovery Cafe Board Member

Comment: As a Recovery Cafe board member I was thrilled to learn this organization is still being considered for MIDD support. Recovery Cafe is one of but a very few programs that truly helps people with addition clean and sober for the long run, which is a cost savings for King County in the long run. There is a great recent report that supports this claim that the Department of Public Health has seen. Not only should MIDD support this organization, the amount of support should be greater than currently indicated. It's a smart investment of public dollars and is a cost savings in the fight against addiction in the long run and big picture.

Name: Angela Wolle

Organization: None

Comment: I am delighted to see that the Recovery Cafe is included in this. Their work is phenomenal and I hope that this model can be spread throughout the county.

Name: Barbara Johns

Organization: None

Comment: I support the renewal of the levy and urge funding of Recovery Café as part of Recovery and Reentry.

Name: Victoria Allen MD

Organization: None

Comment: Please fund Recovery Cafe's request for funding to build an additional Recovery Cafe site. Recovery Cafe offers a unique setting for members in recovery. Without a safe place to go, to be known and to work daily on recovery and mental wellness, individuals struggling with mental illness and substance addiction are lonely, lost, isolated and at very high risk of relapse. I have been in primary care for over 20 years and have worked with many patients that may get short term treatment but there is nothing to hold them and support them as they leave the treatment program and relapse inevitably occurs again and again. The Cafe model is simply incredible and offers radical hospitality, accountability, support for those in recovery. It is the vital missing piece on the recovery journey which so many need. I often say I wish there were a Recovery Cafe (instead of a Starbuck's) on every corner because it too serves great coffee but offers something much more important for all of us, a place of healing and hope for every single person that walks through the doors--members, donors, volunteers all receive so much from this incredible model. Please fund Recovery Cafe, it is a model that will be replicated across the country and Seattle will be proud that we continue to offer innovative solutions for those struggling with mental illness and addiction.

Name: Patricia Song

Organization: None

Comment: Please include Recovery Cafe in the MIDD. I have been a weekly volunteer teacher at the Cafe for over four years and can attest to the miraculous work they are doing there. They are a true, bright light in our community. MIDD funding will help to ensure that they are able to continue their life-changing, transformative work. I am convinced that Recovery Cafe is a most effective model for the highest positive change in the world.

Name: John Morefield

Organization: None

Comment: I was a volunteer at Recovery Cafe for over a year and in that time I was continually amazed at the quality of care provided to some of the most marginalized in our society. Day after day the remarkable staff goes the extra mile to insure quality service for their clients/customers. Dental care, quality delicious food, AA groups, yoga classes, employment counseling...the list just goes on and on. This past Monday I was visiting a prisoner in the Pierce County jail. On my side of the window I could here visitors talking about how wonderful Recovery Cafe is in Seattle and how excited they were about the Tacoma venture. Amazing to hear such testimony from people in real need. I strongly recommend including Recovery Cafe in the MIDD II funding. Thank you. John Morefield

Name: John Schochet

Organization: Seattle City Attorney's Office

Comment: The Seattle City Attorney's Office supports the funding for the involuntary treatment triage. This program, which was previously operated at Harborview's expense, has improved the process for timely evaluating for civil commitment purposes defendants whose Seattle Municipal Court criminal cases were dismissed for lack of competency. These evaluations play an important role in ensuring that individuals with mental illness receive treatment and improving public safety in King County.

Name: Maureen Lee

Organization: None

Comment: I am so pleased to see Recovery Cafe in the MIDD. It is an asset in the downtown neighborhood. It needs more funding to increase services! Thanks.

Name: Keith Capasso

Organization: None

Comment: Please make sure to include Recovery Cafe in the MIDD. Thank you.

Name: William Schipp

Organization: Juvenile Court Services

Comment: King County Juvenile Justice Assessment Team Response to MIDD II Funding Recommendations May 2016 The Programmatic Recommendations for MIDD II Number PR1-11, Juvenile Justice Youth Behavioral Health Assessments, dated 4/28/2016 provides for a proposed budget of $500,000, which is substantially less than the amount at which the Juvenile Justice Assessment Team (JJAT) is currently funded (- $63, 820). With program enhancements that would increase clinical services to youth from assessment through referral and enrollment, the amount requested from MIDD II is $730,

650.00. Absent these enhanced services, it appears that the program would be funded at a rate lower than currently funded, which would greatly impact the program's ability to meet the needs of our youth and the court, as well as our ability to meet the target numbers required. To date, JJAT has served over 2500 unique youth through its screening, assessment, consultation and referral to community based services. For each year of MIDD 1, JJAT has met or exceeded its targets for screenings (GAIN Short Screener and Trauma Screenings), mental health and chemical dependency assessments, psychological evaluations, and made numerous referrals to community based services for psychiatric and neuropsychological evaluations. We provide cross disciplinary consultations for Juvenile Court Services staff, as well as community partners working with our youth. As the number of youth referred for filings and the number of youth held in secure detention continue to decline, thanks to the many Alternatives to Secure Detention (ASD) opportunities, the severity of Behavioral Health and Substance Use Disorder affected youth increase proportionately. JJAT serves this population and cannot continue to provide the required services if we are funded at a level where we cannot sustain current staffing levels. Fully staffed, JJAT is comprised of a 1.0 FTE Program Coordinator, a .8 FTE Clinical Psychologist, 2.5 FTE Mental Health Liaisons, and 1.0 FTE Chemical Dependency Liaison. Historically, we have also relied upon 1.0 FTE contracted on a fee for service basis through a community based agency. With our target for Mental Health Assessments set at 140/MIDD year, each Mental Health staff is expected to complete approximately 56 assessments. Our Chemical Dependency assessment target is set at 165 assessments per year, and each Chemical Dependency Liaison is expected to complete approximately 83 assessments. Reductions in staff would greatly impact not only our ability to meet these targets, it would also result in fewer youth being served. With the recent Behavioral Health Integration changes that have been implemented just recently, it is not clinically sound to continue to conduct assessments under the old system of separate Mental Health and Chemical Dependency structure. Under the guidance of our Clinical Psychologist and with input from the King County Behavioral Health and Recovery Division, Department of Community and Health Services, JJAT has developed an integrated Behavioral Health Assessment Tool and programmatic approach to completing assessments and evaluations for referred youth. This tool and approach will look at the clinical needs of the whole child, provide diagnoses where appropriate, and make recommendations that will address the complete Behavioral Health needs of the young person. This approach will assist youth from initial screening, through assessment, referral to services and ongoing clinical oversight to assure that the youth is receiving the necessary services. Serving as a support to the youth, family, the court and the community based agencies, our clinician will provide this additional service to further ensure progress in treatment, family preservation, and compliance with court requirements. At a time when the availability of in-patient Substance Use Disorder resources has decreased significantly, the court is seeing an increase in the number of Opioid Use Disorders and Amphetamine Use Disorders among the youth referred for evaluation and assessment. While some of these youth may benefit from enhanced Juvenile Drug Court Services, not all youth are able to participate in these services. From a Behavioral Health approach to these issues, it is difficult to address the comprehensive needs of the youth and family from a standard Juvenile Court Services approach. These youth need the additional clinical oversight to ensure success, enhancements and fine tuning to clinical case plans when needed, and additional clinical support to increase familial involvement and ultimately a successful treatment experience. JJAT has seen an increase in the number of referrals for youth involved in Truancy actions in the court. While some may believe that any youth involved in the Juvenile Justice System is beyond the scope of preventions services, it is our experience that these youth, as well as those involved in At Risk Youth petitions, are in a particularly vulnerable position to become involved in the well-publicized "School to Prison Pipeline," in which youth rapidly progress from school failures to criminal activities, often with lifelong consequences. JJAT intervention, with Behavioral Health recommendations at this stage may serve to reduce the causes behind truant behavior and familial dysfunction and prevent further Juvenile Justice

System involvement. A reduction in funding for the Juvenile Justice Assessment Team will have a direct impact on staff and resources that will hinder JJAT's ability to provide the scope of these necessary services. Our proposed programmatic enhancements cannot effectively be implemented absent the funding for these services. A reduction of over $63,000 from our current funding level will decrease our ability to provide the kind of cross-disciplinary approach mandated through Behavioral Health Integration. Please consider fully funding the Juvenile Justice Assessment Team at its requested budget levels.

Name: Mike Heinisch

Organization: Kent Youth and Family Services

Comment: Thank you for the opportunity to provide public comment on the initial draft funding and programmatic recommendations. And for the vast amount of work, by staff, stakeholders, the public, and many, many others to move the MIDD Review and Renewal Process leading to MIDD II along to this point. My comments follow. The MIDD II Funding and Programmatic Focus Areas" and "Key MIDD II Assumptions" capture well the community voices and priorities as well as the current environment, 2016 v. 2008, as the County embarks on MIDD II. I am particularly pleased to see the inclusion of "upstream prevention and diversion activities;" "treatment on demand;" "community driving grants processes so geographic and culturally diverse communities can customize behavioral health services for their unique needs." The overarching MIDD ii framework "Strategies" that seems to be well designed to implement to the extent MIDD II resources are available those focus areas. I would encourage a cautious approach to the MIDD II assumptions that "leveraged Medicaid replaces MIDD funding…" Previous such assumptions with the implementation of federal ACA and Washington healthplanfinder Exchange were overly optimist, particularly for SUD leveraged Medicaid treatment, and has led to continuing extensive financial stress, if not actual continuing crisis, in the publicly funded SUD treatment services and providers. Even with the recognition of needing to get the leverage Medicaid assumptions "right is so important" that KC has engaged a consulting firm to review, be very cautious and very conservative with these assumptions. They can always be revised should they prove to be wrong in a favorable direction for the County and the providers and clients access to services. It will no doubt be much more difficult if not impossible should the assumptions prove to be wrong in an unfavorable direction however. On the "Initial Draft MIDD II Funding Programmatic Recommendations: Overall it appears to me that more thought needs to be given to which MIDD II Framework Strategies each MIDD II Initiative Title is best placed. This is particularly true for the "Systems Improvement" Framework Strategy MIDD ii Initiatives listed under Systems Improvement. I am very pleased to see the New Zero Suicide Initiative Pilot. Very timely with the continuing population (demographic) wide escalations in suicide attempts/completions. The New Youth and Young Adult Homelessness I would hope will work in close coordination with BSK's Youth and Youth Adult and Families Homelessness Initiative. Also I would like to see consideration of a significant proposed budget increase for the initiative title. Fully endorse the New Law Enforcement Assisted Division (LEAD) into MIDD II. I would hope that LEAD efforts will be extended to none hot spots throughout the County, particularly of course here in SKC. New Behavioral Health Urgent Care-Walk In Clinic, while I am supportive I would encourage a clear and distinct differentiation between the MIDD II Initiative (and MIDD I Strategy) Next Day Appointments. "NDA's", long a feature of the mental health center system, understandably are agency based and have always been a valued immediate crisis intervention/prevention. The should remain so and be a very important part of MIDD II. Seemly be cautious to differentiate between this New Urgent Care-Walk In and NDA's. Fully support New Family Intervention Restorative Services – FIRS. What has been developed with MIDD II fund balance funding

(as well as the long existing “Step Up” Program) has proven to be a very successful intervention with these youth who are violent towards a family member. Fully support New Youth Mental Health Alternative to Secure Detention. So many of these Alternatives to Secure Detention efforts were originally implemented and demonstrated early positive results after the adoption of JJOMP in the late 1990s/early 2000s and then abandoned due to budget constraints. We are well past time ASD’s should be restored as a proven effective part of the services system. I have some concerns and urge careful consideration of MIDD II Initiative Titles: Housing Capital and Rental, New Rapid Rehousing-Oxford House Model, Housing Vouchers for Adult Drug Court. Coordinate closely with All Home on these, if eventually implemented. My caution, particular with making MIDD II (or MIDD I initially for that matter) is that there are significant other “pots” for access to capital for housing, albeit not enough for the need being experience in the Crisis of Homelessness” in King County. I am not in favor of MIDD being looked to repeatedly for access to capital for housing. Fully support New Recovery Café. I realize that it may appear unusual or otherwise bias/favoritism to one particular agency. However Recovery Café has proven itself with complex chronically mentally ill and SUD individuals well deserving of being called out as a MIDD II Initiative. New South County Crisis Diversion Services/Center would be a huge benefit to all MH/SUD involved systems and providers in SKC. From first responders through treatment providers, schools, family members, etc. of individuals in crisis as a preventative and pre-full blown crisis. Similar to my comments on the New Behavioral Health Urgent Care-Walk in Clinic Pilot, I urge clear differentiation between the SKC Crisis Diversion Center and the Urgent Care-Walk in. I would not want, nor would any of us in SKC I trust, a dilution of the SKC Crisis Diversion Center simply because there is a (perceived duplication of services) with the Walk in Center. Supportive of the New Behavioral Health Services in Rural King County Initiative. Thank you, on behalf of SKC unincorporated residents for its inclusion. Thank you again for the opportunity to comment. Continue the fine work on the MIDD II processes.

Name: Judge Lisa O'Toole

Organization: King County District Court

Comment: Dear MIDD Oversight Group, I am a Judge in King County District Court, East Division. I am writing to urge King County to allocate MIDD funding to combat the drastic increase in heroin addiction that we see here in King County. The number of defendants that we see in District Court who are heroin addicts is truly staggering. Each and every week here in Redmond I see dozens of defendants who are heroin addicts. One of the remarkable things about this is that not only do I see defendants charged with crimes that one might expect of a heroin addict, such as Driving Under the Influence (of heroin) or Possession of Drug Paraphernalia, but I also see defendants charged with other crimes such as theft and assault, including domestic violence. So very often the genesis of the criminal activity is the addiction. Many of the people in the criminal justice system who are heroin addicts are indigent and without stable housing. Without stable housing it is nearly impossible for these individuals to participate in, and be successful in, substance use disorder treatment. I urge King County to use MIDD funding to prevent further needless deaths due to heroin overdoses and to combat increasing risks to public safety. Ideally, a criminal justice diversion program in District Court would help defendants to address legal issues while engaging in treatment arranged through the program and while living in stable housing arranged through the diversion program. I realize that such a diversion program would be an expensive proposition, however. At a minimum, I urge King County to use MIDD funding to develop programs that will provide treatment and housing options for defendants in the District and Municipal courts. Thank you for your consideration. Judge Lisa O’Toole

Name: Sue Shaw

Organization: King County Advisory Council on Aging & Disability Services

Comment: Please excuse my earlier blank submission. I am writing in support of increased funding for the Geriatric Regional Assessment Team(GRAT). As the homeless population grows and ages, it is critically important that the mental health needs of older adults are able to be met immediately. It is totally unacceptable for our elders in King County to spend one night without shelter. We must fund the GRAT program at a level that allows immediate response to a mental health crisis among our aged in order to avoid that possibility.

Name: Diana Forman

Organization: None

Comment: I am writing in support of including Recovery Cafe in the MIDD Tax Levy, which will be considered for renewal in November. As an organization founded to help those living on the margins of society, Recovery Cafe is a key member of the "Reentry and Recovery" strategy area being consider for funding. The Cafe not only provides meals to those who are struggling with homelessness and addiction but helps them find a path to recovery, self-respect, and stability. The program has won three community and State awards for its work and has become a nationally-recognized model for other communities working to end the cycle of addiction, suffering, and despair. Over the years I have been impressed and moved by the stories of Recovery Cafe members who credit the cafe with leading them to recovery and supporting their determination to remain drug-free and able to believe in themselves once again. This is a program that benefits both the recipients of the effective on-going support the Cafe and its many programs provide and the greater Seattle community as a whole. I sincerely hope that the Cafe and its remarkable leadership and staff will be selected to continue and expand their life changing work by receiving funding as part of the MIDD Tax Levy. All the best, Diana Forman, Seattle

Name: Kathleen Southwick

Organization: Crisis Clinic

Comment: On behalf of Crisis Clinic, I want to extend our thanks to Kelli Carroll and her team for such a great job on shepherding this process and conducting the extensive community outreach. It gives us confidence in the recommendations made! Overall, I think the recommendations were very good and build on the success of many existing programs. I understand that some new elements may be added to existing programs, but it is difficult to tell from the just the titles so I hope there will be time for more comment when the service improvement plans are developed. In particular, Crisis Clinic supports these new initiatives: PRI-VI: New Zero Suicide Initiative. We are highly supportive of this new initiative and gave suggestions for program elements that we hope will be included. Our 24-Hour Crisis Line received more than 5,000 calls last year from people seriously considering suicide so we know this is an important public health issue and we applaud the county for taking a community-wide approach to building systems and supports to address this issue. We are especially excited about the plans to provide immediate follow-up support to people discharged from the hospital after a suicide attempt. This is the most vulnerable time for people and they are at a high risk for re-attempting. We have proposed a

telephone-based follow up service, along with a on-going support group , both are evidence-based practices which have shown to be highly effective in reducing a future attempt. CD-IV New South County Crisis Diversion Services/Center & SI-X New Behavioral Health Services in Rural King County. We know from the calls we receive on the 24-Hour Crisis Line and King County 211 that there is a tremendous need for more services in south, southeast and rural King County. We are glad that MIDD is making this a priority. I want to address a gap in the continuum of behavioral health services that was not selected as a priority, but which is foundational to the success of the clients receiving these services. Stabilizing and Expanding Access to Community Services: King County 211 Each of the programs recommended for continued or new funding in some way depends on the effectiveness of King County 211, yet there has been no funding to help support this service through the behavioral health system. MIDD funding would provide an opportunity to remedy that. King County 211 is the county's comprehensive information and referral call center. It also maintains the database of all the health, behavioral health and community services in King County. This is the database that case managers, ED social workers, educators, court personnel, and public safety officials depend on when they are seeking resources for their clients. For example, in April, the King County District Court judges asked for a presentation on 211 because they recognized that many of those appearing before them are there because of crimes related to their poverty, mental illness and lack of housing and basic needs service. They wanted to learn more so they could refer those appearing before them to 211 to get help. The characteristics and needs of those with behavioral health/criminal justice challenges fit the profile/needs of 211 callers. Many probably already use 211 services. Addressing mental health/substance use disorders is significantly easier if the person has stable housing, food, transportation, training/employment. King County 211 helps them create a solid foundation from which to address their health concerns. A few of the specialized human services systems fund 211 as a key entry point to their array of services including rental assistance, family homelessness, and civil legal assistance, the new Community Living Connections program (aging and disability services) But the health/behavioral health system does not provide funding to the 211 system and this is a significant gap in our funding mix, especially since Medicaid clients are likely high users of 211. Even DCHS provides only minimal funding through the Vets and Human Services Levy. The 211 system is at serious risk and needs investments from MIDD, BSK and the Vet and Human Services Levy. When the County had general fund monies, 211 received $100,000 annually and we would like to see MIDD fund 211 at that level. King County 211 is the 911 of the health, behavioral health and human services and it is important that the County invest to assure it can continue to support the rest of the programs/providers funded by MIDD. Thank you

Name: Jimmy Hung

Organization: King County Prosecutor's Office

Comment: The Family Intervention and Restorative Services (FIRS) needs to be fully funded. Currently the draft MIDD II recommendation only funds 57% of what is needed and provides zero funding for operations of a 24/7 respite center. The pilot FIRS respite center will open on July 1, 2016 as a result of a one time contribution from the City of Seattle. The respite center model is a non-secure 24/7 receiving facility that eliminates the need for detention bookings on the majority of family violence cases. This model allows flexibility for families to receive respite services that are not tied to the criminal justice system and will greatly reduce booking and formal charging. The respite center will provide a welcome resource for law enforcement as many youth who do not meet the stringent detention intake criteria are turned away and law enforcement is forced to make the difficult decision to leave the violent offender in the home with his/her victim. This often results in subsequent 911 calls for help that strain

emergency services. Without this respite center we will return to the ineffective and harmful practice of booking these youth into juvenile detention. FIRS is not a concept or an idea. It is presently a fully functioning program that is providing immediate services to youth and families in crisis and it is serving as a beacon for juvenile justice reform. It is a partnership between the courts/prosecutors/defense/probation/law-enforcement/community that has never been seen in King County. It is a program that bucks the county's reputation as an entity that just likes to talk a big game, but takes no action. A failure to fully fund FIRS will do more damage than simply being further evidence of county government's inability to act. Failing to fully fund FIRS will harm youth and families, and will make our communities less safe.

Name: Mike Graham-Squire

Organization: Neighborhood House

Comment: One thing that is working and a gap that I do not see addressed in the summary of recommendations is that we have successful prevention coalitions in that provide early intervention and prevention services however these coalitions currently only serve a handful of communities and the funding provided does not cover the full costs of providing the service. These types of coalitions are proven effective through the communities that care model, Drug Free Communities Program, and CPWI. King County should use MIDD funds to expand these coalitions to additional communities in King County and use MIDD funds to cover the cash match and indirect costs required to run these coalitions that are currently not paid for by state or county dollars. This funding gap has prevented King County from being able to start new coalitions and threatens the sustainability of existing ones. A small investment in this area can leverage 7 state dollars for every 1 dollar invested by MIDD funding as well as have a long term return on investment by preventing future addiction and delinquent behavior.

Name: John Ciochon

Organization: None

Comment: The Recovery Cafe should be needs to be included in the MIDD. The Cafe is a vital part of mental health recovery in greater Seattle area.

Name: Angela Heald

Organization: Asian Counseling and Referral Service

Comment: The are a lot of great programs/funding recommended. Crisis Diversion initiatives 1,2,4,7,8 seem especially important, as do housing supports in RR-2,4,5. I am concerned however about the significant cut to CIT funding given that SPD and other first responders play such a crucial role in diverting consumers to appropriate services and away from the criminal justice system. Without proper training this has potential to create tragic situations (as it has in the past). It is great that the proposal includes funding PRI-7 to essentially create community first responders. A few other areas of concern to me are the cut to GRAT given the rapid increase in the elderly population and the high likelihood of increased need for their services; the cut to supported employment programming given that meaningful work is important for recovery; and the amount available for non-Medicaid funding of MH given that the

current funding level is very quickly exhausted given the high level of need for these consumers. Finally, I'd like to comment that in community mental health we struggle constantly with funding training to create good providers but lose most of the investment as they move on to better positions. The funding of caseload reduction and workforce development is crucial in this perpetual struggle.

Name: Cathy Callans

Organization: None

Comment: I would like to recommend that the Recovery café be a recipient of some of these funds. I worked as an intern there for two years and now that I am a licensed mental health counselor, I continue to recommend the café to many of my clients. The mission of the café fills a need in the city that is not met by any other agency in the same way. It truly is a school of "transformation" and works hard to move people along on their journeys back to recovery and independence and healing. They offer their members a "hand up" as opposed to a "hand out" which I believe instills a sense of self efficacy, self-respect and dignity that is hard to find in other organizations helping this same population. They promote kinship there like no other place I have worked. It provides a community of loving caring individuals who are all working together to enhance the lives of one another.

Name: Ann Allen

Organization: None

Comment: Surprised how little the public comment was taken into account on this draft. Seems like re-funding existing programs rather than looking to expand successful programs, or decrease funding to non- successful programs was a consideration.

Name: Mary Katherine Byrd

Organization: None

Comment: I am writing to support the funding of Recovery Cafe. I cannot thank Killian and Recovery Cafe's staff enough for what they do. Recovery Cafe is so valuable in part because there is no other place like it, and I found that it helped to support the other services available for me when I was recovering from addiction, mental illness, homelessness and trauma.

Name: Denise Rhiner

Organization: None

Comment: I urge you to include Recovery Cafe in MIDD II funding. This organization has made a phenomenal difference in the lives of people who are struggling with addiction and homelessness. Theirs is a model that works. At the core, it works on healing the trauma that is the cause of addiction and homelessness and helping people find their dignity, self-respect, and self-power. Many organizations and programs treat a symptom. Recovery Cafe is presenting a cure, one that ripples out

from the people it serves. Please support what works and makes a -sustainable- difference in people's lives.

Name: Brett Gurzick

Organization: DSHS

Comment: I would like to express my sincere gratitude for the Geriatric Regional Assessment Team (GRAT) and convey by public comment that the importance of this highly-skilled and highly-motivated team has had an immeasurable influence on service access and protective services for those suffering from mental illness, as well as the elderly. Their work is a challenging, necessary service and we are very fortunate to have them in the King County region. I sincerely hope that the Geriatric Regional Assessment Team is allocated the funds they need to continue or advance the irreplaceable public service that they provide.

Name: Ben Curtis

Organization: None

Comment: Please consider funding for Recovery Café and the brilliant work that they do in providing a safe community for folks to come together on their journeys. Thank you.

Name: Elizabeth Miller

Organization: None

Comment: My comment is pertaining to the allocation of resources. I am not in the profession of recovery, however I have understanding and have witnessed the methods that impact positively on this challenged community. The Recovery Cafe provides a pivotal need in the mental health community, a sober and healing place of refuge. The percentages of people who Recover from the disease of addiction is abysmal. However, the availability of a community of addicts in recovery increases the chances of recovery exponentially. The Recovery Cafe provides this necessary component and keeps the me mentally ill and those suffering with disease off the streets and communing with abusers. Please grant to this remarkable organization. Thank you.

Name: Rev. Rick Reynolds

Organization: Operation Nightwatch

Comment: I am writing in support of the Recovery Cafe in Seattle. This organization is a valuable partner in the community for our homeless clients who are recovering from chemical dependency disorders. They provide a much-needed service to the community and work well with other programs. They are well-managed, and well-integrated into the broader community.

Name: Leslie Yamada

Organization: Recovery Cafe

Comment: I volunteer at the Recovery Cafe and am always moved by the embracing, supportive , non judgmental atmosphere that pervades the cafe. it provides its members, not only with lunch and dinner, but with a place to be accepted as a fellow human being. All to often, for those who suffer from mental illness and/or addictions the rest of society ignores them as if they do not exist. The Recovery Cafe helps them realize that they do count and can be active in their own lives and a part of their own recovery. Please continue funding the Cafe and other entities that provide important services for this portion of our population.

Name: Randy Brothers

Organization: University Presbyterian Church

Comment: I am a ministry director at University Presbyterian Church. I have helped coordinate young people and adults to experience Recovery Cafe, learn about it's mission, and get involved. I have not only been consistently impressed with it's proven effectiveness, but also it's exceptional quality. Recovery Cafe aligns well with the goals of MIDD II. It leverages many resources into results and is an asset for our community.

Name: Mary Ellen Stone

Organization: KCSARC

Comment: I am pleased to see sexual assault therapy is continued in the MIDD II plan. Community sexual assault programs provide holistic trauma informed services including mental health treatment to victims and their families. Both the holistic venue and specialized treatment are essential to the positive outcomes our agencies produce. With trauma informed mental health treatment, victims are able to reduce their debilitating symptoms and live productive lives.

Name: Ivetta Scott

Organization: HCS-APS

Comment: as an APS investigator, who works with many elderly, who has dementia or could have dementia, I truly appreciate and need GRAT help.

Name: Sylvia Burges

Organization: None

Comment: I strongly support including Recovery Café in the “Reentry and Recovery” strategy area and providing ample funding for the Café.

Name: Molly Kimble

Organization: None

Comment: Please include Recovery Cafe in your program allocations. It is a very effective organization I have personally sponsored for years.

Name: Michelle Bunn

Organization: None

Comment: I believe providing support to The Recovery Cafe will in the end be a cost saving proposition. All one needs to do is travel around the city to see how desperate the need is for these kinds of services.

Name: Brad Harris

Organization: None

Comment: My wife and I have been supporters of the Recovery Cafe for the last seven years. I feel that it provides excellent outreach and assistance in an area that is so critical in the Seattle area. I would strongly urge continued support for the fine work that this group is doing to improve our city. Brad Harris

Name: Victoria Bozzacco

Organization: None

Comment: As an RN, I used GRAT team in an Adult Day Health setting. Their service is a great resource and support to health care providers/caregivers in assessing and managing mental health issues.

Name: David Ketola

Organization: None

Comment: I recommend that Recovery Cafe be funded as part of the Reentry and Recovery" strategy. Myself and many others have experienced the Recovery Cafe as a place of hope, healing and life transformation. Please consider my support for funding to go towards the Recovery Cafe. Thank you so much

Name: Angela Bultemeier

Organization: None

Comment: I fully support the MIDD program and budget and urge you to include the Recovery Cafe in designating budget funding. The Recovery Cafe is a vital source of healing and recovery in building our community. Thank you.

Name: Lynn Poser

Organization: None

Comment: Please include Recovery Cafe in the budget for MIDD funding.

Name: Kathryn Collins

Organization: Christ Our Hope Parish

Comment: We are gateful for your support of the amazing work of the Recovery Cafe, and hope that this continues to be well-funded.

Name: Nathaniel Muller

Organization: None

Comment: I would like to see Recovery Cafe included in the funding.

Name: Cui Openshaw

Organization: None

Comment: I highly recommend recovery cafe. They have been doing a great job. Also the funding should go to organization that help people finding job. Finding the jobs will help them become more independent. It is a win win situation. Corporation should be able get a tax credit if they hire people with disabilities, mental health, drug addiction or alcohol related issues. Building the bridge for employment will be a win win for those people and to the society as a whole.

Name: Laurie Mallett

Organization: None

Comment: As someone very familiar with the benefits of recovery, I urge you to support the Recovery Cafe at every level possible---particularly the financial.

Name: Mishelle Wentz

Organization: TAM WA chapter

Comment: It is imperative that this be made apart of the funding so many people don't want to live as an addict however they got there at some point it's not a fun thing is becomes an illness that is out of control. Myself, I have great insurance and have money to put down for my son....he can get a bed asap and go any place for treatment. My sister on the other hand, has WA. Basic health and is told she has to wait their not sure when help will be available? This is all too common and its appalling!!!!!!

Name: Christa Palmberg

Organization: None

Comment: Please include funding for Recovery Cafe. My family and I have been supporters of the cafe for years. Their work is tremendous. It's transformative for the members who receive services (and find a community!) and it promotes public health and safety.

Name: Liz Hunter

Organization: None

Comment: Please include Recovery Cafe in the MIDD. Recovery Cafe offers a unique supportive community for those who desperately need it. Our community cannot afford to lose this valuable resource.

Name: Jamie T. Shilling

Organization: 1953

Comment: Please include Recovery Cafe in the new MIDD budget. Thank you! Jamie Shilling

Name: Kate Maughan

Organization: None

Comment: I am writing in support of the Recovery Cafe. An amazing group of people helping to provide a place of hope, healing and life transformation for those in need. They do a tremendous job collaborating and partnering with individuals and other organizations that can help assist in their mission in serving their clientele. The "program" is so successful it is being modeled by other cities throughout the country. The Recovery Cafe is most deserving of funding in the "Reentry and Recovery" strategy area. Thank you.

Name: Ed Phippen

Organization: None

Comment: Please include the Recovery Cafe in the MIDD. They provide an important refuge for folks seeking addiction services.

Name: Katy Willis

Organization: None

Comment: I support Recovery Café being included in the MIDD. Recovery Café's inclusion in the MIDD is a critical part of their strategy to ensure that they can continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Madeline Condon

Organization: None

Comment: Recovery Cafe is an amazing organization

Name: Barbara Guzzo

Organization: None

Comment: I would ask that you provide funding for The Recovery Café. The work they do with regarding recovery and reentry is truly amazing. They continue to help countless numbers of women and men who suffer mightily addiction, mental illness, and the related issues (i.e. homelessness). Thank you for your consideration.

Name: Kelly Hickman

Organization: Archdiocese of Seattle

Comment: Please include Recovery Café the MIDD, thank you!

Name: Monica Wood

Organization: None

Comment: Thank you for the good work you do. I am writing to put in a strong word for Recovery Cafe. Everything I know about this place, the staff, members of the community has impressed me. I helped teach a couple of classes there and was touched by the sincerity of the members to grow and change and approach their recovery with integrity and the general sense of compassion, accountability and effectiveness. There seems to be something magical going on there ... and whatever the magic is, it works!! I hope you will continue to include Recovery Cafe in your funding program.

Name: Judith Ryan, SNJM

Organization: St. James Cathedral

Comment: I strongly support including the Recovery Cafe in the MIDD funding. Their wholistic program of empowering individuals in recovery through the support of Community has great success.

Name: Julie Callahan

Organization: The Food Bank @ St. Mary's

Comment: I'm very familiar with the many ways that Recovery Café helps people with broken lives--to pick themselves up and become whole again--so they can become productive members of our community again. This wonderful organization has depended greatly on the past resources they've received from MIDD II Funding. I strongly recommend Recovery Café's inclusion in MIDDII Funding and Programmatic Recommendations. These funds have been, and hopefully will continue to be, a critical part of their strategy to ensure that Recovery Café can continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Ken Kierstead

Organization: None

Comment: I'm writing to advocate particularly for the Recovery Café as a critical resource for recovery care, and effective community re-entry for those who suffer addictions. Recovery Cafe's unique presence and services were affirmed in the community surveys and are critical to continue in the next round of program funding.

Name: Sharon Callahan

Organization: None

Comment: Please include the Recovery Cafe in the funding list for the MIDD II Funding and Programmatic Recommendations. As a supporter of this innovative work for the better good of all, I think the model this institution/ organization employs is one that many could benefit from learning.

Name: Judy Lightfoot

Organization: None

Comment: I strongly support ensuring that Recovery Cafe receives the resources it needs to continue its excellent Reentry and Recovery work in the County.

Name: Barry Eben, Ph.D.

Organization: Retired

Comment: I am a recently retired clinical psychologist. While working at Cornish College of the arts, I referred several students to Recovery Cafe. These students reported substantial benefit from participating in that community, benefit that was clearly apparent in my contacts with them. I urge you to be generous in your support of recovery café, in that it provides a unique and effective atmosphere for people struggling with addiction problems. Barry Eben, Ph.D.

Name: Anne Potter

Organization: None

Comment: I strongly urge you to include the Recovery Café in this program. They do remarkable work in supporting individuals who want to make a change in their lifestyle, providing ongoing assistance with maintaining a clean and sober life. The staff and volunteers are marvelous, helpful and caring.

Name: Krista Harris

Organization: Private citizen

Comment: The Recovery Café is an amazing success story, helping homeless and addicted people be in relationship with caring RC staff and volunteers who help them turn their lives around. The RC is committed to fostering change through relationships, personal support, social services, addiction recovery, and life and job training skills. The programs at RC WORK! The RC model has inspired similar programs in other cities and in other countries. My husband and I have been making annual pledges to RC for seven years. RC is a model of hope. This is a very important and successful Recovery and Reentry program. I STRONGLY SUPPORT its being included in the MIDD II budget so it can continue to help many more people heal and recover from addiction and homelessness in the future.

Name: Alysse Bryson

Organization: None

Comment: Please consider adding Recovery Café to the budget allocations from the MIDD II program. They are doing significant work here in Seattle and it would be amazing to see them grow into multiple locations.

Name: Ann Sakaguchi

Organization: None

Comment: The services provided by the Recovery Cafe are critical for those in recovery and those afflicted with mental health challenges. Please retain funding for the Recovery Cafe in your plan.

Name: Christie Lynk

Organization: None

Comment: I heartly endorse Recovery Cafe for their stunning work in recovery and addition. I volunteered for them and have sent numerous people their way - both as clients and staff. Please support them through the funding available.

Name: Sep and Rita Egrari

Organization: None

Comment: thank you for this important funding. We wanted to voice our support for your funding for Recovery Cafe - we have seen time and again the effectiveness of this recovery model in sustainable, long term healing of community members struggling with addiction/mental health/homelessness. we feel it is cost effective and deeply needed. We need more of this model.

Name: Beth Morgan

Organization: None

Comment: Please include the Recovery Cafe in MIDD. The organization does amazing work by providing a loving community and skills that will help sustain long term recovery from addiction.

Name: Cheryl Berenson RN, MS, MPH

Organization: King County Medical Reserve Corps; NCJW WA State Policy Advocate

Comment: Please include the Recovery Cafe in your funding stream. The Cafe has a unique and successful program for people in recovery in our communities. I am a part of a KC nursing project and do foot care, health screening and referral at the Recovery Cafe once a month. They are a critical organization for those patients who are looking to stay sober! thank you, Cheryl Berenson RN, MS, MPH

Name: Anne Mohundro

Organization: None

Comment: I strongly support the inclusion and funding of the Recovery Cafe. I have been a volunteer once a week there for three years, and have witnessed first hand the incredible help the Cafe provides to those living with mental illness and the many related difficulties they face. The Cafe provides community and normalcy for all its members.

Name: Anna Jenkins

Organization: None

Comment: I want you to continue to support the Recovery Cafe in Seattle. The work it does helps so many people in so many ways!

Name: Chuck Pecka

Organization: None

Comment: Recovery Cafe - I would like to add my voice in support of the services provided by Recovery Cafe. I have seen the incredibly positive impact the Recovery Cafe has had on the lives of its members and the community. I urge King County to continue supporting the Recovery Cafe and the great work they do for individuals in our community that need recovery support and services.

Name: Melisa Barbera

Organization: None

Comment: Please include Recovery Café has in MIDD II in the "Reentry and Recovery" strategy area to receive funding.

Name: Leah

Organization: None

Comment: It is vital that older adult continue to be supported through the use of MIDD II funding, specifically the GRAT program. There is no other available crisis outreach program that specializes in older adult issues. The older adult population is quickly growing in King County and the need for appropriate evaluation and assessment is necessary. Please ensure funding is available to GRAT for continued service provision and growth to accommodate the ongoing needs of our seniors.

Name: Katherine McIntyre

Organization: None

Comment: Please support the Recovery Cafe, it's changed the lives of so many people I know in a positive way.

Name: Donna Tucker

Organization: King County District Court

Comment: Considering the MIDD Policy Goal 1 and 2 to reduce the number of mentally ill and chemically dependent people using costly interventions such as jail and further considering the current opiate crisis along with the highest property crime rates in the nation – it is difficult to understand why there is no recommendation to expand therapeutic courts in King County. The King County Executive's commitment to the people of King County is to invest in what works and to apply proven approaches that produce remarkable results. Studies of therapeutic community courts at the San Francisco Community Justice Center, at the Neighborhood Justice Center in Yarra, Melbourne Australia, and the Red Hook Community Justice Center in New York are all showing successful results. The National Institute on Drug Abuse revised report from April 2014 on the Principles of Drug Abuse Treatment for

the Criminal Justice Populations provides a research-based guide in providing effective treatment for offenders suffering from chemical dependence and/or mental health conditions. The research shows that a large percentage of those admitted to drug abuse treatment cite legal pressure as an important reason for seeking treatment. Most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Individuals under legal pressure also tend to have higher attendance rates and remain in treatment for longer periods, which can also have a positive impact on treatment outcomes. A local treatment educator explained that "forced treatment" does work because dealing with addiction in treatment will ultimately require the individual to deal with really difficult areas in their lives and when entering into treatment without an 'outside force', like the courts or threat of criminal conviction, it is much easier to abandon treatment and walk away. Therapeutic community courts provide not only the incentive but also the guidance and support system needed for drug addicted and mentally ill individuals who are committing crimes to address their underlying issues. Unfortunately, in King County there are many individuals in the criminal justice system with untreated addictions/mental illness who have engaged in misdemeanor and gross misdemeanor criminal activity, while under the influence and/or done to support the addiction. These criminal activities put others in the community at risk for harm to persons or property. For way too long, the only response available has been the use of jail with very little resources to provide real help to address the underlying problems to the criminal behavior. MIDD funding has the ability to recognize this reality and make a change by supporting and/or expanding the existing therapeutic courts and reaching more of those in desperate need, though the development of a therapeutic community court with the King County District Court.

Name: Mary Pat Osterhaus

Organization: None

Comment: Recovery Cafe in Seattle has become an intergral player in the effort to form community with, and support for, indivduals struggling with mental health and addiction. Recovery Cafe is a vital part of providing care, services, and support for recovery to at risk individuals in our community. Please fund the efforts they are making.

Name: Ariel Duncan

Organization: None

Comment: Recovery Cafe provides a valuable resource to our community as a whole, particularly members struggling with mental health issues. Please continue to include their work in your funding. They do their work with such excellence!

Name: Robin Lorenzini

Organization: None

Comment: I highly recommend Recovery Cafe!

Name: Mary Case

Organization: None

Comment: I strongly recommend that Recovery Cafe be funded through MIDD 11. It is a unique organizations that offers safe environment and the opportunity to stay sober while giving the opportunity to better each person's life. No other program does this in quite the same way.

Name: Anne Frantilla

Organization: None

Comment: I am writing in support of the Recovery and Reentry Briefing Paper for Recovery Cafe, B 91, B92. As a long-time volunteer at Recovery Cafe, I can attest to the value of this loving community, meeting people "where they are." Not everyone who comes through leaves in a better place, but for someone who is ready to improve their life, the Cafe offers the best wholistic model I have seen for providing support. I help out with a writing class where people find their "lost" voices and heal through words. I run with the running club, "Sole Train," and hear people attest to how this healthy activity has helped them eat better, calm the voices in their head, and just help them feel better all around. The Cafe addresses a population that has exhausted or never had the support of family and friends. When there is no place else to go, people can come to the Cafe and find immeidate loving care. Health food, a Circle that helps them be accountable, and access to meditation, art, writing classes and more that help heal the whole body, not just "fix" a temporary problem. Members travel long distances to come to the Cafe. As housing gets more expensive and transitional housing fills up, this type of resources in other places (south King County especially) is essential. Please fund Recovery Cafe.

Name: Michelle Dillon

Organization: None

Comment: Please ensure that funding for Recovery Cafe is sustained in the allocation decision for the MIDD tax levy. This organization provides daily stability in the lives of hundreds of individuals in the Seattle Metro area who need assistance during the recovery process. As a volunteer, I see their work in action every day firsthand. Recovery Cafe manages an irreplaceable system of services (daily hot meals, spiritual support in every capacity, and references for additional services) to ensure that our most vulnerable citizens meet and exceed their personal goals for recovery. Without funding from this levy, Recovery Cafe will be less equipped to provide these extraordinary services and community connections every week.

Name: Alexis Nelson

Organization: None

Comment: I have been involved with Recovery Cafe for over 10 years as a staff member and volunteer and, knowing its important work in the Seattle community, urge policymakers to designate funding to the organization as part of the MIDD. Recovery is the cornerstone of healthy communities and needs to be funded alongside effective housing, mental health, medical, and workforce programs. As

stakeholders are aware, drug addiction has significantly increased in Seattle and threatens the stability of residents throughout the city. Recovery Cafe has a long-term record of excellence and would be an excellent investment by the city and its taxpayers. Thank you for your consideration. Best, Alexis Nelson

Name: Molly M McCarthy

Organization: None

Comment: Please make sure to include Recovery Cafe. They have the best program in the county for recovery efforts.

Name: Blair Carleton

Organization: None

Comment: Please oh please include Recovery Cafe, and its amazing results that help so many individuals turn around their lives, by including it in MIDD II. You will be so happy you did, I promise!

Name: Richard Israel

Organization: None

Comment: As a taxpayer, I support the MIDD program. I would like to call out Recovery Café as a worthy part of the Re-entry and Recovery strategy.

Name: Kayla Zobel

Organization: None

Comment: I would like to recommend that Recovery Cafe be included in MIDD II. The organization has a shown itself to be a high-impact organization, especially in relation to the recently declared "State of Emergency" regarding homelessness in Seattle.

Name: Lynette Lewis

Organization: None

Comment: Please include the Recovery Cafe

Name: Paul Kilian

Organization: None

Comment: Please include Recovery Cafe in your funding. They do amazing work creating community amongst those who are in most desperate need of it to literally save their lives.

Name: Wendy Rush

Organization: None

Comment: Please maintain funding for the Recovery Cafe in Seattle. They do important, life changing work using a model that prioritizes loving accountability, community support, and compassion. We need this program!

Name: Sheri Zimmerman

Organization: None

Comment: Please continue support and include funds for Recovery Café. Thank you!

Name: Ben Wiselogle

Organization: None

Comment: The Recovery Cafe plays an important part in servicing those working through addiction. The Recovery Café needs to be included in the MIDD.

Name: Donna Thorson

Organization: None

Comment: I have first hand knowledge how effective The Recovery Cafe is at helping people turn their lives around. Please fund this program as it is doing a good job of getting the addicted off the streets and into productive lives. Thank you.

Name: Lara Okoloko

Organization: Caresnw.com

Comment: I hope that robust funding will be included for recovery café. They provide a valuable service for people with addiction and their families. They are a model that offers low barrier services, which is an important need not meet by many organizations.

Name: Kay Bradford

Organization: None

Comment: As a member of the Recovery Café's Young Professionals boards, I've witnessed how the Cafe is central to destigmatizing and building community with those suffering from addiction, mental health issues and homelessness. I'd recommend funding the “Reentry and Recovery” program so that Recovery Café can be beacon of hope for those suffering in our community and for starting the healing process.

Name: Donna Haggarty-Robbins

Organization: None

Comment: Please include funding support for Recovery Cafe in the MIDD. It provides such essential and compassionate service to those in need in our community. There is nothing quite like Recovery Cafe, and they have saved so many lives and returned people to being productive and happy members of our County.

Name: Hugo Cruz-Moro

Organization: None

Comment: Since relocating to Seattle from Miami FL in 2014, we have been supporting the Recovery Cafe as volunteers, contributors, and have taken part in many of the activities offered to members. As an artist and artist educator with what is reffered to as "long term sibriety" I appreciate and support the RC Cafe in its offering the opportunity for those living on the margins of society, but also in its ability to facilitate a venue for people like myself to give back.

Name: Amy Stolov

Organization: Recovery Cafe

Comment: I am a volunteer at the Recovery Cafe. Please continue to fund this organization at the maximum level that you can. I have seen how the Cafe transforms people's life and have been transformed myself by the process. Thank you

Name: Molly Hancock

Organization: FareStart

Comment: I am in strong support of Recovery Café’s inclusion in the MIDD is a critical part of our strategy to ensure that Recovery Café can continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Charles Heffernan

Organization: Dharma Gate Yoga

Comment: Recovery Cafe is fantastic and deserving of full support.

Name: Michele Moore

Organization: None

Comment: I wish to support Recovery Cafe's inclusion in the MIDD Tax Levy.

Name: Laura Little

Organization: None

Comment: Please include Recovery Cafe in the MIDD II tax levy renewal. This is a vital service for so many in our community.

Name: Catherine Endicott

Organization: None

Comment: As a past Recovery Café volunteer and follower of their work since their inception, I can attest to the success of their programs. Their approach ensures full compliance with behavior changing principles, and, they address many root problems of addiction, which helps lessen the impact on homelessness.

Name: Karen Allman

Organization: None

Comment: The continued support for Recovery Cafe is a crucial issue. Recovery Cafe provides support to help people into recovery (and grow into healthy and productive lives). Recovery Cafe is very active and vital in providing a safe place for vulnerable individuals in our community. Funding their efforts is crucial.

Name: Ted Neill

Organization: None

Comment: Please include the Recovery Cafe in the MIDD II budget. The cafe offers incredibly important services to the recovery community. Thanks.

Name: Julie Chandler

Organization: None

Comment: Please consider including Recovery Cafe in the MIDD and allocation a portion of the funding towards this very worthy and well run organization. I have spent many years watching the growth and operation of this center and been amazed at the positive impact that Recovery Cafe has in our Seattle community.. The outreach, assistance and resources that exist at Recovery Cafe is nothing short of amazing. The stories of healing and hope are an inspiration for all. Those struggling with substance abuse and addition have a true home and partner at Recovery Cafe. An allocation of money provided in the MIDD would be so beneficial for this organization and the impact would be substantial and visible. Thank you for considering my request.

Name: Jessica Matthews

Organization: None

Comment: Recovery Café needs this financial support continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Rick Workman

Organization: Lease Crutcher Lewis

Comment: I strongly support the Recovery Cafe' being included in the MIDD based on their exceptional results in improving the lives of so many of our marginalized citizens. As a downtown worker, I have witnessed the dramatic improvements made by the Recovery Cafe'.

Name: Richard Jones

Organization: None

Comment: Please continue public support for Recovery Café and its many important programs. We have too many homeless people in Seattle and many/most of them are homeless due to addiction and other mental health problems. This program makes a difference for this population.

Name: Rev. Colette Mercier

Organization: Amazing Grace Spiritual Center

Comment: I am writing in support of recovery Cafe is inclusion and funding under this appropriation. I have seen firsthand its good work as know that it provides an essential support for those who have made the difficult decision to step onto the path of recovery. I advocate strongly for their inclusion in this funding. There's a welcoming and supportive environment, both physically and in terms of staff and volunteers support, for those who have decided to make this change.

Name: Karina Saunders

Organization: Real Change Homeless Empowerment Program

Comment: Please include Recovery Cafe and Real Change in the MIDD funding!

Name: Joseph Sparacio

Organization: Neighborcare Health

Comment: Neighborcare Health currently operates two program under MIDD I initiatives: 1.g.) Prevention/early intervention mental health and substance abuse services for older adults, and 4.c.) School district based mental health and substance abuse services. This funding has allowed us to provide very specific, focused treatment for older clients as well as population-based strategies in the schools, which can then be complemented by group or individual therapy for those students most in need. We are grateful to the MIDD Oversight Committee for their recognition of the significant, life-saving work being done in these areas and their commitment to include a similar focus in MIDD II funding. As Neighborcare Health continues to refine its behavioral health program to respond to the needs we see in our community, increased access is a continual concern. To that end, we are introducing even further integration of SBIRT, MAT, and brief intervention focused behavioral health into our primary care model, and bringing services to locations such as supportive housing, schools, and our homeless clinic locations. These creative approaches aim to reduce barriers to accessing services and provide care to patients along the entire continuum of need. It is our hope that MIDD II will include flexibility in service provision, such as models other than MHIP, to allow organizations to respond to populations-specific needs more efficiently and effectively.

Name: Ahmed Ali

Organization: Somali Health Board

Comment: Overall, the budget looks fine, however, I think the NEW Community Driven Behavioral Health Grants (SI-IX) should be allocated more funding in providing technical assistance, evaluation and support with community initiated behavioral health programs. I should also point out that due to strong stigma associated with mental/behavioral health within certain ethnic communities, self driven, grassroot efforts such as the Somali Health Board should be given direct access to funding rather than larger organizations that receive findings simply by stating they're culturally competent. Small CBOs with a proven track record of working within the community should be encouraged and financially supported on their work - in order to better serve the community on such needed work. MIDD number SI-IV, peer to peer training is a great model that I see can work really in limited English proficiency communities- it's a pilot, anticipated and hope to see it materialize. I'm also encouraged by the Parent Partners Family Assistance, I'd suggest increasing the funding in that area - $1M, simply because I'm aware of the direct positive impact it has with getting families support their loved and reducing stigmatization.

Name: Abdul Karim Taifour

Organization: None

Comment: Please support services for older adults including GRAT.

Name: Pratima Lakhotia

Organization: None

Comment: Please do not decrease the clubhouse funding of Hero House. It is the only organization in King County that provides a non-clinical way of recovery to mentally ill patients and provides them the ability to get a job. Save Hero House by not decreasing the funding.

Name: Savinay Dangi

Organization: Hero House, Secretary

Comment: Proposed clubhouse funding of $230K for Hero House is 36% reduction from the current budget of 362K. This is extremely low and will make the Hero House in Bellevue unsustainable. Hero House is unique in King County as we are the only organization that provides a non-clinical approach to mental illness recovery and help them get a job. Hero House offers a very diversity rich environment to support the diverse community of King County. Lastly, the proposed decrease of funding for IPS Supported employment will directly impact the ability of recovering patients to get back into employment. We need the funding for Clubhouse and Supported Employment to increase so we can serve more.

Name: Sandy Nisperos

Organization: Asian Counseling and Referral Service

Comment: I support increased $ to MIDD II. AT ACRS we serve the community of non-English speaking Asian/Pacific Islanders who suffer from serious mental illnesses. Many of these people don't have the resources to apply for Medicaid. Due to the MIDD II funding, we can serve this population and get them the services they need such as mental health counseling, medication management , case management.....and more delivered to them in their own Asian language. Please increase the funding for the MIDD II so that we can serve more of the population that needs services. In additon, we help these clients get jobs through our Supported Employment program, so please increase funding for this through the MIDD II.

Name: Deb Lewy

Organization: HERO House

Comment: Hello, Here are my comments on the initial draft MIDD II program and budget recommendations: (1) For clubhouse funding, the county is suggesting $230,000 per year serving 20/30

members per day. This is extremely LOW since at HERO House, we serve this number of members already and our budget for MIDD is currently $362,000 a year. (2) HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a non-clinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program.)3) At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff. (4) For IPS Supported Employment, the county has suggested $950,000 per year. This is $50,000 less than the previous year. In order to expand the IPS program within the county, this shortfall will negatively impact how many individuals we are able to serve. Last year, all 7 IPS programs (including HERO HOUSE) served approximately 1,000 individuals combined in employment. All of the funds were used. The county cannot and should not expect to increase the employment rate among individuals with mental illness by decreasing the funding by $50,0000. Thank you for allowing the feedback and for serving the community of adults who live with mental illness. Deb Lewy President, HERO House Board of Directors

Name: Michelle Vance

Organization: DSHS - APS

Comment: Our main service that we have a close working relationship with is the Geriatric Regional Assessment Team. They have provided excellent services in assessing seniors with a mental health crisis and I feel that this service is essential to APS and the community at whole. Without their assessments, it would be difficult to obtain the information on the cognitive limitations of vulnerable adults and to determine the need for APS to file a guardianship if warranted.

Name: Sue Bunn

Organization: None

Comment: As a geriatric case manager with a masters degree in mental health counseling, I have seen first hand the amazing work done by the GRAT program. It is very clear to me that clients who otherwise would have been hospitalized or a significant threat to themselves or others have been provided stabilizing services not offered by any other program. The GRAT team rocks and should be give a very high funding priority.

Name: Gary Bright

Organization: DSHS/HCS/APS

Comment: I have been an Adult Protective Services worker going into my 16th year, and 10 years in Children's Administration. I have seen a variety of programs come and go over the years with varying results. I wish to give an editorial comment on GRAT and the need to continue this very appropriate program for the King County geriatric population. In contrast to King County, Snohomish County does not have such a program with direct service delivery. Absent GRAT, APS social workers will have to fall

back on RCW 71.05.153 "Emergent detention of persons with mental disorders" to request police to involuntarily take a person to an emergency room for a mental health evaluation. Herein lies the problem: Without good information to show the vulnerable adult is gravely disabled and in a setting impacting their health and welfare, a Mental Health Professional is more likely to release the person after ER contact. GRAT has been extremely helpful networking with APS and other agencies to help establish a need for additional intervention. Early intervention means a cost savings to the immediate medical, long term care and governing health care authorities which provides quality of life to vulnerable adults in King County. Losing GRAT means one less link in the chain of agencies that assist gravely disabled people in need. On my wish list is a request for GRAT to expand their program to include Snohomish County as well. I know, "If wishes were horses, beggars would ride." My wish remains for GRAT to help us here in Snohomish County as well. A case example may help to illustrate: An elderly lady was assigned to me in south King County some years back. There was also an administrative lock on the case. In addition to the extra security required to address the case confidentiality concerns internally, GRAT involvement during this case was extremely helpful as a credible, reliable and relevant source of information gathered from the alleged victim, alleged perpetrator and other non-professional witnesses. GRAT helped with baseline information to provide a positive outcome for this case. The GRAT model is invaluable. As Washington State is one of the top states which heads the nation in quality of care to vulnerable adults, so is King County the model for the rest of this state. Budget constraints aside, there is every reason for GRAT to continue their good work. Please contact me if I can be of further assistance to keep GRAT.

Name: Todd Beller

Organization: None

Comment: I'm glad to participate in this survey. I was employed with the Geriatric Regional Assessment Team from 6/2008 - 6/2013 as their substance abuse specialist. I worked with hundreds of clients impacted with addiction and other co-occuring disorders who would have otherwise not received any support as they were significantly impacted and unable to leave their residence. The GRAT team has a significant impact in the community and offers services for people in crisis as well as clients taking care of people they love (Caregiver support) I implore you to continue this service and continue funding; it's valuable, needed and helps more than you can quantify in a spreadsheet or debate in a legislative session. Thanks, Todd

Name: Kathleen Sullivan, Ph.D.

Organization: Generations with Pride

Comment: The draft shows the work and thoughtfulness of the Advisory Committee and Staff. I would like to again urge you to consider the LGBT senior community. Mental health disparities are compounded with the lack of early detection and prevention programs for this group.

Name: Mark Bernstein

Organization: Aging and Disability Services - Case Management

Comment: The Geriatric Regional Assessment Team is and has been a vital service to our case management program. GRAT's availability, capacity to respond, assess and consult on how to best serve those in our community who find themselves in difficulty and at significant health, physical or emotional risk is a critical part of the continuum of support in helping people in our community.

Name: Amy Sill

Organization: Neighborcare Health

Comment: Very, very helpful resource for our patients! Fred in Seattle is so caring and did all he could to help one of my pts.

Name: Ramona Graham

Organization: Center for Human Services

Comment: MIDD Wraparound should not be reduced because of WISe funding. WISe Programming has requirements and is intensely costly as compared to the MIDD Wraparound. The funding for this program needs to remain the same in order to continue these services to those clients who do not qualify for WISe, but need the support of Wraparound services.

Name: Karen Larsen

Organization: City of Seattle

Comment: GRAT provides excellent mental health assessments for my agency, Aging and Disability Services. Their assessments and expert insight into mental health disabilities give ADS counselors essential information for effective case management. This service cannot be matched. Please, for the sake of the elderly and disabled residents we serve, do not eliminate this important piece of social service care.

Name: Samantha Santor

Organization: City of Seattle HSD, ADS

Comment: I am writing to support continued funding for the GRAT program. We refer to GRAT on a regular basis as they are the only service that goes to see our older/homebound clients in their homes. This is a vital service and many clients will lose access to critical mental health services if funding is cut. Please continue to fund GRAT. The system does not have the capacity to absorb this loss.

Name: Kathi Church

Organization: Aging & Disability Services

Comment: PLEASE PROVIDE FUNDING FOR THE GERIATRIC REGIONAL ASSESSMENT TEAM! (GRAT). GRAT has been invaluable to those of us in the ADS case management program who work with older adult populations, many vulnerable due to cognitive deficits and other mental health issues. GRAT clinicians and their assessments have been critical to inform us and others involved as to options for the client in living independently (or not), what the appropriate services would be given their challenges and strengths, and help inform those at Adult Protective Services when a guardianship is recommended due to capacity issues, etc. If GRAT were to lose funding and were no longer able to serve the clients they do, we at ADS (and our clients) will lose an extremely valuable service.

Name: Rachel Diaz

Organization: Reach

Comment: RE: Treatment on Demand: It's a really great concept but I would like the actual quality of treatment to be addressed. At this point, there really are few treatment options in King County. The one's that exist do not, in general, keep up with best practices as put forth by the federal government. Most treatment facilities are entrenched in only the AA model and that leaves many people out of luck if they do not embrace that model. Many of the providers are rigid in their approaches and clients leave treatment early or relapse immediately. The lack of detox and SUFFICIENT number of days for detox is sorely lacking--many people (alcoholics, opiate users) end up starting treatment while still dealing with post acute withdrawal syndrome and they are not ready to do the hard work. They don't feel better for a good 10 plus days and are half way through treatment by the time their brain really starts to clear. Also, I have yet to hear a client tell me that they worked on coping skills around re-entry to their same housing or living situation. Sorry, but our SU treatment system is quite broken.

Name: Sompasong Keohavong

Organization: ACRS

Comment: I like the proposal. Case load reduction and Non-medicaid PHP funding for behavioral health clients are the two most important issues, I think. This is based on my daily work experience with my clients and my Southeast Asian American community.

Name: Hiede Holmes

Organization: ADS

Comment: I am interested in making certain that the impact that Evergreen's Geriatric Regional Assessment Team be supported in funding. They are often the only contact that vulnerable seniors have available at a time of mental health crisis and their services are invaluable to our case management program in both providing clear assessment of cognitive functioning and also educating and consulting with us on difficult cases. It would be a terrific loss to the community if this service was not to be funded.

Name: Lauren Mirzakhalili

Organization: REACH

Comment: I believe it is absolutely necessary for the city to renew the MIDD program. There are many gaps in our city's services for those experiencing mental illness and/or drug dependency, and I believe there would be serious repercussions if the MIDD program renewal is not put into place.

Name: Alicia Sacko

Organization: DSHS-APS

Comment: Geriatric Regional Assessment Team(GRAT) is a much needed service and should continue to receive funding. The GRAT team is able to evaluate clients quickly and help start services in place for the client. Adult Protective Services uses GRAT services and evaluations on a weekly basis. GRAT is able to reach some of our most vulnerable elderly populations, which would normally not get services.

Name: Christine Illan

Organization: None

Comment: Without the funding for mental health crisis, diversion and recovery support the 10,000+ homeless will continue to grow in King Co.

Name: Tramanh Nguyen

Organization: Asian Counseling and Referral Service

Comment: As a mental health case manager for the past 10 years, I have been through many ups and downs with my clt as the funding fluated, I strongly believe that more funding should be located for non Medicaid and reduce caseload because there are still many people in the community that needs the mental health service but d/t limited of funding we cannot serve everyone who are in needs. I, myself, many years ago had received outpatient mental health treatment and as a result of treatment, I was able to lift myself up, went through grad school and got my MSW and has been serving in the mental health field since 2005, if I didn't get the treatment that I have gotten, I probably not end up where I am today (back then I have made many suicides attempts). Speaking of reducing caseload, right now I have close to 50 caseload and with 40 hrs/week and some of those hours are used for meetings and other necessary trainings, I don't have much time left to meet all of my clts needs, I have to struggle with prioritize my clt's needs and that is very sad because some of them would have making much more progress if they get more support from me. Therefore, pls allocate more funding for non-Medicaid and reduce caseload.

Name: Kim

Organization: DSHS

Comment: GRAT is a great resource please don't take money away from them. We need all the mental health resources we can get. Its very limited and mental health issues are increasing to a hazard. Peoples lives depend on more mental health resources.

Name: Karin Taifour

Organization: None

Comment: I noticed there are only two programs providing support to older adults, the fastest growing population. With issues like dementia, housing, and access to services, our elders are in great need of support. Please consider expanding support to seniors.

Name: Brenda Abbenante

Organization: APS

Comment: Continue with GRAT services as they are a huge benefit to the community.

Name: Tom Lang

Organization: None

Comment: I hope funding will be continued for the GRAT. As the President of an HOA, we were very concerned about one of our elderly owners who called 911 at least 3 dozen times over about 4 months and who had signs of dementia. The advice GRAT offered was most helpful. They came out did an on-site assessment that was also valuable. We needed, and appreciated, that we had someone to call and advise us on how to deal with this owner.

Name: Barbara de Michele

Organization: Issaquah Schools Foundation Healthy Youth Initiative

Comment: I strongly support development of a treatment on demand system. For youth, please consider placing treatment on demand in public schools where access to treatment is currently woefully lacking. Young people who are experimenting or already in addiction have great difficulty accessing appropriate substance abuse counseling and referrals. We have long waiting lists for mental health counseling. School-based treatment on demand would meet these challenges effectively, saving many lives.

Name: Crystal Hanson-Garrett

Organization: DSHS-APS

Comment: This service is invaluable without it, our vulnerable population would not receive much needed services.

Name: Kim Spector

Organization: Northwest Care Managers

Comment: I am writing in support of the GRAT at Evergreen. It has been a life-saver to me and many of my clients over the years. I believe this worthwhile and much-needed program deserves all the support, financial and otherwise, that it needs to serve the people of King County and the greater Seattle area.

Name: Kathy Penn

Organization: Adult Protective Services

Comment: I have used GRAT services to assist in determining whether vulnerable adults need a guardianship in order to protect their interests. This service is very much needed in order for us to timely serve our aging adult population.

Name: Karen Kent

Organization: None

Comment: I believe it is essential that GRAT continue to get MIDD money. It is a program of great value in the community and the only one that deals specifically with isolated older adults in crisis. The population is growing older so there will be more and more need for GRAT.

Name: Abe Liu

Organization: None

Comment: I support the Geriatric Regional Assessment Team (GRAT) efforts to continue to receive MIDD funding (Mental Illness and Drug Dependency levy). I have experienced the value that the GRAT team provides through their support of our family's issues. They fill a need, and should be fully funded!

Name: Angela

Organization: None

Comment: We need to continue to support mental health therapist and government agencies because the Mental Health crisis is growing in our state as well as our country. If we don't help the therapist the provider's the nurses Etc do what they do best things can only get worse.

Name: Lenh Vong

Organization: DSHS APS

Comment: It is critical to continue to have GRAT provide the needed mental health services to all clients in our community to help them access and provide better services etc.

Name: Ashley Kraft

Organization: SHAG Community Life Foundation

Comment: GRAT is a key program to help support our residents, we are at a loss if we do not have this program.

Name: Diane Stone

Organization: Seattle Police Department

Comment: My comment is to attest to the invaluable service of the GRAT program. I work as an advocate for seniors who have been abused, neglected and or exploited. This program has been a phenomenal help to myself and the detectives that investigate the cases. The expertise, hard work, professionalism and compassion shown by the GRAT personnel is invaluable to us and to the older people that they come into contact with and serve. Please, keep this extremely valuable service to our older community up and running! We cannot imagine our job without their expertise and assistance.

Name: Denise Malm

Organization: Wallingford Community Senior Center

Comment: As a social worker at the Wallingford Community Senior Center, I encourage MIDD decision makers to support the Mental Illness and Drug Dependency levy/ funding. In my job, I am noticing an increase of older adults with and without support systems in desperate need of mental health assessments, interventions and services. Too often I see and hear from concerned family members, friends, professionals and neighbors regarding elders with limited resources in critical life and death situations. Personally, I have relied on the Geriatric Regional Assessment Team for help when seniors are in crisis. Professionally, I would not know what to do or who to call (other than 911) when working with an individual who is suicidal, suffering from memory loss or is incoherent. Without this funding, these situations will need to be dealt with by local fire departments, law enforcement and medical facilities.This put a strain on services that are already stretched beyond capacity, ultimately costing the County more in the long run. Furthermore, organization like GRAT have the knowledge and experience with aging populations. Please value seniors in need by fully funding these programs.

Name: Stephen Allar

Organization: APS Region 2

Comment: GRAT is essential to assist our community in making sure that vulnerable adults have their needs being met. All of our society benefits from their critical work.

Name: Jeff Quigley

Organization: DSHS

Comment: Would love to see the GRAT Program funded from the MIDD II program as it is a program which has benefitted the service structure in King Co for many years. Currently, the program is slated to go away due to Evergreen Care Network discontinuing their community service programs.

Name: Rachel Wang Martinez

Organization: None

Comment: As a community health nurse, I have worked in partnership with GRAT many times to provide crucial services to our underserved aging population in crisis. This program is vital to keeping our communities healthy and decreasing the burden of emergency services provided to older adults who benefit from the support provided by GRAT.

Name: Janet Smith

Organization: Northwest Elder Law Group PLLC

Comment: I feel strongly that the Geriatric Regional Assessment Team is a vital resource for frail elders in King County and should continue to be funded. This is a life saving service for elders at risk who live alone, or vulnerable elders who are being exploited by others. Please continue this funding.

Name: Gigi Meinig

Organization: Aging and Disability Services

Comment: I highly recommend the Geriatric Regional Assessment Team (GRAT) be included as a provider in the MIDD process. GRAT is one of the few Behavioral Health (mental health and substance abuse) organizations to serve older adults. In the not so distant future, older adults will increase to 25% of the overall population. As the demographics shift there will be a huge need for practitioners with geriatric experience, knowledge of dementia and understanding of the affects of psychotropic medications on the elderly. GRAT continues to be a leader in the field of geriatrics. Much of their work is done in the client's home. They are connected to the medical community through it's umbrella organization Evergreen Health. As a former contract specialist and agency assessor I always found GRAT's Administrative work to be high quality and appreciated their willingness to maintain flexibility

regarding data collection. I strongly urge you to incorporate the needs of older adults in the MIDD planning process. Thank you.

Name: Amanda Froh

Organization: King County Prosecutor's Office

Comment: I would encourage you to continue funding the Geriatric Regional Assessment Team. These evaluators provide cognitive assessment to elderly and vulnerable adults in crisis (such as those who are victims of the crimes of neglect and financial exploitation), and direct them into services to better their lives. As prosecutors, we often rely on cognitive assessments done by GRAT evaluators of our victims, as they are often first on the scene following discovery of the crisis. Prosecuting crimes against the elderly would be exponentially more difficult without this resource available to law enforcement, social workers, and APS/DSHS.

Name: Kay (Kyung Hwa) Jun

Organization: Sound Generations, formerly Senior Services of Seattle and King County

Comment: My program (I&A for Seniors and younger folks with disabilities) has been working with GRAT closely, with the capacity as an referral agency. There has been huge volume of crisis calls (daily basis) from concerned community members who does not know where to turn. GRAT is the one who was there to go out to the community and help out the senior individuals who's in crisis while no other could reach out that effectively and fast (within 3 days). I'd like to advocate for GRAT in your decision to keep funding the much needed program like GRAT.

Name: Kathy Van Olst

Organization: KCPAO

Comment: The Geriatric Regional Assessment Team provides an incredible service to the community. In the prosecutor's office, there are many elders in the community that are not currently in the mental health system but are experiencing crisis due to evolving cognitive impairments (as victims and offenders). GRAT is the agency where we can refer families whose elders are in crisis to have a competent mental health assessment done in order to plan next steps for these individuals. They are an incredible resource for our community.

Name: Annie Jacobsen

Organization: SHAG Community Life Foundation

Comment: In my 3 years with SHAG as Resident Services Manager we have found the GRAT team to be an invaluable resource and service. The caliber of the team is extraordinary in their efficient, skill and compassion. As a state with below standard services for mentally challenged individuals, they are often falling to unskilled options - housing not meant for the challenges they face as one example. It is often

humiliating for our residents to be a person with a mental health issue being shunned in a community where they simply want to make a home - because of behavior issues or habits. We need to do better by those with mental health challenges and it is of vital importance to have programs like GRAT and DMHP for this reason.

Name: Elizabeth Strewler

Organization: UW School of Social Work

Comment: I write to you today as a concerned citizen and advocate for one of our area's consistently at-risk and underserved communities, our LGBTQ older adult population. Despite being an at-risk group in itself, the LGBTQ community includes many particularly high risk groups, some of whom are: LGBTQ veterans, trans* older adults, LGBTQ older adults of color, those living with HIV, those of limited ability status, those living in poverty, as well as the 'oldest old' and caregivers. In King County, LGBTQ older adults represent about 2.4% of the older adult population and are expected to double by 2030.

Numerous reports and studies, several of them conducted here at the University of Washington, confirm that the LGBTQ aging community faces considerably higher rates of mental health challenges (including suicidality), substance use, and isolation than their heterosexual counterparts. Troublingly, LGBTQ identities and behavioral health challenges continue to be highly stigmatized, even in a progressive region like King County. This continued stigmatization translates to an increased threat of victimization and discrimination for our local LGBTQ older adults, who often face a combination of challenges as they move through their daily life. We know that the LGBTQ aging community can be both resourceful and resilient when provided with the supports and resources they need. At present, our local LGBTQ older adults rely primarily on their informal peer groups and networks for support, few of which are equipped to address the mental health and substance use challenges that so often affect members of this community. This is because programming that could serve them more comprehensively does not yet exist. Several core components of MIDD's programmatic focus areas would directly address the unmet needs of this growing population. As the MIDD moves forward with plans for new prevention, intervention, and systems improvements that will address the behavioral health challenges experienced by King County constituents, I urge you to forge programming specifically tailored to the needs of our LGBTQ aging community. Thank you for your time in taking my public comment into consideration.

Name: Yoon Joo Han

Organization: Asian Counseling and Referral Service

Comment: There is great need for mental health services for minority community members as many are not eligible for Medicaid or health benefit. We would like to see increased amount designated for Non-Medicaid funding for mental health and CD outpatient services. Workload reduction funding has been very helpful in addressing workload of our case managers who carry such a high caseload. Although it is not enough to solve the problem, certainly it has been helpful as it can be used in a creative way for each agency. We would like to see an increase in workload reduction fund and the kind of support to support the infrastructure. I would have liked a focus on cultural competency, whether it is to increase the level of cultural competency in the system or providers' level, or in direct service staff. I am not sure how or whether this MIDD II took equity, social justice and cultural competency into consideration.

There is more need to address these important values and issues that we all share. Thank you for the important work!

Name: Reza Hosseini Ghomi

Organization: None

Comment: I fully support renewal of the MIDD.

Name: Perla Castaneda

Organization: None

Comment: To whom it may concern: I am writing today to urge the MIDD Oversight Committee to recognize and continue to support the ever-growing needs of the aging LGBT community. As a community that is facing pronounced mental health and behavioral health disparities, the aging LGBT community is in dire need of preventative and supplemental services. Despite the growth of the this community, now making up about 2.4% of the older adult population in Seattle/King County, no services exist that address their unique needs. LGBT are at higher risk for poor health as mental health related issues and therefore need specialized resources as well. Poor mental health can lead to other health related issues such as increased drug use and higher risk for suicide. One of the themes that came up in MIDD focus groups was the stigma that is often associated with using mental health care services. This stigma is even more prominent with the LGBT community given stigma surrounding identifying as LGBT is still outstanding. Older adults face these and other hardships, such as mobility issues and economic instability, in attempting to access services. For these reasons, it is critical that programming be dedicated to the older LGBT community in King County. I would like to commend the efforts of the Committee to include our aging community in the initial MIDD recommendations and would ask that we recall that the LGBT aging community should be specifically addressed in these efforts as well. With more efforts in behavioral health services focused in prevention and early intervention, our aging LGBT community can have a better chance of aging in a healthy and dignified manner.

Name: Lisa Nelson

Organization: None

Comment: The treatment on demand should also allow for mobile medical services. The urgent care clinic is a good start, but expand the funding eligibility to help with funding the new mobile medical van.

Name: Michelle Peterson

Organization: HERO House

Comment: It is very important to keep in mind the most important factor that benefits the club house members, and the community -- as it is so eloquently written in the MIDD II Recommendations: "Seattle

Clubhouse is well- positioned to overcome the challenges faced by past programs and fully support those working towards their own long-term, SUSTAINED RECOVERY (emphasis added)."

Name: Sarah Boye

Organization: None

Comment: As someone who has worked closely with the MIDD Wraparound program in multiple capacities, I object to the reduction of this program's budget. An assumption has been made that "Medicaid dollars" (aka WISe program funding) will enhance or supplement the current Wraparound delivery model, and therefore the overall budget for this program could be reduced without changing the service delivery. What this assumption fails to take into account is twofold:

1. The WISe funding model is not sustainable in itself, and does not provide adequate funding for the program design, and
2. MIDD Wraparound dollars provided key program elements which are not at all funded in the WISe model.

One of these key elements funded through the MIDD funding is Flex Funds. Flex Funds help to fill "gaps" in a client's care plan, and address needs that would not be otherwise paid for through categorical services. Examples of this would be sports fees to allow a youth in CD treatment to engage in prosocial activities which the family could not pay for, or items needed to create a safe living space for a child with Autism, or camp fees for a child with profound behavior needs to engage in "typical" summer activities, build skills, and give parents a needed break. Flex Funds are a crucial part of the service delivery model specifically because they are flexible. The child's team can decide to use them in a way that is culturally appropriate and clinically indicated. A second key element of the MIDD Wraparound program includes "following" a youth who has been admitted to a CLIP facility. Under the WISe program model, Wraparound would end when a youth enters long-term residential treatment facility. However with MIDD funding, the Wraparound team could continue to support this family and enhance the treatment and discharge planning of the youth. Our experience has found that this is crucial in ensuring that the expert clinical work done at the CLIP facilities can be effectively "translated" back to the child's family, school, outpatient mental health team, and natural support network. We have received feedback from more than one CLIP facility that they see more parent engagement, increased support network involvement, and an overall better prognosis for the future when Wraparound has maintained involvement throughout a youth's stay. Finally, and perhaps most importantly, MIDD funding allows families who do not have Medicaid to have access to the Wraparound program. In our community we serve families across a socioeconomic spectrum, because mental health, substance abuse, and behavioral needs affect all communities. Reducing this funding would limit access for our non-Medicaid families, and eliminate their opportunity to engage in this research based, team-based planning process. There are many families in our community who do not receive Medicaid, yet have children with profound emotional or behavioral disturbances. Wraparound supports these families in navigating the complex mental health, DDA, Juvenile Justice, Children's Administration, Special Education or Substance Abuse systems. The process also supports the family in developing robust proactive crisis and care plan which reduce the need for hospital or detention stays, and allow youth to remain in appropriate school and home settings. Please consider restoring the MIDD Wraparound budget to its original funding level. This program is unique in that it supports youth up to age 21, and enhances the work of providers across a variety of child-serving systems. By appropriately funding this single program, the efficiency of several

others are increased, and the burden on our hospitals, schools, social workers, and therapists can be distributed across a team of cross-agency supports. Thank you for your consideration.

Name: Kailey Fiedler

Organization: HERO House

Comment: I believe the recommendations are appropriate and help focus on preventative treatment rather than reactive treatment. It is imperative that the Clubhouse Model of Recovery that is accredited by Clubhouse International is at the forefront of MIDD II funding. The clubhouse model has proven outcomes to reduce hospitalization, cost effective in treatment and reduces individuals in jail. This is one area which the county has determined is vital to improving our mental health system.

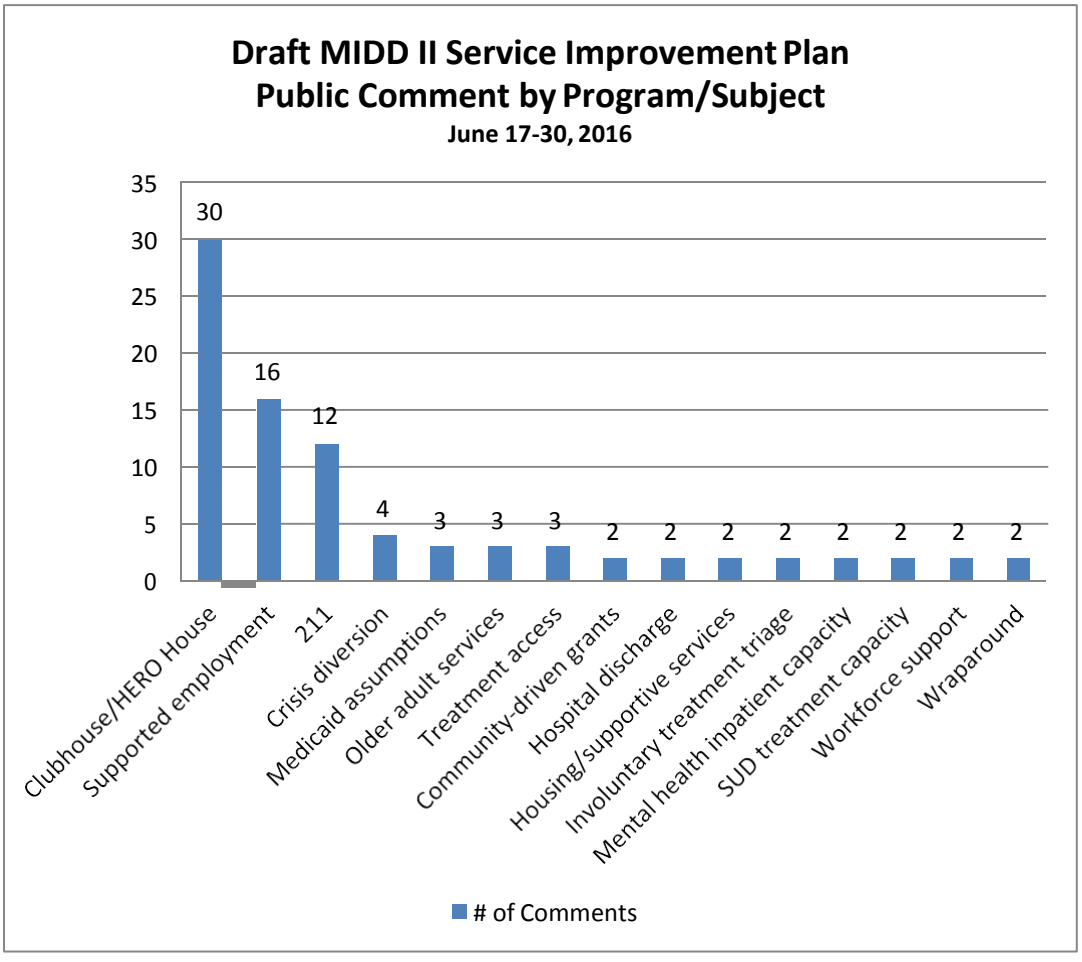
Draft MIDD II Service Improvement Plan

Public Comment Summary: June 17 – 30, 2016

A total of 65 comments on the draft MIDD II Service Improvement Plan were received by King County. The comments were provided online June 17-30 through a survey portal, via email, or in person at the MIDD Oversight Committee meeting on June 23.

The vast majority of comments endorsed or supported particular program(s), in some cases advocating for additional funding. Notably, 46 percent of commenters (30 total) advocated for additional funding for clubhouse/HERO House. About one quarter of public comment participants (16 total) advocated for increased funding for supported employment services. About 18 percent of respondents (12 total) supported MIDD funding for 211 services.

When comments referenced multiple subjects, they were counted under each subject discussed. Programs or subjects mentioned by two or more commenters are shown in the chart below.



Public Comment on Draft MIDD 2 Service Improvement Plan (June 2016)

Name: Kelly Rider, Alison Eisinger, Janet Pope, Paul Lambros, Daniel Malone, Matt King, Bill Hallerman, and John Hickman

Organization: Housing Development Consortium Seattle-King County, Seattle/King County Coalition on Homelessness, Compass Housing Alliance, Plymouth Housing Group, DESC, YMCA Seattle | King | Snohomish, Catholic Community Services, and Catholic Housing Services

Comment: Thank you for the opportunity to comment on the forthcoming draft of the MIDD II Service Improvement Plan (SIP). We appreciate that the current MIDD II proposal would invest a significant amount of funding in permanent supportive housing and related uses. In particular, we are grateful the proposal identifies sufficient funding to create an ongoing allocation of capital funding, compared to the one-time allocation in MIDD I. That said, we are concerned that the proposed funding level does not sufficiently respond to the crisis level of homelessness our County is experiencing. At a time when the One Night Count of unsheltered homeless individuals has increased by 20% over one year, the proposed funding does not bring this proven best practice to scale. Unfortunately, it would create fewer permanently affordable homes over the life of MIDD II than were created over the life of MIDD I due to increased costs and reduced external leveraging resources. We recognize MIDD II is being shaped to respond to a variety of needs our communities are facing. However, we recommend the following actions to better address homelessness among our county's population facing mental illness and substance abuse challenges.

Unallocated Funds: We strongly urge the County to prioritize permanent supportive housing capital dollars in the Service Improvement Plan's policy regarding additional allocations, underspending, and/or recapture of funds. A similar policy is currently in place for the Veterans & Human Services Levy and serves as a best practice for promoting enhanced housing outcomes over time should additional funding opportunities become available. This serves our community well as recipients do not require ongoing funding of capital dollars.

Flexibility of Housing-Related Funds: While we respect the County's need to create predictability and accountability within the Service Improvement Plan, we encourage you to create more flexibility within the housing-related funding allocations. Services and operating dollars in particular are incredibly challenging to identify and have reached a "cliff," where the current service dollars available have already been committed to current sites, leaving a shortage of funding available to commit to new permanent supportive housing sites. Given King County's position among a variety of other funders with varying priorities, flexibility will allow you to best leverage other funding sources to create the desired outcomes. In addition, this would align well with the unallocated funds policy recommended above, allowing the County to increase yearly funds for service dollars above $2 million if recaptured or other funds are identified to allocate toward capital funds.

Thank you for your leadership throughout this important process. We look forward to continuing to work with you and other County leaders to advance a successful MIDD II proposal later this year and to identify the other funding sources necessary to bring our homelessness strategies to scale. [Stakeholder letter submitted to MIDD June 15, 2016]

Name: Corrina Reily

Organization: HERO House

Comment: It has helped me get along with people. I learned how to do the right thing and to be honest and not steal. I have learned how to listen here and how to work well with others.

Name: Carol Bashaw

Organization: HERO House

Comment: HERO House lets me do reception when I'm there. HERO House allows me to have lunch too. I feel a sense of belonging to the clubhouse. Greg or Matt give me rides here and back because I can't get here otherwise.

Name: Alex Odesskiy

Organization: HERO House

Comment: I met a lot of new people. I had a volunteer job for 3 school years. I like the staff and get along well with them. I help out with shopping and go on socials. I also participated in a conference two years ago in Canada. HERO House helps me with my recovery.

Name: Joseph C.

Organization: HERO House

Comment: HERO House is a great place for people who have a mental illness to come and be accepted and feel at home here. It serves as a good foundation to help you sort of get on with life, move forward with life. The socialization aspects are really crucial. Also, the work activities are meaningful and it provides an atmosphere of comradery which is motivational. I'm getting a whole lot more interaction with people so it's really helped me to engage with people and brought me out of my shell. It's been very satisfying socially, which that when I go home, I can focus on other things and not feel isolated. It's eliminated the feeling of isolation, which has allowed me to be more productive.

Name: David Honrath

Organization: HERO House

Comment: It keeps me more active and more stable. I work well with a standard. HERO House helps me keep my body moving. I've met quite a few people at HERO House. Segregated place that lives up to standards. I appreciate HERO House and what it's done for me. I have a better living situation thanks to HERO House. Good things and bad things about work ordered day.

Name: Susan Ericksen

Organization: HERO House

Comment: I like the people here. It's helped me get along with people. I get to help with stuff, like cooking, setting the table, and my self-worth. I like the friends here.

Name: Anthony Gomez

Organization: HERO House

Comment: I'm not drinking and using drugs anymore. HERO House makes me feel like I'm a part of something. I'm able to ask for someone's help to explain things to people what don't want to listen to me. Peer support and advocacy. I feel like I have something to do now. It feels like I'm worth something now. Before, I was depressed, because I felt like I wasn't worth anything, but now I have someplace to go. They accept me for who I am. I get to cook anything I want to for the members if they have it. I'm developing skills and I hope to get a job. It's a new standard on my life.

Name: Michelle Ragan

Organization: HERO House

Comment: HERO House got me a real job. It's the only way I get paid. If I wasn't working, I wouldn't have any money in my bank account. I've been working for six months. This is my first job in a long time. I like the activities they do. They give me two free shirts I can keep at my work.

Name: Ben Miksch

Organization: Seattle/King County Coalition on Homelessness

Comment: Ben Miksch, representing the Seattle/King County Coalition on Homelessness, spoke on behalf of the groups who signed the letter regarding the MIDD II Service Improvement Plan (Kelly Rider of the Housing Development Consortium Seattle-King County, Janet Pope of Compass Housing Alliance, Daniel Malone of Downtown Emergency Service Center, Bill Hallerman of Catholic Community Services, Alison Eisinger of Seattle/King County Coalition on Homelessness, Paul Lambros of Plymouth Housing Group, Matt King of YWCA Seattle/King/Snohomish, and John Hickman of Catholic Housing Services [included in the packet everyone received for today's meeting]). He thanked the Oversight Committee for their work which is hugely appreciated by everyone in the community. He described permanent supportive housing, which was supported by MIDD I, as a national best practice for some of the most vulnerable people in our community, who often cannot be served without housing and cannot get housing without supportive services. He expressed the hope of the Coalition on Homelessness that some of the unallocated MIDD dollars be used to raise funding for permanent supportive housing or, given the current draft of the Service Improvement Plan, that money from emerging issues category could be considered for use in supportive housing. His other request was for flexibility of spending: comparing housing to a three-legged stool – capital projects, operations and maintenance, and services – with varying requirements at the federal and local levels, flexibility of spending MIDD dollars would be very helpful in respect to supportive housing.

Name: Alicia Tillery

Organization: Valley Cities Behavioral Health

Comment: Alicia Tillery, Vocational Specialist at Valley Cities Behavioral Health, thanked the MIDD Oversight Committee for their support of Supported Employment. She shared a success story about a consumer from DVR [the state Division of Vocational Rehabilitation] whom she was able to place at a CVA store where he boosted book sales by over 30 percent. Originally, this consumer had been unable to communicate, had no friends, and had never worked, at 25 years of age. But as a result of the job at CVA, his life has turned 180 degrees: his verbal communication has increased, he has friends, he is self-sufficient, his symptoms have decreased, and he is a productive citizen. This is why we are asking for an increase of $250,000 from the present Service Improvement Plan. We need to continue building our success numbers.

Name: Sue Wyder

Organization: Valley Cities Behavioral Health

Comment: Sue Wyder of Valley Cities Behavioral Health thanked the MIDD Oversight Committee for the work they have done on the budget, which she also has some experience with. Her public comment was in support of the Supported Employment Program at Valley Cities Behavioral Health, requesting the MIDD Oversight Committee recommend $250,000 more in funding for this program. She described the spiral effect that follows decreased funding has: low performance leads to low outcomes leads to decreased services from South King County and Auburn to Northgate, the area that Valley Cities serves. A large number of consumers at Valley Cities are motivated to work because of the time that staff spends supporting them. And employment works: it establishes routines, boosts confidence, lifts people out of homelessness and addictions, and they become role models for others. These are signs of what that extra funding can do and we want everyone to have the opportunity to work.

Name: Katharine Wisner

Organization: HERO House

Comment: Katharine Wisner, a consumer giving public comment about Hero House, described the critical importance of Hero House in helping her to live with severe anxiety and panic disorder after leaving a very stressful job last year. At Hero House, she has felt safe and accepted. No one asked questions about her mental health; they asked her to edit the newsletter and answer the phones, so that she felt like she was contributing even while she was still experiencing symptoms, which she while working through her symptoms. Thanks to her involvement in Hero House, some therapy, and other things, she began to feel better and spoke with Isabelle at Hero House about Supported Employment. She is now working part time in something that feels meaningful to her, and she is gaining confidence; her plan is to work full time by the end of the year with the help of Supported Employment. She advocated for funding of the Supported Employment Program at the $1.25 million level rather than the proposed $950,000 level. Working for her is the next step in reclaiming full recovery.

Name: Earl Peterson

Organization: HERO House

Comment: Earl Peterson, a consumer giving public comment about Hero House and the Supported Employment Program, described how Hero House has helped him greatly over the past seven years in his recovery from drug addiction, homelessness and severe depression. To live and be successful in life is important and not easy for anyone. Since joining Hero House, he's been able to attend college and initiate a new charter with the Kiwanis Club to donate funds to Hero House. Other members are regularly employed and also volunteer for nonprofits. More recently, he has committed to a new workshop at the Clubhouse on life goals, sponsored by Hero House. For most in recovery, progress is slow. The improvements he has been able to observe in himself and others within the Clubhouse environment seem directly proportional to the growth of this organization. Helping people be all they can be is the business of this organization; lives are being changed for the better, to be more constructive, clear, with a purpose. My hope is to convey how important funding dollars are to this program.

Name: Greg Davis

Organization: HERO House

Comment: Hi my name is Greg Davis i am a peer support Generalist at HERO House, HERO House is a safe place for people who have special needs we give hope to our members,we offer opportunities for people with special needs to rejoin their communitys.

Name: Matt Valdespino

Organization: HERO House

Comment: Hi, my name is Matt Valdespino and I'm a staff member at HERO House here in Bellevue. I have been working at the Clubhouse for a little over a year and it has been a truly incredibly experience. The work we do helps transform lives every day, and as we have expanded our services over the past year new people from all over the county are being rehabilitated through the unique recovery-through-work model that is unparalleled in Western Washingotn. It is for that reason that I urge you to, at the very least, maintain funding for HERO House at the current level through MIDD II, if not expand it. We are a proven, cost-effective method of psychosocial rehabilitation that helps individuals return to the workforce and re-engage with the community at large: a year of services from HERO House costs roughly the same as a 2 week stay at a psychiatric hospital. If the funding is cut, we will be forced to ration our services to the point where we will have to turn away individuals seeking assistance. This will not only damage that individual's recovery but damage the relationship of trust the members have in our program that if they want to get back to work, we will do everything to get them back to work. It is this trust, based on the strong individual relationships built through member-staff participation in the work ordered day, that distinguishes us from any other program in the area. When members come into the Clubhouse, they know they are dealing with people who will treat them as individuals and work to support them based on their goals, their personalities, and their strengths. Our diverse staff is representative of the community at large, with eight languages between our staff members and even more from our active members. By supporting HERO House, the county is supporting a holistic approach

to recovery that engages the strengths of individuals with mental illnesses rather than fixating on their weaknesses. I urge you, on the behalf of adults living with mental illness throughout King County who have not given up on reaching their full potential, to keep supporting our wonderful program.

Name: Olga Yarmoshik

Organization: HERO House

Comment: I am so thankful for MIDD funding as it vitally helped our program - HERO House to survive and prosper. My hope is that everyone could see the importance of continuing to fund this unique program at current level the least. Our clubhouse is currently the only clubhouse in King County that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery from mental illness. Members have opportunity to be active part to reach their goals, whether it is employment education, skills, meaningful life, connection to others and most importantly increased self esteem and confidence. Members and staff run the program side by side, resulting in many of the members returning to work, being less isolated and finding meaning in life. Over the past 10 years I have witnessed dozens of members going to work for the first time in very long time or even in their lifetime. These members are being able to be successful because of the many layers of support provided by HERO House program - prevocational building of skills and confidence, support from peers, encouragement from staff and opportunities to participate in social activities in safe and familiar environment. For members that are not interested in employment there is everyday support dealing with personal advocacy, community resources, and opportunity to participate in meaningful work of running the clubhouse. Clubhouse is effective and cost efficient option for those recovering from mental illness. Please do continue to fund our agency.

Name: Gail Kowall

Organization: HERO House

Comment: Would like to ask for King County/MIDD 11 to continue the current funding level of Hero House at $362,489 per year. Ask for funding of SE at $1,250,000-250k above previous MIDD 11 level Thank you

Name: Riley Holbrook

Organization: HERO House

Comment: HERO House has given me access to computers, found clothing in which to go to interviews. Provide cheap lunches and free pastries. Normally, I come to the morning meeting and sign up for 1-2 tasks and meet with Isabelle who is an employment generalist and go on a wellness walk with Corey. I got a job at PCC because of HERO House, developed friendships, volunteer at an organic farm, which is part of my chosen career.

Name: Kuong Quach

Organization: HERO House

Comment: I started 2 years ago. I heard about HERO House from my roommate who said HERO House is good for getting out of the house and getting a job. Kaz helped me get a job at Ross. I am proud to have work. It makes me happy to come here and it makes my recovery stable. Because of HERO House I have something to do every day. Also I get to socialize with the members. HEROHouse refreshes my job skills.

Name: Monika Swanson

Organization: HERO House

Comment: HERO House has given me a place to go each day so I don't isolate. I have found a place where I get a sense of belonging. I also get to do things that help me gain both social and job skills. I also find that I get support and encouragement in all my situations.

Name: Susie Willard

Organization: HERO House

Comment: HERO House helps me stay out of trouble and gives me something to occupy my time. HERO House has also been instrumental in assisting me to gain friendships. The computer skills I have learned will be helpful when I become employed.

Name: Kellen Ryan

Organization: HERO House

Comment: Helped me develop a sense of belonging. Helped me find and retain a part-time job. Helped me develop friendships. Helping me grow as a person (inter/intrapersonal growth). Share feelings

Name: Sei Obara

Organization: HERO House

Comment: There's a lot of social activities at HERO Hosue. I like being with people and in a friendly environment. HERO House helps me with resumes and applications for getting a job. It gives me time to reflect on my own self. I run the snackbar and help set up the Daily Dish. I also am the Lunch List attendant when I'm here.

Name: Jeffrey Parr

Organization: HERO House

Comment: It helps me in three ways: I'm not staying at home; it's a place in the community that I feel I'm doing something productive for the community if not for myself; it keeps me off the streets. We're learning to be training to go out and work and be part of the community, instead of sitting at home vegitating.

Name: Earl Peterson

Organization: HERO House

Comment: I have something to do to keep my mind off the problems in Seattle and the communities, and the chaos that spreads. It's like an oasis in the sewer, like a protective bubble.

Name: Michael Given

Organization: Hero House

Comment: I do a lot more in the computer, more than I did before. I've learned at HERO House how to do 3-D photos. I make the member cards for HERO House. In the past, I did a lot of movies, but never have people to help me. I do a lot of slide shows. HERO House helps those with mental illness to function better. It gave me the space to learn and people to help me. I was working as a drafter. I'm working with employment services to try to get back to work and to improve my CAD skills.

Name: Ann Allen

Organization: Harborview Medical center

Comment: This is a service that is vital to getting people with serious and acute mental illness out of jail. I provided the service for my agency at one point, please consider our efforts to get treatment for those in need.

Name: Idabelle Fosse

Organization: Sound Generations

Comment: Having read through the materials, I would like to comment on some of the themes that you outlined. Given the lack of access to hospitalizations, I think that the continuum of care would benefit greatly from using a system of crisis homes that are more effective and less expensive to run than trying to add more hospital beds. This idea would also help discharge planners from hospitals access a supportive transitional living environment for clients who need more services in order to become stabilized. San Diego has (or used to have) an excellent model for this. We need more services for folks who are homebound because of their mental illness, and need help to access services in order to prevent their becoming homeless, And lastly, we need more services that will help support older adults

with mental illness remain in their homes. The specific needs of older adults with mental illness is not addressed in any of the programming that is listed.

Name: Ursula Whiteside

Organization: NowMattersNow.org

Comment: Please include $200,000 to support King County 2-1-1 in the MIDD process. 2-1-1 is a foundational and critical part of the behavioral health system and deserves to be fully funded.

Name: Kristin Middleton

Organization: None

Comment: Please include $200,000 to support King County 2-1-1 in the MIDD process. 2-1-1 is a foundational part of the behavioral health system and deserves to be funded.

Name: Janice Tufte

Organization: Hassanah Consulting

Comment: Please fund MIDDII and fully fund 2-1-1 both organizations help many with a hands up, resources

Name: Mindy Brown

Organization: OESD 114

Comment: 211 is very important to the clients we serve. Without resources available to our families, they will never see the bigger picture that they could be part of.

Name: Gary Davis

Organization: None

Comment: I urge the King County Council to include $200,000 in support of King County 2-1-1 in the MIDD process. 2-1-1 saves lives, money, and critical time in serving our neighbors in need of crucial behavioral health care and is a vital resource in accomplishing the MIDD goals. Thank you for your advocacy for 2-1-1.

Name: Jason Austin

Organization: None

Comment: Please fully fund the $200,000 proposal to King County 2-1-1. 2-1-1 is a foundational element of King County behavior health safety net and should be strengthened to better meet the needs of King County residents.

Name: Dennis Raymond

Organization: None

Comment: Funding is needed for the 211 line in King County. This is a vital service for those needing social services, and don't know who to contact.

Name: Cynthia Drover

Organization: None

Comment: Please set aside 200,000 for 2-1-1. As a professional human service worker with direct contact with clients, I have utilized this resource many times when asked for resource and referral.

Name: Bonnie Thane

Organization: Olympic Educational Service District 114

Comment: Please include $200,000 to support King County 2-1-1 in the MIDD process. 2-1-1 is a foundational part of the behavioral health system and deserves to be funded. This service is VITAL to our community. Thank you.

Name: Lori VanderBilt

Organization: None

Comment: 211 is critical to our infrastructure. I have volunteered for the crisis line, offered it as a resource as a therapist, and donated money to support it! Please keep it going--so many people in desperate straits rely on it daily for resources!

Name: Jerilyn Anderson

Organization: 14834 119th Pl NE

Comment: The 2-1-1 service is underwritten financially by other line items in the Crisis Clinic budget. It is a value of it's own, serving so many thousands of residents. It should be funded sufficiently on its own so it can continue to provide this essential referral service for our community.

Name: Tanya McGee

Organization: Sound Generations

Comment: Working for 12 years with Senior Services now Sound Generations, I interact daily with client's 60 and over and clients 18-59yrs old who are struggling with depression and other mental health issues. Most are unable to access free or low cost mental health services and are struggling to maintain households, relationships, and get safe and secure placements when they are in a crisis. I also talk frequently with caregivers of client's with mental health needs and the caregivers are overwhelmed with navigating mental health systems; especially involuntary commitment. More wrap around services, care coordination, and crisis diversion services (like GRAT) are needed for older adults and younger disabled client's. I see firsthand that many clients could be assisted if there was more funding, more intensive supports, and more creative housing environments. The alternative being costly hospitalizations where no specialized treatment is being received, becoming homeless, or living in unsafe living environments frequently calling 911 and going in and out of the hospital with no follow up or care plans. I have several client's that are not in a mental health crisis, but have undiagnosed mental health conditions and need care coordination including home visits, and assistance to get connected to a doctor. I have researched current options but so far can't find the assistance they need to live safely in the community. Washington State is one of the best places to live. It needs to be one of the best places to live to access mental health services also. There are so many great ideas for the MIDD funding….all of them should be funded.

Name: Debbie Fuller

Organization: Mom

Comment: This specific funding needs to be addressed for its Unique ability to address very Basic and REAL needs. You can have Housing ,Food, Education, etc. needs met but if a Mom needs her hair cut to feel REAL to herself or a front door needs repair so a family entering doesn't have to be reminded that their Dad slammed their Mom's head into that space....THIS is the Funding that is not OUT THERE....THIS is the funding that precedes ALL the other interventions. ....this is the funding that is the platform for CHANGE.....lasting/fundamental /genuine Change! Please HEAR THIS !

Name: Tina Budell

Organization: None

Comment: I have read through the draft and am still thinking there is more focus on overhead and oversight than getting more treatment centers open. I have a friend who's brother is struggling with addiction and can't get into treatment. He is waiting to hopefully get in at Yakima, he is from federal way and has been a homeless addict in and around Seattle to Tacoma. He has been in the methadone program to no success and keeps slipping back to heroin due to ease of access. The clinics don't always work for people who are working and need access quickly, the waiting months to get in a treatment center if you are low income is counter productive to offering poor and lower income people with REAL options for getting help and getting treatment for their addictions. As a person who's own older brother struggled with addiction for over 20 years of his life and became homeless and addicted I know first hand the struggle for addicts who are ready to get help. The waiting game only makes it easier to go

back to the drugs and lifestyle that they desperately want to leave behind. The idea that all this reporting is going to make the addiction problem in our county/state/country go away is foolish and a waste of tax dollars. We need more treatment centers, we need intake centers that can take an addict in when they are ready and get this on the road to recovery that day, not 6 weeks later. Watching your loved one spiral into a drugged out zombie is heart breaking and destroys families, not just the addict. While my brother was trying to get into treatment was relapsed and stole jewelry from my mother who was in the hospital fighting for her life in her struggle with cancer. Had my brother been able to get in treatment when he realized he was ready and tired of being a drain on the family, he might not have been homeless for 7 years and addicted for over 20 years. Your plan needs to think about not just the future, it needs to have a concrete plan for NOW. How do we get these folks into treatment NOW, not 6 weeks from now and in a different part of the state.

Name: Gail Stone

Organization: King County

Comment: Thank you for the herculean effort. It is clearly the result of a sustained, deep fact-finding and challenging moral discussions. Please accept my comment on one item in particular. MIDD II Number: CD-14, ITA Triage: Too long ago to admit in public, a group of CJ actors, DCHS, state and local hospitals came together to address the escalating, intractable problem of people waiting in jail unconstitutionally long periods of time for an evaluation bed to open up at Western State Hospital. While this is clearly the State's obligation, it wasn't happening and wasn't going to be happening in the foreseeable future. The group developed the triage model in CD-14. Harborview Medical Center generously stepped into the gap and committed staff to do jail-based evaluations, cutting the wait time significantly and, unexpectedly, resulting in better outcomes for people needing evaluation. The rest of the group committed to find ways to fund this service, which Harborview continued to provide until they simply couldn't sustain within current capacity. Our workgroup hasn't found any other funding source. This program works, Harborview has the expertise and the geographic proximity to make it successful. On behalf of our workgroup, thank you for including the ITA Triage project in the MIDD II SIP, and please keep it in as you wrestle with the difficult choices before you.

Name: Jobyna Nickum

Organization: Enumclaw Senior Center

Comment: As a direct service provider, for 25 years in rural South East King County, providing person to person assistance to older adults, I am submitting the following comments/input on the MIDD II Service Improvement Plan: GRAT: Geriatric Regional Assessment Team is an extremely valuable resource for King County for our most at risk elders. Continued funding is essential. Would recommend a South King County based GRAT team to better address growing senior population. Mental Health Services/Case Management Model: I urge King County- MIDD II SIP to develop/support innovative strategies to address the growing "silver tsunami" that we are woefully unprepared for: the mental health needs of older adults Strategies and programs regarding older adults and homelessness Strategies and programs regarding older adults and heroin and opiate addiction

Name: Harry J. Mccarthy

Organization: Retired King County Superior Court judge

Comment: The single most important thing MIDD can do is to lobby strongly for many more residential mental health facilities, both inpatient and outpatient, in King County. We have all heard for years that both the King County jail and the juvenile detention facility are the de facto residences for the mentally ill. Indeed, the King County jail houses more mentally ill people than any facility other than Western State Hospital. Unless and until the Legislature commits to many more community mental health facilities, the mentally ill will continue to be incarcerated in our jails. That intolerable situation must end before any meaningful treatment and counseling can begin . We have been lobbying for this for many years with no change. Frankly, it leaves us who have been fighting for changes in the care for the mentally ill somewhat doubtful that the legislature will make the necessary commitment, particularly in light of their long standing failure to fund public education, their first duty.

Name: Amanda Clark

Organization: League of Women Voters, Seattle-King Co.

Comment: The League of Women Voters of Seattle-King County urges King County to support and fund the King County Mental Illness and Drug Dependency (MIDD) Improvement Plan for inclusion in the 2017-2018 biennial budget. The League of Women Voters of Washington supports measures to expand and fund drug abuse prevention education and drug abuse treatment programs as a means to reduce the demand for drugs. In particular, we support integrated services as appropriate, including long-term treatment, counseling and mental health services, to all drug abusers and to meet the needs of individuals with co-occurring disorders. As a community, we are all stronger by supporting the mental health of all of our citizens. Thank you for your continued support for drug dependency programs in King County through MIDD.

Name: Mike Heinisch

Organization: Kent Youth and Family Services

Comment: Comments submitted on the draft MIDD II SIP issued for public comment June 17, 2016
First off, thank you for the opportunity to provide comment once again as well as compliments on the thoroughness and thoughtfulness that went into development of the draft. It is clear through reading it that a great amount went into it's development, as with the entire planning process design of MIDD II development.

- I note very positively recognizing the challenges of King County MH providers sustaining a qualified, expert workforce and applaud the explicit inclusion of provider Economic Adjustments to the extent of referencing the situation as a workforce crisis.

- I am very much supportive of creating community driven grants and the opportunity this initiative presents for locally responsive, culturally competent MH services.

- I am supportive of expanding crisis diversion and mobile crisis services through the establishment of a crisis center in South King County. You will find tremendous support throughout the first responders and municipalities in SKC for this initiative.

- The draft SIP clearly calls out the BH Medicaid rate, "20-25% lower than pre ACA adoption, making it even more for providers to operate" (dovetailing legitimately and, in part, fueling the workforce capacity and sustainability cited elsewhere in the report. It has been obvious for years, well before ACA era, as the draft SIP states, "the system continues to be significantly underfunded."

- I applaud the recommended revision to the MIDD policy goals as well as the new Strategic Framework of MIDD II.

- I appreciate the recognition of the need that results in the expansion of Family Treatment Court to South King County.

- I ask you to be cautious with assumptions on Medicaid, the likely MIDD savings projections (whatever amount however cited as $4.8M in the draft SIP). Continue to think thoroughly through any assumptions and recommendations from any consultant(s) contracted to work with the County staff on Medicaid assumptions.

In general the array of NEW MIDD II projects/programs is very much reflective of the current BH care environment. Well done on crafting them with the extensive community and key stakeholders input.

Name: Laura Collins

Organization: None

Comment: Re: MIDD Initiative CD-14: Involuntary Treatment Triage Project which serves mentally ill individuals who have committed a serious misdemeanor and are found not competent to assist in their defense. This project provides a safer, more efficient and local evaluation process for these individuals, and has demonstrated great impact in multiple spheres – including diversion from costly ER visits and State hospital admissions, improved utilization of local resources and ensures compliance with the requirements of the civil commitment evaluation process outlined in RCW 10.77. This project has brought the required evaluation process back in-line with the Statute, which requires that these persons be evaluated for possible long term civil commitment (90 day inpatient treatment) vs. a shorter 72 hour commitment. If funded, this program will hire the providers that are qualified to file and testify for the possible 90 day commitment as required by law. Without this project, these individuals will continue to be evaluated for the 72 hour commitment only. Prior to December 2013, these individuals were either referred to Western State Hospital or Harborview's Emergency Department for these evaluations. Both processes were costly, risking longer lengths of stay (at Western State) and safety of patients and staff by treating these persons in an unpredictable emergency department environment of highly vulnerable patients. This project would bypass transfers to Western State or the Emergency Department, by allowing the evaluation to take place in the jail – a more safe and cost effective process. The other strong benefit of this project is its promotion of local care – both inpatient and outpatient. This project includes in the evaluation a thorough coordination with both existing and new outpatient providers, and encourages the development of a safe outpatient alternative plan that can prevent unnecessary hospitalizations. One discovery Harborview made when piloting this process, was that a majority of these individuals were already connected with care, and with some extra leg-work, the evaluators were

able to ensure that connection was in place in creating an outpatient plan. For the individuals who were believed to require inpatient level of care, this process ensured the admission to a local psychiatric facility (rather than the State hospital), in turn promoting shorter lengths of stay by keeping these persons in their own community. Moreover with this local process This supports fewer State Hospital admissions. In the original pilot of this project, it was found that a very small percentage (10%) of these individuals were actually ultimately placed on the long term (90 day) commitment and only 4% ultimately transferred to Western State Hospital. Please support the funding of the Involuntary Treatment Triage Project! Thank you, Laura Collins

Name: Jennifer Phillips

Organization: None

Comment: It appears that some of the new initiatives proposed may address what we've experienced as parents of a teen with mental illness. But I didn't find the details explained in the report or missed if there were fuller descriptions. As part of preventing ED visits/hospitalizations, our personal experience is that much clearer and quickly responsive gap services are needed. She has a behavioral health team but we've repeatedly been in a situation where we see several warning signs that mean a 911 call or journey to the ED is imminent and yet the ability to get a very rapid intervention to try preventing this is non-existent. There's no where else we can take her in these situations. And we've also been left without intensive outpatient services upon her discharge, basically teetering on the edge of crisis during fragile weeks after hospitalization. I'm not sure if a behavioral health urgent care center would be a twist on an ED but will be curious to learn more. Information about what is available in services and how to match to needs also feels fractured. Hope this is part of the next wave of improvements, so professionals can more easily advise patients/families on options. Also couldn't tell from the report whether those with developmental and intellectual disabilities and/or parents and guardians were consulted as part of this process. Hoping yes. This also is a dimension to our situation and it creates complicated situations in receiving services. Thanks.

Name: Bradley K Benson

Organization: Member NAMI

Comment: My son 25 year old Chad R Benson was diagnosed type 1 bipolar and schizophrenic at 19 years old. Chad has been hospitalized twice and taken into custody twice by the police for manic mental events. Chad has been stable and medically compliant for nearly three years. Any all programs that support mental health awareness and services in our city, state and nation deserve attention. Washington state ranks 49th in the nation for mental health services. Washington state has the fastest growing economy and population in the nation. One in Five people in our city, state and nation suffer from a mental illness. Prisons and two week inpatient treatment facilities are not the answer. For the sake of our city, state and nation vote to improve the services of our most misunderstood citizens.

Name: Tsegaye Gebru

Organization: Horn Of Africa Services

Comment: Every SINGLE day we are using 211 for our clients to find several resources. I am not sure how to put in word but it is very critical that 211 is fully funded. We can not do the work we are doing for over 4000 client we are serving at HOAS without 211. Thank you

Name: Elizabeth Krijger

Organization: None

Comment: Thank you so much for all the effort you are putting into the well being of our community. I especially appreciate the emphasis on prevention. While looking over the MIDD II proposal, I noticed the inclusion of housing and treatment, but didn't see anything on specific life skill development that would enable people to have more satisfying & productive lives. If it's not already included, I encourage you to consider inclusion of services that can provide life skill training, such as community-based occupational therapy.

Name: Christopher S

Organization: HERO House

Comment: I think HERO House benefits me in terms of being more social, accepting my mental illness, and helping me find a job, employment-wise. I've been out of work for three years, and I imagined one day I would go back to work. HERO House is an integral part of making that happen. I'm developing job skills with my activities at HERO House. I've spoken at a few NAMI meetings and other community type organizations as a HERO House representative. These opportunities have helped me regain confidence in myself. Because it's a non-clinical environment, I like that. I like the clubhouse environment, because it's a real friendly atmosphere, people are equal, people are treated like peers to the staff.

Name: Denise

Organization: n/a

Comment: we must continue to keep funding MIDD II! this is more important than throwing away money on "dumb" projects, like bertha, for instance! those with a mental illness and/or addiction problems, need continuous help! not only with initial hospitalizations, but also continuously follow-up treatment .... no matter how many months and/or years it takes to have the clients get well .... and healthy .... and back to being contributing members of society again!

Name: Michael J. Brown

Organization: HERO House

Comment: I graduated not knowing that there was a resource in mental health as personal and community oriented as HERO House. The work that clubhouse does is unprecedented in making people with mental illnesses feel wanted, needed, and included, which is something that society is not good at. I've seen mental illness in my family a lot and I only wish that I had known about organizations like HERO House as a resource for everyone I know with mental illness. Every resource here is used sparingly and wisely. There is no waste here. We'd love to stick around longer and be able to grow to be a front runner in mental health in King County. I work as a Program Generalist at HERO House and as such I am intimately involved in the workings of the everyday clubhouse. The King County/MIDD II current funding level of HERO House at $362,489 per year is essential to our running smoothly and not a cent is wasted. Here are a few of the ways I believe that we merit such funding.

1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program.

2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff.

3. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective.

4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system.

Although I am in wise a SE specialist I do know that there are a few of the specifics that we are seeking in regards to funding of Supported Employment at $1,250,000.

1. If funded at 950K this would be a decrease by 210K compared to the previous year's funding level. If funding at the 950k level currently proposed, this successful employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding.

Name: Elizabeth Archambault

Organization: The DoVE Project

Comment: My comment is more general. At DoVE, our mission is domestic violence. Many of our clients need therapists to be sure and many cannot afford private therapists and cannot, for many reasons, go to VYFS (past trauma, their abuser goes there, abuser's "people" are there). This is very limiting. Last year after the most recent youth suicide, I had community members coming up to me saying that their teens were sitting around tables with their friends saying "What if it's me next?" It was like there was no control over suicide and that was horrifying to parents. So. Two things happened. We started sending teens (as prevention) and adults (as intervention) to Axiom Equine Assisted Education (not exactly therapy -- and with great results). We have sent approximately 30 folks through and we get requests for this weekly even though the money for this program is gone. Also, because of the bleak situation on the island, a family foundation approached us in December and gave us $15000 to develop and implement a plan where we pay for islanders to attend therapy with a therapist (private) of their choice. This also covered substance abuse counselling. This program was crazy popular and half way through the year, the money is gone and we have more people asking us for it. My point here is that on Vashon different methods can work. We must be innovative because there is no other choice. I hope that MIDD can allow room for innovative projects that help the overall health of the community in the ways that they need and want.

Name: Kailey Fiedler

Organization: HERO House

Comment: HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program.This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding. We are asking for funding of SE at $1,250,000---250k above previous MIDD 1 level. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system. I am asking For King County/MIDD II to at least continue the current funding level of HERO House if not, increase the funding.

Name: Ramona K. Graham

Organization: Center for Human Services

Comment: I am gravely concerned about two issues in the SIP. One, Wraparound serves are being considered for a cut, which will affect those youth in King County who are in Crisis. By cutting the MIDD wraparound, the flex funds that are vitally important to this EBP will not cover the MIDD Wraparound families needs and WISe does not include these funds at all. Two, the North end of the county is being overlooked for many of the SIP services especially the services for children and youth. The North part of the county also has needs and it would be a huge blow to our community to be excluded.

Name: Guy Andrews

Organization: None

Comment: 1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program. 2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff. 3. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective. 4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system.

Name: Caprice Andrews

Organization: None

Comment: The ASK: Funding of SE at $1,250,000---250k above previous MIDD 1 level.

1. If funded at 950K this would be a decrease by 210K compared to the previous year's funding level. If funding at the 950k level currently proposed, this successful employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding.

On Clubhouse: The ASK: For King County/MIDD II to continue the current funding level of HERO House at $362,489 per year.

1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program.

HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program.

2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff.

3. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective.

4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system.

Name: Kaz Uchimura

Organization: HERO House

Comment: I am an Employment Generalist at HERO House (Non profit organization working with people who got mental health challenges) and follow IPS (Individual Placement and Support) model for our members' job placements. We also follow the fidelity scales supported by King County, Mental Health, Chemical Abuse and Dependency Services Division. Now I would like to share my opinions about the draft MIDD II Service Improvement Plan.

1. If funded at 950K this would be a decrease by 210K compared to the previous year's funding level. If funding at the 950k level currently proposed, this successful employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retention because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding. I truly believe that Supported Employment program works well with individuals who have mental health challenges not only they start earning money, but also they find their desired goal in employment. I placed 7 members at work since last November and would like to work with more individuals who are willing to get back to work and we will appreciate your support. Thank you.

Name: Beratta Gomillion

Organization: Center for Human Services

Comment: There is a major flaw in the thinking behind reducing Wraparound funds. WISe program funds will not adequately fund the deficit created by the reduction proposed. This must be reconsidered immediately. Thank you.

Name: Ashley Fontaine

Organization: NAMI Seattle

Comment: I fully support the addition of seats to the MIDD Oversight Committee, especially those which ensure the voices of traditionally underrepresented groups are heard. Behavioral Health Workforce Shortage, Behavioral Health on Demand, Behavioral Health Urgent Care Walk in Clinic – We have to find a way to address our workforce shortage in King County. While the behavioral health walk in clinic does not directly address this issue, it has the potential to mitigate a huge barrier to treatment: waiting. When someone is seeking help and ready to walk through that door, we have to have a mechanism to keep that door open. A walk in clinic is a vital middle-of-the-road entry point and will support our commitment to recovery by helping create a "no wrong door" approach to care. Community Driven Grants - I am extremely happy to see that creating community-driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs is a listed priority for MIDD II. Clubhouse - the Clubhouse model needs ongoing support from MIDD and should not have funding reduced. Currently, Hero House is the only place in King County accredited by Clubhouse International, and acts as a model for other Clubhouses in the county. We desperately need a clubhouse on the west side of the county, to provide employment training and support, social engagement and friendship, and a sense of purpose for people working the path to recovery. We know that employment is a crucial component of recovery for so many people, and we know that social isolation can contribute significantly to negative mental health outcomes. Clubhouses provide much needed services outside the clinical/medical model - we need more this type of community based care, and we need to ensure that Clubhouses are not subjected to the changing whims of Medicaid funding. First Episode Psychosis Programs - Multiple research studies from around the world show that the longer psychosis goes untreated, the more serious it becomes. Other states, including our neighbor Oregon, have implemented FEP programs with great success. While Washington has its first FEP program pilot underway in Yakima, we need FEP here in the most densely populated county in our state. I interact with countless families whose lives have been turned upside down by psychosis in their teens and young adults, who are frustrated that this type of programming isn't available to them. This is a prime opportunity to pair MIDD funds and Best Starts for Kids funds to create a robust FEP program. Early interventions like FEP programs are a game changer that can dramatically improve the trajectory for young people experiencing psychosis.

Name: Deborah Lewy

Organization: HERO House

Comment: On SEP: The ASK: We are asking that funding of SE be at $1,250,000 which is 250k above previous MIDD 1 level.

1. If funded at the only 950K, this would be a decrease by 210K compared to the previous year's funding level. If only funded at 950K, our SEP employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys. Jobs are critical for our members to feel like they are back in the community; it increases their self esteem and lowers society's costs for supporting them.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance-based payment program, when we cut

performance-based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding.

On Our Clubhouse: The ASK: We are asking for King County/MIDD II to continue the current funding level of HERO House at $362,489 per year.

1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education and training programs.

2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff.

3. One year of recovery at HERO House costs the same as a 2-week psychiatric hospital stay: Clubhouse has been shown to be cost-effective.

4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House, which is double the average employment rate for people in the public mental health system.

We sincerely hope you continue to support HERO House and our funding needs over the next years, helping adults in King County with mental illness get back on track and recover their lives and jobs.