MIDD Briefing Paper

BP 141 Community-Driven Behavioral Health Grants for Cultural and Ethnic communities

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept X (Attach New Concept Form) Please note that is no new concept form provided. This paper was developed by county staff in response to extensive community feedback from MIDD review and renewal focus groups, especially with cultural and ethnic communities, conducted in January 2016.

Type of category: New Concept

Collaborators:

Name	**Department**

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below. *

** Note that these organizations' input was provided only in advance through the focus group process. Due to time limitations, staff were unable to provide these organizations with the opportunity to review and comment on drafts.*

Name	**Role**	**Organization**
Asian Pacific Islander communities focus group, January 19, 2016		Host organization: Asian Counseling and Referral Service
Hispanic communities focus group, January 20, 2016		Host organization: Consejo Counseling and Referral Services
Refugee Forum discussion, January 21, 2016		Host organization: DSHS Office of Refugee and Immigrant Assistance
African American communities focus group, January 21, 2016		Host organization: Atlantic Street Center
Native American communities focus group, January 22, 2016		Host organization: Seattle Indian Health Board
Trans* community focus group, January 25, 2016		Host organization: Ingersoll Gender Center
Somali community focus group, January 30, 2016		Host organization: Somali Health Board

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

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,[1] but culturally specific and accessible resources, along with community-designed and -informed services, are relatively lacking. The need for an avenue for community self-determination and services focused on the needs of specific groups, was highlighted by multiple population-specific focus groups conducted by King County MIDD in January 2016, as detailed in section B1.

MIDD would provide funding, oversight, and evaluation for small grants designed to support targeted community-initiated behavioral health-related services or programs designed by particular cultural or ethnic communities to address issues of common concern. This approach would replicate the structure of the successful King County Community Service Area Program's existing Community Engagement Grants,[2] except that this concept would be organized around particular populations rather than by geographic locations. In particular, this program would 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.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

☐ **Recovery and Re-entry** ☐ **System Improvements**

Please describe the basis for the determination(s).

By having cultural and ethnic communities design services that have the potential to improve access to care and retention in services in order to stop problems before they start and/or prevent problems from escalating, this concept fits best under prevention and early intervention.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need**

[1] 2014 census data, available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/king-county-profile.

[2] 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. Body text from this page, without links, is available as an attachment at the end of this document.

for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

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

- Underutilization and premature termination of treatment despite continued need;
- Disproportionately higher burden from unmet mental health needs;
- Poorer-quality care;
- Mistrust of the behavioral health system resulting from the cultural insensitivity of treating clinicians;
- Lack of culturally appropriate services including bilingual and bicultural staff;
- Collectivist cultural values that may make the individualistic process of psychotherapy foreign;
- Varying conceptions of the nature, causes, and cures of behavioral health conditions;
- Perceptions of stigma and shame; and
- Lack of health insurance coverage.[3]

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 focus groups conducted with seven cultural and ethnic groups in January 2016 as part of DCHS' work on review and potential renewal of MIDD.

Across all of the MIDD focus groups conducted for MIDD renewal activities, there was one main overarching theme: community organizations dedicated to specific populations need to be empowered and resourced to provide the needed services to their communities. The felt sense of cultural understanding and connection that marginalized community members experience with each other is viewed as vital to healing and creating healthy individuals and communities.

Under this umbrella, several requests for culturally responsive services emerged from the groups in King County that consulted as part of MIDD's community outreach:

- Address significant stigma around mental illness and substance abuse;
- Provide education around prevention;
- Provide education about behavioral health, via a focus on wellness due to stigma;
- Pay specific attention to subcommunities;
- Honor cultural beliefs;
- Use a holistic approach, addressing mental, emotional, physical, and social health needs;
- Encompass whole families, more than just the individual; and
- Provide organizational infrastructure resources and supports for culturally specific groups.[4]

[3] 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

Results from King County's MIDD review and renewal survey also highlighted this theme. In response to the question, "Please briefly describe needs or mental health or substance abuse service gaps you see in your community, where new or expanded mental health, substance abuse, or therapeutic court services could make a difference," respondents identified culturally and linguistically appropriate services as a major service gap and need area.

One survey participant summed up the issue this way: "Minority community members continue to experience disparity in mental health and substance abuse service access and outcomes. It applies to all MH/SA services including crisis, residential, inpatient and outpatient. Are minority members served at parity in each service area? If not, it is not because minority members do not experience crisis, or in no need for residential, inpatient or outpatient service. It is because the system is not equipped to create access for them. The minority community members as being from a certain population group, carry risk factors, such as many barriers and challenges stemmed from their cultural background, immigration and refugee experience, language, and stigma. These impacts access, quality of services, accurate diagnosis, and outcomes. The system should recognize the importance of equity and additional funding support to minority serving agencies and any agencies serving minority member. It does costs more to address the additional steps to ensure access and service for this population through culturally competent services. But at the end, regardless of their background and minority status, everyone deserves the same access and quality service."[5]

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

The community-initiated service delivery approach would provide a mechanism by which interventions can be tailored to the felt needs of disparate cultural and ethnic communities for whom standardized treatment approaches (such as traditional mainstream behavioral health clinics) do not fit or are not feasible due to a lack of culturally and linguistically appropriate services that address the community's felt needs.

This programming approach could support prevention and early intervention efforts that originate from community groups or are targeted to serve a particular population. Funds allocated through this concept could be distributed to nonprofit organizations and/or community groups for projects that address culturally specific behavioral health needs and include adequate and culturally relevant evaluation components and community-based oversight mechanisms.

Depending on the amount of funding allocated, staff could be funded through this strategy to help develop, implement, and/or evaluate community-initiated projects. Such coordinating staff would be expected to have deep ties to the particular community, and would most likely be housed at culturally specific grassroots organizations in order to increase their accessibility to community members.

Services delivered under this concept would engage community members to employ a public health approach, involving:

[4] 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.

[5] MIDD Review and Renewal Survey, September 2015 – February 2016. A summary of responses to this question about needs and service gaps is available at www.kingcounty.gov/middrenewal.

- Defining and measuring the problem;
- Determining the cause or risk factors for the problem;
- Determining how to prevent or ameliorate the problem;
- Implementing effective strategies on a larger scale and evaluating the impact; and
- Grounding interventions in the context of a balanced community health system, which includes health promotion, disease prevention, and early detection.[6]

This concept of community-initiated service design would follow the Harwood Institute's established key principles for ensuring that all voices are heard in public decision-making. Grassroots cultural and ethnic community groups seeking to launch services through this concept would have the opportunity to:

- Identify community issues rooted in people's shared aspirations;
- Develop strategies that fit their community's context;
- Create the community conditions that enable change to take hold;
- Forge relationships with the right partners;
- Build networks for innovation and learning;
- Adopt culturally appropriate metrics to gauge progress; and
- Cultivate can-do narratives in their communities.[7]

Furthermore, empowerment approaches like this one acknowledge every person's rights and responsibilities to contribute to and receive from community participation in a reciprocal relationship.[8] Empowerment approaches provide power to disenfranchised individuals and groups, and have been reported by local programs serving ethnic communities as an effective approach to service and support for their populations, especially those coping with trauma.[9]

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Public health research and policy supports community-driven approaches to service delivery, not only for behavioral health conditions but also for broader health promotion. The National Agenda for Healthcare Research and Policy Change from the Centers for Disease Control and Prevention (CDC) suggests that addressing the unmet health care needs of minority communities requires "culturally appropriate, community-driven programs focused on eliminating racial and ethnic disparities in health." The CDC further asserts that the needs of a particular community must be identified and health care resources, education, and services must be tailored to and made available to the entire community in a culturally appropriate manner.[10]

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[6] Satcher and Higginbotham (2008). The Public Health Approach to Eliminating Disparities in Health. *Am J Public Health*. 2008 March; 98(3): 400–403. doi: 10.2105/AJPH.2007.123919.

[7] http://www.theharwoodinstitute.org/approach/

[8] http://www.sau.edu/Academic_Programs/Master_of_Social_Work/Program/Curriculum/Empowerment_Method.html

[9] Phone interview with Carlin Yoophum, Refugee Women's Alliance (ReWA), December 2015.

[10] Disease Burden & Risk Factors, and Eliminating Racial and Ethnic Health Disparities. 2005. Centers for Disease Control and Prevention. Both cited in https://www.researchgate.net/profile/Luis_Riquelme/publication/6560541_Community_health_education_Reaching_ethnically_diverse_elders/links/02e7e52b87c7d4e89a000000.pdf

A foundational 2001 report of the Office of the US Surgeon General, called Mental Health: Culture, Race, and Ethnicity, endeavored to study mental health treatment needs in four major ethnic minority populations and make recommendations for approaches that might meet needs more appropriately. Below are some of its relevant conclusions:

- "African American communities must be engaged, their traditions supported and built upon, and their trust gained in attempts to reduce mental illness and increase mental health."
- "Professionals are encouraged by Indian and Native people to move beyond the exclusive concern with disease models and the separation of mind, body, and spirit, to consider individual as well as collective strengths and means in the promotion of mental health."
- "The ethnic matching of therapists with clients and the services of ethnic-specific programs have been found to be associated with increased use of services and favorable treatment outcomes. The development of culturally and linguistically competent services should be of the highest priority in providing mental health care for Asian Americans and Pacific Islanders."
- "To provide culturally responsive therapy for Latinos, it is critical that providers access the local world of their patients and their families. Doing so will suggest ways practitioners can integrate effectively the social and cultural context of their Latino patients with their own worlds to provide effective care."
- "Concerted efforts are needed to give voices to these relatively unheard stakeholders of the mental health system."[11]

The flexible, community-driven approach to behavioral health service delivery is based on an established model for empowering underserved communities that is already in place in King County. Formal evidence to demonstrate the efficacy this specific customized approach to behavioral health service delivery was not available at the time of this writing.

However, models of program design focusing on self-determined approaches for particular communities are also evident, both in King County and in other communities nationwide. Although many of these models are geographically based rather than grounded in particular ethnic communities, and often focus on infrastructure development, the principle of community-driven service design is a common theme.

King County's Communities of Opportunity (COO) effort – in partnership with the Seattle Foundation and the Living Cities initiative that invests in neighborhoods and improving quality of life in urban communities nationwide,[12] – aims to create greater health, social, economic, and racial equity in King County so all people can thrive and prosper. COO focuses on specific geographic areas in King County where there is evidence of elevated need and adverse outcomes,[13] engaging grassroots community groups to help determine what investments to make. COO and includes three strategy areas: helping all people thrive economically; ensuring all people have healthy, affordable homes; and supporting the

[11] http://www.ncbi.nlm.nih.gov/books/NBK44243/

[12] Basic information about Living Cities is available at https://www.livingcities.org/work. Living Cities' Integration Initiative is investing in neighborhoods and improving the quality of life for residents in Baltimore, Cleveland, Minneapolis-St. Paul, and Newark, as described in this executive summary of its recent three-year evaluation: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwi386fa3t7KAhVHzmMKHbyrA0cQFggjMAE&url=https%3A%2F%2Flivingcities.s3.amazonaws.com%2Fresource%2F283%2Fdownload.pdf&usg=AFQjCNECMdd7v4xozQBnl5D--I9v8lFSEA.

[13] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/coo/~/media/exec/HHStransformation/COO-2Pager-Factsheet.ashx

health of all people. This last strategy area includes increasing access, knowledge, perceptions, and cultural connectivity to preventive behavioral health (and social/emotional) opportunities.[14]

Engaging communities to design the changes that improve their quality of life is also an increasingly popular model nationwide. For example, the Minneapolis-St. Paul Corridors of Opportunity initiative through Living Cities supports the goals of Hennepin Community Works, an initiative that launches infrastructure projects involve a significant degree of local control, with multiple goals, among them to reshape troubled neighborhoods; to improve transportation; and to create new jobs.[15] Hennepin County's largest city, Minneapolis, has also responded to the evolving cultural needs of its population by designating a mayoral liaison specifically to the Somali community.[16]

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Emerging Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Community participants in local focus groups identified lack of resources and infrastructure as significant barriers to evaluation to develop evidence of program effectiveness. Culturally specific practices lack research support due to lack of funding and motivation in the research field to examine these community developed programs.[17] An alternative to evidence based programs, which one focus group participant described as "marginalizing,"[18] is practice based evidence (PBE).

According to a 2005 study of the intersection of evidence based practice and cultural competence in children's mental health, practice based evidence is "a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally specific framework. Practitioners of practice based evidence models draw upon cultural knowledge and traditions for treatment and are respectfully responsive to the local definitions of wellness and dysfunction. Practitioners of practice based evidence models have field-driven and expert knowledge of the cultural strengths and cultural context of the community and they consistently draw upon this knowledge throughout the full range of service provision: engagement, assessment, diagnosis, intervention, and aftercare."[19]

This service delivery approach, although based on an existing structure for investing in communities, would be an emerging approach to behavioral health service delivery. In principle it draws from prevention work being done through the state's Community Prevention and Wellness Initiative (CPWI) to reduce teen drug and alcohol use,[20] where communities are being engaged to implement prevention services. However, since the scope of potential interventions under this approach encompasses the full range of mental health and substance abuse services, it could address a range of potential issues of

[14] http://www.seattlefoundation.org/getinvolved/Pages/GlossaryandResources.aspx
[15] http://www.hennepin.us/~/media/hennepinus/your-government/projects-initiatives/community-works/2008-03-martin-jacobson-article.pdf?la=en
[16] http://www.minneapolismn.gov/mayor/news/WCMS1P-119899
[17] http://begun.case.edu/wp-content/uploads/2015/02/Road-to-Evidence-Cultural-Comp.pdf
[18] MIDD review and renewal focus group with Native American communities, January 2016.
[19] http://begun.case.edu/wp-content/uploads/2015/02/Road-to-Evidence-Cultural-Comp.pdf
[20] https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1464.pdf

concern, and could serve people of any age, offers much more flexibility than CPWI in what intervention could be offered in each community.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Potential outcomes of expanded upstream behavioral health capacity via this service delivery approach could include any of the following results for service users: reduced utilization of crisis systems including emergency departments; reduced behavioral health symptoms and risk factors as people reduce isolation and access needed supports. Symptom reduction could be measured using standard scales such as the PHQ-9, GAIN-SS, other proven tools that assess common mental health or substance abuse conditions.[21] Referrals to needed community-based services, including housing and entitlement resources, could be a measure of any intervention's effectiveness in delivering holistic assistance in alignment with focus group input regarding service to culturally specific communities.

Although participant outcomes are likely measurable for many potential interventions, statistically significant population-level outcomes (for whole communities) are not likely to be demonstrable given the modest scale of this concept and the relatively small number of community participants.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

- ☒ **All children/youth 18 or under**
- ☒ **Children 0-5**
- ☒ **Children 6-12**
- ☒ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☒ **Older Adults**
- ☒ **Families**
- ☒ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☒ **Racial-Ethnic minority (any)**
- ☒ **Black/African-American**
- ☒ **Hispanic/Latino**
- ☒ **Asian/Pacific Islander**
- ☒ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☒ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**
- ☒ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

[21] Depending on the interventions designed by the ethnic and cultural communities that participate in this program, administration of these clinical measures may or may not be appropriate. Alternative measures of effectiveness would need to be developed for communitywide interventions such as population-level prevention, or to ensure that unique cultural factors or local conditions are given sufficient consideration.

This concept, through its flexible service delivery model, would have the capacity to serve individuals of all ages. Specifically, eligible participating organizations or groups would need to demonstrate that they would provide services primarily to members of identified cultural or ethnic communities.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

As noted above, this concept focuses specifically on services to King County's cultural and ethnic communities. Marginalized communities have historically been located in underresourced urban areas. Climbing rent and housing costs in Seattle are leading displaced communities to relocate to south King County.[22] As a result, population specific organizations are serving broader geographic areas, increasingly focused on the south end of the county.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Partnerships between King County government and community groups, nonprofit organizations, faith-based organizations, senior centers, human service providers, and local elected officials will help ensure that: community members are aware of the opportunity to design and implement potential service enhancements; services are implemented where they are most needed; and interventions are designed with the involvement of community members and fit the needs of the particular cultural or ethnic community. This community-driven service delivery model depends especially on such community engagement and partnerships.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Because the baseline availability of publicly funded culturally specific behavioral health care in King County's cultural and ethnic communities is low, the need for interventions such as these will persist. It is conceivable that as clinical integration of physical and behavioral health becomes more widespread, primary care clinics could begin to address some of the behavioral health needs of some residents. Although important, behavioral health service through primary care clinics is unlikely, on its own, to address the full range of needs as thoroughly as community-based approaches that focus specifically on behavioral health and include culturally relevant engagement, case management and/or service delivery methods.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

[22] http://www.seattleglobalist.com/2015/07/07/confronting-gentrification-columbia-city-angeline-apartment/39095

Barriers to implementation of a community-driven approach include disseminating information effectively and equitably about the funding opportunity and guidelines. As noted above, community stigma around behavioral health conditions, including unwillingness to seek help, may also present challenges in carrying out interventions that are designed.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Some people may not be interested in services within their cultural or ethnic community. Due to concerns about confidentiality, embarrassment, and stigma service participants may prefer mainstream organizations as their care provider. (These funds would be targeted to culturally specific community organizations.)

Additionally, economies of scale allow larger organziations to provide services in a more cost-efficient manner than smaller organizations.

Enchancing the capacity of cultural and ethnic community organizations may lead to increased consolidation of expertise in these groups. Larger mainstream organizations need to continue to pursue cultural competence for cultural and ethnic communities including subcommunities. Decreased staff expertise and possible perceptions that cultural and ethnic community members can receive services elsewhere may slow momentum and impede progress in the effort to improve cultural competence at generalist organizations.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Access to behavioral health care in King County's cultural and ethnic communities will continue to be constricted as a result of the access barriers articulated in section B1 above.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

A volunteer-based approach is used by some community groups. Some of the outreach, engagement, education, and culturally specific services that community organizations currently provide are unfunded. While it may negatively impact staff and limited resources, these services are seen as a community need that must be met. By necessity, volunteer-based and unfunded services are limited in scope.

Communities may utilize grants or funding from foundations, city, state, or federal governments. For example, the Seattle Youth Violence Prevention Initiative works with community organizations and local communitites to ensure youth are safe and have a safe community.[23] Alternative approaches may be confined to a geographic area or may not include the level of engagement with cultural or ethnic

[23] http://safeyouthseattle.org/

populations that would be involved in the community-developed services that would be supported by this concept.

As noted in D3 above, established mainstream providers, and existing mid-sized and larger culturally specific behavioral health providers, may be able to provide some culturally relevant services using existing state or federal funding. However, these organizations' ability to provide flexible services – that are truly designed by the local community to address current felt needs – may be constricted by the regulations and traditional structures that come along with state and federal funding.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

As noted above, although the communities to be served under this concept are organized culturally and ethnically rather than geographically, this approach supports the main principle of the Health and Human Services Transformation Plan's Communities of Opportunity strategy, which aims to support targeted communities in developing capacity and solutions that shape the health and well-being of residents.[24] At the individual/family level, HHSTP's goal to improve access to person-centered, integrated, culturally competent services when, where, and how people need them is at the heart of this overarching concept.[25]

The overarching goals of physical and behavioral health integration, to create a system of care that improves health and social outcomes, improves clients' experience of services, and reduces avoidable emergency system use, with the aim of delivering whole person care, are also strongly reflected in this concept.[26]

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

Adding new mechanisms for individuals in communities to receive culturally specific, community-driven behavioral health services would help take this community's system toward the vision of the 2012 King County Recovery and Resiliency Ordinance, which promotes service delivery within a "trauma-informed, recovery and resiliency focused system that offers respect, information, connection and hope."[27] To serve the entire county, it is important to extend the reach of this vision to cultural and ethnic communities that are often unable to receive culturally competent care in the larger King County provider system.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

[24] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/coo.aspx
[25] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/background.aspx
[26] http://www.kingcounty.gov/healthservices/MHSA/BehavioralHealthIntegration.aspx
[27] http://www.kingcounty.gov/~/media/health/mentalHealth/Recovery/Documents/130502_Recovery_Ordinance_11-6-12.ashx?la=en

This concept directly addresses a key determinant of equity identified as part of the County's equity and social justice (ESJ) work. It would improve access to health and human services for individuals who currently do not or cannot access traditional behavioral health service resources, due to the fact that the services are not culturally competent. These individuals often end up either untreated or waiting to seek help until they must access emergency care due to a crisis.[28]

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

This approach could be very minimally staffed if needed. Particular resources needed would be determined by the proposals that are generated by the community groups who apply for funds.

2. **Estimated ANNUAL COST.** $100,001-500,000 per service delivery option. **Provide unit or other specific costs if known.**

A pilot of the community-driven grant program is estimated to cost approximately $50,000 per program per year, for a total of $500,000 to cover as many as ten community-driven programs. Funding for community-designed services could be increased to $100,000 or more per year per program if there is sufficient demand and available resources.[29] Due to the grantmaking framework of this approach, this service delivery option could be scaled up or down over time to fit with available resources and community needs. An important consideration in the distribution of these funds would be to ensure that the mix of programs funded through this concept is broadly representative of King County's cultural and ethnic communities, with multiple communities and organizations engaged actively in the design process and receiving funding.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

There may be intermittent grant opportunities that could fund some of these programs, from private, municipal, county general fund, state, or federal sources. However, such funding is limited and – aside from the CSA program at King County that is designed for rural communities – often does not originate from a community-driven process.

Best Starts for Kids (BSK) is a new King County levy designed to invest in prevention and early intervention services. It may present funding opportunities for community-informed programs that are focused on children and youth, although program approaches for BSK are still being designed.[30] The Department of Community and Human Services will be coordinating BSK and MIDD efforts to ensure that there is no duplication of services or funding.

[28] http://www.kingcounty.gov/elected/executive/~/media/elected/executive/equity-social-justice/2015/2015ESJinfographic_pagesLTR_print_booklet,-d-,pdf.ashx?la=en

[29] In-person consultation with Geoff Miller, King County BHRD (MHCADSD), December 2015.

[30] Community-informed approaches are being considered as part of BSK's effort to support programs built on practice based evidence, according to personal communications with Margaret Soukup, King County BHRD (MHCADSD).

While there may be funding from other sources, this MIDD concept could enable more communities to be served and allow for a completely community-driven program or service that is not focused on the goals of a specific grant program or age group.

4. **TIME to implementation:** Less than 6 months from award
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

Because this service delivery approach would require more detailed design to ensure a match between resources and the needs of specific ethnic or cultural communities, and would require a selection process to identify providers or community organization grantees, implementation would take some time. Existing community organizations with deep community relationships and sufficient infrastructure may be able to implement services within three to six months of award.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Programs and services for cultural and ethnic groups are increasingly recognized as an area where further program development is needed, since the specialized needs of subcommunities can be lost or overlooked. As one MIDD focus group participant said "LGB is not the same as T," referencing the unique needs of trans* individuals.[31] Worldviews, values, traditions, and experiences can vary greatly and need to be honored and addressed with tailored services. As one Somali focus group participant stated, "There are no two communities that handle this the same way."[32]

This paper links to at least the following other briefing papers:

The organizational and funding approach for this concept, along with some of the information about the need for and potential benefits of community-designed services, parallel BP 11 36 94 Improving access to behavioral health services in rural King County, which incorporates this approach as one of its service delivery options.

Two other briefing papers with links to this concept are BP 32 Community based mental health for youth at risk and BP 31 121 Area prevention network and communities in action promoting prevention.

[31] MIDD review and renewal focus group with trans* community, January 2016.
[32] MIDD review and renewal focus group with Native American communities, January 2016.

Information about the Existing King County Community Engagement Grants Program
Retrieved from http://www.kingcounty.gov/exec/community-service-areas/engagement-grants.aspx
February 1, 2016

2016 Community engagement grants

King County Community Service Areas

Purpose
The purpose of the Community Engagement Grants is to fund community projects that offer unincorporated area residents in the Community Service Areas an opportunity to participate and be more connected in their communities. Funded projects must demonstrate how activities are accessible to all residents regardless of race, income, or language spoken.

Due
Applications are due by 5 p.m. on Monday, November 16, 2015.

Funds Available
A total of $60,000 will be reimbursed for projects in 2016. The King County Department of Natural Resources and Parks Community Service Areas Program will provide funds to selected projects through a letter of award and Memorandum of Agreement. Amounts will be limited to less than $5,000 per project. A complete list of selected projects will be available online.

Funding priority goals
Community Engagement Grants will support projects that advance the King County Strategic Plan and achieve one of the following goals:

- Promote the engagement of unincorporated area residents in community or civic activities
- Educate local residents about issues impacting them
- Implement a community enhancement project
- Meet King County's equity and social justice goals of increasing fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency.

Project examples (Not Inclusive)
Community events such as concerts, festivals, educational/safety
Community enhancement projects such as tree planting, graffiti removal and neighborhood clean-up
Community-led planning or training
Neighborhood or community signage

Selection criteria

- Priority will be given to projects that are one time or time limited in scope; ready to be implemented, and will be completed in 2016.
- Project clearly addresses one or more of the Funding Priority Goals stated for the Community Service Area Grants.
- Project location and target population are within the unincorporated Community Service Areas and are free and open to all members of the general public within unincorporated King County and provides a public benefit.

- Projects are not intended to support infrastructure or ongoing operational costs of locally funded governmental organizations.
- Project demonstrates how activities are accessible to all residents regardless of race, income, or language spoken.
- Project objectives and activities encourage community engagement and high community participation.
- Project has identified clear outcomes or results and a specific work plan to achieve them.
- Project has a viable plan for continued support and maintenance.
- Project demonstrates community outreach and support.
- Project demonstrates community support based on the level of community involvement by the project partners.
- Project budget is realistic and achievable and the funding request is specific and attributable to the project.
- Project match is at least 25% of total project budget.
- Geographic distribution of funds will be considered.

Match
A minimum match of 25% of the total project cost is required. Match can be in the form of volunteer time, cash or other forms of in-kind services and other resources from project partners and contributors.

Eligible applicants
Locally-based community-led organizations in the unincorporated Community Service Areas and organizations based within a city but serve unincorporated area residents that encourage collaborations and partnerships in unincorporated King County.

Applicant status
If your organization is not incorporated, you must designate a fiscal sponsor. Partnership with local non-profits is encouraged. Please contact the CSA Grant staff lead for guidance and support.

Unincorporated Community Service Area description

Bear Creek/Sammamish Area – Western boundary is the urban growth line near Woodinville, the northern boundary is the King-Snohomish County line. The east and south boundaries follow the watershed ridge line. This CSA contains the Sammamish Agricultural Production District.

Snoqualmie Valley/NE King County Area – Western boundaries are the ridge line of the Bear Creek CSA and the urban growth line. Southern boundaries are the watershed line, forest production district and I-90. Northern boundary is the county boundary with Snohomish County. This CSA contains the Snoqualmie Agriculture Production District and a portion of the Forest Production District.

Four Creeks/Tiger Mountain Area – The western and northern boundaries are the urban growth line, I-90 and the Forest Production District boundary (joint boundary with Snoqualmie Valley/NE KC Area). The eastern and southern boundary is the Tahoma School District boundary (joint boundary with Greater Maple Valley/Cedar River CSA).

Greater Maple Valley/Cedar River – The western boundary is the urban growth line, north boundary is the watershed line, forest production district boundary and I-90 (Snoqualmie Valley CSA). The eastern

boundary is the county boundary with Kittitas County; the southern boundary is the watershed line (SE KC CSA). This CSA contains portions of the Forest Production District.

SE King County Area – The western boundary is the urban growth boundary, the northern boundaries are the urban growth and the watershed line (Greater Maple Valley CSA). Boundaries to the east are Kittitas County and to the south is the Pierce County line. This CSA contains the Lower Green, Middle Green, and Enumclaw Agriculture Production Districts and a portion of the Forest Production District.

Vashon/Maury Island Area – Vashon-Maury Island is bounded by and located in Puget Sound.
West King County Areas – This CSA contains the remaining urban unincorporated potential annexation areas located throughout West King County. All of these areas are either bounded by existing cities or the urban growth boundary. The identified major potential annexation areas include: North Highline, West Hill, East Federal Way, Fairwood, and East Renton.

Application deadline
Applications are due Monday, November 16, 2015 by 5 p.m.
Please use the King County Community Service Areas Grant Program Application Template (99 KB MS Word Doc) for your application.
Applications must be received by 5 p.m. on November 16, 2015 via the following:

- Electronically: Marissa Alegria
- Physically at the following location:
  Dept. of Natural Resources and Parks, Director's Office ATTN: Marissa Alegria
  201 South Jackson Street, Suite 700
  Seattle, WA 98104

The application packet is available to download in either MS Word or PDF format.
Marissa Alegria, CSA Grant staff lead will be available to respond to questions in person regarding the CSA Grant Application at the following location and time:

- Wednesday, October 14, 2015, 9-11:30 a.m.
- Tuesday, November 3, 2015, 1:30-3 p.m.

King Street Center, 8th Floor Conference Room 8-E
201 South Jackson Street
Seattle, WA 98104
Marissa Alegria is also available to answer questions by phone at 206-477-4523 or e-mail or by setting up an appointment to meet at a more convenient location.

Project Completion
Projects must be completed within 12 months.

Allowed Costs
Reasonable expenses that are attributable and clearly needed for the project and outlined in the budget.
King County reserves the right to determine the nature and manner in which costs and items will be paid for in any grant.

Reporting Requirements
Grantees will submit a final report documenting that the outcomes and measures defined for project success were met. Project results may be published in a report which will be available online.

Other Requirements
Funded projects may be asked to participate and/or attend the annual CSA Open House held in the project area.
Funded projects must acknowledge King County contribution to event or project.
The project applicant is responsible for the following:

- Establish a record keeping system which includes a breakdown of cash and in-kind contributions as well as grant funds and retain these records for three years after the project is completed.
- Tax reporting is the responsibility of the applicant.

For more information, please contact Marissa Alegria 206-477-4523 / TTY 711.

*Final funding availability is contingent on approval of the 2015-2016 King County Budget