MIDD Briefing Paper

ES 14a: Sexual Assault/Mental Health Services and System Coordination

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number: 14a **(Attach MIDD I pages)**
New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: MIDD I Strategy 14a (Sexual Assault/Mental Health Services and System Coordination) primarily funds mental health services for a minimum of 135 clients per year[1] at two of King County's community sexual assault programs (CSAPs).[2] Taken together, provider agencies funded under this strategy typically exceed this target significantly, due to their ability to blend funds from other resources. This program/strategy aims to increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County, and increase coordination between programs serving sexual assault survivors who are experiencing mental illness, substance abuse and domestic violence.[3]

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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.

[1] MIDD Seventh Annual Report.
[2] http://www.wcsap.org/find-help
[3] MIDD Action Plan Strategy Description, 2008.

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?

MIDD I Strategy 14a (Sexual Assault/Mental Health Services and System Coordination) primarily funds mental health services for a minimum of 135 clients per year[4] at two of King County's community sexual assault programs (CSAPs).[5] Taken together, provider agencies funded under this strategy typically exceed this target significantly, due to their ability to blend funds from other resources.

Services currently provided by the CSAPs as part of this program 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; and
- Referrals to community mental health and SUD treatment agencies for those sexual assault survivors who need more intensive services.[6]

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 needs including medical, forensic, crisis response, information, advocacy and counseling. Often victims and families do not even have a clear sense of what their needs are. In traditional public mental health settings, they are eligible for services if they meet access to care criteria related to a mental health disorder, and they receive mental health services that may or may not be evidence-based.

Specialized sexual assault programs are designed to provide holistic services that can be tailored to the sexual assault-specific needs of victims. Because of their experience with and depth of knowledge of all aspects of sexual assault, the organizations are equipped to anticipate and respond based on an individualized assessment of needs. These programs can provide the services directly through a trauma-informed lens, or refer to other providers. This holistic response means that the programs can address the full range of concerns about legal, medical and other systems that may adversely affect mental outcomes, while also providing brief early interventions to reduce the likelihood of longer term mental health distress. Those who develop persisting sexual assault-specific mental health problems are effectively treated via evidence-based interventions delivered by these specialized programs.

In addition, this strategy and strategy 13a (Domestic Violence Mental Health Services and System Coordination) together fund a 0.8 full time equivalent (FTE) mental health professional at an agency specializing in the provision of services to immigrant and refugee survivors of domestic violence (DV).

[4] MIDD Seventh Annual Report.
[5] http://www.wcsap.org/find-help
[6] Contract Exhibits for King County Sexual Assault Resource Center (KCSARC) and the Harborview Center for Sexual Assault and Traumatic Stress (CSATS).

This person primarily serves as a clinical consultant and trainer for the agency's team of domestic violence counselors providing direct care to clients in 17 languages.[7]

In addition to the collaboration and coordination that currently exists within the domestic violence and sexual assault response networks, strategies 13a and 14a also together currently fund a 0.8 FTE Systems Coordinator/Trainer to coordinate ongoing cross training, policy development, and consultation on 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.[8]

The target populations for this strategy are:

- Adult, child and youth survivors of sexual assault who are experiencing mental health and substance abuse concerns will have access to early intervention services and prevention of severe mental health issues, and
- Providers at sexual assault, mental health, substance abuse, and domestic violence agencies who work survivors of sexual assault with mental health and substance abuse issues and participate in the coordination and cross training work of this program.[9]

According to the demographic information collected by the MIDD evaluation team, this strategy served 1,191 individuals from October 2008 through September 2014.[10]

This program/strategy aims to increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County, and increase coordination between programs serving sexual assault survivors who are experiencing mental illness, substance abuse and domestic violence.[11]

A recommendation for a modest expansion, to include staff at additional agencies serving special populations, is reflected in this analysis. However, additional needs arising from a focus group whose input is informing MIDD program development are identified in section B1.

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).

[7] Phone interview with Carlin Yoophum, Refugee Women's Alliance (ReWA), December 3, 2015. NOTE: FTE will increase to 1.0 in 2016 due strategy restoration/supplemental budget

[8] Phone interview with Alicia Glenwell, Coalition to End Gender-Based Violence (CEBGV, formerly known as the King County Coalition Against Domestic Violence), December 15, 2015. NOTE: FTE will increase to 1.0 in 2016 due strategy restoration/supplemental budget

[9] MIDD Action Plan Strategy Description, 2008.

[10] Demographics by strategy, strategy 14a Sexual Assault Services.

[11] MIDD Action Plan Strategy Description, 2008.

Strategy 14a fits well within the Crisis Diversion strategy area, as a specialized and evidence-based response to individuals who have recently been the victims of sexual assault addresses unique needs of individuals at a pivotal crisis moment and in the weeks thereafter.[12] Appropriate and timely intervention can prevent or reduce more severe or longer-term trauma-related health or mental health conditions,[13] so the Prevention and Early Intervention strategy area may fit as well.

This strategy also addresses the Systems Improvements area. The coordination element of this strategy aims to boost traditional mental health and SUD agencies' ability to provide appropriate and informed immediate responses and evidence-based treatment to victims of sexual assault, while also expanding the capacity of CSAPs to deliver needed mental health treatment within the specialty program based on clinical need rather than benefit eligibility.[14]

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 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.

Although the rates of rape and child sexual abuse are declining like other types of crimes, the demand for sexual assault-related services has stayed steady. This makes sense considering that the large majority of victims have not historically come forward. In all likelihood the availability of specialized services has played a very important role in promoting a community climate where the gap can be closed. By having specialized sexual assault services available, victims know that they can expect a supportive and tailored response.[15] This is especially true in communities like Seattle and King County where specialized CSAPs have received broad-based support.[16]

The National Intimate Partner and Sexual Violence Survey (NISVS) is an ongoing, nationally representative survey conducted by the Centers for Disease Control that assesses experiences of sexual violence, stalking, and intimate partner violence among adult women and men in the United States. The most recent 2010 report[17] indicates the following statistics:

- Nearly 1 in 5 women (18.3 percent) and 1 in 71 men (1.4 percent) in the United States have been raped at some time in their lives.
  - Nearly 3 in 10 women and 1 in 10 men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one impact related to experiencing these or other forms of violent behavior in the relationship (e.g., being fearful, concerned for safety, post traumatic stress disorder (PTSD) symptoms, need for health care, injury, contacting a crisis hotline, need for housing services, need for victim's advocate services, need for legal services, missed at least one day of work or school).

[12] Phone interview with Lucy Berliner, Harborview CSATS, December 10, 2015.
[13] Phone interview with Mary Ellen Stone, DeAnn Yamamoto, and Larraine Lynch, KCSARC, December 2, 2015.
[14] Phone interview with Alicia Glenwell, CEGBV, December 17, 2015.
[15] Memo from Lucy Berliner, Harborview CSATS, December 14, 2015.
[16] Interview with Lucy Berliner, Harborview CSATS, December 10, 2015.
[17] http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf

  - Men and women who experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health than men and women who did not experience these forms of violence. Women who had experienced these forms of violence were also more likely to report having asthma, irritable bowel syndrome, and diabetes than women who did not experience these forms of violence.
  - Analyses of 2010 NISVS data suggest that nearly half of female victims and approximately two thirds of male victims who indicated a need for services did not receive any of the services needed as a result of intimate partner violence experienced during their lifetimes.
- Washington State:
  - An estimated 42.6 percent of Washington State women have a lifetime incidence of rape, physical violence, and/or stalking by an intimate partner. This translates to an estimated 1,094,000 victims.

Intimate partner violence (IPV), which may include sexual assault, is associated with a range of trauma-related health and mental health effects. Research conducted over the past 30 years has consistently demonstrated that being victimized by an intimate partner increases one's risk for developing depression, PTSD, substance abuse and suicidality as well as a range of chronic health conditions.[18] Reviews of the literature support this with the following statistics:

- Survivors of sexual assault are significantly more likely to be diagnosed with anxiety disorder, depression, eating disorders, posttraumatic stress disorder, sleep disorders and suicide attempts.[19]
- Psychological consequences of sexual trauma in childhood and adulthood are diverse and highly individualized. Whereas a large portion of the literature has focused on PTSD symptoms, survivors are also at risk of experiencing a range of other mental health problems, such as depression, suicidal thoughts and attempts, problem alcohol abuse, disordered eating behaviors, and sexual dysfunction.[20]
- Compared to women who have not experienced IPV, survivors have nearly double the risk for developing depressive symptoms, and three times the risk for developing major depressive disorder.[21]
- Women exposed to IPV are up to three times more likely to engage in deliberate self-harm.[22]
- Women who reported partner violence at least once in their lifetime are nearly three times as likely to have suicidal thoughts and four times as likely to attempt suicide.[23]

[18] National Center on Domestic Violence, Trauma & Mental Health 2014 Fact Sheet entitled *Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness*

[19] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2894717/

[20] http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=349

[21] Beydoun, H.A., Beydoun, M.A., Kaufman, J.S., Lo, B, Zonderman, A.B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. Social Science & Medicine, 75(6), 959-975.

[22] Boyle, A., Jones, P., Lloyd, S. (2006). The association between domestic violence and self-harm in emergency medicine patients. Emergency Medicine Journal, 23, 604–607.

[23] Ellsberg, M., Jansen, H.A., Heise, L., Watts, C.H., Garcia-Moreno C; WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. Lancet, 371(9619), 1165-1172.

National studies such as the NSVIS advocate for the coordinated approach provided by King County's CSAPs. "In addition to prevention efforts, survivors of sexual violence, stalking, and intimate partner violence need coordinated services to ensure healing and prevent recurrence of victimization. The healthcare system's response must be strengthened and better coordinated for both sexual violence and intimate partner violence survivors to help navigate the health care system and access needed services and resources in the short and long term. One way to strengthen the response to survivors is through increased training of healthcare professionals. It is also critically important to ensure that legal, housing, mental health, and other services and resources are available and accessible to survivors."[24]

While there is a certain overlap between domestic violence and sexual assault, with some domestic violence victims also being sexually assaulted, sexual assault victims have different experiences and special needs following the assault. DV by definition always involves an intimate partner. The large majority of adult sexual assault victims are assaulted by acquaintances with 10 to 15 percent assaulted by strangers.[25] The statistics are similar for children, with most sexual abuse being committed by known offenders with only a minority being family members.[26] In addition, up to one third of child victims are assaulted by adolescent offenders.

Victims of sexual assault face two unique challenges. Sexual assault by its nature occurs in private. Witnesses are rare and typically the acts do not leave visible injuries or scars. When coercion through manipulation, deception, intimidation or force is not present, adults can consent to sex, whereas no one consents to be beaten or robbed. These factors combine with social and cultural beliefs, perspectives of gender roles, sexual relationships and violence to create higher rates of disbelief and blame of sexual assault victims. This is in part why so many victims do not come forward and those who do are often uncertain, worried and fearful. Therefore availability of a specialized response is critical for sexual assault victims. Many victims turn to their natural supports or other professionals when they first tell someone. Those family and friends as well as professionals typically will not have the specialized knowledge about what victims need, what is available, and what happens. They benefit by having a specialized community resources that can assist them in directing the victim to the best services. Victims (or parents of child victims) have several typical concerns and needs for which a specialized response is essential. The specialized response includes the availability of a Sexual Assault Nurse Examiner (SANE) exam[27], which is now the standard of care, access to support and validation, accurate and helpful information and help in decision-making about next steps.[28]

Child and adult victims of sexual assault have among the highest rates for developing significant and persisting trauma-specific psychological distress (higher than veterans, for example), including depression, anxiety and post-traumatic stress disorder (PTSD). Many victims are initially reluctant to engage in trauma-focused therapy because they are apprehensive about facing up to what happened and directly dealing with it. Therefore, they often need additional engagement efforts to undertake therapy. And like all clients seeking mental health services, victims may not engage or do not always complete a full course of therapy. This means the usual barriers to engagement in needed mental health

[24] http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf
[25] Berliner, Fine, Moore. (2001). Sexual assault experiences and perceptions of community response to sexual assault: a survey of Washington women. Office for Crime Victims Advocacy, Washington State Office of Community Development.
[26] http://www.unh.edu/ccrc/pdf/CV171.pdf

[27] http://www.forensicnurses.org/?page=aboutsane
[28] Memo from Lucy Berliner, Harborview CSATS, December 14, 2015.

services are magnified for sexual assault victims, increasing the importance of a well-informed and evidence-based approach.[29]

Local service needs identified in October 2015 by a focus group of domestic violence and sexual assault providers in King County[30] included:

- Increased sexual assault therapy capacity;
- More cross-training for mental health, substance abuse, domestic violence, and sexual assault providers in areas where they lack expertise, including specific training for community agencies by domestic violence and sexual assault specialists;
- More mental health professionals in traditional mental health agencies who specialize in domestic violence and sexual assault, and co-located advocates;
- Mobile child/parent services for survivors and their families, which could be provided in homes, workplaces, or community spaces;
- Greater access to services for people who are undocumented; and
- Funding for language and cultural consultation for providers.
- Funding to cover the gap between insurance coverage and out of pocket costs for victims such as co pays.

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

As described above, survivors of sexual assault are at greater risk of developing a variety of mental health disorders, including depression, anxiety and PTSD. Some survivors may be in an environment of ongoing trauma, which can prolong and exacerbate their mental health concerns, increase their vulnerability and compromise their safety. Compared to other mental health clients, sexual assault victims (children, teens and adults) may have a unique interaction with the child protection or criminal legal system that can be protracted. For criminal cases, it is not unusual for cases to take 2 years to reach resolution. This extended period where the outcome is uncertain can prolong stress and result in victims feeling that their lives are on hold. Because, unlike domestic violence, few offenders in sexual assault cases are intimate partners, victims mostly want prosecution and their mental health can be negatively affected by the lengthy process and certain aspects of it such as defense interviews.

The model of an early, accessible mental health intervention offered by these programs combined with integrated advocacy and other supportive services decreases the risk of significant mental health impact of participation in the legal process and increases survivor stability and capacity to cope. The availability of these holistic services serves as a mechanism to promote survivor coping during the process and reduce barriers to help seeking. Furthermore, as described in B3 below, CSAP-based programs under this strategy offer evidence-based approaches that have been proven effective in reducing trauma symptoms.

Services offered under this strategy are more accessible, appropriate and effective for many survivors than other existing mental health service options in King County.

[29] Memo from Lucy Berliner, Harborview CSATS, December 14, 2015, and memo from Mary Ellen Stone, KCSARC, December 15, 2015.
[30] MIDD Focus Group Behavioral Health Discussion, October 8, 2015, Mercer Island Community Center.

- These programs enable survivors of sexual assault without Medicaid, insurance or private means of payment to access trauma-informed services that are specific to their MH and safety needs.
- The mental health professionals in this strategy have expertise in providing appropriate trauma-informed services that reduce safety concerns and other negative implications of accessing MH services.
- Services are culturally and linguistically appropriate for a significant number of refugee and immigrant communities; many services at traditional community and private mental health organizations are not. This funding increases the capacity of the advocates at this agency to identify, understand and respond to survivors' MH concerns.
- Many sexual assault survivors are victim/witnesses and are heavily involved in criminal justice proceedings related to their experience. Community and private MH providers are not familiar with what to expect in criminal and/or civil justice matters and less able to help a survivor navigate the often confusing, intimidating legal system.
- The CSAPs offer mental health services as part of a specialized, comprehensive package of holistic services that speak to the unique needs of sexual assault survivors. In addition to working directly with victims, CSAPs provide supportive counseling and specialized education to parents whose child has been sexual assaulted or partners of adult rape victims. This insures that the victim's family is able to understand and cope with the assault as a key part to victim recovery.

Strategy 14a funding for mental health professionals working in sexual assault agencies provides survivors greater access to appropriate mental health services, but many survivors still receive their primary behavioral healthcare elsewhere. The significant links between survival of sexual assault and behavioral health concerns mean that many service recipients at community behavioral health agencies have had or will have experience with this kind of trauma. Sexual assault can have far-reaching implications for a therapist's role in addressing a survivor's physical health, safety, healing, and connection to community support, as well as the use of trauma-informed clinical practices. Though therapists can work individually to address their clients' trauma, many agencies do not have effective screening and identification practices, protocols for consistent, meaningful assessment of the nature of the assault or safety implications, or strong consultative and referral relationships with their sexual assault service colleagues. The systems coordinator addresses these gaps through training, consultation, policy and practice review, referral facilitation, training protocol development, and formal relationship-building.[31]

The coordinator role funded in part by this strategy also supports the broader domestic violence and sexual assault response system by improving the collaboration and coordination between survivor advocacy programs, connecting survivor advocacy programs to criminal and civil legal systems, advocating on behalf of community-based agencies and coordinating system change efforts. Furthermore, through training and consultation, it increases the capacity of the clinicians in traditional mental health and substance abuse agencies to identify, understand, and respond to survivors' mental health concerns.

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**

[31] Notes on Systems Coordination for MIDD Strategy 14a, received from Alicia Glenwell (CEGBV), December 17, 2015.

evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

For those victims who do develop PTSD or trauma-specific depression, there are well established psychological treatments. These treatments are not specific to sexual assault, but have been shown to work for the range of trauma experiences including sexual assault. Such early intervention decreases the risk of mental health concerns, increases stability and one's capacity to cope. Empirically supported techniques and interventions to treat sexual assault also reduce the incidence and severity of chemical dependency and mental and emotional disorders in children, youth and adults.[32] Evidence-based treatments delivered by one or both of the CSAP providers funded under this strategy include:

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)[33]
- Prolonged Exposure (PE)[34] and Prolonged Exposure-Adolescent (PE-A)
- Cognitive Processing Therapy (CPT) [35]
- Parent Child Interaction Therapy (PCIT)
- Common Elements Treatment Approach (CETA)[36]
- Other evidence-based approaches proven effective for post-traumatic stress disorder,[37] including interventions specifically for children.[38]

Services provided by the immigrant and refugee organization under this strategy are not as strictly or consistently evidence-based as the work of the CSAPs. Counselors who deliver mental health screening and care use relational approaches focused on empowerment, which the agency has found to be most effective in its work with a continually evolving and international client population that may not be as open to direct work on trauma. Although efforts focus primarily on case management work such as housing stabilization and employment, clinical progress is measured at the individual client level using a brief survey tool and depression scales such as the PHQ-9.[39] The evidence base for practices serving refugee and immigrant communities is still evolving and developing. The relational and empowerment model that is used is anecdotally reported by clients to be empowering and provide a safe place to talk. Staff members are being trained in CETA, and it provides a helpful structure for working with clients.

Despite the strong evidence base from national and international literature of the effectiveness of the approaches used at CSAP providers, outcome data for the specific clients served through the direct

[32] Memo from Lucy Berliner, Harborview CSATS, December 14, 2015, and memo from Mary Ellen Stone, KCSARC, December 15, 2015.

[33] http://nctsnet.org/sites/default/files/assets/pdfs/tfcbt_general.pdf

[34] http://www.apa.org/monitor/jan08/ptsd.aspx, http://www.ptsd.va.gov/public/treatment/therapy-med/index.asp, and http://www.ptsd.va.gov/professional/treatment/overview/index.asp

[35] http://www.ptsd.va.gov/public/treatment/therapy-med/index.asp, http://www.ptsd.va.gov/professional/treatment/overview/index.asp

[36] Bolton P, Lee C, Haroz EE, Murray L, Dorsey S, et al. (2014) A Transdiagnostic Community-Based Mental Health Treatment for Comorbid Disorders: Development and Outcomes of a Randomized Controlled Trial among Burmese Refugees in Thailand. PLoS Med 11(11): e1001757. doi:10.1371/journal.pmed.1001757.

[37] Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). *The Cochrane Database of Systematic Reviews* 2005, Issue 3. Art. No.: CD003388.pub2. DOI: 10.1002/14651858.CD003388.pub2.

[38] http://www.sciencedirect.com/science/article/pii/S1056499313001065

[39] Phone interview with Carlin Yoophum, ReWA, December 3, 2015.

service aspects of this MIDD strategy are limited, as data reported to MIDD to date has primarily taken the form of outputs and client or clinician surveys. However, agencies report frequent ongoing monitoring of client progress, especially in symptom reduction, using a variety of standardized instruments that relate to the therapy being provided.[40]

One CSAP provider reported that according to such measures administered every 90 days in 2015, 94 percent of adult clients achieved symptom reduction, understanding of the impact of sexual assault on their lives, and increased coping ability, while 91 percent of youth clients showed gains in such areas as emotional stability, interpersonal functioning, and achieving their goals.[41] MIDD reports (encompassing results from all three direct service providers) showed similar results. For example, the most recent report showed that all providers reported outcomes success for measured variables in excess of 85 percent for eligible clients. Cases where clients did not increase their understanding of the experience affecting them were extremely rare. Therapists noted that coping skills increased for nearly all clients at the same time that negative symptoms in these clients were reduced. Only about one in ten adults and children were unable to achieve their treatment goals, often due to relocation prior to treatment completion.[42] Older MIDD reports included such information as positive overall outcomes (88 percent of clients in 2010-11),[43] reduced negative symptoms (65 percent of adults in 2010-11),[44] and achievement of two or more of the following: understanding their experience, coping skills, symptom reduction, and accomplishing treatment goals (92 percent of clients in 2010-11).[45]

The work of the system coordinator over the course of MIDD to date is measured primarily in terms of outputs, as evidence of changed clinician behavior toward victims has not been measured. Key activities include:

- Over 1,800 professionals trained on a wide range of topics, including: screening and assessment practices, clinician safety planning, community resources, working with advocates, engaging with survivors, etc.
- Average of 29 hours of consultation per year with a wide variety of behavioral health, DV, sexual assault, King County administrative, and law enforcement agencies.
- Many projects with individual programs including policy and practice review, referral facilitation, training protocols, and formal relationship-building.

Several outcomes can reasonably be expected from this coordination activity. Training evaluations, anecdotal reports, and concrete policy/practice changes reportedly suggest progress in these areas, although no rigorous outcome measurement has occurred:[46]

- Increased clinician and advocate knowledge and understanding of the intersections of sexual assault and behavioral health and skills necessary to address them.
- Enhanced agency polices and practice for screening, assessment and response.
- Increased clinician and advocate knowledge of and comfort with effective referral practices.
- Increased access to knowledgeable therapists for survivors with behavioral health concerns
- Increased consultation support for clinicians, both from the Systems Coordinator and advocacy organizations.

[40] At KCSARC, these include the PCLC, TSCC, and TSCYC, which are mentioned in a subsequent section.
[41] Memo from Mary Ellen Stone, KCSARC, December 15, 2015.
[42] MIDD Seventh Annual Report, page 25.
[43] MIDD Year 3 Progress Report, August 2011.
[44] Fifth MIDD Annual Report, February 2013.
[45] MIDD Year Five Progress report, August 2013.
[46] Individual communication from Alicia Glenwell, CEGBV, December 28, 2015.

- Improved communication and relationships between behavioral health and sexual assault professionals and organizations.[47]

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

As noted in B3 above, the CSAPs that receive funding from MIDD through this strategy employ a high level of fidelity to evidence-based treatments for trauma, and also deliver best practice approaches for initial contact with a sexual assault survivor. They serve as leaders and trainers in trauma recovery in the broader behavioral health provider community.

While there has not been any significant research to examine evidence-based service models for immigrant and refugee survivors of domestic violence and sexual assault, approaches used in this strategy, developed in consultation with staff at the King County Mental Health Chemical Abuse and Dependency Services Division (MHCADSD), represent the accumulated practice wisdom of an agency with significant experience serving immigrants and refugees with trauma histories.[48]

System benefits from the coordinator's significant dissemination of appropriate practices can reasonably be inferred but do not have a specific evidence base.

In December 2015, as part of MIDD I strategy 1e, which provides for training for behavioral health clinicians, King County supported the launch of a training/learning collaborative through Harborview CSATS around the Common Elements Treatment Approach (CETA). CETA was originally developed and tested in low resource countries with populations affected by trauma, many of whom were refugees or living in refugee camps. CETA is a structured, time-limited, component-based cognitive-behavioral therapy (CBT) developed for individuals affected by trauma that have PTSD, anxiety, and/or depression.[49] Positive clinical outcomes demonstrated in published studies of CETA include a 77 percent reduction in mean baseline depression scores, a 76 percent reduction in anxiety, and a 75 percent reduction in posttraumatic stress, among other clinical outcomes.[50] Participating staff in the local training/learning collaborative planned to use this approach with clients as appropriate starting in January 2016.

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?

Although data collection for the current strategy has typically been more focused on outputs (i.e. number screened, number of referrals to mental health or substance use disorder treatment, etc.), the survey and anecdotal information outlined in B3 above suggests that this strategy is having some impact on the following outcomes as intended:

- Increased access to mental health and substance use treatment services for sexual assault survivors

[47] Notes on Systems Coordination for MIDD Strategy 14a, received from Alicia Glenwell (CEGBV), December 17, 2015.

[48] Interview with Carlin Yoophum, 12-3-15.
[49] Murray et al., 2013.
[50] Bolton et al., 2014.

- The provision of culturally relevant mental health services provided to sexual assault survivors from immigrant and refugee communities in their own language
- Increased resiliency and coping skills among sexual assault survivors served
- Consistent screening for mental health and substance abuse needs among sexual assault agencies
- Improved ability of mental health and substance abuse providers to serve individuals with sexual assault and mental health issues.

The therapy interventions offered by the two currently funded CSAPs have been well researched and have been demonstrated to result in positive outcomes for victims. These two CSAPs have committed to training and supporting staff in the delivery of evidence-based trauma-specific treatments. Because the programs have adopted evidence-based approaches, they do use standard measures to track individual symptom reduction outcomes. Among the measures being used by one or both of the CSAP agencies are the Patient Health Questionnaire (PHQ-9),[51] the Generalized Anxiety Disorder Screener (GAD-7),[52] and the Posttraumatic Symptom Scale (PSS),[53] the PTSD checklist civilian version (PCLC),[54] the Trauma Symptom Checklist for Children (TSCC),[55] and the Trauma Symptom Checklist for Young Children (TSCYC),[56] although such data has not historically been aggregated or provided to King County for analysis.

It should be noted that CSAPs currently conceptualize these measures as progress monitoring for the duration of involvement in active therapy, and not as pre-post measurement of outcome.[57]

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

☒ **Other – Please Specify:** Sexual assault survivors and some of their parents, caregivers, and/or partners. 84 percent of participants identify as female, while 52 percent identify as a person of color with an additional 23 percent identifying as Hispanic.

[51] Kroenke et al., 2001
[52] Spitzer, et al., 2006
[53] Foa et al., 1999
[54] https://sph.umd.edu/sites/default/files/files/PTSDChecklistScoring.pdf
[55] http://www.ptsd.va.gov/professional/assessment/child/tscc.asp
[56] http://www.ncbi.nlm.nih.gov/pubmed/11601594
[57] Individual communication from Lucy Berliner (CSATS) and Mary Ellen Stone (KCSARC), January 5, 2016.

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.

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

Current agency partners provide services to DV survivors in Central/Downtown Seattle, First Hill, Renton, King County locations. The CSAPs provide services at their main offices and as well through satellite offices of the two contracted CSAPs in Redmond, Bellevue, Shoreline and Federal Way. To support the linguistic needs of its service region, KSARC is committed to maintaining Spanish-speaking therapists on its staff at all times.[58] Harborview provides interpreter services in multiple languages both telephonically and in-person.

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.**

The two CSAPs funded through this MIDD strategy partner closely in ensuring high-quality services are available to sexual assault survivors, both through their own therapists' work as well as their efforts to provide carefully screened referrals when necessary, and to consult with and train other community mental health agencies. The two agencies share a high level of confidence in each other's clinical work.

Other key partners in providing funding and support for the range of services required to support safety and recovery for sexual assault survivors include the King County Community Services Division's Women's Program (which has provided a total of $1.3 million per biennium in a combination of county general funds and MIDD supplantation funds for sexual assault services),[59] the King County Prosecuting Attorney's Office, Superior Court, and city governments.[60] Other key stakeholders include community-based agencies, law enforcement, and philanthropic agencies. These partnerships provide for a range of core services including information and referral; crisis intervention; medical, legal and other advocacy; system coordination; and other specialized services including therapy, support groups, and medical evaluation.[61]

System coordination activities are provided in partnership with Coalition Ending Gender Based Violence (CEGBV), formerly known as The KC Coalition Against Domestic Violence. The sexual assault providers are working closely with the domestic abuse providers in order to provide support and collaboration with each other. The collaboration and support meetings held on a regular basis through the CEGBV provide smaller agencies opportunities to collaborate with larger, more established agencies.[62]

[58] Interview with Mary Ellen Stone, DeAnn Yamamoto, and Larraine Lynch, December 2, 2015.
[59] Draft Proviso Response 4.0, provided by Linda Wells, King County Community Services Division, December 3, 2015.
[60] City of Seattle funding for sexual assault services was recently reduced. Phone interview with Lucy Berliner (CSATS), December 14, 2015.
[61] Draft Proviso Response 4.0, provided by Linda Wells, King County Community Services Division, December 3, 2015.
[62] Draft Proviso Response 4.0, provided by Linda Wells, King County Community Services Division, December 3, 2015.

Potential partnerships to expand needed sexual assault-specific services in King County to populations whose needs are not otherwise sufficiently met include an identified CSAP based in King County that serves deaf women who are survivors of violence; and another agency that provides multilingual services to a broad range of Asian Pacific Islander communities including many immigrant populations.

It is notable that the organization currently serving immigrant and refugee organizations has expressed an interest in consolidating its funding solely under the domestic violence strategy 13a, rather than having funding split evenly between 13a and 14a, at least in part to consolidate reporting requirements.[63] Further, the treatment approach and the consultation model being used by this organization appear more aligned with domestic violence services, and relatively few individuals receive sexual assault-related treatment as compared to domestic violence-related care.

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?

Health care reform and Medicaid expansion in Washington State have provided health care coverage for many previously uninsured or underinsured individuals. Mental health treatment is now possible for many who could not access it before. However, community mental health and primary care providers (who typically provide the bulk of publicly funded mental health care) are not always trained and prepared to provide appropriately responsive, integrated, and evidence-based approaches to acute trauma such as sexual assault.

Recent or forthcoming reductions in funding from local governments and other historical funding sources may affect feasibility of this strategy, as the trauma treatment provided under this strategy is only effective when paired with appropriate other interventions to support survivors, as described above. Local government funding from King County, Seattle and suburban cities have funded sexual assault services for many years. The funding has remained generally stable but has not kept up with the increased costs of providing services. Recently, the city of Seattle made 13 to 18 percent reductions in funding for the specialized sexual assault providers, and the United Way has given indications that it may change its funding priorities in 2017.[64]

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?

Existing MIDD strategy 14a has been funded since 2008, so many of the initial barriers regarding implementation have been addressed. Some of the barriers that continue to exist include:

- **Capacity** – The demand for services exceeds agencies' ability to provide appropriate evidence-based care. There are routinely waiting periods to access mental health services at each agency. Specific data are not available, since specialized programs will seek to provide some services to victims/families even if they must wait to access to a mental health provider for ongoing therapy.

[63] Interview with Carlin Yoophum, December 3, 2015.
[64] Individual communication from Lucy Berliner (CSATS) and Mary Ellen Stone (KCSARC), January 5, 2016.

- **Funding** – Funding for mental health therapists does not fully cover the cost of the treatment they are providing, so agencies blend funding sources or caseloads to attempt to meet demand. As is the case throughout the community behavioral health workforce, there is continuing difficulty for many agencies in hiring and retaining qualified professionals.

The issues described above and potential impacts/strategies to address will be included in the unintended consequences sections below.

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?**

It is possible that some aspects of work provided through this strategy to certain individuals could potentially be Medicaid-eligible, or be payable via other resources, so there is a possibility that MIDD funding could overlap with the programs of other payers. However, for many individuals who do not have access to this specialized care, or for whom traditional community mental health care is inadequate or unprepared to meet their needs, the service still plays an important role in early recovery and prevention of future problems.

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?**

Not funding specialized trauma treatment would lead to these unintended consequences:

- Survivors would lose access to specialized, trauma-informed/focused, holistic services that have a strong evidence base.
- Survivors would lose access to culturally and linguistically appropriate sexual assault services.
- Coordinated efforts to provide training and consultation for traditional community behavioral health providers in evidence-based culturally appropriate trauma treatment would be curtailed.
- Work to support agencies to develop survivor-friendly policies and approaches, and mutually beneficial organizational relationships across disciplines, would also stop.
- Some sexual assault survivors would lose integrated and coordinated care from providers with specialized knowledge and skills sets unique to addressing their needs.

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?**

Mental health services are available through the Regional Support Network of outpatient providers to those who meet the eligibility criteria for access to care and who have Medicaid or other alternative funding (i.e. private insurance). Mental health services are also often available through primary care centers for those who have health insurance. Community mental health centers have an important role to play in providing for overall behavioral health recovery including a full range of mental health conditions, and expanding access to trauma-specific among other types of EBPs, but they are not a

substitute for the highly specialized service provided by CSAPs for victims seeking sexual assault specific care. CSAPs have a depth of expertise in sexual assault and trauma impact that is not matched by other mental health providers.

While community mental health centers can provide some level of mental health support to sexual assault survivors, they are often not ideal for a number of reasons:

- Many survivors, despite healthcare expansion, still do not have access to healthcare. This applies to many undocumented immigrants, working poor individuals who can't afford costly premiums, and others.
- Services in community mental health agencies are not always tailored and/or culturally specific for refugee and immigrant populations and other non-white or non-mainstream groups.
- Mental health staff at non-sexual assault agencies often do not have awareness of sexual assault survivors' needs, do not always provide a trauma-informed approach or understand the safety concerns and potential negative impacts of accessing mental health services for sexual assault survivors.
- Sexual assault survivors are often heavily involved in legal proceedings with regard to their situation. Community mental health providers are not always able to help survivors navigate difficult and complex legal systems.
- Community mental health providers are not formally connected to the sexual assault service system and typically do not offer the full range of services and supports available to sexual assault survivors available at CSAPs.

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?

The work of existing MIDD strategy 14a aligns closely with the goals, objectives and planned outcomes for a number of King County initiatives including the following:

- Accountable Communities of Health – System coordination goals in both the Domestic Violence (13a) and Sexual Assault (14a) MIDD service strategies are aligned with this initiative's outcomes to improve access and coordinate service delivery and collaborative decision-making across multiple sectors and systems, as well as developing a set of shared priorities and strategies for holistically addressing the needs of domestic violence survivors.

- All Home – Although this MIDD strategy does not directly provide housing for sexual assault survivors, it does support the goal of addressing crises as quickly as possible, assessing needs and connecting people to supportive services to address identified needs, achieve stability and prevent further escalation of the crisis. There is a strong connection between untreated trauma, particularly sexual assault and youth homelessness. Project360 is a program that provides trauma focused therapy and dedicated case management in to homeless youth who have a history of sexual abuse. Services are provided in YouthCare and Friends of Youth. Clinical results have been equal to those of clients seen in more traditional clinic settings.

- Health and Human Services Transformation Plan – the provision of MH and SUD services to sexual assault survivors is directly related to the Health and Human Services Transformation Plan's vision of increasing community health and well-being by "focusing on prevention, embracing recovery and eliminating disparities." As previously discussed, provision of trauma-informed, culturally responsive, MH and SUD services on site to sexual assault survivors regardless of funding and without need to meet larger system "access to care standards" supports this initiative's planned outcome of "improving access to person-centered, integrated and culturally competent services when, where and how people need them."

- King County Strategic Plan (2010) – the KCSP prioritizes the "need to provide safe communities and accessible justice systems for all." MIDD strategy 14a exemplifies this goal by offering sexual assault survivors proven treatment via an integrated approach, including support in navigating the medical and legal systems. In addition, the systems coordination portion of this strategy strengthens linkages and collaborations within cities and communities in improving partnerships within the sexual assault service system.

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

MIDD strategy 14a provides behavioral health services in accordance with 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."

When seeking mental health services through the programs supported by this strategy, survivors are generally viewed as experiencing psychiatric symptoms that are "understandable responses to terror and entrapment that are likely to resolve with safety and support" rather than long-term pathology or specific deficits within the victim. Assessment begins with a "what happened to you" vs. "what is wrong with you" approach. As noted in preceding sections, high fidelity to such trauma-informed approaches, including evidence-based treatment that is effective, is the norm among providers funded by this strategy.

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

King County's Fair and Just Ordinance 16948 (2010) requires that organizations intentionally consider equity and integrate it into decisions and policies, practices, and methods for engaging all communities. The County is committed to serving all residents, regardless of race, culture or disability, by promoting fairness and opportunity, eliminating inequities and working to remove barriers that limit an individuals' or a community's ability to fulfill their full potential.

MIDD strategy 14a aligns closely with this mission as it is designed to improve access to MH and SUD treatment for sexual assault survivors by eliminating some of the barriers that exist in the current behavioral health system. Clients can access treatment at the same agency where they are receiving other advocacy and supportive services and do not need to meet access to care (diagnostic/functional) requirements or be eligible for Medicaid funding to receive services.

The proposed expansion of this strategy to include additional providers serving specialty populations would strengthen its impact on people with disabilities, people of color, and refugee/immigrant groups.

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.)**?**

Resources needed to implement this strategy include:

- Staff (salary and benefits). The proposed expansion, offset partially by the potential withdrawal of one current contractor, would result in a net increase of 1.5 FTE to serve specialty populations.
- Supervision
- Administrative and operating costs
- Space and equipment (cell phone, computer, etc.)
- Training

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

The estimated range above is based on inclusion of a modest expansion, and would likely fall toward the low end of that range.

Because all therapy and consultation work funded by this strategy partially funds positions rather than providing full funding, an increase in the amount of funding provided could address capacity issues at each provider agency and extend the reach of coordination efforts. Providers estimate that the true cost to fund and retain an appropriately trained full-time staff member is approximately $100,000, which is greater than the current funding amount.[65]

There is also interest in the community in the idea of adding a net 1.5 FTE by bringing specialized sexual assault services to two new providers serving special populations while removing the portion of an FTE funded at the existing culturally specific provider from this strategy (instead funding the existing organization's consulting mental health professional solely through the domestic violence strategy 13a). This proposed expansion would cost an estimated $150,000 above current funding levels.[66] Two organizations have indicated an interest in adding an additional staff person under this strategy to address the need for evidence-based sexual assault services for special populations: deaf, deaf/blind, and hard of hearing individuals; and Asian Pacific Islander youth.[67] These expansions could decrease wait times for responsive sexual assault treatment and expand capacity to serve more clients[68] and/or launch additional support groups for underserved youth.[69]

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

[65] Strategy 13a/14a proposed expansion data, provided by Alicia Glenwell (CEGBV), December 17, 2015.
[66] Strategy 13a/14a proposed expansion data, provided by Alicia Glenwell (CEGBV), December 17, 2015.
[67] Strategy 13a/14a proposed expansion data, provided by Alicia Glenwell (CEGBV), December 17, 2015.
[68] Individual communication with Libby Stanley, Abused Deaf Women's Advocacy Services (ADWAS), December 22, 2015.
[69] Individual communication with Junko Yamazaki, Asian Counseling and Referral Service (ACRS), December 24, 2015.

As previously described Medicaid behavioral health funding is accessible for some participants to receive care through an outpatient benefit with the current mental health provider network. However, many do not have access to this funding and services provided are not always the best fit for sexual assault survivors.

Grant funding might be available to support services being currently provided within strategy 14a and is currently being utilized at some agencies to subsidize additional costs. However, this source of revenue is not consistent and/or comprehensive, and dependence on it could lead to inconsistency in available services.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**

As this is an existing strategy, additional implementation factors are not applicable. Potential expansion to new agencies would take several months to implement.

    b. **What are the steps needed for implementation?**

Implementation is under way, but expansion would involve provider selection, hiring, and training.

    c. **Does this need an RFP?**

An RFP would be necessary if new agencies were to be funded. The program model as implemented at current CSAPs does not require modification. If an RFP is announced, then currently funded agencies would need to compete in order to ensure transparency of the RFP.

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?

As indicated, above, if these programs are funded under a potential MIDD II, they could benefit from revised reporting to promote greater articulation and assessment of outcomes at an aggregate level and in a standardized way, rather than focusing on outputs and surveys. Specifically, it is recommended that clinical outcome measures be standardized across the strategy and collected by MIDD, to show the degree to which clients' target symptoms and/or emergency system contacts are reduced. Emergency system use reduction may require data sharing agreements that may be complex to negotiate.

Concrete outcomes for the Systems Coordinator role, which might include changes in community mental health and substance abuse staff behavior toward sexual assault victims, are not easily measured. Exploration of appropriate measures to identify this effect may be beneficial to explore as the program continues.

This paper was developed in coordination with the paper on existing strategy 13a (Domestic Violence Services and System Coordination). Several elements of the above analysis are common to both papers.

King County

Mental Illness and Drug Dependency Action Plan

Strategy Title: Expand Access to Mental Health Services for Survivors of Sexual Assault

Strategy No: 14a-Sexual Assault Services

Policy Goal Addressed:

- Reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

One third of women in King County will have a sexual assault experience during their lifetime, based on the Washington State Prevalence Survey. Of these women, at least 30% will develop Post Traumatic Stress Disorder (PTSD), a trauma-specific diagnosis, or depression. These women will have higher rates of binge drinking and drug use than women who have not experienced sexual assault, as well as co-morbid depression and substance abuse disorders. In the study sample, 80% of the women's experiences had occurred by the age of 18. The prevalence study only included women, but men are sexually assaulted as well and have comparable rates of mental health conditions. Virtually all sexual assault victims are affected by their experiences and have at least some distressing mental health symptoms. There is effective treatment; however, victims frequently cannot access treatment for the following reasons:

- A significant number of victims do not have insurance and therefore have limited access to specialized mental health services. Some are experiencing impaired functioning but their symptoms are not severe enough to enable them to qualify for services at public mental health programs. Those victims who do not get access to timely treatment may deteriorate or develop maladaptive ways of coping such as abusing substances.
- Public mental health programs do not always have the specialized expertise to deliver the proven treatments combined with advocacy and support services. Their treatment focus is often on other urgent problems and needs for victims that do not include the impact of the victimization.
- For sexual assault victims from many immigrant and refugee communities, there are no cultural and sexual assault-specific mental health or substance abuse services available.

Washington State is a national leader in providing integrated services to sexual assault victims through Community Sexual Assault Programs (CSAPs). In 1995, recognizing the unique service needs of sexual assault victims, the Washington State Office of Crime Victim's Advocacy established the CSAP model to ensure that

sexual assault victims would receive uniform, integrated services throughout the state. CSAPS must be accredited, and are required to meet specific service training requirements, participate in a common data collection system, provide legal and

medical advocacy, prevention education, case management, therapy or access to therapy, and a 24-hour response. In King County the accredited CSAP programs provide evidence-based cognitive-behavioral therapy integrated with the other sexual assault advocacy services described above. For example, a child victim who has been abused, is experiencing PTSD, and has to go to a trial as a witness, receives integrated legal and medical advocacy, therapy and support through a single program. The four Community Sexual Assault Programs (CSAPs) in King County have limited capacity and funding for treatment (for example, for every client accepted at the King County Sexual Assault Resource Center for mental health treatment, eight were turned away/ referred out).

◊ *B. Reason for Inclusion of the Strategy*

This strategy will increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County, and increase coordination between programs serving sexual assault survivors who are experiencing mental illness, substance abuse and domestic violence.

◊ *C. Service Components/Design*

Expand the capacity of Community Sexual Assault Programs (CSAPs) and culturally specific providers of sexual assault advocacy services to provide evidence-based mental health services to adult and child victims of sexual assault throughout King County. Increase access to services for women and children from immigrant and refugee communities by housing a mental health provider specializing in evidence-based trauma-focused therapy at an agency serving these communities. Develop consulting relationships between specialized providers of sexual assault services and community mental health agencies to ensure mental health treatment that addresses the specific trauma of sexual assault. A Systems Coordinator/Trainer will coordinate ongoing cross training, policy development, and consultation on sexual assault and related issues between mental health, substance abuse, sexual assault and DV agencies.

◊ *D. Target Population*

- Adult, child and youth survivors of sexual assault who are experiencing mental health and substance abuse concerns will have access to early intervention services and prevention of severe mental health issues.
- Providers at sexual assault, mental health, substance abuse, and domestic violence agencies who work survivors of DV with mental health and substance abuse issues and participate in the coordination and cross training work of this program.

◊ *E. Program Goal*

Increase access to evidence-based and culturally-appropriate services for adult and child victims of sexual assault with mental health and advocacy needs. Improve

screening, referral, coordination and collaboration between mental health, substance abuse, domestic violence and sexual assault service providers.

◊ *F. Outputs/ Outcomes*

Expected Outcomes for Sexual Assault survivors served:

- Therapy and case management services provided to 400 adult, youth and child victims of sexual assault.
- Increased access to services for adult, youth and child victims who currently do not have access to specialized sexual assault services.
- Reduction in trauma symptoms for adult, youth and child victims of sexual assault receiving services.
- Culturally relevant mental health services provided to sexual assault survivors from immigrant and refugee communities in their own language
- Increased resiliency and coping skills among sexual assault survivors served

Expected System Outcomes

- Increased coordination between public mental health programs and CSAPS to better serve sexual assault victims.
- Increased coordination between CSAPS and culturally specific providers of sexual assault advocacy services.
- Improved ability of sexual assault, domestic violence, mental health and substance abuse providers to serve individuals with DV and mental health issues.

2. Funding Resources Needed and Spending Plan

This program requires $500,000 of MIDD funds annually to expand the regional capacity to provide evidence-based trauma-focused therapy to adult, youth and child victims of sexual assault throughout King County.

Date	Activity	Funding
Sept 2008 October-Dec 2008	Providers identify, hire and train staff Begin service provision	**$110,000**
	Total Funds 2008	**$110,000**
Jan – Dec 2009	Service provision continues. Establish and maintain consultation between CSAPS and mental health providers. Provide annual training in evidence-based therapy for PTSD and depression in child, youth and adult sexual assault victims.	$500,000
	Total Funds 2009	**$500,000**

Ongoing Annual	**Total Funds**	**$500,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and Type of Providers (and where possible FTE capacity added via this strategy)*

- 4 FTES added to CSAP agencies.
- .5 FTE added for Mental Health Provider housed at culturally-specific provider of sexual assault and domestic violence advocacy services (linking with the .5 FTE in the domestic violence proposal for the MIDD)
- .5 Systems Coordinator/Trainer (linking with the .5 FTE in the domestic violence services strategy 14a).
- Funds for interpreters for services to immigrant and refugee survivors

Providers will be the accredited CSAP agencies providing services throughout King County. The Refugee Women's Alliance will house a mental health provider to serve refugee and immigrant victims of sexual assault, as this program serves sexual assault survivors from 16 different language communities. The King County Coalition Against Domestic Violence will house the .5 FTE systems coordinator/trainer.

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

Dates:	Activity:
Oct-Dec 2008	• CSAPS begin service provision • Staff of CSAPS and culturally-specific provider collaborates to develop protocols for culturally specific provider to incorporate MHP onto staff.
Jan – Dec 2009 and ongoing	• CSAPS continue service provision. • MHP at culturally-specific provider agency begins service provision. • Coordination efforts begin. • CSAPS, mental health providers and culturally-specific providers establish consult group re service provision to sexual assault victims, and consult on complex cases. • Annual training for mental health providers in providing evidence-based therapy for PTSD and depression in child, youth and adult sexual assault victims.

◊ *C. Partnership/Linkages*

The CSAPs, public mental health agencies, and culturally specific providers of sexual assault advocacy services will work together to strengthen and maintain existing partnerships to improve the quality of mental health services available to victims of sexual assault. The project will partner with all member agencies of the King County Sexual Assault Coalition.

Note: This strategy is linked with the domestic violence strategy, which will also fund an .5 FTE systems coordinator and trainer to providing systems coordination and training on sexual assault issues, and an .5 FTE MHP to serve immigrant and refugee victims of sexual assault who are experiencing mental health concerns.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. Staff identified and hired by or before September 30, 2008
2. Services at CSAPS begin October 2008.
3. Services at Refugee Women's Alliance will begin January 2009
4. System coordination efforts begin January 2009.

◊ *B. Procurement of Providers*

The strategies are designed to be implemented within the Community Sexual Assault Provider agencies. The County will contract with the accredited CSAP programs, with the Refugee Women's Alliance, which is uniquely positioned to serve survivors from refugee and immigrant communities, and with the King County Coalition Against Domestic Violence (as described in #13a). CSAP programs have a high level of statutory protection for client records and client communication (Relevant statutes are RCW 5.60.060 (8), 70.123.075, 70.123.076).

C. Contracting of Services:

◊ *D. Services Start Date(s)*

October 2008