Mental Illness and Drug Dependency

Implementation and Evaluation Progress for October 1, 2014—March 31, 2015

Year Seven Progress Report

King County

Mental Illness and Drug Dependency Oversight Committee

August 2015

King County Department of Community and Human Services

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Year Seven Progress Report
October 1, 2014—March 31, 2015

Cover shows a portion of Daniel De La Cruz's Honorable Mention poster from the 2015 King County Behavioral Health Recovery and Resiliency Poster Art Contest

Report design by Lisa Kimmerly
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For further information on
the current status of MIDD activities,
please see the MIDD website at:

www.kingcounty.gov/healthservices/MHSA/MIDDPlan

Alternate formats available
Call 206-263-8663
or TTY Relay 711

Complete Listing of MIDD Strategies

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

Progress Report Requirements

In accordance with King County Ordinances 15949, 16261, and 16262, this report updates the Metropolitan King County Council on programs supported with the one-tenth of one percent sales tax revenue for the delivery of Mental Illness and Drug Dependency (MIDD) fund services. The ordinances require the King County Executive to submit reports twice yearly: a progress report and an annual report. This streamlined progress report, covering October 1, 2014 to March 31, 2015, includes the following required elements:

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

MIDD Policy Goals*

1. Reduce the number of people with mental illness and substance use disorders using costly interventions, such as jail, emergency rooms, and hospitals.
2. Reduce the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.
3. Reduce the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
4. Divert youth and adults with mental illness and substance use disorders from initial or further justice system involvement.
5. Link with and further the work of other Council-directed efforts, including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.

* *Edited from Ordinance 15949*

MIDD Review and Renewal

Unless renewed by the King County Council, the current MIDD sales tax is set to expire on January 1, 2017 per Ordinance 15949. In preparation for the Council's potential consideration of the renewal of MIDD sales tax and to inform its deliberation, the King County Council passed Ordinance 17998 on March 9, 2015, detailing elements necessary for a comprehensive review and assessment of MIDD-funded strategies, services, and programs. The legislation calls for a historical review of the current MIDD, including summary information on MIDD effectiveness, performance measurement, and changes made over time, due in June 2016. It also calls for a MIDD service improvement plan to guide the investment of a renewed MIDD sales tax, due in December of 2016. Finally, a progress report on MIDD review and renewal work required is due to the Council no later than November 5, 2015.

Year Seven Progress Report Highlights

- Total revenues in the first half of calendar year 2015 were $26.9 million. Expenditures to implement MIDD strategies and supplantation totaled $23.1 million in the same period.
- The MIDD Oversight Committee met four times to monitor implementation and evaluation of MIDD strategies. Budgeting and fund balance work took place and MIDD review and renewal planning efforts began.
- Alignment of relevant MIDD strategies with other King County Council initiatives is shown on Page 5, which also explains the difference between "transformation" and "integration".
- Evaluation matrices for four MIDD strategies were revised since their last publication. See Page 20-21 for details.
- In the community-based care group, Strategy 1g—Older Adults Prevention served 3,757 more people than during the same period a year ago. Universal screening and healthcare reform likely contributed to this exponential growth.
- A recommendation was made by the MIDD Fund Balance Workgroup to fund inflationary adjustments to non-county MIDD providers and contractors for the 2015-2016 biennium.
- As of January 2015, all therapeutic courts formerly funded through MIDD supplantation became fully funded with regular MIDD dollars. Evaluation will be expanded to track individuals served in these base courts, while continuing to track those in expanded services.
- Substance use symptoms were analyzed for adults who were served in three MIDD strategies. Differences were found in the type of primary substances used by each strategy or sub-strategy. For example, under Strategy 8a—Family Treatment Court, women using methamphetamine were most common, but in Strategy 1a-2—Substance Use Disorder Treatment, the most common groups were men using alcohol (outpatient treatment) and both men and women using heroin (opiate treatment programs). The proportions of treatment episodes with reduced substance use over time were statistically significant for all client groupings studied.

MIDD Requests for Proposals Update

Although no Requests for Proposals (RFPs) for MIDD services were needed between October 2014 and March 2015, a decision was made in October to extend MIDD contracts previously awarded by RFP through December 2016. For example, in 2010, contracts for Strategy 4c—School-Based Services were awarded for a five-year period and funding would have expired in June 2015, if extensions were not granted. King County examined all strategies awarded by RFP that were set to expire within 18 months of MIDD expiration and extended those contracts through December 2016, as appropriate, to allow for continuity of services through expiration of the original MIDD plan.

Evaluating MIDD Implementation

Three youth strategies remained unimplemented in MIDD Year Seven: Strategy 4a—Parents in Recovery Services, Strategy 4b—Substance Use Disorder Prevention for Children, and Strategy 7a—Youth Reception Centers.

All strategies initiated between 2008 and 2011 continue to be evaluated by the System Performance Evaluation unit of King County's Department of Community and Human Services' (DCHS) Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). Evaluation results are reviewed by the MIDD Oversight Committee and reports are transmitted twice annually to the King County Council from the King County Executive. A roster of the MIDD Oversight Committee, as of March 2015, is on Page 19.

Oversight Committee Meetings and Actions

Oversight Committee meetings to monitor and guide MIDD implementation were held four times during the current reporting period. Three regular meetings and one special ad hoc MIDD review and renewal planning kick off meeting were held. Highlights from these meetings are summarized below.

MIDD Budget Briefing in October 2014

Adrienne Quinn, Director, King County Department of Community and Human Services, briefed the MIDD Oversight Committee (OC) and facilitated discussion of the Executive's proposed 2015-2016 biennial budget, which referenced a MIDD fund balance that many members were not previously aware of. Factors that contributed to this fund balance were:

1) Not all strategies were fully operational in alignment with budget projections
2) Actual 2013 revenue came in significantly higher than originally forecasted
3) Many contracts are cost reimbursed and use MIDD as the payer of last resort, so not all strategies fully expended their budgets.

By the end of 2014, the MIDD fund balance was expected to reach $11 million, with a required reserve of $5.2 million, leaving a balance of about $6 million to be expended. The OC expressed interest in having a process to provide input on future fund balance expenditures, so the OC Fund Balance Work Group was convened.

MIDD Budget Update in December 2014

In November 2014, the Council adopted the Executive's proposed budget, with no changes. A higher revenue assumption than in previous budgets was used for MIDD items. There was a reduction in supplantation of $1.8 million related to the 10 percent supplantation step-down mandated by state legislation that directs how MIDD funds may be spent. The current supplantation rate is at 30 percent.

The passed budget included the use of $1.2 million in MIDD funds to develop a 16-bed* psychiatric evaluation facility (see pages 16 & 18). When the state Supreme Court ruled that the practice of boarding patients in emergency rooms is illegal, the County worked immediately to fulfill its statutory and contractual obligation to provide appropriate and adequate care for its citizens.

* Limiting the facility size to 16 beds allows the County to maximize use of Medicaid funds to pay for care.

Fund Balance Work Group Convened in January 2015

An OC work group met weekly for five weeks to develop recommendations for the Executive and Council to use when making funding decisions that involve MIDD fund balance. This team identified the following guiding principles to inform decision-making and their approach to making recommendations:

- Prioritizing services for youth
- Addressing impacts of non-Medicaid cuts which disproportionately impact individuals not eligible for care under the Affordable Care Act
- Ensuring inflationary adjustments for contracted community providers on par with County-operated programs.

Other key considerations were strategy readiness to launch, preserving and enhancing existing strategies that had earlier funding reductions, geographic distribution of services, amount of funding available, impact of the state legislature, and timelines and County processes.

Consensus was reached on the three advisory recommendations listed below, and they were accepted by the full MIDD OC at their February 2015 meeting.

1) Fund inflationary adjustments to non-county MIDD providers and contractors for the 2015-2016 biennium
2) Provide funding for programs that will prioritize services for youth and are launch ready
3) Restore funds to six MIDD strategies that were previously reduced due to budget constraints.

MIDD Renewal Planning Kick Off

In March 2015, OC members explored assumptions, hopes, concerns, and values related to the MIDD review and renewal process. In addition to identifying the Committee's values and guiding principles to inform the MIDD review and renewal process, members highlighted emerging needs and discussed ideas for engaging consumers, policy-makers, and communities.

MIDD Linkages to Countywide Initiatives

One of the five MIDD policy goals encourages linkage with and furthering the work of other King County Council initiatives. Twelve MIDD strategies, of the 14 originally aligned with this policy goal in 2009, are currently implemented. Brief descriptions of key Council-adopted efforts are provided below, along with specific MIDD strategies that best align with the various initiatives. While many other MIDD strategies align with County initiatives, the focus here is on those explicitly aligned in the MIDD Second Annual Report.

Initiatives → **Strategies**

Adult & Juvenile Justice Operational Master Plans (2000 and 2002)
Across King County, criminal justice partners are engaged to assure that the criminal justice system is fair and effective.

Ten-Year Plan to End Homelessness (2005)
Collaborating with regional partners, King County strives to build housing and provide supportive services to prevent homelessness.

Veterans and Human Services Levy (2006 & 2011)
Voters approved levy funding to benefit veterans and their families, plus others in need. In April 2006, the Council provided direction on levy spending and oversight responsibilities. The levy was renewed in 2011.

Mental Health Recovery Plan (2005)
Recovery principles include: 1) services that are consumer centered, 2) strengths based assessment and treatment planning, 3) reduction or remission of symptoms, 4) development or restoration of normative life roles, 5) active development and involvement of natural supports, and 6) full community participation.

Recovery and Resiliency-Oriented Behavioral Health Service Plan (2012)
Resiliency is "an inner capacity that when nurtured, facilitated, and supported by others empowers people, including children, youth, and families, to successfully meet life's challenges with a sense of self-determination, mastery and hope."

King County Strategic Plan (2010)
Several MIDD strategies address the need to support "safe communities and accessible justice systems for all" and promote "opportunities for all communities and individuals to realize their full potential."

Equity and Social Justice Initiative (2012)
The MIDD is committed to addressing equity and social justice (ESJ) priorities. For example, an ESJ lens has been applied to program planning, strategy implementation, service distribution, and access to care.

What Is the Difference Between "Transformation" and "Integration"?

Health & Human Services Transformation

King County Council Motion 13768, passed in November 2012, called for development of a plan for an accountable and integrated system of health, human services, and community-based prevention and recovery. The vision statement for this initiative reads:

By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.

Behavioral Health Integration

In 2014, the State of Washington Legislature passed Second Substitute Senate Bill 6312, which states that mental health and chemical dependency services will be purchased after April 2016 from regionally-operated Behavioral Health Organizations through a managed care structure. King County has responded by working to align its behavioral health service delivery model with the new state requirements.

Both of these legislative actions have contributed to the changing behavioral health landscape. The MIDD review and renewal process has been designed to address these and other system changes that have occurred since the 2008 adoption of MIDD.

Community-Based Care Strategies

Performance measurement and program utilization statistics are shown below for strategies designed to increase access to community mental health (MH) and substance use disorder (SUD) treatment for low-income individuals. These strategies are intended to improve care quality and customize services.

All tables in this reporting section show annual targets for each strategy, target adjustments (if needed), projected MIDD Year Seven achievement, and success ratings. Projection multipliers are based on this scheme:

- 2.0 = Programs expected to turn over full client load during the year
- 1.9 = Shorter term programs with fairly stable enrollment (low turnover)
- 1.3 = Programs at capacity or with longer benefits (factors in turnover).

Relevant strategy updates for the reporting period are presented on the pages opposite each table.

Key to Target Success Rating Symbols	
⬆	Percentage of annual target is higher than 85%
➡	Percentage of annual target is 65% to 85%
⬇	Percentage of annual target is less than 65%

Year 7 Performance Measurement Targets	6 Month Progress[1]	Projection Multiplier	Projected % of Annual Target	Target Success Rating
1a-1 - Increase Access to Community Mental Health Treatment				
2,400 clients/yr	2,086	1.3	113%	⬆
1a-2 - Increase Access to Community Substance Abuse Treatment				
50,000 adult outpatient (OP) units 4,000 youth OP units 70,000 opiate treatment program (OTP) units	9,004 adult OP units 1,790 youth OP units 18,191 OTP units	2.0	36%[2] 90% 52%	⬇ ⬆ ⬇
1b - Outreach and Engagment to Individuals Leaving Hospitals, Jails, or Crisis Facilities				
675 clients/yr	534	2.0	158%[3]	⬆
1c - Emergency Room Substance Abuse Early Intervention Program				
6,400 screens/yr 4,340 brief interventions/yr with 8 full-time equivalent (FTE) staff **Adjust for 5.7 FTE in Reporting Period**	1,085 of 4,560 screenings goal 1,288 of 3,092 brief interventions goal	2.0	48% 83% (Adjusted)	⬇ ➡
1d - Mental Health Crisis Next Day Appointments and Stabilization Serivces				
750 clients/yr with enhanced services **Adjust to 634 clients with restored state funding 1/2015**	167 of 634 client goal (using "enhanced" proxy)	2.0	53% (Adjusted)	⬇
1e - Chemical Dependency Professional (CDP) Education and Training				
125 reimbursed trainees/yr 250 workforce development trainees/yr	231 reimbursed trainees at least 146 other trainees[4]	1.3	240% 76%	⬆ ➡
1f - Parent Partner and Youth Peer Support Assistance Program				
400 clients/yr **Adjust to 300 clients/yr (Fully staffed 1/2015)**	106	2.0	71% (Adjusted)	➡
1g - Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+				
2,500 clients/yr (7.4 FTE) **Adjust to 2,196 clients/yr (6.5 FTE)**	6,842	1.3	405% (Adjusted)	⬆
1h - Expand Availabilty of Crisis Intervention and Linkage to Ongoing Services for Older Adults				
340 clients/yr (4.6 FTE) **Adjust to 258 clients/yr (3.5 FTE)**	168	1.9	124% (Adjusted)	⬆
2a - Workload Reduction for Mental Health				
16 agencies participating	16 agencies participating	-	100%	⬆
2b - Employment Services for Individuals with Mental Illness and Substance Use Disorders (SUD)				
920 clients/yr **Adjust to 700 clients/yr (MH clients only)**	618	1.3	115% (Adjusted)	⬆
3a - Supportive Services for Housing Projects				
690 clients/yr	741	1.3	140%	⬆
13a - Domestic Violence and Mental Health Services				
560-640 clients/yr	394	2.0	141%	⬆
14a - Sexual Assault and Mental Health Services				
170 clients/yr	205	2.0	241%[3]	⬆

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Other fund sources were available to pay for these services.
[3] Blended funds allow more clients to be served than the portion attributable to MIDD only, on which performance measurement is based.
[4] Data used to fully track these trainees is temporarily unavailable. Full accounting is expected in the MIDD Eighth Annual Report.

1a-2 Increase Access to Community Substance Use Disorder Treatment

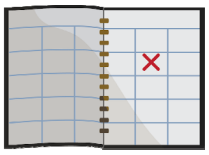
Even with expansion of Medicaid eligibility under the Affordable Care Act, many individuals who need access to substance use disorder (SUD) treatment remain ineligible for coverage. Funding from the MIDD fills this gap, but only after state funds intended for this purpose are exhausted. For this reason, current projections show that in MIDD Year Seven, only 36 percent of the target for the purchase of adult outpatient SUD treatment units will be met (see Page 6), and unexpended MIDD funds are potentially available to meet other strategy goals. For example, in January 2015, funds were made available to the Dutch Shisler Sobering Center to provide services for people needing a safe place to sleep off the effects of alcohol and drugs. As payer of last resort, MIDD monies will only be used for this purpose if other funds run out.

1c Emergency Room Substance Abuse Early Intervention Program

The screening numbers for programs that provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) in area hospitals remain lower than expected. A countywide shortage of qualified and credentialed behavioral health staff continues to impact service levels and filling vacant positions has become a lengthy process. Also, new Medicaid reimbursement for SBIRT services is not sufficient to sustain these programs; continued support from the MIDD or other funding remains necessary.

1d Mental Health Crisis Next Day Appointments and Stabilization Services

The capacity to deliver enhanced services for individuals receiving crisis next day appointments (NDAs) was impacted for several years after state budget cuts to core NDA programming that began in 2011. After four years of operation with reductions in excess of 60 percent, the State of Washington reinstated funding for NDAs in January 2015. During the first six months of MIDD Year Seven, "enhanced" NDA services were delivered to at least 167 people, but the strategy is expected to fall well short of its newly adjusted annual target. Two factors are likely impacting the projected shortfall: 1) the strategy has had to slowly ramp up to reach pre-2011 service delivery levels, and 2) the count of enhanced services relies on a proxy (medical services) that may not accurately reflect the true number of people who benefit from all service enhancements.



1f Parent Partner and Youth Peer Support Assistance Program

In January 2015, Guided Pathways Support (GPS) for Youth & Families added a youth peer coordinator to their staff. With this professional on board, GPS was able to begin providing one-on-one peer support to individuals aged 14 to 21 years. The annual performance target for this strategy has been adjusted to reflect that full staffing was not reached until three months after the start of the MIDD year. The agency is currently projected to reach 71 percent of their new annual target.

1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+

Strategy 1g served 6,842 unduplicated individuals during the six months covered by this report; more than double the number served during the same timeframe a year ago. Two explanations for this exponential growth include:

1) Agencies partnering with Public Health—Seattle & King County continue to add more service sites and to expand universal depression and anxiety screenings, and
2) With healthcare reform, more clients have access to primary and behavioral health care and the increase in screening counts closely matches the percent increase in overall users of King County's primary care safety net system.

3a Supportive Services for Housing Projects

For the first time since the MIDD began, the annual capacity for supportive housing services did not increase this period. Growth in capacity over the course of the MIDD was more than 300 percent, from 140 "beds" in 2009 to 690 for 2014 and 2015. Supports offered include housing case management, group activities, and life skills training.

13a Domestic Violence and Mental Health Services

Therapists at domestic violence programs, working with the MIDD-funded Systems Coordinator, proactively piloted symptom-based outcome measures. The programs considered several existing tools, as no symptom-based outcome measures have yet been validated for survivors of domestic violence or for this service model (brief counseling services on-site at domestic violence programs). Data on symptom reduction will be available for analysis early in 2016.

Strategies with Programs to Help Youth

The strategies in the youth category expand prevention and early intervention programs, increase assessments for youth involved with the juvenile justice system, and provide comprehensive team-based interventions through Wraparound. In addition to helping more youth in crisis, funding is available to maintain and expand both Family Treatment Court and Juvenile Drug Court. Program utilization statistics are provided below and relevant updates for specific strategies appear on Page 9.

For MIDD Year Seven, the performance measurement target for Strategy 8a—Family Treatment Court Expansion was raised to "No more than 120 children per year" from the previous cap of 90. During the current reporting period, this therapeutic court contracted with the University of Washington to conduct an independent cost/benefit analysis.

Only two youth-serving strategies are not currently projected to meet or exceed 85 percent of all annual targets. Strategy 4d—School-Based Suicide Prevention is on pace to reach only half of its target to train 1,500 adults in youth suicide prevention. Efforts are underway to increase attendance by adults in trainings offered countywide. Strategy 5a—Juvenile Justice Assessments was low on coordinations this period, due in part to fewer youth coming in for arraignments, but also to a staff vacancy in the position that conducts the brief substance use disorder (SUD) screenings on which the coordination target is based. Adjustments for low staffing may appear in the next annual report.

Year 7 Performance Measurement Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
4a - Services for Parents in Substance Abuse Outpatient Treatment		**Not implemented yet**		
4b - Prevention Services to Children of Substance Abusing Parents		**Not implemented yet**		
4c - Collaborative School-Based Mental Health and Substance Abuse Services				
2,268 individuals (19 programs) **Adjust to 1,550 individuals/yr (13 programs)**	882	1.5*	85% (Adjusted)	↑
4d - School-Based Suicide Prevention				
1,500 adults/yr 3,250 youth/yr	475 adults 5,545 youth	1.5*	48% 256%[2]	↓ ↑
5a - Expand Assessments for Youth in the Juvenile Justice System				
Coordinate 1,200 assessments/yr Provide 200 psychological services/yr Conduct 140 MH assessments/yr Conduct 165 full SUD assessments/yr	409 coordinations 133 psychological services 80 MH assessments 95 SUD assessments	2.0	68% 133% 114% 115%	→ ↑ ↑ ↑
6a - Wraparound Services for Emotionally Disturbed Youth				
450 enrolled youth/yr	410	1.3	118%	↑
7a - Reception Centers for Youth in Crisis		**Not implemented yet**		
7b - Expansion of Children's Crisis Outreach Response System (CCORS)				
300 youth/yr	635	1.9	402%[2]	↑
8a - Family Treatment Court Expansion				
No more than 120 children/yr[3] No more than 60 children at one time	90 children (weighted) Program monitors capacity	1.3 -	98% -	↑
9a - Juvenile Drug Court Expansion				
36 new youth/yr	18 new opt-ins since 10/1/2013 6 new in pre opt-in phase	2.0	133%[4]	↑
13b - Domestic Violence Prevention				
85 families/yr	117 unduplicated families	1.3	179%	↑

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

2 Blended funds allow more clients to be served than the portion attributable to MIDD only, on which performance measurement is based.

3 Revised target accepted by Council in motion of acceptance on 7/20/2015.

4 Projection is based on counting both pre opt-ins and opt-ins. Youth may be counted as new in either the pre opt-in or opt-in phase, but not both.

* School-based programs use 1.5 as the multiplier due to lower summer numbers.

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

4c/4d Collaborative School-Based Mental Health and Substance Abuse Services and School-Based Suicide Prevention

Suicide prevention consultation and technical assistance (TA) is available to King County school districts and other youth-serving agencies through both of these MIDD strategies. For example, in October 2014, Youth Suicide Prevention Program (YSPP) staff offered TA to an agency working with immigrant/refugee youth. The requesting agency, cognizant of the differences in privilege and cultural backgrounds between their staff and clients, asked how they can best be allies, addressing mental health issues with these youth. Information on being culturally responsive was offered.

The Teen Link program, staffed by the Crisis Clinic, was fully booked presenting youth suicide prevention trainings to King County youth throughout the reporting period.

6a Wraparound Services for Emotionally Disturbed Youth

Results from the University of Washington's fidelity review of MIDD Wraparound programs were made available in January 2015. Key strengths identified were:

- Linking families to community resources
- Involving caregivers in the child and family team
- Celebrating family successes.

Areas for further development include increasing efforts to inform and engage families at the start and to help them build skills for success after exit.

The results of an independent outcomes evaluation by the University of Washington will be summarized in the MIDD Eighth Annual Report.

8a Family Treatment Court Expansion

In December 2014, the King County Family Treatment Court was selected to be a National Peer Learning Court (PLC) for their demonstrated use of evidence-based practices and strong collaboration among the court, child welfare, and substance abuse treatment agencies. The court will serve as a PLC until 2016 by hosting visits from other courts, providing technical assistance, joining webinars, and sharing operational documents.

King County's Youth Action Plan and A Potential "Best Start for Kids" Levy Would Move Funding Upstream of the MIDD

Youth Action Plan—County legislation passed in January 2014 called for development of a plan to set priorities for serving youth. Developed by an appointed Task Force of diverse representatives, the plan guides and informs the County's annual investment of more than $75 million in prevention resources to serve infants through young adults. Working collaboratively and transparently to examine practices and outcomes, youth and children are served more effectively and efficiently. A recommendation of the Youth Action Plan calls for revisiting the allocations of funding streams, such as the MIDD sales tax, to prioritize future spending for more or different services for youth.

Best Starts for Kids—In October 2014, work began to propose a six-year property tax levy, at a cost to the average King County homeowner of about $56 per year, to be invested in prevention programs for children, youth, and families. Key provisions of the levy proposition include: investing early, sustaining the gains made earlier in life as youth grow and develop, and focusing on communities with strategies that are data driven and reliant on outcomes.

The King County Children and Family Justice Center Project

Since 2008, replacing the aging Youth Services Center has been the County's highest priority capital project. Voters approved a nine-year property tax levy lid lift in August 2012 to move the justice center project forward. As of March 2015, a decision was made to cap the number of beds in the new Children and Family Justice Center at 112—cutting the number of King County juvenile detention beds by nearly half.

One recommendation of the MIDD Fund Balance Work Group (see Page 4), was to provide funding for programs that provide services to children and youth, especially those at risk of involvement with the juvenile justice system. The goal is to avoid or reduce detention stays by linking youth with the services they need.

Three other youth-serving MIDD strategies, shown below, could benefit from future relocation to this new facility. Geographic separation from one another currently impedes collaboration and impacts the flow of participants from the assessment process to referral and linkage with other programs.

Jail and Hospital Diversion Strategies

Strategies grouped in the diversion category were developed to reduce costly jail stays and psychiatric hospitalizations for individuals with mental illness and substance use disorders by linking them with community treatment. Diversion programs include: jail and hospital re-entry services, intensive case management, therapeutic courts, and education classes for those involved with the justice system.

The projection algorithm for Strategy 10a—Crisis Intervention Team (CIT) Training was reduced for MIDD Year Seven from 2.0 to 1.5 to adjust for the unprecedented volume of Seattle Police officers trained during the fourth quarter of 2014. Two different strategies in this category had target revisions approved by Council acceptance of the MIDD Seventh Annual Report: Strategy 11b—Mental Health Courts and Strategy 12d—Behavior Modification Classes. A planned reduction in probation staffing impacted the targets for the first strategy. The second strategy was impacted by capped enrollment associated with a change in the type of offender population served by the MIDD-funded staff position.

Year 7 Performance Measurement Targets	6 Month Progress[1]	Projection Algorithm	Projected % of Annual Target	Target Success Rating
10a - Crisis Intervention Team Training for First Responders				
180 trainees/yr (40-hr) 300 trainees/yr (1-day) 150 trainees/yr (other CIT programs)	158 (40-hr) 457 (1-day) 168 (other)[2]	1.5[3]	132% 229% 168%	↑ ↑ ↑
10b - Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team				
3,000 adults/yr	1,610[2]	2.0	107%	↑
11a - Increase Jail Liaison Capacity				
200 clients/yr **Adjust to 100 clients/yr for capacity reduction**	32	2.0	64% (Adjusted)	↓
11b - Increase Services for New or Existing Mental Health Court Programs				
28 new opt-in expansion clients/yr and 83 non-expansion clients/yr for Regional Mental Health Court (RMHC)[4] 300 clients/yr (1 FTE liaison) for Seattle Mental Health Court (SMHC)	RMHC 10 new expansion opt-ins[5] 128 non-expansion cases SMHC 129	2.0	71% 308% 86%	→ ↑ ↑
12a-1 - Jail Re-Entry Program Capacity Increase				
300 clients/yr (3 FTE)	129	2.0	86%	↑
12a-2 - Education Classes at Community Center for Alternative Programs (CCAP)				
600 clients/yr	291	2.0	97%	↑
12b - Hospital Re-Entry Respite Beds (Recuperative Care)				
350-500 clients/yr	193	1.9	105%	↑
12c - Increase Harborview's Psychiatric Emergency Services (PES) Capacity				
75-100 clients/yr	47	1.9	119%	↑
12d - Behavior Modification Classes for CCAP Clients				
40 clients/yr (domestic violence offenders)[4]	26	1.3	85%	↑
15a - Adult Drug Court Expansion of Recovery Support Services				
250 clients/yr[6]	171	1.3	89%	↑
16a - New Housing Units and Rental Subsidies				
25 rental subsidies/yr Tenants in 25 capitally-funded beds without MIDD-funded support services through Strategy 3a	19 rental subsidies 21 tenants at Brierwood	1.3	99% 109%	↑ ↑
17a - Crisis Intervention Team/Mental Health Partnership Pilot		**COMPLETED**		
17b - Safe Housing and Treatment for Children in Prostitution Pilot		**COMPLETED**		

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

2 Not unduplicated - individuals are counted once for participation in each different program component.

3 Projection was lowered to 1.5 from 2.0, as fewer trainees are expected in the second half of MIDD Year 7.

4 Revised target accepted by Council in motion of acceptance on 7/20/2015.

5 Revised data collection will prioritize counting of expansion opt-in cases when clients qualify under both expansion and non-expansion.

6 To be updated prior to MIDD Eighth Annual Report.

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

10a Crisis Intervention Team (CIT) Training for First Responders

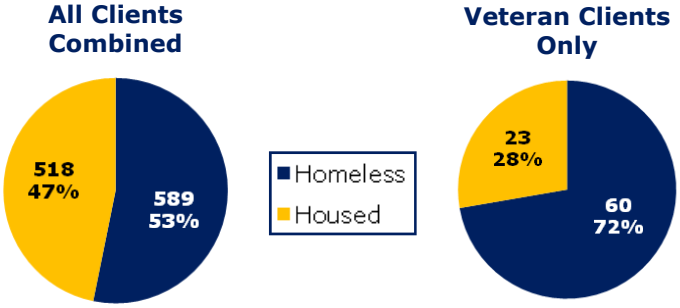
The CIT Force Options training has been a popular hands-on course for those already trained in CIT basics. This eight-hour class debunks myths and provides "lessons learned" from officer-involved shootings, while giving police officers time to practice techniques for effectively defending themselves and for retaining their weapons during crisis situations. De-escalation skills, questions to ask people likely suffering from mental health crises, and action/reaction drills are all key components of Force Options. In feedback from participants, one attendee indicated that "the class was excellent and conducted in a highly professional manner." All surveyed participants in this reporting period said they would recommend the Force Options course to others.

10b Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team

In March 2015, the United States Department of Veterans Affairs awarded staff at the Crisis Solutions Center (CSC) a "Community Partners Heart of a Social Worker Award" for coordination. All programs at the CSC were cited as being excellent, professional, and easy to work with.

Of the 1,107 unduplicated individuals served by the CSC this period, 589 were known to be homeless (53%) and 83 (7%) were known to have served in the U.S. military; 60 of these veterans (72%) were homeless at the time of their first service encounter. Veterans who were homeless had higher service utilization at the CSC with an average of 2.4 program admits over six months (compared to 1.7 for those not known to be homeless or veterans). About 10 percent of all recent CSC clients had multiple admits into all three components of the program. These repeat visits to CSC are essential for many to establish lasting connections with community resources.

Homeless Status of Clients at CSC Intake This Period



11a Increase Jail Liaison Capacity

For reasons unrelated to MIDD funding, King County Work Education Release (WER) was downsized in December 2014, from a capacity of 160 to 79. The WER is a secure facility at night, so special access is required to provide services to individuals housed there. The MIDD-funded WER liaison contract was updated to allow for assisting an additional 30 King County residents housed in Department of Corrections work release facilities. The maximum annual caseload capacity for this liaison is now 109.

11b Increase Services for New or Existing Mental Health Court (MHC) Programs

King County Regional Mental Health Court (RMHC)

By Motion 14404, approved by the Council in July 2015, changes to performance measures and the spending plan for RMHC were accepted, as recommended by the MIDD Oversight Committee. Evaluators began tracking non-expansion cases in October 2013, in anticipation of the shift from supplantation to core MIDD funding for all therapeutic courts.

15a Adult Drug Court (ADC) Expansion of Recovery Support Services

Funding for the base ADC (non-expansion) shifted from MIDD supplantation to the core MIDD fund in January 2015. The court has agreed to provide demographic information for all individuals who opt in during 2015 and 2016, so that those people can be included in the tracking of ADC outcomes.

ADC Celebrates 20th Anniversary

On October 14, 2014, supporters of ADC, also known as Drug Diversion Court, filled the largest courtroom in the King County Courthouse to celebrate 20 years in operation and nearly 2,050 graduates. Participants, graduates, friends and family were treated to words of gratitude and encouragement from past graduates, elected officials, past and current judicial officers, and a special guest: Ben Haggerty, the award-winning Seattle rapper Macklemore.

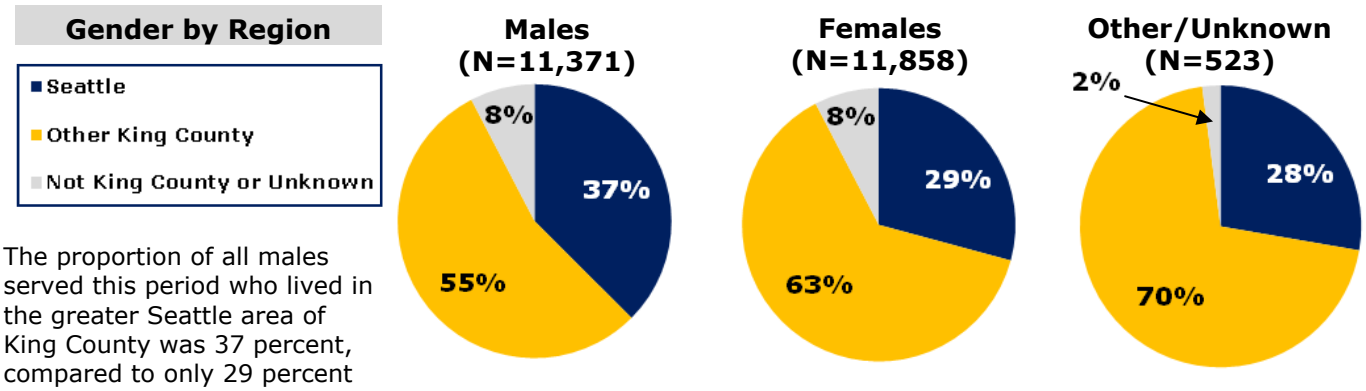
"If I am sober, I have a chance. If I'm not, I don't."
-Macklemore

MIDD Demographics by Geographic Distribution

Client gender, age, primary race, Hispanic origin, and zip code information was available for 23,752 unduplicated people who received at least one MIDD service between October 2014 and March 2015. Individuals who participated in multiple strategies are counted only once in this section. Other demographic information is not available for all cases, but is reported below with relevant denominators. All findings are presented within the context of King County region as determined by zip codes reported at the start of each person's MIDD services.

Demographic Differences by King County Region for MIDD Participants

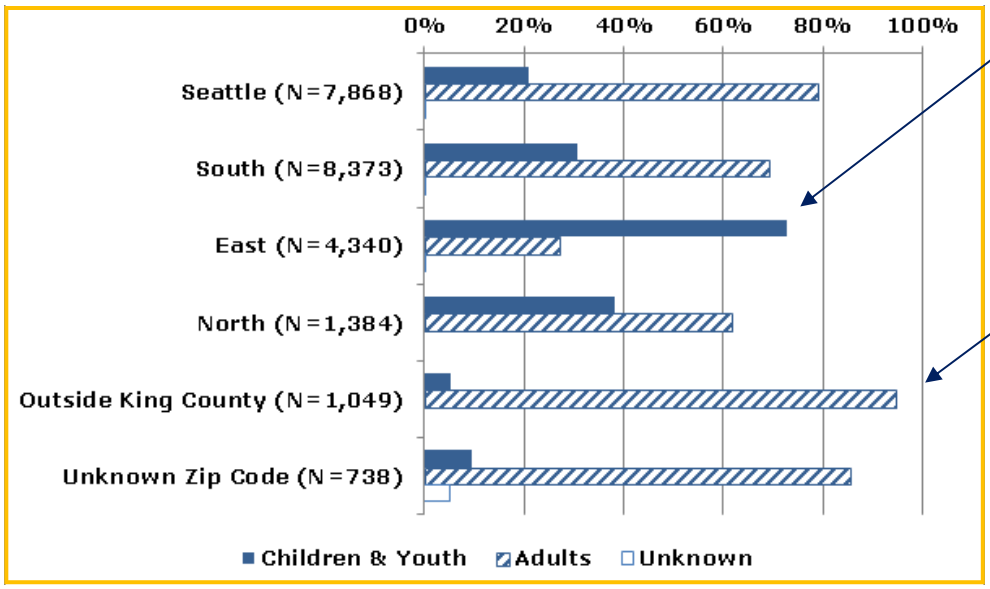
Gender by Region



The proportion of all males served this period who lived in the greater Seattle area of King County was 37 percent, compared to only 29 percent of all females served. Suicide prevention trainees are over-represented in the Other/Unknown gender category as presenters make a visual count of total attendees. This group was served mostly in the south and east regions.

Age Group by Region

N=23,752



In the east region of King County, 73 percent of all persons served in the current timeframe were under the age of 18. A total of 2,808 of the 3,159 children and youth served in this region (89%) were presented with suicide prevention information.

Most zip codes outside the county were reported for adults. Only about 15 percent of these cases were homeless individuals; the majority were people who received brief MIDD services at local hospitals or at primary care "safety net" clinics within the county.

Disability

More clients from the greater Seattle area (30%) had documented disabilities than clients from the east region of the County (18%).

Homeless

1,861 of the 3,044 people known to be homeless (61%) lived in Seattle.

Interpreter

The east region of the county had the highest percentage of MIDD clients (8%) in need of language services. Seattle and the south region had five percent each.

Veterans

Over half of the 709 MIDD participants with past U.S. military service lived in Seattle. Another third lived in the south region. A 2010 survey placed 27 percent of all King County veterans in Seattle and 43 percent in the south region.

Regional Differences in the Racial Identity of MIDD Participants

	 Seattle (N=7,868)	 South (N=8,373)	 East (N=4,340)	 North (N=1,384)	All MIDD Participants Including Other and Unknown Zip Codes (N=23,752)	King County Census Estimate*	
						Below Poverty Level	Entire Population of the County
Caucasian/White	48%	47%	59%	61%	51%	58%	70%
African American/Black	18%	14%	3%	7%	13%	13%	6%
Asian/Pacific Islander	11%	15%	14%	9%	13%	17%	15%
Native American	3%	1%	1%	2%	2%	2%	1%
Multiple Races	4%	5%	9%	5%	5%	5%	5%
Other/Unknown	15%	18%	15%	17%	16%	5%	3%

** Source: 2008-2012 American Community Survey.*

Regional Distribution of Race Compared to Census Data

In the table above, current MIDD participants are grouped by their primary race within four geographic regions. The three additional columns to the right are provided for comparison purposes. The race distribution "below poverty level" likely gives the best approximation of people who would be eligible for publicly-funded services. Key findings are consistent with MIDD distributions of race reported previously.

- The proportion of MIDD clients living in the Seattle region of the county who were African American or Black was higher than in other regions.
- The proportion from the Seattle and north regions who were Asian or Pacific Islander was lower than the south and east regions. The figure for Asian/Pacific Islander among all MIDD participants this period (13%) is up from 2010 (8%), 2011 through 2013 (10%), and 2014 (12%).
- A higher proportion of MIDD clients served in the east and north regions were Caucasian or White than those served in the Seattle or south regions.
- The proportion of clients listing multiple races was highest for the east region.

Hispanic origin continues to be tracked separately from the race categories shown above. Of the 23,752 MIDD cases in this reporting period, at least 3,048 people (13%) endorsed Hispanic ethnicity. Almost half of these Hispanics reported zip codes in the county's south region. In King County, the population census rate for Hispanic origin is estimated at nine percent.

Rooting Out Racial Disparities in the Juvenile Justice System

On March 31, 2015, King County leaders, including Executive Dow Constantine, announced new actions to end racial disproportionality in the juvenile justice system. In their news release, leaders spoke of creating alternatives to detention and shifting toward a restorative justice paradigm. Superior Court Presiding Judge Susan Craighead, who serves on the MIDD Oversight Committee, committed to the goal of reducing by half the use of detention for young probation violators.

The average daily population in detention fell from 205 in 1999 to only 45 in 2014, but racial disparity grew. Half of all youth currently detained are African American—an "unacceptable situation". By capping the number of beds at 112 in the new Children and Family Justice Center (see Page 9 for more information), space can be reallocated to provide programs that address youth crisis intervention and rescue from gangs and human trafficking.

MIDD-Served Youth in Secure Detention

- From October 2008 to 2013, an analysis sample of 7,812 youth were between the ages of 10 and 18 when they began MIDD services; approximately 27 percent had been detained at least once.
- Detention rates varied by MIDD strategy. For example, only eight percent of those in mental health treatment were detained vs. 81 percent of those in Juvenile Drug Court.
- Youth of color in three race groups (Native American, African American/Black, and Multiple Races) were detained at significantly higher rates (36 to 48%) than Caucasian/White youth (22%).
- Average changes in detention bookings and days within individual MIDD clients from pre to first post were about the same for all race groups.
- For nearly all MIDD strategies, the percentage of youth who reduced detention use over the short term did not differ by race.

Substance Abuse Symptom Reduction for Adults in MIDD-Funded Treatment

History of Issues Impacting Analysis of MIDD Substance Use Reductions

When the MIDD was implemented in October 2008, it was proposed that all adult-serving substance use disorder (SUD) treatment providers use existing data collection mechanisms. The State of Washington Division of Behavioral Health and Recovery (DBHR) maintains a data system called TARGET, which houses data on SUD treatment services statewide, including elements from the Addiction Severity Index (ASI). All SUD providers submit their data directly to TARGET and not to the County. These elements were required by the State only on admission and discharge. In late 2009, King County requested TARGET modifications allowing collection of certain ASI measures at six-month intervals to track outcomes at interim time points during the course of treatment. While DBHR was receptive to the request, limited time and resources delayed implementation.

By July 2011, TARGET was updated and adult SUD treatment providers receiving MIDD funds were required to submit what became known as "periodic milestone" data. Over 2,500 records had been entered by 2012, but limited staffing further delayed necessary modifications to the County's own database in order to accept the new data.

Meanwhile, initial symptom reduction findings were published in February 2013, using only admission and discharge data (not periodic milestones) for 2,699 adults in outpatient SUD treatment. At that time, results showed that for adults, treatment was sought most often for alcohol (55%), marijuana (25%) and cocaine (6%). For individuals with primary alcohol use, 128 of 499 (26%) who had data measured at intake and exit reduced their use to abstinence by treatment exit. For marijuana, the abstinence rate was 24 percent; cocaine was 20 percent.

Data quality of discharge reporting, as well as individuals entering treatment from residential treatment, correctional facilities, or detoxification centers (where opportunity to use substances during the 30 days prior to outpatient treatment admission is restricted) may artificially suppress the amount of actual change achieved by individuals in treatment. This report marks the first opportunity to conduct a thorough review of substance abuse symptom reduction for adults served in three MIDD strategies: 1a-2—Substance Use Disorder Treatment, 8a—Family Treatment Court, and 15a—Adult Drug Court.

Adults in Outpatient SUD Treatment

Outcomes were sought for 7,587 individuals who began MIDD outpatient treatment between October 2008 and 2013. Usable information was found for 6,097 treatment episodes for 4,658 individuals (61% match rate). Most people (78%) had one treatment episode[1], while 16 percent had two, and six percent had three or more.

Males accounted for 73 percent of treatment episodes; females only 27 percent. The episodes were evenly divided between Caucasian/Whites and people of color. At admission, 68 percent of individuals were housed; others were homeless (17%), had shared housing (10%), or were in more restrictive settings (6%).

Compared to findings reported in 2013, marijuana treatment admissions declined from 25 to 14 percent, while cocaine, heroin, and methamphetamine each rose to about seven percent of all admissions. Alcohol was still the top primary substance, at 56 percent of admits.

Over half of all people treated reported no primary substance use in the 30 days before treatment admit - a level of use hard to improve upon. Data quality issues may be a factor. Before treatment, daily users of alcohol (8%) were less prevalent than daily users of other drugs (18%). Poly-substance use was also common.

At the time of analysis, only seven percent of treatment episodes were ongoing. Successful completions were recorded for 43 percent, while eight percent transferred. Others ended treatment due to rule violations, lack of engagement, withdrawal from care, incarceration, etc.

Declines in substance use over time are shown on Page 15 for adults receiving MIDD outpatient SUD treatment.

[1] An episode spans from admission to discharge or loss to follow-up, so the length varies widely between individuals.

Adults in Opiate Treatment Programs (OTP)

The analysis sample for adults in MIDD-funded OTP was 1,961 treatment episodes for 1,421 individuals (74% match rate to the 1,917 outcomes-eligible people served). Three of four clients had only one episode of treatment[1]. Males had 59 percent of OTP episodes, compared to 73 percent in outpatient care. Caucasian/Whites accounted for half of all outpatient episodes, but 77 percent of the OTP episodes. The homeless rate was much higher for those in OTP as well, at 27 percent.

Heroin was the primary drug used in 82 percent of all OTP treatment admissions; opiate pills in five percent. Daily use of heroin and other opiates in the 30 days leading up to treatment was found in 64 percent of all cases.

Many OTP cases (34%) were ongoing indefinitely, as expected. Of the 66 percent with exits, transfers to other providers were 17 percent of all discharges and four percent were considered completed at exit. The remainder (45%) had violated rules, withdrew from care, or were lost to follow-up.

From admission to first periodic milestone (collected at six month intervals), 457 of 515 people with active drug use leading up to their OTP treatment admission (89%) decreased use of their primary substance. Among those without interim data, 465 of 901 people (52%) reported decreased drug use between admission and discharge. While unchanged use was recorded for 28 percent of those with some drug use at admission and at least one later measure (400 of 1,416), very few experienced increased use (less than 7%).

The proportion of treatment episodes that showed declines in primary substance use were significant for all race groups using Wilcoxon Signed Rank statistics, the test used to assess all findings reported in this section.

Family Treatment Court (FTC)

A total of 139 adults in FTC were eligible for substance use reduction outcomes. Information on 148 treatment admissions matched 86 people in the eligible outcomes sample (61% match rate). Treatment was successfully completed by 33 percent of admissions (49 people). Withdrawals from treatment and "inappropriate admissions" were two other commonly cited exit dispositions (30%).

The vast majority (82%) of outcomes-eligible FTC clients were female. The most common primary substance used was methamphetamine (27%), followed by cocaine and alcohol at 20 percent each.

Periodic milestone data were available for 49 FTC treatment admissions; thirty individuals (61%) reported no substance use in the 30 days before outpatient treatment began with no change in use over time. Seventeen of the remaining 19 with some substance use (79%) experienced decreased use between admission and the first milestone time point.

By contrast, where milestone data were unavailable, 16 of the 36 people who reported using a substance in the month before treatment (44%) experienced a decline in use by the discharge time point. Explanations for less robust symptom reduction findings using only discharge data, instead of the first milestone, include the high number of cases that end a given treatment episode for reasons other than successful completion and known data quality issues with discharge reporting.

Adult Drug Court (ADC)

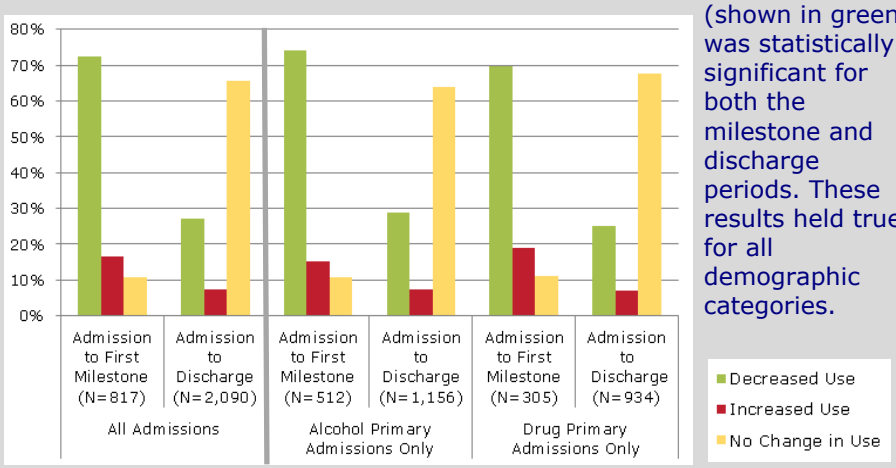
The ADC had 937 clients who were eligible for outcomes assessment; 667 (71%) were males. Case matching found 1,199 treatment starts for 629 individuals (67% match rate). The average number of treatment episodes per person was 1.9. The most common substance used by this group was marijuana (22% primary). Only 13 percent of ADC cases were homeless when they began treatment, compared to MIDD's outpatient treatment strategy (17%) and opiate treatment (27%). Housing status at treatment admit may have contributed to both higher successful completion rates (45%) and to higher percentages of cases with decreased substance use as shown below. Legal leverage may be another factor contributing to more robust outcomes.

	Admission to First Milestone		Admission to Discharge	
	Number	Percent	Number	Percent
Decreased use	43	74%	168	46%
Increased use	13	22%	21	6%
No change	2	3%	177	48%
Total with use	58	100%	366	100%
No use/No change	159	-	569	-
Total cases	217	-	935	-

Note that "no use/no change" is considered a favorable outcome, but the accuracy of these data are questioned.

Declines in Substance Use Over Time for MIDD Outpatient Treatment Episodes

Information about the frequency of primary substance use was available at both admission and discharge for 4,575 outpatient treatment episodes and at admission and periodic milestones for 1,810 episodes. All cases that reported no substance use in the month before outpatient treatment and that had no subsequent change over time (N=3,478) were excluded from the analysis below, although these instances may be indicative of favorable outcomes for individuals. From admission to first milestone, 72 percent of all episodes with active substance use in the 30 days prior to treatment admit experienced declines in use. From admit to discharge, however, only 27 percent showed decreased use and the majority showed no change, as illustrated below. Note that the milestone data points have higher reliability as clients are available for assessment. At discharge, the data matched intake precisely in 65 percent of cases. Decreased use (shown in green) was statistically significant for both the milestone and discharge periods. These results held true for all demographic categories.



Abstinence Rates by Strategy

The prevalence of primary substances used varied by MIDD strategy (see below). The proportion of adults who reduced their substance use from some use at admission to zero use at exit is shown in the center column. The percentage of adults who reduced to zero use or who stayed use free from admission to discharge is shown in the far right column. Recall that OTP should be ongoing, so lower rates of abstinence shown here are reflective of those who were discharged from treatment either prematurely or unexpectedly.

MIDD Strategy (Most prevalent substance used)	Reduced to Zero Use	Reduced to Zero or Stayed Use Free
1a-2—Outpatient (56% Alcohol)	26%	66%
1a-2—OTP (82% Heroin)	33%	40%
8a—FTC (27% Meth)	37%	78%
15a—ADC (22% Marijuana)	46%	78%

MIDD Financial Report

Financial information provided over the next three pages is for the first six months of calendar year 2015 (January 1 through June 30, 2015). The MIDD Fund spent approximately $19.8 million in strategy funding and approximately $3.3 million in MIDD supplantation (see Page 18 for more information). The MIDD sales tax was influenced by the recovering economy, whereby revenues were up nine percent over the same period in 2014. Parts I and II show both budgeted and actual spending by strategy or therapeutic court. Also included in the financial report are summary revenues/expenditures and detailed supplantation spending. Note that amounts appropriated are often spent at differing rates. Strategies 13a and 14a share funds, as needed.

Mental Illness and Drug Dependency Fund - Part I

	Strategy	2015 Annual Budget	Actual Year-to-Date (through June 2015)	2015 Projection (6/30/15)
1a-1	Increase Access to Community Mental Health Treatment & Club House	$ 7,920,000	$ 3,311,382	$ 7,920,000
1a-2	Increase Access to Community Substance Abuse Treatment	$ 2,450,000	$ 170,948	$ 2,450,000
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	$ 495,000	$ 28,625	$ 495,000
1c	Emergency Room Substance Abuse Early Intervention Program	$ 652,000	$ 222,953	$ 652,000
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	$ 225,000	$ 91,670	$ 225,000
1e	Chemical Dependency Professional Education and Training	$ 681,260	$ 283,575	$ 681,260
1f	Parent Partner and Youth Peer Support Assistance Program	$ 375,000	$ 157,092	$ 375,000
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	$ 450,000	$ -	$ 450,000
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	$ 315,000	$ 105,000	$ 315,000
2a	Workload Reduction for Mental Health	$ 4,000,000	$ 1,654,926	$ 4,000,000
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	$ 1,000,000	$ 242,075	$ 1,000,000
3a	Supportive Services for Housing Projects	$ 2,000,000	$ 2,000,000	$ 2,000,000
4a	Services for Parents in Substance Abuse Outpatient Treatment	$ -	$ -	$ -
4b	Prevention Services to Children of Substance Abusers	$ -	$ -	$ -
4c	Collaborative School-Based Mental Health and Substance Abuse Services	$ 1,261,391	$ 498,724	$ 1,261,391
4d	School-Based Suicide Prevention	$ 200,000	$ 50,000	$ 200,000
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 176,938	$ 52,497	$ 176,938
6a	Wraparound Services for Emotionally Disturbed Youth	$ 4,500,000	$ 1,323,816	$ 4,500,000
7a	Reception Centers for Youth in Crisis	$ -	$ -	$ -
7b	Expansion of Children's Crisis Outreach Response Service System	$ 500,000	$ 166,240	$ 500,000
8a	Expand Family Treatment Court Services and Support to Parents	$ 81,250	$ 31,250	$ 81,250
9a	Expand Juvenile Drug Court Treatment (See Part II)	$ -	$ -	$ -
10a	Crisis Intervention Team Training for First Responders	$ 763,747	$ 105,755	$ 763,747
10b	Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	$ 6,100,000	$ 2,401,700	$ 6,100,000
11a	Increase Jail Liaison Capacity	$ 80,000	$ 28,332	$ 80,000
11b	Increase Services for New or Existing Mental Health Court Programs	$ 693,282	$ 227,072	$ 693,282
12a	Jail Re-Entry Program Capacity Increase	$ 320,000	$ 86,942	$ 320,000
12b	Hospital Re-Entry Respite Beds	$ 508,500	$ -	$ 508,500
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	$ 200,000	$ 83,335	$ 200,000
12d	Behavior Modification Classes for CCAP Clients	$ 75,000	$ 25,000	$ 75,000
13a	Domestic Violence and Mental Health Services	$ 250,000	$ 131,641	$ 250,000
13b	Domestic Violence Prevention	$ 224,000	$ 74,672	$ 224,000
14a	Sexual Assault, Mental Health, and Chemical Dependency Services	$ 400,000	$ 133,510	$ 400,000
15a	Drug Court: Expansion of Recovery Support Services	$ 103,778	$ -	$ 103,778
16a	New Housing Units and Rental Subsidies	$ -	$ -	$ -
	MIDD Evaluation and Treatment Capital	$ 1,200,000	$ 1,000,000	$ 1,200,000
	Sexual Assault Supplantation	$ 362,000	$ 362,000	$ 362,000
	MIDD Administration	**$ 3,121,252**	**$ 1,656,448**	**$ 3,121,252**
	MIDD Administration	3,121,252	$ 1,656,448	3,121,252
	Total MIDD Operating Dollars	**$ 41,684,398**	**$ 16,707,180**	**$ 41,684,398**
	Percentage of Appropriation		**40.08%**	**100.00%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	2015 Annual Budget	Actual Year-to-Date (through June 2015)	2015 Projection (6/30/15)
	Department of Judicial Administration	**$ 1,636,165**	**$ 642,516**	**$ 1,636,165**
	Drug Court: Expansion of Recovery Support Services	$ -	$ 73,342	$ -
15a	Adult Drug Court Base	$ 1,636,165	$ 569,175	$ 1,636,165
	Prosecuting Attorney's Office	**$ 1,247,185**	**$ 509,834**	**$ 1,247,185**
	Adult Drug Court Base	$ 583,770	$ 237,245	$ 583,770
	Juvenile Drug Court Base	$ 121,774	$ -	$ 121,774
	Mental Health Court Base	$ 541,641	$ 263,119	$ 541,641
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 9,470	$ -
	Superior Court	**$ 1,702,141**	**$ 796,864**	**$ 1,702,141**
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 235,182	$ 103,526	$ 235,182
8a	Expand Family Treatment Court Services and Support to Parents	$ 672,591	$ 354,588	$ 672,591
9a	Expand Juvenile Drug Court Treatment	$ 621,888	$ 257,619	$ 621,888
	Adult Drug Court Base	$ 172,480	$ 81,130	$ 172,480
	Juvenile Drug Court Base	$ -	$ -	$ -
	Family Treatment Court Base	$ -	$ -	$ -
	Sheriff	**$ 166,216**	**$ 88,396**	**$ 166,216**
10a	Crisis Intervention Team Training for First Responders	$ 166,216	$ 88,396	$ 166,216
	Department of Public Defense	**$ 1,482,760**	**$ 514,925**	**$ 1,482,760**
	Adult Drug Court Base	$ 638,434	$ 317,756	$ 638,434
	Juvenile Drug Court Base	$ 83,443	$ 13,799	$ 83,443
	Mental Health Court Base	$ 440,119	$ 183,286	$ 440,119
	Family Treatment Court Base	$ 320,765	$ -	$ 320,765
8a	Expand Family Treatment Court Services and Support to Parents	$ -	$ -	$ -
9a	Expand Juvenile Drug Court Treatment	$ -	$ -	$ -
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 84	$ -
	District Court	**$ 1,039,385**	**$ 526,790**	**$ 1,039,385**
	Mental Health Court Base	$ 1,039,385	$ 504,854	$ 1,039,385
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 21,936	$ -
	Total Other MIDD Funds	**$ 7,273,852**	**$ 3,079,324**	**$ 7,273,852**
	Percentage of Appropriation		**42.33%**	**100.00%**
	Total All MIDD Funds	**$ 48,958,250**	**$ 19,786,503**	**$ 48,958,250**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	2015 Annual Budget	Actual Year-to-Date (through June 2015)	2015 Projection (6/30/15)
Revenue			
MIDD Tax	$ 54,238,144	$ 26,569,686	$ 56,501,860
Streamlined Mitigation	$ 650,000	$ 298,420	$ 650,000
Investment Interest - Gross	$ 55,000	$ 22,995	$ 55,000
Cash Management Svcs Fee		$ (345)	
Invest Service Fee - Pool		$ 1,159	
Other Miscellaneous Revenue		$ 20	
Total Revenues	**$ 54,943,144**	**$ 26,891,935**	**$ 57,206,860**
Total MIDD Funds	$ 48,958,250	$ 19,786,503	$ 48,958,250
Total MIDD Supplantation	$ 9,090,841	$ 3,274,187	$ 9,090,841
Total Expenditures	**$ 58,049,091**	**$ 23,060,690**	**$ 58,049,091**
Expenditures Over Revenues	**$ (3,105,947)**	**$ 3,831,246**	**$ (842,230)**

Mental Illness and Drug Dependency Fund - Supplantation

MIDD Supplantation	2015 Annual Budget	Actual Year-to-Date (through June 2015)	2015 Projection (6/30/15)
Department of Adult and Juvenile Detention	**$ 367,363**	**$ -**	**$ 367,363**
Community Center for Alternate Programs (CCAP)	$ 28,644	$ -	$ 28,644
Juvenile MH Treatment	$ 338,719	$ -	$ 338,719
Jail Health Services	**$ 3,738,671**	**$ 1,920,464**	**$ 3,738,671**
Psychiatric Services	$ 3,738,671	$ 1,920,464	$ 3,738,671
MH & SUD MIDD Supplantation	**$ 4,984,807**	**$ 1,353,723**	**$ 4,984,807**
SUD Administration	$ 399,752	$ -	$ 399,752
Criminal Justice Initiative	$ 1,031,111	$ 290,484	$ 1,031,111
SUD Contracts	$ 271,757	$ 8,782	$ 271,757
Housing Voucher Program	$ 602,615	$ 175,868	$ 602,615
SUD Emergency Service Patrol	$ 505,325	$ 3,377	$ 505,325
CCAP	$ 472,981	$ 157,742	$ 472,981
MH Co-Occurring Disorders Tier	$ 800,000	$ 264,581	$ 800,000
MH Recovery	$ 187,660	$ 56,186	$ 187,660
MH Juvenile Justice Liaison	$ 90,000	$ 45,835	$ 90,000
MH Crisis Respite Beds	$ 263,606	$ 123,451	$ 263,606
MH Functional Family Therapy	$ 272,000	$ 190,400	$ 272,000
MH Mental Health Court Liaison	$ 88,000	$ 37,017	$ 88,000
Total MH/SUD MIDD Supplantation Funds	**$ 9,090,841**	**$ 3,274,187**	**$ 9,090,841**
Percentage of Appropriation		**36.02%**	**100.00%**

Financial Highlights for the Current Reporting Period

Evaluation and Treatment Facility

As indicated on Page 4, the 2015/2016 King County biennial budget passed with a line item to provide capital funds from the MIDD toward developing an additional 16-bed psychiatric evaluation and treatment facility. An issue paper on mental health written to support the proposed budget and available on the King County Performance, Strategy and Budget Division web page states, "Insufficient inpatient involuntary psychiatric beds and insufficient funds to pay for access to the available beds have been problematic." King County Department of Community and Human Services developed strategies for mitigating the bed capacity and funding issues, including the aforementioned capital funding, as well as MIDD contingency funds to pay for inpatient psychiatric beds if that should become necessary to avoid boarding of patients in area hospitals, a practice found illegal by the Supreme Court of Washington. Although the goal was to avoid using MIDD resources for these purposes, King County needed to be prepared to meet its statutory obligations if state funding was not available.

Therapeutic Courts No Longer Considered Supplantation

In January 2015, funding for King County's therapeutic courts moved from MIDD Supplantation to other MIDD funds (Separate Appropriation Units) as shown in Part II of the MIDD Financial Report (on Page 17). Note that during this transition period, the fiscal report shows some budgeted amounts under the strategy numbers and others under the base court. For an example of the former, see Superior Court; for the latter, see Department of Public Defense.

MIDD Oversight Committee Membership Roster

Ann McGettigan, Executive Director, Seattle Counseling Service (Co-Chair)
Representing: Provider of culturally specific mental health services in King County

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

Dave Asher, Councilmember, City of Kirkland
Representing: Sound Cities Association

Rhonda Berry, Chief of Operations
Representing: County Executive

David Black, Residential Counselor, Community Psychiatric Clinic
Representing: Labor, representing a *bona fide* labor organization

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

David Chapman, Director, King County Department of Public Defense
Representing: Public defense

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

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

Rod Dembowski, Councilmember, Metropolitan King County Council
Representing: King County Council

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

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

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

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

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

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

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

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

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

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

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

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

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

Mark Putnam, Director, Committee to End Homelessness in King County
Representing: Committee to End Homelessness

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

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

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

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

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

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

Oversight Committee Staff:
Kelli Carroll, King County DCHS, Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

Andrea LaFazia-Geraghty, MHCADSD

Bryan Baird, MHCADSD

As of 3/31/2015

Revised Evaluation Matrices

Evaluation matrices that were revised since their last publication are shown below.

5a

Strategy 5 - Expand Assessments for Youth in the Juvenile Justice System				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
5a – Increase Capacity for Social and Psychological Assessments for Juvenile Justice Youth Target Population: Youth aged 12 years or older who have become involved with the juvenile justice (JJ) system (including non-offender youth involved with the Becca truancy process)	1. Hire administrative and clinical staff to enhance and expand the capacity for social and psychological assessments, substance abuse assessment, and other specialty evaluations (e.g., psychiatric, forensic, neurological, etc.) for juvenile justice involved youth. 2. Screening and assessment of youth including the following: a. Coordinate/triage ~~500~~ 1,200 assessment referrals per year; b. Provide 200 psychological services per year; c. Conduct 140 mental health assessments per year; d. Conduct 165 full chemical dependency evaluations (Global Appraisal of Individual Needs – Initial or GAIN-I) per year; and e. Provide up to 10 psychiatric evaluations per year (as needed).	Short-term measures: 1. Hire 1 FTE program coordinator 2. Hire up to 3 assessment professionals (i.e., psychologist, mental health professional and chemical dependency professional) Longer-term measures: 3. Increase # of youth involved in JJ completing a GAIN assessment 4. Increase # of youth involved in JJ completing a MH assessment or specialty evaluation 5. Increase # of linkages to outpatient MH treatment for those referred 6. Increase # of linkages to outpatient substance abuse treatment for those referred 7. Reduce # of detention admissions for youth linked to CD and/or MH treatment	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7.Outcome	Contract report Contract report Assessments.com MIDD Tools MIS (php96) TARGET Juvenile Justice data

Content revised 5/19/2010 (Previous draft published 9/2/2008) Amended 7/1/2011 Further amended 4/29/2014

8a

Strategy 8 - Expand Family Treatment Court				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
8a - Expand Family Treatment Court (FTC) Services and Support to Parents Target Population: Parents in the child welfare system who are identified as being chemically dependent and who have had their child(ren) removed due to their substance use	1. Sustain and expand capacity of the FTC model to serve no more than 60 children at any given time and ~~no more than 90~~ up to120 children per year (space permitting). 2. Enroll up to 15 FTC families at any given time in FTC wraparound services.	Short-term measure: 1. Hire 3.5 FTE staff to expand family treatment court capacity Longer-term measures: 2. Increase positive child placements at parent exit from FTC 3. Increase # of FTC parents who are enrolled in CD services 4. Increase # of FTC parents who complete CD treatment 5. Maintain # of FTC families enrolled in FTC wraparound services 6. Reduce severity of CD symptoms for parents served 7. Reduce # of jail bookings and days for parents served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Contract report MIDD Tools MIDD Tools TARGET MIDD Tools TARGET❶ Jail data

❶ Database revisions completed January 2011

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

Content revised 7/9/2010 (Previous draft amended 5/20/2009) Amended 8/1/2011 Further amended 5/1/2015

11b

Strategy 11 - Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
11b - Increase Services Available for New or Existing Mental Health Court (MHC) Programs Target Population: 1) Adult misdemeanants with serious mental illness who opt-in to the mental health court and those who are unable to opt-in because of their lack of legal competency 2) Access to participate will be developed for individuals in court jurisdictions in all parts of King County	1. Expand MHC programs to serve 115 additional clients ~~per year~~ over a two-year period, or 57 annually*, (over 200 per year current capacity) in Regional Mental Health Court (RMHC). Replace above with: 1. Expand MHC programs to serve 55 additional clients over a two-year period, or 28 annually, in Regional Mental Health Court (RMHC). Also track outcomes for 165 non-expansion cases over two-year period, or 83 annually.* 2. Make MHC services available to any misdemeanor offender in King County who is mentally ill, regardless of where the offense is committed. 3. Provide forensic peer support services to individuals "opting in" to RMHC. 4. Pilot a Veterans Track within the existing RMHC. 5. Provide MHC liaison services to ~~60~~ 300* clients per year, including assessment of competency cases in the City of Seattle Municipal Court (SMC) and cases found through outreach with the broader SMC system. 6. Provide therapeutic treatment and supportive housing for RHMC opt-ins (as needed). 7. Provide staff training, not to exceed $7,000.	Short-term measures: 1. Hire RMHC staff and 1 FTE court liaison for the SMC MHC 2. Increase # of MHC clients referred from King County municipalities for screening 3. Increase # of referrals to needed outpatient MH treatment Longer-term measures: 4. Increase # of linkages to outpatient MH treatment for those referred 5. Reduce severity of MH symptoms for those linked to outpatient MH treatment 6. Increase # of clients with housing at exit 7. Increase # of clients with employment at exit 8. Reduce # of jail bookings and days for those served	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	Contract report Contract report MIS (php96) or MIDD Tools MIS (php96) MIS (php96) and MIDD Tools MIDD Tools MIDD Tools Jail data

* The revised targets were accepted by King County Council in motion of acceptance on May 6, 2013 for MIDD Year Five (October 1, 2012 to September 30, 2013).

*Strategy revisions were approved by the MIDD Oversight Committee for MIDD Year Six (October 1, 2013 to September 30, 2014) on October 24, 2013. The new target is based on a budget reduction from two FTE expansion probation staff (whose caseload size determined the numbers to be served) to one FTE expansion

Content revised 7/12/2010 (Previous draft amended 5/20/2009) Amended 2/14/2012 6/10/2013 3/11/2014 Further amended 5/1/2015

12d

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
12d – Behavior Modification Classes for Community Center for Alternative Programs (CCAP) Clients Target Population: CCAP clients who have been mandated by Superior Court or District Court to report daily to CCAP and participate in treatment or general population classes	1. Provide moral reconation therapy to certain ~~behavior modification outpatient treatment✪ to~~ CCAP clients referred on domestic violence offenses. ~~, including:~~ ~~a. Rational emotive behavioral therapy;~~ ~~b. Moral reconation therapy;~~ ~~c. Cognitive behavioral therapy; and~~ ~~d. Dialectical behavioral therapy.~~ 2. Serve ~~100~~ 40 participants per year.	Short-term measures: 1. Subcontract to provide behavior modification classes at CCAP 2. Increase # of clients participating in behavior modification classes Longer-term measures: 3. Reduce severity of MH symptoms for those served 4. Reduce severity of CD symptoms for those served 5. Reduce # of jail bookings and days for those served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome	Contract report MIS (php96) MIS (php96) ~~MIS (php96)~~ TARGET Jail data

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

Content revised 5/6/2010 (Previous draft amended 5/20/2009) Amended 5/25/2012 Further amended 5/1/2015