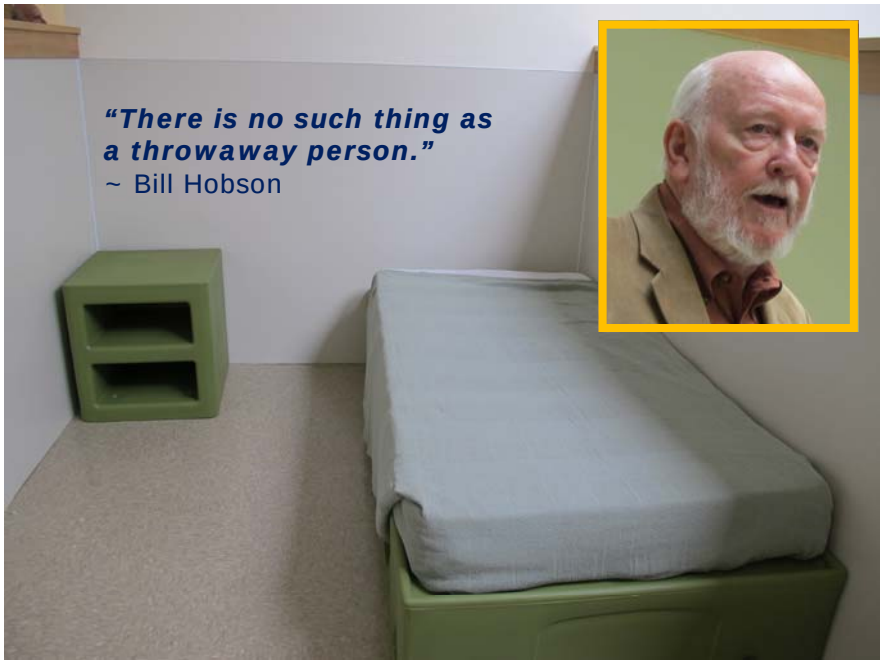
Mental Illness and Drug Dependency

Year Eight Progress Report



Implementation and Evaluation Progress for October 1, 2015—March 31, 2016

King County

Mental Illness and Drug Dependency Oversight Committee

August 2016

King County Department of Community and Human Services

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Year Eight Progress Report

October 1, 2015—March 31, 2016

Cover shows Bill Hobson, former director of Seattle's DESC, who was instrumental in establishing the Crisis Solutions Center under the MIDD plan.
Bill passed away in March 2016 at the age of 76.

For further information on the current status of MIDD activities, please see the MIDD website at:

www.kingcounty.gov/midd

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

MIDD Overview

- King County's Mental Illness and Drug Dependency (MIDD) is a countywide sales tax generating approximately $63 million per year for mental health and substance abuse services and programs.
- As required by state legislation (Revised Code of Washington 82.14.460), revenue raised under the MIDD is to be used for certain mental health and substance use disorder services, including King County's therapeutic courts.
- King County's MIDD was passed by the King County Council in 2007, and MIDD-funded services began in 2008. The eight-year time period from 2008 to 2016 is referenced here as MIDD 1.
- The current MIDD (MIDD 1) is estimated to bring in about $119 million in the 2015-2016 biennium.
- MIDD 1 contains 37 individual program activities; three programs were never launched and two were withdrawn due to other funding becoming available.
- MIDD funds support a wide array of services, from fully funding all of the county's therapeutic courts for adults and juveniles to providing critical services to thousands of individuals who are not covered by Medicaid (immigrants, refugees, undocumented individuals); MIDD-funded services are provided to thousands of King County residents annually.
- The MIDD Oversight Committee is an Executive-appointed and Council-confirmed 30-member body that reviews and makes recommendations to the Executive and Council on MIDD-related matters.
- Unless renewed by the Council, the MIDD will expire on Jan. 1, 2017.
- King County is one of 24 counties in Washington State that has authorized this dedicated tax revenue.

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) funded services. The ordinances require the King County Executive to transmit reports twice each year to the King County Council: a progress report and an annual report. This progress report, for the period of Oct. 1, 2015 to March 31, 2016, includes these 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 from Ordinance 15949

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

Behavioral Health Landscape Changes

As outlined in the MIDD Comprehensive Retrospective Report transmitted to the King County Council on June 30, 2016, as required by King County Ordinance 17998, several factors have impacted the local mental health and substance abuse systems. These and other changes impacting future MIDD planning efforts are shown in the table below.

Change Factor	Description
Behavioral Health Integration	Washington State Second Substitute Senate Bill 6312 passed in March 2014 called for integrated purchasing of mental health and substance abuse treatment services through managed care contracts. King County became a Behavioral Health Organization (BHO) on April 1, 2016.
Affordable Care Act	Expanded coverage and access ensures behavioral health care benefits are now available for people who lacked these benefits; also expands to include substance use disorder services.
Resource Scarcity	Flexible state funding for behavioral health services was cut by more than $40 million between 2009 and 2016.
High Treatment Need	The prevalence of mental illness in Washington State is estimated at 24 percent of the population. King County is in the midst of a heroin/opiate epidemic.
Population Growth	The King County population increased by 22 percent between 2000 and 2015, adding an estimated 380,000 people.

MIDD Renewal Planning: Progress and Activities to Date

Ordinance 17998: Unless extended or renewed by the King County Council, the MIDD sales tax will expire on Jan. 1, 2017. King County Ordinance 17998 passed in January 2015, calling for two reports from the Executive to assist the Council in considering an extension or renewal of the MIDD sales tax. The first document, a historical retrospective on MIDD, was transmitted to the Council on June 30, 2016, and a Service Improvement Plan (SIP) for MIDD 2 is slated to be transmitted to the Council on Aug. 25, 2016. The reports answer key analytical questions for Council as they consider potentially renewing the MIDD sales tax.

Proposed legislation to extend the sales tax was transmitted to the King County Council on June 8, 2016. An executed ordinance (signed by the Executive) is due to the State Department of Revenue by Oct. 18 in order to avoid a lapse in sales tax collections.

MIDD 2 Planning Activities: Executive staff, the MIDD Oversight Committee and stakeholders worked closely to develop and refine information in response to the Council ordinance. Below are some of the important activities collaboratively undertaken by Executive staff and the MIDD Oversight Committee:

- Established a MIDD 2 framework that updates and modifies MIDD services and programs to reflect the changed environment since 2007.
- Held an open call for new concepts for MIDD 2 in September and October 2015; 140 new concepts were suggested from individuals and entities across the King County region.
- Conducted a community process to sort new concepts and MIDD 1 programs and services into high, medium and low priority categories for consideration of MIDD 2 funding.
- Shared draft programmatic and funding recommendations, Retrospective Report and Service Improvement Plan reports publicly, and provided public feedback opportunities for each item.

Community Engagement / Citizen and Community Input: King County conducted its MIDD renewal planning work with an unprecedented level of transparency and community engagement. The Department of Community and Human Services planned and collaboratively developed the deliverables required by Council by sharing information and involving internal and external partners and communities.

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

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

MIDD staff also conducted an electronic survey during this time. Over 360 respondents took the time to answer key questions about MIDD. Summaries and themes from these groups are available on the MIDD renewal website, along with the MIDD survey data, at http://www.kingcounty.gov/MIDDrenewal. See this website for updates, documents, data and other information related to King County's MIDD.

Intentional Collaboration: In addition to involving communities large and small with MIDD 2 planning and development, the Department of Community and Human Services worked with its County partners such as Public Health - Seattle & King County, and community partners such as Harborview Medical Center, to ensure potential MIDD 2 programs and services are developed as a balanced portfolio, integrated with other work, and provided as part of a continuum of services for King County residents.

County staff continue intentional collaborations between MIDD and other efforts such as Best Starts for Kids and the Youth Action Plan, the Health and Human Services Transformation Plan and Familiar Faces Initiative, Behavioral Health Integration, the Veterans and Human Services Levy, the Juvenile Justice Disproportionality Steering Committee, and the King County Strategic Plan.

Next Steps: As of the writing of this progress report, the Council has received proposed legislation to extend/renew the sales tax. It is anticipated that the Council will act before the State Department of Revenue deadline of Oct. 18, 2016. The Retrospective Report has been transmitted to the Council and the MIDD 2 Service Improvement Plan will be submitted to Council prior to submission of this report.

The King County Council will consider the proposed MIDD 2 budget and programmatic recommendations during its 2017-2018 biennial budget deliberations occurring during the end of September through the third week of November 2016. The Council may amend these recommendations or otherwise amend the Executive's MIDD 2 budget or programmatic recommendations.

* *This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. People under the transgender umbrella may describe themselves using one or more of a wide variety of terms - including transgender.* Source: http://www.glaad.org/reference/transgender.

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

Year Eight Progress Report Highlights

- Total revenues through June 2016 for the 2015-2016 biennium were over $87 million. Expenditures to implement MIDD strategies and supplantation totaled nearly $85 million in the same period.
- Behavioral health integration, the Affordable Care Act, resource scarcity, high treatment need and population growth in King County are key factors impacting future MIDD planning efforts.
- King County Ordinance 17998 resulted in delivery of two key reports from the Executive to assist the Council in considering an extension or renewal of the MIDD sales tax, set to expire on Jan. 1, 2017.
- King County engaged hundreds of residents and community partners across the region for input and guidance in order to recommend responsive and relevant MIDD 2 initiatives.
- New performance targets were proposed under MIDD Strategy 1a-2 - Substance Use Disorder Treatment, as recommended in the MIDD Eighth Annual Report, because previous targets underreported services provided by this strategy. See the list of new measures on Page 6.
- Seven of the eight MIDD programs serving youth are currently projected to meet or exceed their performance measurement targets by Sept. 30, 2016.
- The MIDD crisis diversion facility operated at or above 80 percent of its capacity in five of the six months covered by this report. The Crisis Solutions Center is projected to have 3,600 unique service encounters in MIDD Year Eight.
- To put MIDD service delivery into perspective, just under two percent of the King County population are served by MIDD, or about 16 percent of the county's population estimated to be living below the federal poverty level.
- Qualitative data analysis found that youth who are motivated in substance use disorder treatment by jobs and money are more likely to reduce their substance use than those motivated by other coded factors such as friends/family or avoiding trouble.
- Clinically relevant reductions in depression and anxiety were evident for older adults served in MIDD Strategy 1g - Older Adults Prevention, as shown on Page 15.

Evaluating MIDD Implementation

All but three MIDD strategies were eventually implemented (or piloted) within the first eight years of the MIDD, except for: Strategy 4a—Parents in Recovery Services, Strategy 4b—Substance Use Disorder Prevention for Children, and Strategy 7a—Youth Reception Centers.

Fully-implemented strategies were evaluated by the evaluation team (also known as System Performance Evaluation team) for the King County Behavioral Health and Recovery Division (BHRD), which now reports to the Department of Community and Human Services' (DCHS) Performance Measurement & Evaluation (PME) unit. Published evaluation results were reviewed by the MIDD Oversight Committee, whose roster as of March 2016 is shown on Page 19. Since 2010, MIDD evaluation reports have been transmitted two times per year to the King County Council from the King County Executive.

During the current reporting period, evaluation efforts were focused on providing long-term assessment of strategy effectiveness for inclusion in the MIDD Comprehensive Retrospective Report, in addition to monitoring ongoing program utilization and performance measurement statistics. The entire MIDD evaluation process was also assessed by the King County Office of Performance, Strategy and Budget (PSB) to identify the strengths and weaknesses of the MIDD evaluation and to offer recommendations for future MIDD evaluations.

MIDD Requests for Proposals Update

There were no Requests for Proposals (RFPs) for MIDD services between October 2015 and March 2016.

Community-Based Care Strategies

Performance measurement and program utilization statistics are shown below for strategies designed to increase access to community behavioral health treatment for low-income individuals. These strategies are intended to improve care quality and customize behavioral health services to meet client need.

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

- 2.0 = Programs expected to turn over full client load during the year
- 1.9 = Shorter term programs with fairly stable enrollment (lower turnover)
- 1.3 = Programs at capacity or with longer benefits (minimal 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 8 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	2,588	1.3	140%	⬆
1a-2 - Increase Access to Community Substance Abuse Treatment				
12,000 outpatient (OP) units (in first 6 mos.) 600 OP authorizations (in last 6 mos.) 25,000 opiate treatment program (OTP) units 150 detoxification bed days (in first 3 mos.) 7,200 sobering center admissions 2,000 peer services encounters 4,500 outreach service hours	10,160 adult OP units count to begin 4/1/2016 14,989 OTP units 163 detox bed days 3,916 sobering admissions 1,200 peer service encounters 4,568 outreach service hours	1.0 N/A 2.0 1.0 2.0 2.0 1.0	85%[2] N/A 120% 109% 109% 120% 102%	 ⬆ –
1b - Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities				
675 clients/yr	1,143	2.0	339%[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 to 5.5 FTE in reporting period**	1,100 of 4,400 screens goal 1,549 of 2,984 brief interventions goal	2.0	50% 104%	⬇ ⬆
1d - Mental Health Crisis Next Day Appointments and Stabilization Serivces				
750 clients/yr with enhanced services	232 (using "enhanced" proxy)	2.0	62%	⬇
1e - Chemical Dependency Professional (CDP) Education and Training				
125 reimbursed trainees/yr 250 workforce development trainees/yr	236 reimbursed trainees[4] 241 other trainees (13 trainings)	1.3	245% 125%	⬆ ⬆
1f - Parent Partner and Youth Peer Support Assistance Program				
400 individually-identified clients/yr **Adjust to 362 clients/yr due to staffing** 1,000 group clients/yr	109 866	2.0	60% 173%	⬇ ⬆
1g - Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+				
2,500 clients/yr	6,192	1.3	322%	⬆
1h - Expand Availabilty of Crisis Intervention and Linkage to Ongoing Services for Older Adults				
340 clients/yr	167	1.9	93%	⬆
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 MH clients/yr + 75 in SUD pilot[5]**	560 MH clients + 70 in SUD pilot	1.3	106% (Adjusted)	⬆
3a - Supportive Services for Housing Projects				
690 clients/yr	667	1.3	126%	⬆
13a - Domestic Violence and Mental Health Services				
560-640 clients/yr	344	2.0	123%	⬆
14a - Sexual Assault and Mental Health Services				
170 clients/yr	162	2.0	191%[3]	⬆

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Revised targets proposed in this report. See Page 21 for more information. Also served 84 clients in case management and transportation.
[3] Blended funds allow more clients to be served than the portion attributable to MIDD only, on which performance measurement is based.
[4] Includes 148 reimbursed for CDP or CDPT education or certification expenses, plus 88 clinical supervision reimbursements.
[5] Revised target accepted by Council in motion of acceptance on 6/20/2016.

1a Increase Access to Community Mental Health and Substance Use Disorder (SUD) Treatment

Behavioral health integration was prompted by Washington's Second Substitute Senate Bill 6312. During the first quarter of 2016, King County finalized plans to become a Behavioral Health Organization (BHO) in accordance with the new state law. Under the new BHO model, funding for outpatient SUD treatment shifted to case rates from fee-for-services. New performance targets are recommended to reflect this change and to count all of the services provided by MIDD in support of SUD treatment. Please see the revised evaluation matrix on Page 21.

In support of mental health treatment, universal depression screening was piloted at Swedish Hospital in Seattle with strategy funds realized from underspending in 2015.

1b Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities

At the request of Public Health - Seattle & King County, who administers this MIDD strategy, client outcomes were broken down by provider and provider site. While overall use of systems such as jails and hospitals varied by provider, no meaningful differences were found between providers in the patterns of client system use. Comparing outcomes achieved against targeted reduction goals did vary by provider site, but sites with more dramatic reductions served very few clients, which limits the significance of this finding. Lastly, short-term differences in jail use by provider site were balanced out over the longer term, whereby people from all sites studied, on average, significantly reduced their jail use.

1c Emergency Room Substance Abuse Early Intervention Program

The screening, brief intervention and referral to treatment (SBIRT) strategy recently shifted to a cost reimbursement funding model. Previously, if a full-time equivalent (FTE) position was vacant, funds had to be forfeited. Now SBIRT can hire or replace staff and use unexpended funds later in the year. Note, however, that finding or replacing staff who are credentialed to work in hospitals remains a significant challenge. Performance measurement goals will continue to be based upon the original FTE staffing assumptions of providing 800 screenings and 543 brief interventions per staff member per year.

1e Chemical Dependency Professional Education and Training

A total of 241 unique individuals attended workforce development training over the six months beginning Oct. 1, 2015. Nearly half of all trainees were Caucasian females, reflective of the regional workforce demographics. The most common work roles were clinicians or care providers (49), case managers (36), and clinical supervisors (35). The training with the highest quality rating (80% "very satisfied") was Introduction to Motivational Interviewing and the course with the highest usefulness rating (93%) was Clinical Supervision Skills I. Aspects of trainings with high ratings can be further examined for replication and to possibly raise trainee satisfaction with trainings on topics that were rated less favorably.

1g Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+ & 1h Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults

Both of these strategies show performance targets now that are independent of the number of FTE staff employed. The MIDD retrospective review found that the number of clients to be served should not have been adjusted based on FTE counts, but that targets would have been achieved even without such adjustment.

2a Workload Reduction for Mental Health

Despite efforts to reduce agency workloads with increased funding to hire direct services staff, between 2012 and 2015, the average number of clients per direct staff member rose from 28 to 36 (a 29% increase). Data from 13 of the 16 participating agencies was used in this analysis.

13a/14a Domestic Violence and Sexual Assault System Coordination

Training sessions to coordinate the disciplines of domestic violence (DV), sexual assault, mental health and substance use disorders were delivered to 117 individuals this period. Seattle zip codes were most common among trainees (57%), followed by the south (21%), north (19%), and east (3%) regions of King County. The systems coordinator produced a handout entitled "What Behavioral Health Professionals Need to Know about Domestic Violence and Suicide" with helpful tips on screening for DV when women present in treatment as depressed, the need for interventions that break down social isolation, and making referrals to DV programs.

Strategies with Programs to Help Youth

Current program utilization statistics for MIDD youth strategies are provided below and relevant updates during the period Oct. 1, 2015, to March 31, 2016 are shown on Page 9. These strategies aim to increase prevention, assessment and early intervention opportunities for youth, as well as providing a full array of intensive services for children and teens with identified needs. In the Family Treatment Court strategy, parents work to reunite their families by addressing issues associated with substance abuse.

Strategy 5a - Juvenile Justice Assessments continued to be impacted during this time frame by a significant reduction in the number of juvenile court case filings or arraignments. As stated on the King County website, "Referrals to juvenile court in general have continued to decline, and in 2014, there was a 20 percent reduction in juvenile filings." For MIDD Year Eight, an adjustment to the coordinations target was calculated at 10 percent. This factors in the types of cases served by the Juvenile Justice Assessment Team (JJAT) and change-over-time information provided by the court on juvenile filings between 2014 and 2015. Since a reduction in the number of youth coming into contact with the juvenile justice system is viewed as a positive development, this is not a JJAT performance management issue. Additionally, staff vacancies on the team resulted in adjustments to expectations for the delivery of both mental health and full substance use disorder assessments, as indicated below.

Year 8 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	
4b - Prevention Services to Children of Substance Abusing Parents			Not implemented	
4c - Collaborative School-Based Mental Health and Substance Abuse Services				
2,268 individuals (19 programs) **Adjust to 1,550 individuals/yr (13 programs)**	1,051	1.5*	102% (Adjusted)	↑
4d - School-Based Suicide Prevention				
1,500 adults/yr 3,250 youth/yr	994 adults 5,608 youth	1.5*	99% 259%[2]	↑ ↑
5a - Expand Assessments for Youth in the Juvenile Justice System				
Coordinate ~~1,200~~ **1,080** assessments/yr Provide 200 psychological services/yr Conduct ~~140~~ **93** MH assessments/yr Conduct ~~165~~ **110** full SUD assessments/yr **Adjust as above for reduced filings/staffing[3]**	486 coordinations 238 psychological services 63 MH assessments 61 SUD assessments	2.0	90% 238% 135% 111%	↑ ↑ ↑ ↑
6a - Wraparound Services for Emotionally Disturbed Youth				
450 enrolled youth/yr	418	1.3	121%	↑
7a - Reception Centers for Youth in Crisis			Not implemented	
7b - Expansion of Children's Crisis Outreach Response System (CCORS)				
300 youth/yr	590	1.9	374%[2]	↑
8a - Family Treatment Court Expansion				
120 children/yr No more than 60 children at one time	74 children Program monitors capacity	1.3 -	80% -	→
9a - Juvenile Drug Court Expansion				
36 new youth/yr	14 new opt-ins since 10/1/2013 4 new in pre opt-in phase	2.0	100%[4]	↑
13b - Domestic Violence Prevention				
85 families/yr	124 unduplicated families	1.3	130%	↑

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 Juvenile arraignments were down; Dedicated positions were vacated 5/2015 (MH) and 2/2016 (SUD).

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 Collaborative School-Based Mental Health and Substance Abuse Services

On-site technical assistance to improve the quality of evaluation data was provided to Strategy 4c providers "as needed" throughout the current reporting period. Because the school-based program staff are responsible for MIDD data entry, staff turnover results in the need to educate each new clinician regarding spreadsheet completion and secure data submission practices. School-based services were expanded in January 2016 to serve more middle schools and to pilot additional services at existing 4c schools. Because the expansion funds were only available on a one-time basis, the decision was made to exclude the new schools from data collection requirements.

5a Expand Assessments for Youth in the Juvenile Justice System

Data from 2,321 Strategy 5a youth with at least one service prior to September 2015 showed that about 10 percent of assessed youth had committed no crimes (at-risk-youth (ARY) or truancy status) at initial contact. Only one in four of these ARY or truant youth had subsequent JJAT contact wherein criminal charges had been filed against them (offender or probation status). This means that 72 percent of non-offending youth successfully avoided later offenses.

Healthy Youth Survey (HYS) Update

Vaping involves inhaling infused water vapors into the lungs. Not tracked by the HYS in 2012, vaping rates (past 30 days) at Strategy 4c schools in 2014 ranged from 0.8 to 21.8 percent of all 8th graders who responded to the survey. The weighted average, which factors in the number of respondents at each 4c school, was nine percent (vs. 3% for smoking tobacco). The growing popularity of vaping among youth may indicate the need for prevention efforts by MIDD 4c providers, as one study has shown that teens who vaped were six times more likely to smoke cigarettes in early adulthood.

6a Wraparound Services for Emotionally Disturbed Youth

In 2013, as a result of a lawsuit settlement agreement (*T.R. versus Quigley and Teeter*), Washington State initiated a five-year plan to implement Wraparound with Intensive Services (WISe) for Medicaid-eligible youth throughout the state. The WISe program, as defined in the settlement agreement, consists of Wraparound, intensive community-based mental health services, and mobile crisis outreach and stabilization services. The components of the WISe program are similar to what has been available in King County for several years through MIDD-funded Wraparound and MIDD-enhanced youth crisis services.

King County was originally slated to begin WISe services in 2017, but at the request of the state will begin these services earlier. During the current reporting period, King County began the implementation phase of WISe.

Global Appraisal of Individual Needs (GAIN) Update

Baseline GAIN information was available for 872 youth from Strategy 5a - Juvenile Justice Youth Assessments, 17 from Strategy 9a - Juvenile Drug Court Expansion only, and 217 from both. Most were male (73%) and over half were African American/Black or multiracial (55%). Their average age was 16 years. Marijuana was the drug of choice for 70 percent, with alcohol a distant second at 11 percent. Only one in four youth had abstained from marijuana use in the month prior to assessment. One in three had past-year depression. Of those who spent money on substances, 90-day averages were $44 (alcohol) and $128 (marijuana).

Changes in substance use were analyzed using 289 cases with data at two or more points in time. When drug of choice changed between measures, the movement was typically toward marijuana (from alcohol and other drugs). A reduction in marijuana use over time was realized in 43 percent of cases analyzed, with increased or stable use noted for the remainder. Of those with depression at baseline, just over half had no depression at subsequent measure. Conversely, 45 of 200 (22%) with no prior depression became depressed before their second measure (or during their substance use disorder treatment). Money spent to get drunk or high remained fairly stable over time. Having zero substance use in the past 90 days was extremely rare at both baseline (5%) and later measure (7%).

13b Domestic Violence Prevention

In addition to providing coordinated, cross system, mental health treatment services, the Children's Domestic Violence Response Team's monthly narrative report chronicles the care coordination and systems advocacy provided by the team to address the complex needs of children impacted by domestic violence. Topics recently addressed included: legal help for clients, custody issues, housing, safety planning, Child Protective Services cases, parenting plans and coordinating care. Guidelines to ensure safety when responding to battering fathers were also finalized. A total of 44 Kids Club hours were among the 1,895 direct service hours delivered over six months.

Jail and Hospital Diversion Strategies

Through diversion strategies, individuals with mental illness and substance use disorders are linked with community treatment or education classes to reduce their use of costly systems such as jails and hospitals. The King County therapeutic courts working with adult populations are included in this category, along with Strategy 10a—Crisis Intervention Team (CIT) Training, which seeks to educate law enforcement and first responders to identify, understand and de-escalate situations in which individuals are experiencing behavioral health crises.

Both the jail liaison position funded through Strategy 11a and the court liaison position at the Municipal Court of Seattle's Mental Health Court (SMHC) were unfilled during the reporting period. Performance targets have been adjusted because the County was redefining how to implement these strategies.

Year 8 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)	103 (40-hr) 236 (1-day) 175 (other)[2,3]	2.0	114% 157% 233%	↑ ↑ ↑
10b - Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team				
3,000 adults/yr	1,800[2]	2.0	120%	↑
11a - Increase Jail Liaison Capacity				
100 clients/yr **Adjust to 25 clients/yr due to staffing**	count to begin 7/1/2016	N/A	N/A	–
11b - Increase Services for New or Existing Mental Health Court Programs				
55 new opt-in expansion clients/yr[4] and 83 non-expansion clients/yr for Regional Mental Health Court (RMHC) 300 clients/yr (1 FTE liaison) for Seattle Mental Health Court (SMHC) **Adjust to 100 clients/yr due to staffing**	RMHC 25 new expansion opt-ins 40 new non-expansion cases SMHC count to begin 6/1/2016	2.0 N/A	91% 96% N/A	↑ ↑ –
12a-1 - Jail Re-Entry Program Capacity Increase				
300 clients/yr (3 FTE)	126	2.0	84%	→
12a-2 - Education Classes at Community Center for Alternative Programs (CCAP)				
600 clients/yr	221[2]	2.0	74%	→
12b - Hospital Re-Entry Respite Beds (Recuperative Care)				
350-500 clients/yr	179	1.9	97%	↑
12c - Increase Harborview's Psychiatric Emergency Services (PES) Capacity				
75-100 clients/yr	50	1.9	127%	↑
12d - Behavior Modification Classes for CCAP Clients				
40 clients/yr (domestic violence offenders)	25	1.3	81%	→
15a - Adult Drug Court Expansion of Recovery Support Services				
250 expansion clients/yr 300 base clients/yr[5]	191 363	1.3	99% 157%	↑
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 Blended funding covers program administration for some trainings.

4 Revised target reflects budget restoration from one FTE probation staff to two.

5 Revised targets accepted by Council in motion of acceptance on 6/20/2016.

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

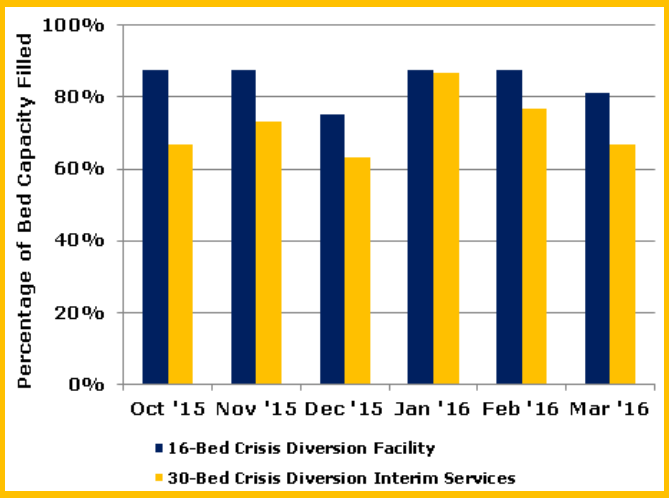
Individuals who have completed the one-day and 40-hour CIT course options often seek further hands-on practice through skills-based courses like CIT Force Options. Other courses, such as Justice-Based Policing, are primarily supported by non-MIDD funds, but participants are counted toward performance measurement goals as MIDD provides funding for backfill and overtime pay. Justice-Based Policing is required of all officers in the King County Sheriff's Office and was offered six times. Over 80 percent of attendees (77 of 94) rated the relevance of this training "excellent."

Another Strategy 10a course, Blue Courage, addresses police officer personal and professional growth and development of health and wellness practices while examining police culture within the context of public perception. Community members may attend these classes to share differing perspectives and to enhance community relations.

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

The graphic below shows recent utilization of the Crisis Solutions Center in Seattle. During the progress report measurement period, the Crisis Diversion Facility (CDF) operated in excess of 80 percent of its 16-bed capacity, while the Crisis Diversion Interim Services (CDIS) program filled beds at an average rate of 72 percent. The average length of stay at the CDF was just over two days, while days spent at the CDIS averaged nearly eight.

Crisis Solutions Center Utilization



Monthly referrals to the Mobile Crisis Team over this period ranged from 192 to 235; the average was 221. This indicates a three percent increase over the same period one year ago.

11a Increase Jail Liaison Capacity

In 2015, the contract for this MIDD strategy was amended with a maximum annual caseload capacity of 109, down from 200. Due in part to future funding uncertainty, the liaison position was open for the entire duration of this reporting period and no clients were served. It is anticipated that 25 clients will be served from July to September 2016.

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

The MIDD-funded liaison position at Seattle's Municipal MHC was re-tooled to better align with the original strategy intent of serving individuals with recurrent legal competency issues. Intensive engagement efforts are intended to divert these MHC clients from involvement with Designated Mental Health Professionals and the civil commitment process. The newly-defined position was unfilled throughout this reporting period.

12a-2 Education Classes at Community Center for Alternative Programs (CCAP)

The number of unique participants in domestic violence education classes at CCAP during the first half of MIDD Year Eight was 27 percent fewer than the prior year comparison figure. Similarly, the number of different topics addressed fell from 28 to 20 (-29%) and attendance sign-ins were reduced from 806 to 644 (-20%). Sentencing data shows that fewer people were court-ordered to CCAP this period, with the program being utilized at only 80 to 90 percent of its capacity.

12b Hospital Re-Entry Respite Beds (Recuperative Care)

- The Edward Thomas House respite facility was recently remodeled to allow private space for the mental health team to meet with clients privately.
- The program will be participating in a Centers for Medicare & Medicaid Services five-site evaluation study looking at medical respite from all angles.
- A need exists for more community-based palliative care options for homeless individuals with behavioral health issues.

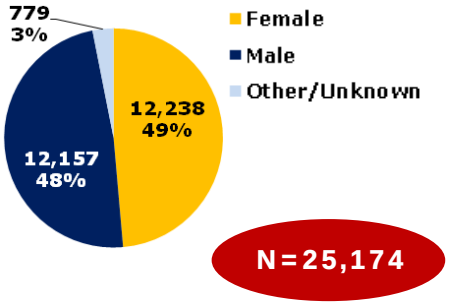
12d Behavior Modification Classes for CCAP Clients

In October 2014, the MIDD-funded clinician who provides moral reconation therapy (MRT) at CCAP transitioned to providing these classes only to individuals serving alternative sentences for domestic violence offenses. Class size limits and randomized assignment to MRT versus other treatment have impacted performance attainment.

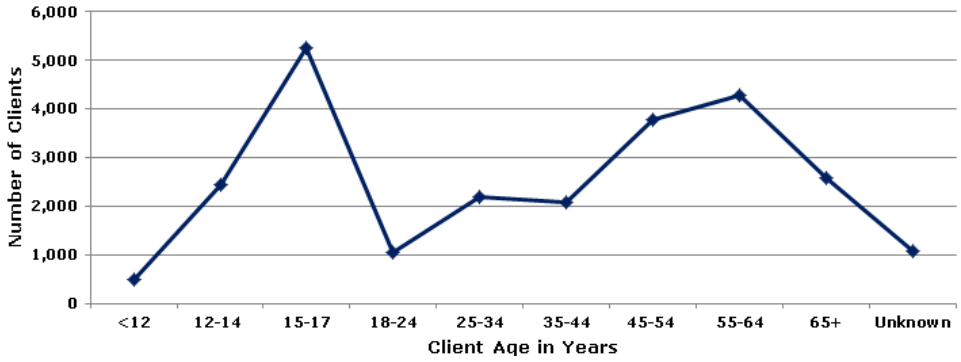
MIDD Demographics and Access to Services

Client gender, age, primary race, Hispanic origin, and zip code information was available for 25,174 unduplicated people who received at least one MIDD service between October 2015 and March 2016. This represents a six percent increase in unduplicated clients over the prior year comparison period. Individuals who participated in multiple strategies are counted only once in this section. Other demographics are available for limited cases as reported on Page 13 with relevant denominators.

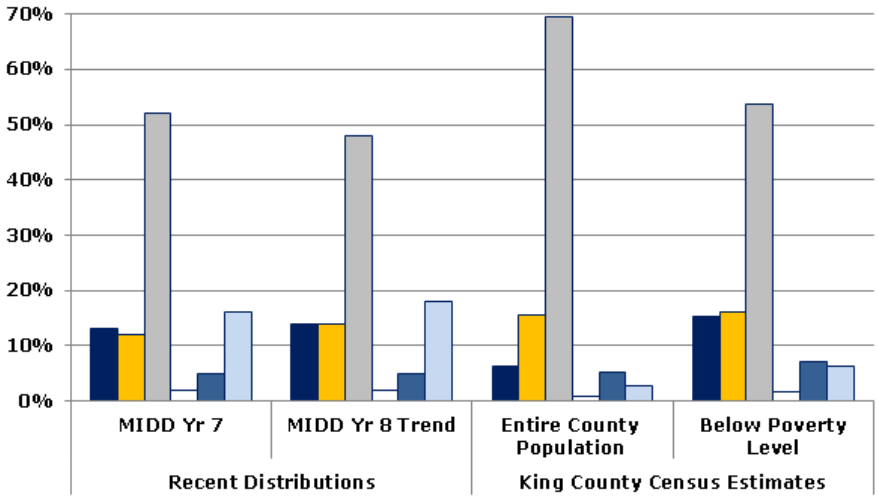
Gender



Number of MIDD Clients by Age Group



Primary Race



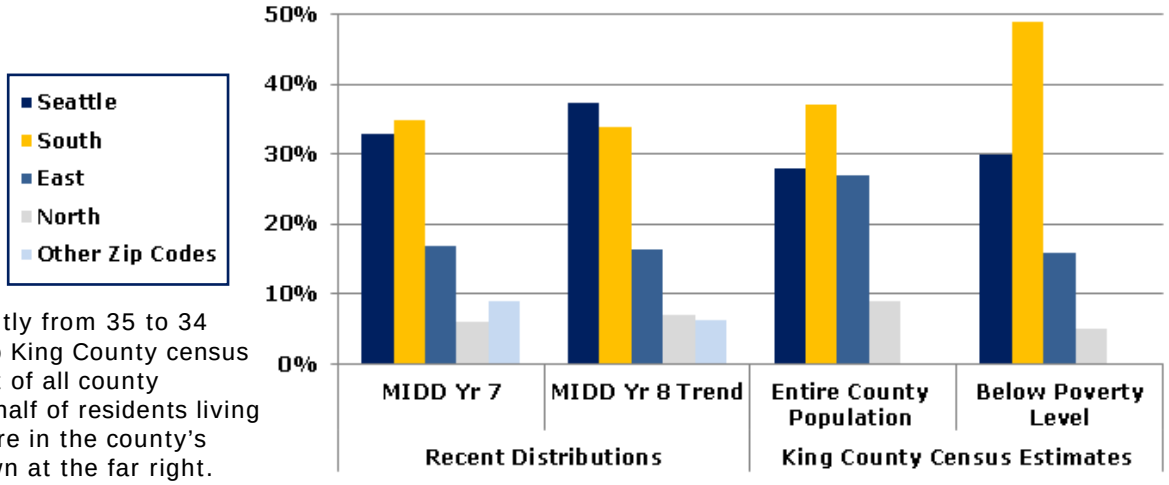
Census Source: 2008-2012 American Community Survey

The percentage of MIDD clients who were Caucasian/White decreased from 52 to 48 percent this period. Compared to the King County census estimates shown at left, this rate is lower than expected. Persons of color tended to access MIDD services in alignment with the King County below poverty level census estimate, but African American or Black clients were served at twice their county population rate.

Hispanic origin is tracked separately from client race. Hispanic endorsement rose from 3,048 to 3,568 compared to one year ago (a 17% increase). Over half of the Other/Unknown race group was Hispanic.

Region

The percentage of MIDD clients with zip codes in the Seattle region of King County increased from 33 to 37 percent of current unduplicated cases. South county zip codes decreased slightly from 35 to 34 percent. Compared to King County census estimates, 37 percent of all county residents and nearly half of residents living below poverty level are in the county's south region, as shown at the far right.



Note: The number of cases in each comparison group was: 35,902 (MIDD Yr 7), 1.9 million (population), 227,519 (2013 poverty).

The demographic elements below are not universally available for MIDD clients. The number of people who were asked these questions is shown in red and results appear in descending order of availability.

Language

One in five MIDD clients with language data had a primary language that was not English. The top three non-English languages were: Spanish (1,262), Vietnamese (466), and Cambodian (190).

N=16,872

Disability

Disabilities were documented for one in four MIDD clients. Of 4,425 people with disabilities, 2,005 (45%) had more than one type, 992 (22%) had only medical or physical issues, and 975 (22%) had other (e.g. psychiatric) disabilities. Only 260 (6%) were developmentally disabled.

N=16,143

Veterans

At least 722 people who received MIDD services this period had prior U.S. military service (5%). Another 206 clients of 5,522 who were asked about their family military status (4%) were dependent children, spouses, or domestic partners of veterans.

N=15,618

Homeless

3,224 MIDD clients this period were known to be homeless at their service start, up from 3,044 in the prior year comparison period. This represents a six percent increase in homeless clients.

N=15,249

Interpreter

Ten percent of MIDD clients who were asked about language interpretation services said they needed an interpreter. Nearly half of those requesting an interpreter (471 of 994) listed Spanish as their primary language.

N=10,291

Employment

Of the 3,853 MIDD clients with a known employment status, 706 (18%) were working at least part time. In Strategy 1a - Mental Health Treatment, 142 clients (5%) worked full time and 276 (11%) worked part time.

N=3,853

Education

Where education status was known for adult MIDD clients, 1,639 (46%) had some college or a college degree. Another 1,055 (29%) had earned a high school diploma or GED.

N=3,589

Immigration

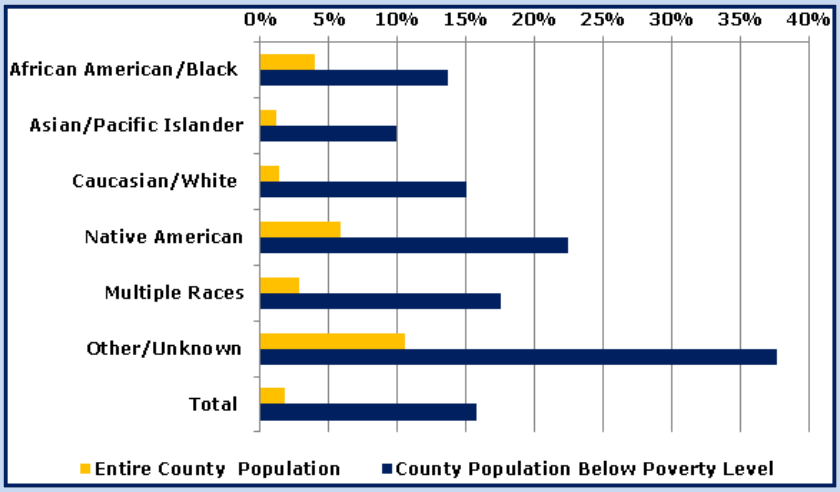
353 of the 2,525 MIDD clients who were asked about their immigration status (14%) indicated that they had immigrated to the United States from another country.

N=2,525

Sixteen Percent of the King County Population Living Below Poverty Received MIDD Services

The percentage of King County residents who received MIDD services has been broken down by race and population type in the graph below. The table shows population estimates for each race group based on the best available census information. As expected, King County residents living below poverty accessed MIDD services at much higher rates than those in the general population. For example, nearly 5,000 African Americans/Blacks were served by the MIDD in 2013, which equates to four percent of King County's African American/Black population at that time, but 14 percent of the African American/Black population living below poverty level in King County then. Overall, just under two percent of the entire County population had participated directly in MIDD services that year, but 16 percent of individuals living below poverty had such MIDD involvement.

Percent of Each Estimated Race Population Receiving MIDD Services



	Number of Clients Receiving MIDD Services in 2013	King County Census Estimates	
		Entire County Population	Below Poverty Level
African American/Black	4,776	119,839	34,753
Asian/Pacific Islander	3,632	302,683	36,322
Caucasian/White	18,301	1,354,642	121,918
Native American	889	15,226	3,959
Multiple Races	2,882	102,347	16,376
Other/Unknown	5,348	50,684	14,192
Total	35,828	1,945,421	227,520

Source: 2013 American Community Survey

Substance Use Disorder Treatment Motivators for Youth in MIDD Services

Wanting to "Get a Job" and "Make Money" Associated with Reduced Substance Use

Global Appraisal of Individual Needs (GAIN) assessments were available for 289 MIDD youth with information at two or more points in time. Teens enrolled only in Strategy 5a - Juvenile Justice Youth Assessments contributed 198 cases, while those with any involvement in Strategy 9a - Juvenile Drug Court contributed the remaining 91 cases. Results from all cases have been combined, because statistically significant differences between strategy groupings were not found. The average age at baseline was 15 years and the average time between GAIN assessments was one year apart.

Up to three open-ended responses to "What is the main reason for wanting to quit using substances?" were coded for each case per time period. The top ten motivations for wanting to quit (N=636), sorted in descending order of frequency at initial measure are shown in the table below:

Motivation	# at Initial Measure	# at Subsequent Measure
Friends/family	76	58
Avoid trouble	69	63
Improve life	40	58
Prove self/true to self	33	48
Health	31	26
Job	20	20
None	18	10
School	14	9
Money	13	14
Sports	12	4

The motivations were further coded, where appropriate, according to the following dichotomies: General/ Specific, Avoidance/Opportunity, External/Internal, Things/People, None/Some.

Over time, it was more common for an individual's treatment motivators to become less specific and more general (35 instances of specific motivators at baseline vs. 26 instances at follow-up) and to move from external to internal (21 instances of external motivators at baseline vs. nine instances at follow-up). Examples of specific-to-general changes in motivation were: "child" to "improve life," "court" to "avoid trouble," and "sports" to "future opportunities." Examples of external-to-internal changes in motivation were: "avoid trouble" to "prove not addicted," "improve life" to "true to self," and "job" to "health." The other coded dichotomies were fairly equally represented in each time period measured. For example, the number of youth with changes from avoidance to opportunity was balanced out by the number of youth with changes from opportunity to avoidance, and so on. Interestingly, of 15 youth who indicated at first measure that they wanted to "prove they were not addicted," only one gave this reason at the second measure.

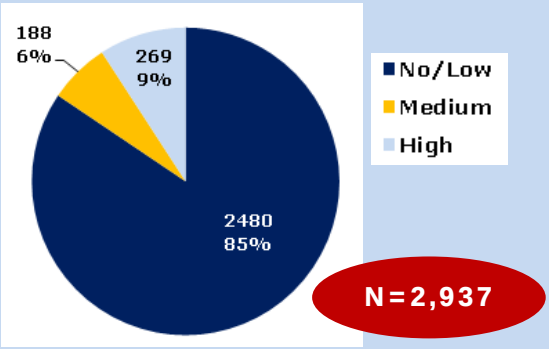
Further analysis examined the relationships between coded motivations and reductions in substance use. Reduced substance use was defined as more days with no use in the past 90 days (or more "clean" days) when comparing the initial measure with a subsequent measure. Only two motivations at initial measure were found to be closely associated with improved outcomes: 1) job (76 percent improved, moving from an average of 39 days with no substance use to 51 days), and 2) money (77 percent improved, rising from 40 to 50 days in the past 90 with no use).

Symptom Improvement for Older Adults Served in Primary Care Health Clinics

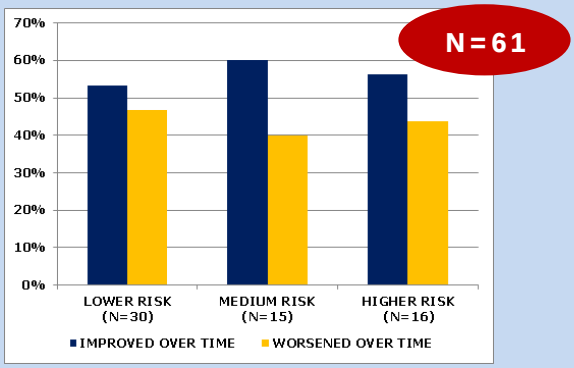
Overall Substance Abuse Risk and Change Over Time Patterns

In MIDD Strategy 1g - Older Adults Prevention, over 6,000 individuals were engaged in behavioral health services beyond the initial assessment of their mental health and substance use disorders. About half of these service recipients were assessed for substance abuse risk using the Global Appraisal of Individual Needs Short Screener (GAIN-SS). The majority had only one GAIN-SS score or showed no change in their scores over time. The distribution for level of substance abuse risk based on these static measures is shown at left below. Where change over time was measureable, the older adults initially at medium risk were most likely to lower their scores or improve their risk level as shown at right below. Improvement in symptom scores was associated with longer time intervals between measures, whereby those who improved averaged nearly three years between measures.

Overall Substance Abuse Risk



Substance Abuse Risk Change Over Time

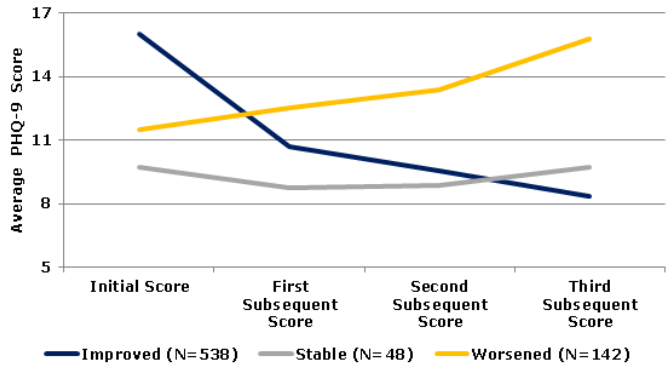


Improving Depression Symptoms

A total of 3,691 MIDD Strategy 1g clients had two or more Patient Health Questionnaire (PHQ-9) depression scores. The table below shows that individuals who were more depressed had higher rates of clinical improvement over time than those with only minimal symptoms.

Level of Depression (Baseline Scoring)	N	Percent of Total	Portion Who Improved
No symptoms (<5)	260	7%	71% (stable)
Minimal symptoms (5-9)	581	16%	**35%**
Minor depression (10-14)	877	24%	58%
Moderate depression (15-19)	940	25%	64%
Severe depression (>20)	1,033	28%	65%
Total	3,691	100%	59%

Data to monitor changes in depression over longer time periods was available for 728 clients after their initial assessment. For those who improved, both clinically relevant and statistically significant symptom reductions were evident.

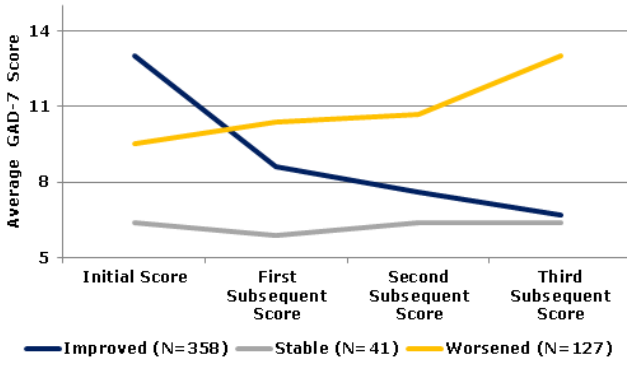


Improving Anxiety Symptoms

A total of 2,747 MIDD Strategy 1g clients had two or more Generalized Anxiety Disorder (GAD-7) scores. The table below shows that those with moderate to severe anxiety levels at baseline demonstrated higher rates of clinical improvement than those with mild anxiety.

Level of Anxiety (Baseline Scoring)	N	Percent of Total	Portion Who Improved
No symptoms (<5)	347	13%	70% (stable)
Mild anxiety (5-9)	685	25%	**39%**
Moderate anxiety (10-14)	695	25%	58%
Severe anxiety (15+)	1,020	37%	57%
Total	2,747	100%	54%

Data to monitor changes in anxiety over longer time periods was available for 526 clients after their initial assessment. As with the depression findings, both clinically relevant and statistically significant symptom reductions were evident for individuals who improved.



MIDD Financial Report

Financial information provided over the next three pages is for the 2015-2016 biennial budget with actual expenditures through the end of June 2016. The MIDD Fund spent approximately $73 million in strategy funding and approximately $12 million in MIDD supplantation since Jan. 1, 2015. One-time funding was also made available to expend MIDD fund balance realized when actual revenues exceeded projections. Parts I and II show the budget and actuals for MIDD strategies and therapeutic courts, as well as the one-time items, which appear after MIDD administration below. This financial report also includes details on the 2016 supplemental appropriation, detailed supplantation spending and summary revenues/expenditures. 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 or MIDD Operating Category	2015-2016 Biennial Budget	Actual Year-to-Date (through June 2016)	2015-2016 Projection (6/30/16)
1a-1	Increase Access to Community Mental Health Treatment & Club House	$ 16,922,598	$ 12,095,683	$ 16,922,598
1a-2	Increase Access to Community Substance Abuse Treatment	$ 5,203,879	$ 4,029,415	$ 5,203,879
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities	$ 1,007,241	$ 525,903	$ 1,007,241
1c	Emergency Room Substance Abuse Early Intervention Program	$ 1,614,345	$ 786,587	$ 1,548,019
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	$ 533,985	$ 350,116	$ 533,985
1e	Chemical Dependency Professional Education and Training	$ 1,730,203	$ 1,007,638	$ 1,730,203
1f	Parent Partner and Youth Peer Support Assistance Program	$ 788,271	$ 673,960	$ 788,271
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	$ 922,819	$ 444,541	$ 922,819
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	$ 641,299	$ 426,869	$ 641,299
2a	Workload Reduction for Mental Health	$ 8,202,832	$ 6,617,024	$ 8,202,832
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	$ 2,050,708	$ 1,558,704	$ 2,050,708
3a	Supportive Services for Housing Projects	$ 4,101,416	$ 4,101,416	$ 4,101,416
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	$ 2,614,758	$ 1,548,482	$ 2,614,758
4d	School-Based Suicide Prevention	$ 407,173	$ 306,847	$ 407,173
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 358,898	$ 175,547	$ 358,898
6a	Wraparound Services for Emotionally Disturbed Youth	$ 9,159,800	$ 5,843,824	$ 9,014,939
7a	Reception Centers for Youth in Crisis	$ 515,260	$ -	$ 515,260
7b	Expansion of Children's Crisis Outreach Response Service System	$ 1,017,887	$ 675,844	$ 1,017,887
8a	Expand Family Treatment Court Services and Support to Parents	$ 165,477	$ 101,632	$ 165,477
9a	Expand Juvenile Drug Court Treatment (See Part II)	$ -	$ -	$ -
10a	Crisis Intervention Team Training for First Responders	$ 1,555,496	$ 665,445	$ 1,555,496
10b	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	$ 12,418,796	$ 8,794,215	$ 12,418,796
11a	Increase Jail Liaison Capacity	$ 163,050	$ 57,919	$ 120,552
11b	Increase Services for New or Existing Mental Health Court Programs	$ 1,411,144	$ 847,948	$ 1,411,144
12a	Jail Re-Entry Program Capacity Increase	$ 649,684	$ 439,324	$ 649,684
12b	Hospital Re-Entry Respite Beds	$ 1,035,241	$ 548,447	$ 1,035,241
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	$ 407,174	$ 271,026	$ 407,174
12d	Behavior Modification Classes for CCAP Clients	$ 152,688	$ 103,407	$ 152,688
13a	Domestic Violence and Mental Health Services	$ 633,616	$ 465,072	$ 633,616
13b	Domestic Violence Prevention	$ 456,033	$ 303,548	$ 456,033
14a	Sexual Assault, Mental Health and Chemical Dependency Services	$ 1,015,440	$ 434,311	$ 1,015,440
15a	Drug Court: Expansion of Recovery Support Services	$ 212,819	$ 138,685	$ 212,819
16a	New Housing Units and Rental Subsidies	$ -	$ -	$ -
	MIDD Administration	$ 6,838,514	$ 4,754,831	$ 6,838,514
	Evaluation and Treatment New Facilities Capital	$ 4,750,000	$ 1,226,328	$ 4,750,000
	Behavioral Health Integrated Data System	$ 982,633	$ 982,633	$ 982,633
	Naloxone	$ 120,000	$ -	$ 120,000
	Peer Bridger	$ 590,000	$ 162,804	$ 590,000
	2016 Supplemental Appropriation (see detail on Page 17)	$ 2,830,000	$ -	$ 2,830,000
	Total MIDD Operating Dollars	**$ 94,181,177**	**$ 61,465,975**	**$ 93,927,492**
	Percentage of Appropriation		**65.26%**	**99.73%**

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	2015-2016 Biennial Budget	Actual Year-to-Date (through June 2016)	2015-2016 Projection (6/30/16)
	Department of Judicial Administration	**$ 3,764,000**	**$ 2,504,599**	**$ 3,764,000**
	Drug Court: Expansion of Recovery Support Services	$ -	$ 227,134	$ -
15a	Adult Drug Court Base	$ 3,764,000	$ 2,277,465	$ 3,764,000
	Prosecuting Attorney's Office	**$ 3,330,000**	**$ 2,206,835**	**$ 3,330,000**
	Adult Drug Court Base	$ 1,558,676	$ 1,308,742	$ 1,558,676
	Juvenile Drug Court Base	$ 325,140	$ 81,185	$ 325,140
	Mental Health Court Base	$ 1,446,185	$ 807,438	$ 1,446,185
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 9,470	$ -
	Superior Court	**$ 3,689,000**	**$ 2,687,595**	**$ 3,689,000**
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 509,703	$ 335,836	$ 509,703
8a	Expand Family Treatment Court Services and Support to Parents	$ 1,457,685	$ 1,051,157	$ 1,457,685
9a	Expand Juvenile Drug Court Treatment	$ 1,347,802	$ 1,039,541	$ 1,347,802
	Adult Drug Court Base	$ 373,809	$ 261,061	$ 373,809
	Juvenile Drug Court Base	$ -	$ -	$ -
	Family Treatment Court Base	$ -	$ -	$ -
	Sheriff	**$ 335,000**	**$ 257,873**	**$ 335,000**
10a	Crisis Intervention Team Training for First Responders	$ 335,000	$ 257,873	$ 335,000
	Department of Public Defense	**$ 3,647,000**	**$ 2,275,258**	**$ 3,647,000**
	Adult Drug Court Base	$ 1,570,294	$ 1,232,391	$ 1,570,294
	Juvenile Drug Court Base	$ 205,235	$ 169,747	$ 205,235
	Mental Health Court Base	$ 1,082,517	$ 553,036	$ 1,082,517
	Family Treatment Court Base	$ 788,954	$ 320,084	$ 788,954
	District Court	**$ 2,115,000**	**$ 1,415,297**	**$ 2,115,000**
	Mental Health Court Base	$ 2,115,000	$ 1,407,603	$ 2,115,000
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 7,694	$ -
	Total Other MIDD Funds	**$ 16,880,000**	**$ 11,347,456**	**$ 16,880,000**
	Percentage of Appropriation		**67.22%**	**100.00%**
	Total All MIDD Funds	**$ 111,061,177**	**$ 72,813,431**	**$ 110,807,492**

Mental Illness and Drug Dependency 2016 Supplemental Appropriation Details

		2015-2016 Biennial Budget	Actual Year-to-Date (through June 2016)	2015-2016 Projection (6/30/16)
	2016 Supplemental Appropriation	**$ 2,830,000**	**$ -**	**$ 2,830,000**
	Youth Detoxification and Stabilization	$ 350,000	$ -	$ 350,000
	Opiate Epidemic Response	$ 300,000	$ -	$ 300,000
	Residential SUD Capital	$ 650,000	$ -	$ 650,000
	SUD Trauma Informed Care	$ 50,000	$ -	$ 50,000
	MIDD 2b Supported Employment	$ 250,000	$ -	$ 250,000
	Adult Drug Court Housing	$ 15,000	$ -	$ 15,000
	Trans Resource and Referral Guide	$ 30,000	$ -	$ 30,000
	Homeless Housing Capital Support	$ 1,000,000	$ -	$ 1,000,000
	Step Up Bilingual Facilitator	$ 5,000	$ -	$ 5,000
	Vashon Youth & Family BH Services	$ 80,000	$ -	$ 80,000
	RADAR	$ 100,000	$ -	$ 100,000

Funds appropriated through the 2016 supplemental budget will support MIDD program enhancements, pilots and stopgap measures on a one-time basis. For example, five detoxification beds may be purchased from a neighboring county with capacity to serve King County's waitlisted youth and medications could be made available to help address the opiate crisis. Capital funds will help to remodel two existing residential substance use disorder (SUD) facilities and to support new construction of housing for individuals with behavioral health needs. Appropriations would also support training for at least 60 individual providers on trauma-informed care and fund a six-month Spanish Bilingual "Step Up" group. The RADAR item listed above is for Risk Awareness, De-escalation, and Referral, a first responder pilot program in the City of Shoreline.

Mental Illness and Drug Dependency Fund - Supplantation

MIDD Supplantation	2015-2016 Biennial Budget	Actual Year-to-Date (through June 2016)	2015-2016 Projection (6/30/16)
Department of Adult and Juvenile Detention	**$ 810,000**	**$ 809,720**	**$ 810,000**
Community Center for Alternate Programs (CCAP)	$ 63,157	$ 57,288	$ 63,157
Juvenile MH Treatment	$ 746,843	$ 752,432	$ 746,843
Public Health: Jail Health Services	**$ 5,690,000**	**$ 4,740,111**	**$ 5,690,000**
Psychiatric Services	$ 5,690,000	$ 4,710,111	$ 5,690,000
MH & SUD MIDD Supplantation	**$ 10,942,823**	**$ 6,440,711**	**$ 10,942,823**
Sexual Assault Supplantation (to CSD)	$ 742,355	$ 742,355	$ 742,355
SUD Administration	$ 817,989	$ 399,752	$ 817,989
Criminal Justice Initiative	$ 2,110,624	$ 1,150,027	$ 2,110,624
SUD Contracts	$ 556,046	$ 143,722	$ 556,046
Housing Voucher Program	$ 1,233,033	$ 778,483	$ 1,233,033
SUD Emergency Service Patrol	$ 1,033,968	$ 545,488	$ 1,033,968
CCAP	$ 967,772	$ 587,647	$ 967,772
MH Co-Occurring Disorders Tier	$ 1,636,915	$ 786,903	$ 1,636,915
MH Recovery	$ 383,979	$ 219,234	$ 383,979
MH Juvenile Justice Liaison	$ 184,153	$ 122,221	$ 184,153
MH Crisis Respite Beds	$ 539,376	$ 415,674	$ 539,376
MH Functional Family Therapy	$ 556,552	$ 423,958	$ 556,552
MH Mental Health Court Liaison	$ 180,061	$ 125,246	$ 180,061
Total MH/SUD MIDD Supplantation Funds	**$ 17,442,823**	**$ 11,990,542**	**$ 17,442,823**
Percentage of Appropriation		**68.74%**	**100.00%**

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	2015-2016 Biennial Budget	Actual Year-to-Date (through June 2016)	2015-2016 Projection (6/30/16)
Revenue			
MIDD Tax	$ 117,053,628	$ 86,393,213	$ 120,247,632
Streamlined Mitigation	$ 1,200,000	$ 887,108	$ 1,200,000
Investment Interest - Gross	$ 110,000	$ 76,691	$ 110,000
Cash Management Svcs Fee		$ (554)	
Invest Service Fee - Pool		$ (864)	
Unrealized Gain (Loss)		$ (8,000)	
Other Miscellaneous Revenue		$ 251,667	
Total Revenues	**$ 118,363,628**	**$ 87,599,261**	**$ 121,557,632**
Total MIDD Funds	$ 111,061,177	$ 72,813,431	$ 110,807,492
Total MIDD Supplantation	$ 17,442,823	$ 11,990,542	$ 17,442,823
Total Expenditures	**$ 128,504,000**	**$ 84,803,972**	**$ 128,250,315**
Expenditures Over Revenues	**$ (10,140,372)**	**$ 2,795,289**	**$ (6,692,683)**

MIDD Oversight Committee Membership Roster

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

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

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

Rhonda Berry, Chief of Operations
Representing: King County Executive

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lynne Robinson, Bellevue City Council 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

Donna Tucker, Chief Judge, King County District Court
Representing: District Court

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

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

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

As of 3/31/2016

Oversight Committee Meetings and Actions

The full Oversight Committee met five times during the current reporting period, for a total of 117 cumulative member hours. The Crisis Diversion Services subcommittee met in both November 2015 and February 2016 logging five total member hours. Highlights from these meetings are summarized below.

Role of the Oversight Committee (OC)

At the October 2015 OC meeting, a discussion of the Committee's crucial role as an advisory body to the King County Executive and Council was held. The Committee's purpose, as detailed in Ordinance 16077 is to "ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative." The Oversight Committee fulfills this purpose by:

- Reviewing, making recommendations and providing comments to the Executive and Council on the implementation and effectiveness of the county's sales tax funded programs in meeting the goals established in Ordinance 15949.
- Reviewing and commenting on the required reports as specified in Ordinance 15949.
- Reviewing and commenting on emerging and evolving priorities for the use of the MIDD sales tax revenue.

In addition, the MIDD Oversight Committee should:

- Promote coordination and collaboration between entities involved with sales tax programs
- Educate the public, policymakers and stakeholders on sales tax funded programs
- Coordinate and share information with other related efforts and groups.

Crisis Diversion Subcommittee

The Crisis Solutions Center (CSC) reported in November 2015 that their Mobile Crisis Team (MCT) manager would take on management of the Crisis Diversion Facility, allowing for program continuity after a staffing turnover. The primary workforce issue as reported by CSC is their inability to compete with state and county salaries and benefits to retain qualified staff.

The 40-hour Crisis Intervention Team training is now available to the MCT, along with fire, emergency medical services and corrections personnel, with both backfill and overtime pay.

Budget Updates and Financial Plans

Budgeting and financials were discussed at all meetings held in the first half of MIDD Year Eight. In early 2016, a $1.6 million undesignated fund balance was projected for the end of 2016. In response, the OC convened a workgroup to develop a list of programmatic options for the Executive and Council to consider for use of the fund balance. In March 2016, the fund balance was revised to be more than $3 million, due primarily to collection of revenues in excess of those originally projected. Recommendations from the fund balance work group included one-time expenditures to address County residents' unmet needs such as an opiate overdose response, detoxification services, housing vouchers, and a resource and reference guide for transgendered individuals.

Community Outreach for Renewal

Planning for renewal of the MIDD, which is set to expire at the end of December 2016, began in the fourth quarter of 2015. A transparent, accessible and collaborative process was developed to gather community input on MIDD strengths, weaknesses and unmet needs.

By the end of January 2016, at least 586 people had participated in 17 Community Conversations about the MIDD, including over 100 members of the Asian and Pacific Islander communities at a gathering in South Seattle.

Revised Evaluation Matrices

Evaluation matrices that were revised since their last publication are shown below and on Page 22.

1a

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
1a-2 – Increase Access to ~~Chemical Dependency (CD)~~ Substance Use Disorder (SUD) Outpatient Services for People Not On Medicaid Target Population: Low-income individuals who are not Medicaid, ADATSA, or GAU eligible who need ~~CD~~ SUD services	1. Provide expanded access to ~~chemical dependency~~ SUD treatment to individuals not eligible or covered by Medicaid, ADATSA, or GAU benefits but who are low-income (have 80% of state median income or less, adjusted for family size). Services to include ~~70,000~~ 25,000 ~~units of~~ opiate ~~substitution~~ treatment program (~~OST~~OTP) units per year, ~~50,000~~ 12,000 ~~units of adult~~ outpatient treatment ~~and 4,000 units of youth outpatient treatment per year.*~~ units* from October 1, 2015 to March 31, 2016 plus 600 SUD outpatient authorizations from April 1 to September 30, 2016, 150 detoxification bed days, 7,200 sobering center admissions, 2,000 peer services encounters, and 4,500 outreach service hours per year. Also cover youth transportation to/from treatment and 1811 case management.	Short-term measure: 1. Increase # of non-Medicaid eligible clients admitted to outpatient substance abuse treatment and ~~OST~~ OTP Longer-term measures: 2. Reduce severity of ~~CD~~ SUD symptoms for those served 3. Reduce # of jail bookings and days for ~~those~~ individually-identified clients served 4. Reduce # of ER visits for ~~those~~ individually-identified clients served	1. Output 2. Outcome 3. Outcome 4. Outcome	~~TARGET~~ New BHO database ~~TARGET❷~~ New BHO database Jail data ER data~~❶~~

~~❶ Data sharing agreement(s) needed~~
~~❷ Database revisions completed in January 2011~~
* Outpatient ~~service~~ treatment units include hours for assessments, individual therapy, group therapy, case management, and urinalysis testing for youth. ~~OST~~ OTP units are days when individuals receive medications such as methadone.

Content revised 4/29/2010 (Previous draft published 9/2/2008) CURRENT 5/25/2012 Amended 6/7/2016

2b

Strategy 2 - Improve Quality of Care				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
2b - Employment Services✪ for Individuals with Mental Illness and Chemical Dependency Target Population: Individuals receiving public mental health and/or chemical dependency services who need supported employment to obtain competitive employment	1. Provide supported employment (SE) services such as trial work experience, job placement, and on-the-job retention support to 920 clients per year. 2. Provide training in vocational services to MH providers and CD providers ~~(on hold)~~. 3. Pilot employment services for 75 clients in substance use disorder (SUD) treatment per year who express a desire to work.	Short-term measure: ~~1. Hire 23 vocational specialists (each serving ~40 clients per year)~~ 1. Deliver a performance based system by reimbursing agencies providing SE services when job placement and job retention outcomes-based payment points are achieved 2. Increase # of community providers trained in supported employment services Longer-term measures: 3. Increase # of enrolled MH and CD clients who receive vocational assessments 4. Increase # of enrolled MH and CD clients who receive job placements 5. Increase # or rate of employed clients who are retained in employment for at least 90 days	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome	Contract report ~~MHCADSD~~ BHRD Contract report Contract report Contract report

✪ Supported employment services adhere to an evidence-based service model.

Content revised 7/9/2010 (Previous draft published 9/2/2008) CURRENT 5/25/2012 Amended 5/1/2016

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~~ 110 additional clients over a two-year period, or ~~28~~ 55 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 ~~50~~ 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 (Oct. 1, 2012 to Sept. 30, 2013).

*Strategy revisions were approved by the MIDD Oversight Committee for MIDD Year Six (Oct. 1, 2013 to Sept. 30, 2014) on Oct. 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 probation staff. Three non-expansion staff serve the remaining clients. Given the timing of this strategy revision, acceptance by King County Council cannot be formalized until May 2015.

* The target for expansion cases was reset due to a budgetary restoration of the probation position, which had been reduced as noted above (in green).

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 5/1/2016

15a

Strategy 15 Adult Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including Target Numbers**	**Performance Measures**	**Type of Measure**	**Data Sources**
15a – Adult Drug Court (ADC) Expansion of Recovery Support Services Target Population: King County Adult Drug Court participants	1. Expand and enhance services to 250* ADC clients per year, which may include providing any of the following: a. Employment services per strategy 2b b. Access to CHOICES classes for individuals with learning or attention disabilities c. Eight recovery-oriented transitional housing units with on-site case management services for transition age youth (ages 18-24), and d. Housing case management. 2. Track outcomes for 300 base ADC clients per year (starting 1/1/2015)	Short-term measures: 1. Hire 1.5 FTE housing case management positions and secure contracts for other service delivery 2. Increase # of clients with learning or attention disabilities accessing the CHOICES program 3. Increase # of transition age youth with access to housing with case management services 4. Increase # of clients participating in housing case management Long-term measures 5. Reduce substance use for those served 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. Output 5. Outcome 6. Outcome 7. Outcome 8. Outcome	Contract report MIDD Tools MIDD Tools MIDD Tools ~~TARGET❶~~ New BHO database MIDD Tools MIDD Tools Jail data

* New target of 250 (reduced from 450) was set in contracts dated 5/11/2010.

**Because drug and mental health courts employ incarceration as a programmatic sanction, reductions in jail utilization are expected to be modest during the first year (prior to participants' court "graduation") with more pronounced reductions occurring in the second year.

~~❶ Database revisions completed in January 2011~~

Content revised 7/9/2010 (Previous draft published 9/2/2008) Amended 5/25/2012 5/1/2016