



King County

DRAFT

Mental Illness and Drug Dependency Comprehensive Retrospective Report

As Required by Ordinance 17998

DRAFT

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Contents

I.	Executive Summary.....	3
II.	King County’s Approach to Fulfilling the Requirements of Ordinance 17998	8
III.	Background: MIDD I and Key Environmental Changes	12
IV.	MIDD Evaluation Overview	27
V.	Evaluating the Effectiveness of the Current MIDD Funded Strategies, Programs, and Services.....	32
	Measuring Success and Determining Effectiveness.....	32
	Performance Measurements and Summary of Performance Outcomes	42
	Unmet Performance Measurement Targets.....	43
	Amended or Adjusted Performance Measurement Targets	46
	Strategy Revisions	51
VI.	Recommended Revisions to Policy Goals	54
VII.	Recommended Revisions to MIDD Evaluation, Performance Measures, and Data Gathering	58
VIII.	Conclusion.....	60
IX.	Appendices.....	62

I. Executive Summary

Key Findings: MIDD's Effectiveness in Meeting Policy Goals

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

Significant reductions in jail, emergency department, and psychiatric hospitalization are documented by MIDD evaluation data.

The MIDD Plan was intended to be a comprehensive approach to creating improvements across the continuum of the behavioral health¹ system and making progress toward five key public policy goals. Ordinance 15949 established five policy goals for King County's MIDD sales tax. These goals have guided and informed all aspects of the MIDD policy and services work since 2007.

MIDD Adopted Policy Goals

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

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

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

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

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

Policy Goal 1: Emergency Department Utilization SIGNIFICANT REDUCTION

Data indicates that over the long term, emergency department utilization decreased significantly. After a modest initial increase in emergency department use in the first year, **reductions in emergency department use exceeded 25 percent for every year thereafter, peaking at 39 percent** in the fifth year after initial MIDD service contact.

¹ Behavioral Health is a term that refers to both mental health and chemical dependency.

Policy Goal 1: Psychiatric Hospital Utilization SIGNIFICANT REDUCTION

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

Policy Goals 1, 2, and 4: Jail Utilization SIGNIFICANT REDUCTION

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

Policy Goal 3: Symptom Reduction NOTABLE REDUCTION

When change was evident and could be measured, **about three out of every four people showed reduced mental health symptom severity or reduced substance use** at some point over the course of their treatment.

Policy Goal 5: Furthering Other Initiatives INTENTIONAL LINKAGE

In general, strategies intended to further the work of other Council-directed efforts were determined to have done so.

Details on the above findings are included in section V of this report.

Approach and Organization of This Report

Ordinance 17998: Calling for a Retrospective Analysis of King County’s Mental Illness and Drug Dependency Sales Tax Supported Strategies, Services, and Programs

Ordinance 17998 calls for two major Mental Illness and Drug Dependency (MIDD) related work products to be submitted to the Council:

Comprehensive, Historical Review and Assessment: This work includes an extensive examination and assessment of MIDD I strategies, programs, and services. It also calls for recommendations on improvements to MIDD performance measures, evaluation data gathering and a review of the MIDD evaluation processes.

Service Improvement Plan: The MIDD II service improvement plan requires detailed descriptions of each proposed MIDD program to be funded by a renewed MIDD sales tax. Spending plans, implementation schedules, performance measures, outcomes, and process changes are also to be included in the report. The programs recommended for funding in the MIDD service improvement plan must demonstrate that they are related to successful outcomes and best or promising practices,

incorporate the goals and principles of recovery, reflect the County's policy goals, and integrate with other policy and planning endeavors. ***This plan will be transmitted to the King County Council in August.***

This report focuses exclusively on the comprehensive historical review and assessment.

The County's approach to fulfilling the requirements of Ordinance 17998 included in-person community outreach and engagement focus groups, electronic surveys, and one-on-one stakeholder interviews, along with significant data gathering, review, and analysis. To assist Department of Community and Human Services (DCHS) Behavioral Health and Recovery Division (BHRD) in conducting an objective assessment of MIDD I's evaluation approach for this report, the King County Office of Performance, Strategy and Budget (PSB) was engaged. In addition, the MIDD Oversight Committee reviewed and provided feedback on the recommendations contained within this report.

Background

MIDD I : Acting in response to new authority from the state legislature for counties to impose taxes to support new and expanded² mental health, substance abuse, and therapeutic court services, the King County Council passed the Mental Illness and Drug Dependency (MIDD) sales tax in 2007. King County's tax was given a sunset date of January 1, 2017 designed to promote evaluation of programming and success in meeting policy goals. The Council further provided guidance for MIDD's formation through adopted oversight, implementation, and evaluation plans that promoted accountability and transparency.

MIDD has provided a venue for groundbreaking collaboration between criminal justice and health and human service systems in King County, spurring yet more innovation as systems work together.

Environmental Changes Since 2007: The world of behavioral health care is rapidly evolving. State-mandated behavioral health integration, court rulings, and the expanded access resulting from implementation of the Affordable Care Act, in the context of a broader landscape of resource scarcity, high treatment need, and population growth, require King County and its behavioral health and criminal justice partners to continue the historical collaboration initiated by the development of MIDD I over eight years ago to make further system improvements. The MIDD planning processes have taken into account the changing landscape of behavioral health, while continuing to build on the strong foundation of MIDD I.

Because the aims of the policy goals are wide-ranging, the breadth and/or depth of impact varies by strategy. Statistical analysis of system use and symptom reduction indicates that the strength of associations between predictors and outcomes are sufficient to demonstrate the MIDD's value.

² State legislative changes in 2009 and 2011 permitted portions of MIDD funding to be used to replace existing funds temporarily. As a result, many programs formerly funded with County general funds were supported by MIDD during the Great Recession. (This supplantation authority ends in 2016.) Other subsequent state legislation also permits therapeutic courts to be fully funded by the MIDD sales tax.

Performance Targets and Associated Changes

Performance targets were developed by county staff and others including stakeholders, providers, and subject matter experts, and created based on the MIDD strategy implementation plan for each MIDD strategy. During the first seven years of the MIDD, 80 percent of annual performance targets were met, while 20 percent were not met. These overall performance results were fairly consistent over time.

Performance targets were revised as strategy implementation plans were altered, budgets changed, and/or certain data elements were determined not to be feasible or relevant for the populations served by the strategies. About half of MIDD strategies underwent a target revision.

The MIDD Evaluation Plan allowed for revisions to strategies over time to meet the changing needs of participants, the service system, the county, and its residents. Some strategies were identified initially as needing further development, while others were revised later. Such revisions were shared with the MIDD Oversight Committee when appropriate according to a decision tree governing review and communication of changes. No strategy revisions were based on performance measurement data, though technical assistance was provided and program adjustments were made using this information.

Policy Goals

Ordinance 17998 also called for this report to contain proposed revisions to 2007 policy goals. Proposed refinements to the five policy goals are set forth, in order to:

- Strengthen and clarify the county’s intent to demonstrate a return on the investment of MIDD funds;
- Use recovery-oriented, person first language;
- Address duplicative goals;
- Reflect intended core outcomes as reflected in the MIDD II Framework that has been guiding MIDD renewal work since early 2015; and
- Reflect feedback from an array of stakeholders gathered during the course of MIDD renewal outreach and engagement.

Specifically, revised policy goals to guide MIDD II would read as follows:

1. Divert individuals with behavioral health needs from costly interventions such as jail, emergency rooms, and hospitals.
2. Reduce the number, length, and frequency of behavioral health crisis events.
3. Increase culturally appropriate, trauma informed behavioral health services.
4. Improve health and wellness of individuals living with behavioral health conditions.
5. Explicit linkage with, and furthering the work of, other King County and community initiatives.

Evaluation Revisions

The potential renewal of MIDD presents a tremendous opportunity to examine MIDD and its evaluation. Informed by an independent assessment of the MIDD Evaluation by King County's Office of Performance, Strategy, and Budget (PSB), as well as other internal assessments and stakeholder feedback, a range of improvements to the MIDD evaluation approach are proposed.

The PSB report sets out 22 specific potential changes to the MIDD evaluation, falling into these four broad categories:

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

Conclusion

This report fulfills the requirements of Ordinance 17998 for a comprehensive historical retrospective report on MIDD I, informed by community and stakeholder input as well as extensive data gathering and analysis.

The public and policymakers need to understand the impact of MIDD's investments, both financially and in human terms. While the evaluation approach of the current MIDD has responded to better understand impact, the county has the opportunity to revise and improve the evaluation of MIDD, including enhancing how it reports on the significant amount of data that it has collected about MIDD.

It is the intent of the Department of Community and Human Services to collaborate with providers, stakeholders, and the MIDD Oversight Committee in implementing a range of improvements to the evaluation of MIDD. Many of the recommendations in this report will require process retooling, and will necessarily lead to changes in data collection approaches, reporting, and timelines. Fulfilling these recommendations will require MIDD resources and willingness to embark upon change. County staff are prepared to lead the work necessary to continue honing MIDD programs, services, and evaluation efforts to achieve and demonstrate even greater impact and outcomes.

Because the aims of the policy goals are wide-ranging, the breadth and/or depth of impact varies by strategy. Statistical analysis of system use and symptom reduction indicates that the strength of associations between predictors and outcomes are sufficient to demonstrate the MIDD's value.

II. King County's Approach to Fulfilling the Requirements of Ordinance 17998

King County's Mental Illness and Drug Dependency Tax and Services

King County's Mental Illness and Drug Dependency (MIDD) is a countywide sales tax generating approximately \$53 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 October 2008. Unless renewed by the Council, the MIDD will expire on December 31, 2016. King County is one of 23 counties in Washington State that has authorized the tax revenue.

Please note that in this report, the first eight years of the MIDD sales tax is referred to as MIDD I, while the potential renewal of MIDD for 2017 and beyond is referenced as MIDD II.

Ordinance 17998 calls for two major Mental Illness and Drug Dependency (MIDD) related work products to be submitted to the Council:

1. Comprehensive, Historical Review and Assessment

This work includes an extensive examination and assessment of MIDD I strategies, programs, and services. It also calls for recommendations on improvements to MIDD performance measures, evaluation data gathering and a review of the MIDD evaluation processes.

2. Service Improvement Plan

The MIDD II service improvement plan requires detailed descriptions of each proposed MIDD program to be funded by a renewed MIDD sales tax. Spending plans, implementation schedules, performance measures, outcomes, and process changes will also to be included.

This report focuses exclusively on the *comprehensive historical review and assessment components of Ordinance 17998*.³ Below are the detailed requirements of Ordinance 17998 related to the comprehensive historical review and assessment of MIDD I.

³ The MIDD II Service Improvement Plan is slated to be transmitted to the King county Council in August 2016.

Ordinance 17998 Requirements

1. An assessment of the effectiveness of the current MIDD funded strategies, programs, and services in meeting the five policy goals outlined in Ordinance 15949 and an explanation of the methodology used to make the determination of effectiveness.
2. An **enumeration of all performance measurements and performance measurement targets** used over the life of all MIDD funded strategies, programs, and services and a summary of performance outcome findings by type by year.
3. **Identification of all MIDD funded strategies, programs and services that did not provide performance measurements** on an annual basis or did not meet established performance measurement targets, including for all an explanation of the basis for not providing performance measurements or not meeting the targets, including strategies, programs and services that received moneys that were supplanted by MIDD revenue or that experienced cuts in funding due to MIDD Oversight Committee prioritization review, steps taken to address underperforming MIDD funded strategies, programs and services and the outcome of the steps taken.
4. Identification of all **MIDD funded strategies, programs and services that amended or adjusted performance measurement targets during the 2008-2015 MIDD funding period** and an explanation of why changes were made and the results of the changed performance targets.
5. Identification of **how performance measurement data was used in MIDD strategy, program and service revisions** and a description of all revisions made to strategies, programs or services over the life of the MIDD.
6. **Proposed recommendations on improvements to MIDD** performance measures, evaluation data gathering, including a review of the evaluation processes, timeframes, and data gathering.
7. **Proposed modifications to the MIDD policy goals** outlined in Ordinance 15949 and the basis of the proposed modifications.
8. The executive shall ensure that recommendations in the comprehensive, historical review and assessment report of the MIDD-funded strategies, services and programs are **developed with input from the MIDD oversight committee**.

In addition to providing detailed responses to the items called for in Ordinance 17998, this report also highlights unique and historical successes of MIDD I. Key background elements that frame and contextualize the information and recommendations are also provided. Additionally, this report acknowledges limitations and opportunities related to MIDD I and charts a path forward for achieving greater outcomes and impacts should MIDD II be authorized by the King County Council.

Methodology for Addressing the Requirements of Ordinance 17998

The County's approach to fulfilling the requirements of Ordinance 17998 included in-person community outreach and engagement focus groups, electronic surveys, one-on-one stakeholder interviews, along with significant data gathering, review, and analysis. To assist Department of Community and Human Services (DCHS) Behavioral Health and Recovery Division (BHRD) in conducting an objective assessment

of MIDD I’s evaluation approach for this report, the King County Office of Performance, Strategy and Budget (PSB) was engaged. Section VII references PSB’s report and recommendations; the PSB report and included as Appendix A.

Oversight Committee Guidance and Input: The Oversight Committee performs a critically important role in MIDD I review and MIDD II planning. In March 2015, the MIDD Oversight Committee established values and guiding principles to inform all aspects of MIDD I review work and MIDD II renewal planning activities. The Department of Community and Human Services’ staff and Oversight Committee members rely on these values and guiding principles as benchmarks as well as checks and balances for all aspects of MIDD I review and renewal tasks, from developing outreach and communications plans, to recommendations contained in this report. The values and guiding principles serve as cues for the continued and expanded transparent and collaborative approach the County has for the review of MIDD I, along with planning for, and implementation of a potential MIDD II.

MIDD Oversight Committee Values & Guiding Principles Revised August 6, 2015
<ul style="list-style-type: none"> • Cultural competency lens with an Equity and Social Justice (ESJ) focus • Client centered; developed with consumer input • Ensure voices of youth and disenfranchised populations are represented • Self sustaining; partnerships that leverage sustainability when possible • Community driven, not county driven • Transparent • Recovery focused • Driven by documented outcomes • Based in promising or best practices; evidence-based when possible • Common goal(s) across all organizations • Strategies move us toward integration and are transformational • MIDD funding leverages criminal justice (CJ) system (youth and adult) changes • Supports King County’s vision for health care; reflects the triple aim: improved patient care experience, improved population health, and reduced cost of health care • More upstream / prevention services • Coordinated services • Community- based organizations on equal status with County for compensation • Continue legacy of CJ/human services coming together • Open to new ways of achieving results • Build on strengths of the system • Services are accessible to those with limited options

MIDD Oversight Committee members and/or the MIDD Renewal Strategy Team⁴ reviewed and provided feedback on the recommendations contained within this report. Some members of the Oversight

⁴ The Oversight Committee appointed a MIDD Renewal Strategy Team comprised of eight Oversight Committee members, representing an array of populations and stakeholders and including staff from the county’s executive and legislative branches, to facilitate a higher degree of collaboration and input from the Oversight Committee. The Strategy Team provided guidance and expertise for MIDD I review and MIDD II planning activities to BHRD staff. Intended to augment Oversight Committee feedback and input, the MIDD Oversight Committee Strategy Team provided in-depth reviews of MIDD I review and MIDD II planning activities and documents. The Strategy Team facilitated analysis, identified issues, offered subject matter expertise, and helped to problem-solve with county staff charged with completing the tasks required by Ordinance 17998.

Committee were interviewed by PSB for its assessment report. Additionally, the Oversight Committee has reviewed and provided feedback on major MIDD review and renewal planning documents, including the MIDD II Framework which is the basis of recommended revisions to the MIDD policy goals and a key driver of recommended revisions to the potential MIDD II evaluation approach. The MIDD II Framework is discussed in detail in Section VI of this report and is included as Appendix B.

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

Data Gathering and Analysis: Over a dozen staff from DCHS and BHRD contributed work that is reflected in this report, collecting and reviewing eight years of reports, evaluation data, performance measurements, adjustments and revisions to strategies called for by Ordinance 17998. Staff conducted policy and operational analysis along with environmental scans to inform the observations and recommendations in this report. The PSB report details its approach to performing the neutral assessment of the MIDD evaluation, which includes meta-analysis of best practices and interviews with 30 individual stakeholders.

BHRD staff performed a comprehensive analysis of available data to assess the effectiveness of MIDD I in meeting the adopted policy goals. MIDD strategies aligned with the policy goal of reducing system use, such as jail utilization, documented a number of factors influencing any conclusions about effectiveness, such as strategy start date and the number of people evaluated. Next, staff plotted, by strategy, incremental changes in system use for jail, emergency department, and psychiatric hospital use against overall target reduction goal trajectories. These system use trend plots include data through the fifth year period after services began where possible. Also in support of this effectiveness work, previously reported symptom reduction analyses were reviewed and summarized, and explicit linkages to Council-directed initiatives were described for all relevant MIDD strategies.

In addition to the analysis described above, reviewing and assessing performance measurement data over the life of the MIDD was a key component to conducting the retrospective review. Strategy information was compiled identifying where strategy performance targets were unmet, why, and what actions were taken in response. Amendments and adjustments to these performance targets were explained, along with the results of changes made to targets over time. Staff cross referenced MIDD Oversight Committee meeting notes and evaluation data to produce a list of strategies that were updated or revised over time.

The MIDD Action Plan, Implementation Plan, Evaluation Plan, Evaluation Targets Addendum, along with the MIDD Quarterly, Progress and Annual Reports, and MIDD Oversight Committee minutes and meeting materials were reviewed to develop historical information on the evolution of the MIDD and its strategies. Interviews of management, contracting, and fiscal staff were conducted by evaluation staff to ensure accurate and up-to-date information was being used.

III. Background: MIDD I and Key Environmental Changes

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

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

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

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

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

(4) All moneys collected under this section must be used solely for the purpose of providing new or expanded programs and services as provided in this section, except as follows:

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

(b) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposes the tax authorized under this section after December 31, 2011, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding for up to the first three calendar years following adoption; and up to twenty-five percent may be used to supplant existing funding for the fourth and fifth years after adoption;

(c) For a county with a population of less than twenty-five thousand, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to eighty percent may be used to supplant existing funding in calendar years 2011-2012; up to sixty percent may be used to supplant existing funding in calendar year 2013; up to forty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016; and

(d) Notwithstanding (a) through (c) of this subsection, moneys collected under this section may be used to support the cost of the judicial officer and support staff of a therapeutic court.

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

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

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

*The expiration of the tax is established to enable progress toward meeting the county's policy goals outcomes, and to enable evaluations of the programs funded with the sales tax revenue to take place and for the county to deliberate on the success of meeting policy goals and outcomes.*⁵

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

⁵ King County Ordinance 15949, section 1 H, lines 73-76.

MIDD Adopted Policy Goals

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

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

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

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

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

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

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

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

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

The MIDD Oversight Plan, adopted by Ordinance 16077, established the MIDD Oversight Committee. It set the role and duties of the Oversight Committee, and established the composition of the Oversight Committee. As described in legislation, the Oversight Committee is responsible for the ongoing oversight of the MIDD services and programs funded with the sales tax revenue. It acts as advisory body to the Executive and the Council, reviewing and making recommendations on the implementation and effectiveness of the sales tax programs in meeting the five established policy goals. It reviews and comments on all required reports and on emerging and evolving priorities for use of the MIDD funds. Ordinance 16077 states that the Oversight Committee “should promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers, and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts.”⁶ Ultimately, the Oversight Committee’s purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable, and collaborative.

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

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

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

⁶ Ordinance 16077 Section 1 E, lines 44-47.

MIDD I Service Areas and Programming

MIDD I Service Area	MIDD Programs and Strategies
Community-Based Care	<ul style="list-style-type: none"> • Increase access to community mental health and substance abuse treatment for uninsured children, adults, and older adults • Improve the quality of care by decreasing mental health caseloads and providing specialized employment services • Provide supportive services for housing projects serving people with mental illness and chemical dependency treatment needs
Programs Targeted to Help Youth	<ul style="list-style-type: none"> • Expand prevention and early intervention programs • Expand assessments for youth in the juvenile justice system • Provide comprehensive team-based, intensive “wraparound” services • Expand services for youth in crisis • Maintain and expand Family Treatment Court and Juvenile Drug Court
Jail and Hospital Diversion	<ul style="list-style-type: none"> • Divert people who do not need to be in jail or hospital through crisis intervention training for police and other first responders and by creating a crisis diversion facility • Expand mental health courts and other post-booking services to get people out of jail and into services faster • Expand programs that help individuals re-enter the community from jails and hospitals
Domestic Violence and Sexual Assault and Adult Drug Court	<ul style="list-style-type: none"> • Address the mental health needs of children who have been exposed to domestic violence • Increase access to coordinated, early intervention mental health and substance abuse services for survivors of domestic violence • Increase access to treatment services for victims of sexual assault • Enhance services available through the King County Adult Drug Diversion Court
Housing Development	<ul style="list-style-type: none"> • Support capital projects and rental subsidies for people with mental illness and chemical dependency

The Implementation Plan contained information on each individual program (strategy) including the following:

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

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

highlighting critical collaboration and coordination are necessary to the successful implementation of the MIDD Plan.

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

The Implementation Plan outlined the steps and timeline for creation of the comprehensive programming that became MIDD programs. The Implementation Plan summarized the collaborative work of many entities over a two-year period to organize and develop the work that eventually became the MIDD. The document states that the Implementation Plan is "a product of a comprehensive, multi-jurisdictional plan to help youth and adults who are at risk for or suffer from mental illness or substance abuse."⁷

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

The MIDD Evaluation Plan identified a framework for evaluating most of the programs (strategies) in the MIDD Implementation Plan except the two added by the Council Crisis Intervention Team / Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project. The Evaluation Plan stated that evaluation would be accomplished "by measuring what is done (output), how it is done (process), and the effects of what is done (outcome)."⁸ The MIDD Evaluation Plan is discussed in Section IV of this report.

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

- 2015: 20 percent

⁷ Ordinance 16261, Attachment A Mental Illness and Drug Dependency Implementation Plan Version 6 – Revised October 6, 2008 – FINAL, page 5.

⁸ Ordinance 16262 Attachment A Mental Illness and Drug Dependency Action Plan Part 3 – Evaluation Plan Version 2 REVISED 9-2-08, page 11.

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

Replacement of lost Federal funds is permitted.

MIDD Today: MIDD serves thousands of people annually⁹, providing services to those who otherwise would not receive services. MIDD funding provides:

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

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

Data from the Eight Annual MIDD Report covering the period of October 1, 2014 to September 30, 2015 shows:

- Twenty strategies or sub-strategies were expected to reduce jail bookings and days for individuals served. It was more common for clients to reduce bookings than to reduce days.
- Fourteen strategies or sub-strategies were expected to reduce admissions to Harborview Medical Center’s emergency department. Ten of these achieved reductions of 20 percent or greater in the second year after the start of MIDD services, which was a favorable outcome.
- Ten strategies were expected to reduce psychiatric hospitalizations for clients served. At least nine strategies achieved targeted reductions during at least one outcomes analysis period.

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

⁹ MIDD Eighth Annual Report, pg. 46: 35,902 unduplicated clients during the October 1, 2014 to September 30, 2015 reporting period, with an additional 21,730 people served in large group settings.
http://www.kingcounty.gov/~media/health/MHSA/MIDD_ActionPlan/Reports/160413_MIDD_8th_Annual_Report.ashx?la=en

for future opportunities to utilize undesignated fund balance.

MIDD continues to build on the groundbreaking collaboration between the CJ and HHS, spurring more innovation such as the Health and Human Services Transformation Plan, the Familiar Faces Initiative, and the FIRS program.

The current MIDD provides a strong foundation on which to plan MIDD II, building on the very best of what worked, examining and retooling to address challenges so that the County's behavioral health system is positioned to serve more people and achieve more notable outcomes even as conditions evolve.

Key Changed Conditions Impacting MIDD

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

Behavioral Health Integration: In March 2014, the Washington State Legislature passed Senate Bill 6312 calling for the integrated purchasing of mental health and substance abuse treatment services through managed care contracts by April 2016, with full integration of physical and behavioral health care by January 2020. The law necessitated the creation of Behavioral Health Organizations (BHOs) to purchase and administer Medicaid funded mental health and substance use disorder services under managed care. BHOs are single, local entities that will assume responsibility and financial risk for providing substance use disorder treatment and the mental health services currently overseen by the counties and Regional Support Networks (RSNs). The BHO services will include inpatient and outpatient treatment, involuntary treatment and crisis services, jail provided services, and services funded by federal block grants. King County Behavioral Health and Recovery Division will serve as the BHO for the King County region.

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

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

More information on statewide BHO development can be found here:

<https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/developing-behavioral-health-organizations>.

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

Since January 1, 2014, when Washington State took advantage of Medicaid expansion under the ACA, King County has seen a significant increase in the number of people enrolled in Medicaid. As of August 1, 2015, approximately 146,000 individuals have become newly eligible for Medicaid services in King County; of those, about 10,000 have accessed outpatient mental health services from the King County RSN. As of August 1, 2015, there are approximately 395,000 Medicaid-covered individuals in King County.

Because the RSN (and now the BHO) is paid on a per member per month basis from the state, the increase in Medicaid eligible individuals has resulted in revenue growth. This in turn has allowed the King County BHO to raise outpatient case rates paid to providers. Unfortunately, the system is experiencing a bow wave: the behavioral health system is struggling to find and/or retain trained, licensed, and qualified staff to provide services to this expanded population. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Workforce development is discussed in detail in a subsequent section of this document.

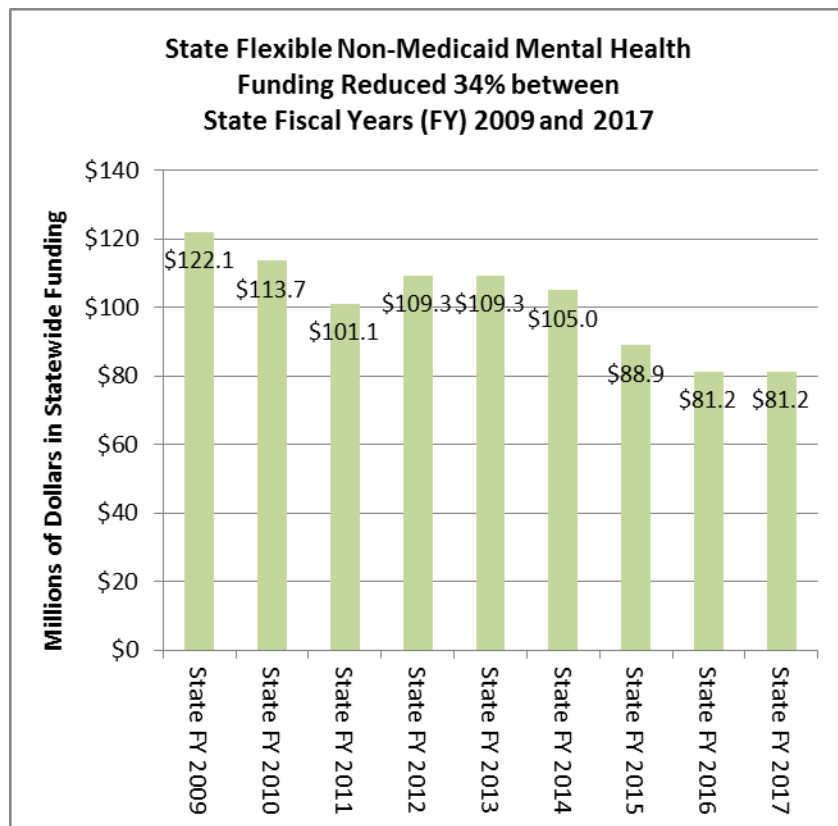
Prior to implementation of the ACA, most people served in the substance use disorder system were not eligible for Medicaid, as Medicaid eligibility was determined by a combination of income and disability and having solely a substance use disorder was not considered a qualifying condition for federal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

As with the mental health system, the massive conversion of funding for treatment to Medicaid has

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

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

Table 1



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

mental illnesses or substance use disorders.

High Treatment Need: Severe resource scarcity has coexisted with a very high prevalence of treatment need in Washington as compared to other states. Analysis of data from the federal Substance Abuse and Mental Health Administration (SAMHSA) 2010-11 Mental Health Surveillance Survey found that Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (seven percent).¹⁰

Population Growth: The population of King County grew by an estimated 22 percent between 2000 and 2015 – almost 380,000 people. Meanwhile, the state’s population increased by approximately 22 percent as well – or nearly 1.3 million.¹¹ Even this one factor alone – the addition of so many more residents – would have placed more pressure on an overstretched community behavioral health treatment system.

Emergency System Use: More and more people are seeking psychiatric care via hospital emergency departments (EDs) – in 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of psychiatric ED visits, 41 percent result in a hospital admission, over two and a half times the rate of ED visits for other conditions,¹² and between 2001 and 2006 the average duration of such visits was 42 percent longer than for non-psychiatric issues.¹³ The growth in these figures may result from the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally, that began as part of deinstitutionalization in the 1960s and has continued until very recently.¹⁴

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

¹⁰ Burley, M. & Scott, A. (2015). Inpatient psychiatric capacity and utilization in Washington State (Document Number 15-01-54102). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.

¹¹ U.S. Census Bureau State and County QuickFacts, retrieved from <http://quickfacts.census.gov/qfd/states/53/53033.html>, and Population for the 15 Largest Counties and Incorporated Places in Washington: 1990 and 2000, retrieved from https://www.census.gov/census2000/pdf/wa_tab_6.PDF.

¹² Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality (2010), as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

¹³ Slade EP, Dixon LB, Semmel S. Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv* 2010, 61(9), 878-84, as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

¹⁴ Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

Court Rulings

Psychiatric Boarding: On August 7th, 2014, the Washington State Supreme Court ruled that hospital boarding of individuals in mental health crisis, absent medical need, is unconstitutional. Psychiatric boarding or “boarding” became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as hospital EDs until a psychiatric bed became available.

Psychiatric boarding hurts patients and drives resources away from community-based and preventive care. Studies show that prolonged waits in EDs for psychiatric patients are associated with lower quality mental health care.¹⁵ This has been a nationwide problem that had been affecting Washington and King County since at least 2009.

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, the Court emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of bed capacity.¹⁶

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

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

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

¹⁵ Bender, D., Pande, N., Ludwig, M. (2008). *A Literature Review: Psychiatric Boarding: Office of Disability, Aging and Long-Term Care Policy*. Retrieved from <http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf>.

¹⁶ *In re the Detention of D.W., et al*. Case 90110-4. Washington State Supreme Court, retrieved from <http://www.courts.wa.gov/opinions/pdf/901104.pdf>.

Other Change Drivers

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

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

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

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

Without workforce improvements, King County will not be able to meet service needs. Individuals who

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

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

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

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

desperately require lifesaving services could go untreated, resulting in high costs, both human and financial. The County is uniquely positioned to both participate in and lead aspects of workforce development in partnership with providers, consumers, and policy makers.

Evolving Values and Approaches to Care: The factors below reflect new directions or policies taken by King County in the provision of behavioral health services since 2007 when the MIDD was first authorized. In addition, each element echoes a MIDD Oversight Committee-identified guiding principle for the development of MIDD II.

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

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

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

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

Most individuals seeking public behavioral health and other public services have histories of physical and

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

sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system.

Providing services under a trauma-informed framework can result in better outcomes than “treatment as usual.” A variety of studies have revealed that programs utilizing a trauma-informed model are associated with a decrease in psychiatric symptoms and substance use. Some programs have shown an improvement in daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms.^{22, 23} Trauma-informed care may lead to decreased utilization of crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed services.²⁴

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

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

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

²² Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.B., Reed, B.G., & Fallot, R. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. *Journal of Substance Abuse Treatment*, 28(2), 109-119.

²³ Morrissey, J.P., and Ellis, A.R. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *Journal of Substance Abuse Treatment*, 28(2), 121-133.

²⁴ Community Connections. (2002). Trauma and Abuse in the Lives of Homeless Men and Women. Online PowerPoint presentation. Washington, DC: Authors. Retrieved September 3, 2007, from http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt

IV. MIDD Evaluation Overview

This section provides an outline of the MIDD evaluation approach. It describes the MIDD Evaluation Plan that was required by the King County Council and how the MIDD evaluations are conducted today.

MIDD Evaluation Plan

The Council called for an Evaluation Plan via Ordinance 15949 that authorized the MIDD, with the intent for the Evaluation Plan to outline an evaluation approach that would provide the public and policy makers with the tools to evaluate the effectiveness of the MIDD strategies, as well as to ensure transparency, accountability and collaboration and effectiveness of the MIDD-funded programs and strategies. Ordinance 15949 states that, “it is the policy of the county that the citizens and policy makers be able to measure the effectiveness of the investment of the public funds of the MIDD”. The elements required to be addressed by the MIDD Evaluation Plan, shown in Table 2 below.

Requirements of the MIDD Evaluation Plan
<ul style="list-style-type: none">● Process and outcome evaluation components● A proposed schedule for evaluations● Performance measurements and performance measurement targets● Data elements that will be used for reporting and evaluation● Performance measures including:<ul style="list-style-type: none">○ the amount of funding contracted to date○ the number and status of request for proposals to date○ individual program status and statistics such as individuals served○ data on utilization of the justice and emergency medical systems.

The MIDD Evaluation Plan adopted by the Council is the blueprint for conducting the evaluation and assessment of MIDD. The plan stated that MIDD evaluation activities will measure both what is done (output), how it is done (process), as well as the effects of what is done (outcome).

The Evaluation Plan included a matrix for each of the MIDD strategies that summarizing the objectives for each strategy. For each strategy, the matrix included the following:

- Strategy/intervention objective(s)
- A list of outcomes and outputs
- A list of performance measures for the strategies
- Initial performance indicators, targets and data sources
- An outline of needed data and data sources.

The MIDD Evaluation Plan was developed in conjunction with the MIDD Implementation Plan. The Implementation Plan specified how each MIDD strategy would be executed and individual MIDD strategy implementation information was used to develop an evaluation approach for each program

supported by MIDD funds. MIDD policy goals and strategies were linked to the results via the matrices, which in turn provided a structure for identifying performance indicators, targets and data sources, and for collecting and reporting results²⁵.

The MIDD Evaluation Plan that was adopted contained preliminary performance measurement targets for five broad MIDD policy goals. Due to timing issues, it was not possible for the county to identify individual performance measurement targets for each of the 37 individual strategies before the due date of the plan. During Council's deliberation on the Evaluation Plan, it was determined that the targets contained in the MIDD Evaluation Plan would be revised over time as programs developed and changed. Ordinance 16262 adopting the Evaluation Plan stated²⁶,

The council recognizes that these targets are preliminary and will be impacted by changes in program implementation as well as available data or other factors. It is the policy of the county that the preliminary targets, and any targets established in the future, for the tax funded programs and strategies are to be revised through the annual reporting process to reflect revisions to the strategies, programs, data and other processes.

In addition to the above material, the MIDD Evaluation Plan outlined how data for MIDD would be collected. The plan noted that some data can be obtained from existing sources, while accessing other data, especially from entities outside of King County government, may require data sharing agreements as well as investments of resources and time. It also included a timeline with a proposed schedule of evaluation activities, reporting to the MIDD Oversight Committee, the County Executive, and the County Council. The Evaluation Plan is included as Appendix E to this report.

Please note that programs that used MIDD funds as supplantation for lost other funds, including treatment courts, were not required to participate in on-going MIDD evaluations.²⁷

MIDD Evaluation Overview

The MIDD evaluation gathers and uses data from a variety of sources. MIDD providers who are mental health contractors with King County upload data in batches from their independent agency systems to BHRD's in-house mental health database. Those who are substance abuse contractors uploaded their data to the state's TARGET database. MIDD-funded entities that were neither contracted mental health nor substance abuse provider agencies submit data on customized excel spreadsheets. These data are then loaded into a stand-alone MIDD database. King County's MIDD evaluators receive data from more than 100 providers, subcontractors, and partners related to the MIDD strategies.

²⁵ The MIDD Oversight Committee reviewed and provided input into the development of the MIDD Evaluation Plan that was adopted by the Council, in accordance with Ordinance 15949. See the MIDD Evaluation Plan that is Appendix E to this report.

²⁶ Ordinance 16262 Lines 66-71

²⁷ With the exception of a one-time, ad hoc evaluation conducted in 2012 when MIDD revenue shortfalls were expected. The evaluation had significant methodological limitations and was not utilized.

Information is typically submitted to King County on a monthly or quarterly basis, as specified in contracts. In some cases providers automatically process the data, while in other cases, spreadsheets are manually completed and submitted to the county via secure file transfer protocols, or uploaded to secure servers. Manually submitted data requires significant staff time to clean, process, and compile information. In order to produce demographic and outcomes findings, strategy clients must be unduplicated and cross-referenced with their system-use results provided by all King County and municipal jails and select hospital partners.

Once the data are clean, they are loaded into the MIDD database and queried for analysis. Depending on the MIDD strategy, the data are then matched with data from other systems that King County BHRD accesses via business associate and data sharing agreements. These include data from municipal jails, the King County Department of Adult and Juvenile Detention (DAJD), Harborview Medical Center, Western State Hospital, Pre-Manage (a new data source accessed for the first time in 2015 for hospital emergency department data beyond Harborview), and the Homeless Management Information System (HMIS).²⁸ Initial matching is automated, and then manually reviewed. This time intensive process involves working with many thousands of records associated with the MIDD, but remains necessary to ensure that evaluation results associated with the MIDD are reliable.

After cleaning and matching the data and conducting the analyses, the results are then summarized in the semi-annual MIDD reports. Summaries for each strategy include recent high-level outcomes that link to the policy goals assigned to the strategy, as well as key outputs that relate to performance targets. These summaries are reviewed by the identified lead staff for the strategy or other stakeholders to ensure accuracy, and revised as needed. After the report is drafted, it is reviewed by BHRD leadership, the MIDD Oversight Committee, DCHS Department leadership, and the Executive's office before it is transmitted to the King County Council. Once transmitted, the MIDD reports are posted on the MIDD website. King County Council Committees typically receive briefings on the MIDD annual reports.

In accordance with the MIDD Evaluation Plan, MIDD strategy data are examined in light of relevant outcome types, eligible sample sizes, either total or average number of system use admissions or days in each time period, and the percent change over time. Analysts look for patterns in the data that suggest relationships between measured variables without implying causation. MIDD evaluators are cognizant of the fact that for all strategies, other factors not being measured, such as law enforcement practices and state or federal policy changes, could also be contributing to any observed results.²⁹

²⁸ Data sharing agreements with medical and jail systems must be established with significant attention to the needs and requirements of each system, including relevant privacy laws and rules. MIDD continues to seek new data sharing partners, especially as it seeks to improve its evaluation efforts in a potential MIDD II.

²⁹ MIDD Eighth Annual Report

Definitions of Key MIDD Evaluation Terms	
MIDD Strategy	A program or series of programs that provide specific services
Output	The quantifiable amount of something being measured, such as how many people served or how many services provided
Outcomes	Measurable or observable end results or effects; something that happens as a result of an activity or process
Target	Quantifiable outputs expected of an entity implementing a strategy such as how many people will be served and/or how many services will be provided
Revised Target	Changed expected output goals, usually permanent, due to new or better information
Adjusted Target	Changed expected output goals, usually temporary, due to changes in funding, staffing, policy or approach
FTE	Full-time equivalent staffing. This is used to contextualize several MIDD targets
Performance Measurement	The actual number of clients seen or services delivered; also represented as a percentage the original, revised or adjusted target
Targeted Reductions	The amount of change expected in system use (jail, emergency department, psychiatric reductions hospital) over time by individuals being served by particular strategies

Evaluating Outcomes

Beginning in the second full year of the MIDD (October 2009 – September 2010), evaluation efforts began moving beyond describing those served, characterizing service delivery, and comparing performance measures against their targets to an outcome-focused evaluation. Although the initial elements continued on an ongoing basis, the evaluation also began to study the impact of the services being provided.

For most MIDD strategies, outcomes were studied using a longitudinal evaluation methodology. This method involves collecting data for the same group of individuals over time and then making comparisons between various time periods. Outcomes are tracked for up to five years after a person begins any particular MIDD service – referred to in evaluation and reporting documents as the person’s “MIDD start date.” The following definitions for study time periods are used in the MIDD evaluation:

- **Pre:** The one-year period leading up to a person’s first MIDD start date within each relevant strategy.
- **First Year Post through Fifth Year Post:** Each subsequent one-year span following a person’s start date.

Cohorts of MIDD clients become eligible for inclusion in various outcomes samples in two ways:

1. **Time Eligible:** Participants who are included in an evaluation sample as a result of the passage of time.
2. **Use Eligible:** Participants who are included as a result of their use of any given system such as jails or hospitals – use that could potentially be reduced as they participated in MIDD-funded services.

This transition from process to outcome evaluation was made possible as outcome measures for some strategies became available in the first quarter of calendar year 2010. Outcomes measurement varied depending upon the primary and/or secondary policy goals associated with each strategy. In some cases, outcomes involved matching information about MIDD service recipients against multiple outside data sources such as jail bookings, psychiatric hospitalizations, and emergency room utilization. In other situations, outcomes were assessed by comparing measures of mental health or substance use disorder symptoms at two different points in time.

As has been stated in the MIDD Annual Reports and in other arenas throughout the life of MIDD, direct causation of outcomes cannot be attributed to MIDD I. Causation cannot be established within the evaluation framework of MIDD, particularly given the lack of a control group. Creation of a MIDD control group was considered and dismissed for a number of reasons, including the ethics of withholding services from one group of individuals in order to compare them with another group. Statistical analysis of system use and symptom reduction indicates that the strength of associations between predictors and outcomes are sufficient to demonstrate the MIDD's value.³⁰

It is important to note that MIDD is comprised of multiple and often interrelated interventions that are designed to achieve the same or similar policy goals. For example, reducing caseloads, enhancing workforce development activities and service capacity are expected to *collectively* reduce incarceration and use of emergency services. MIDD is not a single intervention: it is a very complex set of interventions serving a wide variety of individuals, in an array of settings, by multiple providers. Therefore, evaluating the impact of the MIDD is a multifaceted endeavor. MIDD evaluation involves multiple target populations, goals, strategies,³¹ programs, interventions, providers, administrators, partners, locations, timelines, and expected results. Additionally, the MIDD evaluation was never intended to be a series of independent program evaluations although many programs included within MIDD strategies do undergo their own separate, in-depth evaluations, often conducted by third parties³².

The overall evaluation approach of MIDD is designed to assess whether the expected results are being achieved and whether benefits are derived from MIDD investments.³³

³⁰ MIDD Second Annual Report

³¹ The word "strategies" was used in MIDD I to indicate a category of programming with discrete goals, target populations, and similar intervention approaches, that distinguished them from other "strategies" within MIDD I. A single "strategy" sometimes encompassed multiple related interventions, and often included multiple contracted providers. In MIDD II (if renewed), these categories will be called "programs," but throughout this report, the word "strategies" is used for consistency with language used in other MIDD documents from 2008 through 2016.

³² Screening, Brief Intervention and Referral to Treatment (SBIRT), Supported Employment, for example.

³³ MIDD Action Plan, Part 3: Evaluation Plan

V. Evaluating the Effectiveness of the Current MIDD Funded Strategies, Programs, and Services

Measuring Success and Determining Effectiveness

The MIDD Plan was intended to be a comprehensive approach to creating improvements across the continuum of the behavioral health³⁴ system and making progress toward five key public policy goals. Ordinance 15949 established five policy goals for King County’s MIDD sales tax. These goals have guided and informed all aspects of the MIDD policy and services work since 2007.

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

Aggregating results from all relevant strategies, the following overall findings on effectiveness are evident for MIDD I service participants:

Assessment of Effectiveness of MIDD in meeting Policy Goals
<ul style="list-style-type: none">• Overall, MIDD achieved significant reductions in jail, emergency department, and psychiatric hospital utilization.• Symptom reduction data was limited, but symptom reductions were shown for most individuals in smaller samples where change was evident.• MIDD did not quantitatively measure furtherance of other initiatives.

³⁴ Behavioral Health is a term that refers to both mental health and chemical dependency.

Policy Goal 1: Emergency Department Utilization: SIGNIFICANT REDUCTION

Data indicates that over the long term, emergency department utilization decreased significantly. After a modest initial increase in emergency department use in the first year, **reductions in emergency department use exceeded 25 percent for every year thereafter, peaking at 39 percent** in the fifth year after initial MIDD service contact.

Fourteen MIDD strategies have a primary or secondary policy goal of reducing emergency department (ED) use by individuals with behavioral health disorder(s).³⁵ Data were provided by Harborview Medical Center³⁶ in Seattle in order to monitor changes in use of their ED over time. King County was not able to secure data agreements with other hospitals.

The top three MIDD strategies impacting long term emergency department (ED) reductions were 12c Psychiatric Emergency Services (PES), 1d, Mental Health Crisis Next Day Appointments and Stabilization Services (NDA), and 3a, Supportive Services for Housing Projects. Strategy 12c PES was designed to specifically reduce visits to Harborview's ED use by targeting for intervention those individuals with high use of the ED. Expanding Crisis NDA's (1d) to include psychiatric medication evaluations appears to have had a positive impact on ED use, as well, by helping people to remain stably medicated in the community and reducing their need for emergency services. Supported housing (3a) offers a combination of services and housing that helps those with the most complex challenges, like behavioral health conditions, be successful in housing and not return to homelessness. Supported housing had the best short term reduction data, showing immediate impact on ED use, demonstrating that when people get off the streets, they are less likely to end up injured or in medical crisis.

At the other end of the data spectrum for this policy goal were strategies 1b Outreach & Engagement and 1a-2b Opiate Substance Use Disorder Treatment, as they appeared to have little impact on ED utilization. Strategy 1b helps people with chronic homelessness, mental illness and addictions get the services they need from community service providers. Outreach is conducted to people in need of services, including a significant number participating in Public Health's Needle Exchange program. Strategy 1a-2b provides opiate substitution treatment for individuals in need of services, including intensive outpatient services. It is important to note that outreach is somewhat removed from the goal of reducing ED use, as people contacted may not actually link to needed services. Also, given the high number of participants in these two strategies with active or past needle use, there is an increased risk for ongoing ED use, either for overdose or abscess. See Appendix F for detailed information and graphics.

³⁵ Strategy 17a Crisis Intervention /Mental Health Partnership was excluded from the analysis, as other non-MIDD funding was secured to run the program.

³⁶ Information on emergency department (ED) use throughout the State of Washington did not become available for analysis until the seventh year of the MIDD.

Policy Goal 1: Psychiatric Hospital Utilization: SIGNIFICANT REDUCTION

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

Ten MIDD strategies had a primary or secondary policy goal of reducing psychiatric hospital utilization by individuals with mental illness. Data from community inpatient psychiatric hospitals in King County were combined with data from Western State Hospital in order to monitor changes by strategy in the average days hospitalized per year over time. See Appendix G for details.

For psychiatric hospitalization, a main MIDD driver for reducing admissions for adults is Strategy 1a-1 Mental Health Treatment. This strategy provides access to outpatient mental health services to individuals who have lost, are ineligible for, or who are intermittently eligible for Medicaid coverage. Loss of services disrupts continuity of care and threatens the individual’s clinical stability. Additionally, there is a large unserved population of people who are not on Medicaid, or do not qualify for Medicaid, whose mental health needs are only addressed when their need reaches crisis proportions - either in hospital EDs, inpatient care, or jails. Strategy 1a-1 enables people to receive stabilization services in the community. As with ED use findings, housing strategies were also found to reduce psychiatric hospital use, especially through the third post period. There was a leveling off for 3a Supportive Housing in the fourth post period, and days actually increased slightly in the fifth post. This does not factor in the exit reasons from Supportive Housing where data indicates only 23 percent of exits are “positive” (where people leave for something better). Thus, the trend in initial hospital reductions that ultimately taper off could be explained by the fact that when many people leave their housing it may be accompanied by a mental health crisis event.

Strategy 1h – Crisis Intervention and Linkage for Older Adults saw psychiatric admissions and days rise in the short term. This strategy provides specialized outreach crisis intervention and stabilization to older adults in King County. A multidisciplinary team of geriatric specialists perform outreach and assessments of older adults who are experiencing crises related to mental illness and substance abuse. Services provided include comprehensive assessments at the client’s residence as well as crisis intervention and stabilization with prompt referral and linkage to mental health, chemical dependency, aging, and health care providers in the community. Based on the data, MIDD evaluators postulate that the strategy was serving previously untreated individuals who may have been in considerable crisis (or potentially with dementia) which led to increases in psychiatric hospitalizations as the needed level of care.

For youth in mental health treatment (1a-1), data indicates increased days hospitalized in all time periods studied. Please note that less than 50 youth contributed to these findings, so additional data and analysis is needed to unpack the findings related to youth and psychiatric hospitalizations.

Policy Goals 1, 2, and 4: Jail Utilization SIGNIFICANT REDUCTION

Over both the short and long term, **jail bookings decreased significantly, ranging from 13 percent in the first year to 53 percent** in the fifth year after initial MIDD service contact. Total jail days increased slightly in the first year after MIDD service contact, but then **reductions in jail days reached a 44 percent reduction** by the fifth year were consistently evident starting in the second year.

A total of 25 MIDD strategies seek to reduce jail use, reduce the degree to which individuals cycle through the jail, and/or to divert individuals with behavioral health conditions away from justice system involvement. Of the strategies with jail reduction goals, two were never implemented³⁷, two secured non-MIDD funding³⁸, and four began late³⁹, therefore long-term impacts on jail and detention use (over a five-year period)⁴⁰ are currently available for 17 MIDD strategies. See Appendix H for detailed jail use outcomes.

For policy goals 1, 2, and 4, data shows system use most often bumps up a bit in the first year 1 after initial MIDD service contact and then drops significantly in subsequent years. As individuals are first becoming engaged in MIDD-funded programs, service systems are more likely to become aware of emerging issues, and may respond by helping people access emergency care when needed. However, clear long-term system use reductions soon follow, in many cases extending beyond a person's involvement in a MIDD-funded service.

In Strategy 12d Behavior Modification Classes, where clients receive Moral Reconciliation Therapy (MRT), this evidence-based cognitive-behavioral treatment showed impactful jail reduction results with a demonstrated long term reduction in jail bookings of 74 percent. Jail use reductions were not limited to the MIDD criminal justice strategies, however, as strategies involving housing, behavioral health treatment, and the therapeutic courts showed jail use reductions as well. MIDD evaluation data found⁴¹:

- Providing housing and supports to keep people housed reduced jail bookings and days by as much as 77 percent (fourth post period).
- When people received the behavioral health treatment they needed, whether for SUD (Strategy 1a-2) or mental health (Strategy 1a-1) issues, jail use reductions were as high as 61 percent (fifth post period).
- Many of the therapeutic court programs also showed substantial jail use reductions of about 60% over the long term.

For youth, the strongest long term detention booking reductions were related to Strategy 5a Juvenile Justice Assessments, which provides screening and assessment to determine if juvenile justice and child welfare system involved youth have substance abuse and/or mental health needs and Strategy 9a Juvenile Drug Court. Juvenile Drug Court data indicated a 48 percent reduction in detention was

³⁷ 4b Substance Use Disorder Prevention for Children; 7a Youth Reception Centers

³⁸ 17a Crisis Intervention/Mental Health Partnership; 17b Safe Housing – Child Prostitution

³⁹ 4c School-Based Services; 7b Expand Youth Crisis Services; 10b Adult Crisis Diversion; 12b Hospital Re-Entry Respite Beds

⁴⁰ Long-term impacts are analyzed because it takes time to identify trends

⁴¹ Please see MIDD Eighth Annual Report, Appendix V Aggregate System Use by Relevant Strategies, pgs. 59-69.

http://www.kingcounty.gov/~media/health/MHSA/MIDD_ActionPlan/Reports/160413_MIDD_8th_Annual_Report.ashx?la=en,

achieved, with behavioral health treatment for youth (Strategies 1a-1 and 1a-2) showing the best short term jail reductions for youth (23 percent and 28 percent in the second post period). Use of detention as a sanction for youth in 9a over the short term increased detention days, with long term data showing overall reductions in detention bookings as high as 48 percent⁴².

The strategy appearing to have the least impact on jail use was 1c Emergency Room Intervention for Substance Use, even though reductions from the third post period were evident. Strategy 1c delivers brief counseling, or “brief interventions,” to patients who screen positive for substance use disorders, referring people to substance use disorder community treatment agencies. MIDD evaluators hypothesize it is possible that adults screened for substance use disorder before their substance use became problematic experienced a lag in jail use impacts. Similar to outreach described above, a pattern may exist for the strategy whereby short term reductions are not evident and long term reductions are not as substantial as those seen with strategies that intervene further down the pipeline. This highlights an opportunity to address expectations about how certain strategies may impact jail use.

Most therapeutic court programs use jail days as sanctions, typically related to actions that occurred prior to a participant’s MIDD service start. In such situations, MIDD data indicated that jail days often increased, even as a person was engaged in services and making progress in recovery.

Policy Goal 3: Symptom Reduction

When change was evident and could be measured, about three out of every four people showed reduced mental health symptom severity or reduced substance use at some point over the course of their treatment.

Reducing symptoms associated with mental illness and/or substance use disorder was a primary or secondary goal for 13 implemented MIDD strategies. Tools used to measure symptom reduction depended on the strategy, and included the Problem Severity Summary (PSS), the Children’s Functional Assessment Rating Scale (CFARS), the Patient Health Questionnaire (PHQ-9), the Generalized Anxiety Disorder (GAD-7) scale, Addiction Severity Index (ASI), Pediatric Symptom Checklist (PSC-17), Global Appraisal of Individual Needs (GAIN) and a client satisfaction survey, as applicable. See Appendix I for a complete listing of symptom reduction measurement tools.

Anxiety and depression were found to be the most common clinical symptoms for both adults and children. Analyses of symptom data conducted every two years showed that the majority of clients remained stable over time. For policy goal 3, although over time more people showed improvement, for the majority of participants no change was evident. Analysis revealed that data quality may have contributed to this, as some symptom measurement instruments were more sensitive to change than others, and some data may not have been updated. When symptom scores did change, improvements at some point during treatment were much more common (85 percent) than worsening symptoms (15 percent). MIDD data also showed that staying in treatment over time was associated with increased total percentages of adults who reduced their symptoms (up to 42 percent of all eligible participants).

⁴² Ibid.

For young people, extreme issues were rare, meaning that high symptom scores were uncommon. Of those with high scores, or above the clinical threshold for concern, at first measure, two of every three youth reduced their depression and anxiety scores below the concern threshold by a later measure, indicating improved mental health over time. See Appendix J for a summary of symptom reduction findings published over the life of MIDD I.

Limited staffing capacity has not allowed the rigorous monitoring and technical assistance for MIDD-funded providers that would be necessary to ensure high data quality with the symptom measurement tools.

Policy Goal 5: Furthering Other Initiatives
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In general, strategies intended to further the work of other Council-directed efforts were determined to have done so.
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Alignment with other initiatives was not quantitatively tracked by MIDD evaluation. Anecdotally, DCHS staff tasked with these efforts collaborated on issues such as outreach and data gathering.

Adult & Juvenile Justice Operational Master Plans (2002 and 2004)

A core purpose of King County's justice operational master plans is to work collaboratively across King County criminal justice partners to ensure that the criminal justice system is fair, effective, efficient and integrated.⁴³ The MIDD strategies included improvements to coordination between behavioral treatment and services and the criminal and juvenile justice systems, including diversion programs; alternative sentencing methods such as therapeutic courts; and improvements in screening, assessment and discharge planning that connect directly to community service engagement and placement.⁴⁴ The following strategies advance the Adult & Juvenile Justice Operational Master Plans.

- 10a Crisis Intervention Team Training - By training first responders to recognize signs of mental illness or substance use disorders in the field, efforts to divert individuals from criminal justice system involvement are facilitated at the earliest point in time.
- 11a Increase Jail Liaison Capacity - Individuals to King County Work and Education Release (WER) program, where offenders go to work, school, or treatment during the day and return to a secure facility at night, have the opportunity to work with a liaison that links clients to services and resources, such as housing and transportation, that can reduce recidivism risks.
- 12a Jail Re-Entry and Education Classes - Short-term case management services are provided to incarcerated individuals with behavioral health issues who are near their release date to ensure a successful transition into the community

Ten-Year Plan to End Homelessness⁴⁵ - The plan's goals of "...promot(ing) long-term and sustainable

⁴³ <http://www.kingcounty.gov/exec/PSB/AJOMP.aspx>

⁴⁴ The MIDD Action Plan

⁴⁵ No link available to the original plan. See <http://allhomekc.org/wp-content/uploads/2015/09/All-Home-Strategic-Plan.pdf> for the current strategic plan.

solutions to homelessness including alignment of funding, programs and services among the public, private and non-profit sectors align with MIDD policy goals."⁴⁶The MIDD strategies are designed to prevent and reduce chronic homelessness in alignment with the Plan to End Homelessness. Specific MIDD strategies directly linked to the plan are described below.

- 1b Outreach & Engagement - This strategy is a partnership with Public Health—Seattle & King County’s Healthcare for the Homeless and seeks to engage individuals, including veterans, coping with chronic homelessness.
- 3a Supportive Housing - In this strategy previously homeless individuals, including veterans, are helped to remain safely housed for longer periods of time with additional supports.
- 16a New Housing & Rental Subsidies - MIDD funds were allocated for the provision of capital to create housing units.

Veterans and Human Services Levy - The Veterans and Human Services Levy aims to generate funding to help veterans, military personnel and their families, and other individuals and families in need across the county through a variety of housing and supportive services.⁴⁷ Veterans comprise a large percentage of the population of individuals who are homeless and who enter the criminal justice system and receive services from MIDD strategies. The following strategies promote the Veterans and Human Services Levy.

- 1b Outreach & Engagement - This strategy is a partnership with Public Health—Seattle & King County’s Healthcare for the Homeless and seeks to engage individuals, including veterans, coping with chronic homelessness.
- 3a Supportive Housing - In this strategy previously homeless individuals, including veterans, are helped to remain safely housed for longer periods of time with additional supports.
- 11b Mental Health Courts - Regional Mental Health Court MIDD funding created a pilot Veteran’s Mental Health Court, that later became funded by the Veterans and Human Services Levy.

Mental Health Recovery Plan -This plan seeks to align and integrate recovery and resiliency initiatives for behavioral health services, shaping services to be trauma-informed and to attend to whole-person health.⁴⁸ Many MIDD strategies support individuals working to “improve their own health and well-being”, while meeting “life’s challenges with a sense of self-determination, mastery and hope.” The following MIDD strategies support the Mental Health Recovery Plan.

- 1e Chemical Dependency Trainings - Research-backed practices such as motivational interviewing and advanced clinical supervision have been woven into the fabric of King County’s treatment community through trainings funded by this strategy. Quality workforce development is a key component of the plan.
- 1f Parent Partners Family Assistance - Strategy 1f exemplifies the recovery principle that services should be consumer centered and driven, as evidenced by the Family Support Organization that is

⁴⁶ https://en.wikipedia.org/wiki/Homelessness_in_Seattle

⁴⁷ <http://www.kingcounty.gov/operations/DCHS/Services/Levy.aspx>

⁴⁸ http://www.kingcounty.gov/~media/health/mentalHealth/Recovery/Documents/130524_FINAL_Plan-R_and_R_Oriented_Behavioral_Health_Services_Rev_6.ashx?la=en

implementing this program.

Overall Conclusions about MIDD’s Effectiveness in Meeting Policy Goals

Of the 32 MIDD strategies that were funded, 26 MIDD strategies had measures for least one policy goal area (jail use, ED use, psychiatric hospitalization, and symptom reduction). Of these 26, 19 (73 percent) met or exceeded long term targeted reduction goals in at least one policy goal area. The strategies that met or exceed outcome targets are:

- 1a-1 Mental Health Treatment (ED, Symptom Reduction)
- 1a-2 Substance Use Disorder (SUD) Treatment (Symptom Reduction)
- 1d Crisis Next Day Appointments (ED)
- 1g Older Adults Prevention (Symptom Reduction)
- 1h Older Adults Crisis and Service Linkage (ED, Psychiatric Hospitalization)
- 3a Supportive Housing (Jail)
- 6a Wraparound (Symptom Reduction)
- 8a Family Treatment Court (Symptom Reduction)
- 10b Adult Crisis Diversion (ED)
- 11b Mental Health Courts (Symptom Reduction)
- 12a1 Jail Re-Entry Capacity (Jail)
- 12b Hospital Re-Entry Respite Beds (ED)
- 12c Psychiatric Emergency Services Linkage (ED)
- 12d Behavior Modification Classes (Jail, Symptom Reduction)
- 13a Domestic Violence Services (Symptom Reduction)
- 13b Domestic Violence Prevention (Symptom Reduction)
- 14a Sexual Assault Services (Symptom Reduction)
- 15a Adult Drug Court (Symptom Reduction)
- 16a New Housing & Rental Subsidies (Psychiatric Hospitalization)

Of the 32 MIDD strategies, six were evaluated for effectiveness not on system use or symptom reduction, but on customized outcomes that were not intended to have a direct impact on system use or system reduction. For example, three of the six strategies in this group involve providing training rather than direct services.

Strategy	Evaluation Component Example
1e Chemical Dependency Professional Education and Training	<ul style="list-style-type: none"> • Data collected from individuals attending “Motivational Interviewing” workshops were analyzed to demonstrate training effectiveness. • Comparison of survey responses prior to trainings and at 30-day follow-ups showed statistically significant gains in knowledge or skill level across a variety of topics addressed in the trainings. • Courses continue to be evaluated for quality, relevance, and effectiveness, with satisfaction ratings above 95 percent. • The majority of trainees feel they are better able to serve clients after participating in MIDD-funded workforce development activities.

<p>1f Peer Support and Parent Partner Family Assistance</p>	<ul style="list-style-type: none"> Key outcomes for Strategy 1f involve increasing protective factors for families and youth served, decreasing risk factors by expanding knowledge of service systems and connections to natural supports. <table border="1" data-bbox="670 310 1274 806"> <thead> <tr> <th>Services Provided</th> <th>N</th> <th>Percent</th> </tr> </thead> <tbody> <tr> <td>Assisted in obtaining services*</td> <td>568</td> <td>80%</td> </tr> <tr> <td>Systems navigation</td> <td>487</td> <td>69%</td> </tr> <tr> <td>Life skills</td> <td>466</td> <td>66%</td> </tr> <tr> <td>Gaining advocacy skills</td> <td>359</td> <td>51%</td> </tr> <tr> <td>Self care</td> <td>349</td> <td>49%</td> </tr> <tr> <td>Strengths assessment</td> <td>331</td> <td>47%</td> </tr> <tr> <td>Basic needs assistance</td> <td>197</td> <td>28%</td> </tr> <tr> <td>Identifying natural supports</td> <td>171</td> <td>24%</td> </tr> </tbody> </table>	Services Provided	N	Percent	Assisted in obtaining services*	568	80%	Systems navigation	487	69%	Life skills	466	66%	Gaining advocacy skills	359	51%	Self care	349	49%	Strengths assessment	331	47%	Basic needs assistance	197	28%	Identifying natural supports	171	24%
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<p>2a Caseload Reduction for Mental Health</p>	<ul style="list-style-type: none"> A study was conducted in 2012 to assess the impact of MIDD-funded staff increases on staff-to-client ratios. Data from five agencies showed that each staff member served 17 to 57 clients (depending on the agency), with the average being 40 clients per staff member. Highs and lows over a four-year period balanced out such that overall caseload size was reduced from 42 , on average, to 35 clients per direct services staff member; this represents a 17 percent reduction⁴⁹. 																											
<p>2b Employment Services for Individuals with Mental Illness and Chemical Dependency</p>	<ul style="list-style-type: none"> As reported in the Seventh Annual Report (February 2015), job placement outcomes were tracked for 885 people who had at least one supported employment service during the previous MIDD year, regardless of when they initially enrolled in the program. A total of 271 people (31%) had one or more job placements prior to October 2014; a job placement rate consistent with 2013 findings and up from 20 percent or less in prior MIDD years. Jobs were retained more than 90 days for 177 employed clients (65%), and one in four people retained their job for nine months or longer. 																											
<p>4d School Based Suicide Prevention</p>	<ul style="list-style-type: none"> Retrospective pre/post self-assessments given to a sample of 2,503 youth who attended suicide prevention training presentations in 2009 showed statistically significant increases in knowledge and/or awareness in the following content areas: <ul style="list-style-type: none"> · Teen Link (a teen crisis help line) · Coping mechanisms 																											

⁴⁹ In recent years, two key issues have impacted agency caseloads, despite the availability of MIDD monies to alleviate out-of-control growth: 1) the influx of newly eligible clients through the Affordable Care Act, and 2) the long-standing challenges of hiring and retaining qualified staff to provide care within the mental health system.

	<ul style="list-style-type: none"> · Warning signs for people who may be suicidal · How to help if someone seems suicidal. • For adults, 179 evaluations were analyzed and demonstrated the effectiveness of trainings in increasing knowledge about: <ul style="list-style-type: none"> · Rates and incidence of youth suicide · Signs of depression · Suicide warning signs · Resources and ways to help.
10a Crisis Intervention Training	<ul style="list-style-type: none"> • Since the first MIDD-funded Crisis Intervention Team (CIT) training was offered in October 2010, all CIT attendees have had the opportunity to evaluate their learning experiences through online surveys conducted upon course completion. • Two courses in the 40-hour training have been rated “excellent” by more than 75 percent of respondents since data collection began: Excited Delirium and Communicating with Persons with Mental Illness/De-Escalation Techniques.

As described above, evidence indicates that most of the strategies of MIDD I have played a role in advancing the five policy goals for MIDD as outlined by the King County Council. Because the aims of the policy goals are wide-ranging, the breadth and/or depth of impact varies by strategy depending on the particular strategy or service being considered. As noted previously in this report, statistical analysis of system use and symptom reduction indicates that the strength of associations between predictors and outcomes are sufficient to demonstrate the MIDD’s value.⁵⁰

Methodology for Determining Effectiveness: Strategies relevant to specific policy goals were determined to be effective (or not) by comparing incremental, cumulative, and ultimate reductions against established goals. Additionally,

- BHRD analysis of jail data indicated that jail use had decreased for all detainees.
- To incorporate decreases for the whole system into the targeted reduction goals, an additional 5 percent per year was added for adult jail use targets.
- Strategies that reduced jail days for adults by more than 70 percent by the fifth year after initiation of MIDD services were considered effective.
- For detained youth, reductions in days incarcerated needed to exceed 50 percent by the fifth year after initiation of MIDD services for the MIDD strategy to be considered effective.
- For psychiatric hospital use, original targeted reductions were based on admissions, but analysis of hospital days more fully captured effectiveness in this area.
- At present, sufficient data exists to assess effectiveness through the fifth year after beginning MIDD services for most strategies.
- Targeted reduction goals were not developed for symptom reduction due to the variability of symptoms and measurement tools.

⁵⁰ MIDD Second Annual Report

Expected outcomes represented in the targeted reduction goals were sometimes speculative. As a result, MIDD programs may not have been labeled “effective” even when making a sizeable difference in the areas targeted by the policy goals. Thus, the overarching outcomes described earlier in this section support the conclusion that MIDD was effective despite the fact that its aspirational reduction targets were not completely achieved. For example, total reduction of jail use for adults was set at 45 percent for five years after MIDD program participation. Because the overall adult jail population declined between 2008 and 2013, an additional five percent reduction per period was added to the original reduction goals. This led to a total cumulative jail use reduction goal of 70 percent.

Performance Measurements and Summary of Performance Outcomes

Establishing Targets: Performance targets were developed by county staff and others including stakeholders, providers, and subject matter experts, and created based on the MIDD strategy implementation plan for each MIDD strategy. Not surprisingly, as data has been gathered over time, it is evident that some of the performance measure may have been constructed with untested assumptions about program and staff capacity.

MIDD targets are considered met if 85 percent or more of the established target was achieved after adjustment.⁵¹ In addition, some strategies use blended funding from multiple sources which prevents the separation of people served by MIDD funds from those served by other funds. This, in turn, led to these strategies significantly exceeding the performance target (such as for 7b Expand Youth Crisis Services).

During the first seven years of the MIDD, 80 percent of annual performance targets were met, while 20 percent were not met. These overall performance results were fairly consistent over time, as shown below in Table 2. Each MIDD strategy has at least one performance measure target. Eight strategies have more than one target with one strategy having four targets.

Overall achievement of MIDD performance targets in each MIDD reporting year are in Table 2 based on the detailed data in Appendix L.

⁵¹ See Section Four for more information about adjustments.

Table 2

MIDD Strategies: Performance Target Rating	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	All Years
	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	
Met or Exceeded Target <i>85% or greater of target</i>	19 (70%)	27 (77%)	31 (79%)	38 (86%)	39 (89%)	36 (80%)	33 (73%)	223 (80%)
Did Not Meet Target <i>65-84% of target</i>	5 (19%)	4 (11%)	4 (10%)	3 (7%)	4 (9%)	7 (16%)	6 (13%)	33 (12%)
Considerably Below Target <i>Less than 65% of target</i>	3 (11%)	4 (11%)	4 (10%)	3 (7%)	1 (2%)	2 (4%)	6 (13%)	23 (8%)
Total Performance Targets⁵²	27	35	39	44	44	45	45	279

Performance targets evolved over the seven years of MIDD covered by this report due to changing conditions unique to the implementation of each strategy, including startup, staffing challenges, program adjustments, data-sharing feasibility, or other factors. Where targets differed in any given year from those posted in the “Original or Revised Target” column, an explanatory notation is provided in the far right column under “Target Adjustments and Notes.” These variations and adjustments are discussed in greater detail in Section V of this report. Specific performance measurements used over the life of all MIDD-funded strategies are shown in Appendix L.

Although most strategies substantively met their performance targets in most years, there was some variation, as noted in the chart in Appendix L. Where achievement was lower than 65 percent of the annual or adjusted target, the percentage is highlighted in red. Where achievement ranged from 65 to 85 percent of target, the percentage is highlighted in yellow. Because the MIDD evaluation treats completion of 85 percent of a performance measure as satisfactory accomplishment of the target, achievements in excess of 85 percent of the posted targets are unmarked. In all tables, FTE refers to full-time equivalent staffing. Additional information about the instances of underperformance highlighted in yellow and red in this chart is available, primarily in section 3 of this report.

Unmet Performance Measurement Targets

The previous section of this report provided an overview of the performance measurement targets and outcomes findings. As indicated, some MIDD funded strategies, programs and services did not provide

⁵² The number of performance targets increased over time as more MIDD strategies were implemented.

performance measurements on an annual basis or did not meet established performance measurement targets. Of the 33 implemented MIDD strategies, 6 (18 percent) had annual performance measurement targets that were unmet at least three times between 2008 and 2015. See Appendix M for details.

Why Targets Were Not Met: There are a number of reasons that strategies do not meet performance targets. **Some strategies have a different level of service than originally conceived in the Implementation Plan.** For example, Strategies 1f Parent Partners Family Assistance and 4c School Based Services both served more people in large groups, such as family events and school assemblies, rather than services to identified individuals. MIDD targets generally focus on identified service participants needed to match individuals with other data sets for MIDD policy goal analysis.

Strategies such as 4d Suicide Prevention Training, 8a Family Treatment Court, 9a Juvenile Drug Court, 10b Adult Crisis Diversion, 11b Mental Health Courts, 12d Behavior Modification Classes, and 16a New Housing and Rental Subsidies **experienced low referrals or low participation by those referred despite allowances for start-up time.** Outreach and other development activities were conducted to increase referrals and participation and were largely successful. For example, 9a Juvenile Drug Court staff began enhanced engagement efforts with potential participants early in the referral process to increase opt in rates.

Some strategies were found to have **unrealistic targets once implemented.** Similar to the challenges in determining target reduction goals, as described in Section V, performance targets were often not developed with complete information about eventual program capacity or comprehensive program service details that became known once the program was implemented. In these instances more appropriate targets were developed. This is applicable to Strategies 6a Wraparound, 10a Crisis Intervention Team Training, 11a Increase Jail Liaison Capacity, and 12a Jail Re-Entry and Education Classes.

Strategies 13a Domestic Violence Services and 14a Sexual Assault Services both experienced **funding cuts** early in their implementation, due to the Great Recession. This led to a corresponding decrease in service capacity, so performance targets were adjusted downward accordingly.

Some strategies' performance against established targets were **affected by unique situations.** Strategy 5a Juvenile Justice Assessments did not meet its initial target for Psychological Services, which were defined as testing and assessments conducted by the team psychologist. Evaluation staff worked with Superior Court and determined that the psychologist spent considerable time on consultations rather than testing. The definition of Psychological Services was expanded to include consultations based on client and program need. The Psychological Services target was met in subsequent years.

Strategy 1a-2 Substance Use Disorder (SUD) Treatment did not meet its adult outpatient treatment unit goal except in Year Two. For SUD treatment, federal and state funds are expended before MIDD funds, as MIDD funding is to be used only when other funds are not available (MIDD is "funder of last resort" for this strategy). The SUD treatment system has limited capacity which was maximized and did not allow for further use of MIDD-funded treatment services. State funds are not stable enough to allow the

treatment system to expand capacity. In one year underspent funds were redirected to the MIDD fund balance, and in subsequent years underspent funds were used to enhance treatment success with treatment support activities such as outreach and transportation.

In April 2015, Recovery Centers of King County (RCKC) unexpectedly ended its contract with King County and closed its operations. RCKC was the sole provider of County-funded detoxification services, and other options were rapidly developed to address the major loss of service. The County quickly contracted with Fairfax Hospital and Cascade Behavioral Health for temporary detoxification services. From April 2015 – November 2015 state and MIDD 1a-2 Substance Use Disorder (SUD) Treatment funds were used to provide the necessary detoxification services while a long-term solution was implemented. MIDD provided \$1.75 million in funding for detoxification services, which in turn impacted availability funds for other levels of service in Strategy 1a-2 Substance Use Disorder (SUD) Treatment. As a result, none of the 1a-2 Substance Use Disorder (SUD) Treatment performance targets were met during Year Seven. Detoxification targets were not developed due to the temporary nature of these services.

Strategy 1c Emergency Room Intervention for Substance Abuse did not meet its screening target in any year, but for four years, it did exceed its brief intervention target. Evaluation staff consulted with the programs and identified how a relatively small increase in screenings would improve performance on the target. The primary provider indicated that the additional capacity to meet the screening target did not exist since their program structure was designed to ensure that brief intervention services were provided at the level needed for the clients in the facility. A change to the screening target was not proposed because it was determined to be achievable with reasonable effort. In Year Seven the brief intervention target was not met due to agency staff providing training and technical support for the expansion of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to primary care clinics rather than providing direct services to clients.

Strategy 1d Crisis Next Day Appointments did not meet its performance target in Year Four and Year Seven. This strategy funds expanded services where the base programming is funded by the state. When state funding was cut for the base services from 2011-2014, the expanded services decreased accordingly. The state funding was restored in 2015.

Strategy 11a Increase Jail Liaison Capacity did not meet its performance targets during four years, including Year Five through Year Seven, for a variety of reasons. In addition to the initial projected target not being practical for the strategy, there were other situations impacting the performance such as difficulties filling staff vacancies, delays in staff clearance for the secure facility, and changes to the base program, including downsizing and eligibility modification, that changed the target population. Strategy 12a Jail Re-Entry and Education Classes did not meet its target in the first year of operations due to limited class capacity restricting the number of clients who could be served initially. Additional classes were added and the targets were consequently met after a start-up period.

Programs Not Included in MIDD Evaluation: While some MIDD-funded programs did not meet their performance targets, others were not included in the MIDD evaluation and as such had no performance targets, such as those programs that were supplanted to MIDD.

In addition to supplanted programs, some other MIDD-funded programs have not been included in the MIDD evaluation. Due to economic growth, the MIDD fund balance grew in 2015. The County used the unbudgeted MIDD sales tax revenue to provide one-time funding for programs and services that could have a significant impact in areas of greatest need. These programs and services were not included in the MIDD evaluation, and did not have established performance targets, due to their temporary nature.

Amended or Adjusted Performance Measurement Targets

Revisions to Targets: Performance targets were revised as strategy implementation plans were altered, budgets changed, and/or certain data elements were determined not to be feasible or relevant for the populations served by the strategies. As noted above, some targets were based on untested assumptions about program and staff capacity.

Revisions of the original performance measures for 23 strategies were completed in 2010. The revisions were included in the MIDD Year Two Progress Report which was electronically transmitted to the MIDD Oversight Committee and reviewed and approved at the August 26, 2010 MIDD Oversight Committee meeting.⁵³ See Table 3 for summary of the performance target changes made in 2010.

Table 3

Type of Change	Reason for Change	Strategies Impacted by Change													
Alter unit of measurement	Service units more accurate measure than clients per year	1a-2													
Remove detox measure	Detox may be a relevant treatment option for target population	1c													
Remove psychiatric hospital measure	Not a mental health strategy or not a relevant measure for target population	1a-2	1c	1g	4c										
Remove jail measure	Not a relevant measure for target population	1h													
Remove ER measure	Not a relevant measure for target population	4c													
Remove public assistance measure	Individual level data unavailable	2b													
Remove hospitalization costs measure	Individual level data unavailable	12b													
Remove housing measure	Not directly related to strategy objectives	2b	11a	12a											
Remove outcomes directly linked to individuals	Infrastructure strategy or not directly attributable to individuals	1e	2a	4d	10a										
Replace "self-report" with actual measures	Better measurement options available	1g													
Replace vague measures with more concrete deliverables	Measures impractical or could not be standardized across MIDD strategies	4a	4b	4d	5a	6a	7a	8a	9a	13a	13b	14a			

Adjustments or amendments to MIDD strategies post 2012 have typically been made collaboratively with BHRD program and evaluation staff and most strategy stakeholders (providers). For example, whenever data indicated a strategy was meeting less than 85 percent of performance targets, county staff followed up with the strategy stakeholder to understand why and to provide explanation during the reporting process. If the reason for not meeting the performance target was attributable to the target being inappropriate or unreasonable for a known reason – and not a program or implementation issue – a recommendation for a change in the target was developed and included in the subsequent MIDD progress report. The MIDD OC reviews and approves the recommendations when they accept the report. An amended target is adopted after the Council accepts the report.

Types of Revisions: MIDD strategies 1a-2 Substance Use Disorder (SUD) Treatment, 1c Emergency Room Intervention for Substance Abuse, 4d Suicide Prevention Training, 5a Juvenile Justice Assessments, and 6a Wraparound had performance targets changed to different types of measures that were more appropriately matched to the services being provided. For example, Strategy 1a-2 Substance Use Disorder (SUD) Treatment target was revised from unduplicated people served to units of service since

⁵³ See Section Five for more information on MIDD OC Review of Strategy Revisions

providers are reimbursed for each service and a person may receive multiple services. The intent of the adjustment was to fully capture what services are being provided to participants.

When targets were not being met for other strategies, 10a Crisis Intervention Team Training, 10b Adult Crisis Diversion, 11a Increase Jail Liaison Capacity, 12a Jail Re-Entry and Education Classes, and 15a Adult Drug Court, implementation and program reviews concluded that the original targets were too high or could not be met based on program capacity. In these cases, targets were changed to match staffing realities or other factors that were influencing the number of service units that could be delivered or the number of people who could be served.

In other cases, performance targets were amended when programs were enhanced or redesigned. Strategies 1e Chemical Dependency Trainings, 1f Parent Partners Family Assistance, 5a Juvenile Justice Assessments, 9a Juvenile Drug Court, 11b Mental Health Courts and 15a Adult Drug Court expanded their program in some manner or had changes to the implementation plan.

Of the 37 original MIDD strategies, 19 (51%) had performance measurement targets amended between 2008 and 2015. Of the remaining strategies, three were not implemented, two secured other non-MIDD funding, and 13 kept their initial targets for the duration. Strategy 11b – Mental Health Courts had targets amended three times, while Strategy 10a – Crisis Intervention Team Training and Strategy 5a – Juvenile Justice Assessments each had targets amended twice. All other strategies were changed only once during the first seven years of the MIDD.

The table below shows changes made to unadjusted targets by strategy. In the “Result of Change” column, a target was considered met if it achieved 85 percent or more of its new goal when adjusted. FTE indicates full time equivalent staffing. Note that original targets were often based on incomplete information prior to implementation of programs and changes to early targets based on actual service delivery were not unexpected. See details amended targets in Table 4.

Table 4

Strategy		Date	Old Annual Target(s)	New Annual Target(s)	Reason	Result of Change
1a-2	Substance Use Disorder (SUD) Treatment	4/29/2010	400 outpatient (OP) clients 461 opiate (OTP) clients	50,000 adult OP units 4,000 youth OP units 70,000 OTP units	Units purchased more accurate measure than clients served	Adult OP targets not met as other funds were used
1c	Emergency Room Intervention	7/1/2011	7,680 clients	6,400 screens and 4,340 brief interventions with 8 FTE	Service type was better measure	Screening targets never met
1e	Chemical Dependency Trainings	5/25/2012	125 reimbursed trainees	125 reimbursed trainees 250 workforce development trainees	Expanded in Year 4	Targets always met
1f	Parent Partners Family Assistance	5/1/2013	4,000 clients	400 families (individual data) 1,000 clients in groups (summary data)	New program design	Too soon to assess (Began Year 6)
3a	Supportive Housing	2/14/2012	N/A	Targets adjust to new capacity each year	Beds increase annually	Targets always met
4d	Suicide Prevention Training	5/3/2010	12 presentations for 200 adults	40 presentations for 1,500 adults	New targets based on Year 1 results	Target met in 2 of 6 years
5a	Juvenile Justice	7/1/2011	1,230 youth	500 assessment coordinations	Service type was better measure	Only one target (psychological)

	Assessments			200 psychological services 140 mental health & 165 full SUD assessments		services) not met in 2 of 5 years
5a	Juvenile Justice Assessments	4/29/2014	500 coordinations	1,200 coordinations	Added short screener assessments	Too soon to assess (New target Year 6)
6a	Wraparound	5/25/2012	920 youth (including siblings)	450 enrolled youth only	Unable to track siblings	Target always met
8a	Family Treatment Court	8/1/2011	45 additional children	No more than 90 children	Cap imposed per FTC proviso	Cap not exceeded in calendar year
9a	Juvenile Drug Court	5/1/2013	36 new youth with 5.5 FTE	36 new youth including pre opt-ins	Program redesign	Target met with increased counts
10a	Crisis Intervention Team Training	7/12/2010	40-hour: 480 trainees One-day: 1,200 trainees	40-hour: 375 trainees One-day: 1,000 trainees	Old target too high	New targets still high for capacity
10a	Crisis Intervention Team Training	2/14/2012	40-hour:375 trainees One-day:1,000 trainees	40-hour: 180 trainees One-day: 300 trainees Other: 150 trainees	Matched targets to actual capacity	Targets always met
10b	Adult Crisis Diversion	7/9/2010	3,600 clients	3,000 clients	Old target too high	Target met in 1 of 3 years
11a	Increase Jail Liaison Capacity	5/5/2010	360 additional clients	200 additional clients	Old target too high	Target met for 3 consecutive years
11b	Mental Health Courts	7/12/2010	250 Regional clients over current 300	115 Regional clients over current 200 (Note: Actually two-year period)	Old target too high	Target met in 1 of 4 years
11b	Mental Health Courts	6/10/2013	Seattle Muni Court 50 clients (not competent for trial)	Seattle Muni Court 300 clients (competent or not)	Expanded competency status inclusion	Targets always met
11b	Mental Health Courts	3/11/2014	Regional Court 57 clients	Regional Court 28 expansion opt-ins & 83 non-expansion cases	Probation staff position not filled	Targets met in Year 6
12a	Jail Re-Entry & Education Classes	7/21/2010	1,440 additional clients 480 for re-entry 960 for education	300 re-entry clients with 3 FTE 600 education clients (Duplicated OK)	Old target too high	Targets not always met
13a	Domestic Violence Services	2/14/2012	700-800 clients	560-640 clients	Funding cut (19%)	Target always met
14a	Sexual Assault Services	7/1/2011	400 clients	170 clients	Funding cut (20%)	Target always met with blended funds
15a	Adult Drug Court	7/9/2010	450 clients, then 300	250 clients	Old target too high	Target always met
16a	New Housing & Rental Subsidies	5/1/2013	25 tenants; 50, then 40 rental subsidies	25 tenants 25 rental subsidies	Fewer available subsidies	Targets always met

Excluding the first year, when targets for all implemented strategies were adjusted to account for the number of months each strategy was able to provide data, other strategies were adjusted for a variety of reasons in subsequent years. Of the 45 performance targets measured consistently between program

implementation and 2015, 19 (42%) were adjusted at least once. The table below provides the primary reasons for adjusting targets and the MIDD years in which each strategy was impacted by the adjustment. Note that some MIDD strategies have more than one performance measurement target.

Table 5

Fewer FTE/Programs Funded Than Planned	Allowance Made for Startup	Unable to Fill Staff Vacancies
1c – Emergency Room Intervention (Years 1 to 6) 1d – Crisis Next Day Appointments (Years 3 to 6) 1g – Older Adults Prevention (Years 1 to 7) 1h – Older Adults Crisis & Service Linkage (Years 3 to 7) 2b – Employment Services (Years 1 to 7) 4c – School-Based Services (Years 3 to 7) 9a – Juvenile Drug Court (Year 2) 12a-1 – Jail Re-Entry (Year 2 and 3)	1f – Parent Partners Family Assistance (Year 6) 5a – Juvenile Justice Assessments (Year 2) 10b – Adult Crisis Diversion (Year 4) 11b – Mental Health Courts (Year 2) 12b – Hospital Re-Entry Respite Beds (Year 3)	5a – Juvenile Justice Assessments (Year 3 and 6) 6a – Wraparound (Year 3) 11a – Increase Jail Liaison Capacity (Year 5 and 6) 11b – Mental Health Courts (Year 4)

In one instance, Strategy 1f Parent Partners was completely redesigned from its initial plan in order to fulfill its intended goals of providing support to families in the behavioral health system. Family, youth and system partner roundtables were held to gather information and input regarding the opportunities and challenges to the successful support of families. Inputs from the meetings and best practices research were used in the redesign. It was determined that a Family Support Organization⁵⁴ could most effectively meet community and family needs. The redesign created a centralized hub for family support technical assistance, groups and other activities, which in turn led to a considerable revision of the performance target for this strategy. Along with measuring the number of individual people, targets were set around numbers of families and group attendees.

Funding cuts impacted performance targets for certain strategies. When MIDD’s overall revenue decreased due to the Great Recession, strategies 13a Domestic Violence Services and 14a Sexual Assault Services received reductions in MIDD funding, which were accompanied by commensurate target revisions along with the initial adjustments described in Section Three. Strategies 11b Mental Health Courts and 15a Adult Drug Court experienced cuts in probation staff and services respectively, which impacted capacity and led to decreases in the targets.

Distinct performance targets are used for some strategies based on implementation or program design. The target for Strategy 3a Supportive Housing climbed each year as five-year grants were awarded to pay for supportive services at new or existing housing that was developed or set aside for those with

⁵⁴ A family-run support organization is an organization directed and staffed by family members who have personal life experience parenting a child with a serious emotional or behavioral disturbance and/or a substance use disorder. 1057-10_ad1.pdf (1f Request for Proposal Addendum 1)

special needs. As more grants were awarded, the target rose accordingly. Capacity did not grow in Year Seven as funding was ending for some existing programs they received funding in the next set of awards.. Fifteen rental subsidies ended in November 2012 for Strategy 16a New Housing and Rental Subsidies when a facility closed. As a result of the facility closing, the performance target for 16a was decreased. A 2011 budget proviso⁵⁵ for Strategy 8a Family Treatment Court led to its performance targets having a maximum by serving no more than 90 children per year and 60 children at one time. In Year Seven, this performance target was 120 children per year due to changes in funding of staff positions.

The original MIDD implementation plan expanded services of the County's therapeutic courts under Strategies 8a - Family Treatment Court, 9a Juvenile Drug Court, 11b Mental Health Courts and 15a Adult Drug Court. Beginning in 2010, King County began using MIDD funds for the "base" therapeutic courts costs due to a change to RCW 82.14.460 which allowed for partial supplantation as described earlier in Section Three. In 2011, RCW 82.14.460 was further amended to exempt therapeutic courts from the supplantation limitation, enabling the full cost of the therapeutic courts to be supported by MIDD funds, replacing declining General Fund support.

Due to the design of 8a Family Treatment Court and 9a Juvenile Drug Court MIDD expansions, which affecting all court participants, these strategies report on all of the people served in the courts. Alternatively, Strategies 11b Mental Health Courts and 15a Adult Drug Court reported only on people served by the MIDD expansion services which did not encompass everyone in the therapeutic courts. Strategy 11b Mental Health Courts began submitting the additional data on base participants in October 2013. Strategy 15a Adult Drug Court began submitting the reporting information for all court participants in January 2015. Performance targets were adjusted for 11b Mental Health Courts and 15a Adult Drug Court when the base court participants were added to the MIDD evaluation.

Many strategies' performance targets are based on the premise that programs had certain levels of staffing. Staffing levels were described as Full-Time Equivalents (FTE)⁵⁶ in the Implementation Plan. As noted in the Section III, there is a significant workforce issue, as nationally⁵⁷ and locally, the behavioral health system has a shortage of skilled workers, an aging workforce, and inadequate compensation, which together make it difficult for community agencies to hire and retain qualified staff.⁵⁸ When positions in MIDD programs are unfilled, temporary adjustments were made to prorate targets based on which positions were unfilled and the amount of time in the reporting period the position remained open. Meanwhile, BHRD staff work with provider agencies to support recruitment and explore options for backfilling positions to maintain continuity of MIDD services, although this is not always possible.

Adjustments were also commonly made to performance targets at startup. Strategies typically require

⁵⁵ Ordinance 16984, Section 69, Proviso PI

⁵⁶ An FTE is the hours worked by one employee on a full-time basis. <http://www.accountingtools.com/questions-and-answers/how-to-calculate-ftes.html>

⁵⁷ Source: <http://store.samhsa.gov/>; Search on: PEP13-RTC-BHWORK

⁵⁸ MIDD Seventh Annual Report

http://www.kingcounty.gov/~media/health/MHSA/MIDD_ActionPlan/Reports/150616_MIDD_Seventh_Annual_Report.ashx?l a=en

time to develop referrals or capacity when they are just beginning. Strategies 1f Parent Partners Family Assistance, 5a Juvenile Justice Assessments, 10b Adult Crisis Diversion, 11b Mental Health Courts, and 12b Hospital Re-Entry Respite Beds had their targets adjusted for a period of time after they were launched.

The practice of adjusting and amending targets were one way that the evaluation team modified the evaluation plan to be linked with the program developments in the MIDD strategies. Another means to ensure the evaluation stayed connected with long-term program changes was through inclusion of strategy revisions as described in the next section.

Results of Changed Targets: Of a total of 33 MIDD strategies and sub-strategies implemented over the life of the MIDD, 20 strategies (61 percent) adjusted or amended performance targets (excluding startup allowances). Of the 20 strategies that had performance targets changed, 70 percent consistently met subsequent revised targets. Of the six strategies that did not consistently meet changed performance targets, three strategies (1a2 Substance Use Disorder (SUD) Treatment, 1d Crisis Next Day Appointments, and 11a Increase Jail Liaison Capacity) experienced significant systemic instabilities to the core programs on which the MIDD expansion was based. See Appendix L and Table 4 for more details on performance target results and amendments.

Strategy Revisions

As anticipated, many MIDD strategies have been revised over time. It was intended that the MIDD strategies would evolve to meet the changing needs of participants, the service system, the county and its residents. When the MIDD Implementation Plan was created, several strategies were identified as needing further development:

- 1b Outreach & Engagement
- 1d Crisis Next Day Appointments
- 4c School-Based Services
- 11b Mental Health Courts
- 12c Psychiatric Emergency Services Linkage.

Other strategies were determined at a later date to need revisions:

- 1a1 Mental Health Treatment
- 1a2 Substance Use Disorder (SUD) Treatment
- 1c Emergency Room Intervention
- 1e Chemical Dependency Trainings
- 1f Parent Partners Family Assistance
- 1g Older Adults Prevention
- 2b Employment Services
- 8a Family Treatment Court (FTC)
- 9a Juvenile Drug Court
- 10a Crisis Intervention Team Training
- 10b Adult Crisis Diversion
- 11a Increase Jail Liaison Capacity

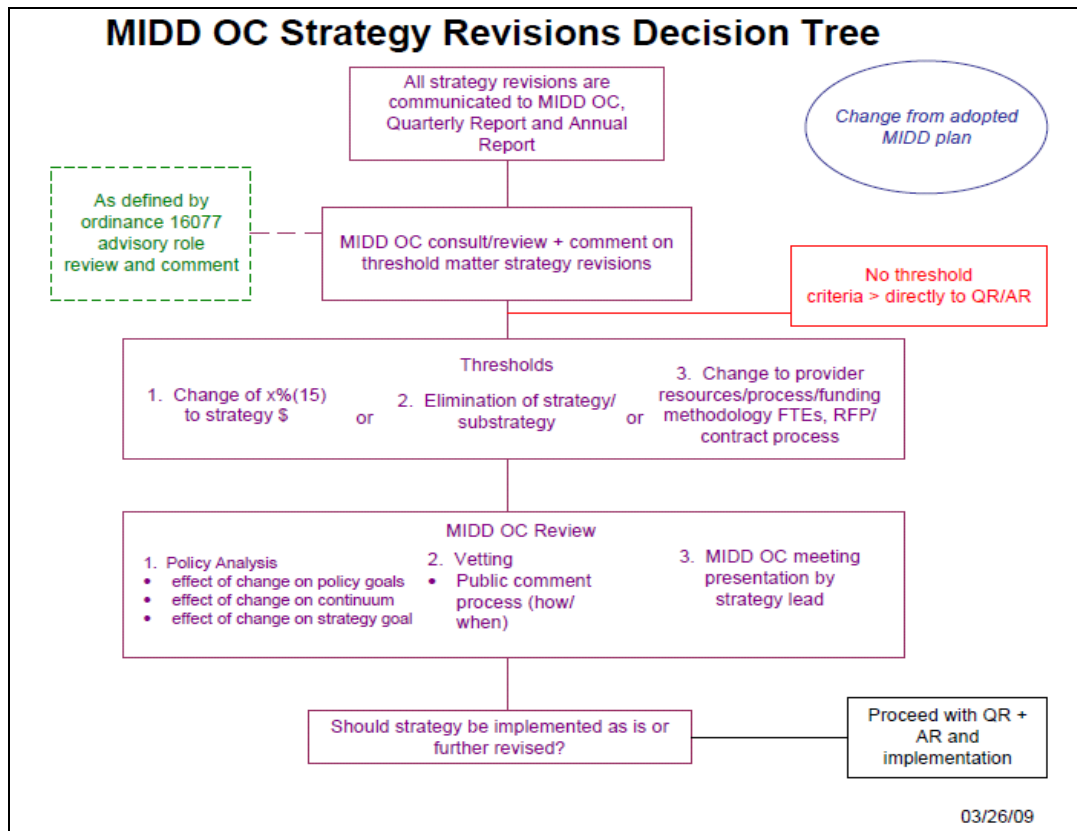
- 12d Behavior Modification Classes
- 15a Adult Drug Court
- 16a New Housing and Rental Subsidies

See Appendix N for a detailed list of basis of the strategy revisions.

Due to a number of factors, such as the design of the evaluation, infrequent reports, and combined reporting of programs in a single strategy⁵⁹, evaluation data was difficult to use for quality assurance processes. Consequently, there were no strategy revisions based on performance measurement data, though technical assistance was provided and program adjustments were made using this information. For example, intensified education and outreach with first responders was conducted to increase referrals to 10b Adult Crisis Diversion.

MIDD Oversight Committee Review of Strategy Revisions: The MIDD Oversight Committee endorsed an approach for the review of strategy revisions. The decision tree, shown below in Table 6 outlined how strategy revisions would be reviewed and communicated. Identified thresholds specify when a revision/decision is to be presented to the OC for review. An analysis of the effects of the proposed change is to be provided at an OC meeting, allowing for public comment, to determine if advancing, eliminating or further revising a strategy is needed.

Table 6



⁵⁹ For example, Strategy 4c School-Based Services has 10 providers but the strategy is reported on collectively. One provider may be high on the performance target while another may be much lower but this cannot be determined from the reported evaluation data.

As expected the MIDD Plan allowed and encouraged flexibility to grow as time passed and the environment evolved. The ability to update strategies as needed allowed for a more meaningful interaction between the evaluation results and program implementation than a more fixed plan would have permitted.

VI. Recommended Revisions to Policy Goals

The King County Council established the MIDD policy goals via Ordinance 15949, creating a policy framework whereby the public and policymakers could see the return on the investment of MIDD. As stated in the Ordinance, “It is the policy of the county that citizens and policy makers be able to measure the effectiveness of the investment of these public funds.”⁶⁰ The Council further stated its intent that the MIDD programs were to be designed to achieve the five policy goals. Consequently, the five policy goals have shaped not only the programs and services, but also provide the foundation for the evaluation and reporting of MIDD, including assessment of strategy effectiveness. Maintaining policy goals as overarching guidance to the work of MIDD is necessary, as is refining them for the current environment.

Proposed Policy Goal Modifications

Ordinance 17998 requires this report to include “proposed modifications to the MIDD policy goals outlined in Ordinance 15949 and the basis of the proposed modifications.”⁶¹ In response to this requirement, the county staff and the MIDD Oversight Committee’s Renewal Strategy Team worked to refine the policy goals in order to:

- Strengthen and clarify the county’s intent to demonstrate a return on the investment of MIDD funds;
- Eliminate duplicative goals;
- Reflect intended core outcomes as reflected in the MIDD II Framework that has been guiding MIDD renewal work since early 2015; and
- Reflect feedback from an array of stakeholders gathered during the course of MIDD renewal outreach and engagement.

The policy goal revisions described later in this section were reviewed by the MIDD Oversight Committee at its April 2016 meeting. Although discussions about policy goal amendments occurred concurrently with decision-making around MIDD II programs and strategies, a robust MIDD Framework and guiding principles were already in place to inform both funding recommendations and policy goal recommendations in a coordinated way prior to the discussion at the April MIDD Oversight Committee meeting.

MIDD II Framework: The MIDD II Framework is an accountability framework that is driven by the result stakeholders want to see in the community, the indicators that the county will use to signal that it’s headed down the right path to get there, and the actions MIDD & its partners will take to create the change stakeholders want to see. To develop this framework, DCHS drew upon the principles of results-based accountability practices.

The MIDD II Framework identifies and organizes the central components of MIDD II. It identifies the

⁶⁰ Ordinance 15949 lines 80-82

⁶¹ Ordinance 17998 lines 103-104

MIDD II approach at four different levels:

- 1) what will happen as a result of MIDD services;
- 2) the theory of change driving the result of MIDD;
- 3) key strategies and outcomes intended to achieve MIDD’s II result; and
- 4) sample performance measures used to demonstrate progress toward outcomes.

As discussed in the MIDD Renewal Progress Report that was submitted to the Council in November 2015, King County BHRD, in consultation with the MIDD Oversight Committee, developed the MIDD II Framework as a tool to succinctly summarize the MIDD II approach, activities, policies and outcomes. Since the Progress Report was transmitted, updates to the MIDD II Framework have been made based on stakeholder input and further clarifying the intent of sections that address potential performance measures.

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

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

A major component of the MIDD II Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area.

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

Each of the framework’s four strategy areas includes sample performance measures for individuals along with outcomes and indicators for the wider population. They are noted as “sample” because they represent examples of the types of information to be sought in evaluation of MIDD II strategy areas and

programming. Indicators reflected in the framework are expected to change over time based on final MIDD II programming decisions and community and stakeholder feedback.

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

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

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

Recommended Policy Goal 2 addresses the emergency medical system use aim of the 2007 policy goal 1 by addressing reduction of behavioral health crises. It further recognizes that return on investment in this area can be achieved either by reducing how often people are in crisis, or helping people in crisis stabilize more quickly.

Recommended Policy Goal 3 targets a common and significant theme from MIDD’s community

outreach efforts around improving and supporting culturally appropriate services. It further reflects recent years' advancements in recovery-oriented approaches to care, and actively supports King County's equity and social justice aims.

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

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

This report recognizes a key driver for recommending amendments to the MIDD policy goals: **MIDD programs and services alone cannot achieve the policy goals.**

- For example, simple changes to policing practices or prosecution policies can greatly impact the number of people who enter the criminal justice system. MIDD data after such a shift could suggest that MIDD services were either more or less successful in reducing the number of people who returned to jail, irrespective of the individuals' behavioral health conditions, when the larger driver may actually have been the criminal justice policy change.
- Likewise, shifts in federal or state funding or policies for behavioral health services impact the amount, availability, and/or quality of behavioral health services, which in turn influences the incidence and severity of behavioral health conditions. For example, many MIDD services provide enhancements to underlying services provided via federal or state funding, or are designed to address gaps between such services. When core state or federal services are reduced, or more rarely expanded, this is likely to affect the apparent effectiveness and/or relevance of the MIDD-funded service.
- Finally, macroeconomic factors including access to employment and affordable housing – both of which are well beyond MIDD's capacity to impact in a substantive way – have a major effect on recovery outcomes.

In light of these factors, the recommended policy goal revisions highlight clearly the fundamental intentions of MIDD while at the same time recognizing its limitations. These proposed revised MIDD policy goals focus primarily on **expected results for MIDD program participants and improvements in access to services**, rather than suggesting that a modest 0.1% sales tax on its own can achieve broad-scale population-level reductions.

In summary, if adopted, the revised policy goals will **drive outcomes in a way that demonstrates impact for the people MIDD touches.**

VII. Recommended Revisions to MIDD Evaluation, Performance Measures, and Data Gathering

The potential renewal of MIDD provides a tremendous opportunity for the county and stakeholders to examine MIDD and the MIDD evaluation, particularly in the context of the evolution of behavioral health services and King County’s commitment to meaningful community engagement.

Conducting the review and assessment of the evaluation highlighted the strengths of MIDD on which to build MIDD II, along with identifying its limitations so that a path to overcome challenges can be charted. This section of the report offers recommendations for improvements in evaluation, performance measurement, and data gathering should the sales tax be renewed.

PSB MIDD Evaluation Assessment Report: The assessment of the MIDD evaluations found that **there are many strengths to build upon for MIDD evaluations**, stating, “The(se) evaluations provided information for stakeholders and the community to understand how MIDD funding was spent and the progress made toward the targets and goals identified in the MIDD Evaluation Plan.” (pg. 26) Framing the recommendations, PSB states,

When reading this report, it is important to keep in mind that the assessment compares MIDD evaluations conducted between 2008 and 2015 to (1) the MIDD Evaluation Plan adopted by the King County Council in 2008; (2) current expectations of stakeholders, which may not have been the same in 2008; and (3) to current practices in behavioral health care evaluation, which is a continually evolving field. Therefore, in some cases the findings reflect gaps between the original evaluation plan and its implementation, but other times they reflect how expectations and practices have changed over time. All findings are important learnings that roll into actionable recommendations that can inform the design of the evaluation of a potential MIDD renewal. (pg. 2)

Recommendations

Recommendations in this section were informed by provider and stakeholder feedback, internal assessment, and the MIDD evaluation assessment conducted by the King County Office of Performance, Strategy, and Budget (PSB). They reflect best and promising practices and King County’s focus on stakeholder involvement. Recommendations address the “what” of MIDD evaluations (what is evaluated) and the “how” of MIDD evaluations (processes).

I. Update and Revise the Evaluation Framework

- a. Revise or establish relevant output and outcome measures (see section II below).
- b. Involve stakeholders in developing the evaluation framework.
- c. Clarify and communicate the purpose of the evaluation and logic of the evaluation framework.

II. Revise Performance Measures, Targets and Outcomes

- a. When possible, select valid, reliable, and sensitive outcome measures.
- b. Adjust performance targets only when clear evidence exists that the original target was an over- or underestimation of feasible service delivery given available resources.
- c. Outcome targets should be based on evidence that supports the expected results.
- d. Focus on using clinically and practically meaningful changes in outcomes.
- e. The basis for modifying a target, rather than working to improve performance, should be clearly documented when target modifications are requested.

III. Upgrade Data Collection and Infrastructure

- a. Invest in data collection infrastructure.
- b. Create an online dashboard of selected performance indicators to be updated quarterly.
- c. Incorporate client surveys to gather more evaluative feedback from the client perspective on subjects such as service satisfaction and key indicators such as improved quality of life.
- d. Seek opportunities for better data sharing, involving more and more reliable data sources, to improve the speed and efficiency of data gathering and analysis.
- e. Consider a web-based data submission approach.

IV. Enhance Reporting and Improve Processes

- a. Align the MIDD program year with the calendar year, rather than October through September.⁶²
- b. Replace semi-annual progress reports with digitally available dashboard data.
- c. Increase the frequency of performance evaluation availability.
- d. Establish guidelines for report creators and editors on the scope of their decision making.
- e. Continue to avoid presenting non-causal results in ways that imply causality.
- f. Continue to produce one annual report that includes both performance measurement and outcome evaluation.
- g. Enhance the quality and frequency of communication regarding evaluation data and reporting, updating the MIDD Oversight Committee and others on substantive findings.
- h. Develop and deploy a continuous quality improvement process for MIDD programs and services based in part in evaluation.
- i. To the extent possible, align MIDD evaluation approach with Best Starts for Kids initiative evaluation approach to ensure consistency.

These recommendations chart a path to enhance the MIDD evaluation approach and provide clearer data and findings to the public and policy makers. The recommendations work together to position a potential MIDD II to better demonstrate return on investment.

⁶² The move to a calendar year evaluation could be achieved by extending the evaluation and ALL report due dates for MIDD I Year 8 by three months, thereby including 15 months of data on a one-time basis.

VIII. Conclusion

This report fulfills the requirements of Ordinance 17998 for a comprehensive historical retrospective report on MIDD I. County staff, in partnership with the MIDD Oversight Committee, accomplished the assessment and analysis called for by through broad and specific community and stakeholder activities, extensive data gathering and analysis.

The public and policymakers need to understand the impact of MIDD's investments, both financially and in human terms. While the evaluation approach of the current MIDD has responded to better understand impact, the county has the opportunity to revise and improve the evaluation of MIDD, including enhancing how it reports on the significant amount of data that it has collected about MIDD.

It is the intent of the Department of Community and Human Services to implement as many of these recommendations as possible, in collaboration with providers, stakeholders, and the MIDD Oversight Committee. The recommendations range from low cost and easily executed, such as "align evaluation reporting period to calendar year" to those that may involve additional resources and be more complex to enact, such as developing a digital dashboard. Many of the recommendations require retooling internal processes and will necessarily lead to changes in data collection approaches, reporting, and timelines.

Fulfilling these recommendations will require MIDD resources and willingness to embark upon change. All MIDD stakeholders, internal and external to King County, including policymakers, providers, separately elected officials, and jurisdictional partners are impacted by these recommendations, and as such their support and participation is critical for the ongoing success of MIDD and MIDD evaluations. For example, continuous quality improvement activities promote accountability and service quality and can lead to strategy revisions that stakeholders are unwilling or unable to make. Scoping expectations about changes expected and changes made based on data and evaluation is a critical component of understanding the role of MIDD evaluations.

MIDD-supported programs have resulted in reduced jail bookings and shorter hospital stays. However, individuals with mental health and substance use conditions continue to end up in jails and emergency services because other options are not available – to them or to first responders who come into contact with them – during times of crisis. Individuals with behavioral health conditions are often also impacted by homelessness, receive uncoordinated and fragmented services, and experience other significant barriers to getting the resources and supports needed in order to thrive in the community. Behavioral health conditions are further exacerbated by lack of diverse culturally and linguistically competent services available in the community.

In keeping with the county's transparency in MIDD, DCHS is committed to involving its provider partners in the retooling of MIDD's Evaluation Plan. All revisions, however, require time to thoughtfully implement and avoid unintended consequences. Should the King County Council call for an Evaluation

Plan for MIDD II as it did for MIDD I, the Evaluation Plan deliverable timelines must take into consideration the need to involve stakeholders and providers in the development of the Evaluation Plan, as recommended.

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

IX. Appendices
