Attachment A

Mental Illness and Drug Dependency

Ninth Annual Report

Implementation and Evaluation Summary for Year Eight
October 1, 2015—September 30, 2016

King County

Mental Illness and Drug Dependency Advisory Committee

February 2017

King County Department of Community and Human Services

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Behavioral Health and Recovery Division (BHRD)

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Ninth Annual Report

October 1, 2015—September 30, 2016

Cover photo features Larry, a successful client enrolled in
MIDD Strategy 2b - Employment Services
(See his story on Page 8)

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

www.kingcounty.gov/midd

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

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What is MIDD?

King County's Mental Illness and Drug Dependency (MIDD) is a countywide sales tax generating revenue that supports mental health and substance abuse services and programs across King County. In 2015-2016, MIDD revenues were nearly $120 million.

As required by state legislation (Revised Code of Washington 82.14.460), revenue raised under the MIDD is to be used for certain behavioral health services, including King County's therapeutic courts. King County's MIDD was passed by the Metropolitan King County Council in 2007, and MIDD-funded services began in 2008. King County's MIDD was extended to 2025 on Aug. 22, 2016, via Ordinance 18333. King County is one of 23 counties in Washington state that has authorized the tax revenue.

What's Next for MIDD?

King County's 2007 legislation that authorized the sales tax included a sunset provision, ending MIDD collections on Jan. 1, 2017 unless extended by the King County Council. After nearly two years of robust, thoughtful, and inclusive work by the MIDD Advisory Committee and King County staff, the MIDD sales tax was extended to 2025. The Executive transmitted a required[1] MIDD Service Improvement Plan (SIP) to the Council in August 2016. The SIP included recommendations on services, programs, and funding levels and recommendations on the composition of the MIDD Advisory Committee. Amended and passed by the Council on Nov. 14, 2016, the MIDD SIP provides guidance on the investment of the MIDD funds.

The SIP outlined next steps to be worked on throughout early 2017 by Executive staff, including a revised MIDD evaluation plan and an updated MIDD implementation report. As directed by Ordinance 18407, the revised evaluation plan and implementation report are due to the Council on Aug. 3, 2017. One of the key items for MIDD in 2017-2018 is the revision of the MIDD evaluation reporting period to correspond to the calendar year. August 2018 will see the first annual report for MIDD developed under the forthcoming revised MIDD evaluation plan.

One significant change anticipated for MIDD is changing of the name from "MIDD" to something based in recovery and wellness. Through the course of MIDD 1 review and MIDD 2 planning, the county received feedback that the name of the MIDD - the Mental Illness and Drug Dependency sales tax and programs - is outdated, negative, disrespectful and stigmatizing. In essence, the name of the MIDD is not itself recovery based and may be counterproductive to wellness.

You can track progress of MIDD work on the MIDD website: www.kingcounty.gov/midd.

[1] Required by Ordinance 17998

The Evolving Behavioral Health World

Medicaid Expansion: One of the main goals of the Affordable Care Act (ACA) is to increase access to health care coverage for individuals. As a Medicaid expansion state, more individuals than ever are covered by Medicaid in Washington and in King County, allowing them to access and receive Medicaid-covered physical, mental health and substance use disorder services. As such, Medicaid can now pay for more traditional outpatient and inpatient mental health and substance use disorder treatment services for a larger number of covered children, youth and adults. The increase in Medicaid-eligible individuals and subsequent increase in Medicaid funding, allows King County to continue to direct MIDD funding toward services that are not covered by Medicaid and/or individuals who remain uninsured to help build a robust continuum of care.

Behavioral Health Integration: A second goal of the ACA is to achieve the "Triple Aim" - improved care, improved outcomes and reduced overall costs in healthcare services. One significant strategy to achieve this goal is through the integration of physical and behavioral healthcare. In 2014, Washington State legislature passed ESSB 6312 calling for the integrated purchasing of mental health and substance use treatment services (collectively behavioral health) for the Medicaid program through a single managed care contract by Apr. 1, 2016. The previous, siloed system of Regional Support Networks (RSNs) and County Chemical Dependency Coordinators went away and were replaced by Behavioral Health Organizations (BHOs). BHOs are local entities at full risk and responsibility for providing the continuum of Medicaid funded inpatient and outpatient behavioral health services. On Apr. 1, 2016, King County, through the Behavioral Health and Recovery Division (BHRD), became the BHO for the region. Today, BHRD is able to braid together multiple funding sources including Medicaid, state general fund, mental health and substance use disorder block grant and MIDD dollars to ensure a comprehensive continuum of behavioral health services are available to clients in need.

MIDD Reporting Requirements

This is the Ninth Annual MIDD Report covering the time period of Oct. 1, 2015, through Sept. 30, 2016.

Through MIDD legislation (Ordinances 15949 and 16262), King County policymakers established the timeline and requirement to report on MIDD's services and programs. This legislation set forth MIDD's Policy Goals, along with key components to be included in every MIDD annual report:

a) A summary of semi-annual report data

b) Updated performance measure targets for the following year of the programs

c) Recommendations on program and/or process changes to funded programs based on the measurement and evaluation data

d) Recommended revisions to the evaluation plan and processes

e) Recommended performance measures and performance measurement targets for each mental illness and drug dependency strategy, as well as any new strategies that are established.

The five adopted MIDD Policy Goals* (applicable through Dec. 31, 2016) were:

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

** Edited from Ordinance 15949*

As required, the annual MIDD reports are reviewed by the MIDD Advisory Committee[1] and transmitted by the County Executive to the Council for acknowledgement by motion. MIDD progress reports were also compiled, reviewed and transmitted for the Council's review.

Six Ways MIDD Has Made a Difference in King County

Data gathered and analyzed over the course of the MIDD has demonstrated the following key impacts:

1) New Programs - Through the MIDD, new programs were created in response to unmet community need and now provide important services to residents that did not exist before 2008. Examples of new programs include peer support for youth and families, youth assessments, medical respite, and a crisis solutions facility.

2) More Services - The MIDD expanded services in existing programs to meet the needs of underserved populations or geographic regions. Examples of expansions include supported housing and employment, education offerings, mental health courts, outreach and engagement, screening, psychiatric crisis medication evaluations, suicide prevention and in-home supports for youth in crisis.

3) More People Served - Service access increased over time with growth in both the number of clients served and workforce members trained. Service categories such as Prevention & Outreach, Support Services, Workforce Development, Therapeutic Courts, Liaison & Linkage and Crisis Response were available to more King County residents. It was only in the Treatment category that MIDD served fewer clients over time and this was because more people became Medicaid-eligible through the Affordable Care Act.

4) Reduced Use of Expensive Systems Like Jails and Hospitals - Overall, jail use was cut in half, psychiatric hospitalizations fell 46 percent, and Harborview Emergency Department use declined by 60 percent.

5) Reduced Symptoms - Many adults and youth showed evidence of reductions in depression and anxiety over time, as well as reductions in the use of substances.

6) Systems Change - Workforce development, workload reduction, cross-system coordination and technical assistance for school crisis response planning all benefitted from MIDD investments.

[1]Per Ordinance 18452, the name of the committee was changed from "Oversight" to "Advisory." This change became effective in February 2017. For purposes of this report, the committee will be referred to as the MIDD Advisory Committee.

MIDD Annual Report Purpose, Processes, Timelines and Terms

The purpose of the MIDD annual report is to demonstrate the progress of MIDD-funded programs and services toward meeting the adopted policy goals of MIDD. This report is required by the King County Council to document accountability for the use of MIDD sales tax funds along with changes in how services and programs are implemented, and outcomes for people who receive MIDD services.

MIDD data is gathered from over 100 service providers and subcontractors (see Page 50). The process of gathering and storing MIDD data is complex and varied. Data is stored in two major county databases. As outlined in provider contracts, data are typically due to the county on a monthly or quarterly basis. In some cases, providers generate automated MIDD data, while in other cases, spreadsheets are completed by hand data and submitted to the county. It is important to note that when the data submission process is manual rather than automated, significant county staff time is required to process and compile the information. In order to produce the necessary MIDD demographic and outcomes findings, MIDD-served clients must be unduplicated and cross-referenced with their system-use results provided by all King County and municipal jails and select hospital partners. Data preparation and analysis timelines for this report were as follows:

Last Evaluation Data Due (through Sept. 30)	Data Cleaned and Loaded in DB	Queries Ran and Results Unduplicated	Outcomes Data Ready and Analysis Began	Report Review Began
Mid-Nov.	Mid-Dec.	Early Jan.	Mid-Jan.	Early Feb.

Evaluation of System Use Outcomes Over Time

For many MIDD strategies, client outcomes (changes in their use of costly systems such as jails, hospitals, and emergency departments) are studied using a longitudinal methodology. Longitudinal means collecting data for the same group of individuals over time and then making comparisons between various time periods, such as before vs. after services. Percent change reflects the amount of increase or decrease over time. In this report, system use outcomes are studied for up to five years after a person's MIDD start date. The following definitions for study time periods are used throughout the report:

- **Pre**: The one-year period leading up to a person's first MIDD start date within each relevant strategy.
- **First through Fifth Post**: Each subsequent one-year span following a person's start date, up to five years after their start. Also referred to as Post 1, Post 2, Post 3, Post 4, and Post 5.

Clients in relevant strategies become eligible for inclusion in system use outcomes analyses through the passage of time (time eligible) and their system use (use eligible). Tables on Pages 54 to 60 show information on MIDD outcomes samples and average use of relevant systems (jails, psychiatric hospitals, and/or Harborview's emergency department). Detailed tables show data in strategy order.

Note that services may be delivered in a single encounter (service visit) or they may be ongoing for an extended time, such as months or even years. Service delivery varies widely both within and between strategies. Analysts look for patterns in the data but cannot say that a MIDD strategy caused the reported changes to occur, as other factors not being measured could also be contributing to any observed results.

Definitions of Key Terms and Symbols

Strategy	A service, program, or series of programs that provide specific supports or employ specific approaches to achieve intended goals.
Target	Established quantifiable outputs expected of an entity implementing a strategy; How many people will be served and/or how many services will be provided. May be *revised* permanently or *adjusted* temporarily.
Performance Measurement	The actual number of clients seen or services delivered; also represented as a percentage of the original, revised or adjusted target.
FTE	Full-time equivalent staffing. A given number of FTE may be needed to meet a MIDD target.
Outcomes	Measurable or observable end results or effects; something that happens as a result of or can be associated with an activity or process.
Percent Change	Shows the amount of increase or decrease over time in the difference between two numbers.
Target Success Rating Symbols	 More than 85% of target  65% to 85% of target  Less than 85% of target

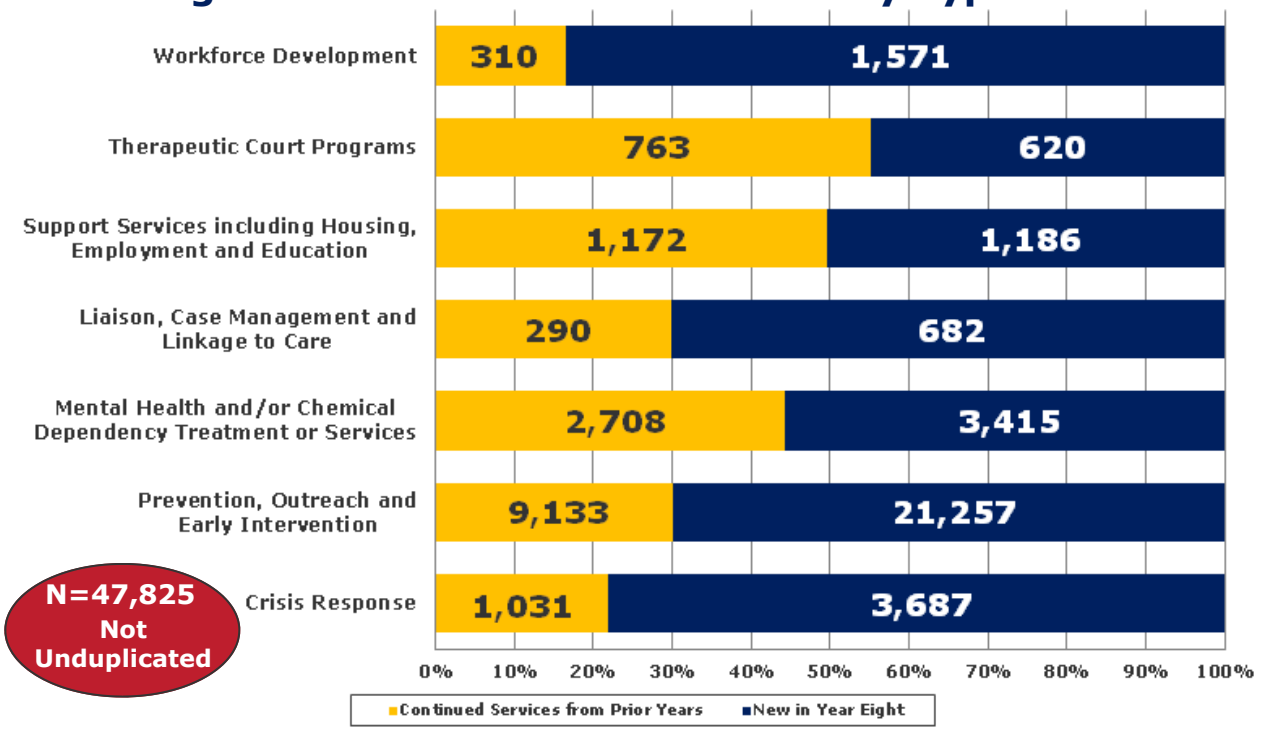
Annual Report Highlights

The following are highlights from the annual reporting period of Oct. 1, 2015, through Sept. 30, 2016.

- The MIDD expended $128.5 million during the 2015-2016 biennial. The unreserved fund balance is $5.9 million. The entire financial report can be found on Pages 46 to 48.
- The number of unduplicated clients served during the reporting period was 42,398; an 18 percent increase over the prior year. An additional 27,750 people (not unduplicated) were served in large group settings. Demographic information appears on Pages 44 and 45.
- Just over two percent of the estimated King County population (2,016,519) received a MIDD service in MIDD Year Eight (42,398). Of those estimated to live below poverty (233,842), 18 percent were served by MIDD this period. Access to MIDD services is detailed on Page 45.
- The majority of MIDD strategies received the highest target success rating by exceeding 85 percent of their performance expectations this period. Performance measurement details begin on Page 51.
- In Strategy 1g - Older Adults Prevention, the number of clients screened for behavioral health issues in primary care clinics rose 690 percent over the life of the MIDD. More details are on Page 16.
- For clients in mental health (MH) treatment who participated in Strategy 2b - Employment Services, employment rates reached 37 percent. Historically, less than six percent of MH clients without evidence-based supported employment services gain new employment. See Page 19 for other positive findings.
- Eighty-five percent of Strategy 15a - Adult Drug Court (ADC) clients who received housing case management services were permanently or temporarily housed at exit from ADC, as shown on Page 42.
- When comparing the one-year period leading up to a person's first MIDD start date (Pre) with their fifth year after that start date (Post 5),
  - Jail bookings were cut in half and jail days were reduced by 44 percent
  - Psychiatric hospital admissions were reduced by 46 percent and the number of days hospitalized was reduced by 27 percent
  - Emergency department admissions at Harborview Medical Center were reduced by 60 percent.

  The MIDD strategies that seek to reduce each of these types of system use are listed on Page 54.
- The MIDD Advisory Committee members contributed over 450 cumulative hours in meeting and subcommittee activities, focusing heavily on MIDD retrospective and renewal work, as summarized on Page 7.

Year Eight Total of Individuals Served by Type of Service



Advisory Committee Membership Roster

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

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

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

Rhonda Berry, Chief of Operations
Representing: King County Executive

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

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

Doug Crandall, Chief Executive Officer, Community Psychiatric Clinic
Representing: Provider of behavioral health services in King County

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

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

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

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

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

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

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

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

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

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

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

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

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

Mark Putnam, Director, All Home
Representing: All Home

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

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

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

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

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

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

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

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

As of 9/30/2016

Letter from Advisory Committee Co-Chairs

Dear Reader:

This Ninth Annual Report provides the Mental Illness and Drug Dependency (MIDD) Implementation and Evaluation Summary for Year Eight (Oct. 1, 2015 – Sept. 30, 2016). The report focuses on performance measurement data and services delivered during the period, along with client outcomes, such as reduced jail use and behavioral health symptom reductions. Please note that data collected after Oct. 1, 2016, through the end of MIDD 1 on Dec. 31, 2016, is outside the timeframe of this report.

This report also contains information on MIDD 2, which began on Jan. 1, 2017. New and improved programming, policy goals, population-level outcome goals, and streamlined measures are included in MIDD 2, which builds on the successes of MIDD 1. We are please to see the legacy of MIDD continue.

Page 2 provides a brief summary of the wonderful things MIDD 1 was able to accomplish. From providing new services and expanding existing ones, to serving more people and helping many reduce their use of expensive systems like jail and hospitals, MIDD 1 contributed toward symptom reduction and led to vast improvements across the entire behavioral health system. From 2009 to 2016, nearly $400 million in local MIDD funding was invested to improve the lives of King County residents experiencing behavioral health issues.

In addition to detailed information about each MIDD strategy, please see the success stories on Pages 8, 23 and 32 of this report. These stories remind us that we are in the business of helping people to succeed in life. It is an honor to live and work in a county that values humanity, equity and understanding.

We value your opinion about the MIDD and invite you to attend a MIDD Advisory Committee meeting, typically held on the fourth Thursday of each month. A public comment period is included at each meeting. Alternatively, you may contact us via email at midd@kingcounty.gov. Your voice matters to us.

For the latest information on MIDD, please go to:

http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/midd.aspx

Once again, we thank you for your interest and support of King County's MIDD.

Johanna Bender
Judge, King County Superior Court,
Outgoing Co-Chair

Merril Cousin
Executive Director, Coalition Ending Gender-Based Violence, Co-Chair

Acknowledgments

Thank you to the residents and elected officials of King County, the MIDD Advisory Committee and Co-Chairs, and the many dedicated providers of MIDD-related services throughout the county. As always, a special thank you to those willing to share their personal experiences and photos in this report.

MIDD Advisory Committee

The Mental Illness and Drug Dependency (MIDD) Oversight Committee was formally established via Ordinance 16077 in 2008. The name of the Committee was revised to Advisory Committee by Ordinance 18452 to align its title with its ongoing role as advisory to the King County Executive and King County Council. Both ordinances include a description of the required membership for the MIDD Advisory Committee and its roles and responsibilities.

The MIDD Advisory Committee is an advisory body to the Executive and Council. Its purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the MIDD sales tax revenue are transparent, accountable, collaborative and effective.

The Committee is a unique partnership of representatives from government and communities, including the health and human services and criminal justice communities. Recognizing that King County is the countywide provider of behavioral health services (mental health and substance abuse services), the Committee works to ensure that access to mental health and substance use disorder services is available to those who are most in need throughout the County.

The MIDD Advisory Committee held regular meetings ten times during the reporting period to monitor program implementation and progress of the MIDD and plan for renewal of MIDD. Members of the committee cumulatively contributed 281 hours of service in these meetings. This represents a 51 percent increase in time spent over the prior year comparison. The Crisis Diversion Services subcommittee, the Fund Balance Work Group, and Co-Chair monthly meetings contributed an additional 169 cumulative member hours for a total of 450 cumulative member hours.

Please note that all Advisory Committee members, to varying degrees, spend time on MIDD matters outside of meetings reading and responding to information provided about MIDD. For example, leading up to transmittal of the MIDD Comprehensive Retrospective Report to the King County Council in June 2016, members spent countless hours reviewing materials and providing feedback to County staff. In support of future MIDD planning efforts, members also participated in briefing paper concept reviews, regional Community Conversations, focus groups and drafting of the MIDD Service Improvement Plan report.

Briefings and Discussions at Advisory Committee Meetings

Key Advisory Committee briefings and discussions during the current reporting period included:

- The role and composition of the Advisory Committee
- A "Best Starts for Kids" update
- Community outreach and engagement efforts for MIDD renewal
- Financial plans and budget updates, including fund balance and supplemental budget recommendations
- New concepts briefing papers and review process for MIDD renewal
- Supplantion information (when an agency uses a new revenue source for existing programs)
- Family Intervention and Restorative Services program update (a pilot with one-time fund balance)
- Approval of the MIDD Comprehensive Historical Retrospective Report
- Review of the proposed MIDD Service Improvement Plan (SIP) funding and programmatic recommendations
- The King County Council's unanimous vote to extend the MIDD sales tax through 2025
- Changes made to the MIDD SIP transmitted to Council by the King County Executive
- A revision to Strategy 10b - Adult Crisis Diversion whereby chemical dependency professional certification becomes a preferred, rather than required, job qualification
- Review of the King County Council's Adopted Biennial MIDD Budget.

Community-Based Behavioral Health Intervention Strategies

Satisfying Employment Leads Man Out of the Darkness

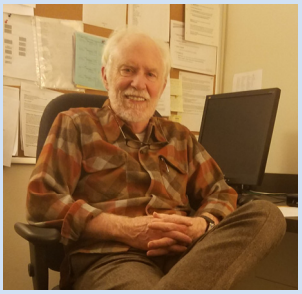
Blind and hearing-impaired since birth, Larry was known as "The Blind Kid" living on the streets since he was a teenager. Every once in a while, he would try to change his life by getting a job. Unfortunately, having money in his pocket often led to a cycle of drinking and drugs, burning bridges with the people who helped him out. Substance use disorder was taking its toll and Larry felt like he was running out of chances when he finally decided to go to the DESC agency in downtown Seattle for housing services where housing was found for him. He was feeling "completely hopeless" and figured he would die if he continued to use drugs and alcohol. He knew he needed help.

Larry prepares to lead a training on Supported Employment.

Over the years, Larry became sober and stopped using drugs. His housing case manager at DESC encouraged him to speak with the on-site evidence-based[1] Supported Employment (SE) team. At first he was hesitant to join the employment program. He was concerned it would not be able to help him find a real job.

Kaitlyn, the supported employment specialist to whom he was assigned, assured Larry that as long as he wanted to get back to work, she would help him find a job. She counseled him about how earning wages would impact his Social Security benefits and put him in touch with Washington State's Division of Vocational Rehabilitation (DVR). Larry was provided with equipment such as hearing aids and a cell phone set up for those experiencing blindness. He also received help with clothing for work and an Access pass that provides van transportation between his work and home. True to her word, Kaitlyn had Larry in front of an employer within 20 days of joining the SE program and he has been working 25 hours a week for over a year now. As he says, "It's kind of like somebody custom-tailored for me a way to get out of this mess."

Larry loves his job working in an office. His boss recently told him, "...you come to work every day smiling. You are grateful to have a job. You are a good employee, not that you are blind, you are just a good employee." The SE team at DESC, managed by Mike Donegan, provides Larry with follow-up support, which the evidence shows is essential to achieving long-term job retention. In his spare time, Larry now reaches out to other clients as an ambassador for the program. Living with his wife and sister-in-law in a condominium, he is grateful to the MIDD for giving him an opportunity to turn his life around.



Supported Employment team members Kaitlyn and Mike love helping clients find work.

Strategy 2b

Employment Services

By Titus Chembukha and Lisa Kimmerly

[1] Evidence-based means a way of delivering care or services that has been shown in at least one research study to make a difference for a group of people.

Strategy 1a-1

Mental Health Treatment

Increase Access to Community Mental Health Treatment

1a-1

The MIDD funds mental health (MH) treatment services for people who meet clinical and financial criteria for services, but who are otherwise not eligible for Medicaid. The MIDD supports continuous access to MH services during changes in Medicaid eligibility, which helps prevent costly emotional and financial disruptions to treatment and recovery. Twenty-one licensed community MH agencies deliver highly individualized, consumer-centered treatment services in outpatient settings under MIDD. Uninsured King County residents of all ages are served by this MIDD strategy. The MIDD policy goals are reducing symptoms and use of jails, emergency rooms and psychiatric hospitals.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
2,400 clients	**1,603**	**1,691**	**3,294**	**137%**	↑

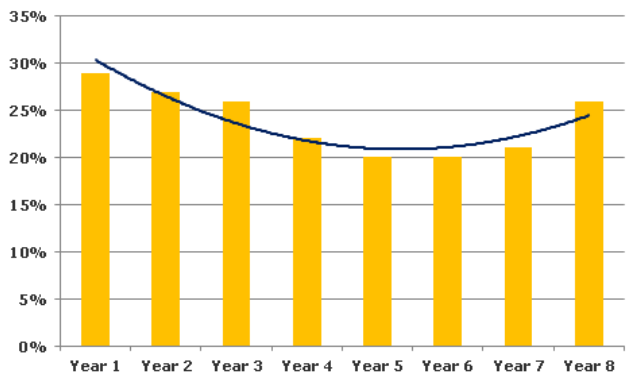
Service Highlights

In 2016, King County became a Behavioral Health Organization (BHO) in accordance with Washington's 2014 Second Substitute Senate Bill 6312. The new state law called for integration of mental health and substance use disorder treatment services under the umbrella of behavioral health care. Adopting the new BHO model brought significant changes to the local collection, storage and retrieval of client data.

The number of unique clients receiving at least one service under this strategy rose nearly 20 percent over the prior year comparison. Despite expanded eligibility for mental health treatment under the Affordable Care Act, the need for coverage remains high among those unable to access Medicaid funds.

Historically 20 to 29 percent of clients served by this strategy have indicated they are Hispanic, which is double the King County population estimate for Hispanic origin.

One in Four Strategy Clients Endorsed Hispanic Origins this Period



Long-Term Outcomes

Symptoms: Data indicates that 85 percent of adults with demonstrated change over time improved their symptoms, typically in the areas of depression and anxiety. By contrast, 67 percent of youth with demonstrated change over time had improved mental health. The tools used by MIDD 1 to measure changes in symptom reduction produced scores that remained stable over time for most clients, so new measures are recommended for MIDD 2.

Jail Use: With results for adults and youth combined, jail bookings declined by 59 percent for the 717 Strategy 1a-1 participants who had at least one jail booking and five years' worth of data after their MIDD start date. The greatest reductions in the number of days jailed were in the fourth post period when averages fell from 46 days (Pre) to 20 days (Post 4). Detailed information on system use over time appears in Appendix III, which begins on Page 55.

Psychiatric Hospital Use: Only 13 percent of strategy participants had hospitalizations in community inpatient psychiatric facilities or at Western State. In the first year after starting MIDD services, average use fell by 42 percent. Over longer periods of time, admissions were essentially cut in half, while reductions in the number of days spent hospitalized ranged from 13 percent (Post 4) to 42 percent (Post 1 and Post 2).

Emergency Department (ED) Use: Admissions to Harborview's ED decreased by 44 percent by the fourth post period, from an average of 1.83 (Pre) to 1.03 (Post 4) for individuals served by this strategy.

Strategy 1a-2

Substance Use Disorder Treatment

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

Assessment, individual and group counseling, and case management are types of substance use disorder (SUD) treatment services provided to adults in outpatient (OP) settings under this MIDD strategy. Outpatient treatment for youth includes all of these components, plus urinalysis. Opiate treatment programs (OTP), by contrast, typically provide daily medication, such as methadone, in combination with other treatment support. More than 30 provider agencies participated in delivering these MIDD-funded services prior to April 2016. Under the newly adopted Behavioral Health Organization model (see Page 1), four youth SUD providers opted to become subcontractors of a larger behavioral health provider. In addition, the funding for SUD services shifted from paying for services to paying per person served. Performance targets were added to this strategy to provide a more robust accounting of all MIDD SUD treatment and supports offered. The MIDD policy goals are reducing symptoms and use of jails and emergency rooms.

Year 8 Target	Year 8 Total	Percent of Year 8 Target	Target Success Rating
12,000 outpatient (OP) units (first 6 months)	**10,160 OP units**	**85%**	
600 OP authorizations (last 6 months)	**630 OP authorizations**	**105%**	
25,000 opiate treatment program (OTP) units	**14,989 OTP units (first 6 mos)***	**-**	
150 detoxification bed days (first 3 months)	**163 detox bed days**	**109%**	
7,200 sobering center admits (36% of total)	**7,284 sobering admits**	**101%**	
2,000 peer services encounters	**2,652 peer encounters**	**133%**	
4,500 outreach service hours (first 6 months)	**5,246 outreach hours**	**117%**	

* Fiscal data on OTP units were unavailable for the last 6 months due to data system integration issues. This strategy also served 135 clients in case management and transportation.

Service Highlights

As of February 2016, 87 percent of adults and 76 percent of youth who were enrolled in King County SUD treatment were eligible for Medicaid. Using Medicaid funds allows local MIDD dollars to be spent on other services in support of SUD recovery.

A total of 941 unique individuals had at least one outpatient SUD service in this reporting period. The number of new clients was 661 (70%) and the remainder carried over from prior years. For opiate treatment, 265 people, including 22 who only participated in detoxification services, received MIDD supported treatment under this strategy. Just over half of these opiate treatment clients carried over from prior years. Identification of unique individuals is not currently available for sobering, peer, outreach, case management or transportation services, as only summary reports are provided.

King County geographic distribution of the 1,206 individually-identified clients was as follows: Seattle (39%), South (35%), East (9%), North (6%) and Other/Unknown (11%). Note that 48 percent of the King County population living below poverty is estimated to be geographically located in the south region of the county.

Long-Term Outcomes

Symptoms: Substance use data for this strategy indicates that 1,919 of 2,907 adults in outpatient treatment (66%) reduced their use to zero or remained use free over time. Over half of these outpatient clients (1,668) were being treated primarily for alcoholism. For OTP, 40 percent of the 1,416 adults treated for opiate use reached abstinence or stayed use free. According to national statistics, the heroin relapse rate is close to 75 percent when OTP is not a part of treatment.

The majority of youth engaged in SUD treatment received help for marijuana use. While days with use decreased on average by 22 percent, few youth reached abstinence over a year-long period. Wanting a job and making money were motivators associated with more drug-free days for youth, but further study is needed to impact abstinence rates.

Jail Use: Over six years, adults and youth in SUD treatment cut both jail or detention bookings and days in half. Days jailed fell from an average of 34 days (Pre) to 15 days (Post 5). Jail outcomes have not yet been examined by type of drugs used.

Emergency Department (ED) Use: People enrolled in OTP were much more likely to use Harborview's ED (32% vs. 19% for OP) and experienced less robust use reductions over time (long term reductions of -26% vs. -37% for OP).

Strategy 1b

Outreach & Engagement

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

1b

This MIDD strategy helps people experiencing chronic homelessness, mental illness, and substance use disorders (SUD) get the services they need from community service providers. Through partnerships with Public Health—Seattle & King County, Healthcare for the Homeless, and other organizations, outreach is conducted to find and connect people in need of services, with priority given to serving people leaving hospitals and jails who would otherwise be exiting into homelessness. Outreach and engagement efforts employ principles of motivational interviewing, trauma-informed care and harm reduction. This primary MIDD policy goal is to reduce jail, emergency department and psychiatric hospital use. A secondary policy goal is linking directly with King County and All Home's efforts to make homelessness rare, brief, and one time.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
675 clients	**603**	**1,179**	**1,782***	**264%**	

* Blended funding allows more clients to be served than MIDD funds alone.

Service Highlights

This strategy directly links to the All Home strategic plan, which lays out steps necessary to achieve the goals of making homelessness rare, brief, and one time, including "ensuring adequate resources for proactive and consistent outreach efforts." To this shared end, MIDD has partnered with providers to reach both urban and rural clients without housing.

Provider staff conduct screenings and mental health assessments, provide counseling and referrals to services, and advocate for individuals not currently connected with behavioral health services. A trauma-informed[1] care approach helps clients "focus on improving their lives in the present, while accepting the depth and pain of their past experiences."

The following example illustrates how outreach impacts those in homelessness: "Steven" had lived outdoors for a year when he met with a MIDD mental health provider. He was alcohol dependent, had zero income, and had been evicted from housing three times. By focusing on engagement and rapport building, regular contact was established with the provider, resulting in Steven's entry to inpatient SUD treatment. Exiting treatment to housing with harm reduction values and sobriety supports helped this client reduce his nightly stays at the Dutch Shisler Sobering Support Center from 200 per year to zero.

[1] Trauma-informed means recognizing that people often have many types of trauma in their lives.

Long-Term Outcomes

Initiative Linkage: This MIDD strategy links to the work of All Home (formerly the Committee to End Homelessness). It is notable that the director of All Home is a member of the MIDD Advisory Committee. MIDD Strategy 1b provides funding to support services that help to eradicate homelessness by linking people with services and helping them overcome barriers to housing.

Jail Use: By the fifth post period, over 1,000 strategy participants were eligible for jail outcomes based on the passage of time and use of area jails. For this group, jail bookings were reduced by 44 percent and jail days were reduced by 34 percent, from an average of 33 days (Pre) to 21 days (Post 5).

Psychiatric Hospital Use: Long-term reductions in psychiatric hospitalizations in MIDD Year Eight were 24 percent for the 122 clients eligible for the fifth post period analysis. By contrast, in MIDD Year Seven, reductions of 37 percent were recorded for the 60 strategy participants eligible to be considered for long-term outcomes at that time. This shows how the results being reported can be impacted greatly when the sample sizes are small.

Emergency Department (ED) Use: After an initial rise in Harborview ED admissions, eligible Strategy 1b participants ultimately reduced their ED use by 35 percent over the longest term.

Emergency Room Substance Abuse Early Intervention Program

1c

Screening, Brief Intervention and Referral to Treatment (SBIRT) is used to engage persons who are at early risk for substance use disorders (SUD). The SBIRT approach involves establishing rapport with the person and asking to discuss their alcohol/drug use, providing feedback, enhancing motivation for potential change, and making referrals to treatment if needed. The MIDD provides funding for SBIRT services at three emergency departments (ED): Harborview, St. Francis, and Highline. As a prevention or early intervention strategy, reductions in jail and emergency room use must factor in the greatest measurable passage of time. In other words, immediate behavior change is not expected after only one brief encounter, but disrupting a pattern of potentially problematic substance use can lead to reduced system use over the long term. The MIDD policy goal for Strategy 1c is to reduce jail and emergency room use.

Year 8 Target	Year 8 Total	Percent of Year 8 Target	Target Success Rating
800 screenings per FTE (4,400 total) **543 brief interventions per FTE (2,987 total)** **(5.5 FTE staff in period)**	**2,206 screens** **2,649 brief interventions**	**50%** **89%**	

Service Highlights

For each SBIRT encounter, service information was gathered on:

- Level of service provided
- Service minutes
- Number and type of referrals given
- Substances used and frequency of use
- Alcohol and drug use risk scores.

An historical analysis utilizing all data collected over the life of the MIDD found that Strategy 1c participants who received more intensive services were less likely to reduce their use of emergency departments and jails. In other words, individuals at higher risk for alcohol and drug misuse typically had less robust system use reductions over time.

By contrast, these same clients who had more intensive services were more likely to reduce their use of substances over time.

A recent pilot at Swedish Medical Group's primary care clinics began testing the efficacy of using the SBIRT model for universal depression screening. Swedish has introduced SBIRT into 10 of their clinics in King County and plan to continue SBIRT implementation at all 30 of their clinics. Also, over 70 clinical staff have been certified to conduct and bill for SBIRT services through Medicaid and Medicare.

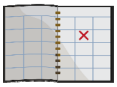
Long-Term Outcomes

Jail Use: In the fifth year after their first MIDD SBIRT encounter at Harborview, individuals with a history of jail use reduced their jail bookings by as much as 42 percent. Reductions over the same term for individuals engaged in SBIRT at the two south county hospitals were 15 percent. This could be a reflection of how the strategy is differentially implemented by the various providers. Further investigation is needed to understand why the jail use outcomes are not more similar for SBIRT clients across the region.

Emergency Department (ED) Use: Clients receiving SBIRT at Harborview reduced their use of the Harborview ED by 54 percent over the long term, not counting the ED visit marking the start of their MIDD services. Very few south county hospital SBIRT clients used Harborview's ED, but those who did reduced admissions by 15 percent, from an average of 1.50 (Pre) to 1.28 (Post 5).

Treatment Linkage: The rate at which individuals were linked with SUD treatment within one year of their MIDD start for Harborview SBIRT clients was 20 percent; for St. Francis and Highline SBIRT clients the rate was 12 percent. For all clients with linkages, the distribution was about half to outpatient treatment, 36 percent to detoxification and 12 percent to opiate treatment programs.

Strategy 1d



Crisis Next Day Appointments

Mental Health Crisis Next Day Appointments and Stabilization Services 1d

The Next Day Appointment (NDA) program helps to divert people experiencing a behavioral health crisis from psychiatric hospitalization. The NDA program provides an urgent crisis response follow-up (within 24 hours) for individuals who are presenting in emergency rooms at local hospitals with a behavioral health crisis, or as a follow-up to the Designated Mental Health Professionals (DMHPs) who have provided an evaluation for involuntary treatment and found the person not eligible for, or could be diverted from detention with follow-up services. MIDD funding enhances the NDA program by providing follow-up services such as psychiatric medication reviews (medical services) and to increase participant linkages to ongoing care. The MIDD policy goal for Strategy 1d is to reduce jail, emergency room and psychiatric hospital use.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
750 clients with enhanced services*	**23**	**309**	**332**	**44%**	↓

*Clients with medical services are counted to approximate the total number of clients with enhanced services.

Service Highlights

In county contract language, agencies providing enhanced NDAs were required to have capacity to make available "psychiatric evaluation and medication management services, when clinically indicated, that include access to medications via prescription or direct provision of medications or provides access to medication through collaboration with the individual's primary care physician." During the current reporting period, clients requesting NDAs were screened by the Crisis Clinic for referral to one of four provider agencies with slots set aside for these crisis appointments.

Low numbers of reported NDAs in late 2015 led to contract monitoring that revealed 63 percent of available slots had been scheduled in 2015. Once scheduled, the slots were utilized at rates as high as 80 percent for some providers, dispelling an initial belief that client "no shows" were driving low utilization of NDAs.

Chart reviews with provider agencies showed that 39 out of 41 applicable charts had evidence that individuals received a psychiatric appointment following their first crisis visit, so lack of availability does not account for the low utilization of the MIDD-funded enhancements. Further investigation is needed to understand how the NDA screening and scheduling process may be contributing to access barriers. This strategy will be modified in 2017 to address underutilization and to create additional opportunities for "treatment on demand."

Long-Term Outcomes

Jail Use: Nearly one in four NDA clients who received medical services had been jailed in King County the year before their MIDD service start date or in subsequent years. Of the 495 clients with jail bookings over the longest period measured, the annual number of days spent in jail decreased on average from 43 days (Pre) to 20 days (Post 5). This represents a reduction in jail days of 53 percent over time.

Psychiatric Hospital Use: Of the people who received enhanced NDAs, 14 percent were utilizers of community inpatient psychiatric hospitals or Western State Hospital. Admissions to these facilities fell on average by one-third for those eligible for the third and fourth post periods based on both time and use criteria. By the fifth post period, psychiatric hospital use was reduced

Emergency Department (ED) Use: For the 2,121 clients served by this strategy who were eligible for fifth post period analysis, 1,050 (50%) had admissions to Harborview's ED. The average number of Harborview ED admissions for this group was reduced from 2.00 (Pre) to 0.66 (Post 5), or 67 percent over the longest term. The ultimate goal for ED reductions was 60 percent, as established in 2008.

Treatment Linkages: This strategy tracks confirmed linkages to publicly-funded mental health (MH) treatment benefits within a year of MIDD-funded service starts. For clients who received enhanced NDAs, the linkage rate for MH treatment was 32 percent.

Strategy 1e

Chemical Dependency Trainings

Chemical Dependency Professional (CDP) Education and Training

1e

A 2010 workforce development plan was adopted by King County's Department of Community and Human Services to bring more industry-standard evidence-based practices into the substance use disorder treatment system. A key element of the plan involves training professionals in motivational interviewing, a universal skill set expected of all well-qualified CDPs. Training ensures fidelity to this and other treatment models. The MIDD provides reimbursement for expenses incurred while earning or renewing CDP or prevention professional credentials, and in 2015 began covering the costs of providing clinical supervision to over 100 CDPs and trainees[1]. The MIDD policy goal for this strategy is linkage with the 2005 Mental Health Recovery Plan authorized by King County Ordinance 15327.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
125 reimbursed trainees **(plus clinical supervision cases)** **250 workforce development trainees**	**254** **56** **N/A**	**143** **48** **558**	**397** **104** **558**	**318%** **-*** **223%**	⬆

* No targets were set for this deliverable.

Training Topics

Thirty-two Strategy 1e trainings were delivered over 12 months covering the 17 topic areas listed below. A total of 424 unduplicated individuals were among the 558 trainees counted.

Topic	Individuals Trained
Assessing and Managing Suicide Risk	86
Treatment Planning MATRS	67
Introduction Motivational Interviewing	51
Clinical Skills in the Era of Legal Cannabis	50
Ethical Considerations for Behavioral Health Professionals	46
Introduction to Group Counseling and Facilitation Skills	38
Clinical Supervision I: Developing Counselor Skills	34
Motivational Interviewing Skill-Building Intensive	27
Advanced Motivational Interviewing	26
American Society of Addiction Medicine Criteria Changes	26
Cognitive Behavioral Therapy	23
Developing Clinical Supervision Skills II	23
Developing Clinical Supervision Skills I	14
Introduction to CRAFFT	14
Clinical Supervision II: Managing Supervisory Dilemmas	11
Group Facilitation II	11
Motivational Interviewing for Supervisors	11
Total	558

Evaluation Highlights

Strategy 1e trainees rated their educational experiences immediately upon completion of each course and again 30 days later. During the current period, nearly half of all trainees completed the 30-day follow-ups, which focused on specific skills, knowledge and effectiveness in applying techniques.

A detailed demographics analysis found that trainees mirrored the regional CDP workforce, whereby 73 percent were female and 64 percent were Caucasian/White. Nearly half of all trainees indicated work zip codes within the Seattle region of King County. The top three work roles were: clinician or direct care provider (110), clinical supervisor (61) and case manager (59). The top three work settings were community or faith-based organizations (103), outpatient addictions treatment (84) and other agencies, such as community mental health treatment (69).

Overall, 94 percent of attendees rated the trainings as useful and said they would recommend them to colleagues. Asked if they now possess adequate skills in the topic presented, 82 percent agreed or strongly agreed. For adequate knowledge, this figure was 79 percent. The trainings on Assessing and Managing Suicide Risk had the highest number of trainees who indicated that further knowledge and skill development was needed.

[1] In 2016, unexpended strategy funds were approved to provide health care safety net trainings for county staff and providers.

Strategy 1f
Parent Partners Family Assistance

Parent Partner and Youth Peer Support Assistance Program

1f

A family support organization, Guided Pathways—Support (GPS) for Youth and Families, was launched in 2012 to provide services for families, by families with children or youth experiencing serious emotional or behavioral problems and/or who have substance abuse issues. Strategy 1f empowers families with information and support to promote self-determination and the well-being of families. This MIDD policy goal for this strategy is linkage with King County's 2010 Strategic Plan under Ordinance 16897 to promote "opportunities for all communities and individuals to realize their full potential."

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
362 individually-identified clients* 1,000 group clients	**40 N/A**	**233 1,830**	**273 1,830**	**75% 183%**	

*This target was adjusted down from 400 clients due to staffing issues. Group client counts are not unduplicated.

Service Highlights

In MIDD Year Eight, GPS continued to engage groups and individuals throughout King County to provide family assistance and support. Monthly narrative reports outlined service provision, including:

- Twice monthly after school support groups
- Outreach to kinship caregivers
- Hosting numerous family social events
- Providing parent and peer trainings
- Launching a youth empowerment program
- Presenting parent workshops based on the evidence-based curriculum Guiding Good Behaviors
- Participating in the South King County Resource Day and Job Fair.

The MIDD also funds a county parent partner specialist position that facilitates monthly Parent Partner Network meetings, among other duties associated with this strategy.

A geographic shift is evident in the delivery of group services under this strategy when compared to statistics from the MIDD Eighth Annual Report. Attendance at events in the south region of the county rose from 43 percent of all attendees to 70 percent. Attendance at events in the Seattle region fell from 48 percent to 23 percent. Fewer than seven percent of all attendees listed zip codes in the north or east regions of the county, consistent with the prior year findings.

Client Outcomes

In the current period, 617 client visits were recorded for 273 unique people. The average number of support hours provided per person was four hours. Strategy 1f worked to increase protective factors, or skills that help people deal more effectively with stressful events, for enrolled families and youth while decreasing their risk factors through delivery of the services listed below. Multiple services per client visit were possible.

Services Provided	N	% of Visits
Assisted in obtaining services*	544	88%
Life skills	317	51%
Systems navigation	314	51%
Basic needs assistance	226	37%
Gaining advocacy skills	204	33%
Self care	191	31%
Identifying natural supports	142	23%
Strengths assessment	102	17%

*Including treatment for mental illness and substance use disorders, as well as special education and other benefits.

Treatment Linkages: For 281 people with GPS service starts prior to September 2015, 20 (7%) showed a linkage to publicly-funded mental health treatment in the first year after their MIDD start. Of those with linkages, eight were newly enrolled and 12 showed evidence of enrollment prior to their first GPS encounter.

Strategy 1g

Older Adults Prevention

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

1g

Older adults receiving primary medical care through a network of "safety net" clinics have access to screening for depression, anxiety and substance use disorders (SUD) through this MIDD strategy. When needed, short-term behavioral health interventions are made available for people who are age 50 or older. This strategy continues to lead healthcare integration efforts and serves as a model for incorporating behavioral health care into primary care settings. The primary MIDD policy goal for this strategy is a reduction in the incidence and severity of mental illness and SUD symptoms. A secondary policy goal is reducing emergency room use.

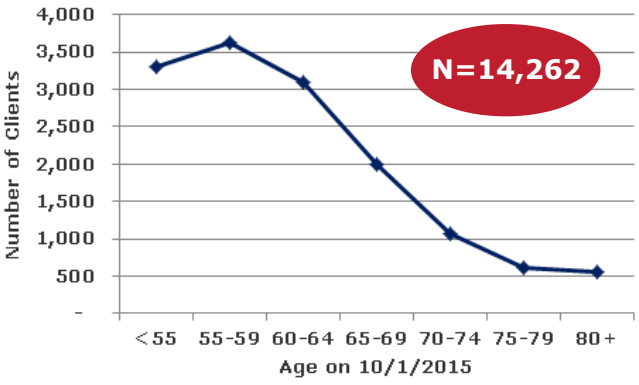
Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
2,500 clients	**7,238**	**7,024**	**14,262**	**570%**	↑

Service Highlights

The number of older adults screened by Strategy 1g for the most common symptoms of mental illness and SUD rose exponentially (690 percent) over the life of the MIDD, from 1,805 in the first year to 14,262 in the last. In the current period, about half of the 14,262 clients screened through this strategy had prior screenings reported in earlier reporting periods. This is not unexpected as it is common practice for the "safety net" clinics to screen individuals on an annual basis.

Thirty-two primary care clinics participated in Strategy 1g. Three of these clinics averaged over 100 screenings per month: Neighborcare at High Point in West Seattle, Neighborcare at Rainier Beach in South Seattle, and HealthPoint in Auburn, a city in south King County.

Half of Strategy Clients Were Over Age 60



Where client race was known, 53 percent were persons of color and 47 percent were Caucasian. Hispanic origin, tracked separately from race, was endorsed by 15 percent of all clients.

Long-Term Outcomes

Symptoms: As reported in the most recent MIDD progress report (August 2016), more than 6,000 clients over the life of Strategy 1g were engaged in behavioral health services beyond their initial screening. Depression scores at two different points in time were available for 3,691 clients and anxiety scores at two different points in time were available for 2,747. Of the 1,973 adults with moderate to severe depression at baseline, 1,282 (65%) demonstrated clinical improvement over time; similarly, of the 1,715 adults with moderate to severe anxiety, 995 (58%) showed clinical improved of their symptoms. Not enough scores were provided to assess reductions in SUD symptoms.

Emergency Department (ED) Use: Only those clients who engaged in mental health or SUD services beyond their initial screening visits in primary care clinics were entered into the outcomes analysis sample for this measure. One in four such Strategy 1g participants had at least one admission to the ED at Harborview.

Over the short and the long term, reductions in the total number of Harborview ED admissions improved year after year for participants served by this MIDD strategy. Reductions of 16 percent found in the first post period (from 1,651 total admissions to 1,391 for 1,080 people) grew to 50 percent by the fifth post period (from 949 total admissions to 478 for 542 people). See Page 60 for the average number of ED admissions in each outcomes analysis period.

Strategy 1h

Older Adults Crisis & Service Linkage

Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults

1h

For this MIDD strategy, the Geriatric Regional Assessment Team (GRAT) delivers community-based crisis intervention services for adults age 60 and older. In response to calls from police, other first responders, and community referents such as landlords, the team is deployed countywide to assess those in crisis and connect them with appropriate service providers. The GRAT often helps divert clients from hospitals and evictions. With MIDD funding, the team has hired additional geriatric specialists to serve more clients in a timely manner and has increased collaboration with law enforcement and King County Designated Mental Health Professionals. The MIDD policy goal for Strategy 1h is to reduce emergency room and psychiatric hospital use.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
340 clients*	**39**	**289**	**328**	**96%**	

*This target should not have been adjusted down to 258 in MIDD Years 3 to 7. This error was discovered in 2016.

Service Highlights

During the current reporting period, GRAT responded to 511 total referrals within one day of receiving them. There were 443 referrals for mental health concerns (87%) and 68 referrals for substance use disorders (13%). The provider recorded diversions from costly dispositions as follows: 113 emergency department visits, 111 psychiatric hospital admissions and 88 criminal justice events. The team also diverted 104 people from eviction or the experience of homelessness.

Seniors and Behavioral Health

Statistics Provided by EvergreenHealth

- Over 20% have disorders unrelated to aging
- Over 15% meet criteria for depression
- Often report physical symptoms versus psychological
- Highest suicide rate of any age group
- Rates of drug abuse expected to double by 2020 (to 12%), including opiates, cocaine and marijuana
- Elders least likely to seek SUD treatment.

EvergreenHealth

Long-Term Outcomes

Psychiatric Hospital Use: Very few GRAT clients experienced psychiatric hospitalization, as the team focused its efforts on diverting individuals from this eventuality. The psychiatric hospital statistics for clients with use (less than 4% of the 4,601 GRAT clients eligible for outcomes analysis) indicates that hospitalizations occurred as a last resort. The highest average number of days hospitalized in any pre period sampling was 13 days, which represents relatively low usage in the baseline timeframe prior to GRAT services. The average number of days hospitalized in each post period, however, ranged from 25 (Post 4) to 47 (Post 2). These increases in excess of 87 percent over time coincide with identification of individuals needing inpatient care who likely went untreated prior to their first GRAT crisis contact.

Emergency Department (ED) Use: Less than one in ten GRAT clients was admitted to the ED at Harborview Medical Center during the longitudinal outcomes analysis. In samples ranging from about 500 people to 1,000, the general trend was that first-year increases in Harborview ED use were offset by drastic reductions in all subsequent post periods. One factor that could have influenced these findings is shifting of GRAT clients to EDs other than Harborview. Unfortunately, data on statewide ED usage were not available for this report, but will be studied in the future. Another factor explored, given the age group served (average age was 76), was client death. Statistically significant reductions in system use were found, however, even after removal of cases where lack of system use was due to client death.

Strategy 2a
Workload Reduction

Workload Reduction for Mental Health 2a

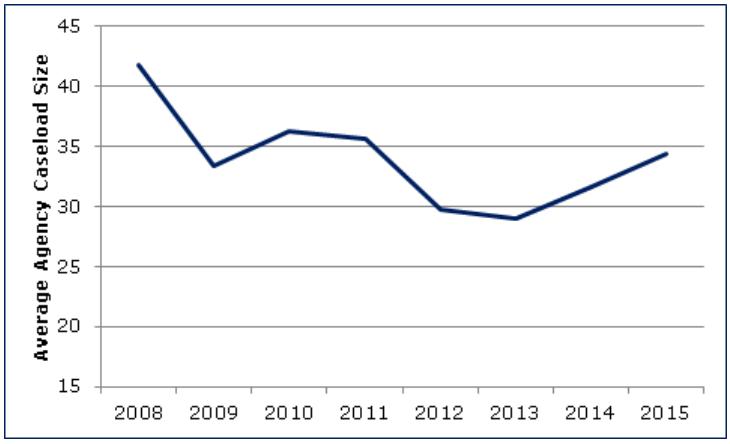
The MIDD workload reduction strategy was designed to decrease the caseload of direct services staff in community mental health (MH) agencies. The frequency and quality of services delivered to clients is typically improved when caseloads are reduced. Thus, by funding more or different staff positions, overall caseload sizes can be reduced. The MIDD policy goal for Strategy 2a is linkage with the Recovery and Resiliency-Oriented Behavioral Health Services Plan adopted in King County through Ordinance 17553 in April 2013.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
16 agencies participating	**16**	**N/A**	**16**	**100%**	↑

Average Agency Caseloads on the Rise Again

Prior to the MIDD, approximately 869 direct services staff members were employed by mental health provider agencies participating in this strategy. As of September 2010, the number of direct services staff had risen to 1,160. Of the 291 "new" staff brought on across the mental health system to improve staff-to-client ratios and quality of care, over 45 percent were attributed to MIDD funding in summary reports submitted by each agency. By March 2011, total staffing attributed to workload reduction was 145 people, despite state budget cuts which led seven agencies to eliminate more than 75 staff positions.

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, down to 35 clients per direct services staff member for all participating agencies; this represents a 17 percent reduction.



In 2016, the study referenced above was replicated with data through 2015, using the same five representative agencies. The highest agency caseload was 59 and the lowest was 15; the eight-year average was 34 clients per staff member.* The graphic at right shows the overall trend observed in average agency caseload size over the life of the MIDD.

While MIDD funds appeared to have an immediate impact on mental health system-wide staffing, other factors have pressured caseloads upwards over time. As reported previously, two recent 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.

* Note: With reliable recent data from 13 of the 16 agencies participating in MIDD Strategy 2a, the average number of clients per staff member rose between 2012 and 2015, from 28 to 36 (+29%).

Strategy 2b

Employment Services

Employment Services for Individuals with Mental Illness and Substance Use Disorders

2b

Supported employment (SE) programs funded in part by MIDD help people who are enrolled in community mental health (MH) and substance use disorder (SUD) treatment agencies find and maintain competitive-wage jobs. Following the evidence-based SE model developed at Dartmouth College, some of these programs focus on zero exclusion, rapid and individualized job searches, customized job development in the client's community, and post-employment support. The MIDD policy goal for Strategy 2b is linkage with other Council-directed initiatives; initially linked with the Mental Health Recovery Plan (2005) and later with the Recovery and Resiliency-Oriented Behavioral Health Services Plan (2012), this strategy helps people in recovery to find and keep mainstream jobs.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
700 clients* 75 clients in SUD pilot	**420 27**	**355 82**	**775 109**	**111% 145%**	↑

*This target was adjusted down from 920 clients as not all clients had access to the evidence-based services.

Service Highlights

The total number of clients at participating community mental health agencies who participated in at least one MIDD-funded SE service has held fairly steady over the past eight years. By contrast, the number of people participating in the SUD pilot for employment services rose over 200 percent compared to the previous year when the pilot program began. One reason for this growth is extensive outreach by the pilot's MIDD-funded facilitator to providers through presentations and trainings. Over 115 staff have attended these trainings.

"Improving Employment Outcomes for People with Mental Health Disorders in Washington State"

Key Findings from Department of Social and Health Services Research and Data Analysis Division (June 2016)

In the 12 months after receiving their first supported employment service, clients were more likely than a matched comparison group:

- to become employed
- to use outpatient mental health services
- to decrease their arrest rates.

Job Placements and Retentions Remain High

Recent information has shown the rate of new employment for persons receiving publicly-funded, year-long MH benefits in King County to be as high as six percent. Comparatively, clients who are actively enrolled in both a MH benefit and an SE program, have employment rates as high as 37 percent, as shown below in 2015.

Data from 2013 through 2015 revealed that approximately 60 percent of all jobs obtained through MIDD SE programs were retained for at least 90 days and nearly half were retained for six months. For jobs that began in 2015, about one in three was retained over a nine-month period, as shown in the table below.

					Retentions					
	Active SEP Participants	Individuals Employed	Employment Rate	Total Jobs	90-day		180-day		270-day	
2015	522	191	37%	211	127	60%	93	44%	64	30%
2014	534	180	34%	197	120	61%	97	49%	75	38%
2013	475	139	29%	151	88	58%	67	44%	54	36%

Please see the evidence-based supported employment success story on Page 8.

Strategy 3a

Supportive Services for Housing Projects

3a

Overcoming homelessness can be especially challenging for people with mental illness and/or substance abuse issues. Research has shown that providing supportive services within housing programs increases the likelihood that people will remain safely housed for longer periods of time, enhancing their chances of maintaining successful recoveries. Examples of supportive services provided by MIDD funds under this strategy include housing case management, group activities and individualized life skills assistance. The primary MIDD policy goal for Strategy 3a is to reduce jail, emergency room and psychiatric hospital use. A secondary goal is linkage with the 2005 Ten-Year Plan to End Homelessness and the All Home strategic plan.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
690 clients	**583**	**136**	**719**	**104%**	↑

Service Highlights

For the current reporting period, 720 individuals were enrolled in MIDD supportive housing programs. Males accounted for 65 percent of all participants; 25 percent were African American or Black. The estimated rate for this race group living below poverty in King County is about 13 percent. Over 100 veterans were among those served in Strategy 3a during MIDD Year Eight.

With data through March 2016, analyses were conducted to understand how supported housing services were related to client demographics, housing retentions and jail use. Key findings included:

- Females engaged in support services at rates twice that of men.
- The average length of stay was over 3.5 years for clients who remained housed through Sept. 30, 2016, compared to 2.5 years for those who exited before then.
- Exits from supported housing were coded as negative (36%), positive (31%), deceased (16%) or other/unknown (17%). Examples of negative exits are incarceration or policy violations. Examples of positive exits are moving to less supportive housing or reuniting with family.
- On average, those with positive exits were significantly older than those with negative exits (46 years vs. 42).
- Of those with positive exits, 80 percent reduced jail use (vs. only 65% of those with negative exits).
- Longer housing retention was associated with lower jail use rates.

Long-Term Outcomes

Jail Use: In 2008, MIDD planners adopted goals of cutting jail use in half for clients in certain strategies by the fifth year after their enrollment in MIDD services. Across-the-board reductions in jail use over that period, however, led evaluators to add an additional amount of reduction to the overall goal, resulting in a long-term target of reducing adult jail use by 70 percent. The strategy that came the closest to achieving this stretch goal was Strategy 3a with a 68 percent reduction in bookings and days over time. Average bookings fell from 2.98 (Pre) to 0.95 (Post 5) and days declined from 62 (Pre) to 20 (Post 5).

Psychiatric Hospital Use: The greatest reductions in psychiatric hospitalizations (-50%) and days spent in such inpatient care (-55%) were found in earlier post periods for this strategy, shortly after supportive housing was attained by MIDD clients. These positive results did not hold over the longer term, however, likely due to issues arising from negative program exits as discussed under Service Highlights. How to maximize housing retention for MIDD clients should be addressed in future program implementation plans.

Emergency Department (ED) Use: Harborview ED admissions were reduced significantly in both the short and long term. The greatest reductions achieved were 54 percent (in both Post 4 and Post 5). Note that the target for ED reductions was 45 percent for the fourth post period (met), but rose to 60 percent for the fifth post period (not met).

Strategy 13a

Domestic Violence

Domestic Violence and Mental Health Services

13a

This MIDD strategy enhances services for individuals dealing with the trauma of domestic violence (DV). The work is conducted in partnership with community agencies providing 1) screening for mental illness and substance misuse, 2) therapeutic counseling by staff mental health (MH) professionals, and 3) consultation with DV advocates and others on issues pertaining to MH and substance abuse. System coordination services are included in this strategy. The primary MIDD policy goal of Strategy 13a is reducing the incidence and severity of mental illness symptoms. A secondary policy goal is linkage with the 2010 King County Strategic Plan to ensure "safe communities and accessible justice systems for all."

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
560-640 clients	**229**	**245**	**474***	**85%**	

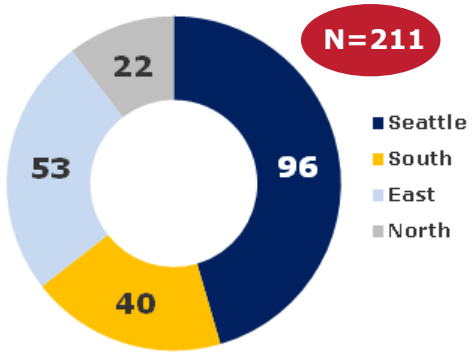
*The need for longer term interventions resulted in fewer clients being served during this time period.

Service Highlights

The total number of DV survivors who agreed to be screened for behavioral health issues this reporting period was 664 (68%) of the 974 who were asked. Results indicated a need for potential behavioral health follow-up for 583 people (88% of those screened); of those, 474 (81%) engaged in at least one service with a MH professional located on site at the community agencies.

All regions of the county were reached by system coordination trainings and consultation activities in 2015/2016 as shown below.

Total Coordination Contacts by Region



Long-Term Outcomes

Symptoms: Symptom reduction or change over time analyses were limited for this MIDD strategy. Instruments measuring depression and anxiety were administered to 85 unique individuals in this reporting period; of those, 14 people had scores provided at two different points in time.

Results showed a high baseline incidence of depression and anxiety. Nearly 75 percent of 85 measured cases showed medium to high levels of depression at baseline; the baseline rate was 59 percent for medium to high anxiety. Higher baseline scores support the need to provide services that can address these common mental health issues in DV situations.

Depression and anxiety were reduced over time:

- Six of 14 (43%) showed clinical improvement in their depression scores over time.
- Ten of 14 (71%) showed clinical improvement in their anxiety scores over time.
- Time between measures averaged 109 days.

These preliminary findings support the use of PHQ-9 and GAD-7 as instruments sensitive to measuring clinical changes in depression and anxiety symptoms over time and to show that services help survivors feel better.

Annual Narrative Reports Shed Light on Program Challenges and Successes

In 2015 the mental health concerns of clients were complex, leading to longer interventions than funding allowed. Building trust and rapport with therapists takes time and premature exits often prove detrimental to clients. Despite such challenges, most clients felt safe, welcomed, and confident in the services received. Therapists noticed a reduction in mental health stigma, as clients gained insight and clarity by working with professionals who understand DV issues and client ambivalence about ending abusive relationships. Training in CETA - Common Elements Treatment Approach increased "tools" available to clinicians and improved their evidence-based skillsets.

Strategy 14a

Sexual Assault Services

Sexual Assault and Mental Health Services

14a

This MIDD strategy supports trauma informed therapy services for survivors of sexual assault. By blending MIDD funds with other sources of revenue, providers can offer therapy to more clients. Universal screening for mental health (MH) issues and/or substance use disorders (SUD) is another key component of this strategy. In conjunction with Strategy 13a, a systems coordinator provides ongoing cross-systems training, policy development, and consultation to bridge the gaps between the MH and drug abuse treatment agencies and the fields of domestic violence (DV) and sexual assault (SA) advocacy. The primary MIDD policy goal of Strategy 14a is reducing the incidence and severity of mental illness symptoms. A secondary policy goal is linkage with King County's 2010 Recovery and Resiliency-Oriented Behavioral Health Services Plan.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
170 clients	**109**	**136**	**245***	**144%**	↑

* Providers reported only those cases attributed to MIDD funding this period. In the past they reported clients served with blended funds.

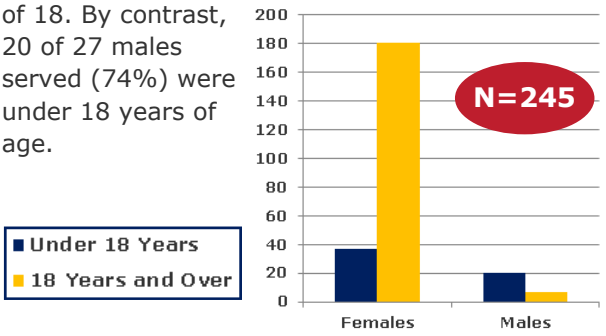
Service Highlights

There were 951 behavioral health screenings conducted at three sexual assault agencies this reporting period, or nearly 80 per month. Agencies also reported provision of 428 hours of internal and external consultation on mental health issues by their MIDD-funded staff. Newly added to the 2015/2016 contracts were requirements that advocacy staff receive 30 hours of sexual assault core training (including the impact of trauma) and 12 hours of on-going annual training.

The provider agencies varied in the mix of clients served with MIDD funds, as shown below:

Provider	Child/ Youth	Adult
Refugee Women's Alliance	0 (0%)	82 (100%)
Harborview Center for Sexual Assault & Traumatic Stress	10 (18%)	47 (82%)
King County Sexual Assault Resource Center	47 (44%)	59 (56%)

Of the 218 females served this period, 38 (17%) were under the age of 18. By contrast, 20 of 27 males served (74%) were under 18 years of age.



Outcomes

Symptoms: Positive outcomes were reported for 29 children or youth who gained emotional stability, positively engaged in treatment or attained their treatment goals. For adults, data from 42 of 46 (91%) showed desired outcomes by meeting two or more of the following criteria:

- increased understanding (44)
- increased coping skills (42)
- reduced symptoms (38).

The following story illustrates how MIDD-funded therapy services benefited one family in 2015:

"Selah" was sexually assaulted by her father from the time she was eight years old until the age of 13, when she told a friend about the abuse. Her friend's mother made a police report and Selah entered services at a sexual assault agency via legal advocacy. As the family slowly began to develop trust and build rapport with agency staff, they entered into more services, including mental health therapy. Selah's mother came to realize this wasn't simply "a family matter" and began therapy herself after disclosing her own sexual abuse as a child to a parent educator. Both mother and daughter were grateful for help through the MIDD and they are better equipped now to deal with the future as they continue through the legal process.

Strategies with Programs to Help Youth

A Wide Variety of School-Based Programs Contribute to Student Success

Several of the community agencies providing school-based services continue meeting with students during the summer when school is no longer in session. One such student was preparing to transition from middle school to high school while continuing to work with his MIDD-funded therapist to get to a stable place in his relationship with his mother. Before moving on to the next step in his education, this student's mother reported that she had noticed "a huge improvement."

A student who had missed several days of school due to her family's involvement in a Child Protective Services case was able to connect with the MIDD-funded provider at her school and quickly developed rapport. She said what she really needed was time to catch up on her schoolwork. Having a safe place to process her experiences and complete her work allowed her to raise her class grades while demonstrating resilience in the face of adversity.

An 8th grader experiencing family homelessness had stopped coming to school consistently. The MIDD provider reached out to address the provision of basic needs and arranged an intervention with the family concerning gang affiliation due to signs the student was demonstrating. The parent became very involved in the intervention and the student began coming back to school every day, with teachers emailing positive comments to the counselor.

One 7th grade student came to the attention of an in-school MIDD provider because she was always frowning and alone in the hallways. After practicing smiling and other social skills, the counselor encouraged her to write about her thoughts. The student's entire demeanor is now brighter, she is saying good morning in the hallway, making positive statements about herself and writing almost every day.

Membership at a Gay Straight Alliance group in one middle school was enhanced by presenting an informational meeting as a low-barrier point of access. Several students expressed excitement about joining the group and making connections with other LGBTQ students and allies, stating their willingness to commit to the group as active participants.

Individual meetings with students who joined a Life Skills group allowed the MIDD facilitator to connect one-on-one to get a better sense of what was going on in each of their lives, how dedicated they were to staying in the group and which teaching and learning styles work best for them. These meetings improved the pace and flow of the first group session.

Strategy 4c

School-Based Services

Stories Compiled by Maria Guizar

Strategy 4c

School-Based Services

Collaborative School-Based Mental Health and Substance Abuse Services

4c

The earliest identification of youth with mental health (MH) or substance use disorders (SUD) often occurs within school settings. With MIDD funds, Strategy 4c supports partnerships between local treatment agencies and neighboring schools, serving youth ages 11 to 15 years. Agency staff are integrated at selected middle schools to provide services that include indicated prevention and early intervention, plus screening, brief intervention and referral to treatment. Technical support is also made available to these schools by the Youth Suicide Prevention Program to bolster crisis plans and develop suicide prevention programs using best practices. The primary MIDD policy goal for Strategy 4c is to reduce the incidence and severity of mental illness and SUD symptoms. A secondary policy goal is to divert youth from initial or further justice system involvement.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
1,550 individuals* in 13 programs	**341**	**968**	**1,309**	**84%**	

*This target was adjusted down from 2,268 individuals as only 13 of 19 proposed programs were actually funded.

Service Highlights

In addition to the 1,309 individual youth served in Strategy 4c schools, an estimated 25,920 people attended school assemblies and group events sponsored by the community providers of these school-based services. The number of group participants this period represents a 34 percent increase over the prior year comparison.

Before 2016, there were 21 schools from 11 districts served by 13 programs delivered by 10 providers. Services were expanded to additional middle schools in January 2016, but data were not required at that time due to the one-time nature of the funding.

Youth Substance Use Rates Decreased Slightly from 2012 to 2014

Data from the Washington State Healthy Youth Survey (HYS) showed that in 2012, the weighted average for drinking (past 30 days) for 8th graders in MIDD Strategy 4c schools was 11.2 percent. The rate for this group fell to 7.5 percent in 2014. Marijuana use rates declined slightly over this period, from 8.9 to 6.5 percent. These findings align with both King County and statewide changes over time.

Vaping, or inhalation of infused water vapors, was measured for the first time in 2014. In 4c schools, vaping rates for 8th graders ranged from 0.8 to 21.8 percent, with a weighted average of nine percent (vs. 3% for tobacco smoking). This trend will be monitored closely when the 2016 HYS results become available in 2017.

Outcomes

Symptoms: From a list of 1,291 youth who were eligible for symptom reduction outcomes, 392 (30%) matched with baseline symptom measurement scores. Only 76 of these students, however, had two or more scores allowing for change over time analysis. Anxiety levels were found to have decreased slightly within individuals over time, although the differences were not statistically significant due to the small sample size.

For depression, 41 of 76 youth (54%) improved their scores or remained stable below the level for clinical concern. The results for suicide risk showed that 63 (83%) improved their risk levels or remained stable at low risk. By contrast, sleep problems in these youth improved or remained stable at a low level for only 34 (45%).

Detention Use: The number of students eligible for first year outcomes nearly doubled in MIDD Year Eight, but the percentage who were involved in the juvenile justice system remained extremely low (3%). Over all outcomes analysis periods, days in detention prior to starting MIDD services averaged less than five. Average days detained after MIDD starts rose as high as 40, for 79 students detained in the fourth post period.

Treatment Linkage: For a sample of 3,811 youth in 4c, 440 (12%) showed linkage to MH treatment in the first year after their MIDD start. The linkage rate to publicly-funded SUD treatment was only two percent.

Strategy 4d

Suicide Prevention Training

School-Based Suicide Prevention 4d

In the 2012 Healthy Youth Survey conducted by the State of Washington, approximately 11,600 King County high school students (14% of all students) said they had made a plan to commit suicide within the past 12 months. In an effort to reduce alarming statistics such as these, MIDD youth suicide prevention trainings are delivered to school-aged youth and concerned adults throughout the county. Teen trainings offer a safe place to talk openly about suicide, self-harm, depression, concern for friends, and how to ask for and get help. Under this strategy, school districts also have opportunities to improve safety planning and their written crisis response policies. This MIDD policy goal for this strategy is linkage with King County's Strategic Plan to support safe communities.

Year 8 Target	Year 8 Total	Percent of Year 8 Target	Target Success Rating
1,500 adults 3,250 youth	**1,390 adults 8,949 youth***	**93% 275%**	↑

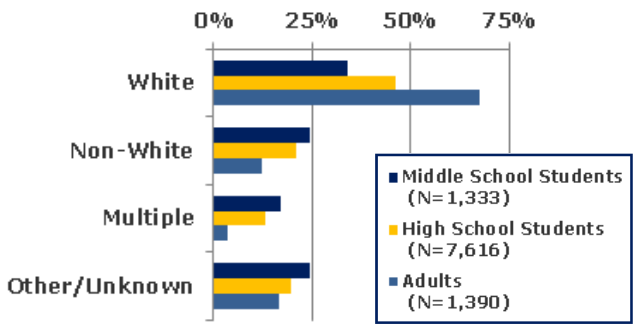
* Blended funds allow more youth to be served than MIDD funds alone.

Service Highlights

The number of adults served this period represents an improvement in achieving the adult performance target. The Youth Suicide Prevention Program delivered a total of 56 trainings for adults, 16 more than the contracted 40 per year, in order to more closely meet attendance goals. At least five of the adult trainings were conducted in Spanish; a language resource that was recently added.

Funding from the MIDD accounts for only about 40 percent of the total funds available for Teen Link at the Crisis Clinic to deliver youth suicide prevention trainings for teens throughout King County, but the program gathers data on all clients served. Classroom demographics are estimated by each trainer in conjunction with a show of hands for endorsement of race and gender classifications. Results of simplified race tallies for youth and adults are illustrated below.

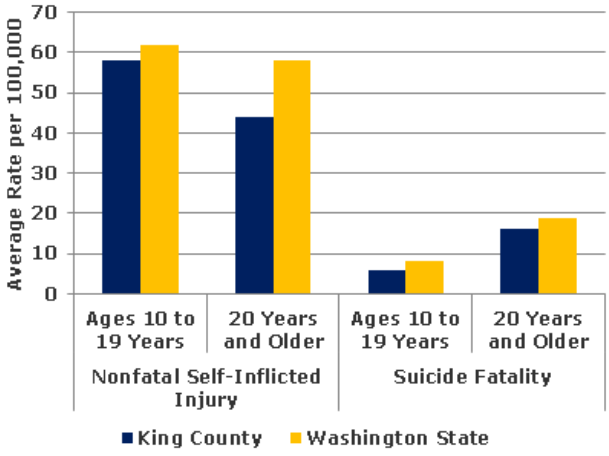
Students Trained Were Racially Diverse



Population Level Outcomes

Suicide Statistics: Data from the Washington State Department of Health (DOH) for the years 2009 through 2013 (combined) showed that rates of nonfatal self-inflicted injuries and suicide fatalities in King County lagged behind rates for the rest of the state, as shown below. While a causal relationship cannot be proved, it bears noting that King County has prioritized suicide prevention efforts with dedicated MIDD funding over this time period.

King County Has Lower Suicide Rates than State



At the state level, suicide rates per 100,000 citizens aged 10 to 19 years were cut in half between 2009 and 2010 (from 12 to 6). Since that time, however, rates have slowly climbed back up, reaching a rate of 10 in 2013. More recent statistics will soon be available from the DOH website for further analysis.

Strategy 5a

Juvenile Justice Assessments

Expand Assessments for Youth in the Juvenile Justice System

5a

This MIDD strategy provides mental health (MH) and/or substance use disorder (SUD) assessments for youth who are involved with the juvenile justice system. The Juvenile Justice Assessment Team (JJAT) provides many screening and evaluation options for youth, including: triage, consultation, MH and SUD assessments and psychological evaluations. Referrals to psychiatric and neuropsychological evaluations within the community are also provided. This team helps teens reconnect with their families, schools and communities, as well as with appropriate treatment services to meet their behavioral health needs. The primary MIDD policy goals for JJAT are to divert youth from justice system involvement and to reduce youth detentions. Symptom reduction and linkages to treatment are tracked as well.

Year 8 Target	Year 8 Total	Percent of Year 8 Target	Target Success Rating
1,080 assessment coordinations* 200 psychological services 93 MH assessments 110 full SUD assessments	**886 assessment coordinations 449 psychological services 117 MH assessments 143 full SUD assessments**	**82% 225% 126% 130%**	

* Targets have been adjusted due to a general decline in juvenile arraignments and JJAT staff vacancies.

Service Highlights

Historical JJAT service information through March 2016 was used to examine relationships between service delivery and detention/jail outcomes for 600 youth with any justice system involvement in the third post period. Service types ranged from referral or quick assessment only to psychiatric services. Client status was coded at the highest level of progression through the courts: probation (N=325), offender (N=235), or non-offender (N=40).

Overall, 63 percent of the sample "improved" or showed reductions in detention use after their JJAT services. Three of every four were male and one in four was African American/Black.

Key findings included:

- From pre to third post, probation clients decreased their days detained by seven days on average, compared to increases of 17 days for offenders and two days for non-offenders.
- Youth who were referred to Juvenile Drug Court (N=597), outpatient SUD treatment (N=205) or MH treatment (N=127) showed statistically significant reductions in detention episodes over time.
- In general, as the number of referrals per youth increased (more "need" for services), successful detention use outcomes decreased.
- Improvers had fewer service contacts on average than non-improvers (2.3 vs. 3.2).

Long-Term Outcomes

Symptoms: Baseline Global Appraisal of Individual Needs (GAIN) data were available in 2016 for 1,089 youth served by the JJAT. Marijuana was the drug of choice for 70 percent, with alcohol a distant second at 11 percent. Only one in four youth had abstained from marijuana use in the month prior to their initial GAIN assessment.

Change over time was analyzed for 289 cases with data at two points in time. Reduced use of marijuana was found for 43 percent of these youth. Drug abstinence was extremely rare at both baseline (5%) and at later measure (7%).

Detention Use: Of 655 JJAT youth now eligible for fifth post outcomes by time alone, 466 (71%) had been detained in the year prior to MIDD services and/or in the last period studied, excluding the booking that launched their JJAT involvement. Detention bookings for this group were reduced from an average of 2.23 (Pre) to 1.32 (Post 5), a reduction of 41 percent. Days detained did not decrease in any of the time periods examined.

Treatment Linkage: Within one year of their first JJAT contact, 411 of 2,350 youth (17%) were linked with mental health benefits paid via public funding. Similarly, 431 youth (18%) had confirmed linkages to SUD treatment. Note that parental insurance is often available to cover needed behavioral health care.

Strategy 6a
Wraparound

Wraparound Services for Emotionally Disturbed Youth

6a

Wraparound is an evidence-based practice that coordinates both formal and informal supports for youth with serious emotional/behavioral disorders. The wraparound process customizes care for high-need youth throughout King County, focusing on their individual and/or family strengths and cultural factors. MIDD funding supports teams at five community treatment agencies work collaboratively within their communities to surround all youth they serve with support and a package of services that addresses their unique needs and goals. The primary MIDD policy goals for Strategy 6a are to divert youth from justice system involvement and to reduce youth detentions. A secondary policy goal is to reduce behavioral health symptoms over time.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
450 enrolled youth	**307**	**212**	**519**	**115%**	

Service Highlights

As reported in the MIDD Year Eight Progress Report, a lawsuit settlement agreement (*T.R. versus Quigley and Teeter*) in 2013 resulted in Washington State initiating a five-year plan to implement Wraparound with Intensive Services (WISe) for Medicaid-eligible youth throughout the state. Services under WISe, as defined in the settlement agreement, consist of Wraparound, intensive community-based mental health care and mobile crisis outreach stabilization. The components of WISe are similar to what has been available in King County for several years through MIDD-funded Wraparound (Strategy 6a), outpatient mental health treatment, and MIDD-enhanced youth crisis services (Strategy 7b).

King County was originally slated to begin WISe services in 2017. At the request of the state, implementation began Apr. 1, 2016. During the current reporting period, a total of 519 youth were enrolled in WISe or continued in the traditional MIDD Wraparound program. The demographic information below combines both populations.

During the current reporting period, 59 percent of the youth served in Strategy 6a were male. The average age for males was 12 years, compared to an average age of 13 years for females. Where race was known, youth of color made up 46 percent of all service recipients. Of the 57 youth who identified their race as "other," 42 (74%) were of Hispanic origin. Altogether, 83 youth (16%) endorsed Hispanic origin. Zip code information was missing for more than half of all strategy participants this period.

Long-Term Outcomes

Detention Use: One of every five youth served by Wraparound had at least one juvenile justice system encounter. For the 131 youth eligible for the longest term outcomes evaluation, the average number of detention or jail bookings fell from 1.66 (Pre) to 1.16 (Post 5). This represents a detention reduction of 30 percent. For days detained over the long term, increases of 17 percent were evident, from an average of 25 days (Pre) to 29 (Post 5). In all shorter term outcomes periods, both detention bookings and days rose over time.

Other Measures: Detailed data from MIDD Wraparound providers showed a decrease of 77 percent in school suspension days over time. At baseline, 239 unique youth averaged nine suspension days over a six-month period. After one year in Wraparound, the average number of suspension days per youth was only two. A total of 158 youth had zero suspensions when measured at follow up.

Caregiver Satisfaction Rose Over Time

In a report released Mar. 4, 2016, researchers from the University of Washington found that between 2014 and 2015 caregivers involved with local Wraparound programs had improved satisfaction with the Wraparound process, their youth's progress, their family's progress toward meeting needs, and feeling like things had improved at home. The 2015 scores were in line with averages reported nationally by other Wraparound programs.

WERT
Wraparound Evaluation & Research Team

Strategy 7b
Expand Youth Crisis Services

Expansion of Children's Crisis Outreach Response System (CCORS) 7b

Youth crisis services were expanded under the MIDD in 2011 to address increased demand and to augment staffing with in-home behavioral support specialists. The CCORS team provides direct assistance to families in order to maintain troubled youth safely in their own homes and communities. The MIDD also partially supports marketing and communication efforts for the purpose of increasing awareness about CCORS services. Brochures and posters are available to the public in four languages: English, Spanish, Somali and Vietnamese. The MIDD policy goals for Strategy 7b are to reduce youth detentions, emergency room and psychiatric hospital use and to divert youth from justice system involvement.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
300 youth	**165**	**833**	**998***	**333%**	

*Blended funds allowed more youth to be served than MIDD funds alone.

Service Highlights

Youth served by CCORS in the current period lived in all regions of King County, as shown in the table below:

Region	Number	Percent
Seattle	218	21%
South	336	34%
East	240	24%
North	76	8%
Other/Unknown	128	13%

Half of all CCORS clients in the south and Seattle regions were youth of color, compared to only 37 percent in the north region and 29 percent in the east. Service counts averaged nearly eight per client and did not vary significantly by race or region.

Since MIDD funding of CCORS began in October 2011, 4,445 unique youth had a total of 5,438 service records. For all 4,354 records showing direct services (80%), clients received outreach contacts. Additional crisis stabilization services were provided in 2,706 instances (62%). Out of 5,438 total service records, only 15 (<1%) indicated that the CCORS encounter ended with a foster care placement.

Where the referral reason was hospital diversion, annual diversions between 2013 and 2015 ranged from 91 percent to 94 percent. No significant trend over time was found in the rate of diversions from hospitals.

Longer-Term Outcomes

The 951 CCORS youth who began services prior to October 2012 were eligible for fourth post outcomes analysis on time alone. Within that group, 223 youth (23%) had some measurable system use. Only seventeen youth had use of all three systems: detention, psychiatric hospitals and Harborview's ED. Another 41 had use of two of these systems.

Detention Use: About one in 10 youth served by CCORS had juvenile justice system involvement. Analysis of change over time showed increases in detention bookings by as much as 93 percent (Post 1) and detention days by as much as 192 percent (Post 2). Detentions for the 118 youth eligible by time and use for the fourth post period increased from an average of 1.03 to 1.41 (+37%) and days went up from 11 to 17 (+61%).

Psychiatric Hospital Use: After increases in admissions and days during the first and second post periods, admissions declined in both the third year after MIDD services began (-11%) and the fourth (-23%). Days spent psychiatrically hospitalized increased in all post periods. Over the longest term for this strategy (Pre to Post 4), the average increase was from 10 days to 13 (+33%).

Emergency Department (ED) Use: While the ED at Harborview rarely admits children, records were found for 269 individuals aged three to 18 years at their Strategy 7b start. The greatest reduction in Harborview ED use was -27 percent.

Strategy 8a

Family Treatment Court

Family Treatment Court Expansion 8a

When parental substance abuse results in removal of children from their homes by the state, the MIDD-funded Family Treatment Court (FTC) provides an opportunity for families to reunite. Enrolled individuals are closely monitored by this specialized therapeutic court throughout their substance use disorder (SUD) recovery, with a goal of minimizing their children's involvement in the child welfare system. The primary policy goals for Strategy 8a are reducing parental jail recycling and reducing the incidence and severity of SUD symptoms for participating parents.

Year 8 Target	Year 8 Total	Percent of Year 8 Target	Target Success Rating
120 children* No more than 60 children at one time	**114 children Program monitors capacity**	**95%**	

*Children from families with Native American ancestry are counted at a rate of 1.3 each.

Service Highlights

In addition to the children counted for performance measurement purposes, a total of 83 parents participated in FTC services this period. Nearly half of these families were homeless at their MIDD service start. Families reporting zip codes in the south region of the county were least likely to be experiencing homelessness when they started FTC.

All FTC parents but one were admitted to substance use disorder treatment: four in inpatient, 43 in outpatient, and 35 in both. The majority (62 of 83, or 75%) had achieved a sober date prior to October 2016. Of the 31 parents enrolled in FTC wraparound services, the sober date achievement rate was even higher, at 81 percent.

Achieving sobriety is an important part of successfully completing FTC. Of the 33 parents with exits during MIDD Year Eight, 23 had documented sober dates and 10 did not. Fourteen of the parents who achieved sobriety (61%) graduated from the program, compared to zero of the parents who did not. The average length of time for FTC participants to graduate after their sober date was about one year. By contrast, those who exited from the program without graduating averaged less than four months after their sober dates.

Current graduates averaged nearly two total years in the program while non-graduates averaged just over one year.

Long-Term Outcomes

Jail Use: About half of the 190 parents eligible for outcomes analysis had at least one jail booking other than the one that prompted their involvement with FTC. That means that the other half of FTC enrollees were able to limit their criminal justice system involvement to a single episode over each relevant outcomes analysis period. Of the 49 clients eligible for the longest outcomes period on both time and use criteria, average jail bookings were reduced from 1.76 (Pre) to 0.69 (Post 5), a 60 percent drop. The average number of days spent in jail was cut in half, from 16 to eight days.

Symptoms: A total of 69 adult FTC clients had valid primary substance use frequency data associated with their first SUD treatment episode after MIDD start and their last subsequent discharge date. The time between analyzed measures ranged from 16 days to five years. Two out of three clients showed positive SUD symptom reduction outcomes: 26 who reported no use in the 30 days before starting treatment and no use in the 30 days prior to discharge, 16 who had some use but reduced to no use, and three who had some use but reduced to less use. The remaining 24 clients increased their substance use or continued to use at the same rate over time.

Other Measures: Fourteen FTC participants graduated from the program in 2016, which led to a total of 23 children returning home from alternative placements such as foster or kinship care. Another seven children returned home to their parents after dismissal of their dependency cases.

Strategy 9a

Juvenile Drug Court

Juvenile Drug Court Expansion

9a

Juvenile Drug Court (JDC) expansion under the MIDD has allowed more youth living in the south region of King County to receive therapeutic court services, often in lieu of incarceration. The MIDD funded five additional positions: four specialized juvenile probation counselors and one treatment liaison. The court offers weekly hearings and introduces youth to substance use disorder (SUD) treatment through a number of different engagement track options. The primary policy goals for Strategy 9a are to divert youth from justice system involvement and to reduce SUD symptoms.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
36 new youth	**102**	**20 new opt-ins 14 new pre opt-ins**	**136**	**94% (Total new)**	

Service Highlights

Performance measurement for this strategy counts only those youth who are new in the time period, whether they have formally enrolled in the JDC program (opted in) or not. The total number of youth receiving at least one service through the court in MIDD Year Eight, however, was 136.

Three separate dates are tracked for JDC participants, including their engagement date if they become involved in court services prior to formal opt-in. Of those served in the current period, 79 (58%) had engagement dates. Only 16 of those clients (20%) did not show a subsequent start date. For the remaining 63 youth, the average time between engagement and the formal start of services was two months; the longest lag being six months. Another 57 youth without engagement dates opted directly into the JDC.

Of the 120 youth who had official start dates, 42 (35%) exited services between October 2015 and September 2016. The average time between start and end dates for both successful and unsuccessful clients was just shy of one year. Altogether, 30 of 42 (71%) graduated from the program or successfully completed engagement track activities.

Admissions to SUD treatment were evident for 61 youth: two in inpatient, 44 in outpatient, and 15 in both. Ten of the 30 youth with successful outcomes (33%) had a SUD treatment admission that was documented by the court.

Long-Term Outcomes

Detention Use: Nearly all JDC youth had juvenile justice system involvement outside of charges that brought them into contact with the therapeutic court. Over the longest term measured, JDC participants reduced their detention bookings by 38 percent, from an average of 2.78 (Pre) to 1.73 (Post 5). Their corresponding days detained rose, on average, from 36 to 42.

Symptoms: As reported in August 2016, SUD symptom reduction was analyzed for 234 JDC youth. High level findings are summarized on Page 26 of this report, in combination with individuals served by the Juvenile Justice Assessment Team.

Additionally, a qualitative analysis of open-ended responses to a question about "the main reasons for wanting to quit using substances" included 91 cases from JDC. Friends/family and wanting to avoid trouble were the top motivators at initial and subsequent measure. Over time, motivators tended to change from external (avoiding trouble) to internal (being true to oneself). Only two coded motivators were closely related to reductions in substance use: wanting to 1) "get a job" and 2) "make money." Of the 26 youth listing these reasons as motivators, 19 (73%) reduced their use of marijuana.

Treatment Linkage: Publicly-funded SUD treatment linkages within a year of their MIDD service starts were confirmed for 142 of the 327 youth eligible for short-term outcomes (43%). As the SUD treatment enrollment rate reported by the court is much higher than this, it is probable that many JDC youth had access to private sector treatment.

Strategy 13b

Domestic Violence Prevention

SAFE PLACES

Domestic Violence Prevention

13b

In collaboration with two domestic violence (DV) agencies, Sound Mental Health operates the Children's Domestic Violence Response Team (CDVRT), seeking to reduce the severity of DV-related trauma effects on children and non-abusive parents. The availability of CDVRT services in the south region of the county has been greatly enhanced because of the MIDD. The CDVRT integrates mental health (MH) treatment with DV prevention/intervention practice. The primary MIDD policy goal for Strategy 13b is to reduce the incidence and severity of mental illness symptoms. A secondary policy goal is linkage with King County's 2004 Safe and Bright Futures for Children Initiative, 2014 Youth Action Plan (Ordinance 17738) and 2015 Best Starts for Kids (Ordinance 18088).

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
85 families	**103**	**58**	**161**	**189%**	↑

Service Highlights

During MIDD Year Eight, 190 children were screened for participation in CDVRT-South. A total of 295 unique individuals (158 under the age of 20 and 137 adults) received at least one service. Eighty-three percent of all clients provided zip codes from the south region of the county and 20 percent endorsed Hispanic origin. When language interpretation services were required, the primary language was Spanish.

Program successes were documented by the providers in monthly narrative reports. The list below summarizes key current year highlights:

- Sharing the family law toolkit, created by the King County Coalition Ending Gender Based Violence and other agencies, helped survivors prepare for the complexities of protection orders and family law proceedings.
- Kids Club sessions throughout the year allowed families to interact and bond.
- Support for parents seeking to modify their court-ordered parenting plans strengthened these families.

One documented program challenge involves the provision of services to families for whom English is a second language. The CDVRT recognizes an ongoing need to increase organizational capacity to serve these communities in ways that are equitable and culturally competent. Helping language interpreters understand the dynamics of domestic violence, for example, may ultimately lead to service quality improvements.

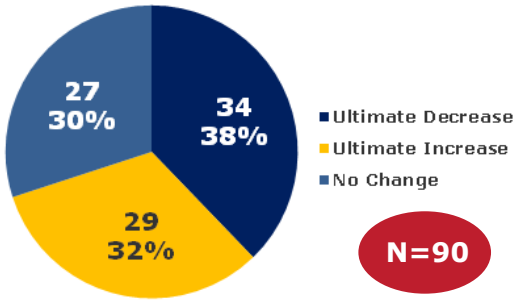
Long-Term Outcomes

Symptoms: The Pediatric Symptom Checklist (PSC-17) provides data for measurement of symptom reduction in children served by the CDVRT. The PSC-17 rates behavioral issues on a scale of zero to 34, with all scores above 14 indicating a need for clinical concern or intervention.

From MIDD inception to March 2016, a total of 436 PSC-17 scores were submitted for 260 unique CDVRT clients. The maximum number of scores per person was eight. Of the 170 youth who had only a single score, 104 (61%) were rated above the clinical threshold for concern and 66 were rated below the threshold.

The remaining 90 individuals had PSC-17 scores at two or more different points in time. Analyses found that 38 percent of these clients showed ultimate decreases over time between the minimum and maximum recorded score (symptom improvement), as illustrated below. For children impacted by DV, worsening of behaviors is often associated with stressors such as contact with the battering parent, threats, or new episodes of DV.

One in Three Kids Decreased Symptoms Over Time



Jail and Hospital Diversion Strategies

Veteran Overcomes Issues to Graduate from King County District Court's Veterans Court

After leaving the military, Alec suffered from Post-Traumatic Stress Disorder (PTSD), had anger issues and started using alcohol to cope with some of these issues. He was arrested for driving under the influence. Each time he tried to stop drinking he always went back to it. He felt his life was over. Things began to change, however, when his mother received a letter in 2014 about the Regional Mental Health Court and Regional Veterans Court.

Alec saw this opportunity as his only chance for recovery and he and his family decided to give it a try. He participated in more treatment than the court recommended and was always in full compliance with his probation terms. Since joining the therapeutic court, he has not been arrested, no longer has issues with PTSD and has learned better coping mechanisms to be able to control his anger. Alec also overcame issues with a past relationship that would often trigger his mental health issues. He's now able to engage with others without fear.

Alec has nothing but praise for this program and its staff who are willing to give veterans "a fair chance and to always go the extra mile." They did not want him to go to jail for a long sentence, but rather to get counseling and addiction treatment. He was so impressed by everything the court did for him. "I am speechless. Thank you for giving me this opportunity to better myself."

Alec is thriving in recovery. He graduated on Nov. 10th, 2016 and received the Veterans Inspiration Award from the King County Veterans Consortium.

Strategy 11b

Mental Health Courts

Story by Titus Chembukha

Medical Respite Program Offers Clients a Second Chance

Homeless for over a decade, sleeping in his car or on the streets, Mr. Doe was 58 years old when he entered services at the Edward Thomas House Medical Respite Program in March 2016. His initial admission was related to a skin abscess, but follow-up testing revealed previously undiagnosed colon and bladder cancers. Mr. Doe underwent extensive surgeries and began his cancer treatment during one of his stays at the respite facility.

While Mr. Doe identified himself as a person who injects heroin and uses alcohol, he did not endorse these issues as a problem in his life. Harm reduction groups offered during his recuperative stay helped him to identify goals and provided him with non-judgmental care. Over the course of several visits to Medical Respite, he began to trust the healthcare system and his providers. Mr. Doe eventually considered starting medication-assisted treatment, as he felt taking daily methadone would be easier than continuing to find heroin on the streets. Discharged to permanent housing, this patient was also able to connect with outpatient mental health care, case management services, methadone maintenance, primary medical care and Public Health-Seattle & King County's Healthcare for the Homeless Network's palliative care program.

Strategy 12b

Hospital Re-Entry Respite Beds

Strategy 10a

Crisis Intervention Team Training

Crisis Intervention Team (CIT) Training for First Responders

10a

Specialized trainings introduce law enforcement officers and other first responders to concepts, skills and resources that can assist them when responding to calls involving people in behavioral health crisis. Delivered at the Washington State Criminal Justice Training Commission in partnership with the King County Sheriff's Office, MIDD-funded CIT trainings focus on diverting people to appropriate services while maintaining public safety. Funds from MIDD also reimburse agencies, as needed, for backfill when officers are in training. The primary policy goal for Strategy 10a is linkage with King County's Adult & Juvenile Justice Operational Master Plans of 2000 and 2002 "to ensure that the criminal justice system is fair, effective, efficient, and integrated."

Year 8 Target	Year 8 Total*	Percent of Year 8 Target	Target Success Rating
180 trainees (40-hour) **300 trainees (one-day)** **150 trainees (other CIT programs)**	**175 (40-hour)** **325 (one-day)** **322 (other)**	**97%** **108%** **215%**	

*Individuals are counted once for participation in each training attended.

Service Highlights

A total of 54 trainings were conducted between October 2015 and September 2016 in support of MIDD Strategy 10a. In addition to week-long basic CIT courses and day-long refreshers, other offerings included Force Options, Mental Health First Aid, Justice-Based Policing, Blue Courage, and Advanced CIT for Hostage Negotiation Teams. As blended funds pay the administration costs for some of these trainings, they are counted even if MIDD is not the sole funder.

For performance measurement calculations, attempts were made to exclude class attendees from agencies outside of King County. During the current period, many of the participants in the CIT refresher courses were Washington State Patrol personnel. These individuals were counted toward performance goals, as their jurisdiction may include areas of King County.

Lifetime training statistics (October 2010 through September 2016) showed that first responders from all regions of the county are being CIT-trained. In addition to 1,379 from the Seattle Police Department (SPD) alone, trainees have included at least 528 from Auburn/Kent/ Renton (South), 466 from Bellevue/Kirkland/ Issaquah/ Mercer Island (East), and 169 from Bothell/Lake Forest Park/Shoreline-King County Sheriff's Office (North). Altogether, 865 King County Sheriff's Office employees have been trained; 16 percent of the 5,269 total lifetime trainees. Note that SPD engages officers in CIT training above and beyond that offered by MIDD.

Course Feedback/Outcomes

"Excited Delirium" (a condition characterized by agitation, anxiety, violent and bizarre behavior, insensitivity to pain, elevated body temperature and superhuman strength) remains the most highly rated topic in the basic course. "Suicide by Cop," a new training topic, was rated second highest. All topics evaluated in MIDD Year Eight received "excellent" or "good" ratings in excess of 90 percent for their relevance and usefulness.

Crisis Intervention Training Works

"Initial data indicate that officers use force against individuals in crisis less than two percent of the time and, when they do use force, 80 percent of the time they use the lowest level of force (and not once used the highest level of force), even in high risk situations."

Seattle Police Monitor, Fifth Systemic Assessment (pg. 1), February 2016

"This is a testament to the impact of enhanced training...Given the Department of Justice's 2011 estimate that more than 70 percent of force incidents involved persons in crisis, these numbers show that officers have embraced, and are applying in practice, the de-escalation and CIT skills that are now emphasized in training."

spdblotter.seattle.gov

In 2016, SPD data showed that at least 697 different officers responded to behavioral health crises. The maximum number of crisis events per officer was 129; the average was 13 each.

Strategy 10b

Adult Crisis Diversion

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

10b

Strategy 10b relies on three interconnected programs operated by DESC through the Crisis Solutions Center (CSC) that opened in August 2012. The MIDD-funded programs include: 1) a Mobile Crisis Team (MCT) responding to first responder requests for crisis de-escalation; 2) a facility specializing in short-term stabilization for adults in crisis; and 3) an interim services facility with up to two weeks of further services to address individualized needs after initial crisis resolution. The primary MIDD policy goals for the CSC are to divert individuals from initial or further justice system involvement and to reduce jail, emergency department and psychiatric hospital use.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total*	Percent of Year 8 Target	Target Success Rating
3,000 adults	**827**	**2,565**	**3,392**	**113%**	

*Individuals are counted once for participation in each of the three different program components.

Service Highlights

The unduplicated number of people served by the CSC during MIDD Year Eight was 2,371, half of whom were served only at the MCT level. Of the 1,196 people known to be homeless at the start of CSC services, 404 (34%) were persons of color and 708 (59%) were Caucasian/White. Race was unknown for the remaining 84 clients.

In August 2016, a request to change the staffing model for the MCT was brought before the MIDD Advisory Committee. The proposed revision would change the requirement for MCT staff to have chemical dependency professional or trainee certification and licensure to a preferred qualification. Comments were heard on licensure challenges at the state level leading to frequent staff turnover, and support was voiced for having dually-trained staff (both mental health and chemical dependency), rather than requiring dual-licensure of staff.

Qualitative Review Yielded Positive Feedback from CSC Clients

Dr. Maria Yang, King County Behavioral Health and Recovery Division's Medical Director and Managing Psychiatrist, visited the CSC in September 2016 to talk with eight clients. Their praise included, "the best place I've ever been"; the staff are "caring", "kind", and "helpful"; "we need more facilities like CSC." One client criticism was that "they need more staff." Client feedback about the CSC was encouraging.

Longer-Term Outcomes

Jail Use: Fourth post period outcomes were available for the 101 CSC clients with any jail use who began services prior to October 2012. Jail bookings for this group declined by 10 percent, from an average of 1.82 (Pre) to 1.63 (Post 4). Days spent in jail over this time period also showed a slight reduction from 30 days, on average, to 27.

Psychiatric Hospital Use: Psychiatric hospitalizations, including stays at Western State Hospital, were reduced by 46 percent when comparing the pre period with the fourth year post. The average length of stay, however, rose slightly over this period from 28 days to 30.

Emergency Department (ED) Use: Over half of all outcomes-eligible CSC clients had at least one admission to Harborview's ED. Increased use of the ED in the first post period was offset by reduced use over the longer term. Going from an average of 3.51 admissions (Pre) to 1.53 (Post 4) represented a 56 percent decrease for the 167 clients entered into the analysis.

Treatment Linkage: Of the 5,367 people who began CSC services prior to October 2015, at least 2,116 were either connected (57%) or re-connected (43%) with publicly-funded mental health treatment in the first year after their MIDD start. The overall short-term linkage rate was 39 percent of unique clients.

Strategy 11a
Increase Jail Liaison Capacity

Increase Jail Liaison Capacity 11a

During court proceedings, judges have the option to assign individuals to King County Work and Education Release (WER), a program where clients can go to work, school or treatment during the day and return to a secure facility at night. During the first seven years of the MIDD, liaison services were available to WER participants prior to completion of their court-ordered time. The liaison's job involved linking clients to services and resources, such as housing and transportation, to reduce recidivism risks. In 2014, the capacity at WER was reduced, so the work of the liaison was expanded to serve additional criminal justice system populations. The contracted liaison position was vacated in 2015 and remained unfilled throughout 2016. The primary MIDD policy goal for Strategy 11a is to reduce jail recycling for clients with mental illness or substance use disorders.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
25 clients*	**0**	**0**	**0**	**0%**	↓

*This target was adjusted from the contracted goal of 100 clients per year to account for staff vacancies. The program anticipated serving 25 clients in the third quarter of 2016, but the position was never filled.

Service Highlights

Although no clients were served under Strategy 11a during MIDD Year Eight, historical data was compiled to illustrate the most common types of referrals offered when liaison services were provided. Detailed spreadsheet data for 228 unique individuals with start dates early in the MIDD was combined with query data for another 459 unique program participants. The most common referrals given to these 687 people were 306 to housing (45%), 267 to state financial benefits (39%), and 181 to community support (26%).

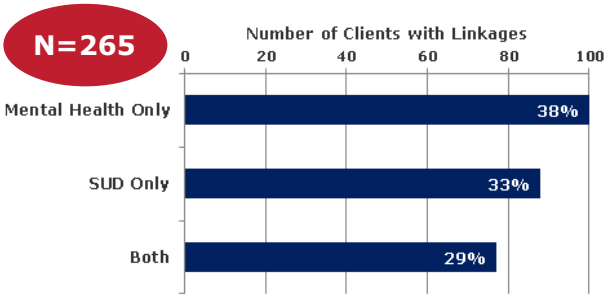
Washington State Department of Corrections (DOC) data became available for analysis for the first time this period. Of the 731 total clients with MIDD Strategy 11a start dates through April 2015, 452 people (62%) were known to have some involvement with the DOC over the past five years. The rate of DOC incarceration was higher for African Americans or Blacks (72%) and for individuals who were experiencing homelessness at the start of their MIDD services (68%). There were no significant differences in prison incarceration rates based on Hispanic origin or veteran status.

Department of Corrections
WASHINGTON STATE

Long-Term Outcomes

Jail Use: Participation in Strategy 11a services was found to be associated with reductions in jail bookings over all post periods studied. For the 354 individuals eligible for outcomes analysis over the longest term, the average number of bookings in King County and local municipal jails was reduced by 60 percent, from 2.67 (Pre) to 1.07 (Post 5). Jail days were similarly reduced over this interval by 34 percent, from an average of 42 days (Pre) to 28 (Post 5). Further analysis is required to understand how local jail recidivism rates are related to the recent DOC findings. In other words, were local jail use reductions offset by incarcerations managed by the State of Washington?

Treatment Linkage: Public sector behavioral health treatment linkages within one year of their MIDD start date were found for 265 of the strategy's 731 outcomes-eligible clients (36%), as shown below.



Strategy 11b

Mental Health Courts

Increase Services for New or Existing Mental Health Court Programs

11b

King County District Court's Regional Mental Health Court (RMHC) began accepting referrals from 39 municipalities throughout the county in 2010. The MIDD provided funding for nine staff, including a dedicated judge, prosecution and defense attorneys, probation officers, court staff and clinicians (formerly called liaisons) to manage these additional "expansion" clients. Strategy 11b was further expanded over time to provide: 1) a court clinician for the Municipal Court of Seattle's Mental Health Court (SMHC) that handles legal competency cases for people booked into jail on charges originating in the City of Seattle; 2) forensic peer support and/or community support services; and 3) a Veterans Court piloted and now operating within the existing RMHC. In 2014, funding switched from supplantation to core MIDD for all therapeutic courts. At that time, a new target was added to count the number of base or "non-expansion" clients served each year. The primary MIDD policy goal for Strategy 11b is to divert clients from initial or further justice system involvement. A secondary policy goal is to reduce behavioral health symptoms over time.

Year 8 Target	Year 8 Total*	Percent of Year 8 Target	Target Success Rating
55 new opt-in expansion clients (RMHC) **83 new non-expansion clients (RMHC)**	**42 new expansion** **94 new non-expansion**	**76%** **113%**	
100 clients after 6/1/2016 (SMHC)	**83 clients**	**83%**	

*See Page 53 for additional detail on the total number of clients served. For RMHC, Veterans Court participants may be expansion or non-expansion clients (as defined below). For SMHC, the target of 300 clients was reduced to 100 due to programmatic changes and staffing issues.

Service Highlights

For RMHC, expansion clients are defined as those opting in to the court after referral from cities throughout King County. Non-expansion clients include felony drop downs and misdemeanors. Note that while only new clients in the time period are used in calculating performance, the court serves many more people each year. The total number of clients tracked by MIDD evaluation who received at least one service through RMHC this period was 334, of whom 53 (16%) participated in the Veterans Court. Please see the success story of one such veteran on Page 32 of this report.

As reported in the Year Eight Progress Report, the MIDD-funded liaison position at SMHC was re-tooled to better align with the original strategy intent to serve individuals with recurrent legal competency issues. Intensive engagement efforts are expected to divert these clients from involvement with Designated Mental Health Professionals and King County's Crisis and Commitment Services. The newly-defined position to help people avoid the civil commitment process and proceed directly to treatment was not filled until May 2016. The number of clients engaged by September was slightly lower than expected.

Long-Term Outcomes

Jail Use: Nearly all participants in SMHC's MIDD expansion services (94%) had King County jail bookings exclusive of their MIDD start date; the incidence for RMHC clients was 76 percent. Both groups greatly reduced their jail bookings over time, with SMHC reaching 60 percent reductions in the third post period and RMHC sustaining 50 percent reductions over both the fourth and fifth post periods. Days spent in jail did not improve at the same rate as jail bookings. Over the longest measured period, individuals in RMHC reduced their jail days, on average, from 40 (Pre) to 31 (Post 5), a 23 percent decrease.

Symptoms: The table below shows changes over time in anxiety and depression for 451 strategy clients with at least two valid scores.

	Anxiety		Depression	
	Clinical Threshold for Concern			
	Above	Below	Above	Below
Improved	21 (5%)	101 (22%)	19 (4%)	95 (21%)
No Change	157 (35%)	90 (20%)	184 (41%)	86 (19%)
Worsened	73 (16%)	9 (2%)	51 (11%)	16 (4%)

Strategy 12a-1

Jail Re-Entry & Education Classes

Jail Re-Entry Program Capacity Increase

12a-1

The MIDD supports short-term case management services provided to incarcerated individuals with mental health (MH) issues and/or substance use disorders (SUD) from prior to their release date through 90 days post-release or as needed. Originally expanded through the MIDD to serve more people jailed in the county's south and east regions, the base program was cut and not replaced when state funding was eliminated in 2010. The primary MIDD policy goal for Strategy 12a-1 is to reduce jail recycling for clients with behavioral health concerns.

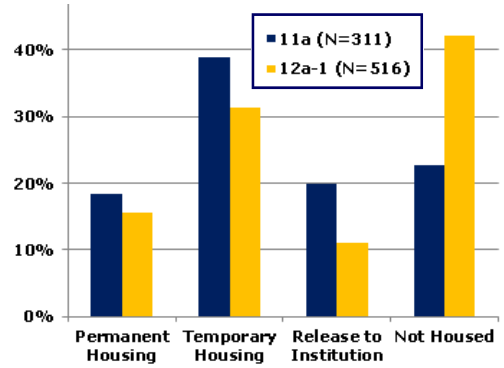
Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
300 clients	**77**	**106**	**183**	**61%**	⬇

Service Highlights

Detailed information on services was available for 903 clients served in this MIDD strategy since 2009. On average, each person who engaged in re-entry services was given three separate referrals. The most common referrals given were to behavioral health care providers within the King County network. Sound Mental Health, the case management provider, referred 633 clients in-house (70%) and 87 to other providers (10%). Other frequent referrals were to social services for 469 clients (52%), to primary care medical providers for 448 (50%), and to housing resources for 255 (28%).

A differential rate of referrals to housing was evident when comparing this strategy to 11a, which served individuals at Work & Education Release instead of the Maleng Regional Justice Center. Strategy 11a's historical referral rate to housing was 45 percent as reported on Page 35. This greater emphasis on finding housing may have contributed to the results reported in February 2016 and illustrated below, whereby 57 percent of 11a clients with data on housing status at exit were permanently or temporarily housed versus only 47 percent of 12a-1 clients.

Housing Status at Exit Differed by Strategy



Long-Term Outcomes

Jail Use: Outcomes information over the longest term measured was available for 565 strategy clients who were eligible on time and use criteria. For this group, jail bookings declined by 66 percent, from an average of 3.48 bookings (Pre) to 1.19 (Post 5).Their days in jail improved by 63 percent over the long term, from 87 days on average (Pre) to 32 (Post 5).

It is possible that the remarkable jail use reductions found for this strategy were offset in part by time incarcerated by the Washington State Department of Corrections (DOC). At least 657 of the 1,247 outcomes-eligible candidates (53%) had some DOC involvement over the past five years. Males (55%) were much more likely than females (39%) to show up in the DOC data. Further analysis is needed to better understand the relationships between King County jail use, DOC incarcerations, and time spent in the community for these MIDD clients.

Treatment Linkages: Within one year of their MIDD service start, 648 of the 1,247 strategy clients eligible for outcomes (52%) were linked with publicly-funded behavioral health care. Mental health treatment linkages were confirmed for 245 people (38%), SUD treatment linkages were confirmed for 179 (28%), and both types of treatment linkages were confirmed for the remaining 224 (34%).

Strategy 12a-2

Jail Re-Entry & Education Classes

Education Classes at Community Center for Alternative Programs (CCAP)

12a-2

Adults in the criminal justice system may be court-ordered to serve time at King County's Department of Adult & Juvenile Detention (DAJD) CCAP and/or The Learning Center (TLC) at South Seattle College. King County's Community Corrections Division (CCD) within DAJD holds people accountable for attendance in various structured programs, including those made possible at CCAP and TLC. With MIDD funding, life-skills, job and general education (GED) preparation, and domestic violence (DV) prevention classes are provided. The primary MIDD policy goal for Strategy 12a-2 is to reduce jail recycling for clients with behavioral health concerns.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total*	Percent of Year 8 Target	Target Success Rating
600 clients	**71**	**363**	**434**	**72%**	

*Individuals are counted once for participation in each different program component.

Service Highlights

A total of 114 CCAP clients took advantage of Life Skills to Work (LSW) and GED classes offered by TLC this period. Twelve percent of participants were female, and 38 percent were known to be persons of color. Note that race was unknown for 22 clients. The average age for female students was 31 years; for male students the average age was 29.

Photo from CCD website

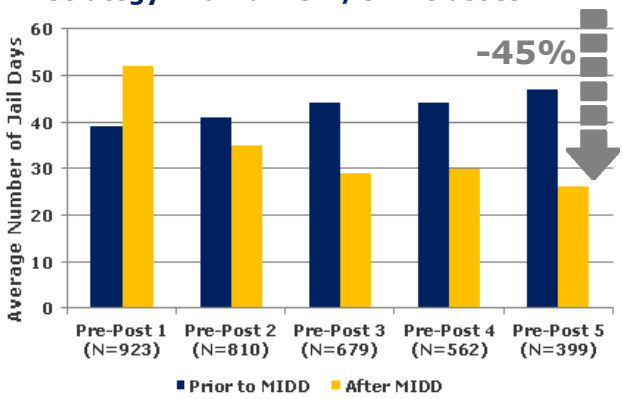
From October 2015 through September 2016, 84 unique females attended an average of eight DV prevention classes each (range 1 to 47 classes). The five topics with greatest attendance for women in descending order of frequency were: Emotions (96), Red Flags/Triggers/Warning Signs of Abuse (91), Healthy Relationships (71), Boundaries (70), and Coping (56).

During the same time period, 238 unique males averaged three DV classes each (maximum was 19). Topics attended by the greatest number of male participants were: Healthy Relationships (206), Emotions (95), Assertiveness (71), Self Esteem (68), and Sexism/Racism/Homophobia (58).

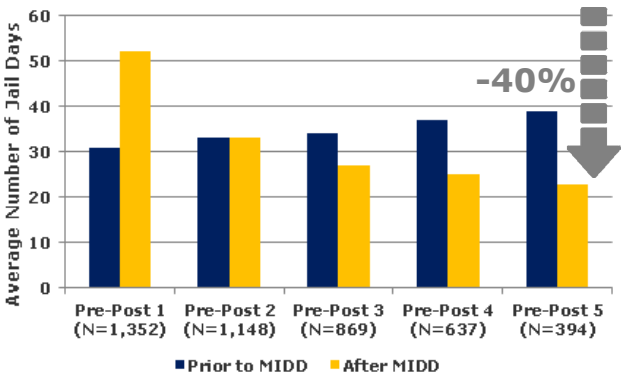
Long-Term Outcomes

Jail Use: Participants in MIDD-funded education opportunities experienced long-term reductions in jail bookings as high as 60 percent. Days were ultimately decreased by as much as 45 percent. The differential declines in average jail days over all time periods are plotted separately below for groups of people taking the different classes.

Strategy 12a-2a: LSW/GED Classes



Strategy 12a-2b: DV Classes



Strategy 12b

Hospital Re-Entry Respite Beds

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

The September 2011 opening of an expanded medical respite program adjacent to Seattle's Harborview Medical Center (HMC) was made possible with funds from over 10 different sources, including the MIDD. The program serves adults without housing who need a safe place to recuperate upon discharge from area hospitals. The MIDD helps provide mental health (MH) and substance use disorder (SUD) services, including case management, treatment referrals and housing linkages. The primary MIDD policy goal for Strategy 12b is to reduce jail, emergency room and psychiatric hospital use.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
350-500 clients	**71**	**292**	**363**	**104%**	↑

Service Highlights

As reported in August 2016, the Edward Thomas House respite facility was remodeled during the current period to allow private space for the mental health team to meet with their clients. The program also began participation in a Center for Medicare & Medicaid Innovation five-site evaluation study to demonstrate improved health outcomes and reduced spending when homeless patients have access to medical respite care following a hospital stay.

Of the 363 unique clients served in MIDD Year Eight, 44 (12%) were admitted twice and 16 (4%) had three or more respite admissions. The average length of stay per admission was 20 days; the maximum stay was 193 days.

Exit reason information revealed that treatment was completed for 221 of the 445 respite stays with exit dates (50%). In 81 cases (18%), the patients needed further hospitalization. The number of stays that ended in clients leaving against medical advice (79) or due to a policy violation (55) was about the same as the prior year comparison. Ideally, treatment completion rates will again reach the 57 to 66 percent range reported in prior MIDD years.

About 82 percent of the cases with successful completions of recuperative care were sheltered or temporarily housed upon exit, including doubling up with friends and families or using hotel vouchers. This means that 20 people were discharged to the streets; client choice is sometimes a factor in these situations.

Long-Term Outcomes

Jail Use: Due to delayed implementation of this strategy, the longest term available for analysis of jail use outcomes was four years beyond the start of MIDD services. The jail use incidence rate of 40 percent also limited the number of clients eligible for the analysis. For the 115 respite care patients with a history of criminal justice system involvement, jail bookings were reduced on average from 2.01 (Pre) to 1.00 (Post 4). The days associated with these bookings fell only 14 percent, from an average of 29 days (Pre) to 25 (Post 4).

Psychiatric Hospital Use: Psychiatric hospitalizations were fairly rare (8%) for medical respite patients. Only 27 people had an inpatient community psychiatric hospital admission or Western State Hospital admission in the year prior to MIDD services or in the fourth post period. For that small group, psychiatric hospitalizations were reduced by 63 percent. Days, by contrast, rose by 32 percent, from an average of 14 (Pre) to 18 (Post 4).

Emergency Department (ED) Use: Admissions to Harborview's ED were common for this group with 93 percent of strategy participants matching to data provided by Harborview. After slight first-year increases in ED use, reductions as high as 63 percent were recorded in all subsequent post periods. By the fourth post period, the average number of admissions was reduced from 3.76 (Pre) to 1.38 (Post 4).

Strategy 12c
Psychiatric Emergency Services Linkage

Increase Harborview's Psychiatric Emergency Services (PES) Capacity

12c

For Strategy 12c, intensive case managers use assertive techniques to engage reluctant clients who have been identified as high-utilizers of Harborview Medical Center's emergency department (ED). By developing therapeutic relationships during outreach efforts and while assisting with medically-centered services, social workers contracted through the MIDD work together with people experiencing homelessness to find solutions to problems that formerly presented insurmountable barriers to their successful investment in more traditional systems of care. The primary MIDD policy goal is to reduce jail, emergency room and psychiatric hospital use.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
75-100 clients	**40**	**59**	**99**	**132%**	↑

Service Highlights

During the current reporting period, 21 percent of the PES high-utilizers served were female and 10 percent were United States military veterans. Client race was evenly split between persons of color and Caucasian/Whites. The oldest client served was 79 years of age and the youngest was 19; the average age was 47. While the program serves a predominantly homeless population, zip code data and information on residential arrangement at MIDD start were missing for 53 of the people served this period.

Nearly half of all individuals served by the PES in MIDD Year Eight had documented disabilities. The most common category was medical or physical, with 25 clients counted. Psychiatric, developmental, and sensory or communication disabilities accounted for the other 16 clients experiencing disabling conditions. Patients seen in the PES traditionally cover a broad spectrum of clinical diagnoses including mood, psychotic, personality and substance use disorder.

Long-Term Outcomes

Jail Use: Nearly half of all Strategy 12c patients were involved with the local criminal justice system. In all outcomes periods examined, jail bookings were reduced by as much as 62 percent, a level sustained over both the fourth and fifth post periods. The number of jail days associated with the aforementioned bookings ultimately fell by 24 percent, from an average of 40 days (Pre) to 30 (Post 5).

Psychiatric Hospital Use: One in three frequent users of the PES had community inpatient psychiatric hospital admissions and/or stays at Western State Hospital. These hospitalizations were cut in half and sustained over the third, fourth and fifth post periods. Associated days at inpatient facilities were also reduced significantly, where the greatest reduction showed average days declining from 36 (Pre) to 24 (Post 5).

Emergency Department (ED) Use: Over the longest period measured, Harborview ED admissions were reduced for MIDD PES clients by 74 percent, from an average of 10.90 (Pre) to 2.83 (Post 5).

Treatment Linkage: Within one year of starting MIDD services, 330 of the 504 eligible clients (65%) were linked with public sector behavioral health benefits. There were 152 people enrolled in mental health treatment only, 86 in substance use disorder treatment only, and 92 in both.

Strategy 12d

Behavior Modification Classes

Behavior Modification Classes for Community Center for Alternative Programs (CCAP) Clients

12d

Moral Reconation Therapy (MRT) is an evidence-based cognitive-behavioral program proven to be especially effective for clients with substance use disorders (SUD). With MIDD funding, a certified MRT facilitator is contracted to work with enrolled clients to enhance moral reasoning, to improve their decision-making skills and to help them engage in more prosocial behaviors. In October 2014, the clinician funded by MIDD transitioned to facilitating specialized MRT classes for a group of individuals assigned to CCAP for domestic violence (DV) offenses. The primary MIDD policy goal for both MRT and MRT-DV classes is to reduce jail recycling. A secondary policy goal is to reduce behavioral health symptoms over time.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
40 clients	**9**	**44**	**53**	**133%**	↑

Service Highlights

Originally serving up to 189 clients in a year, three factors have impacted the number of clients recently served by MIDD Strategy 12d: 1) providing services only to individuals serving alternative sentences for DV offenses, 2) class size limitations, and 3) randomized assignment of clients to MRT versus other interventions. These changes were necessary to enable rigorous assessment of the efficacy of this evidence-based practice for a category of offenders with few verified treatment options. An in-depth analysis is being conducted outside of the MIDD evaluation, but results will be shared through the MIDD reporting process.

Altogether 82 clients have entered MRT under the new DV criteria. Comparing this group with all MIDD participants prior to the change, some key demographic differences, which may lead to differential outcomes, were evident as shown in the table below.

Demographics Differed by Target Population

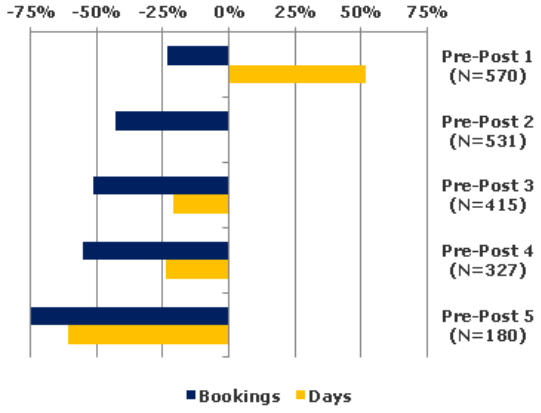
	DV Only Cases (N=82)	Earlier Cases (N=629)
Male	100%	84%
Average Age	31 years	37 years
Caucasian/ White	42%	51%
Hispanic	12%	8%
Homeless	15%	26%
South Region	44%	34%

Long-Term Outcomes

Jail Use: Jail bookings for MRT clients were reduced in all five post periods studied. This strategy was the only one that exceeded the long-term adjusted MIDD reduction target for jail use of 70 percent by the fifth post period. See Page 55 for more information on targets.

Initial increases in jail days for Strategy 12d (shown below) were likely due to sanctioning, or judges using jail time to discipline individuals for non-compliance with court orders. Over the longest term, however, MRT clients who began services prior to October 2011 reduced their jail days from an average of 44 (Pre) to 17 (Post 5).

Jail Bookings Greatly Reduced Over Time



Symptoms: Problem Severity Summary (PSS) scores were available for 553 MRT participants. Of the 435 people with only a single score, about 40 percent had anxiety and depression levels below the concern threshold. Of the 118 with any change over time, about one in three showed improved anxiety and depression scores.

Strategy 15a

Adult Drug Court

RECOVERY

Adult Drug Court Expansion of Recovery Support Services

15a

The Adult Drug Court (ADC) within King County's Judicial Administration has offered clients supplemental services with MIDD support. In addition to enhancing educational opportunities for people with learning disabilities, the ADC employs 1.5 housing case management specialists. These case managers help clients with substance use disorders (SUD) find and keep drug-free housing. In 2012, the court secured eight recovery-oriented transitional housing units with on-site case management for transition age youth (18 to 24 years), replacing Young Adult Wraparound. In 2015, MIDD evaluation began tracking all ADC clients in the base court, in addition to those engaged in the expansion services. The primary MIDD policy goal of ADC is to divert clients with SUD from further justice system involvement. A secondary policy goal is to reduce SUD symptoms.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total	Percent of Year 8 Target	Target Success Rating
250 expansion clients **300 base clients**	**175** **236**	**127** **215**	**302 expansion** **451 base**	**121%** **150%**	↑

Service Highlights

For the purpose of MIDD performance measurement, expansion clients are defined as those participating in CHOICES classes, housing case management and/or receiving housing vouchers. All other ADC participants are considered part of the base program, which offers eligible defendants the opportunity to receive drug treatment and access to other services.

During the current period, the key demographic difference between base and expansion clients was their experience of homelessness, whereby 79 percent of those enrolled in expansion services were homeless at their ADC start versus only 26 percent of those not enrolled. Expansion clients were also more likely to have reported Seattle zip codes (24% vs. 15% of base clients). Overall, zip code information was unknown for nearly half of all ADC clients.

Only five clients participated in classes geared toward individuals with learning disabilities this period and it is unlikely that the contract for these services will continue in 2017. Housing case management remained popular, with 301 unique participants averaging three hours of these specialized services each during the current period. The eight young adult annual housing vouchers were issued to 19 unique clients who were maintained in housing from one to 12 months, with an average of six months per recipient. The average age of those receiving vouchers was 22.

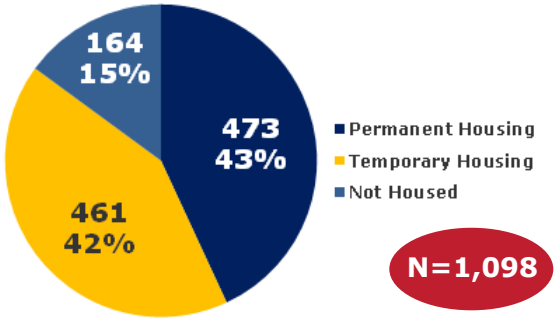
Long-Term Outcomes

Jail Use: Jail bookings were reduced by as much as 61 percent for participants in ADC. For the 512 people eligible for outcomes by both time and use over the longest term, average jail days decreased by 45 percent, from 32 days (Pre) to 18 (Post 5).

Symptoms: Of the 424 ADC clients who reported any substance use in the 30 days prior to SUD treatment, 211 (50%) showed decreased use over time; 179 (42%) had unchanged use.

Housing Status at Exit: A total of 1,098 ADC clients tracked for the MIDD evaluation had exits prior to April 2016, plus data on both housing case management hours and housing status at exit. Housing outcomes varied by the average number of case management hours over the course of ADC involvement: not housed (4.37 hours), temporarily housed (about 10 hours) and permanently housed (nearly 13 hours). While other factors could have contributed to these findings, the differences between housing outcome groups were statistically significant.

85 Percent of Expansion Clients Were Housed



Strategy 16a

New Housing & Rental Subsidies

New Housing Units and Rental Subsidies

16a

Prior to full implementation of the MIDD, capital funding was appropriated for Strategy 16a to expedite construction of new housing units to benefit the MIDD's target population. While the majority of these housing units currently receive ongoing funding for supportive services under Strategy 3a, one capitally-funded project (Brierwood) does not, so those clients are tracked here, rather than on Page 20. This strategy also provides 25 rental subsidies per year, from previously allocated funds. Two primary MIDD policy goals for Strategy 16a are 1) to reduce jail, emergency room and psychiatric hospital use, and 2) to link with King County's 2005 Ten-Year Plan to End Homelessness and the All Home strategic plan.

Year 8 Target	Continued Services from Prior Years	New in Year 8	Year 8 Total*	Percent of Year 8 Target	Target Success Rating
25 rental subsidies **25 Brierwood tenants**	**12** **19**	**14** **3**	**26** **22**	**104%** **88%**	⬆

Service Highlights

The majority of individuals benefitting from MIDD capital funding for housing are being tracked under Strategy 3a - Supportive Housing, as ongoing funds were made available to provide behavioral health supports in almost all of the capitally-funded facilities. The exceptions to that rule are shown here under Strategy 16a.

From October 2015 through September 2016, 48 unique individuals were housed with help from MIDD funds collected back in 2008. The group was demographically diverse as follows:

- 50 percent male and 50 percent female
- All four county regions: north (42%), south (35%), Seattle (19%), and east (4%)
- 66 percent Caucasian/White, 19 percent African American/Black, 10 percent Asian/ Pacific Islander, and 4 percent multiracial
- Primary languages spoken other than English included Amharic, Spanish, and Vietnamese.

Long-Term Outcomes

Jail use: Only 37 percent of Strategy 16a clients had local criminal justice system involvement. Significant reductions in jail bookings were found in all five post periods studied, with the greatest reduction found in the fourth post period (-75%) when the average number of bookings fell from 2.00 (Pre) to 0.50 (Post 4). Days in jail were also reduced drastically in all outcomes analysis periods with the greatest improvement showing a decrease from an average of 50 days (Pre) to 16 (Post 4).

Psychiatric Hospital Use: Three of every four participants in this MIDD strategy had at least one psychiatric hospitalization. By comparison, the next highest incidence of psychiatric hospital use in other MIDD strategies was three out of 10 participants. Reductions in admissions as high as 76 percent were sustained over both the fourth and fifth post periods. Reductions in days hospitalized reached a high of 87 percent for 77 eligible clients over the longest measured period, from an average of 101 days (Pre) to 13 (Post 5).

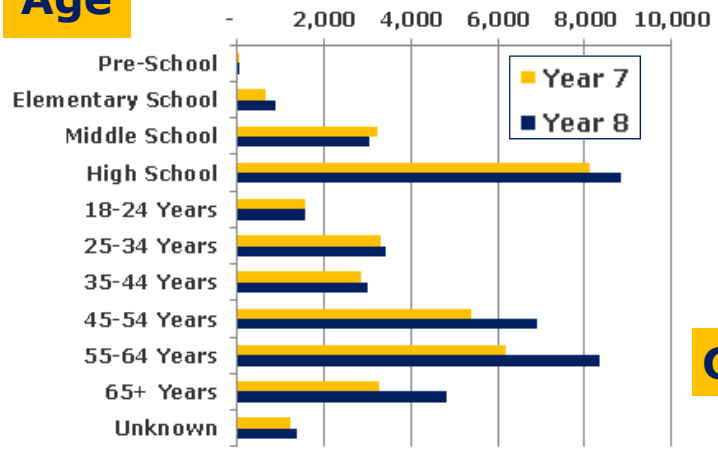
Emergency Department (ED) Use: The number of people eligible for analysis of Harborview ED usage over time ranged from 97 (Post 1) to 58 (Post 5). Regardless of sample size, targeted reductions were met in all periods. The greatest reduction was found in the fourth year after MIDD services began, when clients reduced their average ED admissions from 1.97 (Pre) to 0.75 (Post 4).

MIDD Demographics and Access to Services

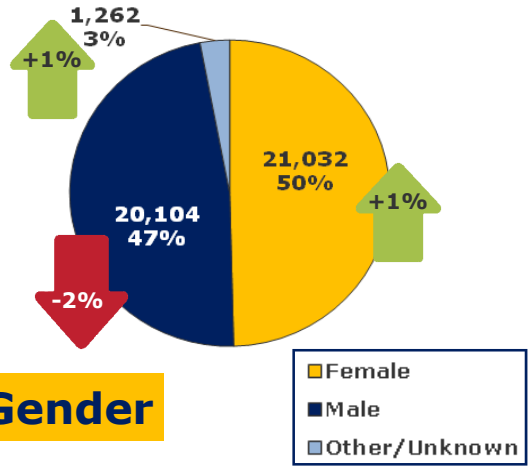
Information on age group, gender, primary race and King County region was available for 42,398 unduplicated people who received at least one MIDD-funded service between October 2015 and September 2016. Those with duplicate demographics across strategies and multiple data sources were counted only once here. The number of unduplicated people with demographics represents an 18 percent increase over the prior year, largely due to another substantial increase in older adults screened in primary care settings. Even more clients, who could not be unduplicated, were served in large groups through school-based services (N=25,920) and the MIDD's family support organization (N=1,830).

Unduplicated Demographic Distributions with Prior Year Comparisons

Age

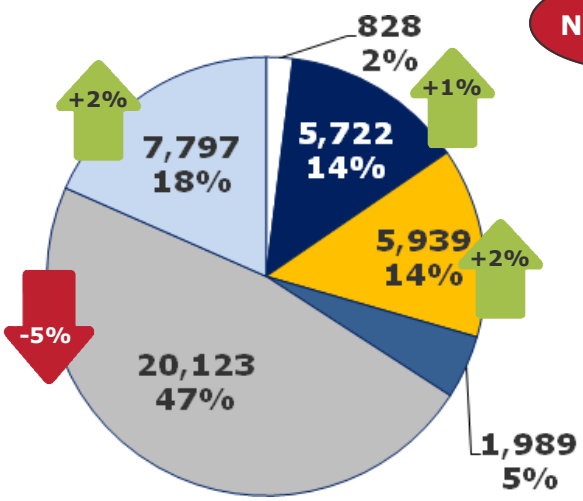


Gender



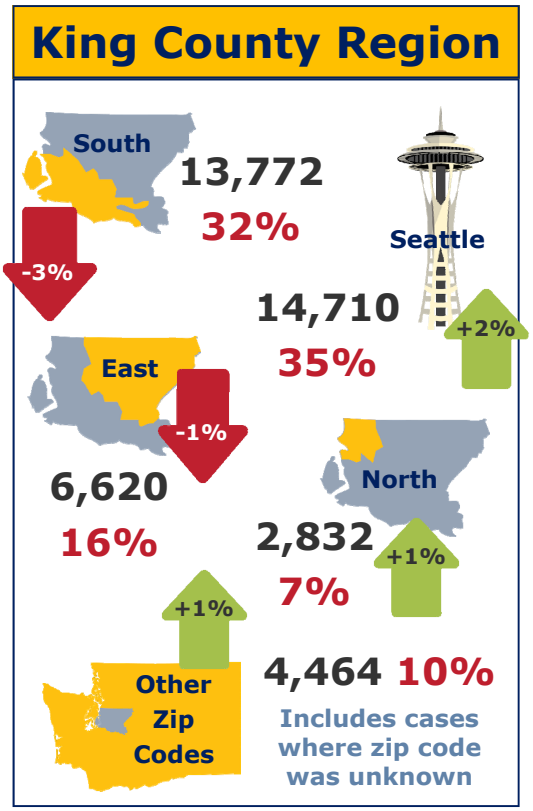
N=42,398

Primary Race



	Portion Known to be Hispanic	
	Year 7	Year 8
Native American	9%	10%
African American/Black	2%	3%
Asian/Pacific Islander	2%	4%
Multiple Races	21%	22%
Caucasian/White	7%	8%
Other/Unknown	56%	49%

King County Region



MIDD Services Accessed at Rates Close to Poverty Statistics

Census data recently became available to update King County population and poverty estimates through 2015. The table below shows the breakdown by race of the estimated total county population, the estimated county population living below poverty level and the MIDD services population for October 2015 through September 2016. This table would indicate that Caucasian or white individuals are accessing MIDD services at slightly lower rates than expected, based on their estimated poverty distribution. For persons of color, however, MIDD service delivery appears to be aligned quite closely with the poverty statistics. In the MIDD sample, we know that 78 percent of the "Other" race category is made up of individuals identifying as Hispanic only. Because of King County's commitment to making services available to people regardless of their immigrant or refugee status, it is not surprising that this percentage runs higher for the MIDD services group. Unfortunately, the high portion of MIDD service recipients whose race is not known makes drawing firm conclusions about equitable access to MIDD services difficult using these types of comparisons.

Race	Estimated* Total King County Population	Estimated* Below Poverty King County Population	Services During MIDD Year Eight
Caucasian/White	68%	53%	47%
Asian/Pacific Islander	16%	17%	14%
African American/Black	6%	15%	14%
Native American	1%	2%	2%
Multiple Races	6%	7%	5%
Other	3%	6%	9%
Unknown	0%	0%	9%

** 2011-2015 American Community Survey 5-Year Estimates*

Higher Percentages of Three Race Categories Accessed MIDD Services

Dividing the number of unduplicated MIDD service recipients in the current period (42,398) by the most recent estimated King County population (2,016,519), shows that just over two percent of the people in King County received at least one MIDD service. Where race was known, nine percent of those categorized as "Other" received MIDD services, compared to five percent of African American/ Blacks, six percent of Native Americans, but only one percent of Caucasian/Whites. Of the estimated county population living below poverty, 18 percent received a service in MIDD Year Eight. The percentages varied by race, however, whereby only 11 percent of those with both multiple races and poverty were served, compared with 23 percent of Native Americans in poverty and 37 percent of the "Other" group with poverty status.

Top Three Strategies Serving Persons of Color in the Current Reporting Period

Strategy 5a
Juvenile Justice Assessments
74%

Strategy 1a-2a
Substance Use Disorder Outpatient Treatment

66%

Strategy 1f
Parent Partners Family Assistance
65%

Homeless status was known for 35,628 cases (one person per strategy) in the current period. Of those cases, 6,921 (19%) were experiencing homelessness at the start of their MIDD services.

Veteran status was known for 23,713 unique individuals. Of the 1,170 who identified as U.S. military veterans, 282 (24%) were not housed when their MIDD services began.

MIDD Financial Reports

Financial information provided over the next three pages is for the 2015-2016 biennial budget with actual expenditures through the end of December 2016. The MIDD sales tax fund spent just over $103 million in strategy, therapeutic courts, and other funding and nearly $17 million in MIDD supplantation since Jan. 1, 2015. The unreserved fund balance on Dec. 31, 2016 was approximately $5.9 million. Parts I and II show budgeted and actual spending by category. Also included in the financial report are 2016 supplemental appropriation details, supplantation spending, summary revenues/expenditures, and a fund balance analysis. Please note that strategies 13a and 14a share funds, as needed.

Mental Illness and Drug Dependency Fund - Part I

	Strategy or MIDD Operating Category	2015-2016 Biennial Budget	Actual Biennial-to-Date (through Dec. 2016)	Actual vs Budget (Rounded)
1a-1	Increase Access to Community Mental Health Treatment & Club House	$ 16,922,598	$ 16,779,742	99%
1a-2	Increase Access to Community Substance Abuse Treatment	$ 5,203,879	$ 5,077,704	98%
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities	$ 1,007,241	$ 935,881	93%
1c	Emergency Room Substance Abuse Early Intervention Program	$ 1,614,345	$ 1,129,911	70%
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	$ 533,985	$ 544,918	102%
1e	Chemical Dependency Professional Education and Training	$ 1,730,203	$ 1,417,904	82%
1f	Parent Partner and Youth Peer Support Assistance Program	$ 788,271	$ 788,271	100%
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	$ 922,819	$ 910,798	99%
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	$ 641,299	$ 641,299	100%
2a	Workload Reduction for Mental Health	$ 8,202,832	$ 8,130,816	99%
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	$ 2,050,708	$ 2,050,708	100%
3a	Supportive Services for Housing Projects	$ 4,101,416	$ 4,101,416	100%
4a	Services for Parents in Substance Abuse Outpatient Treatment	$ -	$ -	
4b	Prevention Services to Children of Substance Abusers	$ -	$ -	
4c	Collaborative School-Based Mental Health and Substance Abuse Services	$ 2,614,758	$ 2,400,165	92%
4d	School-Based Suicide Prevention	$ 407,173	$ 404,219	99%
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 358,898	$ 217,239	61%
6a	Wraparound Services for Emotionally Disturbed Youth	$ 9,159,800	$ 8,893,190	97%
7a	Reception Centers for Youth in Crisis	$ -	$ -	
7b	Expansion of Children's Crisis Outreach Response Service System	$ 1,017,887	$ 1,015,348	100%
8a	Expand Family Treatment Court Services and Support to Parents	$ 165,477	$ 152,690	92%
9a	Expand Juvenile Drug Court Treatment (See Part II)	$ -	$ -	
10a	Crisis Intervention Team Training for First Responders	$ 1,555,496	$ 1,087,493	70%
10b	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	$ 12,418,796	$ 12,037,378	97%
11a	Increase Jail Liaison Capacity	$ 163,050	$ 57,919	36%
11b	Increase Services for New or Existing Mental Health Court Programs	$ 1,411,144	$ 1,256,699	89%
12a	Jail Re-Entry Program Capacity Increase	$ 649,684	$ 630,726	97%
12b	Hospital Re-Entry Respite Beds	$ 1,035,241	$ 1,015,867	98%
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	$ 407,174	$ 390,155	96%
12d	Behavior Modification Classes for CCAP Clients	$ 152,688	$ 159,846	105%
13a	Domestic Violence and Mental Health Services	$ 633,616	$ 707,079	112%
13b	Domestic Violence Prevention	$ 456,033	$ 442,807	97%
14a	Sexual Assault, Mental Health and Chemical Dependency Services	$ 1,015,440	$ 751,124	74%
15a	Drug Court: Expansion of Recovery Support Services	$ 212,819	$ 212,819	100%
16a	New Housing Units and Rental Subsidies	$ -	$ -	
	MIDD Administration	$ 7,363,774	$ 6,670,279	91%
	Evaluation and Treatment New Facilities Capital	$ 4,750,000	$ 3,547,691	75%
	Behavioral Health Integrated Data System	$ 982,633	$ 982,633	100%
	Naloxone	$ 120,000	$ 117,608	98%
	Peer Bridger	$ 590,000	$ 543,981	92%
	2016 Supplemental Appropriation Ordinance 18311	$ 2,730,000	$ 1,525,800	56%
	Total MIDD Operating Dollars	**$ 94,091,177**	**$ 87,730,122**	**93%**
	Percentage of Appropriation		**93.24%**	

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	2015-2016 Biennial Budget	Actual Biennial-to-Date (through Dec. 2016)	Actual vs Budget (Rounded)
	Department of Judicial Administration	**$ 3,764,000**	**$ 3,629,129**	**96%**
	Drug Court: Expansion of Recovery Support Services	$ -	$ 306,690	
15a	Adult Drug Court Base	$ 3,764,000	$ 3,322,439	88%
	Prosecuting Attorney's Office	**$ 3,330,000**	**$ 3,170,189**	**98%**
	Adult Drug Court Base	$ 1,558,676	$ 1,999,911	94%
	Juvenile Drug Court Base	$ 325,140	$ 81,185	111%
	Mental Health Court Base	$ 1,446,185	$ 1,079,623	87%
11b	Mental Health Court Expansion	$ -	$ 9,470	93%
	Superior Court	**$ 3,689,000**	**$ 3,624,834**	**98%**
5a	Expand Assessments for Youth in the Juvenile Justice System	$ 509,703	$ 442,872	87%
8a	Expand Family Treatment Court Services and Support to Parents	$ 1,457,685	$ 1,374,269	94%
9a	Expand Juvenile Drug Court Treatment	$ 1,118,802	$ 1,245,514	111%
	Family Intervention Restorative Services (FIRS)	$ 229,000	$ 213,911	
	Adult Drug Court Base	$ 373,809	$ 348,268	93%
	Juvenile Drug Court Base	$ -	$ -	
	Family Treatment Court Base	$ -	$ -	
	Sheriff	**$ 434,000**	**$ 326,249**	**75%**
10a	Crisis Intervention Team Training for First Responders	$ 334,000	$ 326,249	98%
	Response Planning and De-escalation and Referral (RADAR)	$ 100,000	$ -	
	Department of Public Defense	**$ 3,647,000**	**$ 2,910,546**	**80%**
	Adult Drug Court Base	$ 1,570,294	$ 1,705,232	109%
	Juvenile Drug Court Base	$ 205,235	$ 186,933	91%
	Mental Health Court Base	$ 1,082,517	$ 698,297	65%
	Family Treatment Court Base	$ 788,954	$ 320,084	41%
	District Court	**$ 2,115,000**	**$ 1,944,267**	**92%**
	Mental Health Court Base	$ 2,115,000	$ 1,935,598	92%
11b	Increase Services for New or Existing Mental Health Court Programs	$ -	$ 8,669	
	Total Other MIDD Funds	**$ 16,979,000**	**$ 15,605,213**	**92%**
	Percentage of Appropriation		**91.91%**	
	Total All MIDD Funds	**$ 111,070,177**	**$ 103,335,335**	**93%**

Mental Illness and Drug Dependency 2016 Supplemental Appropriation Details

		2015-2016 Biennial Budget	Actual Biennial-to-Date (through Dec. 2016)	Actual vs Budget (Rounded)
	2016 Supplemental Appropriation Ordinance 18311	**$ 2,730,000**	**$ 1,525,800**	**56%**
	Youth Detoxification and Stabilization	$ 350,000	$ -	0%
	Opiate Epidemic Response	$ 300,000	$ 64,668	22%
	Residential SUD Capital	$ 650,000	$ 135,061	21%
	SUD Trauma Informed Care	$ 50,000	$ 28,333	57%
	MIDD 2b Supported Employment	$ 250,000	$ 177,569	71%
	Adult Drug Court Housing	$ 15,000	$ 10,168	68%
	Trans Resource and Referral Guide	$ 30,000	$ 30,000	100%
	Homeless Housing Capital Support	$ 1,000,000	$ 1,000,000	100%
	Step Up Bilingual Facilitator	$ 5,000	$ -	0%
	Vashon Youth & Family BH Services	$ 80,000	$ 80,000	100%

Funds appropriated through the county's 2016 supplemental budget process, as detailed above, support MIDD program enhancements and pilot programs, and are one time. Note three major changes since the MIDD Year Eight Progress Report (August 2016): 1) funds for RADAR were moved from the 2016 supplemental table to Part II under the Sheriff's MIDD appropriation unit above, 2) funds for FIRS were separated from 9a - Expand Juvenile Drug Court Treatment in Part II above, and 3) funds erroneously allocated to the unimplemented Strategy 7a - Reception Centers for Youth in Crisis are now correctly reflected under MIDD Administration in Part I on Page 46 of this report. Other slight modifications can occur when legislation is adopted to finalize budgets.

Mental Illness and Drug Dependency Fund - Supplantation Details

MIDD Supplantation	2015-2016 Biennial Budget	Actual Biennial-to-Date (through Dec. 2016)	Actual vs Budget (Rounded)
Department of Adult and Juvenile Detention	**$ 810,000**	**$ 809,720**	**100%**
Community Center for Alternate Programs (CCAP)	$ 63,157	$ 57,288	91%
Juvenile MH Treatment	$ 746,843	$ 752,432	101%
Public Health: Jail Health Services	**$ 5,691,000**	**$ 5,546,281**	**97%**
Psychiatric Services	$ 5,691,000	$ 5,546,281	97%
MH & SUD MIDD Supplantation	**$ 10,942,823**	**$ 10,337,545**	**97%**
Sexual Assault Supplantation (to CSD)	$ 742,355	$ 742,355	100%
SUD Administration	$ 817,989	$ 817,989	100%
Criminal Justice Initiative	$ 2,110,624	$ 1,889,382	90%
SUD Contracts	$ 556,046	$ 557,407	100%
Housing Voucher Program	$ 1,233,033	$ 1,226,615	99%
SUD Emergency Service Patrol	$ 1,033,968	$ 1,180,107	114%
CCAP	$ 967,772	$ 819,670	85%
MH Co-Occurring Disorders Tier	$ 1,636,915	$ 1,332,308	81%
MH Recovery	$ 383,979	$ 367,359	96%
MH Juvenile Justice Liaison	$ 184,153	$ 125,073	68%
MH Crisis Respite Beds	$ 539,376	$ 596,995	111%
MH Functional Family Therapy	$ 556,552	$ 497,066	89%
MH Mental Health Court Liaison	$ 180,061	$ 185,218	103%
Total MH/SUD MIDD Supplantation Funds	**$ 17,443,823**	**$ 16,693,546**	**96%**
Percentage of Appropriation		**95.70%**	

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	2015-2016 Biennial Budget	Actual Biennial-to-Date (through Dec. 2016)	Actual vs. Budget (Rounded)
Revenue			
MIDD Tax	$ 117,053,628	$ 118,036,681	101%
Streamlined Mitigation	$ 1,200,000	$ 1,176,057	98%
Investment Interest - Gross	$ 110,000	$ 101,989	93%
Cash Management Svcs Fee		$ (1,532)	
Invest Service Fee - Pool		$ (413)	
Unrealized Gain (Loss)		$ 1,800	
Other Miscellaneous Revenue		$ 301,478	
Total Revenues	**$ 118,363,628**	**$ 119,616,060**	
Total MIDD Funds	$ 111,070,177	$ 103,335,335	93%
Total MIDD Supplantation	$ 17,443,823	$ 16,693,546	96%
Total Expenditures	**$ 128,514,000**	**$ 120,028,881**	**93%**
Expenditures Over Revenues	**$ (10,150,372)**	**$ (412,821)**	

Mental Illness and Drug Dependency Fund Balance Analysis

MIDD Fund Balance Analysis	
Unreserved Fund Balance as of Dec. 31, 2014	$ 9,999,314
Revenue Stabilization Reserve as of Dec. 31, 2014	$ 6,258,669
Actual 2015-2016 Revenue	119,616,061
Actual 2015-2016 Expenditures	120,028,881
	(412,820)
Unreserved Fund Balance Dec. 31, 2016	**$ 5,927,925**
Revenue Reserve Dec. 31, 2016	**$ 6,258,669**
Expenditure Reserve Dec. 31, 2016	**$ 3,658,569**
Total Fund Balance & Reserves	**$ 15,845,163**

Potential Strategy Revision Recommendations

Per legislation, the MIDD implementation, evaluation and oversight of the MIDD sales tax fund require occasional plan modifications. The MIDD Evaluation Plan and associated evaluation matrices were developed in May 2008 by staff in the Mental Health, Chemical Abuse and Dependency Services Division (now the Behavioral Health and Recovery Division) based on the strategy-level implementation plans available at that time. In August 2012, updated matrices were published in the MIDD Year Four Progress Report and matrices modified since that time have been published each year in August. Moving into the future, nearly all strategies from the original MIDD will be revised to incorporate lessons learned over the past nine years and to align with the MIDD 2 Implementation and Evaluation Plans being developed in early 2017. Examples of potential strategy revisions are illustrated below.

MIDD 1 Strategy Number	MIDD 2 Initiative Number*	Initiative Title	Potential Performance Target or Outcomes Revisions	Explanation for Potential Revisions
5a	PRI-2	Juvenile Justice Youth Behavioral Health Assessments	Consider counting the number of youth served rather than the number of services delivered.	This change would allow for better alignment of performance measure expectations with similar initiatives.
4c/4d	PRI-5	Collaborative School Based Behavioral Health Services	Consider removing youth detention as an outcome measure for youth served in this initiative.	Fewer than one percent of youth served in Strategy 4c had any youth detention bookings.
1d	CD-10	Next Day Crisis Appointments	Consider setting new targets based on current utilization or enhance efforts to increase the utilization of these services.	Current performance has failed to reach 65 percent of adjusted target over the past two years.
12b	RR-8	Hospital Re-Entry Respite Beds (Medical Respite)	Consider removing psychiatric hospital and jail as outcome measures for adults served in this initiative. Keep Harborview emergency department (ED) admissions for outcomes measurement.	Only eight percent of strategy participants had any psychiatric hospitalizations and 40 percent had jail use. By contrast, 84 percent had ED admissions at Harborview.
2a	SI-3	Workload Reduction	Consider counting the number of staff hired or funded in support of this effort.	Performance measurement in MIDD 1 tracked only the number of participating agencies.

* PRI=Prevention and Intervention, CD=Crisis Diversion, RR=Recovery and Re-Entry and SI=System Improvements

MIDD Contractors and Provider Agencies by Strategy

Exhibit I

Agency	Type	1a-1	1a-2	1b	1c	1d	1e	1f	1g	1h	2a	2b	3a	4c	4d	5a	6a	7b	8a	9a	10a	10b	11a	11b	12a	12b	12c	12d	13a	13b	14a	15a	16a
Asian CRS	MH & SUD	x	x				x				x	x																					
Atlantic Street Center	MH	x									x																						
Auburn Youth Resources	SUD		x				x							x																			
Cascade Behavioral Health	SUD		x																														
Catholic Comm Svcs	MH & SUD	x	x				x						x																				x
Center for Human Svcs	SUD		x				x							x			x																
Chestnut Health System	MIDD						x																										
City of Seattle	Partner																							x									
Community House	MH	x									x																						x
Comm Psych Clinic	MH & SUD	x	x				x				x	x					x																
Consejo	MH & SUD	x	x				x				x																						
Cowlitz Tribal Treatment	SUD		x				x																										
Crisis Clinic (+)	MH														x																		
DAWN	MIDD																												x				
DESC	MH & SUD	x	x				x				x	x	x									x											x
LifeWire	MIDD																												x				
EvergreenHealth	MH & SUD	x	x				x			x	x																						
Evergreen Recovery Services	SUD		x				x																										
Evergreen Treatment Svcs	SUD		x				x						x																				
FairFax Hospital	MH & SUD		x																														
Friends of Youth	SUD		x				x							x																			
Guided Pathways – SYF	MIDD							x																									
Harborview (+)	MH & SUD	x	x	x	x	x	x				x	x	x													x	x				x		
Hero House	MH	x										x																					
Highline Med Ctr	MIDD				x																												
Integrative Couns Svcs	SUD		x				x																										
Intercept Associates	SUD		x				x																										
KC Coalition Against DV	MIDD																												x		x		
KC Dept Adult/Juv Detention (+)	Partner																								x			x					
KC Judicial Admin (+)	Partner																															x	
KC Sexual Assault Res Ctr	MIDD																														x		
Kent Youth & Family Svcs	SUD		x				x							x																			
Muckleshoot	SUD		x				x																										
Multicare Behavioral Health	MH & SUD	x																															
Navos (+)	MH & SUD	x	x			x	x				x	x																					
Neighborcare Health	MIDD													x																			
New Beginnings	MIDD																												x				
New Traditions	SUD		x				x																										
Northshore Youth & Family	SUD		x				x							x																			
Perinatal Treatment Svcs	SUD		x				x																										
Pioneer Human Svcs	MH & SUD	x	x				x																										
Plymouth Housing Group	MIDD												x																				x
Public Health (+)	Partner			x					x																	x							
Puget Sound ESD	Partner													x																			
Recovery Café	MIDD		x																														
Recovery Centers of KC	SUD		x				x																										
Renton Area Youth Svcs	SUD		x				x																										
ReWA	MIDD																												x		x		
Ryther Child Center	MH & SUD	x					x																										
Seattle Area Support Groups	SUD		x																														
Sea Mar	MH & SUD	x	x				x				x																						
Seadrunar	SUD						x																										
Seattle Children's (Hospital)	MH	x									x			x																			
Seattle Counseling Svcs	MH & SUD	x	x				x				x																						
Seattle Indian Health Board	SUD		x	x			x																										
Snoqualmie Indian Tribe	SUD		x				x																										
Sound Mental Health (+)	MH & SUD	x	x			x	x				x	x	x				x						x	x	x			x		x			x
St. Francis Hospital	MIDD				x																												
Superior Court, Juvenile Div	Partner															x			x	x													
Therapeutic Health Svcs	MH & SUD	x	x				x				x	x		x			x																
Transitional Resources	MIDD												x																				x
TRAC Associates	SUD											x																					
Valley Cities CC	MH & SUD	x	x			x	x				x	x	x				x							x									x
WAPIFASA	SUD		x				x																										
WA St CJ Training Comission	Partner																				x												
WCHS, INC Renton Clinic	SUD		x																														
YMCA	MH	x									x							x															
Youth Eastside Svcs	SUD		x				x																										

(+) = Over 30 subcontractors or community clinics receive MIDD funding through these partners.

Appendix I: Performance Measures by Strategy Category

Community-Based Behavioral Health Intervention Strategies

More than 85% of target | 65% - 85% of target | Less than 65% of target

Year 8 Targets	Continued Services from Prior Year(s)	New in Year 8	Year 8 Totals[1]	Percent of Year 8 Target	Target Success Rating
1a-1 - Increase Access to Community Mental Health (MH) Treatment					
2,400 clients/yr	1,603	1,691	3,294	137%	↑
1a-2 - Increase Access to Community Substance Use Disorder (SUD) Treatment					
12,000 outpatient (OP) units (first 6 months) 600 OP authorizations (last 6 months) 25,000 opiate treatment program (OTP) units 150 detoxification bed days (first 3 months) 7,200 sobering center admits (36% of total) 2,000 peer services encounters 4,500 outreach service hours (first 6 months)	N/A	10,160 OP units 630 OP authorizations 14,989 OTP units (first 6 months)[2] 163 detox bed days 7,284 sobering admits 2,652 peer encounters 5,246 outreach hours	85% 105% - 109% 101% 133% 117%	→ ↑
1b - Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities					
675 clients/yr	603	1,179	1,782	264%	↑
1c - Emergency Room Substance Abuse Early Intervention Program					
800 screens/yr per FTE (4,400 total) 543 brief interventions/yr per FTE (2,987 total) (5.5 FTE staff in period)	N/A	2,206 screens 2,649 brief interventions	50% 89%	↓ ↑
1d - Mental Health Crisis Next Day Appointments and Stabilization Services					
750 clients/yr with enhanced services	23	309	332	44%	↓
1e - Chemical Dependency Professional Education and Training					
125 reimbursed trainees/yr (plus clinical supervision cases) 250 workforce development trainees/yr	254 56 N/A	143 48 558	397 104 558	318% - 223%	↑
1f - Parent Partner and Youth Peer Support Assistance Program					
400 individually-identified clients/yr **Adjust to 362 clients/yr due to staffing** 1,000 group clients/yr	40 N/A	233 1,830	273 1,830	75% (Adjusted) 183%	→ ↑
1g - Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+					
2,500 clients/yr	7,238	7,024	14,262	570%	↑
1h - Expand Availabilty of Crisis Intervention and Linkage to Ongoing Services for Older Adults					
340 clients/yr	39	289	328	96%	↑
2a - Workload Reduction for Mental Health					
16 agencies participating	16	0	16	100%	↑
2b - Employment Services for Individuals with Mental Illness and SUD					
920 clients/yr **Adjust to 700 clients/yr (MH clients only)** 75 clients/yr in SUD pilot	420 27	355 82	775 109	111% (Adjusted) 145%	↑
3a - Supportive Services for Housing Projects					
690 clients for MIDD Year Eight	583	136	719	104%	↑
13a - Domestic Violence and Mental Health Services					
560-640 clients/yr	229	245	474	85%	→
14a - Sexual Assault and Mental Health Services					
170 clients/yr	109	136	245	144%[3]	↑

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

[2] Fiscal data on OTP units were unavailable for the last 6 months due to data system integration issues. This strategy also served 135 clients in case management and transportation.

[3] Providers reported only those cases attributed to MIDD funding.

Strategies with Programs to Help Youth

 More than 85% of target

 65% - 85% of target

 Less than 65% of target

Year 8 Targets	Continued Services from Prior Year(s)	New in Year 8	Year 8 Totals[1]	Percent of Year 8 Target	Target Success Rating
4a - Services for Parents in Substance Abuse Outpatient Treatment					
400 parents/yr	N/A	N/A	Not implemented	N/A	N/A
4b - Prevention Services to Children of Substance Abusing Parents					
400 children/yr	N/A	N/A	Not implemented	N/A	N/A
4c - Collaborative School-Based Mental Health and Substance Abuse Services					
2,268 youth/yr (19 programs) **Adjust to 1,550 youth/yr (13 programs)**	341	at least 968 [2]	1,309	84% (Adjusted)	→
4d - School-Based Suicide Prevention					
1,500 adults/yr 3,250 youth/yr	N/A	1,390 adults 8,949 youth		93% 275% [3]	↑
5a - Expand Assessments for Youth in the Juvenile Justice System					
Coordinate ~~1,200~~ **(1,080)** assessments/yr Provide 200 psychological services/yr Conduct ~~140~~ **(93)** MH assessments Conduct ~~165~~ **(110)** full SUD assessments **Adjust as above due to filings/staffing[4]**	N/A	886 coordinations for 327 unique youth 449 psychological services 117 MH assessments 143 full SUD assessments		82% 225% 126% 130%	→ ↑
6a - Wraparound Services for Emotionally Disturbed Youth					
450 enrolled youth/yr	307	212	519	115%	↑
7a - Reception Centers for Youth in Crisis					
TBD	N/A	N/A	Not implemented	N/A	N/A
7b - Expansion of Children's Crisis Outreach Response System (CCORS)					
300 youth/yr	165	833	998	333%	↑
8a - Family Treatment Court Expansion					
120 children/yr No more than 60 children at one time	N/A	114 children (in MIDD Year 8) Program monitors daily capacity		95%	↑
9a - Juvenile Drug Court Expansion					
36 **new** youth/yr	102	20 new opt-ins 14 new pre opt-ins	136	94% (Total new)	↑
13b - Domestic Violence Prevention					
85 families/yr	103	58	161 unique families	189%	↑

[1] Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.
[2] Program also serves numerous youth in large groups and assemblies.
[3] Blended funds allow more clients to be served than the portion attributable to MIDD only on which the performance measurement targets are based.
[4] Juvenile arraignments or court filings were down; Dedicated positions were vacated 5/2015 (MH) and 2/2016 (SUD).

Jail and Hospital Diversion Strategies

More than 85% of target | 65% - 85% of target | Less than 65% of target

Year 8 Targets	Continued Services from Prior Year(s)	New in Year 8	Year 8 Totals[1]	Percent of Year 8 Target	Target Success Rating
10a - Crisis Intervention Team Training for First Responders					
180 trainees/yr (40-hour) 300 trainees/yr (One-day) 150 trainees/yr (Other) [2]	N/A	175 (40-hour) 325 (One-day) 322 (Other CIT programs) [3]		97% 108% 215%	
10b - Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team					
3,000 adults/yr	827	2,565	3,392 [3]	113%	
11a - Increase Jail Liaison Capacity					
100 **(25)** clients/yr **Adjust as noted due to staff vacancies**	0	0	0	0% (Adjusted)	
11b - Increase Services for New or Existing Mental Health Court Programs					
55 new opt-in expansion clients/yr and[4] 83 non-expansion clients/yr for Regional Mental Health Court (RMHC)	42 expansion 150 non-exp.	42 expansion 94 non-exp.	84 expansion 244 non-exp.	76% 113% (New cases)[5]	
300 **(100)** clients/yr for Seattle Mental Health Court **Adjust as noted due to staff vacancies**	18	65	83	83%	
12a-1 - Jail Re-Entry Program Capacity Increase					
300 clients/yr (3 FTE)	77	106	183	61%	
12a-2 - Education Classes at Community Center for Alternative Programs (CCAP)					
600 clients/yr	71	363	434 [3]	72%	
12b - Hospital Re-Entry Respite Beds (Recuperative Care)					
350-500 clients/yr	71	292	363	104%	
12c - Increase Harborview's Psychiatric Emergency Services (PES) Capacity					
75-100 clients/yr	40	59	99	132%	
12d - Behavior Modification Classes for CCAP Clients					
40 clients/yr	9	44	53	133%	
15a - Adult Drug Court Expansion of Recovery Support Services					
250 expansion clients/yr 300 base clients/yr	175 expansion 236 base	127 expansion 215 base	302 expansion 451 base	121% 150%	
16a - New Housing Units and Rental Subsidies					
25 rental subsidies/yr Tenants in 25 capitally-funded beds without MIDD-funded support services through Strategy 3a	12 19	14 3	26 (rental subsidies) 22 tenants (Brierwood)	104% 88%	
17a - Crisis Intervention Team/Mental Health Partnership Pilot			**COMPLETED**		
17b - Safe Housing and Treatment for Children in Prostitution Pilot			**COMPLETED**		

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

[2] Other trainings included Force Options, Mental Health First Aid, Justice-Based Policing, Blue Courage, and Advanced Hostage Negotiation.

[3] Not unduplicated - individuals are counted once for participation in each different program component.

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

[5] All clients with at least one service are shown, but performance is calculated on new cases in period only.

Appendix II: MIDD Outcomes Samples and Average Incidence of System Use Over Time for Relevant Strategies

		Eligible for Outcomes on Time Alone					Jail	Psychiatric Hospitals	Harborview Emergency Department
		Post 1	Post 2	Post 3	Post 4	Post 5			
1a-1a	Mental Health Treatment	9,414	8,590	7,901	6,806	4,547	17%	13%	22%
1a-1b	MH Clubhouse Participation Only	346	300	248	135	0	10%	15%	17%
1a-2a	Outpatient SUD Treatment	10,336	9,725	8,764	7,583	6,223	48%	N/A	19%
1a-2a	Detoxification Only	288	0	0	0	0	36%	N/A	N/A
1a-2b	Opiate SUD Treatment	2,161	2,084	1,930	1,653	1,356	36%	N/A	32%
1b	Outreach & Engagement	5,150	4,737	4,214	3,607	2,879	40%	5%	43%
1c	Emergency Room Intervention	18,397	17,098	15,409	12,510	9,295	27%	N/A	50%
	Harborview	12,790	12,024	10,992	8,870	6,555	29%	N/A	63%
	South County	5,607	5,074	4,417	3,640	2,740	22%	N/A	17%
1d	Crisis Next Day Appointments	3,138	2,830	2,584	2,325	2,121	23%	14%	50%
1g	Older Adults Prevention*	4,601	4,255	3,715	3,069	2,498	N/A	N/A	23%
1h	Older Adults Crisis & Svc Linkage	2,448	2,204	1,837	1,446	1,144	N/A	4%	9%
3a	Supportive Housing	1,426	1,331	1,104	942	776	48%	21%	64%
4c	School-Based Services	3,724	3,075	2,199	1,126	0	3%	N/A	N/A
5a	Juvenile Justice Assessments	2,305	2,099	1,762	1,031	655	65%	N/A	N/A
6a	Wraparound	1,527	1,314	1,058	757	464	22%	N/A	N/A
7b	Expand Youth Crisis Services	3,580	2,709	1,813	951	0	11%	11%	8%
8a	Family Treatment Court	190	173	144	125	95	54%	N/A	N/A
9a	Juvenile Drug Court	327	267	215	142	97	82%	N/A	N/A
10b	Adult Crisis Diversion	5,365	3,463	1,819	290	0	31%	26%	52%
11a	Increase Jail Liaison Capacity	731	707	686	625	456	81%	N/A	N/A
11b-1	Seattle MH Court Expansion	1,087	823	561	267	0	94%	N/A	N/A
11b-2	Regional Mental Health Court	661	533	385	242	149	76%	N/A	N/A
12a-1	Jail Re-Entry Capacity	1,247	1,143	992	831	644	91%	N/A	N/A
12a-2a	Education Classes at CCAP	1,117	1,003	857	712	516	80%	N/A	N/A
12a-2b	CCAP Domestic Violence Education	1,801	1,562	1,180	817	545	74%	N/A	N/A
12b	Hospital Re-Entry Respite Beds	1,214	913	641	297	0	40%	8%	84%
12c	PES Linkage	504	462	414	345	299	55%	30%	93%
12d	Behavior Modification Classes	650	629	514	405	228	83%	N/A	N/A
15a	Adult Drug Court	1,553	1,223	976	816	630	84%	N/A	N/A
16a	New Housing & Rental Subsidies	170	161	136	124	108	37%	75%	54%

* Limited to those with services beyond screening

Top Three Strategies with Jail Use

Strategy 11b-1
Mental Health Courts
94%
Seattle MH Court Expansion

Strategy 12a-1
Jail Re-Entry Capacity
91%

Strategy 15a
Adult Drug Court
84%

Top Three Strategies with Psychiatric Hospital Use

Strategy 16a
New Housing & Rental Subsidies
75%

Strategy 12c
Psychiatric Emergency Services Linkage
30%

Strategy 10b
Adult Crisis Diversion
26%

Top Three Strategies with Harborview ED Use

Strategy 12c
Psychiatric Emergency Services Linkage
93%

Strategy 12b
Hospital Re-Entry Respite Beds
84%

Strategy 3a
Supportive Housing
64%

Appendix III: System Use Over Time by Relevant Strategies

All strategies (and sub-strategies) that track relevant system utilization over time as an outcome are listed in strategy order in the pages which follow. The tables for jail and psychiatric hospital use show the number of people eligible for analysis by time alone in the columns labeled "Time Eligible." The numbers of people with system use in any given analysis period are shown in the "Use Eligible" columns. The average number of bookings, admissions and/or days (as appropriate) per person with use are then shown for the pre period, or year-long period prior to the start of MIDD services, followed by the average measures for each post period studied. The percent change is calculated as: (Post measure minus Pre measure) divided by Pre measure. The rows marked in gray are subsets of data for which the combined averages appear directly above. Adult and youth outcomes have been combined for this report. Reductions in excess of the targeted reduction goals set in 2008 and shown below are highlighted in light green for all tables appearing on Pages 56 to 60. Note that for adult jail use, an additional five percent per post period was added to account for overall or across-the-board reductions in jail use which occurred between 2008 and 2013. The emergency department (ED) use outcomes have been consolidated into a single table on Page 60, following information on the number of eligible MIDD participants based on both time and use of Harborview's ED. Data on statewide hospital use was not made available in time for analysis.

System Use Reduction Targets Set in 2008

	Adults							Youth	
	Jail or Detention Bookings/Days			Psychiatric Hospital Use		Harborview ED Admissions		All Measures	
Period	Incremental	Additional	Cumulative	Incremental	Cumulative	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-10%	-10%	-5%	-5%	-10%	-10%
Post 2	-10%	-5%	-25%	-8%	-18%	-14%	-19%	-10%	-20%
Post 3	-10%	-5%	-40%	-8%	-26%	-13%	-32%	-10%	-30%
Post 4	-10%	-5%	-55%	-7%	-33%	-13%	-45%	-10%	-40%
Post 5	-10%	-5%	-70%	-7%	-40%	-15%	-60%	-10%	-50%

Overall System Use Changes Over Time

The results below combine the contributions of all relevant MIDD strategies under each system type in the time periods of interest. Overall increases in system use were not uncommon in the first post period, but reductions were found in all longer comparison periods and these reductions continued to grow over time. As more cases become qualified for the longer outcomes intervals, these reductions are expected to improve even more.

System	Measure	Pre - Post 1	Pre - Post 2	Pre - Post3	Pre - Post 4	Pre - Post 5
Jail or Detention	Bookings	-11%	-30%	-41%	-48%	-53%
	Days	+9%	-10%	-27%	-38%	-44%
Psychiatric Hospitals	Admissions	+19%	-32%	-40%	-44%	-46%
	Days	+14%	-16%	-20%	-21%	-27%
Harborview ED	Admissions	-5%	-19%	-32%	-45%	-60%

Average Jail/Detention Bookings and Days in Each Post Period

First Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment[1]	9,760	1,599	2.08	1.57	-24%	45	31	-30%
1a-2a	Outpatient SUD Treatment[2]	10,623	5,189	1.78	1.21	-32%	33	22	-33%
1a-2b	Opiate SUD Treatment	2,161	782	1.74	1.44	-17%	33	26	-20%
1b	Outreach & Engagement	5,150	2,098	1.74	1.80	4%	27	30	11%
1c	Emergency Room Intervention	18,397	5,180	1.69	1.86	10%	27	32	20%
	Harborview	12,790	3,859	1.74	1.83	5%	29	33	13%
	South County	5,607	1,321	1.55	1.92	24%	21	31	48%
1d	Crisis Next Day Appointments	3,138	746	1.32	1.40	6%	32	26	-18%
3a	Supportive Housing	1,426	689	2.59	1.53	-41%	52	28	-46%
4c	School-Based Services	3,724	73	0.37	1.67	352%	4	26	576%
5a	Juvenile Justice Assessments	2,305	1,510	1.46	2.41	65%	16	43	177%
6a	Wraparound	1,527	276	1.56	1.93	24%	23	29	24%
7b	Expand Youth Crisis Services	3,580	384	0.91	1.75	93%	11	24	122%
8a	Family Treatment Court	190	100	1.74	1.20	-31%	18	15	-16%
9a	Juvenile Drug Court	327	268	2.26	2.90	29%	35	69	96%
10b	Adult Crisis Diversion	5,365	1,717	1.56	2.06	33%	24	39	60%
11a	Increase Jail Liaison Capacity	731	604	2.67	1.69	-37%	43	46	7%
11b-1	Seattle MH Court Expansion	1,087	1,035	2.85	1.79	-37%	39	44	13%
11b-2	Regional Mental Health Court	661	529	2.28	1.63	-28%	59	41	-30%
12a-1	Jail Re-Entry Capacity	1,247	1,162	3.57	2.34	-34%	85	60	-30%
12a-2a	Education Classes at CCAP	1,117	923	2.41	1.91	-21%	39	52	31%
12a-2b	CCAP Domestic Violence Education	1,801	1,352	2.28	1.94	-15%	31	52	65%
12b	Hospital Re-Entry Respite Beds	1,214	496	1.96	1.55	-21%	28	32	17%
12c	PES Linkage	504	290	2.46	2.10	-15%	34	36	6%
12d	Behavior Modification Classes	650	570	2.21	1.69	-23%	36	55	52%
15a	Adult Drug Court	1,553	1,353	2.44	1.98	-19%	28	69	144%
16a	New Housing & Rental Subsidies	170	62	1.60	0.90	-43%	38	22	-42%

Second Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 2	% Change	Pre	Post 2	% Change
1a-1a	Mental Health Treatment[1]	8,890	1,494	2.11	1.25	-41%	46	30	-35%
1a-2a	Outpatient SUD Treatment	9,724	4,738	1.81	0.96	-47%	34	21	-38%
1a-2b	Opiate SUD Treatment	2,084	751	1.75	1.19	-32%	33	22	-34%
1b	Outreach & Engagement	4,737	1,925	1.79	1.50	-16%	28	29	5%
1c	Emergency Room Intervention	17,098	4,651	1.72	1.58	-8%	28	31	12%
	Harborview	12,024	3,503	1.79	1.56	-13%	30	32	4%
	South County	5,074	1,148	1.51	1.67	10%	20	30	49%
1d	Crisis Next Day Appointments	2,830	652	1.45	1.17	-20%	36	27	-25%
3a	Supportive Housing	1,331	634	2.63	1.30	-50%	52	27	-48%
4c	School-Based Services	3,075	76	0.25	2.08	732%	1	38	4241%
5a	Juvenile Justice Assessments	2,099	1,252	1.60	1.65	3%	17	34	100%
6a	Wraparound	1,314	258	1.50	1.97	31%	22	28	27%
7b	Expand Youth Crisis Services	2,709	296	0.88	1.65	87%	11	31	192%
8a	Family Treatment Court	173	93	1.74	1.08	-38%	18	17	-5%
9a	Juvenile Drug Court	267	217	2.34	2.11	-10%	34	46	34%
10b	Adult Crisis Diversion	3,463	1,043	1.71	1.72	1%	25	36	47%
11a	Increase Jail Liaison Capacity	707	583	2.67	1.55	-42%	43	41	-5%
11b-1	Seattle MH Court Expansion	823	776	2.83	1.64	-42%	39	46	17%
11b-2	Regional Mental Health Court	533	411	2.35	1.63	-30%	54	44	-18%
12a-1	Jail Re-Entry Capacity	1,143	1,048	3.56	1.99	-44%	86	53	-39%
12a-2a	Education Classes at CCAP	1,003	810	2.48	1.42	-43%	41	35	-15%
12a-2b	CCAP Domestic Violence Education	1,562	1,148	2.37	1.44	-39%	33	33	1%
12b	Hospital Re-Entry Respite Beds	913	366	2.12	1.27	-40%	29	28	-1%
12c	PES Linkage	462	252	2.62	1.74	-33%	34	36	4%
12d	Behavior Modification Classes	629	531	2.31	1.32	-43%	38	38	0%
15a	Adult Drug Court	1,223	1,032	2.45	1.48	-39%	29	32	9%
16a	New Housing & Rental Subsidies	161	59	1.58	0.90	-43%	38	34	-9%

[1] Including Clubhouse participants

[2] Including Detoxification Only clients

Third Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 3	% Change	Pre	Post 3	% Change
1a-1a	Mental Health Treatment[1]	8,149	1,360	2.14	1.11	-48%	47	25	-46%
1a-2a	Outpatient SUD Treatment	8,763	4,261	1.82	0.88	-51%	34	18	-46%
1a-2b	Opiate SUD Treatment	1,930	706	1.74	0.95	-45%	32	16	-50%
1b	Outreach & Engagement	4,214	1,715	1.79	1.33	-26%	29	25	-12%
1c	Emergency Room Intervention	15,409	4,075	1.75	1.32	-25%	29	26	-9%
	Harborview	10,992	3,140	1.81	1.28	-29%	31	26	-16%
	South County	4,417	935	1.55	1.43	-8%	22	26	21%
1d	Crisis Next Day Appointments	2,584	590	1.56	1.12	-28%	38	26	-32%
3a	Supportive Housing	1,104	535	2.71	1.15	-58%	54	25	-53%
4c	School-Based Services	2,199	79	0.23	2.04	794%	1	40	4856%
5a	Juvenile Justice Assessments	1,762	1,032	1.76	1.44	-18%	20	31	56%
6a	Wraparound	1,058	223	1.59	1.57	-1%	24	30	23%
7b	Expand Youth Crisis Services	1,813	212	0.92	1.16	25%	10	18	72%
8a	Family Treatment Court	144	84	1.63	0.94	-42%	16	16	1%
9a	Juvenile Drug Court	215	165	2.66	1.69	-36%	37	38	4%
10b	Adult Crisis Diversion	1,819	521	1.76	1.51	-14%	27	32	17%
11a	Increase Jail Liaison Capacity	686	548	2.74	1.44	-47%	45	33	-25%
11b-1	Seattle MH Court Expansion	561	526	3.03	1.22	-60%	40	37	-7%
11b-2	Regional Mental Health Court	385	294	2.30	1.26	-45%	35	34	-3%
12a-1	Jail Re-Entry Capacity	992	902	3.56	1.64	-54%	88	41	-54%
12a-2a	Education Classes at CCAP	857	679	2.54	1.43	-44%	44	29	-35%
12a-2b	CCAP Domestic Violence Education	1,180	869	2.39	1.36	-43%	34	27	-20%
12b	Hospital Re-Entry Respite Beds	641	253	2.09	1.18	-44%	29	25	-15%
12c	PES Linkage	414	228	2.61	1.51	-42%	33	34	3%
12d	Behavior Modification Classes	514	415	2.44	1.20	-51%	40	32	-21%
15a	Adult Drug Court	976	803	2.52	1.08	-57%	30	21	-28%
16a	New Housing & Rental Subsidies	136	50	1.74	0.62	-64%	43	18	-58%

Fourth Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 4	% Change	Pre	Post 4	% Change
1a-1a	Mental Health Treatment[1]	6,941	1,120	2.16	0.95	-56%	46	20	-56%
1a-2a	Outpatient SUD Treatment	7,582	3,632	1.81	0.77	-57%	34	16	-54%
1a-2b	Opiate SUD Treatment	1,653	576	1.77	0.90	-49%	33	16	-50%
1b	Outreach & Engagement	3,607	1,440	1.90	1.16	-39%	31	21	-32%
1c	Emergency Room Intervention	12,510	3,263	1.80	1.22	-32%	30	23	-24%
	Harborview	8,870	2,514	1.89	1.17	-38%	33	23	-31%
	South County	3,640	749	1.49	1.40	-6%	21	24	15%
1d	Crisis Next Day Appointments	2,325	551	1.62	0.99	-39%	40	22	-45%
3a	Supportive Housing	942	456	2.87	1.07	-63%	59	24	-58%
4c	School-Based Services	1,126	49	0.27	1.73	554%	1	31	5448%
5a	Juvenile Justice Assessments	1,031	708	2.04	1.30	-37%	25	28	12%
6a	Wraparound	757	180	1.57	1.66	5%	22	29	33%
7b	Expand Youth Crisis Services	951	118	1.03	1.41	37%	11	17	61%
8a	Family Treatment Court	125	70	1.67	0.73	-56%	17	8	-53%
9a	Juvenile Drug Court	142	122	2.90	1.43	-51%	42	32	-22%
10b	Adult Crisis Diversion	290	101	1.82	1.63	-10%	30	27	-10%
11a	Increase Jail Liaison Capacity	625	502	2.70	1.43	-47%	44	40	-9%
11b-1	Seattle MH Court Expansion	267	249	2.97	1.24	-58%	37	32	-13%
11b-2	Regional Mental Health Court	242	171	2.43	1.21	-50%	43	33	-22%
12a-1	Jail Re-Entry Capacity	831	746	3.52	1.37	-61%	84	34	-59%
12a-2a	Education Classes at CCAP	712	562	2.49	1.28	-49%	44	30	-31%
12a-2b	CCAP Domestic Violence Education	871	637	2.52	1.17	-54%	37	25	-32%
12b	Hospital Re-Entry Respite Beds	297	115	2.01	1.00	-50%	29	25	-14%
12c	PES Linkage	345	185	2.71	1.06	-61%	36	25	-29%
12d	Behavior Modification Classes	405	327	2.46	1.12	-55%	43	32	-24%
15a	Adult Drug Court	816	673	2.54	1.14	-55%	31	20	-37%
16a	New Housing & Rental Subsidies	124	42	2.00	0.50	-75%	50	16	-68%

[1] Including Clubhouse participants

Fifth Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 5	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	4,547	717	2.14	0.88	-59%	46	24	-49%
1a-2a	Outpatient SUD Treatment	6,222	2,961	1.83	0.73	-60%	34	15	-55%
1a-2b	Opiate SUD Treatment	1,356	477	1.75	0.87	-50%	33	15	-56%
1b	Outreach & Engagement	2,879	1,113	1.95	1.10	-44%	33	21	-34%
1c	Emergency Room Intervention	9,295	2,492	1.86	1.17	-37%	31	23	-26%
	Harborview	6,555	1,946	1.96	1.14	-42%	34	23	-33%
	South County	2,740	546	1.49	1.27	-15%	21	23	12%
1d	Crisis Next Day Appointments	2,121	495	1.72	0.96	-44%	43	20	-53%
3a	Supportive Housing	776	376	2.98	0.95	-68%	62	20	-68%
5a	Juvenile Justice Assessments	655	466	2.23	1.32	-41%	28	31	9%
6a	Wraparound	464	131	1.66	1.16	-30%	25	29	17%
8a	Family Treatment Court	95	49	1.76	0.69	-60%	16	8	-49%
9a	Juvenile Drug Court	97	81	2.78	1.73	-38%	36	42	18%
11a	Increase Jail Liaison Capacity	456	354	2.67	1.07	-60%	42	28	-34%
11b-2	Regional Mental Health Court	149	112	2.36	1.16	-51%	40	31	-23%
12a-1	Jail Re-Entry Capacity	644	565	3.48	1.19	-66%	87	32	-63%
12a-2a	Education Classes at CCAP	516	399	2.59	1.10	-57%	47	26	-45%
12a-2b	CCAP Domestic Violence Education	545	394	2.68	1.07	-60%	39	23	-40%
12c	PES Linkage	299	161	2.95	1.13	-62%	40	30	-24%
12d	Behavior Modification Classes	228	180	2.53	0.63	-75%	44	17	-61%
15a	Adult Drug Court	630	512	2.49	0.97	-61%	32	18	-45%
16a	New Housing & Rental Subsidies	108	43	1.93	0.70	-64%	49	17	-65%

Average Psychiatric Hospital Admissions and Days in Each Post Period

First Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment[1]	9760	1,358	1.81	1.06	-42%	30	17	-42%
1b	Outreach & Engagement	5150	266	1.01	1.31	30%	14	17	24%
1d	Crisis Next Day Appointments	3138	568	0.82	1.22	50%	10	15	46%
1h	Older Adults Crisis & Svc Linkage	2449	221	0.33	1.72	414%	4	31	737%
3a	Supportive Housing	1426	303	2.49	1.24	-50%	55	25	-55%
7b	Expand Youth Crisis Services	3580	606	0.34	1.43	320%	4	20	435%
10b	Adult Crisis Diversion	5365	1,699	1.19	2.23	87%	15	34	122%
12b	Hospital Re-Entry Respite Beds	1214	105	1.36	1.58	16%	16	18	11%
12c	PES Linkage	504	179	1.88	2.10	12%	26	30	15%
16a	New Housing & Rental Subsidies	170	135	3.40	1.08	-68%	95	23	-76%

Second Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 2	% Change	Pre	Post 2	% Change
1a-1a	Mental Health Treatment[1]	8,890	1,243	1.82	0.82	-55%	28	16	-42%
1b	Outreach & Engagement	4,737	231	1.09	1.18	8%	15	16	6%
1d	Crisis Next Day Appointments	2,830	404	1.08	1.01	-6%	13	14	5%
1h	Older Adults Crisis & Svc Linkage	2,205	92	0.68	1.30	90%	8	47	519%
3a	Supportive Housing	1,331	297	2.31	1.26	-45%	53	29	-46%
7b	Expand Youth Crisis Services	2,709	213	0.79	0.98	24%	8	17	121%
10b	Adult Crisis Diversion	3,463	806	1.71	1.63	-5%	23	33	47%
12b	Hospital Re-Entry Respite Beds	913	73	1.78	1.12	-37%	20	23	14%
12c	PES Linkage	462	141	2.10	1.33	-37%	31	25	-19%
16a	New Housing & Rental Subsidies	161	123	3.37	1.17	-65%	94	26	-72%

Third Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 3	% Change	Pre	Post 3	% Change
1a-1a	Mental Health Treatment[1]	8,149	1,083	1.80	0.86	-52%	27	19	-31%
1b	Outreach & Engagement	4,214	198	1.09	1.20	10%	16	20	27%
1d	Crisis Next Day Appointments	2,584	347	1.20	0.84	-31%	15	14	-7%
1h	Older Adults Crisis & Svc Linkage	1,838	62	0.85	1.05	23%	10	43	334%
3a	Supportive Housing	1,104	230	2.34	1.37	-41%	60	36	-40%
7b	Expand Youth Crisis Services	1,813	146	0.95	0.85	-11%	9	18	102%
10b	Adult Crisis Diversion	1,819	423	1.87	1.47	-21%	27	36	32%
12b	Hospital Re-Entry Respite Beds	641	48	1.81	1.06	-41%	23	21	-10%
12c	PES Linkage	414	120	2.00	0.95	-53%	33	23	-31%
16a	New Housing & Rental Subsidies	136	101	3.39	1.16	-66%	98	25	-74%

Fourth Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 4	% Change	Pre	Post 4	% Change
1a-1a	Mental Health Treatment[1]	6,941	885	1.67	0.89	-47%	27	23	-13%
1b	Outreach & Engagement	3,607	175	1.14	1.05	-8%	17	21	23%
1d	Crisis Next Day Appointments	2,325	300	1.30	0.86	-34%	16	18	8%
1h	Older Adults Crisis & Svc Linkage	1,447	35	0.91	0.97	6%	13	25	87%
3a	Supportive Housing	942	198	2.10	1.32	-37%	57	42	-27%
7b	Expand Youth Crisis Services	951	93	0.97	0.74	-23%	10	13	33%
10b	Adult Crisis Diversion	290	79	1.96	1.06	-46%	28	30	6%
12b	Hospital Re-Entry Respite Beds	297	27	1.41	0.52	-63%	14	18	32%
12c	PES Linkage	345	91	2.09	0.98	-53%	36	24	-34%
16a	New Housing & Rental Subsidies	124	90	3.20	0.76	-76%	100	21	-79%

[1] Including Clubhouse participants

Fifth Post

		Time Eligible	Use Eligible	Psychiatric Hospital Admits			Psychiatric Hospital Days		
				Pre	Post 5	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	4,547	562	1.64	0.85	-48%	27	22	-21%
1b	Outreach & Engagement	2,879	122	1.20	0.91	-24%	17	17	-2%
1d	Crisis Next Day Appointments	2,121	272	1.29	0.70	-46%	17	17	-3%
1h	Older Adults Crisis & Svc Linkage	1,145	19	0.79	1.05	33%	12	30	150%
3a	Supportive Housing	776	156	1.97	1.38	-30%	57	50	-13%
12c	PES Linkage	299	84	2.00	0.98	-51%	35	29	-17%
16a	New Housing & Rental Subsidies	108	77	3.09	0.75	-76%	101	13	-87%

Average Harborview Emergency Department Admissions in Each Post Period

		Eligible for Outcomes on Time and Use				
		Pre-Post 1	Pre-Post 2	Pre-Post 3	Pre-Post 4	Pre-Post 5
1a-1a	Mental Health Treatment	2,151	1,928	1,755	1,457	968
1a-1b	MH Clubhouse Participation Only	55	57	45	21	0
1a-2a	Outpatient SUD Treatment	2,111	1,914	1,709	1,435	1,166
1a-2b	Opiate SUD Treatment	694	661	628	546	448
1b	Outreach & Engagement	2,384	2,030	1,791	1,518	1,172
1c	Emergency Room Intervention	10,132	8,489	7,515	5,918	4,410
	Harborview	9,003	7,625	6,790	5,364	4,004
	South County	1,129	864	725	554	406
1d	Crisis Next Day Appointments	1,602	1,398	1,278	1,165	1,050
1g	Older Adults Prevention*	1,080	1,002	851	675	542
1h	Older Adults Crisis & Svc Linkage	292	204	147	112	94
3a	Supportive Housing	945	879	701	586	469
7b	Expand Youth Crisis Services	269	191	144	87	0
10b	Adult Crisis Diversion	2,927	1,599	904	167	0
12b	Hospital Re-Entry Respite Beds	1,049	764	534	247	0
12c	PES Linkage	467	425	384	320	281
16a	New Housing & Rental Subsidies	97	91	73	61	58

* Limited to those with services beyond screening

		Pre	Post 1	% Change	Pre	Post 2	% Change	Pre	Post 3	% Change	Pre	Post 4	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	1.76	1.47	-17%	1.83	1.27	-31%	1.81	1.14	-37%	1.83	1.03	-44%	1.84	1.02	-44%
1a-1b	MH Clubhouse Participation Only	1.75	1.40	-20%	1.46	1.28	-12%	1.76	1.09	-38%	2.19	1.71	-22%	N/A	N/A	N/A
1a-2a	Outpatient SUD Treatment	1.66	1.38	-17%	1.75	1.21	-31%	1.72	1.27	-26%	1.76	1.11	-37%	1.78	1.12	-37%
1a-2b	Opiate SUD Treatment	1.66	1.71	3%	1.71	1.59	-7%	1.68	1.32	-22%	1.64	1.38	-16%	1.68	1.25	-26%
1b	Outreach & Engagement	2.21	2.54	15%	2.41	2.03	-16%	2.34	1.84	-21%	2.38	1.69	-29%	2.37	1.53	-35%
1c	Emergency Room Intervention	1.93	2.41	25%	2.14	1.59	-26%	2.18	1.38	-37%	2.29	1.35	-41%	2.40	1.17	-51%
	Harborview	2.03	2.47	21%	2.24	1.57	-30%	2.28	1.37	-40%	2.38	1.33	-44%	2.49	1.16	-54%
	South County	1.14	2.00	75%	1.32	1.77	35%	1.29	1.51	17%	1.35	1.56	15%	1.50	1.28	-15%
1d	Crisis Next Day Appointments	1.63	1.65	1%	1.80	1.01	-44%	1.87	0.82	-56%	1.92	0.69	-64%	2.00	0.66	-67%
1g	Older Adults Prevention*	1.53	1.29	-16%	1.58	1.07	-32%	1.66	1.11	-33%	1.68	1.00	-41%	1.75	0.88	-50%
1h	Older Adults Crisis & Svc Linkage	1.41	1.64	17%	1.83	1.20	-35%	1.76	0.68	-61%	1.87	0.40	-78%	1.86	0.32	-83%
3a	Supportive Housing	4.48	2.66	-41%	4.42	2.17	-51%	4.11	2.08	-49%	4.14	1.90	-54%	4.08	1.89	-54%
7b	Expand Youth Crisis Services	0.70	0.83	17%	0.79	0.58	-27%	0.78	0.67	-15%	0.69	0.70	2%	N/A	N/A	N/A
10b	Adult Crisis Diversion	2.05	3.06	50%	2.62	2.13	-19%	2.80	1.62	-42%	3.51	1.53	-56%	N/A	N/A	N/A
12b	Hospital Re-Entry Respite Beds	3.32	3.79	14%	3.57	2.32	-35%	3.52	2.01	-43%	3.76	1.38	-63%	N/A	N/A	N/A
12c	PES Linkage	12.21	8.74	-28%	11.98	4.44	-63%	11.68	3.89	-67%	11.05	3.32	-70%	10.90	2.83	-74%
16a	New Housing & Rental Subsidies	1.79	1.15	-36%	1.86	0.93	-50%	1.79	0.93	-48%	1.97	0.75	-62%	1.79	0.71	-61%