King County

1200 King County
Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Agenda

Regional Policy Committee

Councilmembers: Pete von Reichbauer, Chair; Claudia Balducci, Larry Gossett
Alternate: Jeanne Kohl-Welles

Sound Cities Association: Suzette Cooke, Kent; Bill Peloza, Auburn;
Bernie Talmas, Woodinville; Amy Walen, Kirkland
Alternates: Dave Hill, Algona; Dan Grausz, Mercer Island

City of Seattle: Debora Juarez, Kshama Sawant
Alternates: Tim Burgess and Bruce Harrell

Staff: Beth Mountsier, Lead Staff (206-477-0885)
Angelica Calderon, Committee Assistant (206-477-0874)

3:00 PM **Wednesday, September 14, 2016** **Room 1001**

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

To show a PDF of the written materials for an agenda item, click on the agenda item below.

1. Call to Order

2. Roll Call

3. Approval of Minutes

Minutes of July 13, 2016 Regular and Special meetings. pp. *3-8*

4. Chair's Report

Synopsis of current status of PO 2016-0281 – Scarlett Aldebot-Green
Anticipated schedule of meetings October – December

5. Public Comment

Discussion

6. Proposed Ordinance No. 2016-0427 pp. 9-428

An ORDINANCE approving the mental illness and drug dependency service improvement plan to

Sign language and communication material in alternate formats can be arranged given sufficient notice (296-1000).
TDD Number 296-1024.
ASSISTIVE LISTENING DEVICES AVAILABLE IN THE COUNCIL CHAMBERS.

guide the investment of mental illness and drug dependency sales tax revenue, in compliance with Ordinance 17998.

Sponsors: Ms. Kohl-Welles

Wendy Soo Hoo, Council Staff

7. Proposed Ordinance No. 2016-0428 pp. 9-428

AN ORDINANCE revising the King County mental illness and drug dependency policy goals; amending Ordinance 15949, Section 3, as amended, and adding a new section to K.C.C. chapter 4A.500.

Sponsors: Ms. Kohl-Welles

Wendy Soo Hoo, Council Staff

Briefing

8. Briefing No. 2016-B0170 pp. 429-486

Veterans and Human Service Levy (VHSL) Annual Report and planning for VHSL Renewal

Scarlett Aldebot Green, Council Staff
Leonardo Flor, Veterans and Human Services Levy Renewal Manager

Discussion and Possible Action

9. Proposed Motion No. 2016-0419 pp. 487-506

A MOTION requesting the executive's response informing council deliberations regarding possible renewal of the veterans and human services levy.

Sponsors: Mr. Dembowski, Mr. von Reichbauer, Ms. Balducci and Ms. Kohl-Welles

Wendy Soo Hoo, Council Staff

Briefing

10. Briefing No. 2016-B0171 pp. 507-564

Executive’s Solid Waste Rate proposal

Mike Reed, Council Staff
Hiedi Popochock, Council Staff

Other Business

Adjournment

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3:00 PM **Wednesday, July 13, 2016** **Room 1001**

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1. Call to Order

Chair von Reichbauer called the Regional Policy Committee to order at 3:07 p.m.

2. Roll Call

Present: 12 - Ms. Balducci, Ms. Cooke, Mr. Gossett, Ms. Juarez, Mr. Peloza, Ms. Sawant, Mr. Talmas, Mr. von Reichbauer, Ms. Walen, Mr. Hill, Mr. Grausz and Ms. Kohl-Welles

3. Approval of Minutes

Councilmember Peloza moved approval of the June 8, 2016 meeting minutes. Seeing no objections, the minutes were approved as presented.

4. Chair's Report

Chair welcome the members to the meeting.

5. Public Comment

The following people were present to offer public comment:

1. Queen Pearl
2. Alex Zimmerman

3. Jessica Warner
4. David Beard
5. Abigail Echohawk
6. Nate Miles
7. Michelle Sarju
8. Michael Heinish
9. Susan Steckler
10. Eleuthera Lisch
11. George Countz
12. Kassech Zenebe

Discussion and Possible Action

6. Proposed Ordinance No. 2016-0281

AN ORDINANCE approving the Best Starts for Kids Implementation Plan.

Sponsors: Ms. Kohl-Welles and Mr. Dembowski

Scarlett Aldebot Green, Council Staff, briefed the Committee and answered questions from the members. Sheila Capestany, Strategic Advisory, Children and Youth, DCHS, Nadine Chan, Assistant Chief of Assessment, Planning, Development and Evaluation, PHSKC, and Adrienne Quinn, Director, PHSKC were present to offer comments and answer questions from the members.

Councilmember Peloza moved amendments 1 and 2. The amendments were adopted.

Due to the design of the legislative tracking software used to produce the proceedings, the vote on this item is misreported. The correct vote is:

Votes: Yes: 12 Mr. von Reichbauer, Ms. Balducci, Mr. Gossett, Ms. Cooke, Mr. Peloza, Mr. Talmas, Ms. Walen, Ms. Juarez and Ms. Sawant
No: 0
Excused: 0

A motion was made by Councilmember Peloza that this Ordinance be Recommended Do Pass Substitute. The motion carried by the following vote:

Yes: 9 - Ms. Balducci, Ms. Cooke, Mr. Gossett, Ms. Juarez, Mr. Peloza, Ms. Sawant, Mr. Talmas, Mr. von Reichbauer and Ms. Walen

Excused: 3 - Mr. Hill, Mr. Grausz and Ms. Kohl-Welles

Briefing

7. Briefing No. 2016-B0144

Planning associated with a MIDD Renewal

This matter was Deferred

8. Briefing No. 2016-B0145

PSERN Quarterly Briefing

This matter was Not Held

Other Business

There was no other business to come before the Committee

Adjournment

The meeting adjourned at 4:09 p.m.

Approved this _____ day of _____.

Clerk's Signature

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Meeting Minutes

Regional Policy Committee

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Staff: Beth Mountsier, Lead Staff (206-477-0885)
Angelica Calderon, Committee Assistant (206-477-0874)

2:00 PM | **Wednesday, July 13, 2016** | **Room 1001**

SPECIAL MEETING

This is a joint meeting with the Health, Housing and Human Services Committee

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

1. Call to Order

Chair von Reichbauer and Chair Kohl-Welles called the joint meeting of the Regional Policy Committee and Health, Housing and Human Services Committee to order at 2:08 p.m.

2. Roll Call

Also present from the Health, Housing and Human Services Committee were Councilmember Dembowski, Dunn, Lambert and Upthegrove

Present: 9 - Ms. Balducci, Ms. Cooke, Mr. Gossett, Mr. Peloza, Mr. Talmas, Mr. von Reichbauer, Ms. Walen, Ms. Kohl-Welles and Mr. Hill

Excused: 2 - Ms. Juarez and Ms. Sawant

3. Public Comment

There was no public comment.

Briefing

4. Briefing No. 2016-B0141

Best Starts for Kids Implementation Plan: Discussion of Regional Policy Committee Interests per Motion 14592

Scarlett Aldebot Green, Council Staff, briefed the Committee and answered questions from the members. Sheila Capestany, Strategic Advisory, Children and Youth, DCHS, Nadine Chan, Assistant Chief of Assessment, Planning, Development and Evaluation, PHSKC, and Eva Wong, PhD PHSKC Assessment, Policy Development and Evaluation Unit, Clinical Assistant Professor, University of Washington, were present to offer comments and answer questions from the members.

This matter was Presented

Adjournment

The joint meeting adjourned at 2:54 p.m.

Approved this _____ day of _____.

Clerk's Signature

King County

Metropolitan King County Council
Regional Policy Committee

STAFF REPORT

Agenda Item:	6 & 7	**Name:**	Wendy Soo Hoo
Proposed No.:	2016-0427 2016-0428	**Date:**	September 14, 2016

SUBJECT

Proposed Ordinance 2016-0427 would approve the Mental Illness and Drug Dependency Sales Tax Service Improvement Plan.

Proposed Ordinance 2016-0428 would revise the MIDD policy goals and requires transmittal of a detailed implementation plan and an evaluation plan by August 3, 2017.

SUMMARY:

In March 2015, the King County Council passed Ordinance 17998 setting requirements for a comprehensive review of the strategies supported by current MIDD (MIDD 1) investments, and also setting forth requirements for an updated service improvement plan to guide investments of a renewed MIDD (MIDD 2). Proposed Ordinance 2016-0427, which would approve the MIDD SIP, was transmitted on August 25th, along with Proposed Ordinance 2016-0428, which would revise the MIDD policy goals.

This is the first of two discussions of the MIDD SIP by the Regional Policy Committee, with action anticipated at the committee's October meeting.[1]

BACKGROUND:

In 2007, the King County Council adopted Ordinance 15949 authorizing the levy and collection of an additional sales and use tax of one-tenth of one percent for the delivery of mental health and chemical dependency services and therapeutic courts.[2] This tax is referred to as the Mental Illness and Drug Dependency sales tax (MIDD 1) and is projected to generate approximately $117 million in the 2015/2016 biennium.[3]

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[1] Regional Policy Committee Resolution 2016-2

[2] In 2005, the Washington state legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services.

[3] Revenue estimate is the 2015/2016 Estimated Revenue from the November 2015 update to the Financial Plan for the Mental Illness & Drug Dependency fund.

Ordinance 15949 also established a policy framework for measuring the effectiveness of the public's investment in MIDD 1 programs, requiring the King County Executive to submit oversight, implementation and evaluation plans for the programs funded with the tax revenue. The ordinance set forth five policy goals for the programs supported with MIDD 1 funds:

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

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

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

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

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

Subsequent ordinances established the MIDD Oversight Committee (April 2008)[4] and the MIDD 1mplementation Plan and MIDD Evaluation Plan (October 2008).[5]

<u>Ordinance 17998 Passed by Council in March 2015</u>

In March 2015, the King County Council passed Ordinance 17998 setting requirements for a comprehensive review and potential modification of the MIDD 1 strategies described in the council-adopted MIDD 1 Implementation Plan. The required review and reporting processes were intended to provide key information to decision makers in considering continuation of the MIDD sales tax in 2016.

Ordinance 17998 required a comprehensive review of the current MIDD 1 strategies and analysis of the MIDD 1 investments and sets forth a process and criteria for recommendations for new strategies to be considered for a continued MIDD 2. Three deliverables were required by the ordinance:

1) a comprehensive historical review and assessment of MIDD 1 – transmitted to council in June 2016 and approved by the Council on September 6, 2016 (Motion 14712);

[4] The MIDD Oversight Committee was established in Ordinance 16077 and is an advisory body to the King County Executive and the Council. The purpose of the Oversight Committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative.

[5] In October 2008, the Council adopted the MIDD 1mplementation Plan and the MIDD Evaluation Plan via Ordinance 16261 and Ordinance 16262.

2) a MIDD service improvement plan to guide investments under a continued MIDD – Proposed Ordinance 2016-0427 was transmitted to council in August 2016 and dually referred to the Regional Policy Committee and the Budget and Fiscal Management Committee; and
3) a progress report on the first two deliverables, which was transmitted to council in November 2015 (2015-RPT0164).

Broad outreach was conducted in assessing the MIDD 1 and in developing the service improvement plan for MIDD 2. The outreach effort included surveys; five regional community conversations; and 13 focus groups ranging in size from four to 100 participants, involving specific communities, populations or sub-regional areas. More details regarding the outreach conducted can be found in Attachment 7

King County Council Approved Extension of the MIDD Sales Tax in August 2016

Proposed Ordinance 2016-0287 was transmitted to the Council on June 6 and referred to the Budget and Fiscal Management Committee. On August 22, 2016, the King County Council voted to approved Ordinance 18333, extending collections of the MIDD sales tax through 2025. The sales tax is expected to generate approximately $134 million in 2017/2018 and $143 million in 2019/2020.[6]

ANALYSIS

The King County Council via Ordinance 17998 required transmittal of a service improvement plan to guide investments of the extended MIDD sales tax. The ordinance required the plan to include (summarized):

- A detailed description of each proposed strategy, service and program to be funded from the MIDD sales tax beginning in 2017;
- Explanation of how each recommended MIDD strategy, service and program supports the adopted and/or recommended MIDD policy goals;
- A schedule for the implementation of the strategies, programs, and services outlined in the MIDD service improvement plan;
- A spending plan, including recommended 2017-2018 biennial budget levels for each proposed strategy, service and program;
- An initial list of performance measures, outcomes, and/or evaluation; and
- A proposed schedule for at least annual reporting to the council on progress and performance.

The ordinance also required that the proposed MIDD service improvement plan strategies, services, and programs demonstrate that they:

- Are based on evidence related to successful outcomes for chemical dependency or mental health treatment programs and services, or best or promising practices for chemical dependency or mental health treatment programs and services;

[6] MIDD Financial Plan July, 2016 (Attachment 6)

- Incorporate the goals and principles of recovery and resilience within a trauma informed framework;[7]
- Integrate the sequential intercept model that addresses the criminalization of mentally ill individuals;
- Reflect the county's equity and social justice agenda, and other county policy and planning endeavors; and
- Will leverage opportunities provided by the federal Affordable Care Act and the state's requirements for a single behavioral health contract with regional support networks as specified by Chapter 225, Laws of Washington 225.

Ordinance 17998 also required the SIP to identify processes for changing MIDD strategies, services and programs, including specifying how and when the MIDD oversight committee is to be engaged; recommend MIDD fund balance reserve policies; and review and confirm or recommend modifications to the purpose, role, and composition of the MIDD Oversight Committee.

This staff report summarizes the substantive chapters of the service improvement plan. Potential policy issues are highlighted at the end of the Analysis section of the staff report.

I. Executive Summary

II. MIDD Key Environmental Changes

This chapter describes the history of MIDD 1, which was enacted by the King County Council in 2007 via Ordinance 15949 as authorized under Revised Code of Washington (RCW) 82.14.460. The sales tax was authorized by the Washington State Legislature when it passed the Omnibus Mental Health and Substance Abuse Act in 2005.[8]

This chapter also describes key changed conditions impacting MIDD, including behavioral health integration, the U.S. Affordable Care Act, and the 2014 Washington State Supreme court ruling regarding psychiatric boarding (In re the Detention of D.W. et al). In addition, King County has shifted to emphasizing a trauma-informed care framework, which recognizes the role that trauma has played in individuals' lives. King County has also focused on equity and social justice and recognizing that race, place, income and other factors impact quality of life and health outcomes for residents of King County.

Chapter II also discusses the results of the MIDD 1 Comprehensive Retrospective Report.[9] The report found that:

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[7] As specified by K.C.C. chapter 2.43 and King County's adopted behavioral health system principles set out in Ordinance 17553.

[8] The statute has been amended several times since 2005, allowing for housing as a component of a coordinated chemical dependency or mental health treatment program or service; allowing for supplantation of specific percentages of lost revenues on a predetermined schedule; allowing MIDD sales tax revenue to the cost of the judicial officer and support staff of a therapeutic court without being considered as supplantation; and adding transportation to the list of mental health programs and services that may be supported by the revenue.

[9] Proposed Motion 2016-0354

- Aggregating results from all relevant strategies, MIDD 1 is recognized as successful and effective in meeting the established policy goals.
- Significant reductions in jail and emergency department use, and psychiatric hospitalizations, are documented by MIDD evaluation data.

III. Key Components of MIDD 2

This chapter describes the collaborative process (developed jointly with the MIDD Oversight Committee) for creating the MIDD 2 framework. The process involved extensive community outreach and input.

Development of proposed MIDD 2 recommendations included a review of existing MIDD 1 strategies and a call for new proposals. Interested parties submitted new concepts to the county. County staff developed over 90 briefing papers on the new concepts determined to be eligible for MIDD funding and the briefing papers were reviewed and sorted by panels comprised of community members and MIDD Oversight Committee members.

Table 1
Comparison of MIDD 1 Adopted Policy Goals and MIDD 2 Recommended Policy Goals

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

This chapter also describes recommended policy goals for MIDD 2. The policy goals are provided in the table above. According to the SIP, the intent of the recommended policy goals is to "reflect a person centered language approach."

Proposed Ordinance 2016-0428, a companion to the SIP, would amend Ordinance 15949 to reflect and update the proposed policy goals for MIDD 2.

The SIP also proposes a new framework for categorizing programs and services comprised of four strategies that are based on the continuum of care:

- Prevention and Early Intervention: People get the help they need to stay healthy and keep problems from escalating
- Crisis Diversion: People who are in crisis get the help they ned to avoid unnecessary hospitalization or incarceration
- Recovery and Reentry: People become healthy and safely reintegrate to community after crisis
- System Improvements: Strengthen the behavioral health system to become more accessible and deliver onoutcomes

IV. Proposed MIDD 2 Initiatives[10]

The MIDD 2 initiatives will be described further later in this staff report.

V. Responses to Ordinance 17998

The SIP makes recommendations in Chapter V on MIDD 2 implementation issues and processes as required by Council via Ordinance 17998. Note that program descriptions for MIDD 2 are preliminary at this time and the plan recommends transmittal of more detailed implementation plans and an evaluation plan in mid-2017.

<u>MIDD Fund Financial Policy Recommendations</u>

This chapter discusses recommendations related to MIDD fund financial policies. The SIP recommends a 60-day Rainy Day Reserve for the MIDD fund and proposes to fully fund the reserve in 2017/2018. The 60-day reserve was developed in consultation with the Office of Performance, Strategy and Budget to mitigate volatility in sales tax collections and is estimated at about $11.2 million for 2017/2018. When reserves are met, the SIP proposes to prioritize use of undesignated fund balance as follows:

1. Economic adjustments for providers without reducing services or existing initiatives.

2. Allocate up to $650,000 annually to an Emerging Issues initiative.

[10] The chapter entitled "Proposed MIDD 2 Initiatives" was mislabeled as Chapter VI. Council staff plan to correct this during the amendment process.

Adding, Deleting, or Modifying MIDD Initiatives, Strategies, Services and Programs

The SIP calls for a similar revision process as under MIDD 1. Currently, if one of three criteria is met, the MIDD Oversight Committee reviews the proposed revision. Table 2 below shows the current MIDD 1 revision criteria and proposed MIDD 2 criteria.

Table 2
Comparison of MIDD 1 Criteria for MIDD Oversight Committee Review of Potential Revisions to Initiatives, Strategies, Services and Programs

MIDD 1 Revision Criteria	Proposed MIDD 2 Revision Criteria
• Proposed change in funding of 15% or more	• No change
• Proposed elimination of a strategy	• No change
• Changes to provider resources, processes, funding, methodology, FTE, RFP or contract processes	• Changes to population served, outcomes or results, intervention or performance measures

Emerging Issues Initiative Protocols

As noted previously, the SIP proposes to allocate funding annually for an Emerging Issues initiative whereby certain programs can seek funding for up to two years under MIDD 2 and recommends the MIDD Oversight Committee and the Deparment of Community and Human Services develop criteria for funding emerging issues, including:

- Allowable under RCW 82.14.460;
- Furthers the MIDD's continuum of care;
- Based on best or promising practices;
- Reflects a recovery oriented system of care; and
- Demonstrates financial sustainability outside of MIDD reserves.

The SIP indicates that the Emerging Issues initiative is intended to be a flexible, short-term source of funds. Emerging Issues would be considered at least once each year by the MIDD Oversight Committee.

The SIP also indicates that if the Executive determines that MIDD revenues are expected to greatly outpace projections for a sustained period and that economic adjustments can continue for existing providers, BHRD (in collaboration with the MIDD Oversight Committee) may initiate a new initiative process. The SIP states that the process for identifying a new initiative would follow a similar approach as the Fund Balance Workgroup or MIDD 2 process to identify new concepts. The Fund Balance Workgroups have been comprised of MIDD Oversight Committee members and county staff and the workgroups have made recommendations on how to spend excess MIDD fund balance to the Oversight Committee. The Oversight Committee then makes recommendations to the Executive. The Executive considers the recommendations in

proposing supplemental MIDD appropriations to the Council. The new concepts approach was a structured, time-limited invitation to suggest new ideas for MIDD 2 funding described earlier in this staff report (refer to "**Key Components of MIDD 2**"**)**. All new initiatives would ultimately need to be approved by the Council for funding via an appropriation ordinance.

Schedule for Reporting

The SIP proposes a new reporting schedule. The SIP calls for annual reporting to the Council, with the report due August 1, rather than April 1.[11] In addition, the SIP proposes shifting the reporting period to the calendar year rather than the current October through September reporting period. This would align MIDD reporting with local, state, federal and philanthropic reporting timelines, making the reporting process easier and more efficient for providers. The SIP also states the intention to develop a web-based data dashboard for more readily accessible and up-to-date information.

Recommended Changes to the MIDD Oversight Committee

The King County Council adopted Ordinance 16077 in 2008, establishing the MIDD Oversight Committee as an advisory body with the purpose of "ensur[ing] that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative." The ordinance also states that "the oversight committee should: promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts and groups." MIDD Oversight Committee members are appointed by the Executive and confirmed by the Council.

Table 3
MIDD 1 Oversight Committee Composition as Required by Ordinance 16077

*King County Council	King County Mental Health Advisory Board	*King County systems integration initiative
*King County Executive	King County Alcoholism and Substance Abuse Administrative Board	The Community Health Council
*Superior Court	A provider of both mental health and chemical dependency services in King County	Washington State Hospital Association, representing King County Hospitals
*District Court	A provider of culturally specific mental health services in King County	Suburban Cities Association (now Sound Cities Association)
*Prosecuting Attorney's Office	A provider of culturally specific chemical dependency services in King County	City of Seattle
*Sheriff's Office	A provider of domestic violence prevention services in King County	City of Bellevue

[11] Ordinance 15949

*Public Health	A provider of sexual assault victim services in King County	Labor representing a bona fide labor organization
*Department of Judicial Administration	An agency providing mental health and chemical dependency services to youth	*Office of the Public Defender (now Department of Public Defense)
*Department of Adult and Juvenile Detention	Harborview Medical Center	The National Alliance on Mental Illness
*Department of Community and Human Services	The Committee to End Homeless in King County (now All Home)	A representative from a public defender agency that the county contracts with to provide services
* Denotes a King County government seat.		

The SIP calls for modifying the existing composition based on the following:

- Remove the King County Mental Health Advisory Board and King County Alcoholism and Substance Abuse Administration Board positions, as these boards have been dissolved.
- Add a position representing the King County Behavioral Health and Recovery Board, which replaced the two dissolved boards.
- Eliminate the position for the representative from a public defender agency, as public defense services have been brought into the county and the Department of Public Defense is currently represented on the committee.
- Updating the names of organizations.

In addition, the SIP recommends adding six new positions (a net of four additional positions with the changes discussed above):

- Two representatives of communities and consumers to reflect principles of community engagement
- Washington Recovery Alliance to enable a recovery-focused alliance with a broader view than a single agency
- Puget Sound Educational Services District to provide another linkage to children, youth and families
- Many Minds Collaborative to reflect increased partnering with philanthropic organizations
- Medicaid Managed Care Plans to reflect the increasing emphasis on managed care organizations as physical and mental health become increasingly integrated

Council staff requested information from DCHS on why the Washington Recovery Alliance, Puget Sound Educational Services District and Many Minds Collaborative were specified and whether other organizations could be considered for positions on the committee. DCHS's responded, in part:

> "Washington Recovery Alliance (WRA): This is a statewide organization working in the recovery field. The belief is this organization is the most

organized and unified voice for recovery in our region and can bring the perspective of recovery to the work of the MIDD Oversight Committee.

Puget Sound Educational Services District (PSESD): Having the perspective and voices of schools and the needs of school aged kids is a priority for the MIDD OC. PSESD is one of nine regional educational agencies serving school districts and state-approved private schools in Washington. Educational Service Districts are an essential regional delivery system for early learning and K-12 services in the state… Because there are multiple school districts serving King County, it would not be possible to add a seat for each region or district and PSESD is a way to ensure these perspectives and voices are present to inform MIDD. They were also involved with the Youth Action Plan Task Force and have been involved in various advisory capacities with King County initiatives in the past.

Many Minds: Is a new philanthropic organization focused on catalyzing meaningful and lasting improvement in the mental health of people in King County. They are partnering with other stakeholders across the region to invest in and create change in the behavioral health arena, and have been working with our provider community. Adding them to the table brings a focus on behavioral health services.

Note that the SIP proposes to establish a standing Consumers and Communities Ad Hoc Work Group comprised of "individuals with lived experiences of the behavioral health system (consumers) and individuals who are a part of communities with marginalized identities or experiences," including but not limited to the following: transgender, youth, immigrant/refugee, African-American, Asian/Pacific Islander, Hispanic, rural, faith, previous justice system involvement, and peers.

The SIP also recommends changing the name of the MIDD Oversight Committee to the MIDD Advisory Committee to clarify the role of the body.

On August 25, 2016, the Executive transmitted Proposed Ordinance 2016-0429, which would implement these recommendations to amend the composition of the oversight committee. This ordinance was referred to the Health, Housing and Human Services Committee.

<u>Other Policy Recommendations to Comply with Ordinance 17998</u>

The MIDD SIP also makes recommendations in several other policy areas, as required by Ordinance 17998. Specifically:

- <u>Categories of practices</u>: Under the approach in the SIP, MIDD 2 initiatives may be funded if they are emerging practices – practices that are not based on research results, "but for which anecdotal evidence and professional wisdom exists." MIDD 2 initiatives may also be funded if they reflect promising practices, best practices, or evidence-based practices.

- Incorporating Goals of Recovery, Resiliency in a Trauma-Informed Care Framework: The SIP defines "recovery" as a process in which an individual achieves management of the individual's symptoms and regains or develops sufficient skills and autonomy to enable the individual to live, work and participate fully in the community. "Resiliency" is defined as an innate capacity that empowers people across the life span to successfully meet life's challenges with a sense of self-determination, mastery and hope. "Trauma-informed framework" means an approach to engage an individual with a history of trauma that recognizes the presence of trauma symptoms and acknowledges the impact that trauma has had on the individual's life. The SIP indicates that the proposed MIDD 2 initiatives support people in all phases of recovery.

- Sequential Intercept Model in MIDD 2: As in MIDD 1, the Sequential Intercept Model is a guiding principle reflected in the SIP. This framework is used to identify services that can divert people from incarceration, hospitalization and homelessness. The MIDD 2 SIP further adapts this model to include people at risk of justice system involvement due to substance use but without mental illness, and to include diversion from emergency medical services as a priority.

- Equity and Social Justice in MIDD 2: The SIP indicates the county's intent for MIDD 2 to be culturally responsive and specific and recognizing that focusing on evidence-based practices may perpetuate marginalization. MIDD 2 is also proposed to use a harm reduction model, which intends to "meet people where they're at" and accept people regardless of their behavior – this approach, according to the SIP is linked to equity and social justice because it is intended to be non-judgmental and recognize realities of poverty, class, racism, trauma and other inequities. Finally, the SIP indicates that MIDD 2 should provide culturally responsive, specific services and reentry opportunities, recognizing disproportionality in the county's justice system.

- Integration with Other County Policy and Planning Work: Ongoing county policy efforts are already reflected in the MIDD 2 initiatives recommended in the SIP, including the Multiprong Opioid Initiative, which is intended to support recommendations of the Opiate Task Force, and the Youth Behavioral Health Alternatives to Secure Detention initiative is intended to align with the Juvenile Justice Equity Steering Committee. The MIDD 2 detailed Implementation Plan (proposed in the SIP to be transmitted in 2017) will describe how each MIDD funded initiative will align with these other policy efforts.

Another area of policy recommendations required by Ordinance 17998 relate to leveraging Affordable Care Act (ACA) and Behavioral Health Integration opportunities. With Medicaid expansion under the ACA, the SIP indicates that MIDD 2 will focus on directing services not supported by Medicaid and individuals who remain uninsured.

In addition, under the state mandate (ESSB 6312) to integrate mental illness and chemical dependency services, the county's Behavioral Health and Recovery Division (BHRD) has established itself as the region's Behavioral Health Organization. BHRD is able to combine and leverage federal Medicaid, state general fund, mental health and

substance use disorder block grant and MIDD dollars to provide a continuum of behavioral health services.

Note that one area of uncertainty for the future arises from a requirement set forth in ESSB 6312 to fully integrate Medicaid supported mental health, substance use, and physical health care by January 2020. Currently, Medicaid physical health is provided through Managed Care Organizations, while Medicaid mental health and substance use services are provided by Behavioral Health Organizations. How the integration will be implemented remains undetermined and could have implications for prioritizing MIDD 2 investments in the context of potential major changes to the system. According to the SIP, the County is currently considering timelines of achieving integration by July 1, 2018 or January 1, 2020.

VI. Next Steps

The SIP identifies three specific next steps to be completed in collaboration with the MIDD Oversight Committee and other stakeholders: development of implementation plans for MIDD 2 initiatives, completion of an evaluation plan, and a process to change the name of the MIDD.

The implementation plans will provide details on each initiative, including how it aligns with MIDD 2 policy goals, performance measures, expected number of individuals served, spending plan, implementation schedule, whether it will be provided by the county or contractor, procurement details if applicable, and other relevant information. The implementation plans will be transmitted to Council in 2017, along with an evaluation plan. The SIP indicates that to the extent possible the MIDD evaluation plan will align with the BSK evaluation plan. DCHS has provided additional information to staff indicating that "both initiatives share many providers, so coordination of data and dashboards where progress is tracked would be helpful for the providers and for the community." As an example, DCHS indicated that it plans to use similar structure, language and approach for the two evaluation frameworks so there is understanding across all initiatives.

Lastly, the SIP notes that stakeholder feedback indicated concern that the name of the sales tax, "the Mental Illness and Drug Dependency" sales tax is outdated and negative. The SIP indicates the Executive's intent to seek community feedback on a new name and then work with the Council and the Prosecuting Attorney's Office to revise the King County Code and other adopted legislation.

MIDD 2 INITIATIVES – CHAPTER IV[12] AND APPENDIX H

According to Chapter IV of the SIP, the proposed MIDD 2 initiatives prioritize:

- Funding services and programs to keep people out of or returning to jail and the criminal justice system, including upstream prevention and diversion activities.
- Investing in a treatment on demand system that delivers treatment to people who

[12] The chapter entitled "Proposed MIDD 2 Initiatives" was mislabeled as Chapter VI. Council staff plan to correct this during the amendment process.

need it, when they need it, so crises can be avoided or shortened.

- Creating community driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs.

Successful MIDD 1 programs are proposed to continue into MIDD 2, though the SIP indicates that some will be merged or retooled. Twenty-one (21) new programs are proposed for MIDD 2:

1. Law Enforcement Assisted Diversion (refer to Appendices in the SIP – pg. 25 of 290)
2. South County Crisis Diversion (pg. 34 of 290)
3. Alternatives to Incarceration for Youth (pg. 50 of 290)
4. Family Intervention Restorative Services (pg. 44 of 290)
5. Community Driven Behavioral Health Grants (pg. 85 of 290)
6. Behavioral Health Services in Rural King County (pg. 90 of 290)
7. Multipronged Opioid Response (pg. 37 of 290)
8. Behavioral Health Urgent Care Walk-in (pg. 41 of 290)
9. Mental Health First Aid (pg. 60 of 290)
10. Zero Suicide Pilot (pg. 56 of 290)
11. Recovery Café (pg. 71 of 290)
12. Peer Bridgers/Peer Support (pg. 75 of 290)
13. Rapid Rehousing-Oxford House Model (pg. 64 of 290)
14. Emerging Issues Initiative (described on pages 47-49 of the SIP)
15. Youth and Young Adult Homelessness Services (pg. 31 of 290)
16. Young Adult Crisis Facility (pg. 53 of 290)
17. Jail-Based Substance Use Disorder Treatment (pg. 80 of 290)
18. Deputy Prosecuting Attorney for Familiar Faces (pg. 82 of 290)
19. Planning for a Therapeutic Community Court (pg. 95 of 290)
20. Involuntary Treatment Triage Pilot (pg. 47 of 290)
21. Behavioral Health Risk Assesment Tool for Adult Detention (pg. 67 of 290)

Note that the text in the SIP[13] inadvertently identified Housing Capital and Rental Assistance as a new initiative and does not identify Involuntary Treatment Triage Pilot and Behavioral Health Risk Assessment Tool for Adult Detention.

Existing therapeutic courts are proposed to be fully supported by MIDD 2 due to the continued constraints on the General Fund.[14]

Note that several of the new initiatives were added to the SIP by the Executive and were not part of the new concepts review process: Jail-based Substance Use Disorder Treatment, Young Adult Crisis Facility, planning for a new therapeutic Community Court, and a Deputy Prosecuting Attorney for Familiar Faces. These additional initiatives were proposed largely based on increased MIDD sales tax projections and scaling back the costs for some new initiatives that will need ramp-up time to

[13] Proposed Ordinance 2016-0427, Attachment A,"Mental Illness and Drug Dependency Service Improvement Plan," Page 38

implement. The new initiatives, as well as existing MIDD programs, are described in detail in SIP Appendix H.

Table 4 below lists all initiatives proposed for MIDD 2 funding, the MIDD 1 funding budgeted for 2015/2016, and proposed MIDD budget for 2017/2018.

Table 4
MIDD 2 Initiatives, 2015/2016 MIDD Budget and 2017/2018 MIDD Proposed Budget

	MIDD Initiative Title	MIDD 1 2015-2016 Budget	MIDD 2 Proposed 2017-2018 Budget
	Administration & Evaluation	6,839,770	8,386,300
Prevention and Early Intervention ($37.0 million proposed for 2017/2018)	Screening, Brief Intervention and Referral To Treatment-SBIRT (pg. 125 of 290, Appendices)	1,664,345	1,453,655
	Juvenile Justice Youth Behavioral Health Assessments (pg. 128 of 290, Appendices)	868,601	1,183,691
	Prevention and Early Intervention Behavioral Health for Adults Over 50 (pg. 131 of 290, Appendices)	922,819	981,880
	Older Adult Crisis Intervention/Geriatric Regional Assessment Team – GRAT (pg. 134 of 290, Appendices)	641,299	666,605
	Collaborative School Based Behavioral Health Services: Middle and High School Students (pg. 136 of 290, Appendices)	3,021,931	3,187,204
	NEW Zero Suicide Initiative Pilot (pg. 56 of 290, Appendices)	-	1,013,000
	NEW Mental Health First Aid (pg. 60 of 290, Appendices)	-	405,200
	Crisis Intervention Training - First Responders (pg. 139 of 290, Appendices)	1,890,496	1,661,320
	Sexual Assault Behavioral Health Services (pg. 141 of 290, Appendices)	1,015,440	1,183,691
	Domestic Violence and Behavioral Health Services & System Coordination (pg. 144 of 290, Appendices)	633,616	1,142,158
	Community Behavioral Health Treatment (pg. 148 of 290, Appendices)	22,126,477	24,089,140
Crisis Diversion ($35.3 million proposed for 2017/2018)	**NEW** Law Enforcement Assisted Diversion (LEAD) (pg. 25 of 290, Appendices)	-	3,589,500
	NEW Youth and Young Adult Homelessness Services (pg. 131 of 290, Appendices)	-	607,800
	Outreach & In reach System of Care (pg. 97 of 290, Appendices)	1,007,241	830,660

[14] Adult Drug Court, Family Treatment Court, Juvenile Drug Court, Regional Mental Health and Veterans Courts, and Seattle Mental Health Municipal Court

	NEW South County Crisis Diversion Services/Center (pg. 34 of 290, Appendices)	-	2,039,000
	High Utilizer Care Teams (pg. 100 of 290, Appendices)	407,174	519,163
	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (pg. 103 of 290, Appendices)	12,418,796	10,333,569
	NEW Multipronged Opioid Strategies (pg. 37 of 290, Appendices)	420,000	2,289,000
	Children's Domestic Violence Response Team (pg. 106 of 290, Appendices)	456,033	571,079
	NEW Behavioral Health Urgent Care-Walk In Clinic Pilot (pg. 41 of 290, Appendices)	-	506,500
	Next Day Crisis Appointments (pg. 109 of 290, Appendices)	533,985	622,995
	Children's Crisis Outreach and Response System – CCORS (pg. 113 of 290, Appendices)	1,017,887	1,142,158
	Parent Partners Family Assistance (pg. 117 of 290, Appendices)	788,271	851,427
	NEW Family Intervention Restorative Services – FIRS (pg. 44 of 290, Appendices)	-	2,203,655
	NEW Involuntary Treatment Triage Pilot (pg. 47 of 290, Appendices)	-	303,900
	Wraparound Services for Youth (pg. 120 of 290, Appendices)	9,159,800	6,229,950
	NEW Youth Behavioral Health Alternatives to Secure Detention (pg. 50 of 290, Appendices)	-	1,276,000
	NEW Young Adult Crisis Facility (pg. 53 of 290, Appendices)	-	1,430,000
Recovery and Reentry ($19.7 million proposed for 2017/2018)	Housing Supportive Services (pg. 151 of 290, Appendices)	4,101,416	4,146,712
	Behavior Modification Classes at CCAP (pg. 153 of 290, Appendices)	152,688	157,825
	Housing Capital and Rental (pg. 156 of 290, Appendices)	1,650,000	4,849,400
	NEW Rapid Rehousing-Oxford House Model (pg. 64 of 290, Appendices)	-	1,013,000
	Housing Vouchers for Adult Drug Court (pg. 160 of 290, Appendices)	227,819	468,282
	Jail Reentry System of Care (pg. 162 of 290, Appendices)	812,734	882,576
	NEW Behavioral Health Risk Assessment Tool for Adult Detention (pg. 67 of 290, Appendices)	-	954,043
	Hospital Re-Entry Respite Beds (pg. 165 of 290, Appendices)	1,035,241	1,881,445
	NEW Recovery Café (pg. 71 of 290, Appendices)	-	706,500

	BH Employment Services & Supported Employment (pg. 168 of 290, Appendices)	2,300,708	1,972,818
	NEW Peer Support and Peer Bridgers Pilot (pg. 75 of 290, Appendices)	590,000	1,557,488
	NEW Jail-based SUD Treatment (pg. 80 of 290, Appendices)	-	900,000
	NEW Deputy Prosecuting Attorney for Familiar Faces (pg. 82 of 290, Appendices)	-	192,602
System Improvements ($12.5 million proposed for 2017/2018)	**NEW** Community Driven Behavioral Health Grants (pg. 85 of 290, Appendices)	-	709,100
	NEW Behavioral Health Services In Rural King County (pg. 90 of 290, Appendices)	-	709,100
	Workload Reduction (pg. 171 of 290, Appendices)	8,202,832	8,306,600
	Workforce Development (pg. 175 of 290, Appendices)	1,730,203	1,505,571
	NEW Emerging Needs Initiative (described in SIP, pgs. 47-49)	-	1,316,900
Therapeutic Courts ($21.7 million proposed for 2017/2018)	Adult Drug Court (pg. 178 of 290, Appendices)	7,267,294	8,439,000
	Family Treatment Court (pg. 180 of 290, Appendices)	2,412,116	2,908,000
	Juvenile Drug Court (pg. 183 of 290, Appendices)	1,878,267	2,227,000
	Regional Mental Health and Veterans Courts (pg. 186 of 290, Appendices)	7,691,761	7,832,000
	Seattle Mental Health Municipal Court (pg. 189 of 290, Appendices)	176,000	188,722
	NEW Community Court Planning (pg. 95 of 290, Appendices)	-	100,000

Staff analysis of the SIP is ongoing, but several initial policy issues have been identified:

1. Funding Initiatives: As noted previously, most of the new initiatives were identified through an extensive collaborative new concepts process. Several were developed by the Executive outside of that process. The initiatives to be approved by the Regional Policy Committee and the King County Council are ultimately policy choices for the legislative body.

2. Categories of Practice: The SIP as proposed would allow emerging practices to be funded with MIDD. Emerging practices are those not based on research, but that anecdotal evidence and professional wisdom would support. While this would allow for innovative new programs, it may also mean program outcomes may not be clear prior to implementation.

3. Changes to the MIDD Oversight Committee: While a separate ordinance (Proposed Ordinance 2016-0429) was transmitted effectuating changes as described in the SIP, the legislation was not referred to the Regional Policy Committee. Nevertheless, the Regional Policy Committee may wish to consider the proposed changes as they are described in the SIP.

Proposed Ordinance 2016-0428

Proposed Ordinance 2016-0428 would amend Ordinance 15949 to revise the MIDD policy goals, as described in the SIP and in Table 1 of this staff report. Proposed Ordinance 2016-0428 would also require transmittal of detailed implementation plans and an updated MIDD evaluation and reporting plan by August 3, 2017 for review and approval by the Council by motion. The ordinance specifies that these plans shall be developed in collaboration with the MIDD Oversight Committee and community stakeholders. The proposed ordinance also requires annual summary evaluation reports to be submitted to the Council for review and approval by motion by August 1 each year starting in August 2018.

Note that Appendix N, "MIDD 2 Estimated Implementation Schedule," to the SIP indicates estimated service rollout for the MIDD 2 initiatives are largely expected throughout the first, second and third quarters of 2017, so Council staff is working with Executive staff to better understand the role of the legislative body in approving the implementation plan that wil be transmitted by August 3, 2017. Executive staff have indicated that the timelines for transmitting the implementation plan cannot be shortened due to the time needed to conduct outreach and engagement and to develop performance measures. Executive staff have indicated that further discussion is needed on how the timeline will impact the Regional Policy Committee and Council role in considering the implementation plan.

ATTACHMENTS:

1. Proposed Ordinance 2016-0427 and Attachment A
2. PO 2016-0427 Fiscal Note
3. Proposed Ordinance 2016-0428
4. PO 2016-0428 Fiscal Note
5. Transmittal Letter
6. MIDD Financial Plan July, 2016
7. MIDD Community Conversations & Focus Group Themes

INVITED:

1. Adrienne Quinn, Director, Department of Community and Human Services
2. Jim Vollendroff, Division Director, Department of Community and Human Services
3. Kelli Carroll, Strategic Advisor, Department of Community and Human Services

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KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

September 8, 2016

Ordinance

Proposed No. 2016-0427.1 **Sponsors** Kohl-Welles

An ORDINANCE approving the mental illness and drug dependency service improvement plan to guide the investment of mental illness and drug dependency sales tax revenue, in compliance with Ordinance 17998.

PREAMBLE:

In 2005, recognizing the need for additional mental health and chemical dependency programs, the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new programs.

The one-tenth of one percent sales and use tax supporting new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services, known as the mental illness and drug dependency ("MIDD") sales and use tax, generates between fifty and sixty-five million dollars annually for King County.

King County council levied the one-tenth of one percent MIDD sales and use tax in Ordinance 15949, which was enacted November 26, 2007.

The intent of the sales tax is to support new or expanded mental health and substance abuse programs, now referred to as behavioral health programs, reflective of the integration of mental health and substance use disorder programs and services; and the operation of the county's therapeutic court programs.

In March 2014, the Washington state Legislature passed Senate Bill 6312, which became Chapter 225, Laws of Washington 2014, calling for the integrated purchasing of mental health and substance abuse treatment services. Implementation of this law has brought about changes to how mental health and substance abuse treatment services are described and administered and delivered in King County. An integrated behavioral health system allows more flexibility to deliver holistic care especially for individuals with co-occurring mental health and substance use disorders. One change initiated by behavioral health integration is the evolution of terminology used to define and describe the mental health and substance use disorder systems. King County uses "behavioral health" when referencing mental health and substance use disorder systems, reflecting the joining of systems through behavioral health integration.

The MIDD sales tax-funded initiatives, programs and services supported by revenues levied under K.C.C 4A.500.300 and outlined in the attached service improvement plan, which is Attachment A to this ordinance, continue the county's work to transform the approach to health and human services by improving health and well-being and creating conditions that allow residents of King County to achieve their full potential.

Much has changed locally, at the state level and nationally in the realm of behavioral health the eleven years since the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new programs and enhance the state's chemical dependency and mental health treatment services, and in the nine years since King County subsequently authorized the MIDD one-tenth of one percent sales and use tax levied under K.C.C. 4A.500.300: the formerly separate mental health and chemical dependency services are integrated into one behavioral health system; the nation and region experienced a severe economic downturn and recovery; the federal Affordable Care Act was enacted; and there have been several changes in state laws impacting behavioral health services. Throughout all of these change events, King County's MIDD work became a platform for cross system engagement and improvement, collaboration and policy dialogue between the criminal justice and health and human services sectors.

Ordinance 17998 called for the King County executive to transmit to the council two reports in preparation for the council's consideration of an ordinance that would continue the MIDD sales and use tax: 1. A comprehensive, historical review and assessment report of the MlDD-funded strategies, services and programs; and 2. A service improvement plan to guide the investment of a renewed MIDD sales tax.

The comprehensive, historical review and assessment report transmitted to the Council on June 30, 2016, recognized that in aggregate, MIDD sales

tax-funded strategies, services and programs are successful and effective in meeting the established policy goals. Significant reductions in jail and emergency department use and psychiatric hospitalizations are reflected in the report as documented by MIDD evaluation data. The comprehensive, historical review and assessment report of the MlDD sales tax-funded strategies, services and programs was developed with input from, and was reviewed by, the mental illness and drug dependency oversight committee, as required by Ordinance 17998.

Ordinance 17998 called for the executive, with input from the MIDD oversight committee and community stakeholders, to review, update and revise the strategies outlined in the MIDD Implementation Plan adopted in Ordinance 16261, and to submit a MIDD service plan to the council for review and approval. The MIDD service improvement plan that is Attachment A to this ordinance is intended to be used to guide investments of taxes levied under K.C.C 4A.500.300 beginning in the 2017/2018 biennium should the MIDD sales tax be renewed by the council before the tax expires on January 1, 2017.

King County and its behavioral health and community stakeholders embraced the opportunity to review and learn from the MIDD work accomplished between 2008 and 2016, and plan for a robust, forward-looking MIDD for the next service period. The MIDD service improvement plan, Attachment A to this ordinance, represents the collaborative efforts over a nearly two-year period from a wide range of

stakeholders including representatives from communities, provider agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, council staff and many others to thoughtfully plan for the use of MIDD revenues for the next service period.

Community voices and priorities significantly influenced the development of the funding and programmatic recommendations incorporated in the attached MIDD service improvement plan. MIDD planning was conducted in a clear and straightforward way, involving the MIDD oversight committee at each step. As guided by the MIDD oversight committee, the county turned to citizens and community partners across the region for input and guidance in developing the recommendations. Between October 2015 and February 2016, fourteen MIDD focus groups were held involving specific communities, populations or subregional areas, including a focus group with individuals in the King County jail. Five regional community conversations were also held in partnership with best starts for kids planning efforts. Between in person meetings, an electronic survey and other methods of feedback, close to one thousand two hundred citizens and community members provided direct input into the development of the MIDD recommendations reflected in the attached service improvement plan.

The attached MIDD service improvement plan builds on the success of the groundbreaking partnership between health and human services, criminal justice, King County government and community providers during the 2008-2016 MIDD funding period. The recommended MIDD initiatives, policies and processes as described in the MIDD service improvement plan and consistent with RCW 82.14.460 have been informed by community and MIDD oversight committee input; are grounded in the county's social justice and equity work; driven by outcomes; guided by the behavioral health continuum of care; and aligned with other county policy initiatives.

The recommended MIDD initiatives included in the attached MIDD service improvement plan are based in the theory of change that when people who are living with or who are at risk of behavioral health conditions utilize culturally-relevant prevention and early intervention, crisis diversion, community reentry, treatment and recovery services and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.

As required by Ordinance 17998, the attached MIDD service improvement plan makes operational, programmatic, funding and policy recommendations for the implementation of the MIDD sales tax from 2017 through 2025. The recommendations contained in the MIDD service improvement plan reflect the current and evolving behavioral health needs

of King County's citizens, behavioral health workforce challenges and a growing understanding of social justice and equity in the provision of behavioral health services.

The county's equity and social justice initiative recognizes many communities within King County face inequities in key educational, economic, and health outcomes. Consequently, equity and social justice considerations are a major component in the initiatives outlined in the attached MIDD service plan and a driving factor for all aspects of implementing the next years of MIDD work. Guided by the understanding that how the work of MIDD is approached and accomplished is as important as what MIDD supported programs and services accomplish, the planning and development of the MIDD service improvement plan was conducted with a deep focus on social justice and equity.

The initiatives in the MIDD service improvement plan, Attachment A to this ordinance, build on the successes of MIDD to date; ensure timely, affordable and culturally-appropriate access to behavioral health services that focus on recovery and resilience; improve community-based services and programs; and better meet the behavioral needs of people in need of services, thereby reducing costly incarceration and emergency room utilization.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. **Findings:**

A. The initiatives contained in the service improvement plan attached to this ordinance or any future implementation plans may be expanded, revised or eliminated based on, but not limited to, the following reasons: changes to state law or county policy; performance data from the evaluation of sales-tax funded programs and strategies; recommendation from the county executive or the mental illness and drug dependency oversight committee; or county budgetary constraints.

B. The county recognizes that the needs of its residents may change over time and that new and innovative behavioral health programs and services are continually being developed and implemented across the country. Therefore, it is the policy of the county that the county's mental illness and drug dependency sales tax-supported programs shall maintain flexibility to respond to the changing needs of the county's population as well as to accommodate new behavioral health services and programs.

SECTION 2. The mental illness and drug dependency service improvement plan, as required in Ordinance 17998 and that is Attachment A to this ordinance, is hereby approved to guide the investment investments of taxes levied under K.C.C 4A.500.300. The mental illness and drug dependency spending plan and financial plan, including the

next year's projected initiative allocations, is subject to review and possible modification in the county's budget process.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

J. Joseph McDermott, Chair

ATTEST:

_____

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: A. Mental Illness and Drug Dependency Service Improvement Plan

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Mental Illness and Drug Dependency Service Improvement Plan

As Required by Ordinance 17998

August 2016

Acknowledgments

The completion of this Service Improvement Plan would not have been possible without the hard work and dedication of a number of individuals.

The Executive wishes to acknowledge the staff of the Department of Community and Human Services, particularly those of the Behavioral Health and Recovery Division, for their contributions of time and expertise. Thank you to all of the County staff from all agencies and departments who assisted with developing this plan.

Very special thanks are also extended to the Mental Illness and Drug Dependency Oversight Committee members and the Committee's co-chairs, King County Superior Court Judge Johanna Bender and Merril Cousin, Executive Director of the Coalition Ending Gender Based Violence, for their tireless leadership, vision and hard work over the last 18 months.

Additional thanks to the numerous cities, organizations and individuals who hosted meetings, held community conversations, facilitated group discussions, and contributed time, insight and expertise to this Service Improvement Plan and the Mental Illness and Drug Dependency planning process. Without the work of all of these organizations and individuals, and the hundreds of community members that participated in the Mental Illness and Drug Dependency review and renewal process, this report and its recommendations would not reflect the broad, and truly county-wide, perspective it contains.

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I. Executive Summary

Much has changed locally, at the state level, and nationally in the realm of mental health and chemical dependency in the eleven years since the Washington State Legislature passed the Omnibus Mental Health and Substance Abuse Act in 2005 to enhance the state's chemical dependency[1] and mental health treatment services, and in the nine years since King County subsequently authorized the one-tenth of one percent sales and use tax to fund new mental health, chemical dependency, or therapeutic court services enabled by the Legislature. From the integration of the formerly separate mental health and chemical dependency services systems into one behavioral health system, to the economic downturn and uptick, to the enactment of the Affordable Care Act, to changes in state laws, King County's Mental Illness and Drug Dependency (MIDD) has become more than a revenue source. The MIDD has become a platform for cross system engagement and improvement, collaboration and policy dialogue.

In accordance with Ordinance 17998, this Service Improvement Plan makes operational, programmatic, funding and policy recommendations for the MIDD service period of 2017-2025 (referred to in this document as "MIDD 2") should the King County Council extend the sales tax sunset date. The recommendations reflect the current and evolving behavioral health needs of King County's citizens, the reality of a challenged behavioral health workforce, and a growing understanding of equity and social justice in the provision of behavioral health services.

King County embraced the opportunity to review and learn from the 2008-2016 MIDD service period (referred to in this document as "MIDD 1") and plan for robust, forward-looking MIDD sales tax supported initiatives, services, and programs for the 2017-2025 service period. This MIDD Service Improvement Plan represents the collaborative efforts over a nearly two-year period from a wide range of internal and external stakeholders including representatives from communities, provider agencies, consumers, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, Council staff, and many others to thoughtfully plan for a renewed MIDD sales tax.

This blueprint for MIDD builds on the success of the first MIDD which was a groundbreaking partnership between health and human services, criminal justice, King County government and community providers, and sets forth a path to overcome the few challenges of the first MIDD service period. The recommended initiatives, policies and processes that comprise MIDD 2 and are reflected in this Service Improvement Plan are:

- informed by community and Oversight Committee input
- grounded in the County's Equity and Social Justice work
- driven by outcomes
- guided by the behavioral health continuum of care
- aligned with other County policy initiatives.

[1] This term is used in its historic context to describe the State Legislature's actions. This term is replaced by "substance use disorder" in subsequent sections of this report.

Successful MIDD 1 programs are proposed to continue into MIDD 2, though some will be merged or retooled during the implementation planning and/or request for proposal (RFP) process.

21 new proposed initiatives are recommended for MIDD 2, bringing the total number of initiatives to 52.

MIDD 2 reflects the integrated behavioral health system, "busting silos" so that services are person-centered, not program-centered. MIDD 2 was intentionally developed in collaboration with initiatives like Best Starts for Kids so that services and funding can be braided to achieve maximum impact.

The proposed MIDD 2 initiatives prioritize:

- Funding services and programs to keep people out of or returning to jail and the criminal justice system, including upstream prevention and diversion activities. These include initiatives like:
    - Law Enforcement Assisted Diversion (LEAD)
    - Housing Capital and Rental Assistance
    - Crisis Diversion and Mobile Crisis Services, including expanding to South King County
    - Recovery Café.

- Investing in a treatment on demand system that delivers treatment to people who need it, how they need it, and when they need it so crises can be avoided or shortened. These include initiatives like:
    - Behavioral Health Urgent Care Walk In Clinic Pilot
    - Next Day Appointments
    - Peer Bridger and Peer Support.

- Creating community-driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs.

Community voices and priorities significantly influenced the development of the proposed MIDD 2 funding and programmatic recommendations.

MIDD 2 planning was conducted in a clear and straightforward way, involving the Oversight Committee at each step**.** As guided by the Oversight Committee, the county turned to citizens and community partners across the region for input and guidance in developing the MIDD 2 recommendations. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas, including a focus group with individuals in the King County Jail. Between in person meetings, an electronic survey and other electronic feedback, close to 1,200 citizens and community members provided direct input into the development of the MIDD 2 recommendations.

MIDD 2 continues the County's work to transform the approach to health and human services by **improving health and well-being and creating conditions that allow residents of King County to achieve their full potential.**

MIDD 2 is organized by the MIDD 2 Framework into four strategy areas that reflect a continuum from prevention to crisis services, linked to outcomes. The MIDD 2 Framework is an accountability structure driven by the results policymakers and stakeholders want to see in the community as the result of investment of MIDD funds; the indicators that the county will use to signal that it's headed down the right path to get there; and the actions the county and its partners will take to create the change stakeholders want to see.

A major component of the MIDD 2 Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area. Each of the proposed MIDD 2 initiatives is included in one of the four MIDD 2 Strategy Areas.

MIDD 2 Strategy Area Name	Purpose
Prevention and Early Intervention	*People get the help they need to stay healthy and keep problems from escalating*
Crisis Diversion	*People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*
Recovery and Reentry	*People become healthy and safely reintegrate to community after crisis*
System Improvements	*Strengthen the behavioral health system to become more accessible and deliver on outcomes*

The MIDD 2 Framework is a living document that will be further updated over the life of MIDD 2 to reflect specific programmatic and services once they are determined by the Executive and Council in 2016. The framework will continue to be updated over the life of MIDD 2 as a companion to the MIDD policy goals.

Best Starts for Kids is proposed to support an estimated $2.9 million annually for prevention based behavioral health services for children and youth.

Aligning MIDD 2 and Best Starts for Kids (BSK) has been a primary focus of the Department of Community and Human Services (DCHS). From holding joint Community Conversations, to collaborating on strategies and initiatives, to jointly reviewing MIDD 2 concepts and briefing papers, MIDD 2 planning and recommendations development has been a synergistic endeavor with BSK. This strong partnership will continue throughout the life of each of these initiatives, through planned joint meetings of the MIDD Oversight Committee and the Children and Youth Advisory Board and shared approaches to accomplishing the work of each initiative. Operationally, MIDD 2 and BSK are working to coordinate approaches to evaluation, contracting and reporting among other aspects.

Summary of DRAFT MIDD 2 Service Improvement Plan Recommendations

Recommendations that require legislation are noted with ""*

Area of Recommendation	SIP Recommendations
MIDD Fund Financial Policies Recommendations	1. Revise MIDD Fund reserve policy to be 60 days of expenditure. 2. Allocate funds to the Rainy Day Reserve to fully fund the reserve within the current biennium. 3. When reserve levels are met, prioritize use of undesignated fund balance as follows: A. Allocate funds for provider economic adjustments for the next biennium B. Allocate funds to the Emerging Issues initiative to $650,000 annually.
Adding, Deleting, or Modifying MIDD Initiatives, Strategies, Services, and Programs or Initiatives	1. Use updated MIDD 1 revision processes for modifying or adjusting MIDD initiatives, strategies, services and programs. 2. Utilize Emerging Issues initiative to support emerging services and programs for up to two years.
Proposed Schedule for Reporting	1. Revise data collection periods to January to January fiscal/calendar year. * 2. Revise annual report due date to the Council to August.* 3. Launch web data dashboard.
Recommended Modifications to the MIDD Oversight Committee	1. Maintain role as advisory body to the Executive and Council.* 2. Revise membership to reflect changed organizations, boards or entities.* 3. Add four new member seats.* 4. Convene Consumers and Communities Ad Hoc Work Group. 5. Initiate an array of operational improvements. 6. Change the name of the MIDD Oversight Committee to the MIDD Advisory Committee.*

Recommended Additional Seats to MIDD Oversight Committee

Please note that the net increase of seats is four after realigning existing seats to reflect organizational changes.

See report pages 54-59 for details

Focus or Population	Specific Entity
Consumers & Communities – 2 Representatives	From Consumers and Communities Ad Hoc Work Group
Recovery	Washington Recovery Alliance

Education	Puget Sound Educational Services District
Philanthropy	Many Minds Collaborative
Managed Care	Medicaid Managed Care Plans

Highlighted Recommended Improvements to the MIDD Oversight Committee

Convene Consumers and Communities Ad Hoc Work Group – 2 Representatives from Ad Hoc Work Group Elected to MIDD Oversight Committee

The ad hoc work group would be comprised of individuals with lived experience of the behavioral health system (consumers) and individuals who are a part of communities with marginalized identities or experiences, including but not limited to:

- Transgender
- Youth
- Immigrant/refugee
- Black/African American
- Asian/API
- Hispanic
- Rural
- Faith
- Former justice involved
- Peers

This recommendation reflects several key principles of community engagement, including the "nothing about us, without us" concept, where the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy. The ad hoc work group invites communities identified as needing a voice in MIDD while not creating an unwieldy Oversight Committee of 50 or more that would not be feasible to operate. A notable component of the Consumers and Communities Ad Hoc Work Group is that its members will be paid for their participation, similar to the current Familiar Faces Advisors model. Two Consumers and Communities Ad Hoc Work Group members would be recommended to serve as full members of the MIDD Oversight Committee, subject to the existing appointment and confirmation process. One of the two Consumers and Communities Ad Hoc Work Group members elected to participate on the Oversight Committee will be a consumer.

Undertake an array of operational improvements - based on feedback and suggestions from Oversight Committee members, as well as lessons learned from staffing the MIDD Oversight Committee over time.

Change the Name of the Oversight Committee - reflective of the established duties and functions of the Committee that are recommended to continue for MIDD 2, it is recommended that the name of the Committee be amended to reflect its duties as an advisory body: The MIDD Advisory Committee.

Next Steps & Conclusion

The information in this report responds to the requirements of Ordinance 17998.

Ordinance 17998 called for the transmittal of MIDD Service Improvement Plan (SIP) in December of 2016. In order to support the King County Council's desire for expanded review and input of the MIDD 2 SIP, the SIP report called for by Ordinance 17998 is submitted three months earlier than required. The impact of this changed timeline is that two elements of the MIDD 2 – Implementation and Evaluation Plans---require further development. Additionally, the policy goals that were established for MIDD 1 are recommended to be revised, which impacts implementation and evaluation planning outcomes.

Developing Implementation and Evaluation Plans will be conducted in collaboration with the MIDD Advisory Committee[2] and providers.

Three specific next steps are necessary for MIDD 2 - completion of the MIDD 2 Implementation and Evaluation Plans and a process to change the name of the MIDD. Each step will be developed collaboratively with the MIDD Oversight Committee and other stakeholders. The Executive recommends transmitting MIDD 2 Implementation and Evaluation Plans to the Council in mid-2017 for review and acceptance, similar to the sequencing of MIDD 1. Additional planning is needed for most of the new initiatives contained in the proposed MIDD 2, many of them requiring community engagement components.

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. It is recommended that the name of the MIDD be changed to something that more meaningfully and positively reflects the hope of recovery. Changing the name of the MIDD will require revision to the King County Code and other adopted legislation. Executive staff will work with the Code Reviser, the Prosecutor's Office and Council staff on this issue.

In keeping with the established process and timeline for the development of the Mental Illness and Drug Dependency Service Improvement Plan, this document reflects Executive priorities for the programming and funding of Mental Illness and Drug Dependency revenues. In addition to including Executive priorities for the spending of MIDD revenue, adjustments to certain proposed MIDD initiatives have occurred due to or more of the following factors:

1. Updated Office of Financial Analysis (OEFA) MIDD sales tax projections
2. Revised Medicaid assumptions
3. Staged implementation assumptions of select initiatives[3]

Please see Appendix H, Initiative Descriptions and Appendix M, Spending Plan for detailed funding and programmatic recommendations.

[2] Proposed legislation to revise the name of the MIDD Oversight Committee to the MIDD Advisory Committee has been transmitted to the King County Council. Therefore, the term "MIDD Advisory Committee" is used in this document when referencing potential prospective acts by the current MIDD Oversight Committee, assuming King County Council approval of legislation that formally changes the name of the Committee from "Oversight" to "Advisory." A discussion of the proposed name change occurs on page 60 of this document.

[3] Staged Implementation is discussed on page 43 of this report.

II. MIDD 1 and Key Environmental Changes

History of MIDD 1

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

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

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

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

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

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

31, 2011, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding for up to the first three calendar years following adoption; and up to twenty-five percent may be used to supplant existing funding for the fourth and fifth years after adoption;
(c) For a county with a population of less than twenty-five thousand, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to eighty percent may be used to supplant existing funding in calendar years 2011-2012; up to sixty percent may be used to supplant existing funding in calendar year 2013; up to forty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016; and
(d) Notwithstanding (a) through (c) of this subsection, moneys collected under this section may be used to support the cost of the judicial officer and support staff of a therapeutic court.

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

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

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

> *The expiration of the tax is established to enable progress toward meeting the county's policy goals outcomes, and to enable evaluations of the programs funded with the sales tax revenue to take place and for the county to deliberate on the success of meeting policy goals and outcomes.* [4]

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

[4] King County Ordinance 15949, section 1 H, lines 73-76.

MIDD Adopted Policy Goals

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

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

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

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

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

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

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

MIDD 1 was organized based on the Sequential Intercept Model, providing a framework to determine what services were needed under MIDD 1 to help prevent incarceration, hospitalization and homelessness. It is included as Appendix A to this report.

MIDD 1 Implementation: Oversight, Implementation and Evaluation Plans: Ordinance 15949 called for key foundational planning documents necessary to the successful and transparent implementation of the MIDD. The legislation called on the Departments of Community and Human Services, Adult and Juvenile Detention, and Public Health; the Offices of the Public Defender and Prosecuting Attorney; and Superior and District Courts to develop and submit to the Council MIDD oversight, implementation and evaluation plans.

The MIDD Oversight Plan, adopted by Ordinance 16077, established the MIDD Oversight Committee. It set the role and duties of the Oversight Committee, and established the composition of the Oversight Committee. As described in legislation, the Oversight Committee is responsible for the ongoing oversight of the MIDD services and programs funded with the sales tax revenue. It acts as an advisory body to the Executive and the Council, reviewing and making recommendations on the implementation and effectiveness of the sales tax programs in meeting the five established policy goals. It reviews and comments on all required reports and on emerging and evolving priorities for use of the MIDD funds. Ordinance 16077 states that the Oversight Committee "should promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers, and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts."[5] Ultimately, the Oversight Committee's purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative.

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

The MIDD 1 Implementation Plan was adopted via Ordinance 16261 on October 6, 2008. Per Ordinance 15949, the MIDD Implementation Plan was developed in collaboration with the Oversight Committee. The Implementation Plan described the implementation of the programs and services outlined in the MIDD Action Plan. As required, it included a discussion of needed resources (staff, information and provider), milestones for implementation of programs and a spending plan. It also addressed expansion of Adult Drug Court and mental health and substance abuse services for survivors of domestic violence and sexual assault.

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

[5] Ordinance 16077 Section 1 E, lines 44-47.

MIDD 1 Service Areas and Programming

MIDD 1 Service Area	MIDD Programs and Strategies
Community-Based Care	• Increase access to community mental health and substance abuse treatment for uninsured children, adults and older adults • Improve the quality of care by decreasing mental health caseloads and providing specialized employment services • Provide supportive services for housing projects serving people with mental illness and chemical dependency treatment needs
Programs Targeted to Help Youth	• Expand prevention and early intervention programs • Expand assessments for youth in the juvenile justice system • Provide comprehensive team-based, intensive "wraparound" services • Expand services for youth in crisis • Maintain and expand Family Treatment Court and Juvenile Drug Court
Jail and Hospital Diversion	• Divert people who do not need to be in jail or hospital through crisis intervention training for police and other first responders and by creating a crisis diversion facility • Expand mental health courts and other post-booking services to get people out of jail and into services faster • Expand programs that help individuals re-enter the community from jails and hospitals
Domestic Violence and Sexual Assault and Adult Drug Court	• Address the mental health needs of children who have been exposed to domestic violence • Increase access to coordinated, early intervention mental health and substance abuse services for survivors of domestic violence • Increase access to treatment services for victims of sexual assault • Enhance services available through the King County Adult Drug Diversion Court
Housing Development	• Support capital projects and rental subsidies for people with mental illness and chemical dependency

The Implementation Plan for the 2008-2016 MIDD service period contained information on each individual program, called a "strategy," including the following:

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

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

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

The Implementation Plan outlined the steps and timeline for creation of the comprehensive programming that became MIDD programs. The Implementation Plan summarized the collaborative work of many entities over a two-year period to organize and develop the work that eventually became the MIDD. The document states that the Implementation Plan is "a product of a comprehensive, multi-jurisdictional plan to help youth and adults who are at risk for or suffer from mental illness or substance abuse."[6]

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

The MIDD Evaluation Plan identified a framework for evaluating most of the programs (strategies) in the MIDD Implementation Plan except the two added by the Council Crisis Intervention Team / Mental Health Partnership Pilot Project and Safe Housing and Treatment for Children in Prostitution Pilot Project. The Evaluation Plan stated that evaluation would be accomplished "by measuring what is done (output), how it is done (process), and the effects of what is done (outcome)."[7]

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

- 2015: 20 percent
- 2016: 10 percent
- 2017: 0 percent (the King County MIDD 1 expires in January 2017; should MIDD be renewed, the 2017-2018 budget would reflect zero supplantation).

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

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

Replacement of lost Federal funds is permitted.

MIDD in 2016: MIDD serves thousands of people annually[8], providing services to those who otherwise would not receive services. MIDD funding provides:

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

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

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

Key Changed Conditions Impacting MIDD

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

Behavioral Health Integration: In March 2014, the Washington State Legislature passed Senate Bill 6312 calling for the integrated purchasing of mental health and substance abuse treatment services through managed care contracts by April 2016, with full integration of physical and behavioral health care by January 2020. The law necessitated the creation of Behavioral Health Organizations (BHOs) to purchase and administer Medicaid funded mental health and substance use disorder services under managed care. BHOs are single, local entities that will assume responsibility and financial risk for providing substance use disorder treatment and the mental health services currently overseen by the counties and

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

the former Regional Support Networks (RSNs). The BHO services include inpatient and outpatient treatment, involuntary treatment and crisis services, services in jail, and services funded by federal block grants. King County Behavioral Health and Recovery Division will serve as the BHO for the King County region.

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

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

More information on statewide BHO development can be found here:
https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/developing-behavioral-health-organizations

Please also see pages 66-69 for additional discussion of Behavioral Health Integration.

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

Since January 1, 2014, when Washington State took advantage of Medicaid expansion under the ACA, King County has seen a significant increase in the number of people enrolled in Medicaid. As of June 1, 2016, approximately 165,000 individuals have become newly eligible for Medicaid services in King County; of those, about 10,000 had accessed outpatient mental health services from the King County RSN. As of June 1, 2016, there are approximately 405,000 Medicaid-covered individuals in King County.

Because the RSN (and now the BHO) is paid on a per member per month basis from the state, the increase in Medicaid eligible individuals has resulted in revenue growth. This in turn has allowed the

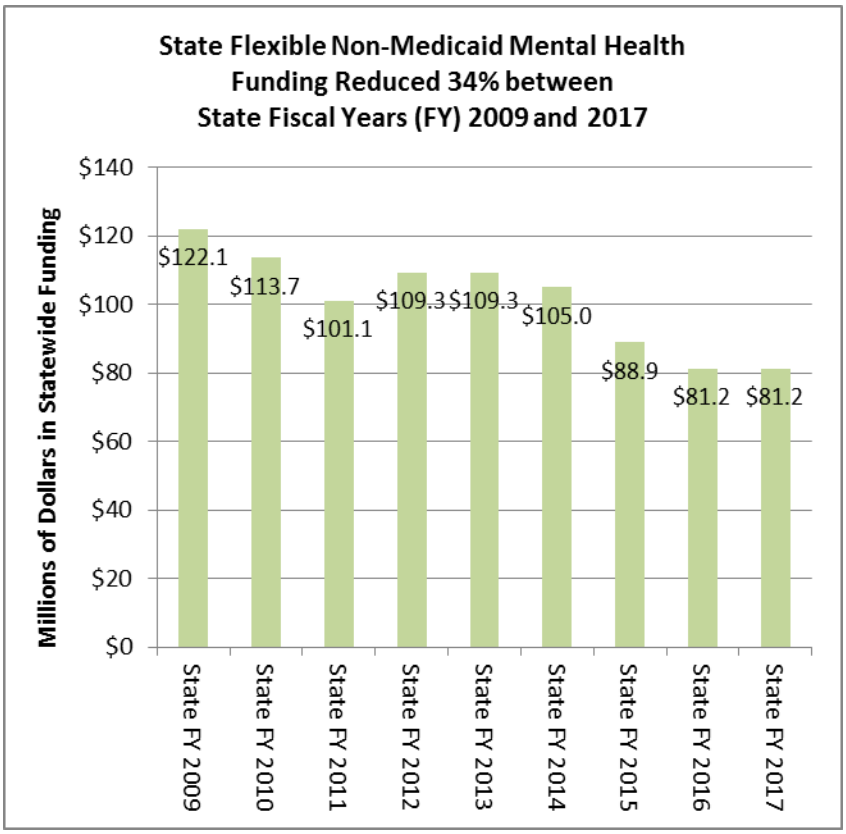
King County BHO to raise outpatient case rates paid to providers. Unfortunately, the system is experiencing a bow wave: the behavioral health system is struggling to find and/or retain trained, licensed and qualified staff to provide services to this expanded population. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Workforce development is discussed in detail in a subsequent section of this document.

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

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

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

Table 1



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

Another aspect to resource scarcity is the ongoing structural deficit of King County's General Fund. For the upcoming 2017-2018 biennium, the General Fund is facing a $50 million deficit. About 75 percent of the General Fund is used to support the county's criminal justice system, including the jail, the courts, prosecution and defense, and the Sheriff's Office. Due to the $50 million General Fund deficit, the County is exploring all options to have other funding sources, like the MIDD sales tax, support programs that would relieve pressure on the General Fund. However, the ability to use MIDD revenue to support previously existing programs is limited by a supplantation restriction in the state MIDD statute, which requires MIDD funding be used on "new or expanded programs or services." One exception to the supplantation restriction in the MIDD statute is therapeutic court activities (e.g. Mental Health Court or Drug Court). Therapeutic courts were originally funded by the General Fund before being funded by the first MIDD. The MIDD 2 spending plan that is included with this report reflects the continued support of King County's four existing therapeutic courts by the MIDD.

High Treatment Need: Severe resource scarcity has coexisted with a very high prevalence of treatment need in Washington as compared to other states. Analysis of data from the federal Substance Abuse and

Mental Health Administration (SAMHSA) 2010-11 Mental Health Surveillance Survey found that Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (seven percent).[9]

Population Growth: The population of King County grew by an estimated 22 percent between 2000 and 2015 – almost 380,000 people. Meanwhile, the state's population increased by approximately 22 percent as well – or nearly 1.3 million.[10] Even this one factor alone – the addition of so many more residents – would have placed more pressure on an overstretched community behavioral health treatment system.

Emergency System Use: More and more people are seeking psychiatric care via hospital emergency departments (EDs) – in 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of 2007 psychiatric ED visits, 41 percent result in a hospital admission, over two and a half times the rate of ED visits for other conditions,[11] and between 2001 and 2006 the average duration of such visits was 42 percent longer than for non-psychiatric issues.[12] The growth in these figures may result from the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally, that began as part of deinstitutionalization in the 1960s and has continued until very recently.[13]

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

Court Rulings

Psychiatric Boarding: On August 7, 2014, the Washington State Supreme Court ruled that hospital boarding of involuntarily detained individuals in mental health crisis, absent medical need, is unconstitutional. Psychiatric boarding or "boarding" became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available,

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

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

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

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

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

individuals were detained and waiting in less than optimal settings such as hospital EDs until a psychiatric bed became available.

Psychiatric boarding hurts patients and drives resources away from community-based and preventive care. Studies show that prolonged waits in EDs for psychiatric patients are associated with lower quality mental health care.[14] This has been a nationwide problem that had been affecting Washington and King County since at least 2009.

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, the Court emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of bed capacity.[15]

State and local partners, including the Community Alternatives to Boarding Task Force[16], are developing system innovations and deploying new resources strategically to improve access to care. Local flexible resources like MIDD play a key part in expanding treatment capacity in King County.

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

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

Other Change Drivers

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

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

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

[16] See www.kingcounty.gov/cabtf for more information about the Community Alternatives to Boarding Task Force, including its June 2016 final report to King County Council in response to Motion 14225.

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

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

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

Without workforce improvements, King County will not be able to meet service needs. Individuals who desperately require lifesaving services could go untreated, resulting in high costs, both human and financial. The County is uniquely positioned to both participate in and lead aspects of workforce development in partnership with providers, consumers and policy makers.

Evolving Values and Approaches to Care: The factors below reflect new directions or policies taken by King County in the provision of behavioral health services since 2007 when the MIDD was first

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

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

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

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

authorized. In addition, each element echoes a MIDD Oversight Committee-identified guiding principle for the development of MIDD 2.

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

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

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

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

Most individuals seeking public behavioral health and other public services have histories of physical and sexual abuse and other types of trauma-inducing experiences.[22] These experiences often lead to mental

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

[22] "NCTIC's Current Framework." National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint. Substance Abuse and Mental Health Services Administration, 26 Oct. 2015. Web. 21 June 2016. Also supported by Lu, Weili, Mueser, Kim T., Rosenberg, Stanley D., Jankowski, Mary Kay. Correlates of Adverse Childhood Experiences Among Adults with Severe Mood Disorders. Psychiatric Services. 2008 (59)"1018-1026.

health and co-occurring disorders such as chronic health conditions, substance abuse, as well as contact with the criminal justice system.

Providing services under a trauma-informed framework can result in better outcomes than "treatment as usual." A variety of studies have revealed that programs utilizing a trauma-informed model are associated with a decrease in psychiatric symptoms and substance use. Some programs have shown an improvement in daily functioning and a decrease in trauma symptoms, substance use and mental health symptoms.[23, 24] Trauma-informed care may lead to decreased utilization of crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed services.[25]

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

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

In October of 2014 Executive Constantine signed an Executive Order calling for advancing equity and social justice in King County, along with the development of a countywide Equity and Social Justice Strategic Plan. Planning of MIDD 2 is driven in large part by the County's commitment to enacting its Equity and Social Justice Agenda.

MIDD 1 Comprehensive Historical Review and Assessment Report Findings

As noted, Ordinance 17998 called for two major MIDD related work products to be submitted to the

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

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

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

Council: this **Service Improvement Plan** and the **Comprehensive Historical Review and Assessment Report.** The latter is an extensive examination and assessment of MIDD 1 strategies, programs, and services and was submitted to the Council on June 30. It included recommendations on improvements to MIDD performance measures, evaluation data gathering and a review of MIDD evaluation processes.
The Comprehensive Historical Review and Assessment Report contained the following findings on MIDD 1:

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

2. **<u>Significant reductions</u> in jail and emergency department use, and psychiatric hospitalizations, are documented by MIDD evaluation data.**

Policy Goal 1: Emergency Department Utilization - SIGNIFICANT REDUCTION
Data indicates that over the long term, emergency department utilization decreased significantly. After a modest initial increase in emergency department use in the first year, **reductions in emergency department use exceeded 25 percent for every year thereafter, peaking at 39 percent** in the fifth year after initial MIDD service contact.

Policy Goal 1: Psychiatric Hospital Utilization - SIGNIFICANT REDUCTION
Over the long term, inpatient psychiatric hospital utilization (including local hospitals and Western State Hospital) decreased significantly. After a modest initial increase in psychiatric hospital use in the first year, **the total number of admissions dropped 44 percent**, and the **total number of hospital days were reduced by 24 percent**, in the third through fifth years after initial MIDD service contact.

Policy Goals 1, 2, and 4: Jail Utilization - SIGNIFICANT REDUCTION
Over both the short and long term, **jail bookings decreased significantly, ranging from 13 percent in the first year to 53 percent** in the fifth year after initial MIDD service contact. Total jail days increased slightly in the first year after MIDD service contact, but then **reductions in jail days that reached a 44 percent reduction** by the fifth year were consistently evident starting in the second year.

Policy Goal 3: Symptom Reduction - NOTABLE REDUCTION
When change was evident and could be measured, **about three out of every four people showed reduced mental health symptom severity or reduced substance use** at some point over the course of their treatment.

Policy Goal 5: Furthering Other Initiatives - INTENTIONAL LINKAGE
In general, strategies intended to further the work of other Council-directed efforts were determined to have done so.

The Comprehensive Historical Review and Assessment Report also identified a number of recommendations to improve evaluations of MIDD 2. The potential renewal of MIDD presents a tremendous opportunity to examine MIDD and its evaluation. Informed by an independent assessment

of the MIDD Evaluation by King County's Office of Performance, Strategy, and Budget (PSB), as well as other internal assessments and stakeholder feedback, a range of improvements to the MIDD evaluation approach were recommended. The 22 potential changes to the MIDD 2 evaluation fall into these four broad categories:

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

III. Key Components of MIDD 2

Overview

The 2016 MIDD Service Improvement Plan represents the collaborative efforts over a nearly two-year period from a wide range of internal and external stakeholders, including representatives from communities, provider agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected officials from jurisdictions in King County, Council staff, and many others. The product of this work is the MIDD 2 Service Improvement Plan which is a comprehensive, multi-jurisdictional proposal to help people living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement. It builds on the success of the first MIDD which was a groundbreaking partnership between health and human services, criminal justice and King County government and community providers, and sets forth a path to overcome the few challenges of MIDD 1.

The recommended initiatives, policies and processes that comprise MIDD 2 are:

- informed by community and Oversight Committee input
- grounded in the County's Equity and Social Justice work
- driven by outcomes;
- guided by the behavioral health continuum of care
- aligned with other County policy initiatives.

Differences between MIDD 1 and Proposed MIDD 2

MIDD 1	Proposed MIDD 2
• **Organized into five service areas that are a mix of services and populations**	• **Organized into four strategy areas corresponding to the behavioral health continuum of care**
• **Constructed to support two separate systems: mental health and substance use**	• **Based on an integrated system of behavioral health services**
• **Envisioned to support expansion of existing therapeutic courts**	• **Supports entirety of therapeutic courts**

Development of Proposed MIDD 2 Recommendations

The MIDD 2 planning process was co-created by the MIDD Oversight Committee. It was intentionally crafted to be transparent and provide ample opportunities for review and input. Hundreds of citizens and community members engaged in the various elements of the MIDD 2 planning process, from completing a survey, to submitting a new concept, to participating in a community conversation or focus group. Regular updates were provided on MIDD 2 planning to provider networks, jurisdictional coalitions, elected officials, Council and Executive staff and internal county stakeholders. A website was launched so that all relevant MIDD 2 planning documents and updates could be easily accessed. Below highlights some of more notable elements of MIDD 2 planning.

Oversight Committee Guidance and Input: The MIDD Oversight Committee performed a critically important role in MIDD 2 planning. In March 2015, the MIDD Oversight Committee established Values

and Guiding Principles to inform all aspects of MIDD 1 review work and MIDD 2 renewal planning activities. County staff and Oversight Committee members relied on these values and guiding principles as benchmarks as well as used them as checks and balances throughout MIDD 2 planning. The Values and Guiding Principle informed everything about MIDD 2 from the development of outreach and communications plans, to recommendations contained in this report. The values and guiding principles served as cues for the transparent and collaborative approach the County executed for the review of planning for, and implementation of, a potential MIDD 2.

MIDD Oversight Committee Values & Guiding Principles **Revised August 6, 2015**
• Cultural competency lens with an Equity and Social Justice (ESJ) focus • Client centered; developed with consumer input • Ensure voices of youth and disenfranchised populations are represented • Self sustaining; partnerships that leverage sustainability when possible • Community driven, not county driven • Transparent • Recovery focused • Driven by documented outcomes • Based in promising or best practices; evidence-based when possible • Common goal(s) across all organizations • Strategies move us toward integration and are transformational • MIDD funding leverages criminal justice (CJ) system (youth and adult) changes • Supports King County's vision for health care; reflects the triple aim: improved patient care experience, improved population health, and reduced cost of health care • More upstream / prevention services • Coordinated services • Community- based organizations on equal status with County for compensation • Continue legacy of CJ/human services coming together • Open to new ways of achieving results • Build on strengths of the system • Services are accessible to those with limited options

MIDD Oversight Committee members and/or the MIDD Renewal Strategy Team[26] reviewed and provided feedback on the recommendations contained within this report. Additionally, the Oversight Committee has reviewed and provided feedback on major MIDD review and renewal planning documents, including the MIDD 2 Framework which is the basis of recommended revisions to the MIDD policy goals and a key driver of recommended revisions to the potential MIDD 2 evaluation approach. The MIDD 2 Framework is discussed in detail later in this section of the report.

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

[26] The Oversight Committee appointed a MIDD Renewal Strategy Team comprised of eight Oversight Committee members, representing an array of populations and stakeholders and including staff from the county's executive and legislative branches, to facilitate a higher degree of collaboration and input from the Oversight Committee. The Strategy Team provided guidance and expertise for MIDD 1 review and MIDD 2 planning activities to BHRD staff. Intended to augment Oversight Committee feedback and input, the MIDD Oversight Committee Strategy Team provided in-depth reviews of MIDD 1 review and MIDD 2 planning activities and documents. The Strategy Team facilitated analysis, identified issues, offered subject matter expertise, and helped to problem-solve with county staff charged with completing the tasks required by Ordinance 17998.

Committee feedback into the final version of this report that is transmitted to the Council.

Citizen and Community Input: King County conducted its MIDD renewal planning work with an unprecedented level of transparency and community engagement. The Department of Community and Human Services (DCHS) planned and collaboratively developed the deliverables required by Council by sharing information and involving internal and external partners and communities. In order to develop responsive and relevant MIDD 2 initiatives, King County turned to residents and community partners across the region for input and guidance. Informed by the MIDD Oversight Committee's Values and Guiding Principles, King County staff conducted a robust outreach and engagement process around MIDD renewal. From September 2015 through February 2016, King County invited citizens and communities to participate in five regional Community Conversations on MIDD.[27] Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas, including a focus group with individuals in the King County Jail. The purpose of these engagement efforts was to hear ideas about services and programs for people living with mental illness and substance use disorders from those who need, use or engage with our county systems. The conversations were intentionally designed so that community members had a role in informing the County's decisions around its investments for children and youth and investments for mental health and substance use disorder services and programs. Focus groups ranged in size from as few as four to over 100 participants. Groups included, in order of meeting:

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

MIDD staff also conducted an electronic survey between September 2015 and February 2016. Over 360 respondents took the time to answer key questions about MIDD. Summaries and themes from these groups are available on the MIDD renewal website, along with the MIDD survey data.

Please see Appendix C for a summary of community engagement themes.

[27] Community Conversations were held in partnership with King County staff planning for what became Best Starts for Kids.

Three Phased MIDD Renewal Process: In addition to the vigorous community engagement work, a structured three phased review and renewal process was established in collaboration with the MIDD Oversight Committee. This process enabled the widest possible access to MIDD 2 funding and facilitated a coordinated analysis of new concepts and existing MIDD 1 programming. The process included:

I. **PHASE I -** Interested parties submitted New Concepts to the County between September 15, 2015 and October 31, 2015. After initial screening of the concept forms to ensure fitness under the RCW, they were forwarded to Phase 2. Only a handful of concepts were not moved forward out of the 141 received.

II. **PHASE II -** County staff drafted over 90 briefing papers in consultation with behavioral health partners, providers and subject matter experts. Briefing papers provided answers to important analytical questions. The process specifically involved review of the papers by concept submitters and every effort was made by DCHS to reflect feedback from concept submitters whenever possible while striving to provide objective analysis.[28]

   The second step of Phase 2 were panel reviews of existing strategy and new concept briefing papers, with the panels sorting the strategies and concepts into high, medium and low categories for potential funding consideration. Four panels, corresponding to the four MIDD 2 strategy areas, convened in March 2016. Over 50 individuals participated on the review panel teams. The panels were intentionally constructed to bring in a diverse array of lived experiences, skills, knowledge, perspectives and insights to the sorting process. Each review panel team had a mix of community members and MIDD Oversight Committee members or their designees. Guiding factors provided to the review panels to use as they conducted their reviews of the briefing papers included questions on community needs, equity and social justice, integration, and recovery and reentry. See Appendix D for the briefing paper panel sorting results. Briefing papers can be found on the MIDD website: http://www.kingcounty.gov/MIDDrenewal.

III. **PHASE III –** County staff aligned MIDD 2 programmatic recommendations, developing the recommendations and identifying funding levels. County staff assessed all existing MIDD 1 programs and potential new concepts for fit, value and ability to help the County achieve MIDD policy goals. The initial recommendations were released to the MIDD Oversight Committee and for public review and a two week public comment period on April 22, 2016. Over 200 public comments were received. County staff made revisions to the draft MIDD 2 funding and programmatic recommendations in May, with revised recommendations released on May 20. Two Oversight Committee meetings (April and May) were dedicated to the review of and feedback on the draft funding and programmatic recommendations.

Please see Appendix E for the detailed MIDD 2 process overview.

[28] Instructions for the New Concept process clearly noted that concepts may be altered, revised, or combined, in briefing papers.

MIDD 1 Policy Goals & Proposed Modifications

MIDD 1's adopted policy goals are the foundational expression of what policymakers expected the MIDD to achieve, or work towards achieving. The policy goals provided the essential framing for all elements of the MIDD, including the MIDD 1 Implementation and Evaluation Plans. The primary focus of the MIDD 1 evaluation was to determine progress of MIDD-supported programs toward meeting the five policy goals.

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

MIDD 2007 Adopted Policy Goals

Policy Goal 1: A reduction in the number of mentally ill and chemically dependent people using costly intervention like, jail, emergency rooms, and hospitals;

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

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

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

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

Calling for proposed modifications to the MIDD policy goals through Ordinance 17998[29], the Council recognized that the behavioral health and criminal justice environments have changed since 2007 when the MIDD 1 policy goals were established via Ordinance 15949 and that refined policy goals may be necessary for MIDD 2. As required, the requested modifications to the adopted MIDD policy goals were submitted to the Council in the Comprehensive Historical Assessment Report submitted to the Council on June 30, 2016.

Because of the fundamental role of the MIDD policy goals for the implementation of MIDD 2, this Service Improvement Plan includes the proposed modifications to the goals that were recommended in the Comprehensive Historical Assessment Report submitted to the Council on June 30. They are also included in this report because the Proposed MIDD 2 Initiative Descriptions reference the 2007 policy goals AND the proposed modified goals.

Person-Centered Language and Goals: Revised MIDD policy goals reflect a person-centered language approach. Person-centered language strives to avoid dehumanizing terms for individuals and groups

[29] Ordinance 17998, lines 103-104

that demean or create barriers to inclusion. For example, instead of saying, "the mentally ill," person-centered language would say "individuals with mental illness." This approach also aligns with RCW 44.04.280, based on 2004 HB 2663, which directed state statue to avoid non-person first language.[30]

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

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

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

Recommended Policy Goal 2 addresses the emergency medical system use aim of the 2007 policy goal 1 by addressing reduction of behavioral health crises. It further recognizes that return on investment in

[30] http://app.leg.wa.gov/RCW/default.aspx?cite=44.04.280

this area can be achieved either by reducing how often people are in crisis, or helping people in crisis stabilize more quickly.

Recommended Policy Goal 3 targets a common and significant theme from MIDD's community outreach efforts around improving and supporting culturally-appropriate services. It further reflects recent years' advancements in recovery-oriented approaches to care, and actively supports King County's equity and social justice aims.

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

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

This report acknowledges an underlying factor related to the MIDD policy goals and to MIDD overall: **MIDD programs and services alone cannot achieve the policy goals.**

- For example, simple changes to policing practices or prosecution policies can greatly impact the number of people who enter the criminal justice system. After such a shift, data could suggest that MIDD services were either more or less successful in reducing the number of people who returned to jail, irrespective of the individuals' behavioral health conditions, when the larger driver may actually have been the criminal justice policy changes.

- Likewise, shifts in federal or state funding or policies for behavioral health services impact the amount, availability and/or quality of behavioral health services, which in turn influences the incidence and severity of behavioral health conditions. For example, many MIDD services provide enhancements to underlying services provided via federal or state funding, or are designed to address gaps between such services. When core state or federal services are reduced, or more rarely expanded, this is likely to affect the apparent effectiveness and/or relevance of the MIDD-funded service.

- Finally, macroeconomic factors including access to employment and affordable housing – both of which are well beyond MIDD's capacity to impact in a substantive way – have a major effect on recovery outcomes.

In light of these factors, the recommended policy goal revisions clearly highlight the fundamental intentions of MIDD 2 while at the same time recognizing its limitations. These proposed revised MIDD policy goals focus primarily on **expected results for MIDD program participants and improvements in access to services**.

MIDD 2 Framework

MIDD 2 is rooted in the County's work to transform the approach to health and human services by improving health and well-being and creating conditions that allow residents of King County to achieve their full potential. This is reflected throughout the planning and development of MIDD 2 recommendations and summarized in the MIDD 2 Framework.

The MIDD 2 Framework is an accountability framework driven by the results policymakers and stakeholders want to see in the community as the result of investment of MIDD funds; the indicators that the county will use to signal that it's headed down the right path to get there; and the actions the county and its partners will take to create the change stakeholders want to see. To inform this framework, DCHS drew upon the principles of results-based accountability practices among other elements, including the Sequential Intercept Model.[31] The MIDD 2 Framework is shown in Appendix F.

The MIDD 2 Framework identifies and organizes the central components of MIDD 2. It identifies the MIDD 2 approach at four different levels:

1) What will happen as a result of MIDD services
2) The theory of change driving the result of MIDD
3) Key strategies and outcomes intended to achieve MIDD's 2 result
4) Sample performance measures used to demonstrate progress toward outcomes.

MIDD 2 Framework Highlights
***MIDD Result**: People living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement.* ***MIDD Theory of Change**: When people who are living with, or who are at risk of, behavioral health disorders utilize culturally-relevant prevention and early intervention, crisis diversion, community reentry, treatment, and recovery services, and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.*

The MIDD 2 Framework shows the outcomes of MIDD 2 as divided into two areas: population and individual outcomes. Each level of outcomes has associated indicators and measures. There are two very important caveats associated with MIDD outcomes and indicators.

1. Population outcomes are predicated on the understanding that MIDD alone is not responsible for broader population outcomes. MIDD, along with other King County and community initiatives work together to contribute to the overall health and well-being of King County residents that is demonstrated by positive outcomes.

2. Performance measures and indicators for MIDD 2 will be identified after the funding and

[31] The Sequential Intercept Model is discussed on page 63.

programmatic decisions are made by the Executive and Council. The measures and indicators must be developed in partnership with providers and other stakeholders.

3. The MIDD 2 Evaluation Framework will include performance measures and indicators necessary to gather and report on population and individual outcomes and progress toward policy goals.

A major component of the MIDD 2 Framework is the creation of four MIDD strategy areas that echo the continuum of behavioral health care and services and include a vital system support area. Each proposed MIDD 2 initiative is included in one of the four MIDD 2 Strategy Areas.

MIDD 2 Strategy Area Name	Purpose
Prevention and Early Intervention	*People get the help they need to stay healthy and keep problems from escalating*
Crisis Diversion	*People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*
Recovery and Reentry	*People become healthy and safely reintegrate to community after crisis*
System Improvements	*Strengthen the behavioral health system to become more accessible and deliver on outcomes*

Each of the framework's four strategy areas includes sample performance measures for individuals along with outcomes and indicators for the wider population. They are noted as "sample" because they represent examples of the types of information to be sought in evaluation of MIDD 2 strategy areas and programming. Indicators reflected in the framework will change based on final MIDD 2 programming decisions and community and stakeholder feedback. Subsequent updates to the MIDD 2 Framework will be shared with the MIDD Oversight Committee for their review and feedback.

As discussed in the MIDD Renewal Progress Report that was submitted to the Council in November 2015, and the Comprehensive Historical Review and Assessment Report submitted to the Council in June 2016, King County Behavioral Health and Recovery Division, in consultation with the MIDD Oversight Committee, developed the MIDD 2 Framework as a tool to succinctly summarize the MIDD 2 approach, activities, policies and outcomes. Updates to the MIDD 2 Framework have been made based on stakeholder input and further clarifying the intent of sections that address potential performance measures.

The MIDD 2 Framework is a living document that will be further updated over the life of the MIDD 2 to reflect specific programmatic and services once they are determined by the Executive and Council in 2016. The Framework will continue to be updated over the life of MIDD 2 as a companion to the MIDD policy goals.

VI. Proposed MIDD 2 Initiatives

MIDD 2 planning work was carefully conducted in clear and straightforward ways. From establishing the MIDD 2 Framework that simply and explicitly explains the purpose and outcomes of MIDD, to developing the review and renewal processes that prioritized the voices of communities, every step of the process that has resulted in the recommendations proposed in this Service Improvement Plan has been transparently shared with stakeholders.

The terms "initiative" and "MIDD initiative" describe individual programs and services supported by the MIDD sales tax.

The Proposed MIDD 2 initiatives prioritize:

- Funding services and programs to keep people out of or returning to jail and the criminal justice system, including upstream prevention and diversion activities.

- Investing in a treatment on demand system that delivers treatment to people who need it, when they need it, so crises can be avoided or shortened.

- Creating community driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs.

Aligning MIDD 2 and Best Starts for Kids (BSK) has been a primary focus of DCHS. From holding joint Community Conversations, to collaborating on strategies and initiatives, to jointly reviewing MIDD 2 concepts and briefing papers, MIDD 2 planning and recommendations development has been a synergistic endeavor with BSK. This strong partnership will continue throughout the life of each of these initiatives, through planned joint meetings of the MIDD Oversight Committee and the Children and Youth Advisory Board and shared approaches to accomplishing the work of each initiative. Operationally, MIDD 2 and BSK are working to coordinate approaches to evaluation, contracting and reporting among other aspects.

As a result of this collaboration, BSK is proposed to support an estimated $2.9 million (annually) for prevention-based behavioral health services for children and youth. This includes expanding screening, brief intervention and referral to treatment (SBIRT) into middle schools across the county along with an infant mental health program.

Leveraging Medicaid to a greater extent is an underlying consideration of the proposed MIDD 2, with some MIDD funding replaced by expected Medicaid dollars. BHRD has concluded that King County and its partner providers can better leverage Medicaid funds, and in doing so, free up MIDD funds for other uses. The proposed MIDD 2 recommendations assume an estimated $3.4 million in Medicaid funds replace MIDD revenue. These assumptions impact not only providers, but also BHRD as well. BHRD is developing technical assistance and support for providers to ensure that they have the tools, training

and support to process Medicaid billing. Because getting the Medicaid assumptions accurate is critically important, BHRD engaged a consulting firm to analyze the Medicaid assumptions.

Successful MIDD 1 programs are proposed to continue into MIDD 2, though some are merged or will be retooled during the implementation planning or request for proposal (RFP) process. Existing MIDD programs received strong support from stakeholders; those programs that were initially slated for marginal reductions launched effective public comment campaigns to restore funds.

Twenty one new proposed initiatives are recommended for MIDD 2, bringing the total number of initiatives to 52. Please note that most newly proposed initiatives, along with existing MIDD 1 initiatives, have other sources of support. Very few MIDD 1 or MIDD 2 initiatives are solely supported by MIDD funds. The following are the new initiatives included in the proposed MIDD 2 funding and programmatic allocations.

- Law Enforcement Assisted Diversion (LEAD)
- South County Crisis Diversion
- Alternatives to Incarceration for Youth
- Family Intervention Restorative Services (FIRS)
- Community Driven Behavioral Health Grants
- Behavioral Health Services in Rural King County
- Multipronged Opioid Response
- Behavioral Health Urgent Care Walk In
- Mental Health First Aid
- Zero Suicide Pilot
- Recovery Café
- Peer Bridgers/Peer Support
- Rapid Rehousing-Oxford House Model
- Housing Capital and Rental Assistance
- Emerging Issues Initiative
- Youth and Young Adult Homelessness Services
- Young Adult Crisis Facility
- Jail Based Substance Use Disorder Treatment
- Deputy Prosecuting Attorney for Familiar Faces

In addition to these items, one time funds to study the concept of creating a new therapeutic court called "Community Court" is included in the Executive's proposed use of MIDD funds.

Please see Appendix H, Initiative Descriptions and Appendix M, Spending Plan for detailed funding and programmatic recommendations.

Therapeutic courts[32] are proposed to be fully supported by MIDD due to the continued constriction of the County's General Fund. While expanding treatment courts was included under MIDD, treatment courts were funded by MIDD as authorized by supplantation[33] starting in 2009. State law was modified to enable sales tax revenue to be used to support the cost of the judicial officer and support staff of a therapeutic court without being considered as supplantation.

The MIDD 2 funding and programmatic proposal includes a recommended expansion of the Family

[32] King County's Therapeutic Courts are: Adult Drug Court, Juvenile Drug Court, Family Treatment Court, and Regional Mental Health Court.
[33] See page 16 for a discussion of supplantation and MIDD.

Treatment Court to south King County due to demand. No other expansions of the courts are recommended, due in large part to strong and consistent feedback from stakeholders who were not supportive of expanding "deep end" criminal justice costs.

The MIDD resource is finite, and while the MIDD Fund has benefitted from a robust regional economy experiencing increasing projected sales tax growth, not all of the suggested MIDD 2 concepts were able to be funded, despite increased revenue. The MIDD's new concept process yielded about $180 million in requests for the estimated $63 million of available MIDD funds. The collaboratively designed MIDD 2 review and renewal process balanced the needs for objectivity, analysis, transparency and community feedback. While most of the feedback on the MIDD review and renewal process has been positive, as with any process where funding recommendations are involved, there has been some expected frustration articulated. The dissatisfaction with the process has largely been from entities whose particular suggestions were not recommended for funding or were recommended to be funded at a lower level.

A survey of the MIDD 2 review and renewal process will occur in early 2017 to inform future similar endeavors.

Economic Adjustments for Providers are included in MIDD 2 to be funded by fund balance as recommended in the MIDD Fund Financial Policies section on page 44. This is a major difference between MIDD 2 and MIDD 1, as MIDD 1 did not provide for adjustments to allocations based on inflation. In most years, but not all, county agencies operating MIDD programs received inflationary adjustments while community providers did not. Consequently, partner agencies have been managing the erosion of MIDD funds while being expected to provide a constant level of services, resulting in provider subsidy of MIDD programs. MIDD 2 seeks to address this inequity by providing economic adjustments to providers. Should future MIDD 2 revenues decline, the county will need to explore the impact of continued economic adjustments on the MIDD 2 services and initiatives.

Supporting and improving the behavioral health system is a vital component of the proposed MIDD 2 funding and programmatic recommendations. As discussed in an earlier section of this report the community behavioral health workforce is in crisis. These challenges negatively impact the publicly-funded behavioral health care system when trained, licensed and qualified staff are difficult to find and/or retain in community provider organizations. Without the people qualified to provide the services, the system is crippled. The proposed MIDD 2 funding and programmatic recommendations maintains the important MIDD 1 initiative, Workload Reduction (formerly "Caseload Reduction") and expands the Workforce Development initiative (formerly "Chemical Dependency Professional Education and Training"). While maintained and expanded respectively, each of these initiatives is planned to be revised and restructured in 2017 in part due to the integration of substance use and mental health services.

MIDD Operations and Management

As with MIDD 1, DCHS will continue to have overall responsibility for the management and implementation of MIDD 2, including managing the budget; behavioral health systems and programmatic development; oversight of the request for proposal (RFP), memorandum of agreement

(MOU), and contracting processes; and evaluation of MIDD.

The great majority of services provided through the MIDD will be contracted out to community agencies, though not all MIDD initiatives will be subject to an RFP process. For example, MIDD 1 services that are provided under an MOU with another King County department and will continue into MIDD 2 will not be RFPd, (but will have a revised MOU). MIDD 2 will use the same approach used for MIDD 1 to determine whether proposed MIDD 2 initiatives will engage in a competitive RFP process. Please see Appendix G for the decision model BHRD will continue to use to determine the need for competitive procurement.

Because of MIDD and BHRD's commitment to equity and social justice and community engagement, many of the initiatives proposed in the MIDD 2 funding and programmatic recommendations (both new and existing under MIDD 1) will involve intentional partnering with communities, particularly around services and RFP development. For example, the revisions needed for the Workload Reduction initiative to include substance use providers will be developed with a workgroup of providers and other stakeholders. A new initiative such as the Youth Behavioral Health Alternatives to Secure Detention requires deliberate and planned community engagement to ensure that the determined approach is truly responsive to community needs.

Not only does MIDD 2 propose funding and programmatic recommendations, the next iteration of MIDD will include a number of internal operating and process improvements designed to enhance transparency, streamline processes, promote collaboration, share information, and make progress on overcoming challenges.

V. Responses to Ordinance 17998

Ordinance 17998 called for the MIDD 2 Service Improvement Plan (SIP) to be submitted to the King County Council in December 2016. In order to support the King County Council's desire for expanded review and input of the MIDD 2 SIP, the SIP report called for by Ordinance 17998 is submitted *three months earlier than required*.

One impact of this changed timeline is that two elements of the MIDD 2 SIP called for by Ordinance 17998 –Implementation[34] and Evaluation information[35] -- are included at *high levels* in this SIP. This is due to the fact that these two elements require further development that needs to occur in collaboration with the MIDD Oversight Committee and providers. The shortened time line impacted BHRD's ability to conduct thoughtful implementation planning in partnership with providers and others.

During the Briefing Paper Review Panels, a number of themes around implementation of MIDD 2 were articulated repeatedly by dozens of community members who participated. Thoughtful implementation planning must:

1. Involve communities and consumers in a meaningful and intentional way
2. Recognize that *how* services are provided is critical for success, particularly for ethnic and cultural communities and populations served
3. Put the consumer, not systems, at the center of decisions.

Developing a MIDD 2 Implementation Plan requires the County to collaborate with providers, consumers and communities which takes time and resources.

Additionally, policy goals that were established for MIDD 1 were recommended to be revised as per the MIDD Comprehensive Historical Assessment Report, and have not been reviewed, discussed, amended or finalized by the Council. The MIDD 1 policy goals played a major role in developing implementation and evaluation outcomes; they are foundational to the entire MIDD 1 evaluation approach. Having MIDD 2 policy goals will enable the county to efficiently and effectively develop meaningful, collaborative implementation and evaluation plans. Finally, adoption of the King County 2017-2018 biennial budget in mid-November will have a significant impact on the final programmatic and funding array for the MIDD 2 and final budgetary decisions which would need to be reflected in the MIDD 2 Implementation and Evaluation Plans.

It is therefore the recommendation of the Executive that the MIDD 2 Implementation and Evaluation Plans be submitted in mid-2017 for review and acceptance by the Council. This approach is similar to the sequencing of MIDD 1 Implementation and Evaluation plans. This timeline allows for BHRD to conduct an intentional implementation and evaluation planning process in collaboration with communities, consumers and the MIDD Oversight Committee; align with BSK and other county endeavors; and thoughtfully enact recommendations related to MIDD evaluation contained in the Comprehensive

[34] Ordinance 17998, lines 119-120
[35] Ordinance 17998, lines 127-128

Historical Assessment Report.

Appendices Table

Ordinance Component	Appendix Name	Appendix Number
A detailed description of each proposed strategy, service and program to be funded from the MIDD sales tax beginning in 2017, including strategy goals, outcomes, expected number of individuals to be served and whether the services are provided by the county or by a contracted provider (lines 115-118) *Explanation of how each recommended MIDD strategy, service and program supports the adopted and/or recommended MIDD policy goals (lines 119-120)* *An initial list of performance measures, outcomes, and/or evaluation data for each proposed strategy, service and program that will inform annual reporting to the executive, the council, the MIDD oversight committee, and the public regarding the investment of MIDD sales tax funds (lines 127-130)*	**MIDD 2 Initiative Descriptions**	**H**
A schedule for the implementation of the strategies, programs and services outlined in the MIDD service improvement plan (lines 121-122)) ***Also referenced in Initiative Description documents.*	**MIDD 2 Implementation Schedule**	**N**
A spending plan for each strategy, program and service outlined in the MIDD service improvement plan, including recommended 2017-2018 biennial budget levels for each proposed strategy, service and program (lines 123-126) ***Also referenced in Initiative Description documents.*	**MIDD 2 Spending Plan**	**M**
The proposed MIDD Service Improvement Plan strategies, services and programs shall: *Demonstrate that they are based on evidence related to successful outcomes for chemical dependency or mental health treatment programs and services;* *Demonstrate that they are based on best or promising practices for chemical dependency or mental health treatment programs and services and that they incorporate the goals and principles of recovery and resilience within a trauma informed framework, as specified by K.C.C, chapter 2.43 and King County's adopted behavioral health system principles set out in Ordinance 17553 (lines 145-151)*	**MIDD 2 Outcomes and Basis Crosswalk**	**J**

Please note that the Initiative Description documents that are included in this Plan as Appendix H provide *initial* implementation and evaluation information. The information in these documents is preliminary and subject to revision based on revised policy goals, the adopted budget and community

feedback that might occur during the upcoming implementation planning work or as a result of changed funding levels that may occur during the County's budget adoption process.

Please note that in most instances, information for the proposed MIDD 2 initiatives is very preliminary due to the need to conduct detailed implementation planning in collaboration with stakeholders and communities. Additionally, most existing MIDD 1 initiatives that are recommended to continue into MIDD 2 will also undergo some form of operational updating to increase efficiency, effectiveness and meet revised policy goals. All initiatives will be included and detailed in a MIDD 2 Implementation Plan that is recommended to be submitted to the Council in 2017.

The sections below detail the specific recommendations called for by Ordinance 17998. In some instances, the recommendations may require legislation; these items are indicated by an asterisk (*) in the summary table associated with each area.

The spending plan (Attachment M) reflects the four strategy areas of the MIDD Framework (Prevention and Early Intervention, Crisis Diversion, Recovery and Reentry and System Improvements).[36] Therapeutic courts and MIDD administration and evaluation are included as separate categories so that those important costs can be seen and tracked separately.

Finally, in keeping with the established process and timeline for the development of the Mental Illness and Drug Dependency Service Improvement Plan, this document reflects Executive priorities for the programming and funding of Mental Illness and Drug Dependency revenues. In addition to including Executive priorities for the spending of MIDD revenue, adjustments to certain proposed MIDD initiatives have occurred due to one or more of the following factors:

1. Updated Office of Financial Analysis (OEFA) MIDD sales tax projections
2. Revised Medicaid assumptions
3. Staged implementation assumptions of select initiatives.

Learning from the experience of MIDD 1, the County recognizes that it is not always possible to begin spending on a MIDD initiative, program or service as soon as budget authority is granted. Requests for Proposals, Qualifications or Information (RFP, RFQ, RFI) are often needed, and communities and stakeholders may wish to be involved in developing the details of services and or locations, all of which take time to thoughtfully address. Given the fact that some new initiatives require time to launch, the spending plan (Attachment M) assumes the staged implementation of some new initiatives. Staged implementation of initiatives allows for the efficient deployment of unspent funds for other needs such as addressing the revised Medicaid assumptions, building of the Rainy Day Reserve and funding other identified priorities.

Please see Appendix H, Initiative Descriptions and Appendix M, Spending Plan for detailed funding and programmatic recommendations.

[36] The MIDD Framework is described on page 35.

MIDD Fund Financial Policies Recommendations

Ordinance Component	SIP Recommendations
Recommend MIDD fund balance reserve policies for the fund, taking into consideration the county's existing fund balance and reserve policies (lines 170-171)	1. Revise MIDD Fund reserve policy to be 60 days of expenditure, placed in a reserve titled "Rainy Day Reserve." 2. Allocate funds to the Rainy Day Reserve to fully fund the reserve within the current biennium. 3. When reserve levels are met, prioritize use of undesignated fund balance as follows: A. Allocate funds for provider economic adjustments for the next biennium. B. Allocate funds to the Emerging Issues initiative to $650,000 annually.

Reserve Policies: In 2007 when the MIDD 1 Fund was created, a Rate Stabilization Reserve[37] of 5.25% of expected revenues was established. Since then, the County has refined and standardized its reserve policies (Motion 14110). Page 21 of the Comprehensive Financial Management Policies[38] states, "the majority of operating funds, including Enterprise Funds and Special Revenue Funds, should maintain a Rainy Day Reserve equal to 30-60 days of expenditures."

In consultation with PSB, it is recommended that the MIDD fund establish a reserve policy of 60 days of expenditure. PSB's reserve analysis concluded that revising the MIDD Fund's reserve policy to 60 days of expenditure would ensure the reserve is adequate to mitigate the volatility of sales tax collections. This would also bring the MIDD fund's reserve into alignment with current County policies.

The effect of this recommendation will be an increase in the level of reserves.

Rainy Day Reserve: In order to achieve the level of reserves that the 60 day policy calls for, it is recommended that funds be allocated to the Rainy Day Reserve to fund the reserve within the current biennium. The County may elect to allocate additional funds to the reserve when feasible.

As a result of the 2008 economic downturn, MIDD 1 was forced to cut funding to strategies, services and programs due to deeply reduced sales tax revenue. Establishing and maintaining the Rainy Day Reserve will help the county preserve services as long as possible during the next economic decline.

Use of Undesignated Fund Balance: When required financial reserves are fully funded, any remaining

[37] These reserves set aside fund balance to minimize rate, fee or revenue increases needed in future years to provide the current level of service. For example, a fund that is primarily funded through central rate allocations can fund a rate stabilization reserve with excess contributions or with underexpenditures in order to limit the annual increases to inflation plus population growth. *Source: King County Fund Balance Reserve and Contingency Guidelines*

[38] http://www.kingcounty.gov/~/media/exec/PSB/documents/CompFinMngmtPoliciesDoc.ashx?la=en

fund balance is considered "undesignated fund balance." Undesignated fund balance can be utilized and generated when the MIDD Fund has under expended budget and/or collected higher than planned for revenue. When an undesignated fund balance exists for the MIDD fund, it is recommended that the funds be allocated in the following order:

1. Allocate funds for provider economic adjustments for following biennia. This ensures future adjustments can occur without reducing services or funding for existing initiatives;

2. Allocate funds to the Emerging Issues initiative to $650,000.

Over the course of MIDD 1, the MIDD Oversight Committee utilized subcommittees and work groups to inform its financial recommendations to the Council and Executive. Most recently in 2015 and in 2016, the MIDD Oversight Committee created an ad hoc work group to generate recommendations for potential use of MIDD fund balance for the Council and Executive to consider during supplemental budget processes. It is recommended that the county continue to utilize MIDD Advisory Committee[39] work groups/subcommittees when fund balance remains after applying it as outlined above.[40]

Adding, Deleting or Modifying MIDD Initiatives, Strategies, Services and Programs

Ordinance Component	SIP Recommendations
Identified processes and procedures to add, delete or modify MIDD strategies, services and programs, including specifying how and when the MIDD oversight committee is to be engaged in the recommendations (lines 167-169)	1. Use updated MIDD 1 revision processes for modifying or adjusting MIDD initiatives, strategies, services and programs. 2. Utilize Emerging Issues initiative to support emerging services and programs for up to two years.

The MIDD 2 initiative revision processes outlined below will ensure that revisions of MIDD-funded initiatives, strategies, services and programs are communicated clearly to MIDD providers, policymakers and the MIDD Oversight Committee. The processes also specify how and when the MIDD Oversight Committee is to be engaged in recommended changes. The modifications to the MIDD 1 strategy revision process, along with other improvements to the operations of the MIDD Oversight Committee, provide the means to transparently share information and develop recommendations regarding changes or additions to MIDD initiatives, strategies, services and programs.

[39] Proposed legislation to revise the name of the MIDD Oversight Committee to the MIDD Advisory Committee has been transmitted to the King County Council. Therefore, the term "MIDD Advisory Committee" is used in this document when referencing potential prospective acts by the current MIDD Oversight Committee, assuming King County Council approval of legislation that formally changes the name of the Committee from "Oversight" to "Advisory". A discussion of the proposed name change occurs on page 60 of this document.

[40] In general, the charge of the Fund Balance work groups/subcommittees is to develop recommendations on the use of the MIDD fund's undesignated fund balance. In turn, the FBWG recommendations are considered, approved, amended or rejected by the MIDD Oversight Committee. Approved recommendations are subsequently forwarded to the King County Executive and Council for potential inclusion in 2016 budget supplementals.

MIDD 1 Strategy Modification Process: In March of 2009, a process to modify strategies, services and programs was established for MIDD 1. It was reviewed and discussed by the MIDD Oversight Committee in March 2009. The process outlined when revisions were to be brought before the Oversight Committee for review and discussion and when revisions could occur at the discretion of the division. Three thresholds were identified that triggered when strategy revisions were to be brought to the MIDD Oversight Committee for consultation, review and comment. They were:

- A proposed change of funding of 15 percent or more
- A proposed elimination of a strategy
- Changes to provider resources/processes/funding methodology/FTE/RFP or contract processes.

When one of the thresholds was met, the suggested revision was brought to the Oversight Committee to conduct a review of the request. For example, in 2011, expansion of the Regional Mental Health Court under Strategy 11b was brought to the OC to create a pilot program for Veterans. In 2012, the revisioning of Strategy 1f Parent Partners Family Assistance underwent Oversight Committee review, as well as changing services at Adult Drug Court (Strategy 15a) from young adult wraparound to transitional housing resources. The Committee's review included analysis and vetting of the requested changes and taking public comment. If approved by the MIDD Oversight Committee, the change was made and was reflected in the MIDD annual reports.

In the instances when the threshold criteria for MIDD Oversight Committee review were not met (i.e., the change was less than 15 percent in funding, a strategy was not eliminated, nor a change to resources, processes, FTE, etc.), the change was made and reflected in the annual and quarterly reports. This process was used frequently in the first few years of MIDD 1 as strategies were evolving. For example, in 2010, a project with the University Of Washington School Of Social Work was piloted to allow students pursuing Masters' degrees to jointly earn their chemical dependency professional certificate. Over time, as strategies matured, fewer modifications were required, and the process for modifying strategies was used less. Each annual report continues to include strategy revisions.

Recommended MIDD 2 Processes for Modifying Initiatives, Strategies, Services and Programs: Building on the MIDD 1 revision approach, MIDD 2 will use the same approach to revisions process with some modification to one of the thresholds for clarity. The third type of threshold modification that would trigger a review by the MIDD Advisory Committee will be revised as shown below.

MIDD Strategy Revision Process

MIDD 1 Strategy Revision Process	MIDD 2 Initiative Revision Process
1. A proposed change of funding of 15 percent or more (increase or decrease)	No Change
2. A proposed elimination of a strategy	No Change
3. Changes to provider resources/processes/funding methodology/FTE/RFP or contract processes	Changes to Population served Outcomes or results Intervention Performance measures

Revisions to MIDD 2 initiatives, strategies, services and programs will be brought to the MIDD Advisory Committee for consultation, review and comment when revisions meet one of three thresholds:

- A proposed change of funding of 15 percent or more (increase or decrease)
- A proposed elimination of a strategy
- Changes to:
    - Population served
    - Outcomes or results
    - Intervention
    - Performance measures.

Similar to the revision process for MIDD 1, in the instances when the threshold criteria for MIDD Oversight Committee review are not met in MIDD 2 (i.e., the change was less than 15 percent in funding, a strategy was not eliminated, nor changes to population served, intervention, outcomes, performance measures, etc.), the change will be made and reflected in the annual reports. Please see Appendix I for the MIDD 2 Initiative Revisions Process Flow Chart.

In addition to the formalized process above, BHRD staff will provide regular updates on all changes to MIDD 2 initiatives to the MIDD Advisory Committee at least two times per year at Advisory Committee meetings. Additionally, BHRD staff and leadership will receive trainings on the revision process to ensure it is used appropriately.

New MIDD Initiatives: Given that MIDD is a limited resource that is proposed to be fully programmed, including the allocation of fund balances to reserves, it is not recommended that new, ongoing initiatives, strategies, services and programs be added to the MIDD during the biennium. Should it be determined by BHRD and PSB that MIDD revenues greatly outpace projections for a sustained period, and that economic adjustments can continue for existing initiative providers, BHRD in collaboration with the MIDD Advisory Committee, may elect to initiate a new initiative process. Such a process would follow a similar approach and methodology to the MIDD 1 Fund Balance Work Group (FBWG) and MIDD 2 New Concepts processes. The MIDD 1 FBWG, comprised of MIDD Oversight Committee members and county staff, reviewed financial and programmatic information and made recommendations to the Oversight Committee regarding services and funding. The New Concepts process for MIDD 2 was a structured, time-limited invitation to suggest new ideas for MIDD 2 funding.

Emerging Issues: MIDD 2 is proposed to include an Emerging Issues initiative whereby certain developing programs or services can seek to be funded for up to two years by the MIDD 2. As was done for certain MIDD 1 strategies, it is recommended that the MIDD Advisory Committee, in partnership with BHRD, develop criteria and processes for utilization of Emerging Issues funds. Among other criteria to be included:

- Allowable under RCW 82.14.460
- Furthers the MIDD's continuum of care
- Based on best or promising practices

- Reflects a recovery oriented system of care
- Demonstrates financial sustainability outside of MIDD revenues.

The section below details the Emerging Issues approach.

Emerging Issues Initiative & Protocols

The MIDD initiative revision processes outlined above specify how revisions to MIDD funded initiatives, strategies, services and programs occur and how and when the MIDD Advisory Committee is to be engaged in recommended changes. This section outlines protocols for utilization of the recommended Emerging Issues initiative of MIDD 2.

The Emerging Issues initiative provides a flexible source of MIDD funds for certain items to be funded for a short term. The Emerging Issues initiative is not intended to be used as an ongoing source of funds for new MIDD 2 initiatives, programs or services, because MIDD is a limited resource that is fully programmed, including the programming of fund balances.

As noted, MIDD is a limited resource that is proposed to be fully programmed, including the allocation of fund balances to reserves. Following the recommendation outlined above for new initiatives, no new, ongoing initiatives, strategies, services and programs should be added to the MIDD during the biennium, including services and programs supported by Emerging Issues funding to be added to the MIDD. Should it be determined by BHRD and PSB that MIDD revenues greatly outpace projections for a sustained period, and that economic adjustments can continue for existing initiative providers, BHRD in collaboration with the MIDD Advisory Committee, may elect to initiate a new initiative process. Such a process would follow a similar approach and methodology to the MIDD 1 Fund Balance Work Group (FBWG) and MIDD 2 New Concepts processes.[41]

The Emerging Issues initiative is modeled in part on the New Strategy reserve that was established early in MIDD 1 via Ordinance 16261. The purpose of the reserve was to support new strategies not provided for in the then current MIDD plan that would meet the established policy goals. Ordinance 16261 stated,

> *The council recognizes that the needs of the county's residents may change over time and that new and innovative mental health, substance abuse and therapeutic court programs and services are continually being developed and implemented across the country. Therefore, it is the policy of the county that the county's mental illness and drug dependency shall maintain flexibility to respond to the changing needs of the county's population as well as to accommodate new mental health, substance abuse and therapeutic court strategies and programs.*[42]

Ordinance 16261 tasked the MIDD Oversight Committee with proposing a new strategies process and schedule. The new strategies process approach was reviewed at the February 2009 MIDD Oversight Committee meeting and was included in the subsequent MIDD Annual Report that was transmitted to

[41] See page 31 for details of the Three Phased Renewal Process.
[42] Ordinance 16261, lines 68-74

the Council. The new strategy process was never launched due to the economic downturn. MIDD strategies were reduced when sales tax revenues declined sharply.

Emerging Issues Policies and Protocols: The following outline the key components of the proposed MIDD Emerging Issues initiative.[43]

A. Emerging Issues funds are one time funds for one to two years. Emerging Issues funds would not be provided in an ongoing fashion for the concepts.

B. The Emerging Issues initiative would be budgeted and appropriated as an expenditure rather than as a reserve, as reserves are not included in the appropriation level approved by the Council.

C. BHRD and the MIDD Advisory Committee would review requests for Emerging Issues funds, recommending to the Executive items to be funded from the Emerging Issues initiative, similar to the existing Fund Balance work group/subcommittee approach.

D. Emerging Issues schedule would be established so that at least once a year Emerging Issues requests would be considered by the MIDD Advisory Committee.

E. How and whether programs supported by Emerging Issues funds are evaluated will be included in the MIDD 2 evaluation framework that is planned to be transmitted to the Council in 2017.

F. A MIDD Advisory Committee workgroup will be established to develop and review criteria and operational details of the Emerging Issues initiative in collaboration with BHRD staff.

The proposed MIDD Emerging Issues initiative recognizes that unexpected behavioral health needs in King County occur. It positions MIDD funds to be deployed in a targeted way to address such issues. The policies and protocols for the proposed Emerging Issues initiative provide a thoughtful and transparent approach to accessing the funds that include MIDD Advisory Committee expert review and recommendation.

Proposed Schedule for Reporting

Ordinance Component	SIP Recommendations
A proposed schedule for reporting to the council, at least annually, on progress and performance of the MIDD funded strategies, services and programs (lines 131-133)	1. Revise data collection periods to January to January fiscal/calendar year. * 2. Revise annual report due date to the Council to August.* 3. Launch web data dashboard.

[43] Because the Emerging Issues Initiative process and timeline will be developed in partnership with the MIDD Advisory Committee, an Initiative Description is not included in Appendix H. It will be detailed in the forthcoming MIDD Implementation Plan.

Reporting on the progress of MIDD toward meeting the established policy goals is a vital aspect of MIDD that must continue with MIDD 2. Reporting is the chief mechanism to share the growth and evolution of MIDD or highlight its challenges. The recommendations included in this section are based on internal and external stakeholder feedback and are intended to streamline and make more efficient the reporting processes for providers and the county.

Recommendations 1 and 2 are linked, as explained below, and intended to be enacted together.

1. **One annual report transmitted to the Council in August:** Ordinance 15949 established the annual report due date to the King County Council as April 1 each year. Moving the due date to August enables the following recommendation to move forward.

   Another key element of this recommendation is based in feedback from the Oversight Committee regarding its review of the MIDD evaluation reports. Some members expressed a desire to spend more time in meaningful review and discussion of the report and its data before it is finalized for transmittal to the Council. In order to accommodate this request, additional time is needed for the Committee to conduct its review.

2. **Revise data collection periods to January to January fiscal/calendar year.** The current data collection period for MIDD 1 strategies is October 1-September 30 each year, with the MIDD annual report due to the Council on April 1.[44] The MIDD 1 data collection timeline was established to enable the preparation and analysis of data to meet the April 1 timeline. As experienced over eight years of MIDD 1 evaluation work, it requires several months to gather, clean, prepare and analyze data for MIDD evaluations. This is due in part to the sheer quantity of data, in part due to the quality of data, and in part to the methodology that providers use to submit their data.[45]

Changing the data collection period would align the MIDD data collection cycles with other entities' (local, state, federal, philanthropic) for providers, making it easier and more efficient for them to provide data. It would necessitate a revised due date for the annual report, as recommended above to be August.

3. **Launch web data dashboard.** This recommendation also stems from MIDD Oversight Committee and stakeholder feedback to have more readily accessible and updated MIDD data available. It is also related to recommendations to improve data infrastructure from the PSB Evaluation Assessment Report that was a component of the MIDD 1 Comprehensive Historical Review and Assessment Report.[46] This recommendation also aligns with Best Starts for Kids which is considering a similar dashboard.

Fulfilling this recommendation will take time and resources, due in part because collaboration with

[44] Ordinance 15949

[45] Recommendations on improving the MIDD 2 evaluation approach were included in the Comprehensive Historical MIDD 1 Report that was submitted to the Council on June 30.

[46] See recommendation III A-E in the MIDD 1 Comprehensive Historical Review and Assessment Report.

internal county stakeholders (such as IT) and external (such as providers) is vital.

All annual reports for MIDD 2 will contain the following information:

- performance measurement statistics and updated performance measurement targets
- service and program utilization statistics
- request for proposal, revenue, and expenditure status updates
- an updated financial plan showing current year revenue and expenditure
- projections, along with adopted and actual expenditure, revenue and reserves identified
- recommendations on program and/or process changes to the initiatives and the rationale for the recommendations.

Recommended Modifications to the MIDD Oversight Committee

Ordinance Component	SIP Recommendations
Review and confirm or recommend modifications to the purpose, role and composition of the MIDD Oversight Committee (lines 167-169)	1. Maintain role as advisory body to the Executive and Council. 2. Revise Committee membership to reflect changed organizations, boards, or entities.* 3. Add new member seats.* 4. Create Consumers and Communities Ad Hoc Work Group. 5. Initiate an array of operational improvements. 6. Change the name of the MIDD Oversight Committee to the MIDD Advisory Committee.*

**Items marked with "*" require legislative action to change.*

Background: In April 2008 the King County Council adopted Ordinance 16077 which established the MIDD Oversight Committee and identified the role of the Committee as an advisory body to the King County Executive and the Council. Ordinance 16077 states,

> *The purpose of the oversight committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative. The committee reviews and comments on quarterly, annual and evaluation reports as required in Ordinance 15949. It also reviews and comments on emerging and evolving priorities for the use of the mental illness and drug dependency sales tax revenue. The oversight committee members bring knowledge, expertise and the perspective necessary to successfully review and provide input on the development, implementation and evaluation of the tax funded programs.*
>
> *The oversight committee should: promote coordination and collaboration between entities involved with sales tax programs; educate the public, policymakers and*

stakeholders on sales tax funded programs; and coordinate and share information with other related efforts and groups.

Recognizing that King County is the countywide provider of mental health and substance abuse services, the committee should work to ensure that access to mental health and chemical dependency services is available to those who are most in need throughout the county, regardless of jurisdiction[47]*.*

As outlined by Ordinance 16077, members of the Oversight Committee are appointed by the Executive and confirmed by the Council. Committee member terms are staggered in accordance with K.C.C. 2.28.010.C. The Committee appoints two co-chairs, one from county government and one from the community.

The MIDD 1 Oversight Committee is comprised of the following entities as required by Ordinance 16077. King County government seats are noted with "*".

MIDD Oversight Committee Members

1. *The Council;
2. *The Executive;
3. *The Superior Court;
4. *The District Court;
5. *The Prosecuting Attorney's Office;
6. *The Sheriff's Office;
7. *The Department of Public Health;
8. *The Department of Judicial Administration;
9. *The Department of Adult and Juvenile Detention;
10. *The Department of Community and Human Services;
11. The King County Mental Health Advisory Board;
12. The King County Alcoholism and Substance Abuse Administrative Board;
13. A provider of both mental health and chemical dependency services in King County;
14. A provider of culturally specific mental health services in King County;
15. A provider of culturally specific chemical dependency services in King County
16. A provider of domestic violence prevention services in King County;
17. A provider of sexual assault victim services in King County;
18. An agency providing mental health and chemical dependency services to youth;
19. Harborview Medical Center;
20. The Committee to End Homelessness in King County;
21. *King County systems integration initiative, which is an ongoing work group established by the executive for addressing juvenile justice matters;
22. The Community Health Council;
23. Washington State Hospital Association, representing King County hospitals;
24. The Suburban Cities Association;
25. The city of Seattle;

[47] Ordinance 16077, lines 34-51.

26. The city of Bellevue;
27. Labor representing a bona fide labor organization;
28. *The Office of the Public Defender;
29. The National Alliance on Mental Illness; and
30. A representative from a public defender agency that the county contracts with to provide services.

Please see Appendix B for a list of MIDD Oversight Committee members as of June 2016.

Recommendations: Most of the recommendations included in this section were generated by Oversight Committee members during committee meetings where specific feedback on role and composition was sought, during other meetings, or through 1-on-1 interviews. Some components of the recommendations were generated from community engagement activities or other feedback mechanisms used by the county during MIDD renewal work. These recommendations were reviewed and revised by the Oversight Committee and/or the Oversight Committee's Strategy Team. Details of the recommendations for the role and composition of the MIDD Oversight Committee are described below.

Maintain role as advisory body to the Executive and Council.
The members of MIDD Oversight Committee provide essential advice and input to King County policymakers on matters involving the MIDD. Each member brings their individual and systems wide experience and knowledge to the MIDD Oversight Committee table to inform discussions and develop recommendations for policymakers. This crucial role is proposed to continue into MIDD 2.

The Advisory Committee should continue to promote coordination and collaboration between entities involved with MIDD programs; educate the public, policymakers and stakeholders on sales tax funded programs; and coordinate and share information with other related efforts and groups.

While the ordinance-established role of the Advisory Committee is not proposed to be changed, *how* the Advisory Committee functions and *what else it can accomplish* within its role and with its unique array of leaders from the behavioral health, physical health and criminal justice systems will evolve with MIDD 2. Based on strong feedback from Oversight Committee members, particularly those who participated in the MIDD 2 planning work on MIDD 2 Briefing Paper Review Panels, the Advisory Committee is envisioned to leverage its position to move systems forward and collaboratively resolve issues. System stakeholders can utilize MIDD to work collectively to explore and align solutions to complex problems. Specific areas and tasks that the Advisory Committee will engage on during MIDD 2 include:

- Engaging in intentional and deep systems discussions that inform, initiate, innovate and enhance outcomes for those served
- Creating a "well connectedness" of systems
- Emphasizing community engagement and two-way information sharing
- Building trust and credibility, particularly in communities of color or other marginalized communities
- Developing a deeper understanding of MIDD 2 initiatives, data and evaluation approaches.

Other operational improvements related to the MIDD Advisory Committee are outlined at the end of this section.

Revise membership to reflect changed organizations, boards or entities.
Since its inception in 2008, some of the various entities named in the Oversight Committee's organizing ordinance have evolved and changed. The following revisions are recommended to the composition of the MIDD Oversight Committee along with the basis for the recommended change.

MIDD Oversight Committee Seat	Recommend Revision to MIDD Advisory Committee	Basis of Change
• Two Seats for King County Behavioral Health Board	Consolidate 2 Behavioral Health Board seats into one MIDD Oversight Net change: -1	On April 1, 2016, King County's mental health and substance use disorder services systems were integrated into one seamless, managed care treatment system as required by state legislation (2SSB 6312). The formerly separate King County Mental Health Advisory Board and the King County Alcoholism and Substance Abuse Administrative Board were merged into one Behavioral Health and Recovery Board.[48]
A representative from a public defender agency that the county contracts with to provide services	Eliminate seat for this entity; Public Defense is represented by existing Office of Public Defense seat Net change: -1	In 2013, King County established the Department of Public Defense (DPD) as a charter-created department within county government and transitioned from a public defense system in which the county contracted with four defender organizations to provide defense services. Defense services are provided by DPD and the county no longer holds contracts with defender agencies.

These changes result in the opportunity to repurpose two of the 30 MIDD Oversight Committee seats as recommended below.

While some input was received suggesting that the number of King County government seats on the committee be reduced, it is important to recognize that each King County government seat represents a key system element. Thus, maintaining the 11 King County government seats ensures the necessary representation to conduct intentional and deep systems discussions that inform, initiate, innovate and enhance outcomes for those served, creating a "well connectedness" of systems that was also called for by community input. Other input stated that no specific King County government member should be eliminated, but that "equalizing" was needed. Please note that just over one third of the committee

[48] Ordinance 18170 passed in 2015 amended the MIDD Oversight Committee to include two members of the Behavioral Health Board rather than one seat for the eliminated Mental Health Advisory Board and the Alcohol and Substance Abuse Administrative Board; the number of seats were not amended.

seats are King County government seats (11 out of 30); with the addition of more seats, the ratio of community to government seats would be even greater than the current 2:1 community to government seats.

Among the changes proposed to be made to the MIDD Oversight Committee are technical changes that reflect organizational name changes by member organizations that in turn require updating the King County Code established member list including:

- Suburban Cities Association is now Sound Cities Association
- Committee to End Homelessness is now All Home
- Office of the public defender is now Department of Public Defense

Add four new seats to the Committee.
Throughout the course of MIDD 2 planning, Oversight Committee members recognized and articulated the need to have additional perspectives represented on the committee. From the Committee's establishment of Values and Guiding Principles in March 2015 to its explicit feedback on the roles and composition of the committee in January and March of 2016, members have been exceedingly clear about the need to have MIDD 2 intentionally informed by the voices and experiences of consumers, youth, immigrants and refugees, the faith community, and specific cultural populations.

The recommended additions to the MIDD Oversight Committee are also driven by the County's Equity and Social Justice Agenda which finds that race, place and income impact quality of life for residents of King County and people of color, and those who have limited English proficiency and/or low-incomes persistently face inequities in key educational, economic and health outcomes. These inequities are driven by an array of factors including the tax system, unequal access to the determinants of equity,[49] subtle but pervasive individual bias, and institutional and structural racism and sexism. These factors, while invisible to some, have profound and tangible impacts for others, particularly those who also may be living with behavioral health conditions and experiencing criminal justice involvement.

With this in mind and based on the guidance of the MIDD Oversight Committee, the county recommends the following entities be added to the MIDD Advisory Committee.

Recommended Additional Seats to MIDD Advisory Committee

Focus or Population	Specific Entity
Consumers & Communities – 2 Representatives	From Consumers and Communities Ad Hoc Work Group
Recovery	Washington Recovery Alliance
Education	Puget Sound Educational Services District
Philanthropy	Many Minds Collaborative
Managed Care	Medicaid Managed Care Plans

[49] http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2015/The_Determinants_of_Equity_Report.ashx?la=en

Each of the recommended additions to the composition of the MIDD Advisory Committee is intended to enrich and deepen the advice and guidance provided by the Committee to the King County Executive and Council. The added seats expand the expertise around the table and strengthen system connections. The following details the basis of the recommended additions.

A. *Convene Consumers and Communities Ad Hoc Work Group – 2 Representatives from Ad Hoc Work Group Appointed to MIDD* Advisory *Committee*

After much discussion with subject matter experts (including specific feedback during the community engagement process), individual MIDD Oversight Committee members, and building off of the learnings from recent efforts that included consumers and communities, the County recommends establishing a Consumers and Communities Ad Hoc Work Group of the MIDD Advisory Committee. The work group would be comprised of individuals with lived experience of the behavioral health system (consumers) and individuals who are a part of communities with marginalized identities or experiences, including but not limited to:

- Transgender (Trans)
- Youth
- Immigrant/Refugee
- African American
- Asian/Pacific Islander
- Hispanic
- Rural
- Faith
- Previous justice system involvement
- Peers.

Consumer inclusion is called for in King County's adopted Recovery and Resiliency Oriented Behavioral Health Services Plan 2012-2017.

This recommendation reflects several key principles of community engagement, including the "nothing about us, without us" concept, where the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy. It further recognizes that no one person should be asked to speak for an entire population or experience, particularly in an environment where lay people are sharing decision- or recommendation-making platforms with those who have significant positional authority, such as elected officials.

Given the number of communities identified as needing a voice in MIDD, and because there are many diverse lived experiences involved with behavioral health, an additional 12-20 consumer and community positions to the MIDD Advisory Committee would be required. An Oversight Committee of 50 or more would not be feasible to operate as the Committee has operated, and more so given the operational improvements planned; therefore, the recommendation to convene a Consumers and Communities Ad Hoc Work Group balances the need to enable a greater number of experiences and perspectives to be brought forward to the Advisory Committee with efficiency and effectiveness

of operation.

One of the chief barriers to ongoing and meaningful consumer and community participation is the expectation that individuals will donate their time to participate and advise. Unlike separately elected or other city or county officials, or executive directors of behavioral health provider organizations whose jobs include participation with MIDD, community members' time has not been considered for compensation. A notable component of the Consumers and Communities Ad Hoc Work Group is that work group members will be paid for their participation, similar to the current Familiar Faces Advisors model. Following contracting protocols, BHRD will contract with Ad Hoc Work Group members for up to $5,000 annually for their participation on the work group. This is reflective of the County and MIDD 2's commitment to enacting principles of equity and social justice.

It is currently envisioned that the Ad Hoc Work Group will have between 12-20 members, with at least half to be people with lived experience as a consumer of behavioral health services. The Ad Hoc Work Group members will be given extra support and preparation to help them fulfill their duties. The charter of the work group, along with other processes including identifying members of the work group, will be developed by BHRD in collaboration with the MIDD Advisory Committee. It is expected that the work group will begin meeting at the beginning of the second quarter of 2017.

Two Consumers and Communities Ad Hoc Work Group members would be recommended to serve as full members of the MIDD Advisory Committee, subject to the existing appointment and confirmation process.

B. *Recovery*

Recovery from mental health and/or substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to achieve their full potential.[50] The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. "Fundamentally, recovery is not a practice; it is a culture. It is not as much what you do, but how you do it. Recovery focuses on values and meaning more than on behaviors."[51]

In 2013 Ordinance 17553, King County established that the principles of recovery are foundational to behavioral health services, thus adding a recovery seat to the MIDD Oversight Committee further enacts the vision of recovery as outlined in Ordinance 17553. Bringing the perspective of recovery to the MIDD Advisory Committee will further embed recovery into the work of the MIDD and help ensure that recommendations from the MIDD Advisory Committee are infused with recovery principles such as trauma-informed care.

Oversight Committee feedback stated that coalitions and alliances representing a group of entities

[50] https://www.mentalhealth.gov/basics/recovery/index.html

[51] King County Recovery and Resiliency Oriented Behavioral Health Services Plan 2012-2017, pg. 10; attachment A to Ordinance 17553

should be considered when possible, rather than individual entities. This would enable broader involvement than one individual or entity. In keeping with that charge, it is recommended that the recovery seat be established for the Washington Recovery Alliance.[52] The Washington Recovery Alliance is a group of organizations and individual from across Washington State that educates, promotes and advocates for recovery issues.

C. *Education*

Bringing a representative of the education domain to the MIDD Advisory Committee provides another connection to children, youth and families served by MIDD and the other systems represented by MIDD Advisory Committee members. Early identification of social, emotional and behavioral problems in children often happen in schools. Schools are critical in linking youth and families with crisis support, respite care, case management, counseling and behavioral health interventions. Schools are directly connected to MIDD via prevention, intervention, treatment and crisis services, so creating a seat for the education domain is a natural evolution of MIDD.

D. *Philanthropy*

King County has become proficient at braiding funds to create a system of care; between state, federal and local resources a continuum of care from early intervention/prevention to crisis services has been created and is demonstrated through MIDD 2. Despite the County's best efforts, gaps remain. The philanthropic community has become an important community partner to advance the public behavioral health system. The Many Minds Collaborative is partnering with King County to research, assess and document the public mental health landscape in King County. That work has grown into early catalytic investments in proven behavioral health programs. Their investments demonstrate commitment to improving the behavioral health system and rationale for participation in the MIDD Advisory Committee.

E. *Managed Care*

As King County is moving toward addressing the question of what form "full" integration of behavioral and physical health care will take, it is clear that whatever the answer, Managed Care Organizations (MCOs) operating in King County will have some kind of role. In recognition of the future role that MCOs may have with full integration[53], it is recommended that a seat on the Advisory Committee be held by the MCOs. Following the approach that the King County Accountable Community of Health Interim Leadership Council outlined in its charter,

> Two people from different organizations may co-hold a seat, for purposes of assuring adequate sector representation and participation in meetings. For Medicaid managed care plans, all plans under contract with the Washington Health Care Authority are invited to participate. In cases where there is more than one representative from a sector, each sector would constitute one "vote" in decision making.[54]

This recommendation was not uniformly supported by all members of the MIDD Strategy Team

[52] https://washingtonrecoveryalliance.org
[53] A more in-depth discussion of integration of behavioral and physical health care takes place on pages 66-69 of this report.
[54] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach/~/media/exec/HHStransformation/ACH-Charter.ashx , page 4.

where it was reviewed and discussed prior to being included in this Service Improvement Plan. Some MIDD Oversight Committee representatives on the Strategy Team articulated grave concerns about inviting the MCOs to participate on the Advisory Committee. Questions were raised regarding whether MCOs could serve individuals and communities most in need while being a for profit entity. Alternatively, some articulated that involving MCOs in the deep systems discussions around behavioral health and the criminal justice systems could help them better understand the needs, populations and services touched by MIDD and the behavioral health system.

In the spirit of inclusivity and in order to further develop the behavioral health system across sectors, it was determined that the benefits of inviting the MCOs to the MIDD Advisory Committee are notable.

Other suggestions for additional member seats were made over the course of the last year that are not included in these recommendations. The additional seats that are recommended to be included represent key system voices that bring a needed perspective to the Committee and its advisory role. It is important to remember that holding a seat on the Advisory Committee is not the only way to participate with MIDD. All MIDD Advisory Committee meetings are open to the public and public comment will continue to be included in each meeting.

Initiate an Array of Operational Improvements: In collaboration with the MIDD Advisory Committee, BHRD is planning a number of operational improvements involving or related to the MIDD Advisory Committee. The majority of these activities are based on feedback and suggestions from Oversight Committee members, while some are based on lessons learned from staffing the MIDD Oversight Committee over time. They are intended to support the systems-spanning work requested by committee members to inform the review and recommendation functions of the MIDD Oversight Committee.

Type of Improvement	Details
1. Alignment & Collaboration	• Co-convene an annual King County Boards and Commissions Summit with Children and Youth Advisory Board, Veterans and Human Services Levy boards, Behavioral Health Advisory Board and others to jointly engage in planning, data sharing and review, and to coordinate and align work • Explore development of Executive Committee of board co-chairs to ensure ongoing alignment of respective committee work and outcomes
2. Training & Education	• Hold annual Advisory Committee retreat to develop annual work plan, create cohesion and shared understanding of role and objectives • Develop and implement training program that may include such matters as: o Trauma and trauma-informed care o Anti-racism o Cultural sensitivity o Evaluations and data o The involuntary court process o How treatment courts work & their outcomes. • Conduct new member orientation for each new committee member within

	two months of appointment and one annual refresher meeting for existing members • Members representing coalitions or groups will be asked to make an annual presentation on their group and how information is shared and gathered
3. Operational & Logistical	• Utilize Advisory Committee workgroups and/or subcommittees to inform the design and development of key MIDD 2 deliverables such as Implementation Plan, RFPs, and Evaluation Framework • Create evaluation subcommittee to work with MIDD evaluation team on MIDD data and analysis • Hold at least one Advisory Committee meeting per quarter in the community, at times and locations that enable wider community participation, with interpretation and childcare available

Change the Name of the Oversight Committee.

Reflective of the established duties and functions of the Committee that are recommended to continue to MIDD 2, it is recommended that the name of the Committee be amended to reflect its duties as an advisory body: The MIDD Advisory Committee.

Generally, an oversight body has the capacity to make final decisions or substantive decisions which the current committee does not. Rather, as an advisory body, the committee makes recommendations to the Executive and the Council. This change would clarify the role of the committee both to members and other stakeholders.

Executive staff have consulted with the Prosecutor's Office on this matter and no potential legal issues were raised. Legislation to effectuate this, and other changes proposed for the Committee, has been transmitted to the King County Council for consideration.

With the name change, the MIDD Advisory Committee is recommended to continue as an advisory body comprised of leaders who represent an array of systems, populations and experiences. Its membership is deliberately constructed to bring the knowledge, expertise and perspectives needed to review and provide input on the development, implementation and evaluation of the MIDD as a whole. The Advisory Committee is also uniquely positioned to leverage the opportunity to engage in deeper, more meaningful behavioral health and criminal justice systems discussions to create innovation and enhance outcomes for individuals served by MIDD. The MIDD Advisory Committee should also be utilized as a forum to create a "well connectedness" between systems, build trust and credibility, particularly with communities of color or other marginalized communities, and resolve systems issues to move whole person care forward.

Evidence Related to Successful Outcomes-Practice Basis-Goals and Principles of Recovery and Resiliency

The proposed MIDD Service Improvement Plan strategies, services, and programs shall: demonstrate that they are based on evidence related to successful outcomes for chemical dependency or mental health treatment programs and services; demonstrate that they are based on best or promising practices

for chemical dependency or mental health treatment programs and services and that they incorporate the goals and principles of recovery and resilience within a trauma-informed framework, as specified by K.C.C, chapter 2.43 and King County's adopted behavioral health system principles set out in Ordinance 17553 (lines 143-151)

Outcomes and Accountability: One way to help assure policymakers and the public that results are achievable is to identify programs that have been shown to be effective. Delivering on outcomes is a major consideration of MIDD 2 funding and programmatic recommendations. This section, accompanied by the data and information in Appendix J, responds to the requirements of Ordinance 17998 related to demonstrating practice categories (i.e., promising, best or evidence-based practice) and how those practice categories are reflected in the recommended MIDD 2 initiatives. Programs recommended to be supported by MIDD funds are expected to show evidence that they advance the MIDD policy goals.

During the Oversight Committee's development of MIDD Values and Guiding Principles and through the course of Community Conversations and other community input, the concept of including "emerging practices" as a basis for MIDD 2 arose. *Emerging Practices* are those not based on research results "but for which anecdotal evidence and professional wisdom exists. These include practices that practitioners have tried and claimed effectiveness. Emerging practices also include new technologies that have not yet been researched."[55] Subject matter experts and community engagement participants communicated that research is often conducted with mainstream participants and results may not be valid or reliable for communities of color or other marginalized groups.

Based on this feedback, the category of Emerging Practices is added to the array of practice considerations for MIDD 2 concepts. It was determined important to include Emerging Practices in the consideration of MIDD programming due to limitations of research-based practices for marginalized communities. Additional information on the use of Evidence-Based Practices is included in a discussion of Equity and Social Justice on page 64 of this report. Consequently, for purposes of responding to the requirements of Ordinance 17998, "emerging practices are included in the category of "promising practices" in Appendix J.

The established categories of practices used as the basis of MIDD 2 recommendations are described below:

- *Emerging Practices* are those not based on research results "but for which anecdotal evidence and professional wisdom exists. These include practices that practitioners have tried and indicate effectiveness. Emerging practices also include new technologies that have not yet been researched."[56]

- *Promising Practices* are those developed based on theory or research, but for which an insufficient amount of research results "have determined the effectiveness of the practice. If a study uses a weak design resulting evidence is categorized as promising."[57]

[55] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc
[56] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc
[57] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc

- *Best Practices* are those that have "been shown by research and experience to produce optimal results and that [are] established or proposed as a standard suitable for widespread adoption."[58]

- *Evidence-Based Practices* are those for which research has been used "to determine the effectiveness of the practice. The research utilizes scientifically-based rigorous research designs (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research)."[59]

Basis of the practice informed the determination of outcomes. The following approaches were used to determine if recommended MIDD 2 programs had evidence of successful outcomes:

- Staff examined data from MIDD evaluations related to the five MIDD policy goals (for most MIDD 1 programs recommended to continue in MIDD 2 where data was available):
    - MIDD 1 policy goals of reduced jail use (goals 1 and 2) were used to identify successful outcomes for criminal justice when there were statistically significant reductions of jail bookings or jail days.
    - MIDD 1 policy goals of symptom reduction, reduced use of emergency departments and psychiatric hospital use (goals 1 and 3) were used to identify behavioral health outcomes.
- Behavioral health outcomes that "improve health and wellness of individuals living with behavioral health conditions (proposed MIDD 2 policy goal) were also considered for MIDD 2 programmatic recommendations. These outcomes include:
    - Increased treatment access
    - Improved quality of life (stable housing, improved social functioning, coping skills, self-determination and well-being)
- For new initiatives recommended for MIDD 2, existing evidence (studies, research findings, data) of expected outcomes based on similar programs were analyzed by subject matter experts during the development of briefing papers.

Incorporating the Goals of Recovery and Resiliency within a Trauma-Informed Care Framework: Building on research, practice and the lived experiences of individuals in recovery from mental and/or substance use disorders, the MIDD will use the following working definition of recovery developed by the Substance Abuse Mental Health Services Administration (SAMHSA): A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. "Recovery" means a process in which an individual achieves management of the individual's symptoms and regains or develops sufficient skills and autonomy to enable the individual to live, work and participate fully in the community. "Resiliency" means an innate capacity that empowers people across the life span to successfully meet life's challenges with a sense of self-determination, mastery and hope. "Trauma-informed framework" means an approach to engage an individual with a history of trauma that recognizes the presence of trauma symptoms and acknowledges the impact that trauma has had on the individual's life.

[58] http://www.merriam-webster.com/dictionary/best%20practice
[59] http://www.cited.org/library/site/CITEd%20Definitions%20EB,%20Promising,%20Emerging.doc

Overarchingly, the proposed MIDD 2 initiatives promote and support people in all phases of their recovery, analogous to the behavioral health continuum of care reflected in the MIDD 2 Framework. The proposed MIDD 2 initiatives work together and with the broader health and human services and criminal justice systems to provide opportunities for people involved with the behavioral health system to realize their full potential.

The Sequential Intercept Model in MIDD 2

Describe how they will integrate and expand the application of the federal substance abuse and mental health services administration sequential intercept model that addresses the criminalization of mentally ill individuals (lines 152-154)

The strategies that made up MIDD 1 were first developed by several community workgroups using the Sequential Intercept Model as a framework to determine what services needed to be provided for which people at what locations in order to help prevent incarceration, hospitalization and homelessness. This model is in use today by a number of communities across the nation as an action blueprint for planning system change in the way that communities address the problem of people with mental illness in their criminal justice systems.

King County further adapted the organizing principles of this model to include people who may have no mental illness but who are at risk for criminal justice involvement due to substance use, and to include diversion from emergency medical services as another priority. These principles remain in place for MIDD 2 and the initiatives recommended to be funded by MIDD 2.

The recognition that the greatest opportunities for diversion exist when individuals are still in the community, and that diversion options decrease as individuals move through the criminal justice system, is reflected throughout MIDD 2. While MIDD 1 articulated the importance of prevention services, early assessment and intervention, and comprehensive and integrated community-based services, MIDD 2 furthers this understanding by grounding the MIDD 2 initiatives in the continuum of care as reflected by the MIDD 2 Framework. As with MIDD 1, MIDD 2 is devoting considerable resources to supporting a community services system that will serve to divert many individuals from the criminal justice and emergency medical systems while also providing the infrastructure needed to help people who have entered these systems rejoin the community in a safe and effective manner.

Through the MIDD programs, individuals with behavioral health needs will be linked to services designed to help them become stable and productive, and prevent unnecessary incarceration and hospitalization. The MIDD 2 Strategy Areas reflecting the behavioral health continuum of care are:

- **Prevention and Early Intervention -** *People get the help they need to stay healthy and keep problems from escalating*

- **Crisis Diversion -** *People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*

- **Recovery and Reentry -** *People become healthy and safely reintegrate to community after crisis*

- **System Improvements -** *Strengthen the behavioral health system to become more accessible and deliver on outcomes*

Together, the MIDD 2 initiatives will result in improved quality of life for people with mental illness and chemical dependency and their families throughout King County. The Sequential Intercept Model is shown in Appendix A.

Equity & Social Justice in the Implementation of MIDD 2 Programs

Demonstrate that they will reflect the county's existing adopted policy goals included in the Equity and Social Justice Initiative and Strategic Plan (lines 155-156)

Equity and Social Justice is a key initiative in King County recognizing that numerous communities within King County face inequities in key educational, economic and health outcomes. Key drivers of such inequities include race and ethnicity, poverty, geographic location, gender and sexual identity, immigration status, limited English proficiency, and physical disability. The County's Equity and Social Justice Initiative is critical to the implementation of the Service Improvement Plan for MIDD 2. Moreover, guided by the Values and Guiding Principles for MIDD developed by the MIDD Oversight Committee that emphasized equity and social justice, the planning and development of MIDD 2 was conducted with a deep focus on equity and social justice.[60]

Below is a list of several key principles that MIDD 2 considers in the procurement, contracting, training, and/or implementation of programs supported by MIDD 2. Appendix K includes an equity tool that will be used as help guide and inform system improvement/system change processes related to MIDD 2.

Culturally Responsive and Informed: The U.S. Department of Health and Human Services (HHS) Office of Minority Health has released *The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care,*[61] which provides some guideposts for providers of behavioral health services to align with the populations they serve and ensure that services are culturally responsive and informed. In the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities,*[62] several strategies directly relate to the provision of care management teams, including *reduce disparities* (strategy I.B.[63]) in access to primary care services and care coordination, which focuses on migrant workers, people experiencing homelessness and residents of public housing. Using such models as community-based health teams (e.g. health home model) are recommended to establish agreements with primary care providers and other health care providers to improve care coordination. Another HHS Action Plan strategy (2.C.3[64]) calls for an increase in the diversity and cultural competency of clinicians,

[60] See Appendix C for more information on MIDD 2 planning community engagement efforts.
[61] https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards.
[62] U.S. Department of Health and Human Services. *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care***.** Washington, D.C.: U.S. Department of Health and Human Services, (April 2011).
[63] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed 12/28/15.
[64] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed 12/28/15.

including behavioral health workers. This guidance provides an opportunity for King County to implement MIDD 2 with a heightened emphasis on serving the County's most marginalized populations, and align with national best practices on care coordination and treatment services that are culturally responsive and informed.

It is the intent of King County that services provided under MIDD 2 be **culturally responsive** and **culturally specific**. Enacting this intention requires the willingness of both providers and King County to acknowledge historical and cultural trauma as sources of substance use and other behavioral health conditions and the willingness to do business differently to serve people in culturally responsive and specific manners. MIDD-supported direct services should address individual level discrimination that those served encounter in their daily lives by recognizing institutional and structural racism, classism, and ableism.

Community-based agencies providing culturally specific and culturally responsive behavioral health, primary care and reentry support services will be sought to provide these services under MIDD 2. Addressing trauma as a result of both interpersonal violence and childhood experiences as well as historical and cultural trauma will be critical for serving the individuals served by publicly-funded behavioral health services. MIDD 2 providers should explore and implement the use of alternative interventions which are culturally informed, such as substance use disorder treatment for historically disempowered communities,[65] which may yield more meaningful treatment outcomes for marginalized populations.

Evidence-Based Practices and Equity: It is expected that whenever possible, evidence-based practices (EBPs) are to be embedded in the service continuum of MIDD 2. Because most mental health/substance use disorder treatment EBPs are researched on predominantly mainstream/White populations, it is important to have a critical and continuous improvement lens to these behavioral health services to ensure that services are not perpetuating marginalization and negatively impacting those individuals being served, furthering their disenfranchisement. It is necessary that whenever possible, MIDD 2 use anti-oppressive practices to complement recovery oriented and person-centered approaches.

Harm Reduction: Where possible, MIDD 2 initiatives should employ a harm reduction model. Harm reduction activities "meet people where they are," enabling individuals to access better health and human potential outcomes, irrespective of whether the individual engages in substance use. Harm reduction is a grass-roots and "user-driven" set of compassionate and pragmatic approaches to reducing substance-related harm and improving quality of life.[66]

While there is no universal definition or formula for harm reduction given the multiple different interventions and policies designed to serve an individual in need of behavioral health services, there are key principles for harm reduction that MIDD 2 initiatives are encouraged to demonstrate such as:

- accepting the individual regardless of their behavior

[65] White, W. & Sanders, M. (2004). *Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities*. Posted at www.bhrm.org.
[66] Collins, Clifasefi et al. 2011; Marlatt, 1998

- understanding the complex continuum of behaviors while acknowledging that there are safer ways to engage in certain behaviors
- establishing quality of individual/community life and well-being as criteria for successful interventions.

Harm reduction is linked to equity and social justice because provision of services should be nonjudgmental, non-coercive and recognize the realities of poverty, class, racism, social isolation, past trauma, sex-based discriminations and all other social inequalities that affect an individual's vulnerability to, and capacity for, effectively changing behavior.[67]

Serving Individuals Who Have Contact with the Criminal Justice System: Though the County is actively working to address overrepresentation of individuals from non-white racial and ethnic groups, disproportionality currently exists in the County's justice system. When providing MIDD 2 services to people involved with the justice system, there is a need to ensure that an anti-oppressive practice lens is applied to the behavioral health services provided to non-white and other marginalized groups. MIDD 2 should provide or leverage the provision of culturally responsive and specific services and reentry opportunities.

Integration with the County's Policy and Planning Work

Demonstrate how they will expand, enhance, and integrate with the County's planning and policy endeavors such as, but not limited to, the Health and Human Services Transformation Plan, the Youth Action Plan, the Veterans and Human Services Levy, the Ten Year Plan to End Homelessness, and recommendations of the Task Force on Prevention, Early Intervention, and Least Restrictive Alternatives for Individuals in Mental Health and Substance Abuse Crisis (lines 157-162)

The MIDD 2 Framework explicitly conveys the expected linkage between MIDD 2 and other county and community initiatives. MIDD 2 is grounded in a collaborative approach to information sharing, evaluation, aligning of services and braiding of funds.

As with MIDD 1, the proposed MIDD 2 initiatives are expected to individually and as a whole advance/integrate with the County's planning and policy initiatives. For example, the proposed Youth Behavioral Health Alternatives to Secure Detention initiative is intended to link to and further the work of the Juvenile Justice Equity Steering Committee. School-based services supported by MIDD 2 will align with BSK work. The proposed Multipronged Opioid initiative is planned to support recommendations from the Heroin and Prescription Opiate Addiction Task Force. Proposed initiatives involving housing supports and resources for capital and rental assistance further the goals of the All Home[68] strategic plan. Elements of the County's Equity and Social Justice[69] strategic plan are reflected throughout the MIDD 2, from how the MIDD 2 recommendations were determined, to the recommended revised composition of the Advisory Committee.

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[67] http://harmreduction.org/about-us/principles-of-harm-reduction/.

[68] Formerly the Committee to End Homelessness. The All Home strategic plan outlines steps to end homelessness. http://allhomekc.org/the-plan/

[69] http://kingcounty.gov/elected/executive/equity-social-justice/strategic-plan.aspx

The MIDD 2 Implementation Plan that will be submitted to the Council in 2017 after adoption of the 2017-2018 MIDD 2 budget will include how each initiative will link to the County's policy and planning work.

Affordable Care Act and Behavioral Health Integration Opportunities

Demonstrate how they will leverage opportunities provided by the federal Affordable Care Act and the state's requirements for a single behavioral health contract with regional support networks as specified by Chapter 225, Laws of Washington 225 (lines 163-165)

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 2 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 April 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 mental health and substance use disorder treatment services. On April 1, 2016, King County, through the Behavioral Health and Recovery Division, became the Behavioral Health Organization (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 2 will support and leverage opportunities provided under the ACA and through implementation of ESSB 6312 in a variety of ways, including

- Increasing access to behavioral health treatment for people with mental health, substance use or co-occurring disorders

- Supporting earlier interventions for people with mental illness and substance use or co-occurring disorders to prevent unnecessary use of jail, emergency rooms, avoidable hospitalizations and crisis services

- Supporting models of care that deliver or drive toward fully integrated physical and behavioral health care, a model known to improve overall health and social outcomes

- Supporting the development and use of mechanisms that engage individuals with mental health, substance use and co-occurring disorders and link to comprehensive treatment through the King County Behavioral Health Organization (KCBHO)

- Enhancing the continuum of care offered through the KCBHO by providing services that are not Medicaid-eligible or serving individuals who would not otherwise have insurance coverage

- Serving as entry points to get people enrolled in Medicaid so that their physical and behavioral health care needs can be covered through the Medicaid program and the KCBHO.

Fully Integrated Managed Care: The 6312 legislation also called for full integration of mental health, substance use and physical health care by January 1, 2020. This includes aspects of both clinical integration and financial integration for the state Medicaid program. Today, Medicaid physical health care services are purchased through five Managed Care Organizations (MCOs) while Medicaid behavioral health services are purchased through regional BHOs. In King County the five MCOs are Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina and United Health Care.

As the state moves forward with plans to fully integrate physical and behavioral health care, King County has significant decisions to make related to what the financial infrastructure for fully integrated managed care will be and what the optimal role of the county is in that model. King County is considering a number of potential options and working with community stakeholders and partners to identify the best path forward. The decisions King County makes regarding its future role in fully integrated managed care will significantly impact how and what programs are implemented under the MIDD and could require a complete retooling of the MIDD 2 programming before it expires at the end of 2025.

Earlier this year, the Health Care Authority and the Department of Social and Health Services jointly issued a letter to counties identifying three potential timelines for moving to fully integrated managed care. Those options include a start date of: July 1, 2017; July 1, 2018; or January 1, 2020. King County is considering the 2018 and the 2020 options and will make recommendations in late 2016 or early 2017 to the King County Executive and Council regarding the recommended path forward and the optimal timeline for implementation based on the magnitude of change required and community readiness.

The implications of this decision for MIDD 2 could be significant regardless of what option King County chooses. For example, if King County selects an option that includes Managed Care Organizations (MCOs) having primary risk and responsibility for the full continuum of physical and behavioral health care for Medicaid eligible individuals through a single managed care contract with the state, the role of King County in the administration and delivery of behavioral health services related to Medicaid would shift to one of primary monitoring/oversight and assurance. This would require revisiting MIDD 2 investments in light of the county's revised role for behavioral health.

Research shows that fully integrated physical and behavioral health care achieves better outcomes for clients. As King County works to determine the optimal path to full integration for the region, the focus will be on keeping clients at the center of planning and ensuring a system care that provides the best experience, improves outcomes and reduces overall costs to the system. Once the decisions about the fully integrated managed care infrastructure and timeline for implementation are known, King County will need to revisit all MIDD 2 supported programs to evaluate them in relationship to the system transformation that will occur.

BHRD commits to sharing progress on this decision openly and frequently with policymakers and the MIDD Advisory Committee. There will be clear points of public comment established and the Advisory Committee and MIDD stakeholders will be invited to weigh in on the recommendations.

VI. Next Steps

This section acknowledges three specific next steps necessary for MIDD 2: completion of the MIDD 2 Implementation and Evaluation Plans and a process to change the name of the MIDD. Each component will be developed collaboratively with the MIDD Advisory Committee and other stakeholders.

MIDD 2 Implementation Plan

Additional planning is needed for most of the new initiatives contained in the proposed MIDD 2, many of them requiring community engagement components. For each MIDD 2 initiative, the MIDD 2 Implementation Plan that will be transmitted to the Council in 2017 will include[70]:

- Description of the initiative/program/services
- How the initiative advances the MIDD 2 policy goals
- Goal of the initiative
- Outcomes and performance measures
- Expected number of individuals served
- Provided by contractor or county
- Spending plan (based on adopted budget)
- Implementation schedule (for new initiatives)
- Procurement and contracting details
- Services start date (new)
- What community engagement will occur and when
- Other relevant information as directed by the Council or requested by stakeholders.

The MIDD Oversight Committee was deeply involved in the development and review of MIDD 1 implementation plan documents. Similarly, it is expected that the Advisory Committee will play a significant role with the implementation planning for MIDD 2 that will occur in 2017.

MIDD 2 Evaluation Plan

The MIDD 1 Evaluation Plan adopted by the Council in 2008 served as the blueprint for conducting the evaluation and assessment of MIDD. The MIDD 1 Evaluation Plan was developed in conjunction with the MIDD 1 Implementation Plan, after the individual MIDD 1 strategies were established in the Council adopted MIDD Action Plan. The MIDD 1 Implementation Plan specified how each MIDD 1 strategy would be executed and individual MIDD strategy implementation information was used to develop an evaluation approach for each program supported by MIDD funds. MIDD policy goals and strategies were linked to the results, which in turn provided a structure for identifying performance indicators, targets and data sources, and for collecting and reporting results.[71]

[70] Please note that the Initiative Description Documents that are included in this Plan are not Implementation Plans. The information in these documents as will be revised to include updated policy goals, adopted budget, and community engagement plans and other required information. Implementation Plans will be reviewed by the MIDD Advisory Committee and stakeholders.

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

A detailed MIDD 2 Evaluation Plan will be transmitted to the Council in 2017. In order to complete an Evaluation Plan for MIDD 2, final MIDD 2 funding and programmatic decisions are needed, which are expected with adoption of the County's 2017-2018 biennial budget. Further, it is necessary to develop a MIDD 2 Evaluation Plan that is built on the recommendations contained in the MIDD Comprehensive Historical Assessment Report, which includes stakeholder involvement in the development of the MIDD 2 Evaluation Plan. See Appendix L for the MIDD evaluation recommendations. To the extent possible, DCHS will align its approach to MIDD 2 evaluation planning with evaluation planning for BSK. The MIDD 2 Evaluation Plan will contain most, if not all, of the same elements as called for in the MIDD 1 Evaluation Plan:

Requirements of the MIDD 1 Evaluation Plan

- Process and outcome evaluation components
- A proposed schedule for evaluation
- Performance measurements and performance measurement targets
- Data elements that will be used for reporting and evaluation
- Performance measures including:
  - the amount of funding contracted to date
  - the number and status of request for proposals to date
  - individual program status and statistics such as individuals served
  - data on utilization of the justice and emergency medical systems.

As with BSK, the MIDD 2 Evaluation Plan will include the overarching principles, framing questions and approaches that will guide the evaluation and performance measurement of MIDD 2. As MIDD 2 initiatives are refined and programs are selected over the remainder of 2016, the MIDD evaluation framework will be developed, particularly with respect to initiative-level performance metrics and targets. The structure for MIDD 2 evaluation and performance measurement will be based on the MIDD 2 Framework (Appendix F).

Much has changed in the eight years since the MIDD 1 Evaluation Plan was completed, including behavioral health integration and technological advances. Yet, the purpose for evaluating MIDD 2 remains the same: providing the public and policy makers with the tools to evaluate the effectiveness of the MIDD strategies in meeting the established MIDD policy goals, as well as to ensure transparency and accountability.

Changing the Name of the MIDD

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.

Initially, changing the name of MIDD was not pursued as part of MIDD review and planning based on the understanding that MIDD is known statewide as a King County brand. Given the feedback the King County Behavioral Health and Recovery Division has received over the last few months, this item is now identified as something that will be staged to move forward in 2017. Community input as well as

Advisory Committee leadership will be critically important.

Changing the name of the MIDD will require revision to the King County Code and other adopted legislation. Executive staff will work with the Code Reviser, the Prosecutor's Office and Council staff on this issue.

VII. Conclusion

This report fulfills the requirements of Ordinance 17998 calling for a MIDD Service Improvement Plan. County staff, in partnership with the MIDD Oversight Committee, accomplished this work through broad and specific community and stakeholder activities, extensive community processes and analysis.

The groundbreaking MIDD 1 provided a strong foundation on which to plan and build MIDD 2, taking the very best of what worked and retooling where needed to address challenges so that the MIDD is positioned to help the County's behavioral health and criminal justice systems to serve more people and achieve more notable outcomes.

The proposed MIDD 2 programmatic and funding recommendations are a holistic approach to the continuum of behavioral health services, grounded in the principles of equity and social justice and recovery and resiliency. The proposed initiatives were deliberately and intentionally developed with input from a wide array of stakeholders and communities; they were subject to wide public review and comment, which yielded meaningful changes to the proposals. The services, programs and systems supported by MIDD 2 initiatives are interwoven and interdependent.

Recommended improvements to the composition of the MIDD Advisory Committee are intended to bring greater depth and breadth of subject matter expertise and knowledge and experiences to the review of MIDD initiatives and outcomes, while operational improvements are intended to make full use of the capabilities of the committee. Revised fund balance and reserve policies are intended to strengthen the MIDD Fund's financial position and provide clarity around use of fund balance. MIDD 2 is deeply aligned with BSK and other initiatives.

If the recommendations in this report are supported by the King County Council, it is the intent of the Department of Community and Human Services to implement them in collaboration with providers, stakeholders and the MIDD Advisory Committee. The recommendations range from low cost and easily executed, such as "align evaluation reporting period to calendar year" to those that may involve additional resources and be more complex to enact, such as developing a digital dashboard, or establishing a Consumers and Communities Ad Hoc Work Group. Many of the recommendations require retooling internal processes and will necessarily lead to changes in data collection approaches, reporting, and timelines. Fulfilling these recommendations will require time, MIDD resources, and willingness of systems and organizations to embark upon and enact change. All MIDD stakeholders, internal and external to King County, including citizens, policymakers, providers, separately elected officials, and jurisdictional partners are impacted by these recommendations, and as such, their support and participation is critical for the ongoing success of MIDD.

While it has been demonstrated that MIDD 1-supported programs have resulted in reduced jail bookings and shorter hospital stays, individuals with mental health and substance use conditions continue to end up in jails and emergency services because other options are not available – to them or to first

responders who come into contact with them – during times of crisis. Individuals with behavioral health conditions are often also impacted by homelessness, receive uncoordinated and fragmented services, and experience other significant barriers to getting the resources and supports needed in order to thrive in the community. Behavioral health conditions are further exacerbated by lack of diverse culturally and linguistically competent services available in the community. MIDD is but one element to address these issues.

As documented in this and other reports, the world of behavioral health care is rapidly evolving. Actions such as state mandated behavioral health integration, court rulings, along with the implementation of the Affordable Care Act, require King County and its behavioral health and criminal justice partners to continue the historical collaboration initiated by the development of MIDD 1 over eight years ago to make further meaningful systems improvements. The MIDD planning processes have taken into account the changing landscape of behavioral health, while continuing to build on the strong foundation of MIDD 1. County staff are prepared to lead the work necessary to re-envision and re-tool MIDD programs to achieve even greater impact and outcomes.

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Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness

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The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. (*Psychiatric Services* 57:544–549, 2006)

Over the past several years, Summit County (greater Akron), Ohio has been working to address the problem of overrepresentation, or "criminalization," of people with mental illness in the local criminal justice system (1,2). As part of that effort, the Summit County Alcohol, Drug Addiction, and Mental Health Services Board obtained technical assistance consultation from the National GAINS Center for People with Co-occurring Disorders in the Justice System. From that collaboration, a conceptual model based on public health principles has emerged to address the interface between the criminal justice and mental health systems. We believe that this model—Sequential Intercept Model—can help other localities systematically develop initiatives to reduce the criminalization of people with mental illness in their community.

The Sequential Intercept Model: ideals and description

We start with the ideal that people with mental disorders should not "penetrate" the criminal justice system at a greater frequency than people in the same community without mental disorders (personal communication, Steadman H, Feb 23, 2001). Although the nature of mental illness makes it likely that people with symptomatic illness will have contact with law enforcement and the courts, the presence of mental illness should not result in unnecessary arrest or incarceration. People with mental illness who commit crimes with criminal intent that are unrelated to symptomatic mental illness should be held accountable for their actions, as anyone else would be. However, people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment—nor should such people be detained in jails or prisons longer than others simply because of their illness.

With both this ideal and current realities in mind, we envision a series of "points of interception" or opportunities for an intervention to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points. Each point of interception can be considered a filter (Figure 1). In communities with poorly developed mental health systems and no active collaboration between the mental health and criminal justice systems, the filters will be porous. Few will be intercepted early, and more people with mental illness will move through all levels of the criminal justice system. As systems and collaboration develop, the filter will become more

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finely meshed, and fewer individuals will move past each intercept point.

The Sequential Intercept Model complements the work of Landsberg and colleagues (3) who developed an action blueprint for addressing system change for people with mental illness who are involved in the New York City criminal justice system. The Sequential Intercept Model expands that work by addressing Steadman's (4) observation that people with mental illness often cycle repeatedly between the criminal justice system and community services. The model addresses his key question of how we can prevent such recycling by showing the ways in which people typically move through the criminal justice system and prompting considerations about how to intercept those with mental illness, who often have co-occurring substance use disorders.

Interception has several objectives (4,5): preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to community treatment upon release from incarceration, and decreasing the rate of return to the criminal justice system.

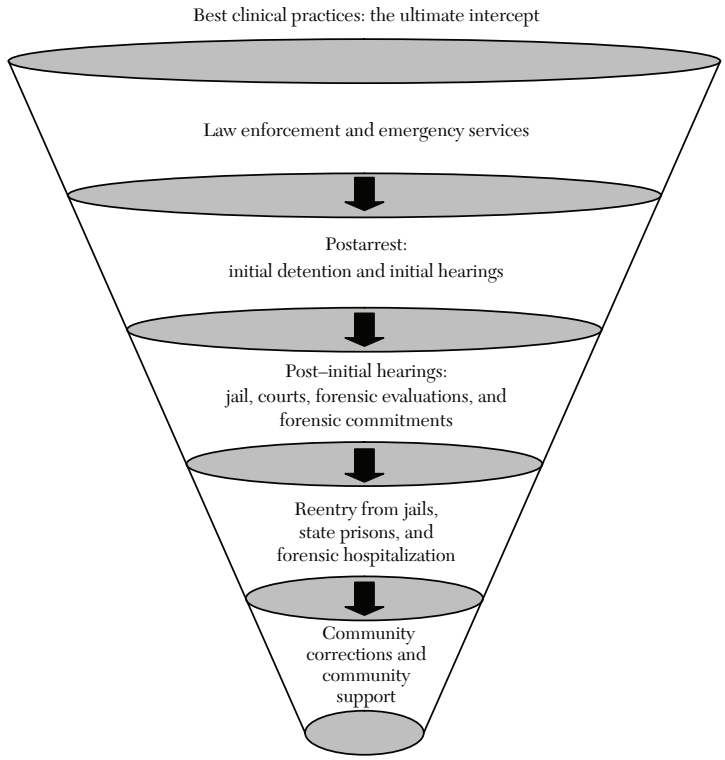
In contrast to the six critical intervention points identified in Landsberg's conceptual roadmap (3), we have specified the following five intercept points to more closely reflect the flow of individuals through the criminal justice system and the interactive nature of mental health and criminal justice systems (Figure 2):

- Law enforcement and emergency services
- Initial detention and initial hearings
- Jail, courts, forensic evaluations, and forensic commitments
- Reentry from jails, state prisons, and forensic hospitalization
- Community corrections and community support services

In the next sections we describe the points of interception and illustrate them with examples of relevant interventions from the research and practice literature.

Figure 1

The Sequential Intercept Model viewed as a series of filters



An accessible mental health system: the ultimate intercept

An accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness. The system should have an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. These services must be available and easily accessible to people in need. Unfortunately, few communities in the United States have this level of services (6).

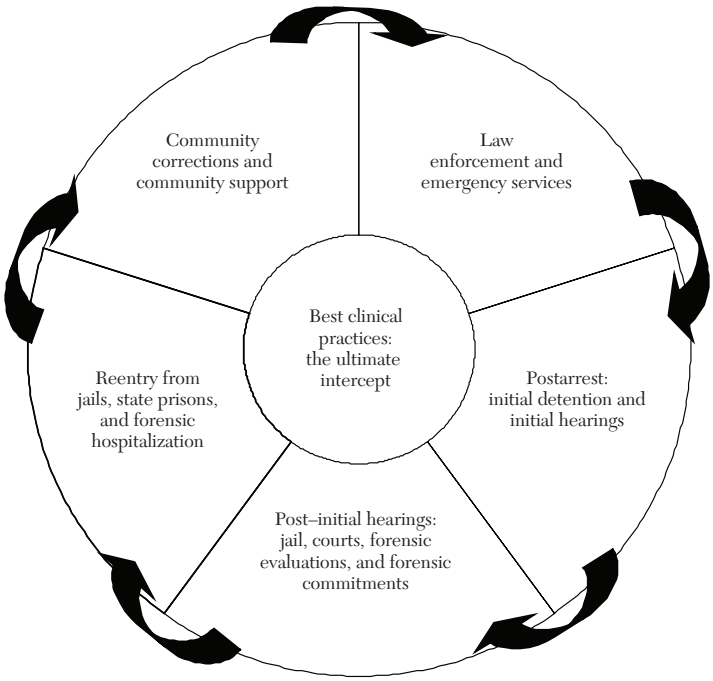
In addition to accessible and comprehensive services, it is increasingly clear that clinicians and treatment systems need to use treatment interventions for which there is evidence of efficacy and effectiveness (7,8). In many systems, evidence-based treatments are not delivered consistently (9). Examples of such interventions include access to and use of second-generation antipsychotic medications, including clozapine (10); family psychoeducation programs (11); assertive community treatment teams (12); and integrated substance abuse and mental health treatment (13). Integrated treatment is especially critical, given the fact that approximately three-quarters of incarcerated persons with serious mental illness have a comorbid substance use disorder (14,15).

Intercept 1: law enforcement and emergency services

Prearrest diversion programs are the first point of interception. Even in the best of mental health systems, some people with serious mental disorders will come to the attention of the police. Lamb and associates' (16) review of the police and mental health systems noted that since deinstitutionalization "law enforcement agencies have played an increasingly important

Figure 2

The Sequential Intercept Model from a revolving-door perspective with best practices at the core



role in the management of persons who are experiencing psychiatric crises." The police are often the first called to deal with persons with mental health emergencies. Law enforcement experts estimate that as many as 7 to 10 percent of patrol officer encounters involve persons with mental disorders (17,18). Accordingly, law enforcement is a crucial point of interception to divert people with mental illness from the criminal justice system.

Historically, mental health systems and law enforcement agencies have not worked closely together. There has been little joint planning, cross training, or planned collaboration in the field. Police officers have considerable discretion in resolving interactions with people who have mental disorders (19). Arrest is often the option of last resort, but when officers lack knowledge of alternatives and cannot gain access to them, they may see arrest as the only available disposition for people who clearly cannot be left on the street.

Lamb and colleagues (16) described several strategies used by police departments, with or without the participation of local mental health systems, to more effectively deal with persons with mental illness who are in crisis in the community: mobile crisis teams of mental health professionals, mental health workers employed by the police to provide on-site and telephone consultation to officers in the field, teaming of specially trained police officers with mental health workers from the public mental health system to address crises in the field, and creation of a team of police officers who have received specialized mental health training and who then respond to calls thought to involve people with mental disorders. The prototype of the specialized police officer approach is the Memphis Crisis Intervention Team (CIT) (20,21), which is based on collaboration between law enforcement, the local community mental health system, and other key stakeholders. A comparison of three police-based diversion models (22) found the Memphis CIT program to high uti-lization by patrol officers, rapid re-sponse time, and frequent referrals to treatment.

Intercept 2: initial hearings and initial detention

Postarrest diversion programs are the next point of interception. Even when optimal mental health service systems and effective prearrest diversion programs are in place, some individuals with serious mental disorders will nevertheless be arrested. On the basis of the nature of the crime, such individuals may be appropriate for diversion to treatment, either as an alternative to prosecution or as an alternative to incarceration. In communities with poorly developed treatment systems that lack prearrest diversion programs, the prototypical candidate for postarrest diversion may have committed a nonviolent, low-level misdemeanor as a result of symptomatic mental illness.

If there is no prearrest or police-level diversion, people who commit less serious crimes will be candidates for postarrest diversion at intercept 2. In communities with strong intercept 1 programs, postarrest diversion candidates are likely to be charged with more serious acts. In such cases, although diversion at the initial hearing stage is an option and treatment in lieu of adjudication may be a viable alternative, some courts and prosecutors may look only at postconviction (intercept 3) interventions.

Postarrest diversion procedures may include having the court employ mental health workers to assess individuals after arrest in the jail or the courthouse and advise the court about the possible presence of mental illness and options for assessment and treatment, which could include diversion alternatives or treatment as a condition of probation. Alternatively, courts may develop collaborative relationships with the public mental health system, which would provide staff to conduct assessments and facilitate links to community services.

Examples of programs that intercept at the initial detention or initial

hearing stage include the statewide diversion program found in Connecticut (23) and the local diversion programs found in Phoenix (24) and Miami (25). Although Connecticut detains initially at the local courthouse for initial hearings and the Phoenix and Miami systems detain initially at local jails, all three programs target diversion intervention at the point of the initial court hearing. A survey of pretrial release and deferred prosecution programs throughout the country identified only 12 jurisdictions out of 203 that attempt to offer the same opportunities for pretrial release and deferred prosecution for defendants with mental illness as any other defendant (26).

Intercept 3: jails and courts

Ideally, a majority of offenders with mental illness who meet criteria for diversion will have been filtered out of the criminal justice system in intercepts 1 and 2 and will avoid incarceration. In reality, however, it is clear that both local jails and state prisons house substantial numbers of individuals with mental illnesses. In addition, studies in local jurisdictions have found that jail inmates with severe mental illness are likely to spend significantly more time in jail than other inmates who have the same charges but who do not have severe mental illness (27,28). As a result, prompt access to high-quality treatment in local correctional settings is critical to stabilization and successful eventual transition to the community

An intercept 3 intervention that is currently receiving considerable attention is the establishment of a separate docket or court program specifically to address the needs of individuals with mental illness who come before the criminal court, so-called mental health courts (29–32). These special-jurisdiction courts limit punishment and instead focus on problem-solving strategies and linkage to community treatment to avoid further involvement in the criminal justice system of the defendants who come before them. The National GAINS Center estimates that there are now 114 mental health courts for adults in the United States (33).

Intercept 4: reentry from jails, prisons, and hospitals

There is little continuity of care between corrections and community mental health systems for individuals with mental illness who leave correctional settings (34). Typically, communication between the two systems is limited, and the public mental health system may be unaware when clients are incarcerated. Mental health systems rarely systematically follow their clients once they have been incarcerated. In a recent survey of jails in New Jersey, only three jails reported providing release plans for a majority of their inmates with mental illness, and only two reported routinely providing transitional psychotropic medications upon release to the community (35).

Nationally, the issue of facilitating continuity of care and reentry from correctional settings is receiving increasing attention. In part these efforts are fueled by class action litigation against local corrections and mental health systems for failing to provide aftercare linkages, such as the successful *Brad H* case against the New York City jail system (36). In addition, pressure is increasing on corrections and mental health systems to stop the cycle of recidivism frequently associated with people with severe mental illness who become involved in the criminal justice system (37–39). The APIC model for transitional planning from local jails that has been proposed by Osher and colleagues (40) breaks new ground with its focus on assessing, planning, identifying, and coordinating transitional care. Massachusetts has implemented a forensic transitional program for offenders with mental illness who are reentering the community from correctional settings (41). The program provides "in-reach" into correctional settings three months before release and follows individuals for three months after release to provide assistance in making a successful transition back to the community.

Intercept 5: community corrections and community support services

Individuals under continuing supervision in the community by the criminal justice system—probation or parole—are another important large group to consider. At the end of 2003, an estimated 4.8 million adults were under federal, state, or local probation or parole jurisdiction (42). Compliance with mental health treatment is a frequent condition of probation or parole. Failure to attend treatment appointments often results in revocation of probation and return to incarceration. Promising recent research by Skeem and colleagues (43) has begun to closely examine how probation officers implement requirements to participate in mandated psychiatric treatment and what approaches appear to be most effective.

Other research by Solomon and associates (44) has examined probationers' involvement in various types of mental health services and their relationship to technical violations of probation and incarceration. Similar to mental health courts, a variety of jurisdictions use designated probation or parole officers who have specialized caseloads of probationers with mental illness. The probation and parole committee of the Ohio Supreme Court advisory committee on mentally ill in the courts (45,46) has developed a mental health training curriculum for parole and probation officers.

Discussion

Some people may argue that the basic building blocks of an effective mental health system are lacking in many communities, and therefore efforts to reduce the overrepresentation of people with mental illness in the criminal justice system are futile. This argument is not persuasive. Even the most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems.

The Sequential Intercept Model provides a framework for communities to consider as they address concerns about criminalization of people with mental illness in their jurisdiction. It can help communities un-

derstand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time. Different communities can choose to begin at different intercept levels, although the model suggests more "bang for the buck" with interventions that are earlier in the sequence.

Five southeastern counties in Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia) used the Sequential Intercept Model as a tool to organize their work in a forensic task force charged with planning coordinated regional initiatives (47). As a result of that year-long effort, Bucks County staff organized a countywide effort to improve the local continuum of interactions and services of the mental health and criminal justice systems (48), and Philadelphia County started a forensic task force that uses the model as an organizing and planning framework. The model is also being used in a cross-training curriculum for community change to improve services for people with co-occurring disorders in the justice system (49).

Conclusions

Although many communities are interested in addressing the overrepresentation of people with mental illness in local courts and jails, the task can seem daunting and the various program options confusing. The Sequential Intercept Model provides a workable framework for collaboration between criminal justice and treatment systems to systematically address and reduce the criminalization of people with mental illness in their community.

Acknowledgments

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References

1. Munetz M, Grande TP, Chambers MR: The incarceration of individuals with severe mental disorders. Community Mental Health Journal 37:361–372, 2001
2. Summit County (Ohio) Alcohol, Drug Addiction and Mental Health Services Board: a systematic approach to decriminalization of persons with mental illness. Psychiatric Services 54:1537–1538, 2003
3. Landsberg G: Planning for system care change for the mentally ill involved with the criminal justice system in New York City: a blueprint for action but obstacles to implementation. Community Mental Health Report, July/Aug 2004
4. Steadman HJ: Prioritizing and designing options for jail diversion in your community. Presented at the Technical Assistance and Policy Analysis tele-video conference, Delmar, NY, Oct 17, 2003
5. Promising Practices Committee: Pennsylvania's Southeast Region Inter-Agency Forensic Task Final Report: Subcommittee Report. Harrisburg, Pa, Office of Mental Health and Substance Abuse, July 12, 2002
6. New Freedom Commission on Mental Health: Achieving the promise: Transforming Mental Health Care in America. Final Report. DHHS pub SMA-03-3832. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2003
7. Drake RE, Goldman HH, Leff HS, et al: Implementing evidence-based practices for persons with severe mental illness. Psychiatric Services 52:179–182, 2001
8. Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illness. Psychiatric Services 52:45–50, 2001
9. Lehman AF, Steinwachs DM, Co-investigators of the PORT Project: Patterns of usual care for schizophrenia: initial results from the Schizophrenia Patients Outcomes Research Team (PORT) client survey. Schizophrenia Bulletin 24:11–20, 1998
10. Swanson JW, Swartz MS, Elbogen, EB: Effectiveness of atypical antipsychotic medications in reducing violent behavior among persons with schizophrenia in community-based treatment. Schizophrenia Bulletin 30:3–20, 2004
11. Dixon L, McFarlane WR, Lefley H, et al: Evidence-based practices for services to families of people with psychiatric disabilities. Psychiatric Services 52: 903–910, 2001
12. Phillips SD, Burns BJ, Edgar ER, et al: Moving assertive community treatment into standard practice. Psychiatric Services 52:771–779, 2001
13. Mueser KT, Noordsy DL, Drake RE, et al: Integrated Treatment for Dual Disorders: A Guide to Effective Practice. New York, Guilford, 2003
14. Abram KM, Teplin LA: Co-occurring disorders among mentally ill jail detainees. American Psychologist 46:1036–1045, 1991
15. The Prevalence of Co-occurring Mental Health and Substance Use Disorders in Jail. National GAINS Center Fact Sheet Series. Delmar, NY, National GAINS Center for People With Co-occurring Disorders in the Justice System, 2002
16. Lamb RL, Weinburger L, DeCuir WJ: The police and mental health. Psychiatric Services 53:1266–1271, 2002
17. Deane MW, Steadman HJ, Borum R, et al: Emerging partnerships between mental health and law enforcement. Psychiatric Services 50:90–101, 1999
18. Janik J: Dealing with mentally ill offenders. FBI Law Enforcement Bulletin 61:22–26, 1992
19. Dupont R, Cochran S: Police response to mental health emergencies: barriers to change. Journal of the American Academy of Psychiatry and the Law 28:338–344, 2000
20. Memphis Police Crisis Intervention Team. Memphis, Tenn, Memphis Police Department, 1999
21. Vickers B: Memphis, Tennessee, Police Department's Crisis Intervention Team: Bulletin from the Field: Practitioner Perspectives. NCJ 182501. Washington, DC, US Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, 2000
22. Steadman HJ, Deane MW, Borum R, et al: Comparing outcomes of major models for police responses to mental health emergencies. American Journal of Public Health, 51:645–649, 2000
23. Frisman L, Sturges G, Baranoski M, et al: Connecticut's criminal justice diversion program: a comprehensive community mental health model. Community Mental Health Report 3:19–20, 25–26, 2001
24. Using Management Information Systems to Locate People With Serious Mental Illnesses and Co-occurring Substance Use Disorders in the Criminal Justice System for Diversion. National GAINS Center Fact Sheet Series. Delmar, NY, National GAINS Center for People With Co-occurring Disorders in the Justice System, 1999
25. Perez A, Leifman S, Estrada, A: Reversing the criminalization of mental illness. Crime and Delinquency 49:62–78, 2003
26. Clark J: Non-Specialty First Appearance Court Models for Diverting Persons With Mental Illness: Alternatives to Mental Health Courts. Delmar, NY, Technical Assistance and Policy Analysis Center for Jail Diversion, 2004
27. Axelson GL: Psychotic vs Non-Psychotic Misdemeanants in a Large County Jail: An Analysis of Pre-Trial Treatment by the Legal System. Doctoral dissertation. Fairfax,

Va, George Mason University, Department of Psychology, 1987

28. McNiel DE, Binder RL, Robinson JC: Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. Psychiatric Services 56:840–846, 2005

29. Goldkamp JS, Irons-Guynn C: Emerging judicial strategies for the mentally ill in the criminal caseload: mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage. NCJ 182504. Washington, DC, US Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, 2000

30. Griffin P, Steadman H, Petrila J: The use of criminal charges and sanctions in mental health courts. Psychiatric Services 53: 1205–1289, 2002

31. Petrila J: The Effectiveness of the Broward Mental Health Court: An Evaluation. Policy Brief 16. Tampa, Fla, Louis de la Parte Florida Mental Health Institute, Nov 2002. Available at www.fmhi.usf.edu/institute/pubs/newsletters/policybriefs/issue016.pdf

32. Steadman HJ, Davidson S, Brown C: Mental health courts: their promise and unanswered questions. Psychiatric Services 52:457–458, 2001

33. National Alliance for the Mentally Ill, TAPA Center for Jail Diversion, National GAINS Center for People With Co-occurring Disorders in the Justice System, et al: Survey of Mental Health Courts, Feb 2006. Available at www.mentalhealthcourtsurvey.com.

34. Griffin P: The Back Door of the Jail: Linking mentally ill offenders to community mental health services, in Jail Diversion for the Mentally Ill: Breaking Through the Barriers. Edited by Steadman HJ. Longmont, Colo, National Institute of Corrections, 1990

35. Wolff N, Plemmons D, Veysey B, et al: Release planning for inmates with mental illness compared with those who have other chronic illnesses. Psychiatric Services 53:1469–1471, 2002

36. Barr H: Transinstitutionalization in the courts: Brad H v City of New York, and the fight for discharge planning for people with psychiatric disabilities leaving Rikers Island. Crime and Delinquency 49:97–123, 2003

37. McKean L, Ransford C: Current Strategies for Reducing Recidivism. Chicago, Center for Impact Research, 2004. Available at www.impactresearch.org/documents/recidivismfullreport.pdf

38. New Freedom Commission on Mental Health, Subcommittee on Criminal Justice: Background Paper. DHHS pub no SMA-04-3880. Rockville, Md, Substance Abuse and Mental Health Services Administration, June 2004

39. Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community. New York, Council of State Governments, 2005

40. Osher F, Steadman HJ, Barr H: A Best Practice Approach to Community Re-Entry From Jails for Inmates With Co-occurring Disorders: The APIC model. Delmar, NY, National GAINS Center, 2002

41. Hartwell S, Orr K: The Massachusetts forensic transition team program for mentally ill offenders re-entering the community. Psychiatric Services 40:1220–1222, 1999

42. Glaze LE, Palla S: Probation and parole in the United States, 2003. NCJ 205336. US Department of Justice, Bureau of Justice Statistics Bulletin, 2004

43. Skeem J, Louden J: Toward evidence-based practice for probationers and parolees mandated to mental health treatment. Psychiatric Services 57:333–342, 2006

44. Solomon P, Draine J, Marcus SC: Predicting incarceration of clients of a psychiatric probation and parole service. Psychiatric Services 53:50–56, 2002

45. Hawk K: The Supreme Court of Ohio Advisory Committee on Mentally Ill in the Courts: A Catalyst for Change. Columbus, Supreme Court of Ohio, 2004. Available at www.sconet.state.oh.us/ACMIC/resources/catalyst.pdf

46. Stratton EL: Solutions for the Mentally Ill on the Criminal Justice System. Columbus, Supreme Court of Ohio, 2001. Available at www.sconet.state.oh.us/ACMIC/resources/solutions.pdf

47. Pennsylvania's Southeast Region Inter-Agency Forensic Task Force: Final Report. Harrisburg, Office of Mental Health and Substance Abuse Services, July 12, 2002

48. Kelsey R: The Bucks County Forensic Mental Health Project: An Update. Presented at the GAINS Conference From Science to Services: Emerging Best Practices for People in Contact With the Justice System. Las Vegas, May 12–14, 2004

49. NIMH SBIR Adult Cross-Training Curriculum Project: Action Steps to Community Change: A Cross-Training for Criminal Justice/Mental Health/Substance Abuse System. Delmar, NY, Policy Research Associates, 2005

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Mental Illness and Drug Dependency (MIDD) 2
Community Conversations & Focus Group Themes

County staff conducted a robust outreach and engagement process around MIDD 2 planning. From September through December 2016, King County invited communities to participate in five regional Community Conversations on MIDD[1]. Between October 2015 and February 2016, county staff held 14 focus groups involving specific communities, populations, or sub-regional areas.

The purpose of these engagement efforts was to hear ideas about services and programs for people living with mental illness and substance use disorders. The conversations were intentionally designed so that community members could have a role in informing the County's decisions around its investments for children and youth and investments for mental health and substance use disorder services and programs. For the Community Conversations, participants engaged in small discussions based on birth to young adult age groups and MIDD Strategy Areas. Conversations were flexible and welcome to all ideas to allow participants to fully engage. A summary of their thoughts on MIDD Strategy Areas are below.

MIDD 2 Planning Community Conversations September – December 2016		
MIDD Strategy Area Table	**What's working?**	**What's not working or needed?**
Prevention & Early Intervention	• Wraparound • Peer Mentors/Counselors • School-based Services • Trauma Informed Care • Suicide Prevention	• Family/In-home Support • Youth-Young Adult Support • Culturally Diverse Resources • Crisis Line Texting • Provider Trainings
Crisis Diversion	• Mental Health First Aid Training • Police De-escalation Training • Crisis Clinic • Crisis Solution Services • Children's Crisis Outreach Response System/Geriatric Regional Assessment Team	• Waiting for Services • Mental Health Aftercare for Young Adults • Mobile Van for Mental Health • Respite Housing/ Crisis beds • Culturally Sensitive Services
Recovery & Reentry	• Non-Medicaid services • Wraparound • Recovery Café • Peer/Mentoring Support • Clubhouses	• Non-Medicaid Services, more needed • Restorative Justice • Recovery House/Oxford House • Treatment on Demand • Recovery High Schools
System Improvement	• Harm Reduction Programs • Specialty Population Behavioral Health Services • MIDD Mental Health/Substance Use Disorder funds • Staff Trainings • Behavioral Health/Physical Health Integration	• High Staff Turnover and Burnout • Caregiver/Parent Resources are lacking • Lack of services in south and rural county areas • Culturally Competent Services • Facility-based Mental Health/Substance Use Disorder services limit access

[1] *Community Conversations were held in partnership with King County staff planning for what became Best Starts for Kids.*

Focus Groups: Groups ranged in size from as few as four to over 100. Groups included:

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

A summary of themes from the focus groups on MIDD and behavioral health services are below.

1. **Culturally specific organizations and groups need to be a central part of development and delivery of programs and services.**

2. **Stigma is a barrier to seeking services.**

3. **Outreach and engagement services are needed. Outreach is needed to educate people about available resources. Engagement is important to develop trust to increase commitment and active involvement in services.**

4. **More affordable housing/housing programs are needed.**

5. **Non-Medicaid services are necessary to fill a significant gap in the service system since many people still do not qualify for Medicaid.**

Primary Needs and Gaps Identified by Respondents to the Mental Illness and Drug Dependency (MIDD) Review and Renewal Survey September 2015 – February 2016

As part of the Mental Illness and Drug Dependency (MIDD) renewal work by King County, an electronic survey was made available between September 2015 and February 2016. The purpose of the survey was to gather feedback on a number of aspects of MIDD. The County received 362 responses.

One question specifically asked respondents to describe in narrative the specific mental health or substance abuse service gaps in their communities where new or expanded mental health, substance abuse, or therapeutic court services could make a difference.

Narrative responses to this question from 262 survey participants identified the following as the top 12 areas of need. Please note that not all survey respondents elected to answer this question.

MIDD SURVEY: TOP AREAS OF NEED OR SERVICE GAPS

1. **Outpatient mental health and substance abuse treatment access, including funding for people who do not have Medicaid**

2. **Housing, including housing supports and improved services for homeless individuals**
3. **Services for youth, especially in schools, including prevention**
4. **Culturally and linguistically competent services**
5. **Support for families**
6. **Inpatient substance use disorders treatment capacity/access**
7. **Crisis services and diversion, including mobile crisis teams**
8. **Support for people with behavioral health needs whose private insurance is insufficient or too expensive**
9. **Improved coordination and continuity of care**
10. **Inpatient mental health treatment capacity/access**
11. **Workforce challenges including high caseloads and turnover and low salaries**
12. **Hospital re-entry services including stepdown options**

Additional information from the survey will be made available as it is reviewed.

MIDD 2 Briefing Paper Review Panel Sorting

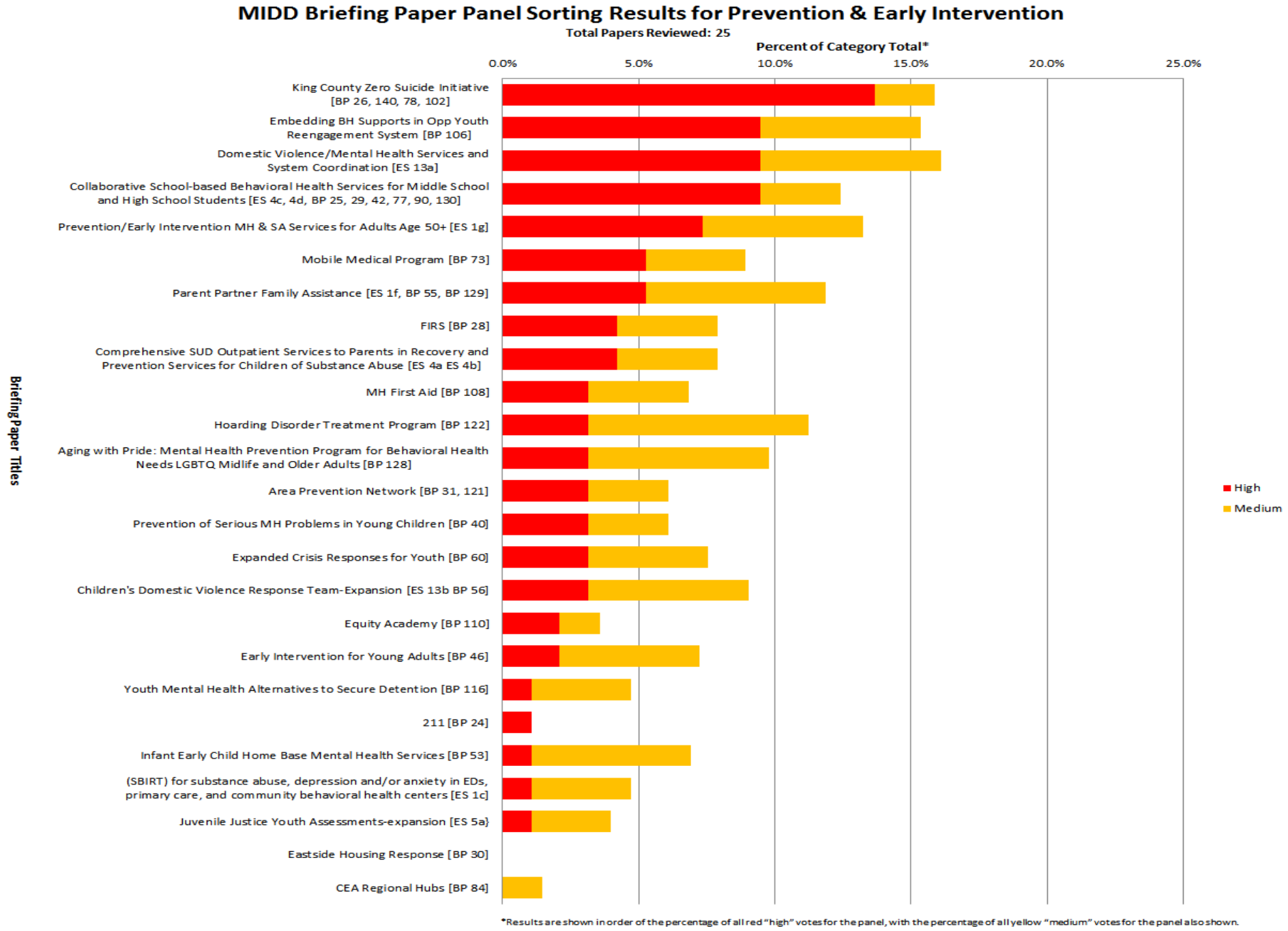
Briefing Paper Review Panel Information

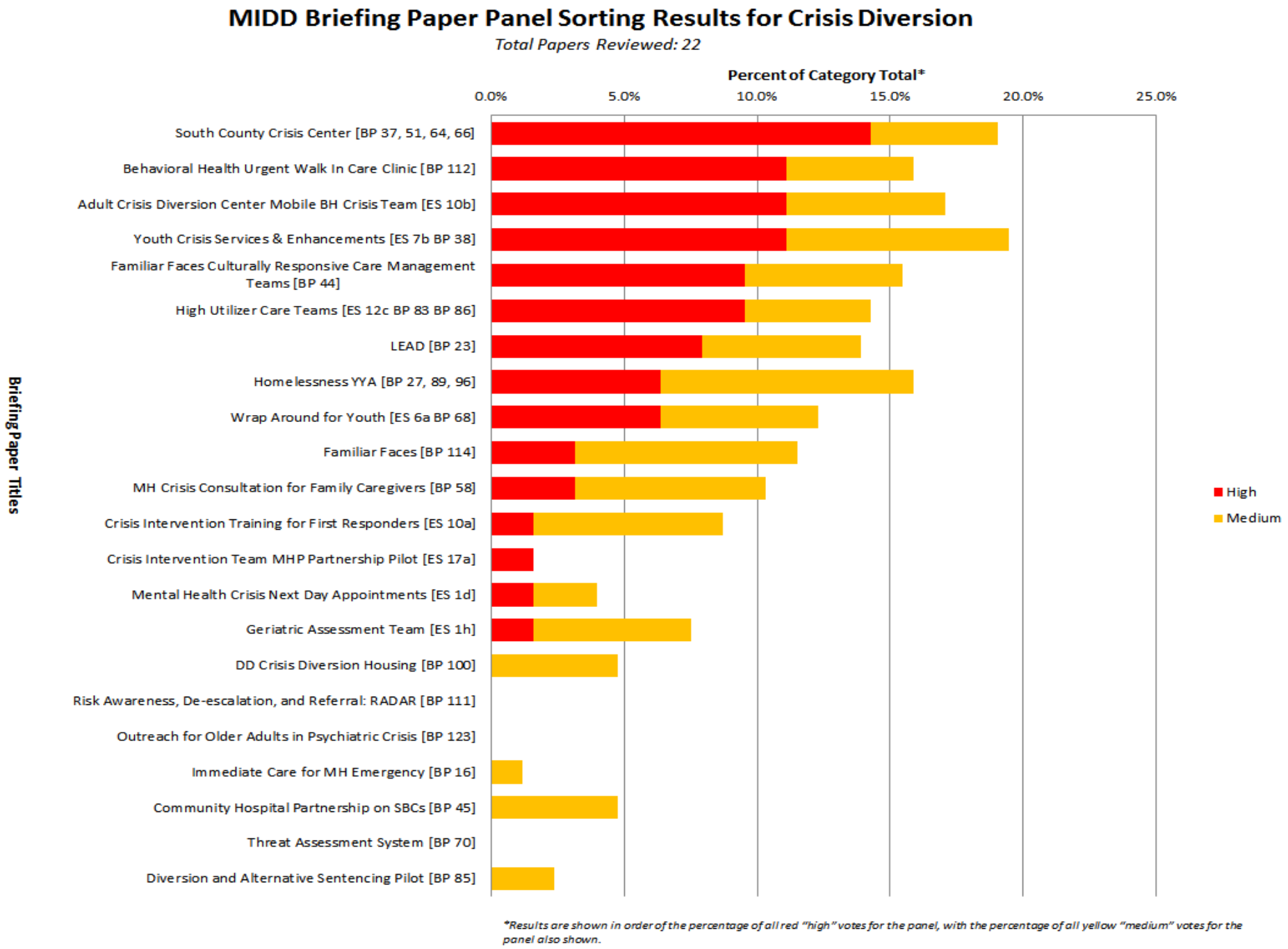
In early March, more than 50 community members, including MIDD Oversight Committee Members, participated on four diverse briefing paper review panels. Briefing papers on new concepts and existing MIDD 1 strategies were created to answer important analytical and policy questions related to the concepts and strategies. The four panels corresponded to the four overarching MIDD 2 strategy areas reviewed existing strategies and new concepts in the form of briefing papers. Briefing papers considered by the different review panels are linked below:

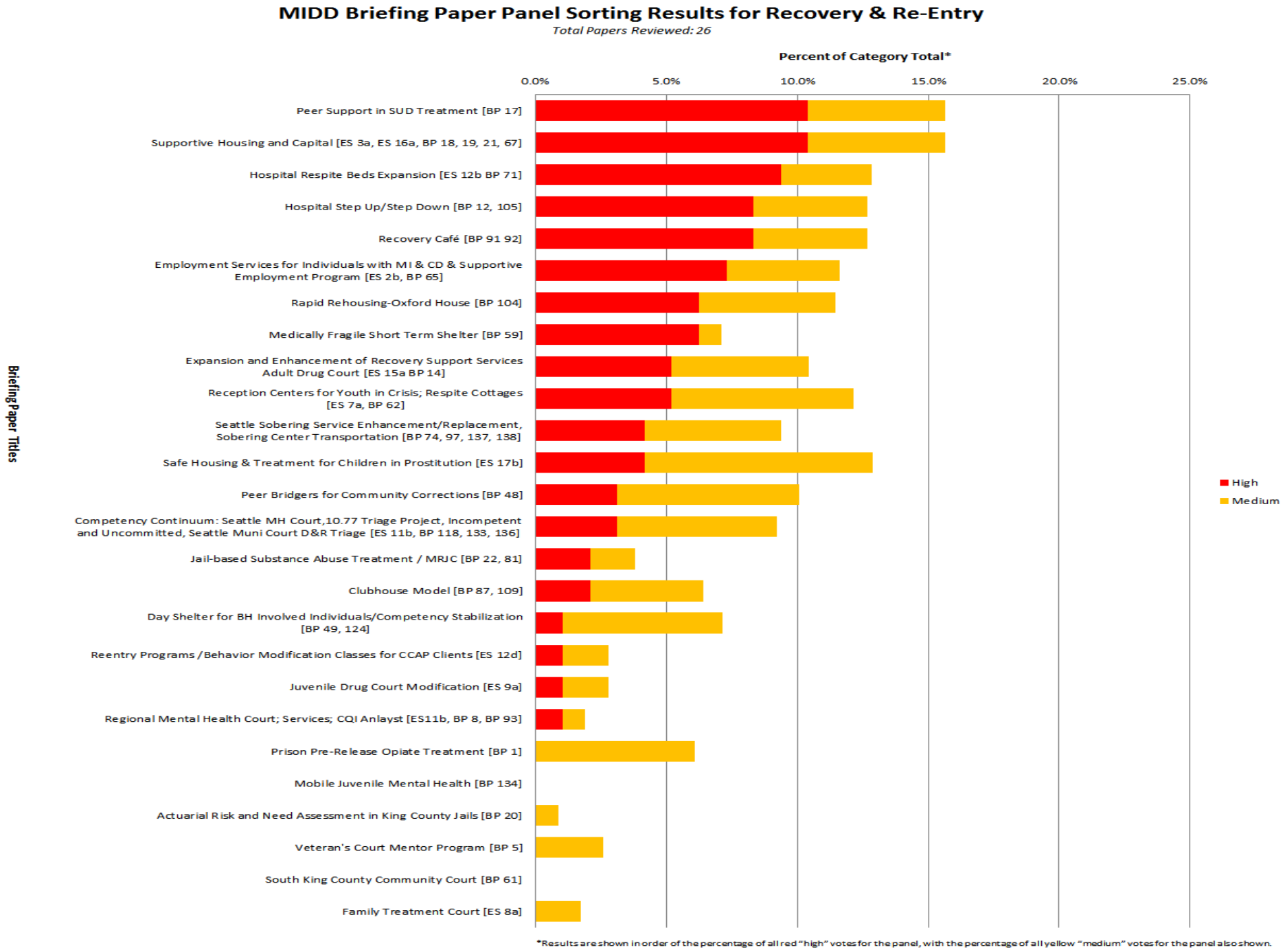
- **Prevention and Early Intervention**
- **Crisis Diversion**
- **Recovery and Re-Entry**
- **System Improvement**

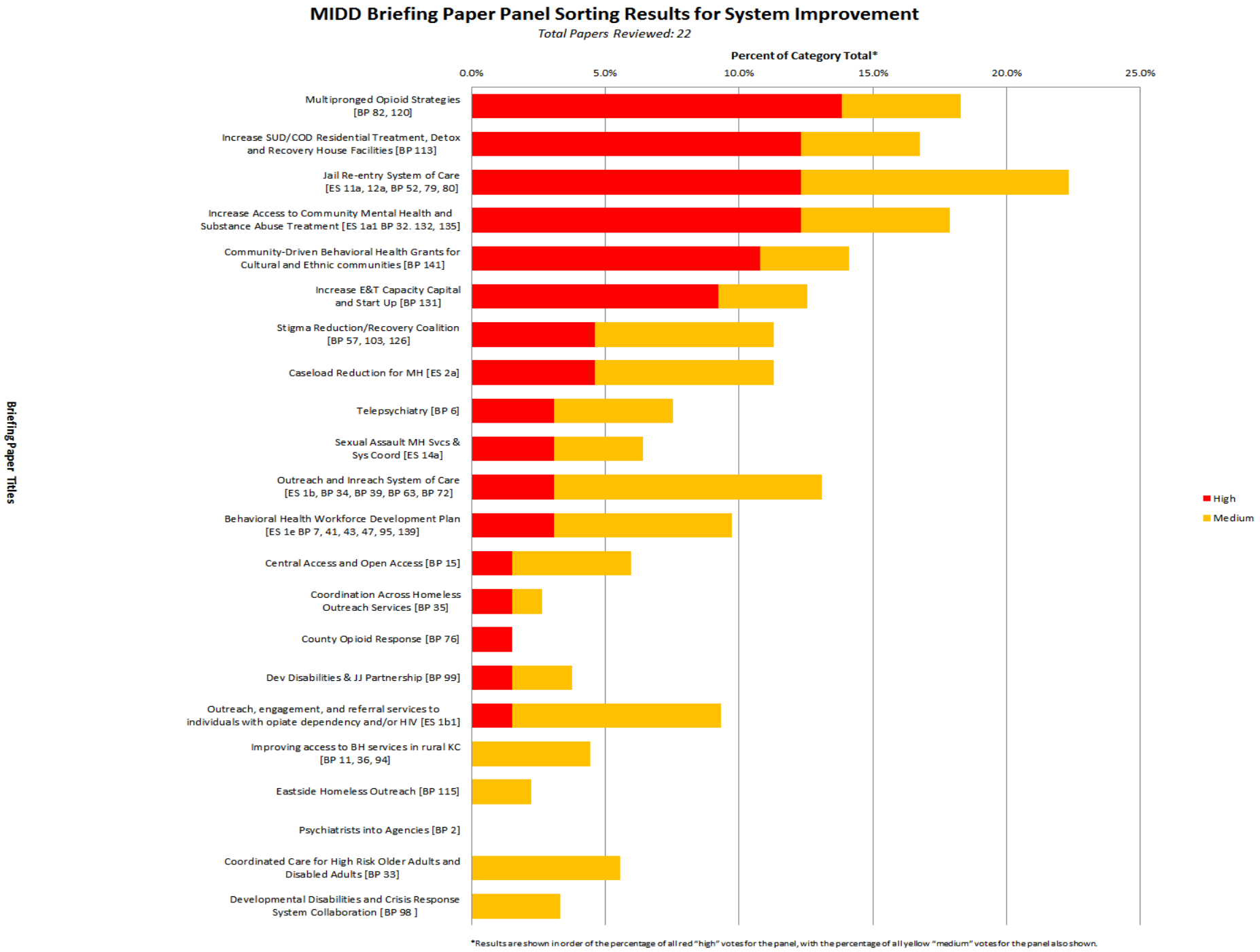
The panels were constructed to bring in a diverse array of lived experiences, skills, knowledge, perspectives, and insights to the sorting process. Each review panel included a mix of community members and MIDD Oversight Committee members or their designees. The work of the panels included deep discussion of each briefing paper and sorting the strategies and concepts into high, medium, and low categories for potential funding consideration. The results are shown in the following graphs in order of the percentage of red "high" votes of all high votes for the panel, with percentage of yellow "medium" votes also shown of all medium votes for the panel.

The work of these review teams, along with the discussions had by the teams in the panel sessions, coupled with the feedback King County has gathered from its robust community engagement process, is informing the next phases of MIDD 2 planning.


MIDD Briefing Paper Panel Sorting Results for Prevention & Early Intervention
Total Papers Reviewed: 25
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
King County Zero Suicide Initiative [BP 26, 140, 78, 102]
Embedding BH Supports in Opp Youth Reengagement System [BP 106]
Domestic Violence/Mental Health Services and System Coordination [ES 13a]
Collaborative School-based Behavioral Health Services for Middle School and High School Students [ES 4c, 4d, BP 25, 29, 42, 77, 90, 130]
Prevention/Early Intervention MH & SA Services for Adults Age 50+ [ES 1g]
Mobile Medical Program [BP 73]
Parent Partner Family Assistance [ES 1f, BP 55, BP 129]
FIRS [BP 28]
Comprehensive SUD Outpatient Services to Parents in Recovery and Prevention Services for Children of Substance Abuse [ES 4a ES 4b]
MH First Aid [BP 108]
Hoarding Disorder Treatment Program [BP 122]
Aging with Pride: Mental Health Prevention Program for Behavioral Health Needs LGBTQ Midlife and Older Adults [BP 128]
Area Prevention Network [BP 31, 121]
Prevention of Serious MH Problems in Young Children [BP 40]
Expanded Crisis Responses for Youth [BP 60]
Children's Domestic Violence Response Team-Expansion [ES 13b BP 56]
Equity Academy [BP 110]
Early Intervention for Young Adults [BP 46]
Youth Mental Health Alternatives to Secure Detention [BP 116]
211 [BP 24]
Infant Early Child Home Base Mental Health Services [BP 53]
(SBIRT) for substance abuse, depression and/or anxiety in EDs, primary care, and community behavioral health centers [ES 1c]
Juvenile Justice Youth Assessments-expansion [ES 5a}
Eastside Housing Response [BP 30]
CEA Regional Hubs [BP 84]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for Crisis Diversion
Total Papers Reviewed: 22
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
South County Crisis Center [BP 37, 51, 64, 66]
Behavioral Health Urgent Walk In Care Clinic [BP 112]
Adult Crisis Diversion Center Mobile BH Crisis Team [ES 10b]
Youth Crisis Services & Enhancements [ES 7b BP 38]
Familiar Faces Culturally Responsive Care Management Teams [BP 44]
High Utilizer Care Teams [ES 12c BP 83 BP 86]
LEAD [BP 23]
Homelessness YYA [BP 27, 89, 96]
Wrap Around for Youth [ES 6a BP 68]
Familiar Faces [BP 114]
MH Crisis Consultation for Family Caregivers [BP 58]
Crisis Intervention Training for First Responders [ES 10a]
Crisis Intervention Team MHP Partnership Pilot [ES 17a]
Mental Health Crisis Next Day Appointments [ES 1d]
Geriatric Assessment Team [ES 1h]
DD Crisis Diversion Housing [BP 100]
Risk Awareness, De-escalation, and Referral: RADAR [BP 111]
Outreach for Older Adults in Psychiatric Crisis [BP 123]
Immediate Care for MH Emergency [BP 16]
Community Hospital Partnership on SBCs [BP 45]
Threat Assessment System [BP 70]
Diversion and Alternative Sentencing Pilot [BP 85]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for Recovery & Re-Entry
Total Papers Reviewed: 26
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
Peer Support in SUD Treatment [BP 17]
Supportive Housing and Capital [ES 3a, ES 16a, BP 18, 19, 21, 67]
Hospital Respite Beds Expansion [ES 12b BP 71]
Hospital Step Up/Step Down [BP 12, 105]
Recovery Café [BP 91 92]
Employment Services for Individuals with MI & CD & Supportive Employment Program [ES 2b, BP 65]
Rapid Rehousing-Oxford House [BP 104]
Medically Fragile Short Term Shelter [BP 59]
Expansion and Enhancement of Recovery Support Services Adult Drug Court [ES 15a BP 14]
Reception Centers for Youth in Crisis; Respite Cottages [ES 7a, BP 62]
Seattle Sobering Service Enhancement/Replacement, Sobering Center Transportation [BP 74, 97, 137, 138]
Safe Housing & Treatment for Children in Prostitution [ES 17b]
Peer Bridgers for Community Corrections [BP 48]
Competency Continuum: Seattle MH Court,10.77 Triage Project, Incompetent and Uncommitted, Seattle Muni Court D&R Triage [ES 11b, BP 118, 133, 136]
Jail-based Substance Abuse Treatment / MRJC [BP 22, 81]
Clubhouse Model [BP 87, 109]
Day Shelter for BH Involved Individuals/Competency Stabilization [BP 49, 124]
Reentry Programs /Behavior Modification Classes for CCAP Clients [ES 12d]
Juvenile Drug Court Modification [ES 9a]
Regional Mental Health Court; Services; CQI Anlayst [ES11b, BP 8, BP 93]
Prison Pre-Release Opiate Treatment [BP 1]
Mobile Juvenile Mental Health [BP 134]
Actuarial Risk and Need Assessment in King County Jails [BP 20]
Veteran's Court Mentor Program [BP 5]
South King County Community Court [BP 61]
Family Treatment Court [ES 8a]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.


MIDD Briefing Paper Panel Sorting Results for System Improvement
Total Papers Reviewed: 22
Percent of Category Total*
0.0%
5.0%
10.0%
15.0%
20.0%
25.0%
Briefing Paper Titles
Multipronged Opioid Strategies [BP 82, 120]
Increase SUD/COD Residential Treatment, Detox and Recovery House Facilities [BP 113]
Jail Re-entry System of Care [ES 11a, 12a, BP 52, 79, 80]
Increase Access to Community Mental Health and Substance Abuse Treatment [ES 1a1 BP 32. 132, 135]
Community-Driven Behavioral Health Grants for Cultural and Ethnic communities [BP 141]
Increase E&T Capacity Capital and Start Up [BP 131]
Stigma Reduction/Recovery Coalition [BP 57, 103, 126]
Caseload Reduction for MH [ES 2a]
Telepsychiatry [BP 6]
Sexual Assault MH Svcs & Sys Coord [ES 14a]
Outreach and Inreach System of Care [ES 1b, BP 34, BP 39, BP 63, BP 72]
Behavioral Health Workforce Development Plan [ES 1e BP 7, 41, 43, 47, 95, 139]
Central Access and Open Access [BP 15]
Coordination Across Homeless Outreach Services [BP 35]
County Opioid Response [BP 76]
Dev Disabilities & JJ Partnership [BP 99]
Outreach, engagement, and referral services to individuals with opiate dependency and/or HIV [ES 1b1]
Improving access to BH services in rural KC [BP 11, 36, 94]
Eastside Homeless Outreach [BP 115]
Psychiatrists into Agencies [BP 2]
Coordinated Care for High Risk Older Adults and Disabled Adults [BP 33]
Developmental Disabilities and Crisis Response System Collaboration [BP 98]
High
Medium
*Results are shown in order of the percentage of all red "high" votes for the panel, with the percentage of all yellow "medium" votes for the panel also shown.

Appendix E MIDD 2 Service Improvement Plan
MIDD 2 PROCESS OVERVIEW
Revised 8.16.16

PHASE I
A. Call for New Concepts
B. Review of Existing Strategies

Open Call Timeframe: 9/15-10/31

PHASE II
Analysis and Collective Review

Existing MIDD Programs* Analysis**

- Did the program do what it was planned to do?
- How well did it do it?
- Can the program as is achieve outcomes that further the adopted policy goal(s) of MIDD & deliver on individual and program outcomes?
- What changes could be made (or were made) to the program to further the adopted goal(s) of MIDD & deliver on outcomes?
- What is the impact of changing the program?
- What happens if this program is eliminated?
- Could it be merged with different or new programs?
- Identify unanticipated outcomes, challenges, or benefits.

**"Programs" refers to all currently funded and operating MIDD strategies*

***These are not the only analytical questions that may be addressed; additional information may be included*

BHRD coordinates analysis of existing programs

Briefing Papers: New Concepts and Existing Programs
Drafted by County staff in consultation with partners/ providers/subject matter experts

Sept-Dec Briefing Paper Drafting

141 New Concepts Submitted!

New Concepts Address/Identify

- What is the specific need that concept addresses?
- How does the concept address need?
- What results/outcomes would the program have?
- What partnering entities are necessary for this concept to be successful?
- Of the four strategy areas in the MIDD 2 Framework, what strategy area does this concept fall under?

New Concepts template will be available electronically on the MIDD website, with instructions and additional information

Submission of New Concepts will be electronic

Additional information may be requested by MHCADSD staff in template or during review

Not all submitted concepts will move to Phase II

BHRD screens new concepts for forwarding to Phase II

Key Questions for Briefing Papers**

- What is the estimated resource need ($, # and type of positions, technology)?
- How long will it take to fully implement?
- What are the barriers or challenges to success for this program/concept? How would barriers be overcome?
- Does this program/ concept positively address disproportionality or enhance cultural competency and if so, how?
- Is it client centered?
- What populations does it serve?
- What MIDD 2 Framework Strategy Area does this program/concept fall under?
- What measureable outcomes are there for this program?
- Plus requirements from Ordinance 17998.

***These are not the only analytical questions that may be addressed in Briefing Papers; additional information may be included*

Jan & Feb Teams Review

Phase II Workgroup/Team Review of Briefing Papers
Review, discussion, and sorting into high, medium, low categories for consideration

Four Briefing Panels Held March 7-10 With Over 50 Reviewers

March - May

Phase III
MIDD 2 Service Improvement Plan Recommendations Development
Align MIDD 2 programs and funding recommendations
County staff drafts recommendations and identifies initial funding levels.
MIDD Oversight Committee reviews recommendations.
Funding recommendations PUBLIC REVIEW AND COMMENT April 22-May 6

May-August

Final Phase: Drafting and Review of MIDD 2 Service Improvement Plan (SIS)

- Recommended programs will be included in the MIDD 2 SIP that is sent to the Executive for review and forwarding to Council
- Transmitted to the King County Council: August 25, 2016
- Changes may be made to the recommendations by the Executive AND/OR the Council

County staff drafts SIP report. MIDD Oversight Committee reviews.
SIP PUBLIC REVIEW AND COMMENT June 16-30

MIDD 2 FRAMEWORK Revised *8.10.16*		
MIDD RESULT People living with, or at risk of behavioral health conditions, are healthy, have satisfying social relationships, and avoid criminal justice involvement.		
MIDD THEORY OF CHANGE When people who are living with or who are at risk of behavioral health conditions utilize culturally relevant prevention and early intervention, crisis diversion, community reentry, treatment, and recovery services, and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.		
OUTCOMES		
Population Indicators	**MIDD and other King County and community initiatives contribute to the overall health and well-being of King County residents that is demonstrated by positive changes in population**	• Emotional health – rated by level of mental distress • Daily functioning - rated by limitations to due to physical, mental or emotional problems • Reduced or eliminated alcohol and substance use • Health rated as 'very good' or 'excellent' • Housing stability • Representation of people with behavioral health conditions within jail, hospitals and emergency departments
MIDD 2 Strategy Areas	**SAMPLE[i] MIDD 2 Performance Measures (to be refined after specific programs/services are selected)**	
Prevention and Early Intervention *People get the help they need to stay healthy and keep problems from escalating*	**How much? Service capacity measures** • Increased number of people receiving substance abuse and suicide prevention services • Increased number of people receiving screening for health and behavioral health conditions within behavioral health and primary care settings **How well? Service quality measures** • Increased treatment and trainings in non-traditional settings (day cares, schools, primary care) • Increased primary care providers serving individuals enrolled in Medicaid **Is anyone better off? Individual outcome measures** • Increased use of preventive (outpatient) services • Reduced use of drugs and alcohol in youth & adults • Increased employment and/or attainment of high school diploma and post-secondary credential • Reduced risk factors for behavioral health problems (e.g., social isolation, stress, etc.)	
Crisis Diversion *People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*	**How much? Service capacity measures** • Increased capacity of community alternatives to hospitalization and incarceration (e.g., crisis triage, respite, LEAD, therapeutic courts, etc.) **How well? Service quality measures** • Increased use of community alternatives to hospitalization and incarceration by first responders **Is anyone better off? Individual outcome measures** • Reduced unnecessary hospitalization, emergency department use and incarceration • Decreased length and frequency of crisis events	
Recovery and Reentry *People become healthy and safely reintegrate to community after crisis*	**How much? Service capacity measures** • Increased in affordable, supported, and safe housing • Increased availability of community reentry services from jail and hospitals • Increased capacity of peer supports **How well? Service quality measures** • Increased linkage to employment, vocational, and educational services • Increased linkage of individuals to community reentry services from jail or hospital • Increased housing stability **Is anyone better off? Individual outcome measures** • Increased employment and attainment of high school diploma and post-secondary credential • Improved wellness self-management • Improved social relationships • Improved perception of health and behavioral health issues and disorders • Decreased use of hospitals and jails	

System Improvements *Strengthen the behavioral health system to become more accessible and deliver on outcomes*	**How much? Service capacity measures** • Expanded workforce including increased provider retention • Decreased provider caseloads • Increased culturally diverse workforce • Increased capacity for outreach and engagement • Increased workforce cross-trained in both mental health and substance abuse treatment methods **How well? Service quality measures** • Increased accessibility of behavioral health treatment on demand • Increased accessibility of services via: hours, geographic locations, transportation, mobile services • Increased application of recovery, resiliency, and trauma-informed principles in services and outreach • Right sized treatment for the individual • Increased use of culturally appropriate evidence-based or promising behavioral health practices • Improved care coordination • MIDD is funder of last resort **Is anyone better off? Individual outcome measures** • Improved client experience of care

Please note that this is a living document; the contents of this document are subject to change and modification.

Adopted MIDD 1 Policy Goals:

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

These goals may be revised for the MIDD Service Period 2017-2025

King County

Behavioral Health and Recovery Division
King County Department of Community and Human Services

Decision Model: Determining the Need For Requests for Proposals/Competitive Procurement

Principles of Purchasing

King County will apply principles that promote effectiveness, accountability and social justice.

Ethical Behavior and Conduct

The objectives of ethical behavior and conduct are to insure that in its procurement activities, the County will:

- Behave with impartiality, fairness, independence, openness, integrity and professionalism in its dealings with suppliers;
- Advance the interests of the County in all transactions with suppliers;

Open and effective competition

The objectives of open and effective competition are:

- To instill confidence in the County and the public about the integrity and cost effectiveness of public sector procurement;
- To support the most effective and efficient outcomes for the County;
- To ensure that all suppliers wishing to conduct business with the County are given a reasonable opportunity to do so; and
- To ensure that bid documents and contracts reflect the requirements and desired outcome of the County and that all participants are subject to equivalent terms, conditions and requirements.

Open and Effective Competition means:

- Procurement procedures and processes are visible to the County, suppliers, and the public;
- Suppliers have a real opportunity to do business with the County; and
- Competition is sought to provide value for money, to achieve the best possible return from County spend on goods and services;

When is a Competitive Process to Secure a Contract Required?

Purchases over $2,499 for a single purchase of goods or services and/or purchases of over $2,500 in a calendar year to a single vendor or provider require a contract. When the County initiates a contracting process the default procurement stance is that a competitive process to identify the vendor/provider must occur. A competitive bid process shall be utilized when:

A. The County has new funding to purchase services(e.g. new grants, new levies, new allocations from funders);
B. A new program/service is to be implemented;
C. There is a change in requirements or regulations related to services/programs currently under contract with the County requiring a substantial revision in the scope of services; or
D. The funder of programs/services requires competitive procurement process for new funds and/or ongoing funds at a specified frequency.

The following categories of purchases are exempt from the requirement of a competitive bid process:

A. Purchases that are covered by a blanket contract entered into by King County Purchasing.

B. Purchases of services where an there is an existing contract within the Division/Department that purchases the same scope of work:

    1. The purchase adds capacity to the program (e.g. purchases more program slots, or bed days); or
    2. The purchase expands the population to be served (without changing the scope of work);

C. Purchases where there is only one source that can provide the scope of work (A Sole Source Waiver must be sought and authorized from King County Purchasing):

    1. The County has been told by a funder to hire a particular (sub)contractor; or
    2. There is only one expert/specialty organization in the region that can deliver the scope of work.

Methods Utilized for Competitive Bid Processes

The competitive bid processes below are solicited by the County. The responses to these solicitations are evaluated against the County's criteria/requirements for the service/program and awards are made for responses that best meet the County's needs/specifications.

1. Requests for Proposals – Prospective bidders complete a proposal to provide services that includes details about: a) their experience providing similar service; b) details on how the agency meets required qualifications; c) a proposal for

how the needed/required services will be provided; and d) a detailed expenditure budget.

2. Requests for Qualifications/Applications – Prospective bidders complete a response detailing their qualifications to provide the needed/required services according to the County specifications and funding.
3. Letters of Intent – A response to a request for a letter of intent that describes the responder's interest, qualifications, and a description of their plan to provide services according to the County's specifications and funding.

Special Purchasing Issues

Divisions/Departments have been delegated the authority to competitively procure and purchase services that are designed to address the needs of the County's citizens (e.g. treatment, supportive services, prevention services, etc.). King County Purchasing may be utilized for the purchase of services if the Division/Department wishes to.

Goods and Consultant Services purchased for King County Divisions/Departments can be competitively procured by the Divisions/Departments if the total expenditure for the consultation will be less than $25,000. For consultation purchase/contracts that exceed $25,000 the competitive procurement process must be directed and run by King County Purchasing.

Criteria for Using King County Procurement for the Competitive Bid Process

King County Procurement buyers should be utilized when:

- There is a need for broad community distribution of the Request for Proposals;
- There will be a large number of potential bidders;
- Regions within King County may be competing with each other;
- The award will go to multiple recipients and will exceed $500,000 each recipient.

Criteria for the Department Running the Competitive Bid Process

The Department may run the competitive bid process when:

- The competitive bid is being distributed to the Department's existing provider network;
- The project is similar to projects that are already in existence in the department;
- The awards are for discreet or small projects.

Appendix H
MIDD 2 Service Improvement Plan

Initiative Descriptions – Preliminary Implementation Information

*Please note that the Initiative Description documents that are included in this appendix provide **initial** implementation and evaluation information. The information in these documents is **preliminary** and **subject to revision** based on revised policy goals, the adopted budget, and stakeholder and community feedback that might occur during the upcoming implementation planning work or as a result of changed funding levels that may occur during the County's budget adoption process.*

Please note that in most instances, information for new MIDD 2 initiatives is very preliminary due to the need to conduct detailed implementation planning in collaboration with stakeholders and communities. Additionally most existing MIDD 1 initiatives that are recommended to continue into MIDD 2 will also undergo some level of operational updating to increase efficiency, effectiveness, and meet revised policy goals. All initiatives will be included & detailed in a MIDD 2 Implementation Plan that will be submitted to the Council in 2017.

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MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

MIDD 2 Initiative Title: Law Enforcement Assisted Diversion (LEAD) **(NEW)**

MIDD 2 Number: CD-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Drug use, mental illness and homelessness often generate behaviors that fuel repeated involvement with the criminal justice system, impede an individual's recovery, and foster legitimate community public safety/order concerns.[1]

The Law Enforcement Assisted Diversion (LEAD) program diverts individuals who are engaged in low-level drug crime, prostitution, and other collateral crime due to drug involvement, from the justice system, bypassing prosecution and jail time, to directly connect drug-involved individuals to case managers who can provide immediate assessment and crisis response, and long term wrap-around services to address the cycling of individuals with behavioral issues through the criminal justice system.

LEAD intercepts the individual and divert the behavioral problem at the point of law enforcement response, to channel drug-involved individuals into a community-based intervention whenever possible and appropriate. LEAD is based in the principles of harm reduction,[2] which focuses on the prevention of harms to individuals and communities that are related to drug usage/dependency in individuals who are unable or unwilling to stop. LEAD is a community policing effort, addressing low-level drug crimes with socioeconomic and health impacts, and providing law enforcement with credible alternatives to booking people into jail.

1. Program Description

◊ *A. Service Components/Design (Brief)*

All LEAD participants receive case management, which supports fulfilment of basic needs, and may include housing stability, job attainment or income stabilization, enrollment in drug and alcohol treatment, and coordination of all criminal justice involvement and prosecution to support and not compromise LEAD intervention plans. In

[1] King County's Familiar Faces project found that nearly all individuals with four or more bookings into the County's jails in a year have a behavioral health indicator of drug dependency or mental illness, and at least one other acute or chronic medical condition. More than half (likely undercounted) were homeless. *Familiar Faces: Current State – Analysis of Population*, September 28, 2015

[2] Harm reduction interventions are designed to meet individuals where they currently are in their lives and their motivation to change, in order to tailor strategies to meet their specific needs and to minimize the specific harms to themselves and their community. "Harm reduction strategies can be effective in reducing harm, increasing the quality of life and decreasing high-risk behaviors." Marlatt, G. Alan; Larimer, Mary E.; Witkiewitz, K., Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

general, LEAD pursues the goals of the individual participant, as identified by the case manager and the participant in an Individual Intervention Plan.

Case managers provide street-based outreach and engagement, as well as immediate response to unscheduled needs wherever possible. Case managers use motivational interviewing techniques, and establish a low- or no-barrier atmosphere that ensures participants are not shamed and can readily re-engage when they have struggled or are struggling.

The second component of LEAD is the coordination of all prosecution and contact participants may have with the criminal justice system for other cases that may not be eligible for diversion. The prosecution coordination component of LEAD supports prosecutors to make discretionary decisions about whether to file charges, recommend pre-trial detention or release conditions, reduce charges, recommend incarceration after conviction, and/or dismiss charges, in a way that supports the intervention plan designed for the particular participant, in order to maximize community health and safety.

Another component of the LEAD program is engagement with the community and addressing neighborhoods' concerns with criminal activity and public safety. This takes the form of ongoing education and dialogue with community leaders about the LEAD approach, coordination of information between neighborhood leaders and the operational workgroup regarding LEAD participants and neighborhood hotspots and concerns. It also generates community-based social contact referrals to LEAD that can be validated by law enforcement as appropriate referrals. Through LEAD, community-generated pressure for traditional enforcement can be transformed into participation in alternative health-based responses.

Specific strategies of the LEAD program include:

- effective training of and engagement with front-line law enforcement officers (officers and sergeants) to enlist their active participation in this approach, to familiarize them with harm reduction principles, and to tap into their experience and knowledge of the street-involved population;
- coordination by prosecutors of LEAD participants' filed criminal cases with the Individual Intervention Plan established by LEAD case managers, wherever possible;
- ongoing community outreach and engagement;
- provision of case management in a harm reduction/Housing First framework;
- assistance in removing legal obstacles to improved life circumstances; and
- coordination with public defenders to receive defense-initiated social contact referrals and ensure defenders integrate LEAD into defense planning for resolution of filed cases as appropriate.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

◊ *B. Goals*

As described above, the primary objectives of LEAD are to reduce recidivism and criminal justice costs, and to increase positive psychosocial, housing and quality-of-life outcomes for participants.

◊ *C. Expected Numbers of Individuals Served*

The increased level of financial participation by MIDD will support the delivery of the LEAD program for approximately 500 participants. Potential service recipients would be located in currently funded areas[3] as well as other communities that have expressed interest in becoming partners in the delivery of LEAD. There is a particular interest among LEAD's policy coordinating group in exploring opportunities to expand LEAD into South and East King County jurisdictions that presently make comparatively high use of King County Jail facilities for individuals with frequent bookings,[4] as part of a countywide strategy to increase access to the program and decrease the unnecessary use of jail.

Of note, the current LEAD case management level of care may need to be enhanced for some individuals who are referred to the program. Through other demonstration efforts, more intensive levels of care will become available to address higher needs. Over time, it is the goal to have agencies contracted by BHRD provide this intensive care as part of the LEAD service mix.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- reduced substance use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduced unnecessary incarceration
- reduced substance use
- increased stability in treatment, employment, or other quality of life measures

[3] LEAD launched as a pilot in Seattle's Belltown neighborhood and King County's Skyway neighborhood in 2011, funded entirely by grants from private foundations. In 2014, with support from the City of Seattle, and at the request of other downtown Seattle neighborhoods, the program was expanded to include the rest of downtown Seattle. LEAD received $800,000 in one-time funding from MIDD 1 in 2016. The City of Seattle plans to expand LEAD to its East precinct (Capitol Hill) in 2016, and, since other Seattle neighborhoods have requested LEAD, the City Council has requested a plan for how to scale up citywide. The Sound Cities Association has also entered discussions regarding expanding LEAD to other King County cities.

[4] This refers to individuals who meet the Familiar Faces threshold of four or more bookings into the County's jails in a year.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

Specific outcomes and measures for LEAD, especially identification of what will be evaluated as part of MIDD 2, are subject to further definition.

◊ *E. Provided by: Contractor*

Prosecution services will be provided by the King County Prosecuting Attorney's Office (KCPAO) and municipal attorneys including the Seattle City Attorney's Office as well as those representing any future cities that may participate in future expansions of LEAD to South and East King County.

Funding for community engagement, project management including accountability to MIDD and other oversight bodies, and stakeholder coordination would be directed to the Public Defender Association (PDA).

Funding for case management will be contracted to PDA through King County BHRD, which will provide program oversight of and contract monitoring for the MIDD-funded portion of LEAD, including ensuring that other funding sources including Medicaid are maximized. (See 3.A below for the expected long-term approach to case management contracting.)

2. Spending Plan

This spending plan shows estimated amounts and expected categories for MIDD 2's recommended contribution to LEAD.

It is designed to invest in expansion of LEAD to other jurisdictions, and/or other Seattle neighborhoods, as part of a countywide strategy. Each additional jurisdiction will be expected to secure or contribute funding for increased case management, project management, community engagement, client legal services, law enforcement overtime, and training costs when LEAD expands into its area, alongside the MIDD 2 investment.

All expenses shown are provisional and may be adjusted depending on the timing of expansion of LEAD into other communities within Seattle and/or throughout the County.

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

Year	Activity	Amount
2017	Case management, prosecution costs, project management, stakeholder coordination, community engagement, and planning to enhance integration and expand to suburban cities	$1,537,500
2017 Annual Expenditure		**$1,537,500**
2018	Case management, prosecution costs, project management, stakeholder coordination, community engagement, and planning to enhance integration and expand to suburban cities	$2,052,000
2018 Annual Expenditure		**$2,052,000**
Biennial Expenditure		**$3,589,500**

3. Implementation Schedule

◊ *A. Procurement of Providers*

County funds will be granted to Public Defender Association (PDA) to support its existing role in project management, stakeholder coordination and community engagement for LEAD, including its role in working with the multisystem LEAD Policy Coordinating Group, the consensus-based governing body of LEAD that includes PDA, prosecutors, law enforcement, the King County Executive's Office, and municipal funders.

Funding for LEAD case management will administered by the through a Memorandum of Agreement between PDA and King County BHRD, which will provide program oversight of and contract monitoring for the MIDD-funded portion of LEAD.

It is the long-term goal for LEAD that King County BHRD oversee the contract for case management services and oversee the social services aspect of LEAD, including behavioral health, primary care and housing. This will occur when BHRD-administered "on demand" referral portals are available featuring harm reduction and trauma-informed care approaches.

If new King County cities wish to launch LEAD, an RFP would be developed by BHRD staff in conjunction with the Policy Coordinating Group in order to identify case management providers appropriate to those new cities.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Law Enforcement Assisted Diversion (CD-1)

◊ *C. Services Start date (s)*

As the initiative is already operating, services are expected to continue uninterrupted in the current service areas.

Expansion to other communities throughout King County is expected to occur gradually between 2017 and 2022 when:

- specific jurisdictions come forward with interest and additional funding;
- agreements and law enforcement/prosecution training is completed; and
- contracted case management provider(s) are identified for South King County as applicable.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth and Young Adult Homelessness Services (CD-2)

MIDD 2 Initiative Title: Youth and Young Adult Homelessness Services **(NEW)**

MIDD 2 Number: CD-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "explicit linkage with, and furthering the work of, other King County and community initiatives."

This program is a coordinated approach to supporting youth and young adults experiencing homelessness. It provides mobile behavioral health team(s) to young adult housing programs as featured in the All Home Comprehensive Plan to Prevent and End Youth and Young Adult (YYA) Homelessness.

This approach is also consistent with the principles of King County's plans for behavioral health integration and health and human services transformation, which call for reduced fragmentation across systems, increased flexibility of services and coordination of care, and strong emphasis on prevention, recovery and elimination of disparities for marginalized populations.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Mental health and/or chemical dependency professionals will be embedded within an existing agency or agencies providing housing in Seattle, East King County, and/or South King County and shared across all young adult (YA) housing programs, including transitional housing, rapid rehousing, and permanent housing. If more than one team is created, each team would serve an identified geographic region.

These staff will provide on-site, timely mental health and chemical dependency screenings and assessment, brief intervention, and connection to ongoing behavioral health services. Because these team(s) will be based at existing housing programs, the "home base" programs will have stronger capacity to provide intensive on-site behavioral health supports.

This will create more appropriate supports within existing housing programs for young adults with ongoing mental health or substance abuse needs. It is anticipated that these programs will be able to stabilize more young people, and support them moving to other programs in the continuum as their service needs change.

◊ *B. Goals*

This initiative focuses on mobile behavioral health team(s) based in young adult housing programs, as a priority element of a coordinated approach that will support youth and young adults experiencing homeless with acute behavioral health needs and/or a history

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth and Young Adult Homelessness Services (CD-2)

of trauma in achieving and succeeding in safe and stable housing.[1] Improving behavioral health services to this population will help ensure that their homelessness is a brief and one-time experience.

◊ *C. Expected Numbers of Individuals Served*

It is not yet known how many individuals may be served by this program. As the program is further developed by King County DCHS Community Services Division's housing and community development section in consultation with All Home and King County BHRD to match appropriated funding levels, the expected number of people to be served will be more clearly identified.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- reduced unnecessary hospital and emergency department use
- increased housing stability

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to community providers and managed by existing staff within King County DCHS' Community Services Division in coordination with King County BHRD.

[1] In addition to the mobile behavioral health team(s) described in this document, this coordinated approach could include wraparound services for homeless youth & young adults (YYA), enhanced crisis response for young adults (YA) in housing programs as well as trauma-specific therapy and supports for homeless youth and young adults, or other programming, if future funding permits.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth and Young Adult Homelessness Services (CD-2)

2. Spending Plan

The spending plan outlined below is limited to the recommended funding level. As such, these expenditure plans may be adjusted as program design continues.

Year	Activity	Amount
2017	Mobile behavioral health team(s) based at young adult housing programs	$300,000
2017 Annual Expenditure		**$300,000**
2018	Mobile behavioral health team(s) based at young adult housing programs	$307,800
2018 Annual Expenditure		**$307,800**
Biennial Expenditure		**$607,800**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposals (RFP) process will result in the selection of one or more provider(s) for these services.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning for this initiative will occur primarily in first quarter 2017, to align plans with final funding levels. Providers will be identified via the RFP process in second quarter 2017, with services to begin in third quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

MIDD 2 Initiative Title: South County Crisis Diversion Services/Center **(NEW)**

MIDD 2 Number: CD-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This program relates to the current MIDD 1 strategy Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team in the availability of in-the-community crisis response and the accessibility of a facility-based crisis diversion program. The program would provide south King County first responders with a therapeutic community-based alternative to jail and hospital settings when engaging with adult individuals in behavioral health crisis.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The South County Crisis Center (SCCC) is envisioned provide crisis services the southern region of King County serving individuals in behavioral health crisis who are coming into contact with first responders, as well as those individuals in South King County who may need a location for preventative and pre-crisis support and/or outreach. This allows for potential co-location and coordination of many crisis receiving and stabilization services accessible 24 hours a day, seven days per week (24/7), including but not limited to: on-site respite/crisis diversion and mobile crisis teams.

◊ *B. Goals*

The goals of the programs at the SCCC would be to meet the individual where they are, rather than expecting the individual to be ready for services, housing, etc. The recovery aspect would be indicated in the expectation that the SCCC will work with individuals on a repeat basis in order to work on motivation for treatment, while also focusing their efforts on addressing what is important for the individual. Without basic needs being met, individuals will likely be moving from crisis to crisis, rather than moving down a path of recovery. By setting the focus on identifying and addressing the most pressing needs – such as obtaining identification, obtaining health benefits, completing housing applications, etc. – the facility will be able to take the extra steps to ensure an individual has access to services and the support they need to help them maintain stabilization.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 1,500 individuals annually when fully operational.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary jail, hospital and emergency department use
- increased use of preventive (outpatient) services
- reduction of crisis events
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

2. Spending Plan

The spending plan outlined here is limited to the pilot funding level. As such, implementation may include only some of the program elements listed above. The timing and/or amounts of some expenditures shown below may depend on when and how the facility is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

Year	Activity	Amount
2017 only	South King County Crisis Diversion Facility/Services capital investment and/or startup costs	$500,000
2017 Annual Expenditure		**$500,000**
2018	South King County Crisis Diversion Facility programs, services, and operations	$1,539,000
2018 Annual Expenditure		**$1,539,000**
Biennial Expenditure		**$2,039,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Planning for this new initiative is expected to be completed during the second quarter 2017. The RFP will be released in the third quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
South County Crisis Diversion Services/Center (CD-4)

◊ *B. Contracting of Services*

The contract is expected to begin during the third quarter 2017.

◊ *C. Services Start date (s)*

The anticipated start of services will likely be in 2018, depending on timeline for planning and procuring a contractor. In addition, depending on the extent of renovations or construction needed, implementation for the project could be extended.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

MIDD 2 Initiative Title: Multipronged Opioid Strategies **(NEW)**

MIDD 2 Number: CD-7

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

There are an estimated 23,000 people who use drugs by injection in King County.[1] Of clients seen at Public Health – Seattle and King County's Needle Exchange Program, 89 percent report having used heroin in the last three months, and 47 percent of these heroin users report being "hooked on prescription-type opiates" before they started using heroin.[2] Accelerating opiate use has been documented by increased treatment admits, increased heroin overdose deaths, an increase in heroin evidence tested by the State Crime Lab, and increased use of prescription-type opioids by 10th grade students.[3] Heroin involved overdose deaths in King County increased from 49 individuals in 2009 to 156 individuals in 2014, the highest number ever recorded.[4] The volume of syringes exchanged in King County in 2015 topped seven million, almost a four-fold increase in the last ten years, and an increase of 18 percent compared to 2014.

While capacity for Medication Assisted Treatment (MAT) has increased in King County, it has not kept pace with need: the number of treatment admissions for heroin in King County doubled between 2010 and 2014 and increased 32 percent from 2013 (2,187 admits) to 2014 (2,886).[4]

This initiative aims to address the trend by supporting the recommendations (due end of September 2016) of the Heroin and Prescription Opioid Addiction Task Force, jointly convened by the King County Executive and the mayors of Seattle, Auburn, and Renton.[5] Specifically, recommended interventions in as many as five categories may emerge from the work of the Task Force:

1. Expanded treatment on demand for office-based medication assisted treatment;
2. Primary prevention efforts including targeted educational campaigns;

[1] Thiede H and Buskin S, *Updated men who have sex with men (MSM) and people who inject drugs (PWID) population estimates for King County*, HIV/AIDS Epidemiology Unit, Public Health – Seattle & King County and the Infectious Disease Assessment Unit, Washington State Department of Health, HIV/AIDS Epidemiology Report 2014, Volume 83, p59-62, http://www.kingcounty.gov/healthservices/health/communicable/hiv/epi/reports.aspx.
[2] Hanrahan M, Kummer K, Thiede H, unpublished results of a comprehensive intercept survey conducted at PHSKC needle exchange sites in June 2015.
[3] Banta-Green C, *Heroin Trends Across WA State*, ADAI Info Brief, UW Alcohol & Drug Abuse Institute, June 2013, http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2013-02.pdf.
[4] Banta-Green C et al, Drug Abuse Trends in the Seattle-King County Area: 2014, Alcohol & Drug Abuse Institute, University of Washington, June 2015, http://adai.washington.edu/pubs/cewg/Drug%20Trends_2014_final.pdf.
[5] http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/heroin-opiates-task-force.aspx. Task Force recommendations will be completed by September 30.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

3. Increased access to overdose reversal drug naloxone to prevent fatalities and problem escalation;
4. Engagement services to link clients of Public Health Seattle-King County's (PHSKC) needle exchange to needed treatment services (as funded under MIDD 1), and potential enhancement and/or expansion to serve more clients and/or address more complex needs.
5. Staffing support for a supervised consumption area[6] in King County.

Such approaches will assure equity in access to limited treatment resources, while also ensuring that residents whose heroin use is chaotically and expensively impacting other publicly funded resources (such as emergency medical care, psychiatric hospitalizations, criminal courts and incarceration facilities) have access to less expensive and responsive treatment services.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Although Task Force recommendations are not yet known, potential services could be implemented in five categories being considered by the Task Force and may include the following. Examples of potential interventions are described for each category.

- Category 1: Expanded treatment on demand for office-based MAT.
  - Offer multiple frequent induction points including needle exchange, jails, and detoxification facilities, community health centers, and behavioral health providers, including centralized coordination of service availability.

- Category 2: Primary prevention efforts, possibly including targeted educational campaigns.
  - Pilot educational campaigns to pediatric and adolescent medical providers regarding opioid prescribing and educating families on the role of opioids in medical treatment.
  - Other primary prevention efforts may emerge but have not yet been defined.

- Category 3: Increased access to overdose reversal drug naloxone to prevent fatalities and problem escalation.
  - Recipients of publicly funded treatment for opioid use disorder or needle exchange services, and those in their social and familial networks, may be enrolled in an overdose education and take-home-Naloxone program.

- Category 4: Continuation of MIDD 1-funded engagement services to link clients of PHSKC's needle exchange to needed treatment services.
  - Social work staff at PHSKC's needle exchange.

- Category 5: Staffing support for a supervised consumption site in King County.
  - Services will include MAT with buprenorphine, and will be staffed in part by a nurse care manager.

[6] Such programs are often referred to as "safe injection facilities."

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

◊ *B. Goals*

Broad goals of this initiative include reduced heroin or opioid-linked overdose fatalities, and an improved continuum of health care services, treatment, and supports for opioid users in King County.

◊ *C. Expected Numbers of Individuals Served*

The social work staff at PHSKC under category 4 serves 700 clients per year, refers 300 clients per year to MAT, and successfully places 200 clients in treatment.

Targets for the number of individuals to be served by categories 1, 2, 3, and 5 of this initiative – or other categories to be determined – will be set once Task Force recommendations are finalized. As the initiative's varied approaches are likely to yield interventions across the continuum of care, some potential interventions may come into contact with many people, while others may have a more focused impact on a smaller number of participants.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced/eliminated substance use
- reduced jail, hospital, and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduction of crisis events
- improved wellness and social relationships
- reduced hospitalization, emergency department use, and incarceration
- improved wellness self-management

◊ *E. Provided by: County and/or Contractor*

Some funding for this project would support County clinical staff at PHSKC, while many other aspects would likely be contracted to community providers.

2. Spending Plan

Aside from needle exchange services, expenditures per service category will be determined after Task Force recommendations are finalized. Expected categories may also change.

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Multipronged Opioid Strategies (CD-7)

staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

Year	Activity	Amount
2017	Task Force-recommended service enhancements to address opiate addiction	$667,000
2017	Continuation of needle exchange social work staff to engage clients with treatment	$83,000
2017 Annual Expenditure		**$750,000**
2018	Task Force-recommended service enhancements to address opiate addiction	$1,456,000
2018	Continuation of needle exchange social work staff to engage clients with treatment	$83,000
2018 Annual Expenditure		**$1,539,000**
Biennial Expenditure		**$2,289,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Request for Interest (RFI) and/or Request for Proposals (RFP) process will result in the identification of providers for services under categories 1, 2, and 3.

Category 4 funding will likely continue to be distributed to PHSKC via a Memorandum of Understanding (MOU).

It is not yet known whether category 5 funding will be distributed via MOU or RFP.

◊ *B. Contracting of Services*

See 3.A above.

◊ *C. Services Start date (s)*

Category 4 funding for PHSKC needle exchange social worker(s) will be implemented January 1, 2017.

King County work to define the various other aspects of this initiative will begin in fall 2016, once Task Force recommendations are released, with stakeholder engagement to occur in first quarter 2017 when a final funding level is known. RFI and RFP processes, as applicable, will be completed in second quarter 2017, with services to be launched via a staged approach between third quarter 2017 and first quarter 2018.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

MIDD 2 Initiative Title: Behavioral Health Urgent Care Walk-In Clinic **(NEW)**

MIDD 2 Number: CD-9

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "reduce the number, length, and frequency of behavioral health crisis events."

In communities where Behavioral Health Urgent Care Walk-In Clinics (BHUCCs) exist, people have rapid access to behavioral health services and supports, including peer specialists, to avert the need for more intensive crisis response by law enforcement, involuntary detention authorities, EDs, and inpatient hospitals. BHUCCs are available to intervene earlier, and to offer alternatives that prevent future destabilization. They promote hope and recovery, and offer skills to promote resilience. BHUCCs are an innovative system improvement and operate in coordination with all other components of a community's continuum of crisis services.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The King County BHUCC[1] is envisioned to serve adults who are experiencing a behavioral health crisis and in need of immediate assistance. The Clinic would be as centrally located as possible and accessible via public transportation. Individuals may self-refer by coming directly to the Clinic during established business hours including evenings. Other referral avenues may be developed. No appointments would be necessary.

As funding permits, services available at the King County BHUCC may include:

- Help with coping skills and crisis resolution planning;
- Support from peer recovery specialists who bring hope to others on their recovery journeys;
- Access to crisis psychiatry as necessary;
- Crisis stabilization services, as needed, for up to 30 days;
- Intake/referral for crisis residential services;
- Substance use disorder screening and referral;
- Family education and support;
- Referral to community services for needs beyond the immediate crisis;
- Coordination of care with an individual's current providers, as permitted by the client; and

[1] The King County Behavioral Health Urgent Care Clinic (BHUCC) for adults experiencing behavioral health crises will be closely modeled after the Mental Health Crisis Alliance's Urgent Care Clinic, which has been in operation in St. Paul, Minnesota for over four years (http://mentalhealthcrisisalliance.org).

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

- Crisis phone support

Services are voluntary and meant to be short-term.

◊ *B. Goals*

The goals of the King County BHUCC are to offer urgent care services to individuals experiencing a behavioral crisis to help them avoid involuntary detention, hospital emergency department (ED) visits, psychiatric inpatient stays, or involvement with law enforcement.

◊ *C. Expected Numbers of Individuals Served*

It is not yet known how many individuals may be served by this program, as the BHUCC's service scope is scaled to available funding.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to community providers, potentially in tandem with Next Day Appointment services as described further below. County staff will provide program management and oversight.

2. Spending Plan

The spending plan outlined here is limited to the pilot funding level. As such, implementation may include only some of the detailed program elements listed above. The timing and/or amounts of some expenditures shown below may depend on when and how the clinic is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Urgent Care Walk-In Clinic (CD-9)

Dates	Activity	Funding
2017 only	Urgent Care Walk-In Clinic capital investment, startup costs, program design, siting, and public awareness	$250,000
2017 Annual Expenditure		**$250,000**
2018 Annual Expenditure	Urgent Care Walk-In Clinic operations and services	$256,500
2018 Annual Expenditure		**$256,500**
Biennial Expenditure		**$506,500**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposals (RFP) process hosted by King County BHRD will result in the selection of one or more Behavioral Health Urgent Care Walk-In pilot provider(s). Procurement for this initiative may be paired with Next Day Appointments, a closely related part of the crisis continuum that is also funded in part by MIDD.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning for this initiative will occur primarily in second quarter 2017, to align plans with final funding levels. Providers will be identified via the RFP process in third quarter 2017, with services to begin after a site is identified, secured, and readied, and staff are in place to implement the program model.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

MIDD 2 Initiative Title: Family Interventions Restorative Services (FIRS) **(NEW)**

MIDD 2 Number: CD-13

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

When law enforcement has probable cause of domestic violence in a home involving a youth, they must make an arrest if the suspected perpetrator is 16 years of age or older. (This state law is slated to change on July 1, 2016 so that parents can determine if the youth should be detained.) Arrested youth are then transported to the King County Youth Service Center and booked into detention. Younger youth may be transported to Spruce Street Inn.

With the FIRS Program, eligible youth involved in a domestic violence situation may avoid detention and have the opportunity to engage in a range of services. Youth are provided a place to stay in a 24/7 non-secure facility run by a contracted community services provider. Youth meet with a specialized FIRS Juvenile Probation Officer (JPC) who provides an assessment, designs a FIRS Agreement, and assigns youth to appropriate services, including Step-Up, evidence-based therapy, or the 180 Program. Youth may also agree to complete community service or engage with other services. In addition to enhancing access to existing services, FIRS expands the capacity of Step-Up, a "nationally recognized adolescent family violence intervention program designed to address youth violence toward family members" run by the King County Department of Judicial Administration (DJA). Step-Up provides safety plans for all FIRS families. The Step-Up curriculum provides 20 sessions of group counseling for parents and youth, which will be provided if FIRS screeners determine Step-Up is the appropriate treatment.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Family Intervention and Restorative Services (FIRS) program is an alternative to court involvement that provides services for King County youth who are violent towards a family member (often their mother). The initial King County Superior Court pilot of the FIRS program is currently active with temporary support from the City of Seattle and MIDD fund balance funding. The concept includes two components:

1. A non-detention 24/7 Respite and Reception Center (FIRS Center) staffed by a contract community services organization
2. Improved access to evidence-based and best practices interventions for families, including expansion of the Step-Up Program

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

◊ *B. Goals*

Goals for this initiative include:

- Improve prompt access to services for families experiencing youth domestic violence;
- Reduce detention and filings; and
- Reduce future domestic violence and other criminal incidents.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected serve more than 300 individuals annually-though figures may be adjusted due to the impact of the change in state law.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- reduced substance use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary incarceration
- reduced substance use
- improved wellness and social relationships
- reduced behavioral health risk factors
- increased access to culturally appropriate recovery services

◊ *E. Provided by: Both County and Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Interventions Restorative Services (CD-13)

2. Spending Plan

Year	Activity	Amount
2017	24/7 non-secure facility for King County youth who are violent towards a family member and evidence-based and best practices interventions for families continue.	$ 1,087,688
2017 Annual Expenditure		**$ 1,087,688**
2018	24/7 non-secure facility for King County youth who are violent towards a family member and evidence-based and best practices interventions for families continue.	$ 1,115,967
2018 Annual Expenditure		**$ 1,115,967**
Biennial Expenditure		**$ 2,203,655**

NOTE: This spending plan assumes $500,000 will be contributed by the City of Seattle to support 2017-18 FIRS expenditures totaling $2.7 million. The City's actual contribution will be finalized during their budget process, with a final budget expected to be adopted in November 2016.

3. Implementation Schedule

◊ *A. Procurement of Providers*

The initial King County Superior Court pilot of the FIRS program is currently active with temporary support from the City of Seattle and MIDD fund balance funding. An RFP may be issued for expansion.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

MIDD 2 Initiative Title: Involuntary Treatment Triage **(NEW)**

MIDD 2 Number: CD-14

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This funding will enable Harborview Medical Center (HMC) to provide local triage evaluations for individuals with severe and persistent mental illness who have been charged with a serious misdemeanor offense and are found not competent to assist in their own defense and not able to be restored to competency to stand trial.

This will enable Designated Mental Health Professionals (DMHPs), dispatched from King County Crisis and Commitment Services (CCS), who currently provide these evaluations, to respond more efficiently to a significant volume of initial referrals for involuntary treatment evaluation services under RCW 71.05 (the civil Involuntary Treatment Act). This triage project also ensures full compliance with the process outlined in RCW 10.77, as HMC can evaluate each person for a 90-day civil commitment, unlike DMHPs who may only evaluate for an initial 72-hour detention.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The HMC evaluator (who is a licensed clinical social worker) receives the court order to evaluate the person in jail within a 72-hour window.

If the person is deemed to not meet the threshold for civil commitment, the HMC evaluator develops a safe plan for release in coordination with outside providers and release planners, and petitions the judge for release of the person to the community.

If the person is determined to meet the legal threshold for civil commitment under Chapter 71.05 RCW (the Involuntary Treatment Act),[1] the evaluator (along with a provider) will file a petition for a 90-day more restrictive order. In coordination with the County and local Evaluation and Treatment (E&T) facilities, the person is placed in the appropriate local E&T for inpatient psychiatric treatment.

[1] Mental Illness and Involuntary Treatment Act statute: http://app.leg.wa.gov/RCW/default.aspx?cite=71.05.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

◊ *B. Goals*

This initiative will ensure that incarcerated individuals with mental illness who may not be competent and not restorable receive the appropriate level of care locally. Specifically, if these individuals do not require hospitalization, they will be connected with appropriate outpatient services to address their primary and mental healthcare needs. This initiative provides a more robust continuum and coordination of care with a more thorough assessment of the individuals' needs and strong linkage to services either from jail or once discharged from the E&T. By keeping individuals in local treatment facilities (vs. WSH) for the initial treatment, there is a decrease in the number of patients being placed on long term court orders and in turn a decrease in placements to WSH. Lastly, this triage project seeks to avoid the unnecessary use of emergency departments, by providing the initial evaluation in the jail.

◊ *C. Expected Numbers of Individuals Served*

Based on the unfunded RCW 10.77 evaluation volume currently handled by King County's DMHPs, it is estimated that between 200 and 250 individuals per year may receive evaluations through this program once funded. In coordination with court partners, efforts will also be made to reduce the number of evaluations that are needed.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

All evaluation services offered under this initiative will be contracted to current 10.77 Triage Project partner Harborview Medical Center.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Involuntary Treatment Triage (CD-14)

2. Spending Plan

This spending plan would create the capacity to provide 200 to 250 evaluations per year.

Year	Activity	Amount
2017	Competency triage evaluation services	$150,000
2017 Annual Expenditure		**$150,000**
2018	Competency triage evaluation services	$153,900
2018 Annual Expenditure		**$153,900**
Biennial Expenditure		**$303,900**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The service would most appropriately be procured from existing triage project partner Harborview Medical Center, which has been performing evaluations via this workgroup since 2013 to the degree such services have been feasible without dedicated funding.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning and measures for this initiative will occur primarily in first quarter 2017, to align plans with final funding levels. MIDD-funded services could begin as soon as second quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

MIDD 2 Initiative Title: Youth Behavioral Health Alternatives to Secure Detention **(NEW)**

MIDD 2 Number: CD-16

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goals of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This program is envisioned to provide community based treatment beds for youth who are involved in the justice system, prioritizing those youth who may be held in detention. These treatment beds address a serious gap in the current behavioral health system. Program treatment services will be offered to stabilize the youth and family, with the intention of diversion from further justice system involvement related to behavioral health conditions.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This program must be developed collaboratively with stakeholders and communities. The final program design and services may include differ and/or contain elements than what is reflected in this initial description of the initiative.

It is currently envisioned that this initiative would create a specialized community placement alternative to secure detention beds for children and youth who are detained in juvenile detention and who have mental health, substance use disorder (SUD) related or other behavioral health needs. The youth utilizing the beds would be supported with a full continuum of therapeutic behavioral health services that includes one on one therapy, family counseling, group counseling, case aide support, vocational training, behavioral support, social skills training, and medication management. It also includes all services included in the Medicaid continuum of care for youth (whatever is medically necessary to treat or ameliorate the condition).

In addition, this proposal would include a complementary less restrictive program where the family would be able to provide the housing for the child/youth as long as the counseling, assessment, case aide support and other interventions would be available to support the family.

◊ *B. Goals*

The goal of this initiative is to provide youth with behavioral health treatment needs in juvenile detention with community based treatment beds in order to safely return youth to their homes with comprehensive supports to the family to prevent further involvement with the juvenile justice system.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

◊ *C. Expected Numbers of Individuals Served*

Depending on the length of stay 16 to 32 youth will be served per year.

◊ *D. Draft Outcomes and Performance Measures- outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- improved daily functioning
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary incarceration
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduced behavioral health risk factors
- Increased connection to community services

◊ *E. Provided by: Contractor(s)*

2. Spending Plan

As noted earlier in the Service Improvement Plan, the county recognizes that it is not always possible to begin spending on all MIDD initiatives as soon as budget authority is granted. This initiative is among a group of programs expected to be implemented via a staged approach, to allow for thoughtful planning and procurement processes. This is reflected in the spending plan below via different expenditure amounts for the first and second years of the 2017-18 biennium.

Year	Activity	Amount
2017	Complete planning, develop and issue Request for Statement of Interest/Request for Proposal, select recipients, complete contracts, and services begin.	$ 250,000
2017 Annual Expenditure		**$250,000**
2018	Alternatives to Secure Detention programs, services, and operations	$1,026,000
2018 Annual Expenditure		**$1,026,000**
Biennial Expenditure		**$ 1,276,000**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Youth Behavioral Health Alternatives to Secure Detention (CD-16)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Planning for this new initiative is expected to be completed during the first and second quarter of 2017. The RFP will be released in the third quarter 2017.

◊ *B. Contracting of Services*

The contract is expected to begin during the third quarter 2017.

◊ *C. Services Start date (s)*

The anticipated start date will likely be in the third quarter 2017, depending on timeline for planning and procuring a contractor.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Young Adult Crisis Facility (CD-17)

MIDD 2 Initiative Title: Young Adult Crisis Facility **(NEW)**

MIDD 2 Number: CD-17

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "Reduce the number, length, and frequency of behavioral health crisis events".

The young adult homeless system has seen a dramatic increase in transition aged youth with serious behavioral health needs. In recent months, there have been two suicides, and several attempted suicides by young, homeless people who are experiencing their first psychotic break. There have been multiple other incidents of high needs young people in homeless housing or shelter situations that were not intended or suited to serve youth with these high needs.

This program will provide community based treatment beds to stabilize these transition-aged youth, or to house youth in crisis on a transitional basis, including those who are exiting from involuntary commitment facilities. Initially, the focus will be on young people who are in homeless housing or shelter situations, but will be expanded to be available to a broader group of transitioned-aged youth to avert more significant crises. Although transition-aged youth are legally considered adults, existing adult facilities are not developmentally appropriate to serve this age group. The treatment beds supported by this funding will address a serious gap in the current behavioral health and housing systems for these transition aged youth. Program treatment services will be offered to stabilize individuals and mitigate further trauma for an already vulnerable population.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This program must be developed collaboratively with stakeholders and communities. The final program design and services may include differ and/or contain elements than what is reflected in this initial description of the initiative.

The model will provide temporary housing for young people who are currently homeless and need an appropriate placement, with a focus on 24/7 services that have the capacity to address suicidal ideation and co-occurring disorders. Lengths of stay are anticipated to be between 3 and 18 months, with most young people staying about a year. The young adult crisis facility will focus on mental health services, medication management, and identifying and treating substance use disorders. It would have capacity for 12-15 young people, using existing facilities if possible that could be repurposed or consolidating certain providers' existing homeless youth programs to create space.

◊ *B. Goals*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Young Adult Crisis Facility (CD-17)

The goal of this initiative is to provide youth in crisis with behavioral health treatment needs with community based treatment beds that reduce crisis events and emergency system contacts.

◊ *C. Expected Numbers of Individuals Served*

Depending on the length of stay, 16 to 32 youth will be served per year.

◊ *D. Draft Outcomes and Performance Measures- outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved emotional health
- improved daily functioning
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services

◊ *E. Provided by: Contractor(s)*

2. Spending Plan

Year	Activity	Amount
2017	Complete site identification, acquisition and any necessary rehabilitation. Complete program design and contracting process. Begin providing services.	$ 705,825
2017 Annual Expenditure		**$705,825**
2018	Provide programs, services, and operations	$724,175
2018 Annual Expenditure		**$724,175**
Biennial Expenditure		**$ 1,430,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

If approved, planning for this new initiative is expected to occur during the fourth quarter of 2016.

◊ *B. Contracting of Services*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Young Adult Crisis Facility (CD-17)

The contract is expected to begin during the first quarter 2017.

◊ *C. Services Start date (s)*

The anticipated start date for the facility and its core services to be operational is targeted for the first quarter 2017, depending on how quickly planning, procurement, site identification and rehabilitation can occur.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

MIDD 2 Initiative Title: Zero Suicide Initiative Pilot **(NEW)**

MIDD 2 Number: PRI-6

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "reduce the number, length, and frequency of behavioral health crisis events."

Zero Suicide[1] is built on the foundational understanding that suicide deaths are preventable. The Zero Suicide Initiative is the beginning of a comprehensive suicide prevention strategy/plan for King County, and will be a new approach for suicide prevention for the region.

Suicide is a major public health problem. In Washington State, suicide is the eighth leading cause of death overall and the second leading cause of death among young people ages 15-35. In King County, there are roughly 250 deaths by suicide every year. For every suicide, it is estimated that 25 attempts are made, some requiring expensive emergency room and hospital visits. For every suicide death, it is estimated that six friends and family members of the deceased will struggle with this particularly devastating and complicated form of grief for the rest of their lives.[2]

Zero Suicide will involve a multi-stage project where the public health and behavioral health systems serving adults with serious mental illnesses will be supported in adopting a specific set of strategies, tools and training to transform these systems to eliminate patient safety failures and to close gaps in depression and suicide care. Zero Suicide is a key concept in healthcare that is contained in the 2012 National Strategy for Suicide Prevention.[3]

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Zero Suicide Initiative is designed envisioning three phases as funding permits:

- Phase 1: King County behavioral health and health care system – provider and county system (DCHS and Public Health) and trainings/development;
- Phase 2: Hospital and Healthcare systems participating in Screening, Brief Intervention and Referral to Treatment (SBIRT), to the degree funding permits;
- Phase 3: Remaining Hospital, Behavioral Health and Healthcare systems, to the degree funding permits.

Additional community trainings may be included as funding allows.

Zero Suicide approach implementation includes the following components:

[1] http://zerosuicide.sprc.org/about
[2] http://www.doh.wa.gov/Portals/1/Documents/5500/IV-SUI2013.pdf
[3] http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

1. Identify sources of data that can be improved and analyzed to assess the extent of suicidal behavior occurring within King County's public behavioral health care system and primary care system and, to put into place a reporting system on suicidal behavior.
2. Analyze provider contracts to recommend changes to incentivize Zero Suicide approaches within contracted agencies.
3. Determine a Zero Suicide implementation provider agency and work to determine and select the first cohort of the provider agencies, who are determined to be ready based on a base-line assessment, to begin work via Zero Suicide grants.
4. Provide intensive training and technical assistance to the first cohort of contracted provider agencies to implement a Zero Suicide approach.
5. Establish a Zero Suicide learning collaborative comprised of implementation teams from each agency. Each team will develop a strategic plan for their work over the next two years and a cross-agency learning collaborative will be established.
6. Provide technical assistance to each agency. Many training opportunities for agency staff will be provided to the learning collaborative of participating contracted agencies over the two-year period.
7. Continued rollout to additional cohorts of contracted providers annually, and then expand to phase 2 and 3 sites as funding permits.

The Zero Suicide Initiative may also include many of the following components. Prioritization of these components will be determined in consultation with suicide prevention partners and other stakeholders:

8. Lethal means restriction training, including exploration of options for means restrictions programming implementation (e.g. implementation of recommendations from the Washington State Safer Homes Task Force);
9. Suicide attempt follow up care program when released from Emergency Department or inpatient settings (including development of a model-based emerging best practice);
10. Universal and proper implementation of suicide risk screening at Emergency Departments (coupled with brief interventions, discharge planning and follow up); and
11. Programming for families/friends who have lost someone to suicide.
12. Universal gatekeeper suicide prevention training.
13. A social marketing/media outreach plan.
14. Partnership with Mental Health First Aid training for stigma reduction.

Stakeholders and partners will be consulted to design and implement the pilot.

◊ *B. Goals*

Through this initiative's training and technical assistance efforts, the following seven elements of suicide prevention care for health and behavioral systems would gradually be adopted by behavioral health and physical health care providers, and become a new best practice standard for publicly funded care in King County[4].

[4] Adapted from the Zero Suicide Toolkit at http://zerosuicide.sprc.org/toolkit

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

- Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
- Train – Develop a competent, confident, and caring workforce. Train all staff commensurate with their potential role in suicide prevention.
- Identify – Systematically identify and assess (screening and assessment) suicide risk among people receiving care.
- Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet their needs. Include collaborative safety planning and restriction of lethal means.
- Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- Transition – Provide continuous contact and support, especially after acute care. Utilize peers who are in behavioral health recovery who also experience suicidal behaviors to help support those who are at-risk.
- Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Additional goals include effective implementation of Suicide Prevention components across King County.

◊ *C. Expected Numbers of Individuals Served*

Each annual provider cohort is expected to include several agencies, each of which will identify implementation teams to pioneer Zero Suicide approaches within their organizations. The number of potential clients who could benefit from the resulting enhanced services provided by these teams is indeterminate and likely to vary by agency. Additional individuals reached by suicide prevention trainings will vary depending on funding allocation.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital, and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved perception of health and behavioral health issues and disorders

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Zero Suicide Initiative Pilot (PRI-6)

The training and services will be contracted to suicide prevention experts and the pilot grants will be contracted to provider agencies. County staff will provide program management and oversight.

2. Spending Plan

This spending plan reflects the pilot funding level. Some activities may be staged later or may not occur.

Year	Activity	Amount
2017	Develop & implement Zero Suicide pilot; begin training and learning collaborative cohorts Implement technical assistance; community engagement and monitoring activities	$500,000
2017 Annual Expenditure		**$500,000**
2018	Continue implementation and services	$513,000
2018 Annual Expenditure		**$513,000**
Biennial Expenditure		**$1,013,000**

* The relative emphasis of the various program elements among components 8-14 during the pilot, will be determined in consultation with suicide prevention partners during the last quarter of 2016 and early 2017 in accordance with the final funding level.

The proposed MIDD 2 allocation for Zero Suicide is a pilot award amount; the initiative may be scaled, and phases reduced or increased according to available funding. Rollout to hospital settings via Phase 2 and 3 may be impacted due to available funding, or scaled in accordance with partner input.

3. Implementation Schedule

◊ *A. Procurement of Providers*

Request for Proposals (RFP) will be conducted. Request for Qualifications (RFQ) and/or Request for Information (RFI) may be conducted.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

A request for interest (RFI) for Zero Suicide pilot implementation will occur by second quarter 2017. Services & training will occur in the third quarter.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

MIDD 2 Initiative Title: Mental Health First Aid **(NEW)**

MIDD 2 Number: PRI-7

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Per year, about one in five Americans experiences a mental illness[1]. Many people are reluctant to seek help or might not know where to turn for care. Many people in society remain ignorant or fearful about the signs and symptoms of mental illnesses,[2] although society has a role through responsible community members to help people experiencing these illnesses. The symptoms of mental illness can be difficult to detect — even when friends and family of someone who appears to be developing a mental illness can tell that something is amiss, they may not know how to intervene or direct the person to proper treatment – which means that those in need of mental health services do not get them until they require emergency medical intervention. If the greater community has a better understanding of psychiatric conditions, then more people will feel both competent and equipped to help people in their communities. If mental illness is destigmatized, more people will feel comfortable asking for and receiving help earlier in the process. This will improve the overall health of the population and promote wellness in the region.

Mental Health First Aid is an 8-hour training course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Mental Health First Aid would be available to a variety of audiences, including: health and human services workers; employers and business leaders; faith community leaders; college and university staff and faculty; law enforcement and public safety officials; veterans and family members; persons with mental illness-substance use disorders and their families; and other caring citizens. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand, and respond to signs of mental illness. It also helps reduce stigma related to behavioral health conditions.

Just as CPR training helps a person with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a person assist someone experiencing a mental health crisis such as contemplating suicide. In both situations, the goal is to help support an individual *until appropriate professional* help arrives. Mental Health First Aid trainees learn a single 5-step strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying appropriate professional help and other supports. Participants are also introduced to risk factors and warning signs for mental health or substance use problems, engage in experiential activities that build understanding of the impact of illness on

[1] Any Mental Illness (AMI) Among Adults. (n.d.). Retrieved December 11, 2015, from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml
[2] Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health. 1999;89(9):1328-33.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

individuals and families, and learn about evidence-supported treatment and self-help strategies. Mental Health First Aid is intended for all people and organizations that make up the fabric of a community.[3]

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Mental Health First Aid training initiative service components will include a combination of direct Mental Health First Aid trainings and "train the trainer" courses, with the numbers of each type of training to be determined by community capacity and interest.

The Mental Health First Aid course runs eight hours and may be offered in a variety of formats (Adult & Youth). Most often, it is provided in one day, or in two 4-hour sessions spaced over a short period of time. In addition, offering 5-day train the trainer courses in Mental Health First Aid, thereby increasing training capacity within the County, will also increase the likelihood that people in a number of different communities will learn about Mental Health First Aid.

The specifics of the service components will be created in partnership with individuals in King County currently trained in Mental Health First Aid and others who are interested in becoming Mental Health First Aid trainers, in consultation with the Mental Health First Aid training developers. The service components will be coordinated by King County DCHS' Behavioral Health and Recovery Division, and the specifics of service delivery and implementation will be based on community input, readiness, and demand. At the beginning stages of implementation, currently trained facilitators can conduct a certain number of trainings in their geographic areas and collect required evaluation data.

In addition, current King County providers will be consulted about their willingness and capacity to have staff trained as facilitators. Other entities such as school districts and law enforcement agencies will be surveyed about their interest in hosting or attending these trainings.

◊ *B. Goals*

Having more people throughout the county who become knowledgeable about psychiatric conditions will ultimately reduce stigma for individuals with these conditions. Giving more people in the community the basic tools to recognize and respond to emergent mental health crises will increase the likelihood of useful interventions from a person' s natural support system during a behavioral health crisis.

◊ *C. Expected Numbers of Individuals Served*

Given current funding levels and national estimates of average costs of Mental Health First Aid training per person, as many as 2,000 people per year could be served if only direct

[3] Mental Health First Aid Frequently Asked Questions. (n.d.). Retrieved December 11, 2015, from http://www.mentalhealthfirstaid.org/cs/faq/

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

trainings are offered, although this number may vary depending on the focus and target population. Costs are variable, depending on the number of individuals trained, and the numbers of trainings offered.

The potential reach of the MIDD investment could be broadened through the strategic use of "train the trainer" certification courses that could create lasting impact beyond the MIDD funding. However, the higher up-front cost of these trainings[4] would decrease the total number of trainees funded directly by MIDD.

The relative number of direct trainings versus certification courses that would be offered by through this MIDD initiative will be determined via the community-informed design process outlined above.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved perception of health and behavioral health issues and disorders

◊ *E. Provided by: Contractor*

Contracting for implementation of Mental Health First Aid training calendar and trainings will be explored in consultation with partners. Most or all trainings are expected to be provided by contractors.

2. Spending Plan

Year	Activity	Amount
2017	Mental Health First Aid trainings to communities and certification courses	$200,000
2017 Annual Expenditure		**$200,000**
2018	Mental Health First Aid trainings to communities and certification courses	$205,200
2018 Annual Expenditure		**$205,200**
Biennial Expenditure		**$405,200**

3. Implementation Schedule

[4] $1,850 to $2,000 per person for a 5-day training. http://www.mentalhealthfirstaid.org/cs/become-an-instructor/certification-process/

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Mental Health First Aid (PRI-7)

◊ *A. Procurement of Providers*

A Request for Qualifications (RFQ) process hosted by King County BHRD will result in the selection of a provider to coordinate the Mental Health First Aid training calendar and Mental Health First Aid training coordinator(s).

A Request for Information (RFI) process hosted by King County BHRD will result in the identification of provider agencies and individuals who want to be trained as facilitators in Mental Health First Aid.

◊ *B. Contracting of Services*

King County BHRD, through the RFQ, will contract with one entity to coordinate the Mental Health First Aid training calendar county-wide; explore with partners setting up a regional system within training contracts in each region to ensure training capacity and saturation; and BHRD offering some trainings itself.

The outreach process and plan development will include finalizing the approach for training implementation and design. BHRD staff will work with selected provider agency for the training calendar coordination and identified training coordinator(s) to create a regional training plan that ensures distribution and training across King County.

◊ *C. Services Start date (s)*

With resources dedicated to up-front community outreach, the projected start for trainings is second quarter 2017, with facilitators already trained in Mental Health First Aid to begin trainings as soon as monthly once the RFQ/RFI and contracting processes are complete. Full-scale implementation could be under way by third quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

MIDD 2 Initiative Title: Rapid Rehousing Oxford House Model **(NEW)**

MIDD 2 Number: RR-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "explicit linkage with, and furthering the work of, other King County and community initiatives."

The rapid rehousing Oxford House voucher program is an immediate solution for affordable, clean and sober housing option for individuals in recovery who are homeless or at risk of homelessness. The program supports the goals of the All Home Strategic Plan, Behavioral Heath Integration, Health and Human Services Transformation and the Veterans and Human Service Levy.

This program will prevent and decrease homelessness and improve the self-reliance and increase employment among program participants. This program would support the King County's vision for health care, reflecting the triple aim of improved patient care experience, improved health, and reduced cost of health care. As more individuals with substance use disorders receive treatment due to health care reform and system improvement, there will be a greater need for next step housing to bridge the gap between residential treatment and fully independent living.

The initiative pairs a proven residential program with rapid rehousing, a best practice for getting people off the street and out of shelters, while also preventing homelessness.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Specifically, the initiative will provide vouchers for clean and sober housing for individuals in recovery.

This program will serve adults who are newly in recovery – typically having recently completed a drug and alcohol treatment program – and who would be homeless without this assistance. Individuals will receive rental assistance for approximately three months while they secure employment.

◊ *B. Goals*

This initiative creates access to rapid rehousing rental support for individuals for whom such recovery support would enable them to regain stability, but may not have chronic conditions that would qualify them for housing assistance through other traditional sources.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

◊ *C. Expected Numbers of Individuals Served*

It is expected that about 333 people in recovery per year will receive vouchers for Oxford housing at the recommended funding level.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- housing stability
- reduced use of jails, hospitals, and emergency departments
- reduced substance use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced behavioral health risk factors
- improved wellness and social relationships
- increased housing stability
- reduced hospitalization, emergency department use, and incarceration
- reduced use of drugs and alcohol

◊ *E. Provided by: Contractor*

All vouchers offered under this initiative will be distributed to community substance use disorders (SUD) treatment providers and managed by existing staff within King County DCHS' Community Services Division's rapid rehousing program, in coordination with King County BHRD.

2. Spending Plan

Year	Activity	Amount
2017	Rapid rehousing vouchers for use in Oxford House settings	$500,000
2017 Annual Expenditure		**$500,000**
2018	Rapid rehousing vouchers for use in Oxford House settings	$513,000
2018 Annual Expenditure		**$513,000**
Biennial Expenditure		**$1,013,000**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Rapid Rehousing Oxford House Model (RR-4)

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Qualifications (RFQ) process will result in the selection of participating qualified SUD treatment agencies who will receive these vouchers for their clients to access.

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Service planning and outcome measurement determination for this initiative will occur primarily in second quarter 2017. Providers will be identified via the RFQ process in second quarter 2017, with services to begin soon thereafter.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

MIDD 2 Initiative Title: Behavioral Health Risk Assessment Tool for Adult Detention **(NEW)**

MIDD 2 Number: RR-7

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Individuals who experience behavioral health issues have increased rates of incarceration.[1] Some jurisdictions in the U.S. have been able to reduce rates of recidivism for individuals who experience behavioral health issues through the complete application of evidence-based practices with fidelity, of which risk and need assessment is foundational.[2] The implementation of the comprehensive risk and needs assessment of incarcerated individuals in King County will guide case management and appropriate services placement, and will position King County Department of Adult and Juvenile Detention (DAJD) and the King County Community Corrections Division (CCD) to partner with providers in an effort to reduce recidivism consistent with national best practices.

The first step in this work is the development and implementation of a validated needs assessment platform in King County.[3] At present, a King county cross-system criminal justice and behavioral health work team[4] is working with the Washington State University Criminal Justice Institute to develop a comprehensive jurisdictional needs assessment tool for King County that, when applied countywide, will not only identify the likelihood of re-offense but will specifically categorize the criminogenic needs of the individual.

This initiative supports implementation of a behavioral health risk assessment instrument in King County's adult correctional facilities.

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[1] Steadman, HJ, Osher, FC, Robbins, PC, Case, B, Samuels S. "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services,* 60, 6, (2009): 761-765.
[2] https://csgjusticecenter.org/nrrc/publications/states-report-reductions-in-recidivism-2/ and https://csgjusticecenter.org/reentry/publications/reducing-recidivism-states-deliver-results/. Accessed 12/31/15.
[3] King County Recidivism Reduction and Reentry Strategic Planning, Progress Report I, Submitted by Patty Noble-Desy (July 2015). Available at http://aqua.kingcounty.gov/Council/agendas/LJEM/20151027-LJEM-packet.pdf. Accessed 12/29/15.
[4] King County (KC) Performance, Strategy and Budget, KC Dept. of Adult and Juvenile Detention, KC Prosecuting Attorney's Office, KC Dept. of Public Defense, KC Behavioral Health and Recovery Division, KC Jail Health Services, KC Superior Court, KC Drug Diversion Court, KC Sheriff's Office, KC Council Staff, KC Executive's Office, City of Seattle, Northwest Justice, Public, Defender Assoc., WA State Dept. of Corrections, University of Washington, Antioch University

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

1. Program Description

◊ *A. Service Components/Design (Brief)*

The needs assessment will be administered to a subpopulation of individuals who are:

- incarcerated in DAJD adult facilities for at least four days and no more than 180 days;
- who are not subject to Washington State Department of Corrections supervision;
- who will not be transferred to another jail or jurisdiction; and
- who will be releasing to King County.

Following completion of the needs assessment, those who are identified as likely having a substance use[5] or serious mental health disorder[6] will be invited to participate in the development of a Recidivism Reduction and Community Reentry Plan using Screening, Brief Intervention, and Referral to Treatment (SBIRT)[7] interviewing, and an evidence-based Risk Need Responsivity Simulation Tool[8] developed by George Mason University. This work considers all relevant individual needs information while factoring local recidivism drivers and develops an individualized community reentry plan designed to measure and reduce recidivism factors.

With signed permission from the individual and after conferring with defense counsel, information obtained from the needs assessment will be shared with any potential service providers in the community or release planning staff in the jail. In some cases, this information may be shared with programs that operate inside the jail.[9]

With a plan developed, referral sources will be better able to direct participants to viable community-based programs that are prepared to address their behavioral health risks and needs and will document their admission to appropriate programs in the community. In the event of a return to custody in King County, the client needs profile and the associated Community Reentry Plan will be reviewed to determine what did not work well and what can be done differently to achieve a positive outcome.

◊ *B. Goals*

As King County begins to identify and address individuals' behavioral health risks and criminogenic needs consistent with best practices, a reduction in the return to custody among adult individuals with SUDs and/or serious mental illness is expected. This new concept addresses a currently unmet need and represents a critical and necessary initial

[5] http://www.casacolumbia.org/newsroom/press-releases/2010-behind-bars-II. Accessed 12/29/15.
[6] Aufderheide, Dean H. and Brown, Patrick H. "Crisis in Corrections: The Mentally Ill in America's Prison." Corrections Today, Volume 67, Issue 1, (February 2005): 30 to 33. Cited from http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/ on 12/31/15.
[7] http://www.samhsa.gov/sbirt. Accessed 12/29/15.
[8] https://www.gmuace.org/research_rnr.html. Accessed 12/29/15.
[9] The Prosecuting Attorney's Office and the Department of Public Defense will be parties to a Memorandum of Understanding that assures the purpose and product of this work to be limited to the collection of data for program and resources planning and for use by the participant and any potential service providers they may choose to release their information to, with written and signed documentation, to assist with reentry and ongoing services in the community.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

component in the application of alternatives that can result in overall reduced County expenses. It includes better meeting the behavioral health needs of the participants by providing them a specific and unique plan of action designed to address their behavioral health needs and decrease their likelihood of further criminal justice involvement.

◊ *C. Expected Numbers of Individuals Served*

Approximately 2,460 individuals per year are expected to receive comprehensive actuarial needs assessments after jail booking, as well as referral to needed services upon release.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduced unnecessary incarceration

◊ *E. Provided by: County*

The services planned under this initiative would be provided by County staff within the intake services unit known as Personal Recognizance Investigators (PR screeners), housed within the jail under the leadership of the Community Corrections Division of the Department of Adult and Juvenile Detention (DAJD).

2. Spending Plan

Year	Activity	Amount
2017	Intake services staff to implement behavioral health risk assessment; materials and training	$470,900
2017 Annual Expenditure		**$470,900**
2018	Intake services staff to implement behavioral health risk assessment; materials and training	$483,143
2018 Annual Expenditure		**$483,143**
Biennial Expenditure		**$954,043**

3. Implementation Schedule

◊ *A. Procurement of Providers*

No procurement would be necessary, as this service would be provided by County staff.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Risk Assessment Tool for Adult Detention (RR-7)

◊ *B. Contracting of Services*

See 1.E. and 3.A. above.

◊ *C. Services Start date (s)*

Funding will be distributed to DAJD immediately in first quarter 2017 as no procurement process is necessary. Hiring and training of intake section staff could extend into second quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

MIDD 2 Initiative Title: Recovery Café **(NEW)**

MIDD 2 Number: RR-9

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The nonprofit Recovery Café provides an alternative therapeutic supportive community for women and men traumatized by homelessness, addiction and other mental health challenges. Operating for over 10 years, Recovery Café has helped thousands of women and men find stability and support on their recovery journey.

MIDD 2's annual investment, in combination with operating and capital funding from other sources, would allow a second location in King County to be launched.

The alternative therapeutic model used at Recovery Café provides support, resources and a community of care along the entire continuum of a person's need for recovery assistance. In crisis, newer to recovery, in long-term recovery, after a relapse, during a difficult life change, or mental health transition, Recovery Café is a refuge of care and evidence-based addiction support.

Recovery Café provides a community in which women and men can stabilize in their mental/physical health, housing, relationships, and employment/volunteer service. This community helps women and men fulfill their potential and live meaningful lives. Recovery Café teaches people ways to manage their mental health, maintain sobriety, and build mutually supportive community.

Through its work, Recovery Café prevents individuals from potentially lethal crises, avoiding the need for emergency intervention to stabilize that person, and allowing mental health and addiction support professionals to focus on health maintenance and additional harm reduction.

Recovery Café has been recognized by Washington State and King County experts as an example of how a Recovery Oriented System of Care (ROSC) works.[1]

[1] ROSC is a fairly new approach that the Washington State Division of of Behavioral Health and Recovery and King County have embraced. A ROSC is a more effective approach for addressing substance use disorder (SUD) issues than traditional models, because it meets people where they are on the recovery continuum, engages them for a lifetime of managing their disease, focuses holistically on a person's needs, and empowers them to build a life that realizes their full potential. This person-centered system of care supports a person as they establish a healthy life and recognizes that everyone needs a meaningful sense of membership and belonging in community.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

1. Program Description

◊ *A. Service Components/Design (Brief)*

Recovery Café provides a safe, warm, beautiful, drug-and-alcohol-free space and loving community to anchor members – Recovery Café's most closely held participants – in the sustained recovery needed to gain and maintain access to housing, social and health services, healthy relationships, education and employment. Recovery Café's program is designed to help people maintain recovery, reduce relapse and fulfill their potential. Important elements of this work include:

- A healing milieu including free nutritious meals, activities, computer access, and individualized encouragement.
- Accountability groups called Recovery Circles, where members become known and get to know others.
- Peer-to-peer member empowerment, enrichment and involvement.
- The School of Recovery, an educational program available to members featuring classes that address the underlying causes of addiction, teach coping skills, develop knowledge, learn new skills and build the resources necessary to begin and maintain recovery from substance use disorders.
- Referral Services to help members navigate the complex social services system to gain and maintain housing, healthcare, mental health services, legal assistance, and a base of support including positive and consistent relationships with service providers.
- 12-step meetings held in a dedicated space.

Recovery Café's community support model has the flexibility to meet the needs of people at any stage of recovery from alcohol and substance addiction. Major elements of the program include behavioral interventions, motivational interviewing style, motivational incentives, psychoeducation including relapse prevention and skill building, and significant peer-to-peer support.

◊ *B. Goals*

Recovery Cafe services aim to meet the need for stabilizing community accountability for women and men suffering from the trauma of homelessness, addiction and/or other behavioral health challenges in King County.

The goal of MIDD 2's investment in Recovery Café is to seed the launch of a second café in King County beyond downtown Seattle, in partnership with other funds to be secured by Recovery Café, and to provide ongoing support for the operations of this additional site.

◊ *C. Expected Numbers of Individuals Served*

The MIDD investment could support services for 85 to 350 members at any one time – or 300 to 1,000 per year – depending on the amount of other funds that are leveraged. Services would begin in 2018.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced or eliminated substance use
- reduced jail, hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness self-management
- improved social relationships

◊ *E. Provided by: Contractor*

Recovery Café will provide this service via a contract with King County BHRD.

2. Spending Plan

The spending plan outlined here is limited to the MIDD funding level. As such, implementation scale and timing will be significantly affected by the degree to which other funds are leveraged for the second King County Recovery Café site. As a result, the timing and/or amounts of some expenditures shown below may depend on when and how the new location is successfully sited. Potential timeframe changes and/or revisions to these approaches should be expected.

Year	Activity	Amount
2017 only	Capital and/or startup funding for second Recovery Café site in King County	$348,717
2017 Annual Expenditure		**$348,717**
2018 Annual Expenditure	Operational funding for second King County Recovery Café site (site management and mental health coordination)	$357,783
2018 Annual Expenditure		**$357,783**
Biennial Expenditure		**$706,500**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Recovery Café (RR-9)

3. Implementation Schedule

◊ *A. Procurement of Providers*

No procurement process will be required.

◊ *B. Contracting of Services*

Funding will be disbursed to Recovery Café via a contract that will be specific to the launch of the second site.

◊ *C. Services Start date (s)*

As no procurement process is needed, funds could be disbursed as soon as January 2017. Services at the second Recovery Café site in King County will begin sometime in 2018, after other funding is secured; a site is identified, secured, and readied; and staff are in place to implement the program model.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

MIDD 2 Initiative Title: Peer Bridgers and Peer Support Pilot **(NEW)**

MIDD 2 Number: RR-11

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health conditions from costly interventions, such as jail, emergency rooms, and hospitals."

Specifically, through its two program components, the initiative provides:

- transition supports for adult individuals who have been hospitalized in inpatient psychiatric units by supporting peer bridger programs that have been shown to be effective in reducing hospital episodes and lengths of stay; reducing rehospitalization; and increasing Medicaid enrollment; and
- peer specialists strategically deployed to substance use disorder (SUD) service settings where peers' unique experiences and skills can have a significant impact on participants' ability to maintain recovery by supporting them to engage successfully with ongoing treatment services and other supports. These peer services are critical to diverting people from criminal justice and emergency medical settings.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The initiative includes two discrete but related components: MIDD support for the Peer Bridger programs at Navos Mental Health Solutions and Harborview Mental Health and Addiction Services, and a pilot to support the strategic use of peer services in settings serving individuals with elevated or emergent substance use needs and risks.

<u>Peer Bridger Component</u>

The Peer Bridger programs provide transition supports for adult individuals who have been hospitalized at the psychiatric inpatient units at Navos and Harborview.[1] Teams of certified peer specialists work in coordination with the inpatient treatment teams to identify individuals in need of this support, and to develop individualized plans to promote each person's successful transition to the community.

[1] The Peer Bridger Program was originally funded in the spring of 2013 by a grant from the State of Washington Attorney General's Office, Consumer Protection Division, from proceeds associated with a class action lawsuit. Those grant funds were exhausted in December 2015. MIDD fund balance dollars were provided to sustain the current program through 2016.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

Peer Bridgers work with individuals for up to 90 days after discharge. Participants are offered:

- concrete support to obtain personal identification documents, medical insurance benefits, housing, treatment services, medications, social supports, transportation, cell phones, and other basic necessities;
- one-to-one and group services during hospitalization;
- support for wellness self-management using evidence-based tools; and
- an authentic personal connection based on personal experience.

If this aspect of the initiative is expanded in future years, peer bridger services could expand to serve additional psychiatric units in King County's other evaluation and treatment facilities and/or community hospitals.

SUD Peer Support Component

SUD peers are people with lived experience who have initiated their recovery journey and are able and willing to assist others who are earlier in the recovery process. They can have a unique role in the provision of recovery support services including access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; and illness management. Peers can also play a key role in helping people engage successfully with formal SUD treatment. Peer support removes barriers to access and is invaluable throughout the continuum of care, prior to treatment, during treatment, and as after-care support.

Peer specialist staff will be deployed to serve in two stand-alone recovery community organizations (RCOs) that have been strong leaders in developing a peer to peer infrastructure in King County. At RCOs, peer positions build connections with recovering people, helping link them to community support and providing emotional assistance to their recovery journey.

Additional peer specialist staff will be deployed to unique location(s) where effective peer interventions are most likely to prevent, reduce, or shorten emergency system use. This may include such settings as the Dutch Shisler Sobering Center, the Public Health Seattle-King County (PHSKC) needle exchange, current or future detoxification facilities, and/or other environments where SUD peer staff can have an especially significant impact on criminal justice system involvement.

The anticipated expansion of the pilot in future years could establish peer services more broadly in SUD treatment agencies, including outpatient, withdrawal management, and residential settings, in accordance with a broader vision to expand peer support in SUD treatment. The remainder of this document describes expected SUD peer support services and expenditures at the pilot level only.

◊ *B. Goals*

Peer Bridger Component

The primary goal of the Peer Bridger Programs is to promote successful community tenure for the identified population. System goals include: reductions in King County

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

funded inpatient admissions, readmissions, and hospital days. The program prioritizes services for the most vulnerable of hospitalized individuals:

- people who are not insured and not enrolled in ongoing mental health services; and
- people who are insured and enrolled, but disengaged from their ongoing mental health provider and at high risk of re-hospitalization.

SUD Peer Support Component

The SUD peer support component in its current pilot phase will aim to deploy a small number of peers to assist individuals, with a goal of reducing their recurring use of emergency systems, including the criminal justice system. As would be the case if the pilot were expanded more broadly, these peers will work to facilitate effective linkage and engagement with ongoing treatment services in the recovery community, outpatient treatment services, withdrawal management, and/or residential settings.

◊ *C. Expected Numbers of Individuals Served*

Peer Bridger Component

The Peer Bridger programs at Navos and Harborview currently together serve approximately 200 individuals per year.

SUD Peer Support Component

The number of individuals to be served by the SUD peer support pilot component will depend on the service setting(s) and role(s) selected.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

Both components of this initiative contribute to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced substance use
- reduced jail, hospital, and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced substance use
- reduced behavioral health risk factors
- reduction of crisis events
- reduced hospitalization, emergency department use, and incarceration

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

◊ *E. Provided by: Contractor*

Services provided under both components of this program will be provided by contracted agencies.

2. Spending Plan

Year	Activity	Amount
2017	Peer Bridger teams at two inpatient psychiatric facilities	$604,750
2017	Peer support specialists deployed to RCOs and other key SUD service settings	$164,000
2017 Annual Expenditure		**$768,750**
2018	Peer Bridger teams at two inpatient psychiatric facilities	$620,474
2018	Peer support specialists deployed to RCOs and other key SUD service settings	$168,264
2018 Annual Expenditure		**$788,738**
Biennial Expenditure		**$1,557,488**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Peer Bridger Component

This funding supports two peer bridger providers: Navos and Harborview Medical Center.

SUD Peer Support Component

At the pilot level of funding for RCOs is likely to continue to be disbursed to the same agencies that were funded under MIDD 1.

For the additional services to be added in other SUD settings, either a Request for Proposals (RFP) process hosted by King County BHRD or a Memorandum of Understanding (MOU) (if services will be provided by a County department such as PHSKC) will result in the selection of provider organizations to deliver additional peer services in accordance with the goals and approaches described above.

Additional Procurement Expected if Programs are Expanded in Future Years

If at any point in the future additional peer bridger services are added, or SUD peer services are expanded to outpatient, withdrawal management, or residential settings using MIDD funds, additional procurement processes would be initiated.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Peer Bridgers and Peer Support Pilot (RR-11)

◊ *B. Contracting of Services*

See 1.E and 3.A above.

◊ *C. Services Start date (s)*

MIDD 2 funding for existing peer bridger programs at Navos and Harborview, and for SUD peer services at RCOs, will be implemented January 1, 2017 to ensure continuous services.

King County's work to select high-impact settings for the pilot SUD Peer Support aspect of this initiative will begin in first quarter 2017 once funding levels are known. Procurement processes will be completed in second quarter 2017, with services to be launched in third quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail-Based Substance Abuse Treatment (RR-12)

MIDD 2 Initiative Title: Jail-Based Substance Abuse Treatment **(NEW)**

MIDD 2 Number: RR-12

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This initiative will expand substance use disorder (SUD) treatment at the King County Maleng Regional Justice Center (MRJC). Persons are often arrested and incarcerated for behaviors either directly or indirectly related to substance abuse. The National Center on Addiction and Substance Abuse (CASA) at Columbia University published a study in 2010 showing that 65 percent of all incarcerated persons in the United States meet medical criteria for a substance use disorder (SUD), yet only 11 percent receive any treatment. Initial withdrawal management (detoxification) is provided at King County correctional facilities. While in jail, the nature of the controlled setting and limited "competing demands" offer an opportunity to initiate evidence-based SUD treatment. This initiative will provide contracted counselors to deliver SUD treatment and include the implementation of a modified therapeutic community (TC).

1. Program Description

◊ *A. Service Components/Design (Brief)*

Jail-Based Substance Abuse Treatment will provide a modified, variable length of stay and evidence-based model of care at the Maleng Regional Justice Center. A provider will be selected with demonstrated skill and expertise in employing fidelity adherent, evidence-based practices and documented experience to train corrections and treatment staff in the implementation of a modified therapeutic community (TC). The provider will also provide a continuum of services including screening, assessment, and a variable length of outpatient SUD treatment and criminogenic interventions at the MRJC. Jail Health will serve in a consultation role specific to integrated behavioral health and medication needs.

◊ *B. Goals*

This initiative seeks to reduce recidivism among populations with reoccurring incarcerations in King County jails by addressing clinical and behavioral factors of individuals that contribute to continued involvement in the criminal justice system. This program includes coordinating continuing outpatient treatment which will include a release plan and hand-off to community-based SUD providers.

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 200-300 individuals annually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail-Based Substance Abuse Treatment (RR-12)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- reduced unnecessary incarceration
- increased use of preventive (outpatient) services
- increased housing stability

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Jail-based SUD and Therapeutic Community services	$444,225
2017 Annual Expenditure		**$444,225**
2018	Jail-based SUD and Therapeutic Community services	$455,775
2018 Annual Expenditure		**$455,775**
Biennial Expenditure		**$900,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Through a competitive Request for Proposals (RFP) process, a provider will be selected with demonstrated skill and expertise in employing fidelity adherent, evidence-based practices and documented experience to train corrections and treatment staff in the implementation of a modified therapeutic community (TC). The RFP will be released in the first quarter of 2017.

◊ *B. Contracting of Services*

Contracting is expected to be completed in the second quarter of 2017.

◊ *C. Services Start date (s)*

Services are expected to begin in the third quarter of 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Deputy Prosecuting Attorney for Familiar Faces (RR-13)

MIDD 2 Initiative Title: Deputy Prosecuting Attorney for Familiar Faces

MIDD 2 Number: RR-13

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The dedicated deputy prosecuting attorney (DPA) for King County's Familiar Faces will support the work of specialized programs that provide mental health and substance use disorder treatment, primary health care, life skills development, and/or assistance with care transitions, for individuals referred to as "Familiar Faces" who have been booked in the King County jail four or more times within a 12-month period. Among the Familiar Faces population,[1] 94 percent have one or more behavioral health conditions,[2] and 93 percent have at least one acute medical condition. The dedicated DPA will work with Familiar Faces care management and/or care transition teams – including the Familiar Faces Intensive Care Management Team[3] (FF-ICMT).

The dedicated DPA will provide needed prosecutorial authority and discretion about legal cases for the FF-ICMT and/or other Familiar Faces care management and transition teams. As part of the FF team, the DPA will consult and collaborate with FF-ICMT, defense, law enforcement, and the community on individual cases. DPA participation on the FF team helps to divert some individuals from further criminal justice contact, and works to reduce costly criminal justice involvement via harm reduction alternatives that support preferred long-term outcomes for participants and communities.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The dedicated DPA funded by this initiative will coordinate closely and frequently with the Familiar Faces Intensive Care Management Team (FF-ICMT) and/or other Familiar Faces care management and transition teams to track any new bookings, pending cases/charges, pre-existing criminal history, and any post-adjudication hearings and requirements involving all active program participants. The dedicated DPA would also serve as a liaison between program steering committee(s) and law enforcement regarding the changing status of pending cases, outstanding warrants, or court hearings. The DPA would seek steering committee and law enforcement input to determine

[1] King County Health and Human Services Transformation: The Familiar Faces Initiative, June 2016.
[2] In addition to individuals booked in the King County jail who have a history of mental health and/or substance abuse treatment, King County Jail Health Services uses certain "flags" to identify people who have a recent history of mood, psychosis, or trauma diagnosis or psychiatric medications, or who have a recent history of substance use disorder diagnosis, detoxification service use or withdrawal risk, or treatment referral.
[3] http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/Familiar-Faces-ICMT.aspx.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Deputy Prosecuting Attorney for Familiar Faces (RR-13)

dismissals, detention, or transfer to an appropriate therapeutic court, and would track, monitor, and negotiate all cases associated with program participants.

◊ *B. Goals*

The addition of a dedicated DPA would increase the effectiveness of Familiar Faces care management and care transition teams in reducing criminal justice involvement and promoting wellness and stability for a portion of the sentinel Familiar Faces population.

◊ *C. Expected Numbers of Individuals Served*

The FF-ICMT that will benefit immediately from the services of this dedicated DPA would serve about 60 adults meeting Familiar Faces criteria at any given time. As additional relevant Familiar Faces programs are launched, this DPA is likely to assist many more people.[4]

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced representation of people with behavioral health conditions within jails, hospitals, and emergency departments
- housing stability

Individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants who benefit from services provided by the dedicated DPA may include:

- decreased use of jails, hospitals, and emergency departments
- improved housing stability
- reduced criminal justice involvement
- reduced avoidable emergency department use

◊ *E. Provided by: County*

[4] The total Familiar Faces population in King County averages over 1,200 people per year, although only a portion of this group will be served via care management or care transition programs. A similar dedicated DPA for the Law Enforcement Assisted Diversion (LEAD) program serves about 350 people.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Deputy Prosecuting Attorney for Familiar Faces (RR-13)

2. Spending Plan

Year	Activity	Amount
2017 partial year	Dedicated deputy prosecuting attorney (DPA) for Familiar Faces, including its flexible care management and care transition teams	$47,091
2017 Annual Expenditure		**$47,091**
2018	Dedicated DPA for Familiar Faces, including its flexible care management and care transition teams	$145,511
2018 Annual Expenditure		**$145,511**
Biennial Expenditure		**$192,602**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Funding for the Familiar Faces DPA would be directed to the King County Prosecuting Attorney's office via a Memorandum of Agreement (MOA).

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

MIDD 2 funding for the Familiar Faces DPA will begin in third quarter 2017 when private grant funding expires.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities (SI-1)

MIDD 2 Initiative Title: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities **(NEW)**

MIDD 2 Number: SI-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "increase culturally appropriate, trauma informed behavioral health services."

By directly empowering communities to design service approaches that meet their needs, this initiative seeks to overcome barriers to behavioral health service participation and recovery that ethnic and cultural communities experience. Such barriers include:

- Underutilization and premature termination of behavioral health treatment despite continued need;
- Disproportionately higher burden from unmet mental health needs;
- Poorer-quality care;
- Mistrust of the behavioral health system resulting from the cultural insensitivity of treating clinicians;
- Lack of culturally appropriate services including bilingual and bicultural staff;
- Collectivist cultural values that may make the individualistic process of psychotherapy foreign;
- Varying conceptions of the nature, causes, and cures of behavioral health conditions;
- Perceptions of stigma and shame; and
- Lack of health insurance coverage.[1]

In King County, as in many ethnic and cultural minority communities nationwide, people are left primarily with behavioral health service options that do not fit their cultural needs, so they remain unserved or underserved. These findings about ethnic communities' preferences around service delivery were confirmed locally via MIDD community engagement, including community conversations, focus groups, and surveys.[2]

This initiative provides a structure and resources for communities to propose projects and receive funding to address community needs using culturally appropriate programs.

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[1] Leong and Kalibatseva (2011). Cross-cultural barriers to mental health services in the United States. Cerebrum 2011 March-April: 5. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3574791/ and U.S. Department of Health and Human Services. (2001). Mental health: culture, race and ethnicity, a supplement to Mental health: A report of the surgeon general. http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf

[2] MIDD review and renewal focus groups in January 2016 whose perspectives surfaced these themes and needs included focus groups specifically for African American, Somali, Hispanic, Asian Pacific Islander, Native American, trans*, and refugee populations. See http://www.kingcounty.gov/~/media/depts/community-human-services/MIDD/documents/160226_FG_Highlights.ashx?la=en. Survey information is summarized at http://www.kingcounty.gov/~/media/depts/community-human-services/MIDD/documents/160226_Community_Engagement_Main_Themes.ashx?la=en.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

1. Program Description

◊ *A. Service Components/Design (Brief)*

King County will provide funding, oversight, technical support, and evaluation for grants designed to support targeted community-initiated behavioral health-related services or programs designed by particular cultural or ethnic communities to address issues of common concern.

This approach will build upon processes employed by King County's Community Service Area (CSA) Community Engagement Grant program,[3] except that it will be organized around particular populations rather than by geographic locations. It will provide MIDD resources to enable local culturally specific grassroots organizations to support implementation of small-scale, local initiative(s) designed by community members to address key felt needs that relate to behavioral health treatment, prevention, recovery, or service access.

Funded projects may include, but are not limited to:
(a) community-initiated engagement efforts, classes, prevention/outreach campaigns, or one-time events related to mental health or substance abuse, and/or
(b) specific behavioral health services requested by a cultural or ethnic community that are expected to meaningfully address its self-identified needs.

◊ *B. Goals*

The goal of this concept is to provide a mechanism for MIDD to invest in locally conceived, community-driven behavioral health services, with a special focus on cultural and ethnic communities. Nearly 30 percent of King County residents are people of color,[4] but culturally specific and accessible resources, along with community-designed and -informed services, are relatively lacking. MIDD's 2015-16 community outreach effort has confirmed the need for an avenue for community self-determination and services focused on the needs of specific groups.

◊ *C. Expected Numbers of Individuals Served*

As the funded programs would be designed by multiple different communities and customized to their particular felt needs, it is not yet known how many individuals will be served. Furthermore, as funded projects change from year to year, the number of people served will vary annually. However, the number of people served will be tracked for each project and aggregated for the initiative as a whole.

[3] Information about the existing Community Engagement Grant program, administered by King County's Department of Natural Resources and Parks, is available at http://www.kingcounty.gov/exec/community-service-areas/engagement-grants.aspx.
[4] 2014 census data, available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/king-county-profile.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of culturally appropriate behavioral health practices
- improved perception of health and behavioral health issues and disorders
- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- improved wellness and social relationships

◊ *E. Provided by: Contractor*

This grant program would be administered by County staff in consultation with stakeholders from each geographic area. All funded programs and services would be delivered by organizations with deep ties to the local communities being served.

2. Spending Plan

Year	Activity	Amount
2017	Startup (partial year of outreach, input-gathering, process design, and program management),[5] and partial year of community-initiated, time-limited small grants to local culturally specific organizations or projects	$350,000
2017 Annual Expenditure		**$350,000**
2018	Community-initiated, time-limited small grants to local culturally specific organizations or projects, and program management	$359,100
2018 Annual Expenditure		**$359,100**
Biennial Expenditure		**$709,100**

* Efforts will be made to distribute funding equitably across communities and populations. However, these efforts will depend on the number and amount of funding requests from each group. Also, as unique community needs may arise among certain

[5] Some aspects of startup work for this initiative and Behavioral Health Services in Rural King County initiative will be shared, so funding for outreach, input-gathering, and process design is divided between the two initiatives.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

communities at times, program procedures will be designed to allow flexibility to shift resources accordingly when necessary.

3. Implementation Schedule

◊ *A. Procurement of Providers*

This initiative will require periodic, low-barrier requests for proposals (RFPs) – no less frequently than annually – to facilitate the selection of time-limited community-driven projects for funding.

The level of complexity and requirements for these proposals will vary depending on the amount of the funding request. Multiple categories will be created in accordance with contracting requirements, in order to ease access for small organizations and small projects. This will include reducing barriers such as insurance and data submission requirement, and technical support as needed. The specifics of these categories are described in section B below.

Applicant organizations will be expected to demonstrate that they have leveraged matching contributions.[6] Matching funds may come in the form of funding from other sources or donated time, space, or other in-kind resources. Combining all sources (including in-kind), the match must total at least 25 percent of the MIDD funding request in the first year, and at least 50 percent in the second and/or third years (if applicable).

◊ *B. Contracting of Services*

An annual request for proposals process would be established to provide a predictable timing and process by which communities could request funds. Organizations selected for funding via this community-driven grant initiative would establish contracts or monitoring agreements with King County covering each proposed program or service and its associated time period.

Criteria for limited renewal of the projects will be developed, up to a limit of three years of funding per project or service. Factors to be considered the decision to renew funding for a project or service may include:
(1) the volume of people served;
(2) community feedback about project effectiveness and engagement/organizing work; and
(3) Efforts to enroll project participants in Medicaid, as applicable.

When renewed grants are sought for equivalent or substantively similar projects after the first year, funding will most commonly be renewed partially, at 50 percent to 75 percent of the initial year's amount, depending on the three factors above. The expectation is that other funding sources beyond MIDD will be leveraged to continue the service.

[6] Match requirements are part of both the CSA small grant program after which this initiative is modeled, and the Community Organizing Program small grant initiative previously operated by King County DCHS.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities
(SI-1)

Processes and requirements specific to particular funding levels, based on known procurement mandates and the overarching goals of the initiative, are outlined below.

Requests of $4,999 or Below
Grants of $4,999 per year per organization and below would be awarded two to four times per year, and would be directly funded without formal County contracts, allowing small grassroots organizations or coalitions to receive funds without having to meet costly insurance and fiscal monitoring requirements. Oversight of expenditures of these grants, including organizations' internal controls, would be performed by County program management staff, allowing for funds to be disbursed either via small advance payments combined with reconciliation against actual expenditures or via simple expenditure reimbursement.

Requests of $5,000 to $49,999
Funding requests from $5,000 to $49,999 per year per organization will be procured via formal annual County contracts. Every effort will be made to minimize administrative burdens associated with these contracts, including reduced fiscal auditing requirements. Contracting requirements specific to particular funding levels are as follows:

(1) For requests of $5,000 to $9,999, simplified contracting will be available, building on existing processes in place for contracting with providers for small special projects.
(2) For requests of $10,000 to $49,999, full contracts will be required, but reduced insurance requirements may be available depending on the type of program or service proposed.

Requests of $50,000 or Above
Any requests of $50,000 or more per year per organization are expected to be rare and would be required to demonstrate a high level of coordination and community engagement involving grassroots groups representing two or more cultural or ethnic communities. Projects at this level of funding would be required to comply with all standard County contracting rules including insurance and financial audit requirements commensurate with the funding level.

◊ *C. Services Start date (s)*

An outreach effort would begin in early 2017 to ensure that communities are aware of the existence of this new funding opportunity and to gather input about the operations and criteria for the initiative. Informed by this engagement work, the first RFP could be issued in spring 2017 with services to begin in the third quarter 2017. New grants of $5,000 or more would be launched no less frequently than annually as each RFP cycle is completed, with grants of $4,999 and below issued quarterly or semiannually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Services in Rural King County (SI-2)

MIDD 2 Initiative Title: Behavioral Health Services in Rural King County **(NEW)**

MIDD 2 Number: SI-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Currently, vast sections of King County have no publicly funded behavioral health clinic option.[1] Rural King County residents lack access to these service sites due to transportation barriers including long distances to behavioral health clinic sites in suburban cities, and very limited bus service in rural areas. In the case of Vashon Island, the only linkage to some aspects of the outpatient service continuum is via ferry.[2]

This initiative's grant process not only may address access issues common to rural communities nationally, but also concerns identified at a local level. Examples of these may include stigma associated with receiving care;[3] elevated rates of obesity, diabetes, and suicide;[4] and/or high prevalence of adverse childhood experiences which are a strong predictor of anxiety and other mental illnesses.[5]

1. Program Description

◊ *A. Service Components/Design (Brief)*

King County would provide funding, oversight, technical support, and evaluation for small grants designed to support targeted community-initiated behavioral health-related services or programs designed by rural communities to address issues of common concern.

It would serve especially the seven community service areas (CSAs) in King County that experience a lack of behavioral health services. These CSAs are: Bear Creek/Sammamish, Snoqualmie Valley/Northeast King County, Four Creeks/Tiger Mountain, Greater Maple Valley/Cedar River, Southeast King County, West King County

[1] http://kingcounty.maps.arcgis.com/apps/PublicInformation/index.html?appid=eaf2562bfde3437f8519fa90a2eaff0b
[2] "Notes from Group Discussion: Snoqualmie Healthy Community Coalition, Sept 17, 2015, facilitators: Alan Painter and DeAnna Martin," and "Vashon Social Services Network, August 14, 2015," provided by Alan Painter, King County Community Services Area program manager. The unique transportation barriers experienced by Vashon Island residents were also highlighted in a January 2016 Best Starts for Kids focus group.
[3] "Notes from Group Discussion: Snoqualmie Healthy Community Coalition, Sept 17, 2015, facilitators: Alan Painter and DeAnna Martin," and phone consultation with Ross Marzolf, January 2016. Participants in MIDD review and renewal focus groups in both Maple Valley (Southeast King County) and Preston (Snoqualmie Valley) in January 2016 identified stigma reduction campaigns and community education about mental illness as priorities for potential funding.
[4] King County Health Profile, December 2014.
[5] Adverse Childhood Experiences ACES 2013 Report.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Services in Rural King County (SI-2)

unincorporated areas,[6] and Vashon/Maury Islands. Programs and services in certain rural cities and towns adjoining these CSAs, such as Skykomish, Duvall, Carnation, Snoqualmie, North Bend, Covington, Maple Valley, Black Diamond, and Enumclaw, would also be included.

This approach would build upon or replicate the existing structure of King County's CSA Community Engagement Grant program,[7] providing MIDD resources to enable local grassroots organizations located within any CSAs or identified adjoining rural cities or towns to design specific initiative(s) that address key felt needs that relate to behavioral health treatment, prevention, recovery, or service access.

Funded projects may include, but are not limited to:
(a) community-initiated engagement efforts, classes, prevention/outreach campaigns, or one-time events related to mental health or substance abuse, and/or
(b) specific behavioral health services requested by a rural community that are expected to meaningfully address its self-identified needs.

◊ *B. Goals*

As described above, this program would improve health and wellness primarily by promoting access to services and community self-determination in areas of King County that have very little access to publicly funded behavioral health care.

◊ *C. Expected Numbers of Individuals Served*

As the funded programs would be designed by multiple different communities and customized to their particular felt needs, it is not yet known how many individuals will be served. Furthermore, as funded projects change from year to year, the number of people served will vary annually. However, the number of people served will be tracked for each project and aggregated for the initiative as a whole.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

[6] The West King County Unincorporated Areas CSA serves unincorporated pockets of West King County that are generally near suburbs where publicly funded behavioral health clinics are located. As a result, funding requests from this CSA will be required to demonstrate that proposed projects are coordinated with any nearby existing providers and avoid duplication of efforts.
[7] Information about the existing Community Engagement Grant program, administered by King County's Department of Natural Resources and Parks, is available at http://www.kingcounty.gov/exec/community-service-areas/engagement-grants.aspx.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Services in Rural King County (SI-2)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved perception of health and behavioral health issues and disorders
- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- improved wellness and social relationships
- improved experience of care

◊ *E. Provided by: Contractor*

This grant program would be administered by County staff in consultation with stakeholders from each geographic area. All funded programs and services would be delivered by organizations with deep ties to the local communities being served.

2. Spending Plan

Year	Activity	Amount
2017	Startup (partial year of outreach, input-gathering, process design, and program management),[8] and partial year of community-initiated, time-limited small grants to local organizations within seven identified geographic areas	$350,000
2017 Annual Expenditure		**$350,000**
2018	Community-initiated, time-limited small grants to local organizations within seven identified geographic areas, and program management	$359,100
2018 Annual Expenditure		**$359,100**
Biennial Expenditure		**$709,100**

* Efforts will be made to distribute funding equitably across seven geographic areas, largely in alignment with the established CSAs but including the named adjoining cities and towns. However, these efforts will depend on the number and amount of funding requests from each community. Also, as unique community needs may arise in certain areas at times, program procedures will be designed to allow flexibility to shift resources accordingly when necessary.

[8] Some aspects of startup work for this initiative and the Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities initiative will be shared, so funding for outreach, input-gathering, and process design is divided between the two initiatives.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Services in Rural King County (SI-2)

3. Implementation Schedule

◊ *A. Procurement of Providers*

This initiative will require periodic, low-barrier requests for proposals (RFPs) – no less frequently than annually – to facilitate the selection of time-limited community-driven projects for funding.

The level of complexity and requirements for these proposals will vary depending on the amount of the funding request. Multiple categories will be created in accordance with contracting requirements, in order to ease access for small organizations and small projects. This will include reducing barriers such as insurance and data submission requirement, and technical support as needed. The specifics of these categories are described in section B below.

Applicant organizations will be expected to demonstrate that they have leveraged matching contributions.[9] Matching funds may come in the form of funding from other sources or donated time, space, or other in-kind resources. Combining all sources (including in-kind), the match must total at least 25 percent of the MIDD funding request in the first year, and at least 50 percent in the second and/or third years (if applicable).

◊ *B. Contracting of Services*

An annual request for proposals process would be established to provide a predictable timing and process by which communities could request funds. Organizations selected for funding via this community-driven grant initiative would establish contracts or monitoring agreements with King County covering each proposed program or service and its associated time period.

Criteria for limited renewal of the projects will be developed, up to a limit of three years of funding per project or service. Factors to be considered the decision to renew funding for a project or service may include:
(1) the volume of people served;
(2) community feedback about project effectiveness and engagement/organizing work; and
(3) Efforts to enroll project participants in Medicaid, as applicable.

When renewed grants are sought for equivalent or substantively similar projects after the first year, funding will most commonly be renewed partially, at 50 percent to 75 percent of the initial year's amount, depending on the three factors above. The expectation is that other funding sources beyond MIDD will be leveraged to continue the service.

Processes and requirements specific to particular funding levels, based on known procurement mandates and the overarching goals of the initiative, are outlined below.

[9] Match requirements are part of both the CSA small grant program after which this initiative is modeled, and the Community Organizing Program small grant initiative previously operated by King County DCHS.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Services in Rural King County (SI-2)

Requests of $4,999 or Below
Grants of $4,999 per year per organization and below would be awarded two to four times per year, and would be directly funded without formal County contracts, allowing small grassroots organizations or coalitions to receive funds without having to meet costly insurance and fiscal monitoring requirements. Oversight of expenditures of these grants, including organizations' internal controls, would be performed by County program management staff, allowing for funds to be disbursed either via small advance payments combined with reconciliation against actual expenditures or via simple expenditure reimbursement.

Requests of $5,000 to $49,999
Funding requests from $5,000 to $49,999 per year per organization will be procured via formal annual County contracts. Every effort will be made to minimize administrative burdens associated with these contracts, including reduced fiscal auditing requirements. Contracting requirements specific to particular funding levels are as follows:

(1) For requests of $5,000 to $9,999, simplified contracting will be available, building on existing processes in place for contracting with providers for small special projects.
(2) For requests of $10,000 to $49,999, full contracts will be required, but reduced insurance requirements may be available depending on the type of program or service proposed.

Requests of $50,000 or Above
Any requests of $50,000 or more per year per organization are expected to be rare and would be required to demonstrate a high level of coordination and community engagement involving grassroots groups representing two or more of the identified seven geographic areas. Projects at this level of funding would be required to comply with all standard County contracting rules including insurance and financial audit requirements commensurate with the funding level.

◊ *C. Services Start date (s)*

An outreach effort would begin in early 2017 to ensure that communities are aware of the existence of this new funding opportunity and to gather input about the operations and criteria for the initiative. Informed by this engagement work, the first RFP could be issued in spring 2017 with services to begin in the third quarter 2017. New grants of $5,000 or more would be launched no less frequently than annually as each RFP cycle is completed, with grants of $4,999 and below issued quarterly or semiannually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Court Planning (TX-CCPL)

MIDD 2 Initiative Title: Community Court Planning **(NEW)**

MIDD 2 Number: TX-CCPL

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative aims to impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals" by exploring the possible development of a new King County Community Court.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative funds the study and preliminary planning of a potential new King County therapeutic Community Court. This court is envisioned to serve individuals with low-level, misdemeanor offenses who have frequent contact with the criminal justice system. Implementation of the Community Court funded by MIDD revenue may be considered in 2018.

◊ *B. Goals*

To Be Determined.

◊ *C. Expected Numbers of Individuals Served*

Not applicable for this initiative.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative may contribute to the population outcome of reduced jail use identified in the MIDD 2 Framework.

Individual-level outcome measures are not applicable to this initiative.

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Court Planning (TX-CCPL)

2. Spending Plan

Year	Activity	Amount
2017	Consultant study	$100,000
2017 Annual Expenditure		**$100,000**
2018	None identified to date	$0
2018 Annual Expenditure		**$0**
Biennial Expenditure		**$100,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposal (RFP) for a consultant to conduct the planning process will be released the first quarter of 2017.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Not applicable for this initiative.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

MIDD 2 Initiative Title: Outreach & In Reach System of Care

MIDD 2 Number: CD-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Community-based outreach and engagement connect individuals in need of services prior to court involvement or as a treatment alternative. Many individuals do not enter into criminal justice system responses, such as specialty courts, when they have health and human service needs and often return to the streets after release from jail still in desperate need of connection to treatment, housing and community.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Existing MIDD 1 services are provided under Public Health through two agencies: 1) Harborview Medical Center (HMC) in downtown Seattle and 2) the Valley Cities Counseling and Consultation (VCCC) in south and east King County, and known as the Bridges program[1] and through the Seattle Indian Health Board at the Dutch Shisler Service Center and the Chief Seattle Club. All provider agencies target individuals who have a recent history of cycling through hospitals, jails, other crisis facilities, psychiatric hospitals, or residential substance use disorder (SUD) treatment facilities. They work with individuals who do not have or are not eligible for Medicaid, and clients with mental health problems who are not eligible for enrollment in the Behavioral Health Organization (BHO) network that has provided publicly funded mental health services, or who are disconnected from their BHO case manager or program. The services are community-based mental health/SUD-based outreach, engagement and service linkages, including advocacy for individuals with mental health and substance use conditions, mental health assessments and linkage to counseling.

County Administration/Oversight resources, Community-based organizations, and other experts will be engaged to use a collective impact approach, in order to assess current defined results and recommend any needs to redefine any determined results. This will include looking at population currently being served, to be served, accessibility, community need, etc.

Public Health – Seattle and King County (PHSKC), King County Behavioral Health and Recovery Division (BHRD) and Housing & Community Development,; Harborview Medical Center (current provider), Valley Cities Counseling & Consultation (current provider), local homelessness advisory boards (e.g. Eastside Homeless Advisory Committee), All Home,

[1] http://www.valleycities.org/services/outreach/bridges/.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

Community-based organizations and other community meeting forums, will be engaged to determine if the current defined scope and parameters of this initiative are properly defined.

PHSKC will continue funding current organizations into early 2017. Component re-design, evaluation, and consultation will happen on a quarterly continuous improvement cycle. A review of utilizer systems will be conducted in early 2017 to ensure that the current agencies are meeting goals and serving the target population.

◊ *B. Goals*

The primary goal of this initiative is to increase availability of outreach, engagement, and case management services for homeless individuals.

Behavioral health professionals engage clients and provide stabilizing services with the goal of making referrals to mental health and SUD treatment providers in order to ensure appropriate ongoing treatment for those individuals who are eligible for services.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals served annually is 675.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- improved daily functioning
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary incarceration
- improved wellness self-management
- reduction of crisis events

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Community-based outreach and engagement services continue.	$410,000
2017 Annual Expenditure		**$410,000**
2018	Community-based outreach and engagement services continue.	$420,660
2018 Annual Expenditure		**$420,660**
Biennial Expenditure		**$830,660**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Outreach & In Reach System of Care (CD-3)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Funding will continue to be distributed to PHSKC via a Memorandum of Understanding (MOU). BHRD currently contracts with Seattle Indian Health Board for services in this initiative. No RFP is needed unless the review process determines that a program change is needed during the second quarter 2017.

◊ *B. Contracting of Services*

This initiative has already established contracts. The contracts will be assessed for renewal during the second quarter 2017.

◊ *C. Services Start date (s)*

Services continue in first quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

MIDD 2 Initiative Title: High Utilizer Care Teams

MIDD 2 Number: CD-5

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The initiative assists people in the midst of crisis by delivering flexible and individualized service beginning in the ED or hospital inpatient unit. This program builds on initial supportive contact to help people reintegrate safely into the community after an immediate crisis, and help them to acquire and engage with stabilizing resources such as housing and community-based care, thereby reducing future emergency system use.

The program focuses on reducing individuals' use of crisis services, including the emergency room, inpatient psychiatry, and inpatient medical care; and enhancing the capacity to link individuals to community services. The initiative serves people who are falling through the cracks of the existing service system, such as people who have no services in place but need intensive outreach to connect to care, or people with mental illness who also have chronic medical conditions.[1]

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative will serve individuals who are frequently seen the emergency department (ED) or psychiatric emergency service (PES) at Harborview Medical Center (HMC). Funding will cover clinicians who will serve individuals that use the HMC ED or PES four or more times in three months.[2] Due to the intensity of service as well as the complex needs of program individuals, caseloads are kept smaller, so people with eight or more ED or PES visits in six months will be prioritized, because they are most likely to benefit from the services offered by this specialized care team. The program also provides support for clients' basic needs that reduce barriers to participating in the plan of care through a modest fund to address transportation, clothing, rent, and similar expenses.

Newly available data from Washington's Emergency Department Information Exchange (EDIE) will also be used to identify Harborview patients who may not meet the priority threshold based on HMC data alone, but have a high level of ED use at other King County hospitals.

[1] Harborview Medical Center, December 2015.
[2] Extracted from 2015 Harborview Medical Center Contract, Exhibit IV.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

Most participants are homeless at the outset of the intervention. Along with homelessness, almost all individuals' vulnerability arises from at least two of the following: chronic medical issues, substance use disorders, and serious mental illness.[3]

Service components include a harm reduction approach to substance abuse, motivational strategies to engage individuals in primary healthcare for chronic conditions, active engagement of community supports, outreach during individuals' crises in the ED or during an inpatient admission, and continued engagement of individuals once they return to the community. Broadly, the team assists individuals to find stable housing, improves de-escalation skills to decrease behavioral barriers to care, and helps individuals with co-occurring disorders access needed behavioral health services and connections to primary care for their medical needs.[4]

The most frequent service connections upon discharge are in mental health, substance abuse, and medical clinics. Staff will coordinate with King County; other EDs; and behavioral health, social service, and housing providers, in order to ensure appropriate referrals and linkages to services. The team uses HMC primary care and aftercare clinics to provide urgent and long-term service connections to primary care. HMC's mental health services provide mental health urgent care, while long-term case management comes from a variety of community mental health providers.[5]

◊ *B. Goals*

This initiative's goal is to connect individuals who have frequent crisis visits to EDs or the PES to care providers and treatment systems in the community in order to decrease their need for emergency services.

◊ *C. Expected Numbers of Individuals Served*

The program will have the capacity to serve approximately 100 individuals per year.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events

[3] Harborview Medical Center, December 2015.
[4] ED/PES High Utilizer Case Management Annual Report, MIDD Strategy 12c, King County Contract 5656153 – Exhibit IV (December 2014).
[5] ED/PES High Utilizer Case Management Annual Report, MIDD Strategy 12c, King Co. Contract 5656153 – Exhibit IV (December 2014).

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
High Utilizer Care Teams (CD-5)

- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to MIDD I provider Harborview Medical Center. The contractor will manage expenditures on basic needs and seek reimbursement from the County up to allowed limits.

2. Spending Plan

Year	Activity	Amount
2017	High utilizer care team services, with support for basic needs to reduce barriers to care plan participation	$256,250
2017 Annual Expenditure		**$256,250**
2017	High utilizer care team services, with support for basic needs to reduce barriers to care plan participation	$262,913
2018 Annual Expenditure		**$262,913**
Biennial Expenditure		**$519,163**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The service would most appropriately be procured from existing MIDD I provider Harborview Medical Center. Changes to staffing levels would be established via contract revisions.

◊ *B. Contracting of Services*

See 1.E and 3.A. above.

◊ *C. Services Start date (s)*

Service planning and contracting will occur by January 2017, in alignment with final funding levels.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

MIDD 2 Initiative Title: Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team

MIDD 2 Number: CD-6

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MID policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The Crisis Solutions Center (CSC), operated by the Downtown Emergency Service Center (DESC), provides King County first responders with alternative options to jail and hospital settings when engaging with individuals, age 18 and older, in behavioral health crisis. The intent of the facility is to stabilize and support individuals in the least restrictive setting possible, while identifying and directly linking them to appropriate and ongoing services in the community. The CSC has three program components intended to stabilize and support an individual in the least restrictive setting possible, while identifying and directly linking that individual to ongoing services in the community.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Adult Crisis Diversion Center strategy (herein referred to as the Crisis Solutions Center or CSC) provides King County first responders with a therapeutic, community-based alternative to jails and hospitals when engaging with adults who are in behavioral health crisis. King County contracts with DESC to provide crisis diversion services in King County at the CSC. DESC has a strong history of engaging with individuals who are homeless, who experience mental health and substance use disorders, and who may be reticent in accepting traditional services. The CSC has three program components; Mobile Crisis Team (MCT), Crisis Diversion Facility (CDF), and Crisis Diversion Interim Services (CDIS). The programs are intended to stabilize and support individuals in the least restrictive setting possible, while identifying and directly linking them to appropriate and ongoing services in the community.

The MCT consists of a team of two mental health clinicians, trained in the field of substance use disorders, who provide crisis outreach and stabilization services in the community 24 hours a day, 7 days per week (24/7). The team responds to requests from first responders in the field to assist with people in a mental health and/or substance use crisis. They intervene with individuals in their own communities, identify immediate needs and resources and, in most cases, relieve the need for any further intervention by first responders. The MCT is available for consultation or direct outreach to any location in King County and may assist individuals in crisis by providing or arranging for transportation.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

The CDF is a 16-bed facility for individuals in mental health and/or substance abuse crisis who can be diverted from jails and hospitals, and voluntarily agree to services. The facility accepts individuals 24/7, with a 72-hour maximum length of stay. Individuals receive mental health and physical health screenings upon arrival. Services include crisis and stabilization services, case management, evaluation and psychiatric services, medication management and monitoring, mental health and substance abuse disorder assessments, peer specialist services and linkage to ongoing community-based services.

The CDIS is a 30-bed program co-located with the CDF. After a crisis has resolved at the CDF, individuals may be referred to the CDIS if they are homeless, their shelter situation is dangerous or has the potential to send them into crisis again, or they need additional services prior to discharge to help support stabilization. Individuals can stay at the CDIS for up to 2 weeks. Services include continued stabilization services, intensive case management, peer specialist services, and linkage to community-based services, with a focus on housing and benefits applications.

◊ *B. Goals*

One of the main goals of crisis services is to stabilize individuals in the community. Crisis services also provide post-stabilization activities, including referral and linkage to outpatient services and supports.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals served is 3000 annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced unnecessary jail, hospital and emergency department use
- increased use of preventive (outpatient) services
- reduction of crisis events
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team (CD-6)

2. Spending Plan

Year	Activity	Amount
2017	Diversion services for people with mental health and substance use disorders experiencing a crisis program management, and stakeholder coordination continue.	$5,125,000
2017 Annual Expenditure		**$5,125,000**
2018	Diversion services for people with mental health and substance use disorders experiencing a crisis, program management, and stakeholder coordination continue.	$5,208,569
2018 Annual Expenditure		**$5,208,569**
Biennial Expenditure		**$10,333,569**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with DESC to provide services for this initiative. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services will continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

MIDD 2 Initiative Title: Children's Domestic Violence Response Team (CDVRT)

MIDD 2 Number: CD-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

CDVRT addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The CDVRT provides a continuum of recovery services to address the needs of the families served. The impacts of domestic violence (DV) vary depending on severity of the violence in the home, age and developmental stage of the child, and the ability of the primary caretaker to meet the child's needs. Children's symptoms range from mild (primary and secondary prevention) to severe impairments in functioning requiring intensive rehabilitation/treatment. Support groups such as "Kids Club" and its concurrent parenting group, are offered for children and non-abusive parents who may not need or want mental health services. For children and families needing a higher level of mental health treatment, child and family therapists use individual, family, and group counseling; Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)[1]; and Parent-Child Interaction Therapy (PCIT)[2].

1. Program Description

◊ *A. Service Components/Design (Brief)*

A team provides mental health and advocacy services to children, ages 0-12 who have experienced DV, and support, advocacy and parent education to their non-violent parent. The team consists of a children's mental health therapist, a children's DV advocate, and other team members as identified by the family (including supportive family members, case workers, teachers, etc.). Children are assessed through a parent and child interview, and use of established screening tools. Children's treatment includes evidence-based Trauma Focused Cognitive Behavioral-Therapy, as well as Kids Club, a tested group therapy intervention for children experiencing DV. Children and families are referred through the DV Protection Order Advocacy program, as well as through other partner agencies.

◊ *B. Goals*

The CDVRT has one primary long-term goal: to help break the generational cycles of violence—to decrease the likelihood that exposure to violence at home will lead to other forms of juvenile and adult violence by children who have been exposed to domestic violence.

[1] http://nctsnet.org/sites/default/files/assets/pdfs/tfcbt_general.pdf
[2] http://www.pcit.org/

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

The CDVRT's more immediate program goals are: 1) to ensure ongoing physical and emotional safety of children and families impacted by domestic violence; 2) to support emotional healing for children and adults who are victims and survivors of domestic violence.

◊ *C. Expected Numbers of Individuals Served*

Approximately 85 families with 150 children are served annually.

◊ *D. Draft Outcomes and Performance Measures - - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Provide CDVRT services to children and their supportive parent	$281,875
2017 Annual Expenditure		**$281,875**
2018	Provide CDVRT services to children and their supportive parent	$289,204
2018 Annual Expenditure		**$289,204**
Biennial Expenditure		**$571,079**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD contracts with Sound Mental Health for this program under MIDD 1, which is anticipated to continue. It is cost effective to utilize existing organizations to develop the integrated model of DV and behavioral health services within community based DV advocacy organizations.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Domestic Violence Response Team (CD-8)

◊ *B. Contracting of Services*

See previous.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

MIDD 2 Initiative Title: Next Day Crisis Appointments (NDA)

MIDD 2 Number: CD-10

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The Next Day Appointment (NDA) program helps to divert people experiencing a behavioral health crisis from psychiatric hospitalization – especially those who are not currently enrolled in the King County mental health outpatient treatment system. Over 91 percent of individuals who participate in NDAs would otherwise be considered for psychiatric inpatient care.

The NDA program is designed to provide 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 enables the NDA program to provide follow-up services for a brief period after an initial appointment, in order to increase the degree to which participants link to ongoing care.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Individuals served in NDA services present with a behavioral health crisis, either to hospital emergency departments or to crisis outreach mental health professionals. These are adults that typically do not have access to any ongoing mental health services. The crisis clinicians that respond to the individual in the hospital or community setting assess the individual and determine that an inpatient psychiatric hospital stay could be averted if the person had access to outpatient crisis stabilization services with the 24 hours following their crisis assessment. A referral is made to the King County Crisis Clinic and an appointment is made with the NDA service in the geographic area of the person's preference.

Including baseline services made possible by the state and other funding partners, NDA Services include:

- Crisis intervention and stabilization services provided by professional staff trained in crisis management.
- Consultation with an appropriate clinical specialist when such services are necessary to ensure culturally appropriate crisis response.
- Referral to long-term mental health or other care as appropriate.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

- Benefits counseling to work with NDA clients to gain entitlements that will enable clients to qualify for ongoing mental health and medical services.
- 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.

MIDD specifically funds an enhancement to NDAs including short-term follow-up services:

- Consumers in crisis are offered additional short-term treatment and stabilization beyond the next day appointment. Potential additional services include:
  - linkage to ongoing services;
  - completion of a Medicaid application process;
  - development of a medication plan;
  - linkage to a primary care provider for those who are not enrolled for ongoing services; and/or
  - referrals to chemical dependency treatment.

As future funding permits, NDA capacity may be expanded to meet demand, as the need for NDAs from the local Emergency Departments far outstrips the current capacity.

◊ *B. Goals*

The Next Day Appointment (NDA) program is a clinic-based, follow-up crisis response program that provides assessment, brief intervention and linkage to ongoing treatment. The goal of the program is to provide crisis stabilization and to divert individuals from psychiatric inpatient care.

◊ *C. Expected Numbers of Individuals Served*

At the recommended level of funding, the NDA program is expected to serve about 1,800 people per year at its five current sites, including state- and MIDD-funded capacity. Of these, most come from hospital emergency departments, while other referrals come from DMHPs, the Crisis Clinic's voluntary hospital authorization team, and other first responder services. MIDD-supported follow-up services will be provided to at least 350 NDA participants per year system wide, based on their needs.[1]

Depending on future funding levels from the state and from MIDD, some MIDD funding under this initiative could potentially be used to expand initial NDA appointment capacity to help meet demand.

[1] Improved methods for counting recipients of the enhanced service will be explored, as even more people may be receiving follow-up services via MIDD than have been counted in recent years.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

All services offered under this initiative will be contracted to community providers, potentially in tandem with Behavioral Health Urgent Care Walk-In services.

2. Spending Plan

Year	Activity	Amount
2017	Short-term follow-up services including medication and/or service linkage for at least 350 NDA participants, at five sites throughout King County	$307,500
2017 Annual Expenditure		**$307,500**
2018	Short-term follow-up services including medication and/or service linkage for at least 350 NDA participants, at five sites throughout King County	$315,495
2018 Annual Expenditure		**$315,495**
Biennial Expenditure		**$622,995**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The county, in collaboration with providers, may determine that it is necessary to re-RFP this body of work, particularly should NDA enhanced services be joined with new behavioral health urgent care walk-in services for procurement and contracting purposes.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Next Day Crisis Appointments (CD-10)

◊ *B. Contracting of Services*

See 1.E. and 3.A. above. Contracts and associated targets may be revised to match with the recommended level of funding.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with continuous availability of crisis services and short-term follow-up, and no disruption of system capacity.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

MIDD 2 Initiative Title: Children's Crisis Outreach Response System

MIDD 2 Number: CD-11

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "reduce the number, length, and frequency of behavioral health crisis events."

The Children's Crisis Outreach Response System (CCORS) supports a countywide crisis response system for King County youth up to age 18 who are currently experiencing a mental health crisis. These services are provided to children, youth, and families where the functioning of the child and/or the family is severely impacted due to family conflict and/or severe emotional or behavioral problems, and where the current living situation is at imminent risk of disruption. CCORS also addresses the needs of children and youth who are being discharged from a psychiatric hospital or juvenile detention center and need intensive short-term services while ongoing supports are being put in place. An enhancement is included to reduce response time when law enforcement is involved, in order to improve de-escalation, follow-through with service linkage, and outcomes for families.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The CCORS program utilizes strength-based, individualized approaches via teams that include Crisis Intervention Specialists (Mental Health Professionals and Children's Mental Health Specialists), Family Advocates, and Parent Partners. Teams meet the referred youth and families in the home and other community locations. CCORS partners with families, as well as other professionals and systems, and uses short-term, evidence-based, crisis intervention strategies. Services are available 24 hours a day, seven days a week, 365 days a year.

The CCORS program has three main components: Crisis Outreach Services and Non-Emergent Outreach; Intensive Stabilization Services (ISS); and, Crisis Stabilization Beds (CSBs) also known as Hospital Diversion Beds.

<u>Crisis Outreach Services and Non-Emergent Outreach</u>

CCORS' Crisis Emergent and Non-Emergent Outreach services are available to children and youth in King County who meet certain crisis service criteria and are not currently receiving services through a contracted mental health agency. Emergent Crisis Response consists of: 1) crisis telephone response available 24 hours a day, seven days a week that includes immediate access to a mental health professional, as well as: 2) an outreach team that, at a minimum, consists of a Children's Mental Health Specialist and a Family Advocate who are trained in crisis management.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

Crisis Outreach services provide rapid face-to-face response at the community site of the escalating behavior. Teams develop crisis safety plans with family and youth input. Teams also provide crisis outreach to children/youth not engaged with a contracted mental health agency that have been referred for inpatient hospitalization. Teams provide referrals for voluntary hospitalization or coordination with the Designated Mental Health Professionals (DMHPs) for involuntary hospitalization when needed, while keeping youth in the least restrictive option available that is clinically appropriate.

Intensive Stabilization Services (ISS)

ISS is an intensive service lasting up to 90 days that provides children and youth whose placement is at risk with immediate crisis stabilization. They build on the family's and child/youth's strengths and provide creative and flexible solutions focused on teaching and modeling parenting and problem-solving skills, developing skills necessary to manage behavior within the home/community environment and to prevent out-of-home placement. A variation of this stabilization service is available to those not enrolled in the pubic mental health system services provided by King County who are determined to need and agree to stabilization services upon initial crisis outreach services. They are available for up to eight weeks. This care is coordinated with new or existing community providers, including, but not limited to, other treatment providers, Department of Child and Family Services (DCFS) social workers and school staff.

Crisis Stabilization Beds (CSBs)

Crisis Stabilization Beds (CSBs) are designed for CCORS clients who would likely be hospitalized or experience another out of home placement without the use of a CSB, or are enrolled in RSN contracted mental health services and are in need of a CSB for hospital diversion. Crisis outreach teams facilitate access to these beds.

Potential Future Service Improvements

As part of broader efforts to improve crisis response countywide, CCORS and King County will explore potential ways to deliver crisis services for transition-age young adults up to age 21, and/or to serve previously homeless youth in behavioral health crisis.

◊ *B. Goals*

CCORS's main goals are:

- to provide a single, integrated, county-wide, comprehensive system of crisis outreach response, stabilization intervention, family reunification, and transition to community supports for children and youth; and
- to ensure the safety of children/youth and their families and/or caregivers who are facing crisis situations while helping them stay the least restrictive location via community-based services and supports.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

◊ *C. Expected Numbers of Individuals Served*

Historically the CCORS provider has not separately identified a number of clients served specifically due to the MIDD investment, although reports show that more than 1,000 clients per year benefit from CCORS services via blended funding from the partners described in section 2 below. King County BHRD may work with the provider to identify an appropriate number of clients to be served specifically as a result of MIDD 2 funding.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced hospital and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships
- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from a community-based organization with expertise in providing this service. See also 3.A and 3.B below.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Children's Crisis Outreach Response System (CD-11)

2. Spending Plan

As MIDD funding represents only a modest portion of the cost of the current comprehensive countywide program, federal block grant funds, state children's administration/DCFS funds, and state non-Medicaid funds remain essential to the program's full operation. The spending plan on the next page relates solely to the recommended MIDD investment.

Year	Activity	Amount
2017	Child/family teams with 24-hour availability to provide in-person support within two hours to any eligible child/family in crisis in King County, as well as short-term follow-up services and CSB access as needed	$563,750
2017 Annual Expenditure		**$563,750**
2018	Child/family teams with 24-hour availability to provide in-person support within two hours to any eligible child/family in crisis in King County, as well as short-term follow-up services and CSB access as needed	$578,408
2018 Annual Expenditure		**$578,408**
Biennial Expenditure		**$1,142,158**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Services will continue to be procured from the current CCORS provider. Competitive bids are not needed at this time, as a provider is already in place.

◊ *B. Contracting of Services*

A contract is in place with the current CCORS provider, the YMCA of Greater Seattle, and is expected to be renewed for the 2017-18 biennium.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with continuous availability of crisis services and no disruption for families served under MIDD I.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

MIDD 2 Initiative Title: Parent Partners Family Assistance

MIDD 2 Number: CD-12

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

This program provides family members and caregivers, youth, and community members (schools, faith organizations, social service and behavioral health agencies, etc.) with information about effectively navigating complex service systems, referrals to services, systems and supports for families, and/or direct support to utilize effective coping skills and strategies in person, via the telephone, or by text. Parent partners and youth peers support families where they need it (e.g., home, school, church, cafes, etc.). The current site for this work is located in an accessible office park in Kent. Some events and services are available at this office. Family social events and community educational offerings are provided throughout the county at parks, libraries, community centers, schools, churches, social service agencies, and other accessible locations.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The existing MIDD funds a free-standing, family-run, family support organization, currently known as Guided Pathways—Support for Youth and Families (GPS). GPS has a staff of three parent partners and one youth peer, in addition to the Executive Director and an administrative/volunteer coordinator. GPS provides parent training and education, 1:1 parent partner support, 1:1 youth peer support, a community referral and education help line, social and wellness activities for families, and advocacy. It also offers continuing education opportunities for peer support specialists employed in King County agencies, and maintains an informative and appealing website that includes a blog, a resource bank, and calendar of activities.

◊ *B. Goals*

The goals are to help families and youth who experience behavioral health challenges to:

- Increase their knowledge and expertise;
- Utilize effective coping skills and strategies to support themselves and/or their children/youth; and
- Effectively navigate complex service system(s).

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

◊ *C. Expected Numbers of Individuals Served*

This initiative serves at least 400 people annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- improved wellness self-management
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	System navigation services, educational and social events, other supports to youth and families, program management, and stakeholder coordination continue.	$420,250
2017 Annual Expenditure		**$420,250**
2018	System navigation services, educational and social events, other supports to youth and families, program management, and stakeholder coordination continue.	$431,177
2018 Annual Expenditure		**$431,177**
Biennial Expenditure		**$851,427**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with Guided Pathways—Support for Youth and Families (GPS) for this body of work. After two unsuccessful procurement processes during MIDD I BHRD worked with a consultant and stakeholders to establish GPS as a Family Support Organization to implement the MIDD 1 strategy. No RFP is needed for MIDD 2.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Parent Partners Family Assistance (CD-12)

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue in First Quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

MIDD 2 Initiative Title: Wraparound Services for Youth

MIDD 2 Number: CD-15

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Families with children or youth who have serious emotional and behavioral disturbances face numerous challenges that traditional services models are unable to address. These children or youth often experience profound difficulties with functioning in school, maintaining relationships with family and peers, coping with their emotions, and controlling their behavior. Sometimes these difficulties strain families to the point that they see no other solution than to place their child outside of their home. When families turn to formal systems for support, they may experience a fragmented process that is driven more by system needs than by the needs of the child, youth and family. This fragmented process further isolates these youth and families as they develop a mistrust of professionals and lose hope in their own recovery.

Families who participate in wraparound often describe it as the only approach that truly worked for them. They report feeling heard, and then begin to develop positive working relationships with professionals and systems, while also increasing their own resilience, self-determination, and overall well-being.[1] Throughout the phases of wraparound, youth and their families learn the skills needed to continue this process, informally creating a sustainable plan of care. This reduces reliance on formal systems, helps families to stay together and avoid the inappropriate use of more costly resources such as inpatient care, foster care, and/or the juvenile justice system.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Wraparound is a team based approach to serving youth with complex needs – typically those involved with two or more child-serving systems – and their families. Wraparound's intensive, strength based and individualized care planning and management supports youth in their community and within their family culture.[2] Wraparound is a proven, effective approach to developing and coordinating plans of care that build on the strengths of the child or youth and family. Resulting plans are individualized and based on the needs and goals identified by the family. Plans address the specific cultural needs of the family, with a goal that services and supports occur in the family's home and community whenever possible. A team of supportive individuals 'wraps' around the family to help them achieve their goals. The team is made up of professionals as well as 'natural' supports like relatives, neighbors, coaches, or clergy

[1] Bruns, E. J., Sather, A., Quick, H., Mudd, R, (2014, 2015) King County Wraparound Evaluation.
[2] The National Wraparound Initiative http://nwi.pdx.edu/

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

who will continue to be involved with the family for years. High-fidelity wraparound follows the guidelines as set forth in the National Wraparound Initiative.[3] Fidelity monitoring includes tracking outcomes and continuous observation and verification of the skills and practices of facilitators. Fidelity monitoring also supports continuous quality improvement.

The implementation of Wraparound in MIDD 2 will feature a blended funding and services model that fulfills the terms of a 2013 legal settlement with Washington State (*T.R. vs. Quigley and Teeter*). That settlement requires the provision of Wraparound with Intensive Services (known as WISe) by all regions in the state to Medicaid-eligible children and youth with complex behavioral health needs.[4] In King County, many of these individuals are currently served by MIDD Wraparound. The WISe program, as defined in the settlement agreement, consists of Wraparound, intensive community-based mental health services, and mobile crisis outreach and stabilization services. These services have been available in King County for several years, due in part to MIDD 1 investments in Wraparound and the Children's Crisis Outreach Response System (CCORS).

While some new Medicaid funds will be provided by the state to deliver WISe, the state's funds do not cover the costs of providing the delivery team and services required of the WISe program, nor do those funds support non-Medicaid activities and services that MIDD currently funds through MIDD 1 funding. MIDD funding also enables Wraparound to be provided to children and families not eligible for Medicaid, or not eligible for WISe services. (Under MIDD 1, Wraparound was provided to all families and children who met multiple systems involvement criteria, without regard to family means and without billing participants' private insurance.)

◊ *B. Goals*

Via a collaborative, facilitated process with an emphasis on family voice and choice, Wraparound brings multiple systems and natural supports together with a youth and family. The process and the system participants work together to create effective crisis and safety planning, support children and their families by addressing behaviors or unmet needs to prevent out of home placement, and help youth get back on track developmentally. As implemented in King County, Wraparound has a specific role in assisting families in avoiding long-term inpatient admission or helping a child rejoin family after a long-term inpatient stay or an institutional placement.

Similarly, the state-funded WISe initiative described in 1.A above, which will be paired with MIDD 2 Wraparound and also used to support outpatient and crisis programs, is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral needs and to their families. The goal of the program is for eligible youth to live and thrive in their

[3] Walker, J.S. and Bruns, E. J. "Wraparound Implementation Guide 2008-2014," National Wraparound Initiative, Portland, Oregon.
[4] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/childrens-mental-health-lawsuit-and-agreement

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements.[5]

◊ *C. Expected Numbers of Individuals Served*

During MIDD 1, Wraparound served an average of just over 600 clients per year from 2011 through 2015, with a maximum capacity of 450 youth at any given time. The MIDD funding level for Wraparound in MIDD 2 is lower than in MIDD 1 in anticipation of WISe funding supporting some aspects of Wraparound for Medicaid-eligible program participants. Under this blended funding and services model, at least 490 youth will be served per quarter, in accordance with the target established by the state. As funding from other sources including WISe permits, additional youth may be served.

A process to enable access to Wraparound services for children and youth from low- to moderate-income families who are not eligible for Medicaid and WISe will be developed in early 2017. This work will be informed by a workgroup in early 2017 as part of MIDD 2 implementation planning. The workgroup will specifically address financial and/or system use criteria. The number of non-Medicaid and/or non-WISe children to be served will be assessed via these criteria. Adjustments to program components to increase access while maintaining required fidelity will also be explored.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced substance use
- reduced jail, hospital, and emergency department use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive (outpatient) services
- educational achievement
- reduced behavioral health risk factors
- reduction of crisis events
- improved wellness and social relationships

◊ *E. Provided by: Contractors*

As in MIDD 1, referral management and other coordinating activities will be provided by King County, although County personnel expenditures will now be underwritten by the WISe Medicaid case rate revenues. Contracted Wraparound Delivery Teams (WDTs)

[5] https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/TR.ImplementationPlan.8.1.2014.pdf

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

will be assigned to specific regions of the county, and eligible referrals are assigned to the appropriate team.[6]

2. Spending Plan

Year	Activity	Amount
Program Elements Supported by MIDD 2:		
2017	Five regional Wraparound Delivery Teams to ensure countywide capacity including ability to serve some non-Medicaid/non-WISe children; flexible funds to meet clients' essential needs, including respite care via behavioral support aides; and training, monitoring, evaluation, and quality management	$3,075,000
2017 Annual Expenditure		**$3,075,000**
2018	Five regional Wraparound Delivery Teams to ensure countywide capacity including ability to serve some non-Medicaid/non-WISe children; flexible funds to meet clients' essential needs, including respite care via behavioral support aides; and training, monitoring, evaluation, and quality management	$3,154,950
2018 Annual Expenditure		**$3,154,950**
Biennial Expenditure		**$6,229,950**
Program Elements Supported by Medicaid WISe Funding:[7]		
Annual	Certain Medicaid-/WISe-eligible services per state plan	Supported by WISe case rate
Annual	Assessment survey instrument and implementation	Supported by WISe case rate
Annual	Program management: referral management, coaching, technical assistance, contract compliance	Supported by WISe case rate

[6] In consultation with a workgroup including stakeholders, the current five-region geographical allocation of funds and services will be adjusted for MIDD 2 to address current variation in caseload sizes and waitlists in different areas of King County.
[7] $2,156 per month per WISe-eligible child (via a case rate) funds some Wraparound services, and other intensive services. In King County, about $1,400 per child per month of this WISe case rate is expected to support Wraparound directly.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Wraparound Services for Youth (CD-15)

3. Implementation Schedule

◊ *A. Procurement of Providers*

As described in 1.C above, a workgroup will be convened to revisit both eligibility criteria and regional boundaries as part of planning for MIDD 2 Wraparound, along with program component adjustments to increase access, starting in first quarter 2017. Changes to these aspects of Wraparound service delivery may result in a new Request for Proposals (RFP), and will at a minimum result in changes to contract terms to reflect the effects of changes to the MIDD contribution level as well as expected revenue from the new WISe case rate funding stream.

◊ *B. Contracting of Services*

See 1.E and 3.A above.

◊ *C. Services Start date (s)*

King County BHRD's work to redefine this initiative will begin in the fourth quarter of 2016, with provider involvement to occur beginning in first quarter 2017 once funding levels are finalized. Implementation of the MIDD 2 initiative, including an RFP if needed, would be completed during the second quarter of 2017.

(Services at the five MIDD 1 Wraparound provider agencies will continue uninterrupted at MIDD 1 levels until this process is completed.)

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

MIDD 2 Initiative Title: Screening, Brief Intervention and Referral To Treatment-SBIRT (SBIRT)

MIDD 2 Number: PRI-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in vehicle and other crashes, as well as a heightened risk for other health problems, which may lead to emergency room admissions. SBIRT is a tool to universally screen and identify people with mild to severe substance use disorders (SUD) and/or who have depression or anxiety. Persons identified by SBIRT screening are given a brief intervention (BI) by a medical professional or counselor. The brief intervention (BI) addresses the individual's substance use, depression and/or anxiety and assists with establishing a plan to reduce use in the future. When indicated, patients are referred to specialty care for their substance use disorder, depression or anxiety.

In addition to identifying and intervening with people who have mild SUDs, SBIRT also identifies individuals with moderate to severe SUD and works to connect them (Referral to Treatment) to substance use treatment or options. In cases where there is not a SUD but there is an indication of depression or anxiety, patients are referred to a behavioral health specialist. In cases where SUD and depression and/or anxiety are present, depression/anxiety are handled first because often times the SUD is the self-medication for the depression/anxiety symptoms. SBIRT services connect behavioral and primary health care to effectively meet the needs of individuals.

1. Program Description

◊ *A. Service Components/Design (Brief)*

MIDD SBIRT services have focused on emergency departments (ED) by providing staff support to assist with SBIRT for SUD. Harborview ED, St Francis ED and Highline ED have staff that assist in SBIRT. Universal screening has not been possible with limited staff resources for an ED with 24 hour seven days per week operation.

SBIRT is provided to individuals when a patient shows an indication of use of alcohol or drugs; the SBIRT clinician is alerted and will complete a brief screen for alcohol and or drugs. The tools chosen are the Alcohol Use Disorders Identification Test (AUDIT)[1] and Drug Abuse Screening Test (DAST)[2]. Based on screen results a brief intervention using

[1] Babor TF, Higgins-Biddle JC , Saunders JB, Monteiro MG. *AUDIT: The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. 2nd Edition.* World Health Organization. 2001
[2] Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982, 7(4): 363-371.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

Motivational Interviewing techniques may be completed. The patient is offered assistance in connecting to further assistance with the behavioral health clinician either for a follow-up brief therapy visit or for a referral for an assessment. "Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence".[3]

◊ *B. Goals*

SBIRT is a universal public health approach to integrate behavioral and primary health care. Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in vehicle and other crashes, as well as a heightened risk for other health problems, which may lead to emergency room admissions. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 2500 individuals annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced hospital, and emergency department use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased use of preventive (outpatient) services
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007, 32:189-198.

[3] Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*, *23*, 325-334.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Screening, Brief Intervention and Referral To Treatment (PRI-1)

2. Spending Plan

Year	Activity	Amount
2017	Screening, Brief Intervention and Referral To Treatment in EDs continue.	$ 717,500
2017 Annual Expenditure		**$ 717,500**
2018	Screening, Brief Intervention and Referral To Treatment in EDs continue.	$736,155
2018 Annual Expenditure		**$ 736,155**
Biennial Expenditure		**$ 1,453,655**

3. Implementation Schedule

◊ *A. Procurement of Providers*

An RFP will be developed and released in the first quarter 2017.

◊ *B. Contracting of Services*

Contracting will be completed with new or continuing providers in the second quarter of 2017.

◊ *C. Services Start date (s)*

Services continue in first quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

MIDD 2 Initiative Title: Juvenile Justice Youth Behavioral Health Assessments & Improvements

MIDD 2 Number: PRI-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

A majority of youth entering the juvenile justice (JJ) system have underlying mental health and/or substance use disorder issues that may have caused the behavior which resulted in the initial need for juvenile justice involvement. This program assesses the behavioral health needs of youth and recommends service and treatment options in order to divert youth with mental illness and substance use disorder needs and diagnoses from further justice system involvement.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The MIDD 1 funds for this initiative provided mental health and substance use disorder screening/assessment services and psychological evaluations serves for King County youth age 12 years or older who have become involved with the juvenile justice system.

The team conducts assessments, makes recommendations to the Court regarding youth needs, including sentencing options and diversion from criminal justice sentencing due to underlying mental health or substance use disorder issues, refers youth to treatment services when a treatment need has been identified; and works to help youth follow-up on the treatment referrals and transition from screening/assessment/evaluation to ongoing treatment services when indicated.

Some of the contracted providers have been unable to keep the positions filled to conduct these services. For MIDD 2, in collaboration with the Court, communities, and stakeholders, BHRD will engage in system mapping and promising practice analysis to determine the best way to serve JJ youth with behavioral health needs and their families through integrated behavioral health with these funds.

◊ *B. Goals*

The goal of this program is to serve youth whose involvement with the juvenile justice system is due to behavioral health issues to get them to the right type of service and treatment so that treatment and justice outcomes are improved, including reduced recidivism, reduced alcohol and substance use, and improved behavioral health of the youth and family.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

◊ *C. Expected Numbers of Individuals Served*

Dependent upon program recommendations and design.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary incarceration

◊ *E. Provided by: Both County and Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Juvenile Justice assessments and treatment linkage services continue.	$584,250
2017 Annual Expenditure		**$584,250**
2018	Juvenile Justice assessments and treatment linkage services continue.	$599,441
2018 Annual Expenditure		**$599,441**
Biennial Expenditure		**$1,183,691**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Proposal and/or Request for Qualifications may be necessary.

◊ *B. Contracting of Services*

Contracts will be completed during the third quarter 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Justice Youth Behavioral Health Assessments & Improvements (PRI-2)

◊ *C. Services Start date (s)*

There is no service interruption; services remain in place into the 2017-2018 biennium.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

MIDD 2 Initiative Title: Prevention and Early Intervention Behavioral Health for Adults Over 50

MIDD 2 Number: PRI-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

Screening for depression, anxiety and substance use disorder is provided for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are enrolled in the Mental Health Integration Program (MHIP)[1], a short-term behavioral health intervention based on the Collaborative Care Model. The Collaborative Care Model is a specific model for integrated care developed at the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center to treat common mental health conditions that are persistent in nature and require systematic follow-up. Services take place in primary care clinics that are contracted under Public Health.

MHIP focuses on a defined patient population identified through screening and uses measurement-based practice and treatment to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7). Primary care providers work with behavioral health professionals to provide evidence-based medications and psychosocial treatments supported by regular consultation with a psychiatric specialist and treatment adjustment for patients who are not improving. Treatment lasts on average for six months.

Adults with more severe or complex needs that cannot be adequately treated in primary care are referred to mental health and substance use disorder treatment.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The MIDD Strategy Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+ provides prevention and intervention services for older adults to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses. This MIDD 2 initiative provides screening for depression, anxiety and substance use disorder for older adults (age 50+) receiving primary medical care in the health safety net system. Older adults who screen positive are be enrolled in the Mental Health Integration Program (MHIP),[2] a short-term behavioral health intervention based on the Collaborative Care Model.

[1] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip
[2] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

◊ *B. Goals*

The goal of this initiative is to reduce depression and anxiety (as measured by validated screening tools such as the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7) and to reduce or prevent more acute illness, high-risk behaviors, substance use, mental and emotional disorders, and other emergency medical or crisis responses.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve at least 4,000 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced emergency department use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary emergency department use

E. Provided by: Contractors

2. Spending Plan

Year	Activity	Amount
2017	Continued screening and intervention services for older adults	$484,639
2017 Annual Expenditure		**$484,639**
2018	Continued screening and intervention services for older adults	$497,240
2018 Annual Expenditure		**$497,240**
Biennial Expenditure		**$981,880**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Prevention and Early Intervention Behavioral Health for Adults Over 50 (PRI-3)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Public Health – Seattle and King County manages this initiative as part of the Mental Health Integration Program (MHIP). No RFP is needed.

◊ *B. Contracting of Services*

See 3.A above.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Older Adult Crisis Intervention/Geriatric Regional Assessment Team (PRI-4)

MIDD 2 Initiative Title: Older Adult Crisis Intervention/Geriatric Regional Assessment Team (GRAT)

MIDD 2 Number: PRI-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

GRAT provides a comprehensive assessment, crisis intervention, and referral and linkage to community resources for older adults struggling with mental health and/or chemical dependency issues. By intervening early, GRAT effectively diverts many of the older adults it serves from using other more costly services, such as inpatient psychiatric hospitalization, emergency rooms, skilled nursing facilities, and jail. GRAT also provides consultation, care planning, and education on older adult mental health issues for other community providers.

1. Program Description

◊ *A. Service Components/Design (Brief)*

GRAT provides a specialized outreach crisis and mental health assessment, including a substance use screening, that is age, culturally, and linguistically appropriate for King County residents age 60 years and older who are experiencing a crisis in which mental health or alcohol and/or other drugs are a likely contributing factor and/or exacerbating the situation, and who are not currently enrolled in mental health services under the King County Mental Health Plan.

◊ *B. Goals*

GRAT provides assessment, crisis intervention and referral for older adults throughout King County, and for many, this service diverts them from using more intensive and costly crisis services (hospital emergency room, psychiatric hospitalization, jail, etc.). This program is consistent with the Recovery model, in that it focuses on helping those older adults most in need to improve their wellbeing, get the assistance needed to accomplish this, and to help older adults live as independently as possible.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 340 annually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Older Adult Crisis Intervention/Geriatric Regional Assessment Team (PRI-4)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced hospital and emergency department use
- reduced substance use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- reduction of crisis events
- reduced unnecessary hospital and emergency department use

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued specialized outreach crisis and mental health assessment, including substance use screening, for older adults	$329,025
2017 Annual Expenditure		**$329,025**
2018	Continued specialized outreach crisis and mental health assessment, including substance use screening, for older adults	$337,580
2018 Annual Expenditure		**$337,580**
Biennial Expenditure		**$666,605**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD contracts with EvergreenHealth (EH) for GRAT services under MIDD 1. The county may elect to re-RFP this service supported by MIDD 2 funds. EvergreenHealth also receives funding from other sources that supports the program.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students (PRI-5)

MIDD 2 Initiative Title: Collaborative School Based Behavioral Health Services: Middle and High School Students

MIDD 2 Number: PRI-5

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

This initiative includes the development and integration of school-based SBIRT (screening brief intervention & referral to treatment)[1] services. School-based SBIRT will include working with all middle schools on the development and implementation of SBIRT services, which includes training and technical assistance in the Global Appraisal of Individual Need - Short Screen (GAIN-SS). The GAIN-SS is a 23-question screening tool that quickly and effectively screens for depression, anxiety, substance abuse, and other behavioral health disorders.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The current MIDD Collaborative School Based Mental Health and Substance Abuse Services strategy invests in prevention/early intervention for school-based services provided in middle schools. These services include: assessments, screenings, brief intervention, referral, case coordination and mental health and behavioral health support groups, including social skills groups, anger management groups, and recovery groups. MIDD School Based Suicide Prevention provides students and schools suicide prevention trainings. Youth are trained on stress management and suicide prevention. Adults are trained on identification of early signs of stress, depression, and suicide ideation, and how to handle these issues in families and in youth-serving organizations. School-based MIDD prevention services will continue and be expanded as part of Best Starts for Kids (BSK).

These previously separate MIDD supported programs are combined into one initiative under MIDD 2.

◊ *B. Goals*

The goals of this initiative are:

- Reduce the risk of students developing mental or emotional illness, or using drugs/alcohol;
- Reduce poor school performance, to prevent school dropout, and to decrease other problem behaviors experienced by youth; and

[1] http://www.integration.samhsa.gov/clinical-practice/SBIRT

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students (PRI-5)

- To build collaboration between organizations in order to connect middle school-aged students or high school-aged students to needed mental health and substance abuse services in the school and community.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 1,000 youth in individual and small group services and 5,000 people in large group activities.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced substance use
- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- educational achievement
- improved wellness and social relationships
- reduced behavioral health risk factors

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	School-Based prevention services, program management, and stakeholder coordination continue.	$1,579,652
2017 Annual Expenditure		**$1,579,652**
2018	School-Based prevention services, program management, and stakeholder coordination continue.	$1,607,552
2018 Annual Expenditure		**$1,607,552**
Biennial Expenditure		**$3,187,204**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Collaborative School Based Behavioral Health Services: Middle and High School Students (PRI-5)

3. Implementation Schedule

◊ *A. Procurement of Providers*

A planning period will involve coordinating this MIDD 2 Initiative with Best Starts for Kids to ensure a comprehensive program is developed across initiatives. A RFP will be released in the second quarter 2017.

◊ *B. Contracting of Services*

Contracts will be completed in the third quarter 2017.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Crisis Intervention Training – First Responders (PRI-8)

MIDD 2 Initiative Title: Crisis Intervention Training – First Responders

MIDD 2 Number: PRI-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goals of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

CIT is an intervention primarily focused on increasing the understanding and use of community-based resources to help reduce the reliance on and use of jail and hospitals. The initial strategy goals were to increase diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement, and to reduce the number of people with mental health and substance use disorders using costly interventions such as jail, emergency rooms, and hospitals.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Crisis Intervention Training (CIT) is a model of police-based crisis intervention with community behavioral health care and advocacy partnerships. CIT provides intensive training to law enforcement and other first responders that teaches them to effectively assist and respond to individuals with mental illness or substance use disorders, and better equips them to help individuals access the most appropriate and least restrictive services while preserving public safety.

◊ *B. Goals*

The goals for CIT are to increase safety for first responders, individuals, and the community; increase options and tools when responding to individuals in crisis; and encourage and increase the use of community resources resulting in decreased jail bookings and hospital emergency department admissions.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 600 participants.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Crisis Intervention Training – First Responders (PRI-8)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased skills related to crisis de-escalation/intervention
- improved perception of health and behavioral health issues and disorders

◊ *E. Provided by: Both County and Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Crisis intervention trainings to law enforcement and other first responders continue.	$ 820,000
2017 Annual Expenditure		**$ 820,000**
2018	Crisis intervention trainings to law enforcement and other first responders continue.	$ 841,320
2018 Annual Expenditure		**$ 841,320**
Biennial Expenditure		**$ 1,661,320**

3. Implementation Schedule

◊ *A. Procurement of Providers*

BHRD currently contracts with the Washington State Criminal Justice Training Commission and coordinates the King County Sheriff's Office for CIT services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Trainings continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

MIDD 2 Initiative Title: Sexual Assault Behavioral Health Services

MIDD 2 Number: PRI-9

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The sexual assault service delivery system addresses a unique set of needs as compared to broader community mental health treatment. In the sexual assault service system, victims and/or their families are seeking services as a result of the crime and its impact. They may have a variety of specific needs including medical, forensic, crisis response, information, advocacy to assist with legal needs and counseling. Often victims and families may not know the variety of issues and the impacts of the assault.[1]

Community sexual assault programs (CSAPs) are designed to provide holistic services tailored to the sexual assault-specific needs of victims. Because of their experience with and in-depth of knowledge of all aspects of sexual assault, the organizations are equipped to anticipate and respond based on an individualized assessment of needs. CSAPs provide empirically supported services through a trauma-informed lens. This holistic response means that the organization can address the full range of concerns about legal, medical and other systems that may adversely affect mental health outcomes, while also providing brief early interventions to reduce the likelihood of longer term mental health distress. For individuals who develop persisting sexual assault-specific mental health problems, effective evidence-based interventions are provided.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Services currently provided by the CSAPs as part of this initiative include the following:

- Screening and assessment to identify the mental health and/or substance use disorder (SUD) needs of survivors receiving sexual assault services at the Contractor;
- Evidence-based trauma-focused therapy for those children, teen, and adult survivors of sexual assault who would benefit from the therapy;[2] and

[1] This contrasts with typical assistance from traditional public mental health settings where clients are eligible for services if they meet access to care criteria related to a mental health disorder, and their unique needs related to the assault may or may not be able to addressed directly in that setting.
[2] Evidence-based services at King County's CSAPs include trauma-focused cognitive behavioral therapy (TF-CBT), prolonged exposure (PE), prolonged-exposure-adolescent (PE-A), cognitive processing therapy (CPT), parent child interaction therapy (PCIT), and the common elements treatment approach (CETA), and other evidence-based approaches proven effective for post-traumatic stress disorder including interventions specifically for children.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

- Referrals to community mental health and SUD treatment agencies for those sexual assault survivors who need more intensive services.

◊ *B. Goals*

This initiative aims to increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County.

◊ *C. Expected Numbers of Individuals Served*

Historically CSAPs have not been able to separately identify a number of clients served specifically due to the MIDD 1nvestment, although reports show that approximately 350 clients per year benefit from CSAP services via blended funding. In consultation with providers, King County BHRD will work to identify an appropriate number of clients to be served specifically as a result of MIDD 2 funding if possible.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:
- emotional health
- daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:
- increased use of preventive (outpatient) services
- reduced behavioral health risk factors
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from community-based organizations. See also 3.A below.

2. Spending Plan

Year	Activity	Amount
2017	Screening and evidence-based sexual assault therapy	$584,250
2017 Annual Expenditure		**$584,250**
2018	Screening and evidence-based sexual assault therapy	$599,441
2018 Annual Expenditure		**$599,441**
Biennial Expenditure		**$1,183,691**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Sexual Assault Behavioral Health Services (PRI-9)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Clinical services will be procured from agencies with expertise in evidence-based sexual assault therapy.

◊ *B. Contracting of Services*

Contracts are in place with two CSAPs for evidence-based therapy services. These are expected to continue without need for a competitive bidding process, and will be revised for 2017 to reflect MIDD 2 funding levels, performance targets, and outcome tracking expectations.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with no disruption for clients served under MIDD 1.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

MIDD 2 Initiative Title: Domestic Violence Behavioral Health Services and System Coordination

MIDD 2 Number: PRI-10

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

Survivors of domestic violence are at greater risk of developing a variety of mental health disorders, including depression, anxiety and post-traumatic stress disorder. Survivors are often in an environment of on-going trauma, which can prolong and exacerbate their mental health concerns, increase their vulnerability and compromise their safety.

This initiative's model of early, accessible mental health intervention combined with integrated advocacy and other supportive services decreases the risk of mental health concerns and other negative impacts of domestic violence and increases survivor stability and capacity to cope. The initiative also decreases barriers for survivors by identifying areas of concern (screening), providing trauma-informed therapy integrated with advocacy, and facilitating referrals to other appropriate behavioral health support.

The system coordination component of this initiative aims to support information-sharing, consultation, and expertise dissemination across the domestic violence, sexual assault, and behavioral health systems.

1. Program Description

◊ *A. Service Components/Design (Brief)*

<u>Co-Located Mental Health Professional (MHP) Component</u>

This initiative co-locates MHPs with expertise in domestic violence (DV) and substance use disorders in community-based domestic violence victim advocacy programs around King County. Of these, some staff are expected to serve in an organization serving marginalized population(s), such as people of color or LGBTQ individuals.

Services provided by co-located mental health professional include the following:

- Screening using an evidence-based instrument
- Assessment
- Brief therapy and mental health support, both individually and in groups
- Referral to mental health and substance use disorder treatment for those DV survivors who need more intensive services
- Consultation to DV advocacy staff and staff of community mental health or substance use treatment agencies

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

Culturally Appropriate Clinical Services Component

This initiative also funds clinical consultation and training for a team of domestic violence advocates providing direct care – including screening, assessment, brief therapy, and referral as above – to clients in multiple languages, at an agency specializing in the provision of services to immigrant and refugee survivors of domestic and sexual violence.

System Coordination Component

In addition to treatment services, this initiative also supports ongoing cross training, policy development, and consultation on domestic violence (DV), sexual assault, and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County. The systems coordinator offers training, consultation, relationship-building, research, policy and practice recommendations, etc. for clinicians and agencies who wish to improve their response to survivors with behavioral health concerns but who lack the time or knowledge to do so.

◊ *B. Goals*

The overall goals of this initiative include the following:

- To promote a reduction in the incidence and severity of substance abuse, mental and emotional disorders in youth and adults.
- To integrate mental health services within community-based domestic violence agencies, including training and consultation for advocacy and other staff, making services more accessible to domestic violence survivors.
- To improve screening, referral, coordination, and collaboration between mental health, substance use disorder, domestic violence, and sexual assault service providers.

◊ *C. Expected Numbers of Individuals Served*

Approximately 750 to 800 clients will be served per year through the clinical components of this initiative.

The system coordination component of this initiative includes training for approximately 1,800 professionals per year, among other services provided.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased use of preventive services

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

- reduced behavioral health risk factors
- improved wellness and social relationships
- improved experience of care
- increased application of trauma-informed principles in services

◊ *E. Provided by: Contractor*

Services for this initiative will be procured from community-based organizations. See also 3.A below.

2. Spending Plan

This spending plan provides for expanded capacity at agencies that were funded under MIDD 1, and creates the potential for added services at a new agency serving marginalized populations.

Year	Activity	Amount
2017	Behavioral health screening, brief therapy, and referral co-located within DV agencies, including services for marginalized populations; culturally appropriate behavioral health consultation within agency serving immigrant and refugee survivors; and system coordination, training, and consultation[1]	$563,750
2017 Annual Expenditure		**$563,750**
2018	Behavioral health screening, brief therapy, and referral co-located within DV agencies, including services for marginalized populations; culturally appropriate behavioral health consultation within agency serving immigrant and refugee survivors; and system coordination, training, and consultation	$578,408
2018 Annual Expenditure		**$578,408**
Biennial Expenditure		**$1,142,158**

[1] Under MIDD 1, funding for this role was divided between strategies addressing sexual assault and DV. Under a potential MIDD 2, although the function of the position is unchanged and is designed to cross between these systems, for administrative purposes it is funded under the DV initiative only at the request of stakeholders.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Domestic Violence Behavioral Health Services and System Coordination (PRI-10)

3. Implementation Schedule

◊ *A. Procurement of Providers*

Clinical services will be procured from agencies with expertise in serving survivors of DV that have the capacity to incorporate a co-located mental health professional. Coordination functions will be procured from an organization with relevant expertise in training, consultation, and/or system coordination.

Competitive bids are not needed at this time for the system coordination portion of this initiative, as a provider is already in place.

Among clinical services funded under this initiative, most are expected to continue to be contracted to DV providers that were funded under MIDD 1 (including culturally appropriate services for immigrants and refugees).

Some funds may be contracted to a new agency that serves marginalized population(s). If this approach is selected, a Request for Proposals (RFP) process may occur to identify an agency to provide this additional system capacity.

◊ *B. Contracting of Services*

Contracts are in place with four DV agencies for co-located MHPs. These are expected to continue without need for a competitive bidding process, and will be revised for 2017 to reflect MIDD 2 funding levels, performance targets, and outcome tracking expectations. A new contract may be needed if a new agency is selected for the expanded clinical services.

The contract for system coordination encompassing sexual assault and domestic violence is similarly expected to continue at the same agency.

◊ *C. Services Start date (s)*

MIDD 2 services can begin immediately in January 2017, with no disruption for clients served under MIDD 1.

If a new agency is selected for the expanded clinical services for marginalized population(s), services would likely be in place by third quarter 2017 after completion of the RFP process.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

MIDD 2 Initiative Title: Community Behavioral Health Treatment

MIDD 2 Number: PRI-11

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The current community need for behavioral health treatment is significant. There is a large unserved population of people who are not on Medicaid, or do not qualify for Medicaid, whose behavioral health needs are only addressed when their need reaches crisis proportions - either in hospital emergency departments, in-patient care, or jails. Over half of the individuals with mental illness who are admitted to psychiatric hospitals do not have Medicaid coverage. Eleven percent of people in King County over the age of 18 suffer from frequent mental distress; most are living in poverty and many live in South King County.[1] Twenty-seven percent of school-aged youth are experiencing depression, many of which are minorities living in South King County;[2] 29 percent of in-school youth in King County report having used some type of illicit drug within the past 30 days. [2] These treatment services decrease disparities across King County so that all residents have the opportunity to achieve their full potential.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative provides mental health (MH) and substance use disorder (SUD) services to those who are not served by Medicaid, including undocumented individuals, incarcerated individuals, people on Medicare, people who are under 220 percent of the federal poverty level and have extremely high co-pays and deductibles in order to access service, people on Medicaid spend down (meaning they have to pay a certain amount of out of pocket expense every six months before Medicaid reimbursement kicks in), and people who are pending Medicaid coverage. In addition, this initiative provides essential services that are part of the treatment continuum not covered by Medicaid such as outreach, transportation, and peer support (SUD specifically).

[1] Behavioral Risk Factor Surveillance System. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014. http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx

[2] Healthy Youth Survey. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014. http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

◊ *B. Goals*

The goals of the strategy are to increase access to and provide services for individuals who are currently ineligible for Medicaid, decrease the number of people with behavioral health issues who are re-incarcerated or re-hospitalized, reduce jail and inpatient utilization, and homelessness.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 3500 people at least annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- reduced substance use
- improved daily functioning
- improved emotional health
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- reduction of crisis events
- reduced unnecessary jail, hospital and emergency department use

◊ *E. Provided by: Contractors*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Community Behavioral Health Treatment (PRI-11)

2. Spending Plan

Year	Activity	Amount
2017	Continued mental health and substance use disorder services for people who are not served by Medicaid, essential services in the care continuum that are not covered by Medicaid, and program management.	$11,890,000
2017 Annual Expenditure		**$11,890,000**
2018	Continued mental health and substance use disorder services for people who are not served by Medicaid, essential services in the care continuum that are not covered by Medicaid, and program management.	$12,199,140
2018 Annual Expenditure		**$12,199,140**
Biennial Expenditure		**$24,089,140**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health providers currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Supportive Services (RR-1)

MIDD 2 Initiative Title: Housing Supportive Services

MIDD 2 Number: RR-1

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

This initiative provides housing support services to chronically homeless adults. Individuals that have previously been unsuccessful in housing due to lack of stability and/or lack of daily living skills become successfully housed with the assistance of housing support specialists. Housing stability reduces use of criminal justice and emergency medical systems.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Housing supportive services includes assistance to help the individual meet the obligations of tenancy, i.e. rent payments, abide by landlord rules, cooperate with neighbors, keep the apartment clean and safe; assistance with learning the daily living skills to live independently, i.e. shopping, cooking, budgeting, cleaning; coordination with behavioral health treatment providers and healthcare providers; and helping individuals get to medical appointments. Housing support services assist individuals in moving from homelessness to housing stability. Services are provided primarily at the individual's housing site and in the surrounding community by housing support specialists.

◊ *B. Goals*

The goal of this initiative is to increase the number of housed individuals with mental illness and chemical dependency who are receiving supportive housing services, leading to increased housing tenure and housing stability. Housing stability is a key determinant in increasing treatment participation and in reducing use of criminal justice and emergency medical systems.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 140 people each year initially with capacity growing over time as new annual awards are included.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- improved daily functioning

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Supportive Services (RR-1)

- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved wellness self-management
- reduction of crisis events
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary jail, hospital and emergency department use

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued housing supportive services for individuals with behavioral health conditions.	$2,050,000
2017 Annual Expenditure		**$2,050,000**
2018	Continued housing supportive services for individuals with behavioral health conditions.	$2,096,712
2018 Annual Expenditure		**$2,096,712**
Biennial Expenditure		**$4,146,712**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The King County DCHS Housing Finance Program (HFP) administers and oversees funding for housing stability and services programs. MIDD 2 funding will be allocated to the HFP in January 2017. HFP distributes MIDD Housing Supportive Services as part of the HFP annual Notice of Funding Availability (NOFA) RFP process.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP) (RR-2)

MIDD 2 Initiative Title: Behavior Modification Classes at Community Center for Alternative Programs (CCAP)

MIDD 2 Number: RR-2

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative is expeced to impact the recommended MIDD policy goal of "Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The Moral Reconation Therapy (MRT) model in this initative uses a positive group dynamic to alter inappropriate thought and behavior amongst domestic violence (DV) offenders. The Moral Reconation Therapy-Domestic Violence (MRT-DV) pilot program adaptation is a cognitive-behavioral program designed to change how DV offenders think (beliefs) and change behavior to one of equality and acceptance. The MRT-DV adaptation takes approximately 55 sessions to complete, which are conducted twice weekly at CCAP. Both the MRT-DV and standard DV education occur within a 60-day court order to CCAP.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative enhances program services offered at CCAP in the areas of behavioral health education and intervention, and addresses criminogenic risk factors specifically associated with DV. Since 2014, MIDD has supported a clinician from Sound Mental Health (SMH) trained in MRT and the specialized DV version to prepare and facilitate groups for one caseload of 15 men participants who are randomly assigned to the MRT-DV program at CCAP for approximately 60 days. All MRT-DV participants have a substance use disorder, primarily involving alcohol and/or cannabis. Participants are clinically assessed and enrolled in appropriate substance use disorder (SUD) treatment at CCAP per American Society of Addiction Medicine criteria.

◊ *B. Goals*

The program goal is to realize an increase in the scope and effectiveness of the services offered at CCAP and appropriately address the changing service needs of court-ordered participants. Specifically, the MRT-DV pilot was implemented to intervene and provide a holistic array of services including outpatient SUD treatment with court monitoring to promote participant behavior change and recovery, and reduce recidivism and victimization.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP)
(RR-2)

◊ *C. Expected Numbers of Individuals Served*

This initiative is expected to serve 40 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- reduced unnecessary incarceration

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Moral Reconation Therapy – Domestic Violence version for CCAP clients	$77,900
2017 Annual Expenditure		**$77,900**
2018	Moral Reconation Therapy – Domestic Violence version for CCAP clients	$79,925
2018 Annual Expenditure		**$79,925**
Biennial Expenditure		**$157,825**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health provider currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavior Modification Classes at Community Center for Alternative Programs (CCAP)
(RR-2)

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

MIDD 2 Initiative Title: Housing Capital and Rental

MIDD 2 Number: RR-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The initiative will provide a dedicated source of capital funding for the creation of housing units specifically set aside for the behavioral health needs population struggling with mental health and substance use disorders (SUDs) who are homeless or being discharged from hospitals, jails, prison, crisis diversion facilities or residential chemical dependency treatment. Dedicated housing for this population decreases homelessness, the need for medical care/hospital stays, and jail time.

It also supports housing stability by investing in rental subsidies individuals living in existing supportive housing settings.

1. Program Description

◊ *A. Service Components/Design (Brief)*

Supportive housing with services targeted to people with behavioral health conditions will feature, as much as feasible, a Housing First approach. Housing First is a homeless best practice, designed to create a stable environment where households can address their health issues while receiving additional employment and stable housing services.

Capital funding to create housing is paired with service funding to ensure success of those being housed. While the level of service may vary, for most households facing behavioral health conditions, some level of services will be required for success.

Permanent supportive housing is the most service-enriched housing environment. Many individuals and households with persistent mental illness and/or chronic addiction need this high intensity level of services. Although costly, permanent supportive housing is still more cost effective when compared to homelessness and frequent hospitalization and/or incarceration.

A portion of funds under this initiative will also be used to continue rental subsidies in existing supportive housing projects. These were supported by MIDD 1.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

◊ *B. Goals*

The primary focus of this initiative is the creation of housing – to be paired with services through companion MIDD 2 initiative Housing Supportive Services, Medicaid supported housing funding, and/or other sources – to support extremely low income households with mental illness and/or substance abuse issues.[1] This initiative will serve extremely low income populations below 30 percent of the area median income struggling with mental illness and/or SUDs who are likely to be predominantly homeless.

In addition to creating new housing, a portion of this initiative supports housing access by providing rental subsidies for individuals in existing supportive housing settings.

◊ *C. Expected Numbers of Individuals Served*

The number of individuals to be served by capital investments from this initiative will vary depending on which projects are funded. The number of ongoing rental subsidies to be provided will be determined based on available funding for this purpose, as well as market factors.[2]

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail, hospital, and emergency department use
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced behavioral health risk factors
- improved wellness self-management
- reduced unnecessary incarceration, hospital, and emergency department use
- increased housing stability

◊ *E. Provided by: Contractor*

As described in 3.A and 3.B below, capital funding will be disbursed to housing developers via RFPs administered by King County. Capital funds from MIDD will be paired with capital investments from other funders, and will be linked to services appropriate to each project's target population.

Rental subsidies are contracted by BHRD to supportive housing provider(s).

[1] A key consideration for this initiative is the connection between housing capital and service funding. Neither service dollars nor capital funds alone can produce the amount of successful supportive housing required to reduce the incidence of homelessness. To be successful any housing dedicated to MIDD populations must include services.
[2] During MIDD 1, 25 rental subsidies were provided for supportive housing.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

2. Spending Plan

This spending plan shows estimated amounts and expected categories for MIDD 2's recommended contribution to housing capital and rental subsidies.

Estimated costs below are expected to be adjusted depending on market factors and/or as specific capital project opportunities arise.

Year	Activity	Amount
2017	Capital investments for new permanent supportive housing units for people with behavioral health conditions; and rental subsidies for people with behavioral health conditions	$2,393,584
2017 Annual Expenditure		**$2,393,584**
2018	Capital investments for new permanent supportive housing units for people with behavioral health conditions; and rental subsidies for people with behavioral health conditions	$2,455,816
2018 Annual Expenditure		**$2,455,816**
Biennial Expenditure		**$4,849,400**

3. Implementation Schedule

◊ *A. Procurement of Providers*

Following existing processes for capital projects, MIDD funding under this initiative for capital projects will be allocated to the King County DCHS Housing Finance Program (HFP) immediately in January 2017, with RFPs for project developers to be released in second quarter 2017, reviewed in third quarter 2017, and awarded in fourth quarter 2017 including specific housing set-aside commitments for funded projects.

The HFP and BHRD program staff will review all capital proposals received through the RFP to determine the capacity and experience of the housing developers and service providers, as well as the financial feasibility of each project. The number of proposals received each year will vary, so the number of projects awarded capital MIDD funding will also vary annually.

Awards will be made based on availability of all funding provided from King County as well as the developer's ability to secure any and all additional capital funding from all other sources, such as other state and local funding.

King County DCHS is moving toward a targeted capital affordable housing allocation process. Rather than publishing a general request for proposals, over several years

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing Capital and Rental (RR-3)

DCHS will shift the request for proposal (RFP) process to one that solicits proposals for specific projects. MIDD funds will be included in this process.

◊ *B. Contracting of Services*

Contract negotiation timing for capital projects will depend on how quickly other funding is secured, including other capital funding and service funding via MIDD and/or other sources. In general, negotiated contracts are in place within six months of award.

Rental subsidy funding will continue to be disbursed by BHRD via contract to supportive housing provider(s).

◊ *C. Services Start date (s)*

Rental subsidies will continue without disruption beginning in January 2017.

Services for clients will begin when housing projects are built, and paired supportive services are in place.

This process will be completed at least annually in order to continue to fund additional units and projects in future years.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing - Adult Drug Court (RR-5)

MIDD 2 Initiative Title: Housing - Adult Drug Court (ADC)

MIDD 2 Number: RR-5

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The recovery-oriented, transitional housing units and housing support services provide the opportunity to stably house vulnerable participants while decreasing the use of jail, shelters and other temporary housing options, which supports recovery and improved behavioral health outcomes. This initiative prevents homelessness for a vulnerable population.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative provides recovery-oriented, supportive, transitional housing units and housing support services for ADC participants. The majority of the added units will be single adult units, however some will accommodate families. Financial assistance for move-in costs for up to 25 percent of the single adults and 75 percent of the families who successfully complete the recovery-oriented housing program and transition to permanent housing will be provided. This initiative reduces and prevents homelessness and recidivism in King County by providing safe, supportive and stable housing.

◊ *B. Goals*

The goals of this initiative are to reduce homelessness for those involved in ADC and increase graduation rates of ADC participants. Those who graduate from ADC have more opportunities for employment, health and overall well-being, and stable, safe permanent housing.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve at least 30 people annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use
- housing stability

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Housing - Adult Drug Court (RR-5)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- reduced unnecessary incarceration
- Achievement of greater equity in ADC graduation rates between those who are experiencing homelessness at ADC start and those who are stably housed

◊ *E. Provided by: Contractors*

2. Spending Plan

Year	Activity	Amount
2017	Housing units and housing support services for ADC participants.	$231,136
2017 Annual Expenditure		**$231,136**
2018	Housing units and housing support services for ADC participants.	$237,146
2018 Annual Expenditure		**$237,146**
Biennial Expenditure		**$468,282**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Department of Judicial Administration manages Adult Drug Court and has contracts with housing providers. A RFP will be released in first quarter 2017.

◊ *B. Contracting of Services*

Contracting of services will be completed in second quarter 2017.

◊ *C. Services Start date (s)*

Expanded housing units and housing support services will be available in second quarter 2107.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

MIDD 2 Initiative Title: Jail Reentry System of Care

MIDD 2 Number: RR-6

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The MIDD 1 Reentry Case Management Services (RCMS) program consists of a small team of reentry case managers, including a Mental Health Professional (MHP) lead, and provides up to 90 days of reentry linkage case management services, which begin prior to release from jail (within 45 days) and continues through transition to the community. The RCMS program provides assistance that may include obtaining the following:

- Public entitlements and Apple Health/Medicaid enrollments (includes linkage to state and federal entitlements application);
- Basic needs resources (e.g. clothing, food, hygiene);
- Transportation;
- Identification (ID) upon release from custody;
- Mental health treatment (primarily outpatient);
- Substance Use Disorder (SUD) treatment (both residential and outpatient);
- Primary physical healthcare (including dental care);
- Housing (linking to emergency shelter, transitional and linkage to assessment for permanent supportive housing and low-income public housing);
- Employment; and
- Education and other job training.

1. Program Description

◊ *A. Service Components/Design (Brief)*

A continuum of care better serves individuals with behavioral health conditions who are booked into jail facilities within King County (including misdemeanor jails). This program links closely with all other programs and services the individual is receiving or needing in order to achieve stability in the community.

◊ *B. Goals*

The goal of this initiative is to provide increased access to intensive, short term case management to individuals with mental health and/or chemical dependency disorders who are close to release/discharge and in need of assistance in reintegrating back into the community. This includes providing immediate assistance for more participants in accessing publicly funded benefits (if eligible), housing, rental

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

assistance, outpatient treatment and other services including education, training, and employment in the community upon release/discharge.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 350 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail and emergency department use
- improved emotional health
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- improved wellness self-management
- increased use of preventive (outpatient) services
- reduced unnecessary jail and emergency department use

◊ *E. Provided by: Contractor-See below*

2. Spending Plan

Year	Activity	Amount
2017	Intensive, short term case management to individuals with behavioral health conditions who are close to release/discharge from jail	$435,625
2017 Annual Expenditure		**$435,625**
2018	Intensive, short term case management to individuals with behavioral health conditions who are close to release/discharge from jail	$446,951
2018 Annual Expenditure		**$446,951**
Biennial Expenditure		**$882,576**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Jail Reentry System of Care (RR-6)

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County contracts with South Seattle Community College, New Beginnings, and Sound Mental Health for services. No RFP is required. A planning process in the first quarter of 2017 will determine what improvements and can be made to this initiative to better serve clients under MIDD 2.

◊ *B. Contracting of Services*

To be determined, pending first quarter 2017 review.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017. If services are revised, new services are expected to begin in the second or third quarter of 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Reentry Respite Beds (RR-8)

MIDD 2 Initiative Title: Hospital Reentry Respite Beds

MIDD 2 Number: RR-8

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Research has shown that people who experience homelessness with health conditions struggle to establish and/or maintain appropriate treatment within the mainstream health care system[1]. Many people experiencing problems are caught up in cycles of crisis and lack the family and other social supports as well as the income and other material resources that might help them break these cycles. The individuals are extremely challenging for behavioral health and medical providers to locate and engage, let alone establish in an ongoing plan of treatment. Their chronic behavioral health and medical conditions worsen, their likelihood of involvement with the criminal justice system escalates, and, in many cases, they begin to cycle in and out of emergency rooms, inpatient hospital stays, and jail.

These dynamics help explain the significantly higher risk of hospital readmission for patients experiencing homelessness that has been established in numerous research studies.[2] This increased risk relates to the scarcity of places in which homeless patients can safely rest and obtain the support they need to fully recuperate. It also relates to behavioral health disorders that can lead to behaviors that complicate or undermine recuperation.[3] Because of this risk, hospitals often delay discharge of homeless patients past the point at which they would discharge a person with housing and other necessary supports for recuperation and thus past the point that is medically indicated.[4] Their experience has shown that when a person's living situation makes it impossible to adequately rest, keep from walking or putting weight on a joint, or keep a surgical site clean, the hospital is much more likely to see the person return for infections or other problems that necessitate readmission.

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[1] Bonin E, Brehove T, Carlson C, Downing M, Hoeft J, Kalinowski A, Solomon-Bame J, Post P. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 50 pages. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2010.
[2] Buchanan, D., Doblin, B., Sai, T. & Garcia, P. *The Effects of Respite Care for Homeless Patients: A Cohort Study* American Journal of Public Health Vol. 96, No. 7: 1278-1281, 2006.
[3] Thompson, SJ, Bender KA, Lewis CM, Watkins R. *Shelter-based Convalescence for Homeless Adults*. Canadian Journal of Public Health, Vol. 97, Issue 5: 379-383, 2006.
[4] Gundlapalli A, Hanks M, Stevens SM, Geroso AM, Viavant CR, McCall Y, Lang P, Bovos M, Branscomb NT, Ainsworth AD.. *It takes a village: a multidisciplinary model for the acute illness aftercare of individuals experiencing homelessness*. Journal of Health Care for the Poor and Underserved. Vol. 16 Issue 2:257-72, 2005.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Reentry Respite Beds (RR-8)

1. Program Description

◊ *A. Service Components/Design (Brief)*

The Edward Thomas House Medical Respite Program provides comprehensive recuperative care after an acute hospital stay for people who are living with homelessness, focusing particularly on those with disabling substance use and mental health conditions. The recuperative care is a critical intervention for a segment of the population with high rates of emergency room and hospital utilization as well as involvement in the criminal justice system. In addition to intensive medical and mental health care, patients at Edward Thomas House (ETH) receive intensive case management services to help them transition from their stay to ongoing behavioral health treatment, housing, social services, and primary care. Recovery is promoted by providing a full continuum of services.

◊ *B. Goals*

The program's overarching goal is to improve health outcomes and reduce community costs in the health, human services, and housing arenas. Within that broad goal, it seeks to stabilize the medical and behavioral health conditions of its patients and effectively link them to (1) ongoing substance use and/or mental health services in the community, (2) an ongoing medical home, (3) social services, and (4) stable, appropriate housing. It strives to ensure that patients leave the program with identified case management provided by partnering agencies in the community that will help them make these linkages.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 350 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced emergency department use
- improved emotional health
- housing stability

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- increased use of preventive (outpatient) services
- reduced unnecessary emergency department use

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Hospital Reentry Respite Beds (RR-8)

2. Spending Plan

Year	Activity	Amount
2017	Continued comprehensive recuperative care after acute hospital stays for people who are living with homelessness as well as disabling substance use and mental health conditions	$928,650
2017 Annual Expenditure		**$928,650**
2018	Continued comprehensive recuperative care after acute hospital stays for people who are living with homelessness as well as disabling substance use and mental health conditions	$952,795
2018 Annual Expenditure		**$952,795**
Biennial Expenditure		**$1,881,445**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The Edward Thomas House Medical Respite Program is managed by Harborview Medical Center through a contract with Public Health Seattle and King County. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

MIDD 2 Initiative Title: Behavioral Health Employment Services and Supported Employment

MIDD 2 Number: RR-10

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "Improve health and wellness of individuals living with behavioral health conditions."

Helping individuals achieve employment outcomes makes a significant difference not only in the income levels of the individuals being served within the behavioral health system, but also helps them achieve self-sufficiency and improve non-vocational based outcomes such as improved self-esteem, sense of purpose, decreased isolation and meaningful activities that employment often provides.[1]

In a four year pre/post examination of MIDD-funded supported employment, the program demonstrated a significant impact decreased the number and length of stays for hospitalizations, but also the number of jail bookings, and lengths of stays in jail.[2]

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative continues the existing MIDD 1 Employment Services for Individuals with Mental Illness and Chemical Dependency, also known as "Supported Employment" and offers modified employment services to for people living with mental illness or substance use disorders.

Based on the needs of each individual job seeker within the integrated behavioral health system (formerly the mental health and substance use disorders systems), this program provides a two-tiered model to assist the job seeker to receive either the fidelity-based, intensive, Supported Employment (SE) services or a modified employment model that provides less intensive services for individuals requiring less employment support who can benefit primarily from linkage and referral to external employment service providers. This model allows employment services to be offered to a greater number of individuals while disseminating the principles of the evidence-based Supported Employment model.

[1] The Impact of Competitive Employment on Non-vocational Outcomes (Luciano, Bond, & Drake, 2014)
[2] Impact of Supported Employment in Reducing Hospitalizations and Incarcerations, Floyd, 2015

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

◊ *B. Goals*

The primary goal of this program is to increase the number of individuals with behavioral health conditions that gain and maintain employment in competitive and integrated jobs in the community that pay at or above minimum wage.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve 800 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased job placement
- Improved job retention
- increased income

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Continued supported employment services at behavioral health provider agencies, with less intensive employment support services also available	$973,750
2017 Annual Expenditure		**$973,750**
2018	Continued supported employment services at behavioral health provider agencies, with less intensive employment support services also available	$999,068
2018 Annual Expenditure		**$999,068**
Biennial Expenditure		**$1,972,818**

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Behavioral Health Employment Services and Supported Employment (RR-10)

3. Implementation Schedule

◊ *A. Procurement of Providers*

The behavioral health providers currently under contract with BHRD will provide the services. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

MIDD 2 Initiative Title: Workload Reduction

MIDD 2 Number: SI-3

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This program primarily addresses the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

The reduction of treatment caseloads by increasing the number of qualified staff provides for better treatment services, promoting the achievement of recovery outcomes for clientele, including proactive care that improves overall health and wellness. Additionally, workload reduction results in higher job satisfaction for treatment staff, thereby reducing staff turnover, which is a critical system improvement in the mental health treatment system.

Studies have suggested that higher caseloads may result in reactive case management, with deficiencies in service planning, support for families and caregivers and liaison with other services.[1] When faced with high caseloads, case managers are more likely to deal with crises and immediate problems[2] with a resulting negative impact on activities such as timely response to client needs, documentation of work, receptiveness to urgent client needs, contact during hospital admissions, home visits and advocacy.[3]

In addition to the impacts cited above, there is evidence that higher caseloads are also associated with increased work-related stress, especially stress associated with workload and professional self-doubt. Higher caseload was also associated with lower case manager personal efficacy. Increased job stress can exacerbate issues of staff burnout and pose problems with the recruitment and retention of case managers,[4] in addition to impacting health and safety outcomes and the quality of care provided to clients.[5] These findings support the need for active management of caseloads to minimize risk of overload.

Although not the subject of a formal research study in King County, the issues outlined above have been reflected qualitatively by outpatient mental health provider agencies, as well as individual clinicians throughout King County.

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[1] Intagliata J. Improving the quality of community care for the chronically clinically mentally disabled: the role of case management. Schizophr Bull 1982; 8: 655–674.
[2] King R, Le Bas J, Spooner D. The impact of caseload on mental health case manager personal efficacy. Psychiatr Serv 2000; 52: 364–368.
[3] King, R., Meadows, G., & LeBas, J. (2004). Compiling a caseload index for mental health case management. Australian and New Zealand Journal of Psychiatry, 38, 455-462.
[4] Evans, S., Huxley, P., Gately, C., Webber, M., Means, A., Pajak, S., et al. (2006). Mental health, burnout, and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry , 188*, 75-80.
[5] Priebe, S., Fakhoury, W., Hoffman, K., & Powell, R. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social Psychiatry Psychiatric Epidemiology , 40*, 223-232.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

1. Program Description

◊ *A. Service Components/Design (Brief)*

Workload reduction funding distributed among outpatient mental health provider agencies during MIDD 1 is recommended to continue in MIDD 2. In addition, substance use disorder providers are now participating in managed care under the integrated Behavioral Health Organization (BHO) structure, the distribution of MIDD 2 funds (in addition to the accompanying Medicaid match) will be revisited with the input of providers, guided by the following principles, at a minimum:

- Medicaid-funded outpatient programs will be targeted, to ensure continued Medicaid match.
- Provider agencies will receive appropriations of funds in an equitable manner.
- All mental health and substance abuse outpatient providers will have access to a portion of the funds.[6]
- Small provider agencies will receive no less than a minimum amount that is sufficient to affect the size of their workforce in a measurable way.
- Accountability measures for providers will be consistent across agencies and will be tied clearly to policy goal outcomes. See section D below for more details.

◊ *B. Goals*

Broad goals of this initiative include creating greater provider agency capacity to allow case managers to see clients more regularly to assist them to achieve greater stability and recovery, as well as be more responsive to clients who are in crisis. This would include increased proactive case management, care coordination, family support, outreach, and advocacy, in alignment with the literature on workload impacts described above. A related goal of this initiative is to decrease case manager turnover resulting from high caseloads, thus creating a more stable and effective workforce.

◊ *C. Expected Numbers of Individuals Served*

Under MIDD 1, only the number of participating provider agencies was measured. The number of providers expected to participate will increase from 17 to approximately 44. Because this initiative has the potential to have broad impact on all outpatient clients of an agency that receives funding, it is not yet known how many individuals would benefit.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- emotional health
- daily functioning
- reduced substance use
- reduced jail, hospital and emergency department use

[6] The distribution of funds in MIDD 2 between mental health services and substance use disorders services may be influenced in part by Washington Administrative Code requirements that keep typical substance use disorders caseloads lower than mental health caseloads. Despite this consideration, at least some funds will be available to all contracted outpatient providers regardless of service type.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- improved experience of care
- reductions in the degree to which front-line staff cite workload as a job stressor and/or a contributor to their decision to seek other work

◊ *E. Provided by: Contractor*

All funding under this initiative will be distributed among contracted providers who offer a Medicaid-funded outpatient service. As part of forthcoming procedural design, a mechanism will be established to ensure that any new providers who may join the network in the future will have access to an equitable share of the funds and will deliver the same level of accountability for funds received.

2. Spending Plan

Year	Activity	Amount
2017	Funding to support hiring of additional direct service staff at agencies that offer a Medicaid-funded outpatient behavioral health service (approximately 44 providers, distribution formula to be determined)	$4,100,000 *(plus Medicaid matching funds totaling $4,100,000)*
2017 Annual Expenditure		**$4,100,000**
2018	Funding to support hiring of additional direct service staff at agencies that offer a Medicaid-funded outpatient behavioral health service (approximately 44 providers, distribution formula to be determined)	$4,206,600 *(plus Medicaid matching funds totaling $4,206,000)*
2018 Annual Expenditure		**$4,206,600**
Biennial Expenditure		**$8,306,600**

3. Implementation Schedule

◊ *A. Procurement of Providers*

A Request for Interest (RFI) and/or a Request for Qualifications (RFQ) process will result in the identification of a full list of provider agencies that are aware of new accountability requirements and interested in receiving these funds under MIDD 2. No competitive bidding process is needed.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workload Reduction (SI-3)

◊ *B. Contracting of Services*

Funds will be distributed to all interested and qualified agencies via contract exhibits unique to this initiative containing clear accountability measures defined via the process described above.

◊ *C. Services Start date (s)*

King County BHRD's work to redefine this initiative, includingprovider involvement, will begin in the first quarter 2017. Implementation of the MIDD 2 initiative, with a new funding distribution methodology along with new outcome measures and accountability procedures, could occur as soon as the first quarter 2017 and will be completed no later than the second quarter 2017.

(Funding levels for the 17 MIDD 1 workload reduction providers will be maintained at MIDD 1 levels until this process is completed.)

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

MIDD 2 Initiative Title: Workforce Development

MIDD 2 Number: SI-4

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative addresses the recommended MIDD policy goal of "increase culturally appropriate, trauma informed behavioral health services."

The behavioral health workforce is in crisis. The behavioral health system is struggling to find and/or retain trained, licensed, and qualified staff to provide services those in need of services. Providers statewide report difficulty hiring and retaining the additional staff they need to fill demand. Behavioral health integration highlights the need for continuing education. Clients benefit when clinical staff are trained on the full spectrum of behavioral health conditions and how to best intervene. Coordinating services with primary care also requires training and education; this again will facilitate clients receiving optimal services. Integrated care benefits from staff stability, confidence, and knowledge. The current workforce shortage, evolving clinical knowledge, as well as the need to provide culturally appropriate services by staff that are reflective of populations being served will be factors in determining the best training programs to be utilized and disseminated.

1. Program Description

◊ *A. Service Components/Design (Brief)*

The original MIDD 1 strategy responded to the workforce shortage of Chemical Dependency Professionals (CDP) and provided reimbursement for Chemical Dependency Professional Trainees (CDPTs) for: tuition, books for CDP-related classes and testing fees. Due to CDP credential requirements mandating CDP clinical supervision, the agencies were also reimbursed for CDPT specific clinical supervision. CDPs received reimbursement for annual license fees and obtained reimbursed Continuing Education Units (CEU) to maintain their credentials. In addition, this strategy funded Evidence-Based Practices (EBP) training, quality assurance (QA) for EBPs, Certified Prevention Professional (CPP) credentials, and a CDP certificate program through the University Of Washington School Of Social Work.

Given the integration of mental health and substance use disorder, the present work shortages, and growing demand, this MIDD 2 initiative will create a develop a sustained, systems based approach to supporting and developing the behavioral health workforce. In collaboration with the MIDD Oversight Committee and stakeholders, a Behavioral Health Workforce Development Plan (WDP) will be developed that may include:

- Investment into initial credentials for behavioral health professionals, including psychiatric nurse practitioners and psychiatrists;
- CEUs for credentialed staff and ongoing training of EBP and Practice Based Evidence (PBE) for mental health and substance use disorder (SUD) treatment including Medication Assisted Treatment (MAT);

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

- Increase in the number of dually credentialed, Mental Health Professional (MHP) and CDP, staff;
- Additional training and initiation of Opioid Prescribing Training Program (OPTP) for professionals with prescriptive authority to assist in treatment opioid addiction; and
- Initiation of a train-the-trainer program to build a work force that can train other clinical staff on adopted EDPs and PBEs.

◊ *B. Goals*

The initiatives goals are:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals;
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults;
- Increase the qualified King County behavioral health workforce;
- Increase capacity to provide quality behavioral health services in King County; and
- Increase adoption of evidence-based, best, or promising practices.

◊ *C. Expected Numbers of Individuals Served*

The revised initiative will have a minimum of 700 participants annually, depending on the types of support and services offered.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- improved daily functioning
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- increased staff retention at agencies and more effective recruitment, which would result in fewer vacancies at agencies
- improved clinical interventions in the outpatient setting

◊ *E. Provided by: Contractor*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Workforce Development (SI-4)

2. Spending Plan

Year	Activity	Amount
2017	Behavioral health workforce development , project management and stakeholder coordination activities continue	$743,125
2017 Annual Expenditure		**$743,125**
2018	Behavioral health workforce development, project management and stakeholder coordination activities continue	$762,446
2018 Annual Expenditure		**$762,446**
Biennial Expenditure		**$1,505,571**

3. Implementation Schedule

◊ *A. Procurement of Providers*

The resources will be available for all providers across the county that were awarded a contract with BHRD and provided Medicaid services. The development of a Behavioral Health Workforce Development Plan (WDP) during the fourth quarter 2016 will guide the initiative improvements.

◊ *B. Contracting of Services*

To be determined.

◊ *C. Services Start date (s)*

Trainings services continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Drug Court (TX-ADC)

MIDD 2 Initiative Title: Adult Drug Court (ADC)

MIDD 2 Number: TX-ADC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

ADC is a pre-adjudication program that provides eligible defendants the opportunity to receive drug treatment in lieu of incarceration. If defendants meet the requirements of each of the four phases of the ADC program they graduate from the program and the charges are dismissed.

1. Program Description

◊ *A. Service Components/Design (Brief)*

After opting into the program, defendants come under the court's supervision and are required to attend treatment sessions, undergo random urinalysis, and appear before the judge on a regular basis.

If defendants meet the requirements of each of the four phases of the ADC program they graduate from the program and the charges are dismissed. If defendants fail to make progress they are terminated from the program and sentenced on their original charge. While this is a minimum 12 month program, the average graduate requires 18 months to complete the program.

◊ *B. Goals*

ADC Goals include:

1. Reduce substance use and related criminal activity;
2. Enhance community safety;
3. Reduce reliance on incarceration for non-violent drug dependent offenders;
4. Hold drug dependent offenders accountable for their actions and decisions;
5. Integrate substance abuse treatment with criminal justice case processing;
6. Provide resources and support to assist the drug dependent offender in the acquisition of skills necessary for the maintenance of sobriety;
7. Reduce the impact of drug related cases on criminal justice resources; and
8. Reward positive life changes while maintaining accountability for negative conduct.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves at least 700 people annually.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Adult Drug Court (TX-ADC)

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- improved wellness self-management
- reduced unnecessary incarceration

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	Adult Drug Court participant supervision and services continue.	$4,165,351
2017 Annual Expenditure		**$4,165,351**
2018	Adult Drug Court participant supervision and services continue.	$4,273,649
2018 Annual Expenditure		**$4,273,649**
Biennial Expenditure		**$8,439,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Department of Judicial Administration manages Adult Drug Court. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services will continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

MIDD 2 Initiative Title: Family Treatment Court (FTC)

MIDD 2 Number: TX-FTC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "improve health and wellness of individuals living with behavioral health conditions."

FTC is a recovery based child welfare intervention. Parents participate in FTC to receive help in obtaining and maintaining sobriety as well as family services that support a recovery based lifestyle, including mental health treatment when applicable. Many of the court's parents have a history of incarceration and FTC supports their reentry into mainstream services. It is an improvement to the current way child welfare cases are handled in the dependency court system. It is also a prevention and early intervention program, working with both the parent and the child to prevent future involvement in the criminal and juvenile justice systems and address the health and well-being of child welfare involved families.

1. Program Description

◊ *A. Service Components/Design (Brief)*

FTC promotes the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other service needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan. FTC is organized around the ten key components that define a drug court:

1) Integrated systems (child welfare, Substance Use Disorder [SUD] treatment services and the court);
2) Protection and assurance of legal rights, advocacy and confidentiality;
3) Early identification and intervention;
4) Access to comprehensive services and individualized case planning;
5) Frequent case monitoring and drug testing;
6) Graduated responses and rewards;
7) Increased judicial supervision;
8) Deliberate program evaluation and monitoring;
9) A collaborative, non-adversarial, cross-trained team; and
10) Partnerships with public agencies and community-based organizations.

◊ *B. Goals*

FTC has four primary goals:

- To ensure that children have safe and permanent homes within permanency planning guidelines or sooner;

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

- To ensure that families of color have outcomes from dependency cases similar to families not of color;
- To ensure that parents are better able to care for themselves and their children and seek resources to do so; and
- To ensure that the cost to society of dependency cases involving substances is reduced.

◊ *C. Expected Numbers of Individuals Served*

This initiative will serve 140 children annually in MIDD 2 including the expanded court in south King County included.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced substance use
- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased use of preventive (outpatient) services
- increase positive child placements at parent exit from FTC

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	FTC supports and services continue.	$1,435,340
2017 Annual Expenditure		**$1,435,340**
2018	FTC supports and services continue.	$1,472,660
2018 Annual Expenditure		**$1,472,660**
Biennial Expenditure		**$2,908,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Superior Court manages the Family Treatment Court. No RPPs Needed.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Family Treatment Court (TX-FTC)

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Drug Court (TX-JDC)

MIDD 2 Initiative Title: Juvenile Drug Court (JDC)

MIDD 2 Number: TX-JDC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative impacts the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The JDC program is effective at reducing recidivism and keeping youth engaged in the treatment process. (Bolan, 2007) King County JDC outcome studies have documented significant reductions in recidivism among program participants. Juvenile justice has increasingly become the service delivery point for adolescents with substance use disorder (SUD) and co-occurring problems that lack resources for other assistance. The JDC model provides improved, expanded, yet cost-effective adolescent SUD treatment in a coordinated system of care. The model of care in King County challenges systemic inequities and facilitates dialogue among justice and treatment professionals, families, and the youth themselves. JDC includes services designed for youth with SUD diagnoses and co-occurring Mental Health issues. All service areas of the JDC program have shown overtime to increase protective factors for youth involved in the program and strengthen the participant's transition to participating in pro-social behaviors and activities.

1. Program Description

◊ *A. Service Components/Design (Brief)*

JDC is a therapeutic court that provides services to juvenile charged with criminal offenses and identified as having a SUD diagnosis. JDC was implemented in July, 1999. This court is an alternative to regular juvenile court and is designed to improve the safety and well-being of youth and families involved in the juvenile justice system by providing the juvenile offender access to SUD treatment, judicial monitoring of their sobriety and individualized services to support the entire family [1](NCJFCJ, 2013).

Juvenile justice-involved youth voluntarily enter the program and agree to increased court participation, SUD treatment, co-occurring mental health treatment if necessary and intensive case management in order to have their charges dismissed. Case review hearings initially occur every week and then become less frequent as the youth progresses through the program. Incentives are awarded to recognize the youths' achievements and graduated sanctions are used when a youth violate program rules. Youth typically spend between 12 and 18 months in the program.

Through a collaborative, non-adversarial approach, the JDC integrates SUD, co-occurring mental health treatment and increased accountability into the process. Each youth has a JDC team and a comprehensive service team that reviews his or her

[1] Seen, Heard and Engaged: A process Evaluation for Children in Court Programs (NCJFCJ, p. 2013)

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Drug Court (TX-JDC)

participation and recommends services. This interdisciplinary team is cross-trained and works collaboratively to resolve issues.

◊ *B. Goals*

JDC improves the safety and wellbeing of youth and families involved in the juvenile justice system by providing the youth in the juvenile justice system access to SUD treatment, evidence based/best practice holistic family intervention services, and judicial monitoring of their recovery.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 50 new participants each year.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced juvenile detention use
- reduced substance use

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased use of preventive (outpatient) services
- reduced unnecessary incarceration

◊ *E. Provided by: County*

2. Spending Plan

Year	Activity	Amount
2017	JDC supports and services continue.	$1,099,211
2017 Annual Expenditure		**$1,099,211**
2018	JDC supports and services continue.	$1,127,789
2018 Annual Expenditure		**$1,127,789**
Biennial Expenditure		**$2,227,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County Superior Court will continue to provide Juvenile Drug Court services. No RFP is needed.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Juvenile Drug Court (TX-JDC)

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

MIDD 2 Initiative Title: Regional Mental Health Court (RMHC)

MIDD 2 Number: TX-RMHC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

RMHC serves individuals experiencing mental illness (and frequently poverty and homelessness), who come into contact with the local criminal justice system. Once in jail, these individuals stay much longer than those with similar charges who are not experiencing mental health disorders. Moreover, these individuals are released to the community with limited behavioral health and social service supports critical to stability in the community.

Mental health court is often an effective strategy for diverting individuals with mental health disorders from further incarceration and engaging these individuals in community-based treatment and supportive services, with regular court monitoring, to address the underlying factors contributing to their criminal justice involvement.[1]

1. Program Description

◊ *A. Service Components/Design (Brief)*

Until 2010, RMHC served individuals who had cases originally filed in District Court or King County Superior Court. In 2010 MIDD funding was used to increase the services available for existing mental health courts and expanded KCDC Mental Health Court to become regional, such that any city in King County could refer court-involved individuals experiencing significant mental illness to the RMHC.

Currently, there are three referral streams through which court-involved individuals can access RMHC. First, court-involved individuals can have cases filed directly into District Court. For tracking purposes, these cases are referred to as "misdemeanor cases." Second, court-involved individuals can be referred to RMHC from any city jurisdiction within King County (referred to as "city cases"). Third, participants can be referred to RMHC from Superior Court when they have committed a felony and plead guilty to a lesser gross misdemeanor or combination of other misdemeanors (referred to as "felony drop-downs").

[1] Edgely, Michelle. "Why do mental health courts work? A confluence of treatment, support & adroit judicial supervision." International Journal of Law and Psychiatry, Volume 36, Issue 6, November–December 2014, Pages 572–580.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

◊ *B. Goals*

RMHC program goals are to:
(1) Protect public safety;
(2) Reduce the level of recidivism (considering frequency, offense severity and length of time between episodes) of persons with mental illness with the criminal justice system;
(3) Reduce the use of institutionalization for persons with mental illness who can function successfully within the community with service supports;
(4) Improve the mental health and well-being of persons with mental illness who come in contact with Mental Health Court;
(5) Develop more expeditious case resolution than traditional courts;
(6) Develop more cost-effective / efficient use of resources than traditional courts;
(7) Develop more linkages between the criminal justice system and the mental health system; and
(8) Establish linkages with other community programs that target services to persons with mental illness.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 130 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:
- reduced jail, hospital, and emergency department use
- reduced substance use
- improved daily functioning

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:
- reduced substance use
- increased stability in treatment, employment, or other quality of life measures
- improved wellness and social relationships
- increased use of preventive (outpatient) services
- reduced unnecessary jail, hospital and emergency department use

◊ *E. Provided by: County*

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Regional Mental Health Court (TX-RMHC)

2. Spending Plan

Year	Activity	Amount
2017	RMHC supports and services continue.	$3,865,746
2017 Annual Expenditure		**$3,865,746**
2018	RMHC supports and services continue.	$3,966,254
2018 Annual Expenditure		**$3,966,254**
Biennial Expenditure		**$7,832,000**

3. Implementation Schedule

◊ *A. Procurement of Providers*

King County District Court will continue to provide Regional Mental Health Court. No RFP is needed.

◊ *B. Contracting of Services*

See 3.A.

◊ *C. Services Start date (s)*

Services to continue on January 1, 2017.

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Seattle Mental Health Municipal Court (TX-SMC)

MIDD 2 Initiative Title: Seattle Mental Health Municipal Court (SMC)

MIDD 2 Number: TX-SMC

The programmatic and budget information below is subject to change pending adoption of the 2017-2018 King County Budget.

How does the program advance the recommended MIDD policy goals?

This initiative will impact the recommended MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

Mental health courts are an essential component of a jail diversion continuum of service and have been shown to be effective in engaging clients in treatment and reducing future jail bookings. In addition to diverting more individuals with mental illness from unnecessary emergency department (ED) and psychiatric hospitalizations, this process provides a more efficient, safe, cost effective process as well as improved resource utilization.

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative provides a care manager position in the Seattle Municipal Court. The position serves individuals who have frequent contact with the criminal justice system, and who receive an evaluation for civil commitment. Most or all of these individuals are not engaged in the public mental health system. The care manager provides assertive outreach and engagement for these individuals to offer services, respite supports, assistance with entitlements and other essential needs, with the ultimate goal of reducing contact with the criminal justice system.

◊ *B. Goals*

This initiative provides outreach and linkage services into the community to locate and serve a group of individuals that are committing low level criminal offenses, and are appearing in Seattle Municipal MHC on a frequent basis. The goal is to prevent future criminal justice involvement.

◊ *C. Expected Numbers of Individuals Served*

This initiative serves 35 participants annually.

◊ *D. Draft Outcomes and Performance Measures - outcomes and measures are expected to be revised and included in the MIDD 2 Evaluation Plan.*

This initiative contributes to population outcomes of the MIDD 2 Framework, including:

- reduced jail use
- reduced substance use

MIDD 2 Service Improvement Plan
Initiative Description – Preliminary Implementation Information
Seattle Mental Health Municipal Court (TX-SMC)

- improved emotional health

The following individual-level outcome measures (MIDD 2 Framework language used where applicable) for program participants may include:

- reduced substance use
- improved wellness and social relationships
- reduced behavioral health risk factors
- increased use of preventive (outpatient) services
- reduced unnecessary incarceration

◊ *E. Provided by: Contractor*

2. Spending Plan

Year	Activity	Amount
2017	Care management for SMC individuals who have frequent contact with the criminal justice system.	$ 93,150
2017 Annual Expenditure		**$ 93,150**
2018	Care management for SMC individuals who have frequent contact with the criminal justice system.	$ 95,572
2018 Annual Expenditure		**$ 95,572**
Biennial Expenditure		**$ 188,722**

3. Implementation Schedule

◊ *A. Procurement of Providers*

This service was revised in 2016. See description above for more details. A review process in early 2017 will determine if an RFP is needed.

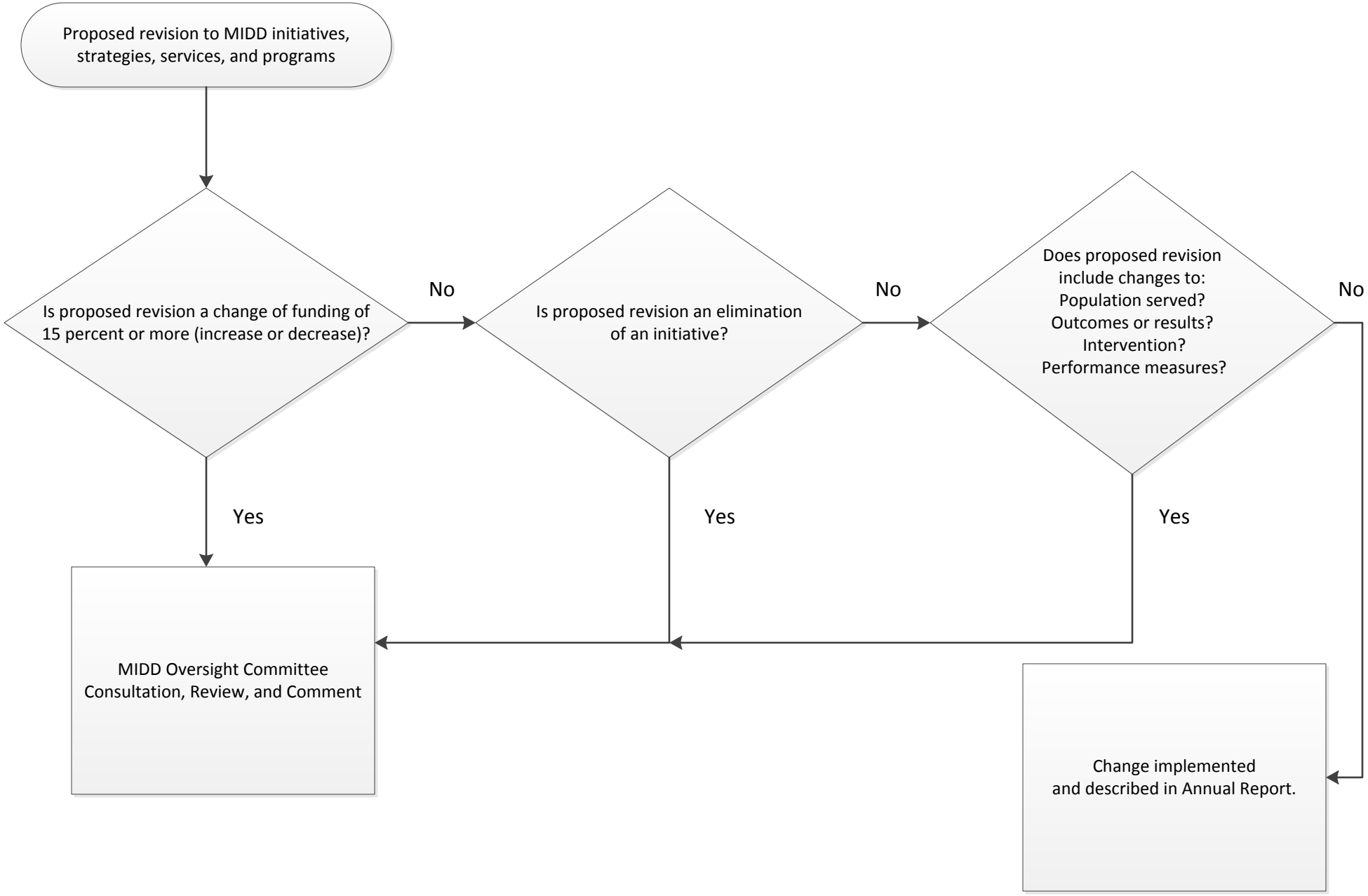
◊ *B. Contracting of Services*

To be determined, pending early 2017 review.

◊ *C. Services Start date (s)*

Services continue on January 1, 2017.

MIDD Initiative Revision Process Flow



MIDD 2 Initiative Outcomes and Basis Crosswalk

The assessment of whether an initiative is considered a “best” or “promising practice” is based on findings included in published research, studies, or other reports of program efficacy as reviewed and/or assessed by Behavioral Health Division Staff. For something to be considered an “evidence-based practice”, it has been subject to scientifically based rigorous research designs, (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research). Please note that "emerging practices" are included in the category of "promising practices".

MIDD 1 Policy Goals were used to identify successful outcomes where results are available. Behavioral Health outcomes also includes increased treatment access and improved quality of life, which are linked to the proposed MIDD 2 Policy Goal of "Improve health and wellness of individuals living with behavioral health conditions."

MIDD 2 EXISTING INITIATIVES

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-03	Outreach & In reach System of Care			X	X		Jail Use Reduction
CD-05	High Utilizer Care Teams		X			X	ED Use Reduction
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	X				X	ED Use Reduction
CD-08	Children's Domestic Violence Response Team			X		X	Symptom Reduction
CD-10	Next Day Crisis Appointments	X				X	ED Use Reduction
CD-11	Children's Crisis Outreach and Response System - CCORS			X		X	Improved Quality of Life
CD-12	Parent Partners Family Assistance	X				X	Improved Quality of Life

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-15	Wraparound Services for Youth		X			X	Symptom Reduction
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT			X		X	ED Use Reduction
PRI-02	Juvenile Justice Youth Behavioral Health Assessments		X		X		Jail Use Reduction
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over 50			X		X	Symptom Reduction
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	X				X	Psychiatric Hospital Use Reduction; ED Use Reduction
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students			X		X	Improved Quality of Life
PRI-08	Crisis Intervention Training - First Responders		X		X		Research supports identified positive person level outcomes.
PRI-09	Sexual Assault Behavioral Health Services	X		X		X	Improved Quality of Life
PRI-10	Domestic Violence Behavioral Health Services & System Coordination	X				X	Symptom Reduction
PRI-11	Community Behavioral Health Treatment		X			X	Symptom Reduction; ED Use Reduction

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
RR-01	Housing Supportive Services			X	X		Jail Use Reduction
RR-02	Behavior Modification Classes at CCAP			X	X		Jail Use Reduction
RR-03	Housing Capital and Rental			X		X	Psychiatric Hospital Use Reduction
RR-05	Housing Vouchers for Adult Drug Court			X	X		Jail Use Reduction
RR-06	Jail Reentry System of Care			X	X		Jail Use Reduction
RR-08	Hospital Re-Entry Respite Beds	X				X	ED Use Reduction
RR-10	BH Employment Services & Supported Employment			X		X	Improved Quality of Life
SI-03	Workload Reduction	X				X	Research supports identified positive person level outcomes.
SI-04	Workforce Development		X			X	Research supports identified positive person level outcomes.
TX-ADC	Adult Drug Court		X			X	Symptom Reduction
TX-FTC	Family Treatment Court	X				X	Symptom Reduction; Increased Treatment Access
TX-JDC	Juvenile Drug Court		X		X		Jail Use Reduction

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
TX-MHC	Regional Mental Health Court	X			X		Jail Use Reduction
TX-SMC	Seattle Mental Health Municipal Court	X			X		Jail Use Reduction

MIDD 2 Outcomes and Basis Crosswalk

The assessment of whether an initiative is considered a “best” or “promising practice” is based on findings included in published research, studies, or other reports of program efficacy as reviewed and/or assessed by Behavioral Health Division Staff. For something to be considered an “evidence-based practice”, it has been subject to scientifically based rigorous research designs, (i.e., randomized controlled trials, regression discontinuity designs, quasi-experiments, single subject, and qualitative research). Please note that "emerging practices" are included in the category of "promising practices".

MIDD 1 Policy Goals were used to identify successful outcomes where results are available. Behavioral Health outcomes also includes increased treatment access and improved quality of life, which are linked to the proposed MIDD 2 Policy Goal of "Improve health and wellness of individuals living with behavioral health conditions."

MIDD 2 NEW INITIATIVES

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-01	Law Enforcement Assisted Diversion (LEAD)	X			X		Criminal Justice System Involvement Reduction
CD-02	Youth and Young Adult Homelessness Services	X				x	Improved Quality of Life
CD-04	South County Crisis Diversion Services/Center	X				X	ED Use Reduction
CD-07	Multipronged Opioid Strategies		X			X	Improved Quality of Life
CD-09	Behavioral Health Urgent Care-Walk In Clinic Pilot		X			X	Psychiatric Hospitalization Use Reduction

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
CD-13	Family Intervention Restorative Services - FIRS	X			X		Criminal Justice System Involvement Reduction
CD-14	Involuntary Treatment Triage	X				X	Increased Treatment Access
CD-16	Youth Behavioral Health Alternatives to Secure Detention	X				X	Improved Quality of Life
CD-17	Young Adult Crisis Facility	X				X	Improved Quality of Life
PRI-06	Zero Suicide Initiative Pilot			X		X	Improved Quality of Life
PRI-07	Mental Health First Aid			X		X	Improved Quality of Life
RR-04	Rapid Rehousing-Oxford House Model			X		X	Improved Quality of Life
RR-07	Behavioral Health Risk Assessment Tool for Adult Detention			X	X		Criminal Justice System Involvement Reduction
RR-09	Recovery Café	X				X	Improved Quality of Life
RR-11	Peer Support and Peer Bridger	X				X	Psychiatric Hospitalization Use Reduction
RR-12	Jail-Based Substance Abuse Treatment	X			X		Criminal Justice System Involvement Reduction
RR-13	Deputy Prosecuting Attorney for Familiar Faces	X			X		Criminal Justice System Involvement Reduction
SI-01	Community Driven Behavioral Health Grants	X				X	Improved Quality of Life

MIDD 2 Initiative Number	MIDD 2 Initiative Title	Basis			Type of Successful Outcomes		Notes
		Promising Practice	Best Practice	Evidence-Based Practice	Criminal Justice	Behavioral Health	
SI-02	Behavioral Health Services In Rural King County	X				X	Improved Quality of Life
TX-CCPL	Community Court Planning	X			X		Criminal Justice System Involvement Reduction

race forward
THE CENTER FOR RACIAL JUSTICE INNOVATION

Racial Equity Impact Assessment

What are Racial Equity Impact Assessments?

A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities.

Why are they needed?

REIAs are used to reduce, eliminate and prevent racial discrimination and inequities. The persistence of deep racial disparities and divisions across society is evidence of institutional racism--the routine, often invisible and unintentional, production of inequitable social opportunities and outcomes. When racial equity is not consciously addressed, racial inequality is often unconsciously replicated.

When should it be conducted?

REIAs are best conducted during the decision-making process, prior to enacting new proposals. They are used to inform decisions, much like environmental impact statements, fiscal impact reports and workplace risk assessments.

Where are they in use?

The use of REIAs in the U.S. is relatively new and still somewhat limited, but new interest and initiatives are on the rise. The United Kingdom has been using them with success for nearly a decade.

EXAMPLES OF RACIAL JUSTICE EQUITY IMPACTS

Equity and Social Justice Initiative

King County, WA

The county government is using an Equity Impact Review Tool to intentionally consider the promotion of equity in the development and implementation of key policies, programs and funding decisions.

Race and Social Justice Initiative

Seattle, WA

City Departments are using a set of Racial Equity Analysis questions as filters for policy development and budget making.

Minority Impact Statements

Iowa and Connecticut

Both states have passed legislation which requires the examination of the racial and ethnic impacts of all new sentencing laws prior to passage. Commissions have been created in Illinois and Wisconsin to consider adopting a similar review process. Related measures are being proposed in other states, based on a model developed by the Sentencing Project.

Proposed Racial Equity Impact Policy

St. Paul, MN

If approved by the city council, a Racial Equity Impact Policy would require city staff and developers to compile a "Racial Equity Impact Report" for all development projects that receive a public subsidy of $100,000 or more.

Race Equality Impact Assessments

United Kingdom

Since 2000, all public authorities required to develop and publish race equity plans must assess proposed policies using a Race Equality Impact Assessment, a systematic process for analysis.

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Racial Equity Impact Assessment **GUIDE**

Below are sample questions to use to anticipate, assess and prevent potential adverse consequences of proposed actions on different racial groups.

1. IDENTIFYING STAKEHOLDERS

Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

2. ENGAGING STAKEHOLDERS

Have stakeholders from different racial/ethnic groups—especially those most adversely affected—been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

3. I IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES

Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

4. EXAMINING THE CAUSES

What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

5. CLARIFYING THE PURPOSE

What does the proposal seek to accomplish? Will it reduce disparities or discrimination

6. CONSIDERING ADVERSE IMPACTS

What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

7. ADVANCING EQUITABLE IMPACTS

What positive impacts on equality and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS

Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

9. ENSURING VIABILITY AND SUSTAINABILITY

Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement. Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

10. IDENTIFYING SUCCESS INDICATORS

What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

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MIDD 1 Comprehensive Historical Assessment Report: Evaluation Recommendations

I. Update and Revise the Evaluation Framework

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

II. Revise Performance Measures, Targets and Outcomes

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

III. Upgrade Data Collection and Infrastructure

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

IV. Enhance Reporting and Improve Processes

a. Align the MIDD program year with the calendar year, rather than October through September.[1]
b. Replace semi-annual progress reports with digitally available dashboard data.
c. Increase the frequency of performance evaluation availability.
d. Establish guidelines for report creators and editors on the scope of their decision making.
e. Continue to avoid presenting non-causal results in ways that imply causality.
f. Continue to produce one annual report that includes both performance measurement and outcome evaluation.
g. Enhance the quality and frequency of communication regarding evaluation data and reporting, updating the MIDD Oversight Committee and others on substantive findings.
h. Develop and deploy a continuous quality improvement process for MIDD programs and services based in part in evaluation.
i. To the extent possible, align MIDD evaluation approach with Best Starts for Kids initiative evaluation approach to ensure consistency.

These recommendations chart a path to enhance the MIDD evaluation approach and provide clearer data and findings to the public and policy makers. The recommendations work together to position a potential MIDD 2 to better demonstrate return on investment.

Appendix M-MIDD Service Improvement Plan
MIDD 2 Spending Plan

MIDD 2 Initiative Number	MIDD 2 Initiative Title	2017 Funding Level	2018 Funding Level	2017-2018 Biennial Funding Level	Planned Staged Implementation
CD-01	NEW Law Enforcement Assisted Diversion (LEAD)	1,537,500	2,052,000	3,589,500	Yes-assumes 75% spending in year one
CD-02	NEW Youth and Young Adult Homelessness Services	300,000	307,800	607,800	NO
CD-03	Outreach & In reach System of Care	410,000	420,660	830,660	NO
CD-04	NEW South County Crisis Diversion Services/Center	500,000	1,539,000	2,039,000	Yes-assumes 33% spending in year one
CD-05	High Utilizer Care Teams	256,250	262,913	519,163	NO
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	5,125,000	5,208,569	10,333,569	NO
CD-07	NEW Multipronged Opioid Strategies	750,000	1,539,000	2,289,000	Yes-assumes 50% spending in year one
CD-08	Children's Domestic Violence Response Team	281,875	289,204	571,079	NO
CD-09	NEW Behavioral Health Urgent Care-Walk In Clinic Pilot	250,000	256,500	506,500	NO
CD-10	Next Day Crisis Appointments	307,500	315,495	622,995	NO
CD-11	Children's Crisis Outreach and Response System - CCORS	563,750	578,408	1,142,158	NO
CD-12	Parent Partners Family Assistance	420,250	431,177	851,427	NO
CD-13	NEW Family Intervention Restorative Services - FIRS	1,087,688	1,115,967	2,203,655	NO
CD-14	NEW Involuntary Treatment Triage Pilot	150,000	153,900	303,900	NO
CD-15	Wraparound Services for Youth	3,075,000	3,154,950	6,229,950	NO
CD-16	NEW Youth Behavioral Health Alternatives to Secure Detention	250,000	1,026,000	1,276,000	Yes-assumes 25% spending in year one
CD-17	NEW Young Adult Crisis Facility	705,825	724,175	1,430,000	NO
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT	717,500	736,155	1,453,655	NO
PRI-02	Juvenile Justice Youth Behavioral Health Assessments	584,250	599,441	1,183,691	NO
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over 50	484,639	497,240	981,880	NO

Appendix M-MIDD Service Improvement Plan
MIDD 2 Spending Plan

MIDD 2 Initiative Number	MIDD 2 Initiative Title	2017 Funding Level	2018 Funding Level	2017-2018 Biennial Funding Level	Planned Staged Implementation
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	329,025	337,580	666,605	NO
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students	1,579,652	1,607,552	3,187,204	NO
PRI-06	NEW Zero Suicide Initiative Pilot	500,000	513,000	1,013,000	NO
PRI-07	NEW Mental Health First Aid	200,000	205,200	405,200	NO
PRI-08	Crisis Intervention Training - First Responders	820,000	841,320	1,661,320	NO
PRI-09	Sexual Assault Behavioral Health Services	584,250	599,441	1,183,691	NO
PRI-10	Domestic Violence and Behavioral Health Services & System Coordination	563,750	578,408	1,142,158	NO
PRI-11	Community Behavioral Health Treatment	11,890,000	12,199,140	24,089,140	NO
RR-01	Housing Supportive Services	2,050,000	2,096,712	4,146,712	NO
RR-02	Behavior Modification Classes at CCAP	77,900	79,925	157,825	NO
RR-03	Housing Capital and Rental	2,393,584	2,455,816	4,849,400	NO
RR-04	NEW Rapid Rehousing-Oxford House Model	500,000	513,000	1,013,000	NO
RR-05	Housing - Adult Drug Court	231,136	237,146	468,282	NO
RR-06	Jail Reentry System of Care	435,625	446,951	882,576	NO
RR-07	NEW Behavioral Health Risk Assessment Tool for Adult Detention	470,900	483,143	954,043	NO
RR-08	Hospital Re-Entry Respite Beds	928,650	952,795	1,881,445	NO
RR-09	NEW Recovery Café	348,717	357,783	706,500	NO
RR-10	BH Employment Services & Supported Employment	973,750	999,068	1,972,818	NO
RR-11	NEW Peer Support and Peer Bridgers Pilot	768,750	788,738	1,557,488	NO
RR-12	NEW Jail-based SUD Treatment	444,225	455,775	900,000	NO
RR-13	NEW Deputy Prosecuting Attorney for Familiar Faces	47,091	145,511	192,602	NO
SI-01	NEW Community Driven Behavioral Health Grants	350,000	359,100	709,100	NO
SI-02	NEW Behavioral Health Services In Rural King County	350,000	359,100	709,100	NO
SI-03	Workload Reduction	4,100,000	4,206,600	8,306,600	NO
SI-04	Workforce Development	743,125	762,446	1,505,571	NO

Appendix M-MIDD Service Improvement Plan
MIDD 2 Spending Plan

MIDD 2 Initiative Number	MIDD 2 Initiative Title	2017 Funding Level	2018 Funding Level	2017-2018 Biennial Funding Level	Planned Staged Implementation
SI-05	NEW Emerging Needs Initiative	650,000	666,900	1,316,900	NO
TX-ADC	Adult Drug Court	4,165,351	4,273,649	8,439,000	NO
TX-FTC	Family Treatment Court	1,435,340	1,472,660	2,908,000	NO
TX-JDC	Juvenile Drug Court	1,099,211	1,127,789	2,227,000	NO
TX-RMHC	Regional Mental Health and Veterans Courts	3,865,746	3,966,254	7,832,000	NO
TX-SMC	Seattle Mental Health Municipal Court	93,150	95,572	188,722	NO
TX-CCPL	NEW Community Court Planning	100,000	-	100,000	NO
ADM	Administration & Evaluation	4,139,338	4,246,961	8,386,300	NO
TOTAL		**64,985,295**	**69,639,587**	**134,624,881**	

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
PRI-01	Screening, Brief Intervention and Referral To Treatment-SBIRT	Fourth Quarter 2016	First Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
PRI-02	Juvenile Justice Youth Behavioral Health Assessments	First Quarter 2017	Third Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
PRI-03	Prevention and Early Intervention Behavioral Health for Adults Over 50	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
PRI-04	Older Adult Crisis Intervention/Geriatric Regional Assessment Team - GRAT	First Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program
PRI-05	Collaborative School Based Behavioral Health Services: Middle and High School Students	Second Quarter 2017	Second Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
PRI-06	NEW Zero Suicide Initiative Pilot	First Quarter 2017	Second Quarter 2017	Second Quarter 2017	
PRI-07	NEW Mental Health First Aid	First Quarter 2017	First Quarter 2017	Second Quarter 2017	
PRI-08	Crisis Intervention Training - First Responders	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
PRI-09	Sexual Assault Behavioral Health Services and System Coordination	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
PRI-10	Domestic Violence and Behavioral Health Services & System Coordination	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
PRI-11	Community Behavioral Health Treatment	Fourth Quarter 2016	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-01	NEW Law Enforcement Assisted Diversion (LEAD)	Not Applicable	Not Applicable	First Quarter 2017	Existing Program Received one-time MIDD Fund Balance support in 2016
CD-02	NEW Youth and Young Adult Homelessness Services	First Quarter 2017	Second Quarter 2017	Third Quarter 2017	
CD-03	Outreach & In reach System of Care	First Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Programming included, Initiative to be reviewed in early 2017
CD-04	NEW South County Crisis Diversion Services/Center	Second Quarter 2017	Third Quarter 2017	First Quarter 2018	Site Development may impact timeline
CD-05	High Utilizer Care Teams	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-06	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
CD-07	NEW Multipronged Opioid Strategies	First Quarter 2017	Second Quarter 2017	First Quarter 2017	Existing MIDD 1 Program (Needle Exchange) included, Initiative to be revised in early 2017
CD-08	Children's Domestic Violence Response Team	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-09	NEW Behavioral Health Urgent Care-Walk In Clinic Pilot	Second Quarter 2017	Third Quarter 2017	Third Quarter 2017	
CD-10	Next Day Crisis Appointments	Second Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program
CD-11	Children's Crisis Outreach and Response System - CCORS	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-12	Parent Partners Family Assistance	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
CD-13	NEW Family Intervention Restorative Services - FIRS	Not Applicable	Not Applicable	First Quarter 2017	Existing Program Received one-time MIDD Fund Balance support in 2016
CD-14	NEW Involuntary Treatment Triage Pilot	First Quarter 2017	Not Applicable	First Quarter 2017	

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
CD-15	Wraparound Services for Youth	Fourth Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program, Initiative to be revised in early 2017
CD-16	NEW Youth Behavioral Health Alternatives to Secure Detention	Third Quarter 2017	Third Quarter 2017	Third Quarter 2017	
CD-17	NEW Young Adult Crisis Facility	Fourth Quarter 2016	First Quarter 2017	First Quarter 2017	Site Development may impact timeline
RR-01	Housing Supportive Services	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-02	Behavior Modification Classes at CCAP	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-03	Housing Capital and Rental	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-04	NEW Rapid Rehousing-Oxford House Model	Second Quarter 2017	Second Quarter 2017	Second Quarter 2017	
RR-05	Housing Vouchers for Adult Drug Court	First Quarter 2017	First Quarter 2017	Second Quarter 2017	Existing MIDD 1 Program
RR-06	Jail Reentry System of Care	First Quarter 2017	To Be Determined based on the Planning Results.	First Quarter 2017	Existing MIDD 1 Program, Initiative to be revised in early 2017
RR-07	NEW Behavioral Health Risk Assessment Tool for Adult Detention	Not Applicable	Not Applicable	First Quarter 2017	

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
RR-08	Hospital Re-Entry Respite Beds	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-09	NEW Recovery Café	Not Applicable	Not Applicable	First Quarter 2018	Site Development may impact timeline
RR-10	BH Employment Services & Supported Employment	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
RR-11	NEW Peer Support and Peer Bridgers Pilot	Not Applicable	Not Applicable	First Quarter 2017	Peer Bridger (PB) - Existing Program received one-time MIDD Fund Balance support in 2016
RR-12	NEW Jail-Based Substance Abuse Treatment	First Quarter 2017	Second Quarter 2017	Third Quarter 2017	
RR-13	NEW Deputy Prosecuting Attorney for Familiar Faces	Not Applicable	Not Applicable	Third Quarter 2017	
SI-01	NEW Community Driven Behavioral Health Grants	Third Quarter 2017	Varies	Third Quarter 2017	
SI-02	NEW Behavioral Health Services In Rural King County	Third Quarter 2017	Varies	Third Quarter 2017	
SI-03	Workload Reduction	First Quarter 2017	Not Applicable	First Quarter 2017	Existing MIDD 1 Program

MIDD 2 Estimated Implementation Schedule

Initiative Number	Initiative Title	Planning Period	Targeted RFP Release	Estimated Services Launch	Additional Information
SI-04	Workforce Development	Fourth Quarter 2016	Varies	First Quarter 2017	Existing MIDD 1 Program Contracts with Trainers will vary depending on training program
TX-ADC	Adult Drug Court	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-FTC	Family Treatment Court	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-JDC	Juvenile Drug Court	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-RMHC	Regional Mental Health and Veterans Courts	Not Applicable	Not Applicable	First Quarter 2017	Existing MIDD 1 Program
TX-SMC	Seattle Mental Health Municipal Court	First Quarter 2017	First Quarter 2017	First Quarter 2017	Existing MIDD 1 Program
TX-CCPL	NEW Community Court Planning	First Quarter 2017	First Quarter 2017	Not Applicable	

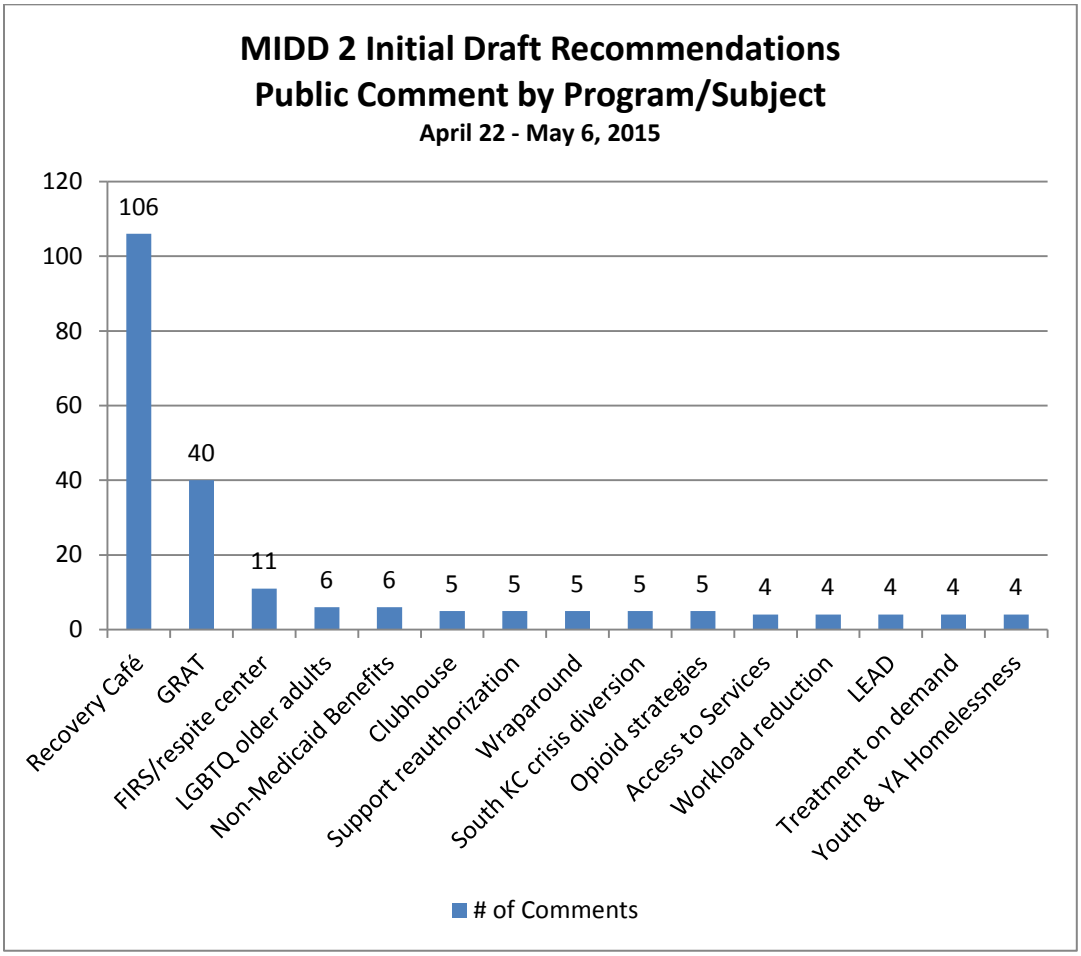
MIDD 2 Initial Programmatic and Funding Recommendations

Public Comment Summary: April 22 – May 6, 2016

A total of 205 comments on the initial draft MIDD 2 programmatic and funding recommendations were received by King County. The comments were provided online April 22 – May 6 through a survey portal, via email, or in person at the MIDD Oversight Committee meeting on April 29.

The vast majority of comments endorsed or supported particular programs that appeared the recommendations, in some cases advocating for additional funding. Notably, over half of commenters (106 total) expressed gratitude for Recovery Café's inclusion in the funding recommendations. Nearly 20 percent of public comment participants (40 total) advocated for funding of the Geriatric Regional Assessment Team (GRAT). About five percent of respondents (11 total) supported the Family Intervention and Restorative Services (FIRS) including its respite center feature.

When comments referenced multiple subjects, they were counted under each subject discussed. Programs or subjects supported by four or more commenters are shown in the chart below.



Public Comment on Initial Draft MIDD 2 Funding and Programmatic Recommendations (April/May 2016)

Name: Judge Lisa Napoli O'Toole

Organization: King County District Court

Comment: I am a Judge in King County District Court, East Division. I am writing to urge King County to allocate MIDD funding to combat the drastic increase in heroin addiction that we see here in King County District Court. The number of defendants that we see in District Court who are heroin addicts is truly staggering. Each and every week here in Redmond I see dozens of defendants who are heroin addicts. One of the remarkable things about this is that not only do I see defendants charged with crimes that one might expect of a heroin addict, such as Driving Under the Influence (of heroin) or Possession of Drug Paraphernalia, but I also see defendants charged with other crimes such as theft and assault, including domestic violence. So very often the genesis of the criminal activity is the addiction. Many of the people in the criminal justice system who are heroin addicts are indigent and without stable housing. Without stable housing it is nearly impossible for these individuals to participate in, and be successful in, substance use disorder treatment. I urge King County to use MIDD funding to prevent further needless deaths due to heroin overdoses and to combat increasing risks to public safety. Ideally, a criminal justice diversion program in District Court would help defendants to address legal issues while engaging in treatment arranged through the program and while living in stable housing arranged through the diversion program. I realize that such a diversion program would be an expensive proposition, however. At a minimum, I urge King County to use MIDD funding to develop programs that will provide treatment and housing options for defendants in the District and Municipal courts.

Name: Merina Hanson

Organization: City of Kent

Comment: Many thanks to King County DCHS staff for the amount of time and effort spent on the MIDD II draft and programmatic recommendations. On behalf of the residents of the City of Kent, we appreciate and support the inclusion of the vast majority of the Initiatives, including:

- upstream prevention and diversion activities;
- treatment on demand;
- community driven behavior health services (We support the concept of cultural communities being able to initiate programs that address their unique needs.);
- new Zero Suicide Initiative Pilot;
- Crisis Intervention Training for first responders (Kent Police Department prioritized this for their officers and it has been very valuable.);
- new Multipronged Opioid Strategies (Treatment options should be available and accessible throughout the County.);
- new Youth Mental Health Alternative to Secure Detention;
- new Involuntary Treatment Triage (System improvements to the involuntary commitment process are critical and our jails are not funded or equipped to properly serve individuals with severe and persistent mental illness.);
- new Recovery Café ; and

- new South County Crisis Diversion Services/Center (Recognizing that siting may be a challenge and close coordination with the community will be required.)

Points of concern include:

- any assumptions related to leveraged Medicaid to replace MIDD funding (Recognizing that County staff is certainly mindful of this, and simply urging extreme caution moving forward.);
- new Youth and Young Adult Homelessness (Urging increased investment and close coordination with Best Start for Kid's Youth and Youth Adult and Families Homelessness Initiative.);
- clarity of where MIDD II Initiative Titles are best placed within the MIDD II Framework Strategies;
- clarity of the differentiation between the Next Day Appointments and New Urgent Care-Walk In; and
- Housing Capital and Rental, New Rapid Rehousing-Oxford House Model, Housing Vouchers for Adult Drug Court (Urging close coordination with All Home and consideration of the variety of other funding sources available for housing capital.)

Name: Steve Chon

Organization: Asian Counseling and Referral Service

Comment: I am a clinical supervisor at Asian Counseling and Referral Service. I also worked as a case manager before I became a supervisor. As I worked with client who suffer from chronic mental health issues directly and indirectly, I can't say more how MIDD helped clients who do not have means to get the service from public agencies such as ours. I personally witnesses clients with chronic mental health issues who find a job, get tx from a doctor and a counselor, and even get housing. I strongly believe in second chance and opportunities in life. I wish our clients continue to get their second chance and opportunity in their life.

Name: Janet Garrow

Organization: King County District Court

Comment: I am serving in my 17th year as a judge in the King County District Court on the Eastside. While I have always seen defendants who have alcohol or drug addictions, the significant increase in the number of misdemeanant offenders with a severe substance use disorders is astonishing. Last week I was on after-hours search warrant duty for King County. Most of the search warrant calls were for drivers who were committing serious driving offenses on freeways and were under the influence of drugs, typically heroin. For example, a driver was going the wrong way on Highway 520, a driver was involved in an accident on I-90, and another driver was speeding on I-5 at 80 mph and weaving in and out of traffic. While I am a strong proponent of early intervention measures to prevent and treat substance use disorders outside of the criminal justice system, the fact of the matter is that we have many people in the criminal justice system who are in serious need of treatment and housing. I see many people on the Eastside, of all ages, who are homeless and drug-addicted. It is truly a tragedy. I know from experience that unless the person has some kind of stable housing it is highly unlikely she/he will be able to effectively engage in substance use disorder treatment. I have defendants ask me NOT to release them from jail until they can be released into an inpatient treatment program. They know that even one day on the street will, in all likelihood, will lead to heroin use. Many of the adult offenders in the criminal justice system in the District and Municipal courts serve their jail sentences in municipal jails such as SCORE, Kirkland and Issaquah. These facilities are ill-equipped to handle offenders

with substance use disorders. Finding treatment placements for these offenders is a daily challenge for our court system. While I am glad to hear there is a proposal to increase treatment options at the Maleng Regional Justice Center jail, that enhancement does virtually nothing for most of the offenders in our District and Municipal Courts. I strongly urge King County to use MIDD funding to develop programs that will provide treatment and housing options for adult offenders in the District and Municipal courts. Most, if not all these offenders, are indigent. Without enhanced services for this population, we will continue to see an increase in loss of life due to substance abuse and serious risks to public safety. Thank you for your consideration of these comments.

Name: James Hopkins

Organization: Member of Recovery Cafe

Comment: Mr. Hopkins shared his life story, how he began to drink at age 9 and to smoke weed and use drugs beginning at age 13. When he first came to Recovery Café, he was homeless, struggling with addiction, hearing voices and hallucinating. Now he has permanent housing, in September he will have been sober for four years, he is employed full-time and he is looking for additional part-time work. He is no longer at risk for Type II diabetes because of changes in his lifestyle. All this is because of Recovery Café. Recovery Café makes him feel like he belongs and can be his genuine, authentic self, and he commends King County for including Recovery Cafe in MIDD II and supporting Recovery Café becoming available to more people in King County.

Name: George Dicks

Organization: Harborview

Comment: Geriatric specialist at Harborview, also representing the aging with pride component of the older adult people in the system. Early intervention and prevention programs are important, given the prevalence of depression in older adults, especially in communities of color. We have well-established evidence-based programs that through sheltering and socialization enhance wellness and fitness, reducing the severity and prevalence of depression in older adults. He urged the Oversight Committee to keep in mind the high cost of depression in respect to its effects on multiple aspects of health and he asked for continued funding that supports the mental health of older adults. He noted especially the expansion in South King County that will help communities of color especially. Mr. Dicks also voiced his support of GRAT. All older adult programs will affect all of us, even in this room.

Name: Jim Marshall

Organization: Retired from Harborview Medical Center

Comment: Jim Marshall, a licensed independent clinical social worker and Chemical Dependency Professional (CDP), recently retired from Harborview Medical Center after 27 years of witnessing the effects of mental illness and substance abuse on people. Mr. Marshall encouraged the Oversight Committee to support for LBGTQ people in particular because of the disproportionate rates of depression in that population: 40 percent say they have considered suicide, with higher rates among minority populations, due to stigma, victimization, and in many cases criminalization. Mr. Marshall

respectfully requested funding for comprehensive, evidence-based mental health and substance use disorder training programs.

Name: Kathleen Sullivan

Organization: Generations with Pride

Comment: Kathleen Sullivan, Director of a new organization called Generations with Pride that is working to reduce isolation and increase accessibility for the aging Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) population in King County. Ms. Sullivan voiced gratitude for the support that is being shown for this important population: as the UW SSW study has shown, there are clear disparities in care for this group within the older adult population in our County, and this group is expected to double. Research has shown that a lifetime of victimization and internalized stigma leads to greater mental health needs of LGBTQ. Isolation and feelings of loneliness increase likelihood of early death of all older adults, but especially LGBTQ older adults.

Name: Judy Strong

Organization: Evergreen Health Geriatric Regional Assessment Team

Comment: Ms. Strong spoke from two pages or prepared comment. She noted that GRAT is one of only two MIDD II recommendations directed to the geriatric population, and that the current recommendation drafted by the Oversight Committee is to cut GRAT's funding. GRAT receives referrals from first responders and other entities, responding to first-responder referrals within 24 hours and all others within three business days. They do assessments for cognitive functioning She shared stories of individuals and families helped by GRAT: one of an elderly woman showing up a school every day, school called police and police called GRAT; another of a 90-year old man experiencing increased difficulty caring for his wife, who called police who in turn called GRAT, who worked with the entire family to set up appropriate care for the elder in need of care; and another story of a woman in her 60s with known mental illness, living in her car in a church, where the church called GRAT, and GRAT arranged the client to go to the hospital. GRAT is not a program-based service but a person-based service that connects people with services, arranges hospitalizations, provides education to families – going everywhere in King County. No one else is providing this service, and it is crucial to the crisis prevention network. Ms. Strong asked the Oversight Committee to restore to current levels GRAT funding in its recommendations.

Name: Anne Lee

Organization: TeamChild

Comment: We are very pleased to see the MIDD II recommendations that emphasize investments in mental health and behavioral supports for youth who are involved in the justice system. Investments that are targeted to diverting children out of the justice system and into supports that show better evidence for health and well being will have a positive impact on reducing the racial disparities in the justice system. New concepts like the Family Intervention Restorative Services and the dedicated funding for alternatives to detention are excellent approaches. As the strategies are developed, we hope that they include flexibility so that supports can be tailored for the individual needs of children who are in conflict with the law. There is opportunity to achieve a tailored approach that provides meaningful,

timely and lasting support to children and families. CORS, behavioral assessments, and wrap around services have potential for such alignment. We believe that they can be better aligned to ensure that youth are getting services when they need them. We also hope to see clear directives around supports that actually meet the needs of underserved children, including children of color and children with disabilities. Racial disparities persist in all of our public systems - education, health care, child welfare, and juvenile justice. MIDD II investments can make a difference, but there needs to be clear direction about improving outcomes for these groups. Finally, missing in the recommendations are a system of ensuring that people who are marginalized and not able to access the system are able to. Legal aid and other advocates are a critical service that could ensure that the systems we create to support people are actually serving those most in need. Advocacy can also play a role in ensuring that individuals are able to transition into state and federally funded programs for longer term support than those services provided by the county. A portion of MIDD II should be dedicated to helping adults and children with access to the MIDD and other behavioral health services.

Name: Kim Hendrickson

Organization: City of Shoreline

Comment: Public Comment Kim Hendrickson, City of Shoreline May 6, 2016
I am writing to urge the reconsideration of the City of Shoreline Police Department's request for a RADAR Outreach Coordinator. This request was not one of the programs recommended by the MIDD Oversight Committee. I believe it should be. I was brought on this year, by the City of Shoreline, to help its police department respond to individuals with behavioral health issues. It's been a troubling experience. Deputies encounter people, every shift, who have untreated or poorly managed mental illness. They are asked to respond to situations, every day, involving people who are visibly suffering and without the ability to help themselves. What they tell me, to an officer, is that there is very little they can do in these critical situations. ITA criteria is high. The mobile crisis team is useful but response time is long and their ability to respond is limited. The crisis diversion center is an option but the distance is significant—and many people in need of help will not willingly be taken. There is no one with the time and training, within the department, to provide counseling, give professional advice, or conduct follow up visits—and/or connect people to needed treatment and services. A single Outreach Coordinator assisting deputies in Shoreline will not help all people in all situations. But if this person is a social worker, or other type of MHP, it will give Shoreline police a person to call who can counsel individuals in need of care, and link them to resources and services. One of the central purposes of MIDD dollars is to divert people from jails and emergency services, and provide them access to care. I urge the MIDD Committee to understand the importance of the Outreach Coordinator in this context, and to reconsider our application. Thank you for your consideration. Kim Hendrickson

Name: Anita Khandelwal

Organization: DPD

Comment: I first want to thank BHRD for its extraordinary work. The MIDD II process has felt thorough and transparent and I truly believe that our community will be healthier as a result of the programming that is eventually implemented. In going through the MIDD process, it seems like there are two implicit

but core principles underlying the recommendations and I thought it might make sense to articulate them and apply them explicitly going forward.

1) any organization or program funded by MIDD II should first look to Medicaid to see if federal dollars can pay for the programming. All programming that could be paid for by Medicaid should be. MIDD II funds should only be used to pay for programming that Medicaid will not pay for;

2) all programs should provide trauma-informed care and should apply principles of harm reduction. This is important because consistency across the continuum of care will more likely result in successful outcomes for individuals. Mixed messages about expectations regarding, for example, abstinence may confuse and frustrate recipients of service;

Regarding specific programming, I want to particularly applaud the creation of a Crisis Diversion Center in South King County and funding for respite beds and mobile behavioral health crisis teams. Given the explosion in the volume of Involuntary Treatment Act cases, it is critical that the County fund programs that could divert individuals away from that system. I also want to applaud LEAD expansion, which will help keep low-level offenders out of the system and accessing services that they need. Finally, I note that while the draft recommends funding FIRS, it fails to provide enough money for the residential component of the program. The full benefits of the program cannot be realized without adequate funding for the residential component of the program. Thank you again for your work!

Name: Paul Daniels

Organization: King County Superior Court

Comment: I am writing regarding the FIRS program and the recommendations to fund it. Family Intervention and Restorative Services represents a paradigm shift in the response to family violence that significantly reduces the number of youth being presented to King County's Juvenile Detention. FIRS is also a departure from formal court processing that allows for an immediate response to families in crisis. It will be necessary to re-address the funding proposals in order to maintain FIRS under MIDD II. Without additional funding, the model will revert to once again booking youth into detention for family violence incidents.

Name: Cecilia Camino

Organization: Superior Court

Comment: The goal of the Family Intervention and Restorative Services (FIRS) is to provide interventions and services to youth and families that are designed to: 1) decrease violence in the home, 2) decrease further police contact and detentions, and 3) minimize court involvement. The FIRS process allows youth an opportunity to divert their legal matter out of the formal juvenile court and detention system while connecting the youth and family with needed services. As a Juvenile Probation Counselor who works directly with this population, I can personally attest to the positive impact this program has had with youth and families involved in family violence. We are able to intervene and provide alternatives to court process immediately, while putting in place direct services more quickly and effectively. The current proposal includes the addition of a non-secure respite center for youth who would normally be detained. Funding this important piece of the program will be key, as it will eliminate the need for

detention in these cases, while allowing families needed respite time and an increased opportunity to engage youth and families in needed services.

Name: Lauren Davis

Organization: Washington Recovery Alliance

Comment: This is a terrific and important set of recommendations. It represents an inclusive process and a tremendous body of work by the BHRD division. Thank you! I think it would be incredibly strategic to invest a small amount of money ($50-75K) to hire a young professional to organize activities for a King County Recovery Coalition, as described in the briefing paper. As proposed, this coalition would operate under the oversight of the Washington Recovery Alliance (WRA), which is a statewide network of behavioral health recovery coalitions. The WRA has the ideas and expertise, but not the time to carry out a planned stigma reduction campaign. Proposed activities include training a speakers bureau of people in recovery and affected families to speak at public meetings, to help ease concerns of neighbors when treated facilities are being sited. The WRA also seeks to host public recovery events and to create a social marketing campaign to reduce stigma. Stigma presents an obstacle to the fulfillment of nearly every strategy proposed in MIDD 2. For example, stigma creates road blocks to the creation and siting of new treatment facilities and it prevents individuals in distress from seeking care. It also isolates families and friends who are supporting a loved one in crisis. We would be remiss not to dedicate a small portion of funds toward its eradication.

Name: Jeremy Crowe

Organization: King County Superior Court

Comment: Family Intervention and Restorative Services (FIRS) represents a example of a needed and appropriate shifting of our focus to assessing needs/services up front and a path of prevention/decreasing recidivism vs. the previous long-standing approach: waiting for more criminal referrals to pile up and what can be a slow and lengthy court process to get to court supervision and services (while the youth/family and surrounding community, in the mean-time, can often continue to struggle immensely). FIRS attacks the number one driver of youth in detention - domestic violence/assault - one of the most intense, complex and difficult to intervene in issues in our community. It needs more funding to allow its full vision to be realized, including "Z-hall" at juvenile detention, a non-secure respite/shelter "unit" for youth involved in DV incidents at home. This will be a staffed/supervised place that promotes entry into an outside-of-court intervention process where they can access support and services in lieu of secure detention and in lieu of initiating the formal court and charging/filing process. FIRS puts a large dent in the number of kids sitting in detention for DV/assault-related referrals and connects youth and families with timely and often immediate support, assessments, safety planning and services. It has shown positive results in it's first 4 months and we continue to assess how best to serve youth and families embroiled in intense conflict in their homes. This team approach combines immediate staffing, risk/violence assessments, negotiating, family/team meetings and truly tailored/matching service referrals, sometimes within hours of the DV incident occurring. Only funding a promising new program and approach like FIRS for a short period of time and/or only funding part of what it demands in order to truly flourish doesn't make much sense. We are moving towards a more informed, family-empowering and healthy approach to domestic violence in our community FIRS is and can continue to be a part of this shift towards something that makes more sense

and is more effective for our families and communities. But it simply can't develop or even stick around if it is not fully/appropriately funded.

Name: Susan Craighead

Organization: King County Superior Court

Comment: I wish to comment wearing two different "hats." First, as a member of the Juvenile Justice Equity Steering Committee, I am pleased to see the focus on youth and alternatives to secure detention. However, the recommendations themselves are insufficiently detailed for members of the Steering Committee to be able to evaluate their merits versus the merits of other ideas. It is difficult to discern how well the existing programs or the new programs will serve highly marginalized populations. I suspect the Committee will be pleased to see the recommendation for Community Driven Mental Health Grants, but would ask why this strategy is not embedded in all of the recommendations. Different parts of our community may need services from small, community based organizations that can be more culturally sensitive. It is important not to relegate cultural sensitivity to a $300k program. The Steering Committee will need more information (perhaps a visit by Kelli Carroll at our next meeting) and time to present comments on behalf of the Steering Committee as a whole. Speaking as the Presiding Judge, I want to express my gratitude on behalf of the Court for the generosity that these recommendations demonstrate for the criminal and juvenile justice systems. My comments need to be taken in this light. First, it appears that FIRS was funded at 50% of the actual cost; the $700k allocated will pay for the professional staff and evidence-based services, but not a home for FIRS. Without an additional $700k (which could come partly from sources other than MIDD) the youth would have to go back to staying in detention for the "cooling off" period before they can return home. Second, with regard to the Mental Health Alternatives to Secure Detention: we are very supportive of this idea, but we would encourage you to add runaways to the list of youth who might be suitable for these beds. Most of those who arrested on warrants and placed in detention suffer from PTSD; without a safe temporary place to put them, DSHS places them in hotels or the next available foster placement, which may not be appropriate and will cause them to run again. The funding recommended for Family Treatment Court does not allow it to be expanded to South King County. Superior Court obtained a grant to allow us to expand because our cases increasingly come from South King County. The grant requires matching funds from MIDD. Without those dollars, we will have to return grant money. For everyone's information, Family Treatment Court is not a diversion from the criminal justice system. Rather, it enables families in the dependency system to reunite rather than have children grow in foster care. FTC offers the best chance for family reunification and beneficiaries are young children who get to be raised by their biological parents. Superior Court is happy to work with MIDD staff to see if there are other ways to raise money for some of these objectives, such as grant funding or contributions from our city partners. We welcome these discussions. Thanks very much to the entire MIDD staff and DCHS for the hard work that has gone into this list of recommendations

Name: David Coffey

Organization: Recovery Cafe

Comment: I applaud King County for including Recovery Cafe in MIDD II. Everyday here at the Cafe I see people transforming their lives- staying drug and alcohol free and stabilizing their mental health to embrace a life of wellness. Thank you King County for investing in this incredible program.

Name: Leesa Manion

Organization: Prosecuting Attorney's Office

Comment: Please consider adding additional funding to the FIRS concept to allow this innovative and effective program to operate at full capacity as a non-secure, pre-booking, pre-filing juvenile diversion program for youth, many of whom, are struggling with chemical dependency and mental health challenges that cause them to lash out physically against parents or siblings. The $700,000 allocated in the Draft MIDD II Funding and Programmatic Recommendations is not enough to adequately serve the 400 or more youth a year that FIRS can effectively divert out of the criminal justice system.

Name: Patricia Sayed

Organization: None

Comment: One purpose of the mission team of my faith community, of which I am a member, is to research organizations which may need help in maintaining their programs for the homeless, addicted and those with mental health problems. With this in mind, I want the King County Council to know why I definitely think the Recovery Cafe should be included in your funding decisions. First, the work of the Cafe saves the county money by reducing the number of 911 calls, emergency room visits, and police interventions because they give people meals, support, friendship, and other opportunities for healing and safety. Their many classes offer people dealing with homelessness, addiction, and other mental health challenges opportunities to learn anger management, yoga, meditation, and others for stress reduction and emotion regulation. Thank you for considering my comments, Patricia Sayed

Name: Dan McDougall-Treacy

Organization: Valley Cities

Comment: Please reconsider the planned 33% reduction in funding for Wraparound. I know the impending availability of Medicaid funding presents an apparent opportunity to shift funds elsewhere. BUT: the Medicaid reimbursement elsewhere in the state has not been able to cover costs; the state requires King to drastically increase the number of Medicaid youth receiving wraparound in the future. Over the lifespan of the MIDD II funding, the service level for all Wraparound youth will gradually degrade.

Name: Lea Ennis

Organization: King Co. Superior Court

Comment: We are very concerned about the lack of funding for the FIRS respite center. We will be opening this non-secure, residential option for youth involved with family violence case in July of 2016. Without the full funding requested in our proposal we will have to shut down the residential component and revert to booking youth into detention. The respite center provides a mechanism for youth to receive services without spending time in secure detention and entering the juvenile justice system. It is also a resource for law enforcement since some youth do not meet the detention intake criteria.

Name: Teresa Perillo

Organization: Recovery Cafe

Comment: We are grateful to be able to be part of the MIDD program, we believe it has been very helpful for our members that we serve!

Name: Stephen DeChiaro

Organization: Recovery Cafe

Comment: I support the initial draft MIDDII program for Recovery Cafe.

Name: Derek Franklin

Organization: Mercer Island Youth & Family Services

Comment: MIYFS recently partnered with the U.W. Center for the Study of Health and Risk Behaviors to create a novel, on-line individualized normative feedback tool for high school aged youth. This tool allows youth to take a short on-line survey that provides them immediate feedback on their drug and alcohol (and potentially mental health) risk in relation to risks of their peers (normative feedback let's youth know if, for example, drinking 5 beers a weekend is "normal" or not among peer their age--it is not normative behavior in King County but many youth think it is). MIYFS funded the first phase of this study. It needs approximately $50K for the next phase. Once completed it can be implemented to youth across the county for almost no cost, except for local schools or human service organizations helping upload local normative data into the system so local youth can see how they compare not only to peers across the county, but to peers in their own school. This is prevention tool that has been studied at UW--its efficacy can be best explained by Dr. Jason Kilmer. It is an extremely cost effective prevention tool that borrows from Motivational Interviewing and SBIRT. Youth who take the quick survey are given feedback about their substance use issues, where to get help, linked to educational videos, etc.

Name: Carrie Rubenstein

Organization: Swedish Medical Center

Comment: I am a family physician and Geriatrician in Seattle. The services funded by this program/budget are critical for many of our vulnerable elder populations. Please continue this important funding.

Name: Anne Nelsen

Organization: None

Comment: I first volunteered (and became a donor) at the Recovery Cafe two years ago. My charge was to be a Minister of Presence, a concept quite foreign to me at the time, though not now. It is to be present, to be "there," in whatever capacity is needed. It is an extraordinary charge, but one that I see fulfilled by staff and volunteers at the Cafe every day I am there. To be there, to meet needs, to listen, to support, to care, to grieve when necessary, to challenge, to celebrate, to love unconditionally. To walk into the Cafe is to walk into an embracing warmth like no other: a safe place, a nurturing place, a place of fresh starts and healing. To me, the Cafe is the most remarkable place I have encountered in decades of volunteering. I see a motivated, profoundly caring staff, volunteers who are drawn into the experience ever more powerfully, members who are thriving and caring for each other. This incredibly innovative organization is most worthy of public support. It is not magic, but it is possibly as close to that as is humanly possible.

Name: Officer Sam Cook #6325

Organization: Seattle Police Department

Comment: I just want to say that I really support the work and good people at the Recovery Café.
I strongly encourage a continued partnership between them and the MIDD.

Name: Dorothy Trueblood

Organization: Valley Cities BHO

Comment: I have always been thankful that MIDD covered families with private or no insurance and for those who have two systems that did not necessarily include mental health. With decreased funding, those things would be gone, which would likely increase the cost in other areas, such as criminal, ER visits, etc.

Name: David Bales

Organization: Washington State Criminal Justice Training Commission

Comment: I am supportive of continued funding for Law Enforcement and first responder Crisis Intervention training. First responders are the only service consistently available to respond to incidents

of people in mental health crisis in the community, where they are, during the crisis- and 24 hours a day, seven days a week. The opportunity to leverage virtually ALL of the other identified programs and interventions starts with having first responders who understand the concepts of CIT as well as the resources that are available. We see all around the country the results of first responders not having this training, knowledge and skill. We are ahead of the curve in King County but we are also in the midst of a hiring spike that the police profession hasn't seen in over 30 years- a significant number of officers are retiring and we MUST train the new ones. I strongly support full continued funding for CIT training for first responders. The need is not diminishing.

Name: Lily Anderson

Organization: King County Step-Up Program

Comment: The addition of a Respite Center component to the Family Intervention Restorative Services program at Juvenile Court is a sensible and purposeful way to significantly reduce the number of youth in detention and the criminal justice system. It will provide more opportunity and time for youth and families to safety plan, learn family violence prevention skills and engage in restorative process to begin re-building relationships. Parents and youth will gain strategies to prevent further violence in the home. If our court, county and community is committed to keeping these youth out of the criminal justice system, this is an attainable and meaningful way to make it happen.

Name: Ruby Takushi

Organization: Recovery Cafe

Comment: I am on the board and staff at Recovery Cafe. Everyday I see the crucial role the Cafe plays in providing recovery support to men and women in our community struggling to heal from homelessness, trauma, mental illness, and addiction.

Name: Elizabeth Trautman

Organization: YouthCare

Comment: Thank you for the opportunity to comment on Programmatic Recommendations for MIDD II Funding. YouthCare is appreciative of the inclusive community process and deep thought that went into forming these recommendations, and are supportive of both the program categories, and the specific strategies and recommendations within each category. In particular, we are supportive of the following interventions that we feel will greatly benefit the homeless, unstably housed, and system-involved young people we serve.

- PRI-VII – Mental Health First Aid – we hope that youth providers can access this training, as our staff can serve as first responders to youth who are decompensating.
- CD-II – Youth and Young Adult Homelessness Services – We believe this strategy provides the necessary supports to ensure we can safely provide housing services to youth with acute behavioral health needs.

- CD-VII – Multipronged Opioid Strategies – we are hopeful that these strategies also consider the needs of homeless youth and young adults.
- CD-IX – Behavioral Health Urgent Care Walkin Clinic Pilot – This proposed pilot meets a huge need in our community, and we hope our young adult clients might access these services.
- CD-XVII – Youth Mental Health ASD This list isn't intended to be exhaustive, as we see many positive elements in the proposed funding list, and look forward to ensuring that our community's homeless youth, young adults, and their families have the behavioral health supports they need to successfully move beyond homelessness into thriving adulthood.

Name: Rachelle Wright

Organization: CIT-King CO Program, WSCJTC

Comment: I like that some of the current programs are still being considered for MIDD II. Please look at continuing the CIT training for first responders as we have just begun the process of implementation of Corrections and Fire/EMS into the training program. With the implementation of new users to the training courses, it has also increased our training need across the county, and we will work as hard as we can to meet that need. We are also looking at new ways to develop sustainability with first responders so that the training continues and collaboration with resources like the MHP, DMHP, hospitals, courts, etc. continues and is strong across the county. We also value the resources available in King County and find the communication and education on resources such as GRAT, CCORS, and King County Mental Health Court have brought a lot of light to available resources many first responders did not know even existed. As a result with more of our training, it has caused a rise in their need to support the referrals from first responders. Please support those crisis resources as they are extremely valuable partners. During MIDD II I would like to expand implementation of training to also include security and other first responders (e.g. Emergency room personnel), transit security, and more to continue to grow the program even further.

Name: Mary Taylor

Organization: King County Step Up Program

Comment: The draft recommendations do not provide the full funding for FIRS. FIRS is a respite center model - a non-secure 24/7 receiving facility that eliminates the need for detention bookings on the majority of family violence cases. The approach represents an entirely new way of doing business, keeping kids out of detention and providing services at the time of crisis. I have been involved in the planning of FIRS since the spring of 2014 as the supervisor of the step up program. Having a physical location to temporarily house the teens, while connecting the family to services and developing safety plans, is the most critical element of the proposal. Without full funding, King County will miss a valuable opportunity supported by the community and juvenile justice professionals, to truly make a difference in an immediate way in the lives of youth and their families.

Name: Kelly Ebels

Organization: None

Comment: Great to see some really helpful and innovative programs being funded. I have heard from several participants in the LEAD program about how positive their experience is and their motivation to

stick with the program. I hope it continues to expand. I see new funding for the Recovery Cafe. I am very pleased to see this. I am a volunteer, supporter, and fan of the Recovery Cafe. I have heard countless stories of struggle and have heard and seen improvement in people's lives through the supportive services offered at the Recovery Cafe. This organization offers crucial support for people struggling with trauma, mental illness, addiction, poverty, and homelessness. The Recovery Cafe uses resources, including volunteers, more effectively than any organization I have ever been involved with. They will stretch this funding far. For this reason, I would like to see their work better funded by the county. I hope that revisions to the MIDD budget will include an increase in funding of their efforts. For example, I see that $800k is budgeted for a peer support pilot. While I have no doubt that this is important work, I wonder why this pilot is receiving significantly more funding than the Recovery Cafe, an organization that already incorporates peer support into all of their programming. The day-to-day engagement with people from the community by the Recovery Cafe significantly responds to the needs identified not only in the recovery and reentry strategy area, but also in the strategy areas of crisis diversion and prevention and intervention. This is a key program that deserves significant support. Please consider increasing funding for the Recovery Cafe in revisions to the budget. Thank you again for funding important community programs and organizations like the Recovery Cafe to invest in improving the lives of people in our community.

Name: Killian Noe

Organization: Recovery Cafe

Comment: We need Recovery Cafe's throughout the city providing support to those seeking to attain and maintain stability in recovery from substance use disorder and other mental health challengers.

Name: David Boyle

Organization: None

Comment: I have been involved with The Recovery Café as a volunteer for over 10 years. I have witnessed the success the Café has had in helping those dealing with drug dependency and mental illness to recover stability and a sense of meaning in their lives. I fully support the Café receiving MIDD funds, and I respectfully request that the MIDD program consider increasing the proposed funding for the Café to provide it with the support necessary to open and operate a Café in South King County.

Name: Amy Worthington

Organization: Recovery Cafe Board Member

Comment: As a Recovery Cafe board member I was thrilled to learn this organization is still being considered for MIDD support. Recovery Cafe is one of but a very few programs that truly helps people with addition clean and sober for the long run, which is a cost savings for King County in the long run. There is a great recent report that supports this claim that the Department of Public Health has seen. Not only should MIDD support this organization, the amount of support should be greater than currently indicated. It's a smart investment of public dollars and is a cost savings in the fight against addiction in the long run and big picture.

Name: Angela Wolle

Organization: None

Comment: I am delighted to see that the Recovery Cafe is included in this. Their work is phenomenal and I hope that this model can be spread throughout the county.

Name: Barbara Johns

Organization: None

Comment: I support the renewal of the levy and urge funding of Recovery Café as part of Recovery and Reentry.

Name: Victoria Allen MD

Organization: None

Comment: Please fund Recovery Cafe's request for funding to build an additional Recovery Cafe site. Recovery Cafe offers a unique setting for members in recovery. Without a safe place to go, to be known and to work daily on recovery and mental wellness, individuals struggling with mental illness and substance addiction are lonely, lost, isolated and at very high risk of relapse. I have been in primary care for over 20 years and have worked with many patients that may get short term treatment but there is nothing to hold them and support them as they leave the treatment program and relapse inevitably occurs again and again. The Cafe model is simply incredible and offers radical hospitality, accountability, support for those in recovery. It is the vital missing piece on the recovery journey which so many need. I often say I wish there were a Recovery Cafe (instead of a Starbuck's) on every corner because it too serves great coffee but offers something much more important for all of us, a place of healing and hope for every single person that walks through the doors--members, donors, volunteers all receive so much from this incredible model. Please fund Recovery Cafe, it is a model that will be replicated across the country and Seattle will be proud that we continue to offer innovative solutions for those struggling with mental illness and addiction.

Name: Patricia Song

Organization: None

Comment: Please include Recovery Cafe in the MIDD. I have been a weekly volunteer teacher at the Cafe for over four years and can attest to the miraculous work they are doing there. They are a true, bright light in our community. MIDD funding will help to ensure that they are able to continue their life-changing, transformative work. I am convinced that Recovery Cafe is a most effective model for the highest positive change in the world.

Name: John Morefield

Organization: None

Comment: I was a volunteer at Recovery Cafe for over a year and in that time I was continually amazed at the quality of care provided to some of the most marginalized in our society. Day after day the remarkable staff goes the extra mile to insure quality service for their clients/customers. Dental care, quality delicious food, AA groups, yoga classes, employment counseling...the list just goes on and on. This past Monday I was visiting a prisoner in the Pierce County jail. On my side of the window I could here visitors talking about how wonderful Recovery Cafe is in Seattle and how excited they were about the Tacoma venture. Amazing to hear such testimony from people in real need. I strongly recommend including Recovery Cafe in the MIDD II funding. Thank you. John Morefield

Name: John Schochet

Organization: Seattle City Attorney's Office

Comment: The Seattle City Attorney's Office supports the funding for the involuntary treatment triage. This program, which was previously operated at Harborview's expense, has improved the process for timely evaluating for civil commitment purposes defendants whose Seattle Municipal Court criminal cases were dismissed for lack of competency. These evaluations play an important role in ensuring that individuals with mental illness receive treatment and improving public safety in King County.

Name: Maureen Lee

Organization: None

Comment: I am so pleased to see Recovery Cafe in the MIDD. It is an asset in the downtown neighborhood. It needs more funding to increase services! Thanks.

Name: Keith Capasso

Organization: None

Comment: Please make sure to include Recovery Cafe in the MIDD. Thank you.

Name: William Schipp

Organization: Juvenile Court Services

Comment: King County Juvenile Justice Assessment Team Response to MIDD II Funding Recommendations May 2016 The Programmatic Recommendations for MIDD II Number PR1-11, Juvenile Justice Youth Behavioral Health Assessments, dated 4/28/2016 provides for a proposed budget of $500,000, which is substantially less than the amount at which the Juvenile Justice Assessment Team (JJAT) is currently funded (- $63, 820). With program enhancements that would increase clinical services to youth from assessment through referral and enrollment, the amount requested from MIDD II is $730,

650.00. Absent these enhanced services, it appears that the program would be funded at a rate lower than currently funded, which would greatly impact the program's ability to meet the needs of our youth and the court, as well as our ability to meet the target numbers required. To date, JJAT has served over 2500 unique youth through its screening, assessment, consultation and referral to community based services. For each year of MIDD 1, JJAT has met or exceeded its targets for screenings (GAIN Short Screener and Trauma Screenings), mental health and chemical dependency assessments, psychological evaluations, and made numerous referrals to community based services for psychiatric and neuropsychological evaluations. We provide cross disciplinary consultations for Juvenile Court Services staff, as well as community partners working with our youth. As the number of youth referred for filings and the number of youth held in secure detention continue to decline, thanks to the many Alternatives to Secure Detention (ASD) opportunities, the severity of Behavioral Health and Substance Use Disorder affected youth increase proportionately. JJAT serves this population and cannot continue to provide the required services if we are funded at a level where we cannot sustain current staffing levels. Fully staffed, JJAT is comprised of a 1.0 FTE Program Coordinator, a .8 FTE Clinical Psychologist, 2.5 FTE Mental Health Liaisons, and 1.0 FTE Chemical Dependency Liaison. Historically, we have also relied upon 1.0 FTE contracted on a fee for service basis through a community based agency. With our target for Mental Health Assessments set at 140/MIDD year, each Mental Health staff is expected to complete approximately 56 assessments. Our Chemical Dependency assessment target is set at 165 assessments per year, and each Chemical Dependency Liaison is expected to complete approximately 83 assessments. Reductions in staff would greatly impact not only our ability to meet these targets, it would also result in fewer youth being served. With the recent Behavioral Health Integration changes that have been implemented just recently, it is not clinically sound to continue to conduct assessments under the old system of separate Mental Health and Chemical Dependency structure. Under the guidance of our Clinical Psychologist and with input from the King County Behavioral Health and Recovery Division, Department of Community and Health Services, JJAT has developed an integrated Behavioral Health Assessment Tool and programmatic approach to completing assessments and evaluations for referred youth. This tool and approach will look at the clinical needs of the whole child, provide diagnoses where appropriate, and make recommendations that will address the complete Behavioral Health needs of the young person. This approach will assist youth from initial screening, through assessment, referral to services and ongoing clinical oversight to assure that the youth is receiving the necessary services. Serving as a support to the youth, family, the court and the community based agencies, our clinician will provide this additional service to further ensure progress in treatment, family preservation, and compliance with court requirements. At a time when the availability of in-patient Substance Use Disorder resources has decreased significantly, the court is seeing an increase in the number of Opioid Use Disorders and Amphetamine Use Disorders among the youth referred for evaluation and assessment. While some of these youth may benefit from enhanced Juvenile Drug Court Services, not all youth are able to participate in these services. From a Behavioral Health approach to these issues, it is difficult to address the comprehensive needs of the youth and family from a standard Juvenile Court Services approach. These youth need the additional clinical oversight to ensure success, enhancements and fine tuning to clinical case plans when needed, and additional clinical support to increase familial involvement and ultimately a successful treatment experience. JJAT has seen an increase in the number of referrals for youth involved in Truancy actions in the court. While some may believe that any youth involved in the Juvenile Justice System is beyond the scope of preventions services, it is our experience that these youth, as well as those involved in At Risk Youth petitions, are in a particularly vulnerable position to become involved in the well-publicized "School to Prison Pipeline," in which youth rapidly progress from school failures to criminal activities, often with lifelong consequences. JJAT intervention, with Behavioral Health recommendations at this stage may serve to reduce the causes behind truant behavior and familial dysfunction and prevent further Juvenile Justice

System involvement. A reduction in funding for the Juvenile Justice Assessment Team will have a direct impact on staff and resources that will hinder JJAT's ability to provide the scope of these necessary services. Our proposed programmatic enhancements cannot effectively be implemented absent the funding for these services. A reduction of over $63,000 from our current funding level will decrease our ability to provide the kind of cross-disciplinary approach mandated through Behavioral Health Integration. Please consider fully funding the Juvenile Justice Assessment Team at its requested budget levels.

Name: Mike Heinisch

Organization: Kent Youth and Family Services

Comment: Thank you for the opportunity to provide public comment on the initial draft funding and programmatic recommendations. And for the vast amount of work, by staff, stakeholders, the public, and many, many others to move the MIDD Review and Renewal Process leading to MIDD II along to this point. My comments follow. The MIDD II Funding and Programmatic Focus Areas" and "Key MIDD II Assumptions" capture well the community voices and priorities as well as the current environment, 2016 v. 2008, as the County embarks on MIDD II. I am particularly pleased to see the inclusion of "upstream prevention and diversion activities;" "treatment on demand;" "community driving grants processes so geographic and culturally diverse communities can customize behavioral health services for their unique needs." The overarching MIDD ii framework "Strategies" that seems to be well designed to implement to the extent MIDD II resources are available those focus areas. I would encourage a cautious approach to the MIDD II assumptions that "leveraged Medicaid replaces MIDD funding…" Previous such assumptions with the implementation of federal ACA and Washington healthplanfinder Exchange were overly optimist, particularly for SUD leveraged Medicaid treatment, and has led to continuing extensive financial stress, if not actual continuing crisis, in the publicly funded SUD treatment services and providers. Even with the recognition of needing to get the leverage Medicaid assumptions "right is so important" that KC has engaged a consulting firm to review, be very cautious and very conservative with these assumptions. They can always be revised should they prove to be wrong in a favorable direction for the County and the providers and clients access to services. It will no doubt be much more difficult if not impossible should the assumptions prove to be wrong in an unfavorable direction however. On the "Initial Draft MIDD II Funding Programmatic Recommendations: Overall it appears to me that more thought needs to be given to which MIDD II Framework Strategies each MIDD II Initiative Title is best placed. This is particularly true for the "Systems Improvement" Framework Strategy MIDD ii Initiatives listed under Systems Improvement. I am very pleased to see the New Zero Suicide Initiative Pilot. Very timely with the continuing population (demographic) wide escalations in suicide attempts/completions. The New Youth and Young Adult Homelessness I would hope will work in close coordination with BSK's Youth and Youth Adult and Families Homelessness Initiative. Also I would like to see consideration of a significant proposed budget increase for the initiative title. Fully endorse the New Law Enforcement Assisted Division (LEAD) into MIDD II. I would hope that LEAD efforts will be extended to none hot spots throughout the County, particularly of course here in SKC. New Behavioral Health Urgent Care-Walk In Clinic, while I am supportive I would encourage a clear and distinct differentiation between the MIDD II Initiative (and MIDD I Strategy) Next Day Appointments. "NDA's", long a feature of the mental health center system, understandably are agency based and have always been a valued immediate crisis intervention/prevention. The should remain so and be a very important part of MIDD II. Seemly be cautious to differentiate between this New Urgent Care-Walk In and NDA's. Fully support New Family Intervention Restorative Services – FIRS. What has been developed with MIDD II fund balance funding

(as well as the long existing “Step Up” Program) has proven to be a very successful intervention with these youth who are violent towards a family member. Fully support New Youth Mental Health Alternative to Secure Detention. So many of these Alternatives to Secure Detention efforts were originally implemented and demonstrated early positive results after the adoption of JJOMP in the late 1990s/early 2000s and then abandoned due to budget constraints. We are well past time ASD’s should be restored as a proven effective part of the services system. I have some concerns and urge careful consideration of MIDD II Initiative Titles: Housing Capital and Rental, New Rapid Rehousing-Oxford House Model, Housing Vouchers for Adult Drug Court. Coordinate closely with All Home on these, if eventually implemented. My caution, particular with making MIDD II (or MIDD I initially for that matter) is that there are significant other “pots” for access to capital for housing, albeit not enough for the need being experience in the Crisis of Homelessness” in King County. I am not in favor of MIDD being looked to repeatedly for access to capital for housing. Fully support New Recovery Café. I realize that it may appear unusual or otherwise bias/favoritism to one particular agency. However Recovery Café has proven itself with complex chronically mentally ill and SUD individuals well deserving of being called out as a MIDD II Initiative. New South County Crisis Diversion Services/Center would be a huge benefit to all MH/SUD involved systems and providers in SKC. From first responders through treatment providers, schools, family members, etc. of individuals in crisis as a preventative and pre-full blown crisis. Similar to my comments on the New Behavioral Health Urgent Care-Walk in Clinic Pilot, I urge clear differentiation between the SKC Crisis Diversion Center and the Urgent Care-Walk in. I would not want, nor would any of us in SKC I trust, a dilution of the SKC Crisis Diversion Center simply because there is a (perceived duplication of services) with the Walk in Center. Supportive of the New Behavioral Health Services in Rural King County Initiative. Thank you, on behalf of SKC unincorporated residents for its inclusion. Thank you again for the opportunity to comment. Continue the fine work on the MIDD II processes.

Name: Judge Lisa O'Toole

Organization: King County District Court

Comment: Dear MIDD Oversight Group, I am a Judge in King County District Court, East Division. I am writing to urge King County to allocate MIDD funding to combat the drastic increase in heroin addiction that we see here in King County. The number of defendants that we see in District Court who are heroin addicts is truly staggering. Each and every week here in Redmond I see dozens of defendants who are heroin addicts. One of the remarkable things about this is that not only do I see defendants charged with crimes that one might expect of a heroin addict, such as Driving Under the Influence (of heroin) or Possession of Drug Paraphernalia, but I also see defendants charged with other crimes such as theft and assault, including domestic violence. So very often the genesis of the criminal activity is the addiction. Many of the people in the criminal justice system who are heroin addicts are indigent and without stable housing. Without stable housing it is nearly impossible for these individuals to participate in, and be successful in, substance use disorder treatment. I urge King County to use MIDD funding to prevent further needless deaths due to heroin overdoses and to combat increasing risks to public safety. Ideally, a criminal justice diversion program in District Court would help defendants to address legal issues while engaging in treatment arranged through the program and while living in stable housing arranged through the diversion program. I realize that such a diversion program would be an expensive proposition, however. At a minimum, I urge King County to use MIDD funding to develop programs that will provide treatment and housing options for defendants in the District and Municipal courts. Thank you for your consideration. Judge Lisa O’Toole

Name: Sue Shaw

Organization: King County Advisory Council on Aging & Disability Services

Comment: Please excuse my earlier blank submission. I am writing in support of increased funding for the Geriatric Regional Assessment Team(GRAT). As the homeless population grows and ages, it is critically important that the mental health needs of older adults are able to be met immediately. It is totally unacceptable for our elders in King County to spend one night without shelter. We must fund the GRAT program at a level that allows immediate response to a mental health crisis among our aged in order to avoid that possibility.

Name: Diana Forman

Organization: None

Comment: I am writing in support of including Recovery Cafe in the MIDD Tax Levy, which will be considered for renewal in November. As an organization founded to help those living on the margins of society, Recovery Cafe is a key member of the "Reentry and Recovery" strategy area being consider for funding. The Cafe not only provides meals to those who are struggling with homelessness and addiction but helps them find a path to recovery, self-respect, and stability. The program has won three community and State awards for its work and has become a nationally-recognized model for other communities working to end the cycle of addiction, suffering, and despair. Over the years I have been impressed and moved by the stories of Recovery Cafe members who credit the cafe with leading them to recovery and supporting their determination to remain drug-free and able to believe in themselves once again. This is a program that benefits both the recipients of the effective on-going support the Cafe and its many programs provide and the greater Seattle community as a whole. I sincerely hope that the Cafe and its remarkable leadership and staff will be selected to continue and expand their life changing work by receiving funding as part of the MIDD Tax Levy. All the best, Diana Forman, Seattle

Name: Kathleen Southwick

Organization: Crisis Clinic

Comment: On behalf of Crisis Clinic, I want to extend our thanks to Kelli Carroll and her team for such a great job on shepherding this process and conducting the extensive community outreach. It gives us confidence in the recommendations made! Overall, I think the recommendations were very good and build on the success of many existing programs. I understand that some new elements may be added to existing programs, but it is difficult to tell from the just the titles so I hope there will be time for more comment when the service improvement plans are developed. In particular, Crisis Clinic supports these new initiatives: PRI-VI: New Zero Suicide Initiative. We are highly supportive of this new initiative and gave suggestions for program elements that we hope will be included. Our 24-Hour Crisis Line received more than 5,000 calls last year from people seriously considering suicide so we know this is an important public health issue and we applaud the county for taking a community-wide approach to building systems and supports to address this issue. We are especially excited about the plans to provide immediate follow-up support to people discharged from the hospital after a suicide attempt. This is the most vulnerable time for people and they are at a high risk for re-attempting. We have proposed a

telephone-based follow up service, along with a on-going support group , both are evidence-based practices which have shown to be highly effective in reducing a future attempt. CD-IV New South County Crisis Diversion Services/Center & SI-X New Behavioral Health Services in Rural King County. We know from the calls we receive on the 24-Hour Crisis Line and King County 211 that there is a tremendous need for more services in south, southeast and rural King County. We are glad that MIDD is making this a priority. I want to address a gap in the continuum of behavioral health services that was not selected as a priority, but which is foundational to the success of the clients receiving these services. Stabilizing and Expanding Access to Community Services: King County 211 Each of the programs recommended for continued or new funding in some way depends on the effectiveness of King County 211, yet there has been no funding to help support this service through the behavioral health system. MIDD funding would provide an opportunity to remedy that. King County 211 is the county's comprehensive information and referral call center. It also maintains the database of all the health, behavioral health and community services in King County. This is the database that case managers, ED social workers, educators, court personnel, and public safety officials depend on when they are seeking resources for their clients. For example, in April, the King County District Court judges asked for a presentation on 211 because they recognized that many of those appearing before them are there because of crimes related to their poverty, mental illness and lack of housing and basic needs service. They wanted to learn more so they could refer those appearing before them to 211 to get help. The characteristics and needs of those with behavioral health/criminal justice challenges fit the profile/needs of 211 callers. Many probably already use 211 services. Addressing mental health/substance use disorders is significantly easier if the person has stable housing, food, transportation, training/employment. King County 211 helps them create a solid foundation from which to address their health concerns. A few of the specialized human services systems fund 211 as a key entry point to their array of services including rental assistance, family homelessness, and civil legal assistance, the new Community Living Connections program (aging and disability services) But the health/behavioral health system does not provide funding to the 211 system and this is a significant gap in our funding mix, especially since Medicaid clients are likely high users of 211. Even DCHS provides only minimal funding through the Vets and Human Services Levy. The 211 system is at serious risk and needs investments from MIDD, BSK and the Vet and Human Services Levy. When the County had general fund monies, 211 received $100,000 annually and we would like to see MIDD fund 211 at that level. King County 211 is the 911 of the health, behavioral health and human services and it is important that the County invest to assure it can continue to support the rest of the programs/providers funded by MIDD. Thank you

Name: Jimmy Hung

Organization: King County Prosecutor's Office

Comment: The Family Intervention and Restorative Services (FIRS) needs to be fully funded. Currently the draft MIDD II recommendation only funds 57% of what is needed and provides zero funding for operations of a 24/7 respite center. The pilot FIRS respite center will open on July 1, 2016 as a result of a one time contribution from the City of Seattle. The respite center model is a non-secure 24/7 receiving facility that eliminates the need for detention bookings on the majority of family violence cases. This model allows flexibility for families to receive respite services that are not tied to the criminal justice system and will greatly reduce booking and formal charging. The respite center will provide a welcome resource for law enforcement as many youth who do not meet the stringent detention intake criteria are turned away and law enforcement is forced to make the difficult decision to leave the violent offender in the home with his/her victim. This often results in subsequent 911 calls for help that strain

emergency services. Without this respite center we will return to the ineffective and harmful practice of booking these youth into juvenile detention. FIRS is not a concept or an idea. It is presently a fully functioning program that is providing immediate services to youth and families in crisis and it is serving as a beacon for juvenile justice reform. It is a partnership between the courts/prosecutors/defense/probation/law-enforcement/community that has never been seen in King County. It is a program that bucks the county's reputation as an entity that just likes to talk a big game, but takes no action. A failure to fully fund FIRS will do more damage than simply being further evidence of county government's inability to act. Failing to fully fund FIRS will harm youth and families, and will make our communities less safe.

Name: Mike Graham-Squire

Organization: Neighborhood House

Comment: One thing that is working and a gap that I do not see addressed in the summary of recommendations is that we have successful prevention coalitions in that provide early intervention and prevention services however these coalitions currently only serve a handful of communities and the funding provided does not cover the full costs of providing the service. These types of coalitions are proven effective through the communities that care model, Drug Free Communities Program, and CPWI. King County should use MIDD funds to expand these coalitions to additional communities in King County and use MIDD funds to cover the cash match and indirect costs required to run these coalitions that are currently not paid for by state or county dollars. This funding gap has prevented King County from being able to start new coalitions and threatens the sustainability of existing ones. A small investment in this area can leverage 7 state dollars for every 1 dollar invested by MIDD funding as well as have a long term return on investment by preventing future addiction and delinquent behavior.

Name: John Ciochon

Organization: None

Comment: The Recovery Cafe should be needs to be included in the MIDD. The Cafe is a vital part of mental health recovery in greater Seattle area.

Name: Angela Heald

Organization: Asian Counseling and Referral Service

Comment: The are a lot of great programs/funding recommended. Crisis Diversion initiatives 1,2,4,7,8 seem especially important, as do housing supports in RR-2,4,5. I am concerned however about the significant cut to CIT funding given that SPD and other first responders play such a crucial role in diverting consumers to appropriate services and away from the criminal justice system. Without proper training this has potential to create tragic situations (as it has in the past). It is great that the proposal includes funding PRI-7 to essentially create community first responders. A few other areas of concern to me are the cut to GRAT given the rapid increase in the elderly population and the high likelihood of increased need for their services; the cut to supported employment programming given that meaningful work is important for recovery; and the amount available for non-Medicaid funding of MH given that the

current funding level is very quickly exhausted given the high level of need for these consumers. Finally, I'd like to comment that in community mental health we struggle constantly with funding training to create good providers but lose most of the investment as they move on to better positions. The funding of caseload reduction and workforce development is crucial in this perpetual struggle.

Name: Cathy Callans

Organization: None

Comment: I would like to recommend that the Recovery café be a recipient of some of these funds. I worked as an intern there for two years and now that I am a licensed mental health counselor, I continue to recommend the café to many of my clients. The mission of the café fills a need in the city that is not met by any other agency in the same way. It truly is a school of "transformation" and works hard to move people along on their journeys back to recovery and independence and healing. They offer their members a "hand up" as opposed to a "hand out" which I believe instills a sense of self efficacy, self-respect and dignity that is hard to find in other organizations helping this same population. They promote kinship there like no other place I have worked. It provides a community of loving caring individuals who are all working together to enhance the lives of one another.

Name: Ann Allen

Organization: None

Comment: Surprised how little the public comment was taken into account on this draft. Seems like re-funding existing programs rather than looking to expand successful programs, or decrease funding to non- successful programs was a consideration.

Name: Mary Katherine Byrd

Organization: None

Comment: I am writing to support the funding of Recovery Cafe. I cannot thank Killian and Recovery Cafe's staff enough for what they do. Recovery Cafe is so valuable in part because there is no other place like it, and I found that it helped to support the other services available for me when I was recovering from addiction, mental illness, homelessness and trauma.

Name: Denise Rhiner

Organization: None

Comment: I urge you to include Recovery Cafe in MIDD II funding. This organization has made a phenomenal difference in the lives of people who are struggling with addiction and homelessness. Theirs is a model that works. At the core, it works on healing the trauma that is the cause of addiction and homelessness and helping people find their dignity, self-respect, and self-power. Many organizations and programs treat a symptom. Recovery Cafe is presenting a cure, one that ripples out

from the people it serves. Please support what works and makes a -sustainable- difference in people's lives.

Name: Brett Gurzick

Organization: DSHS

Comment: I would like to express my sincere gratitude for the Geriatric Regional Assessment Team (GRAT) and convey by public comment that the importance of this highly-skilled and highly-motivated team has had an immeasurable influence on service access and protective services for those suffering from mental illness, as well as the elderly. Their work is a challenging, necessary service and we are very fortunate to have them in the King County region. I sincerely hope that the Geriatric Regional Assessment Team is allocated the funds they need to continue or advance the irreplaceable public service that they provide.

Name: Ben Curtis

Organization: None

Comment: Please consider funding for Recovery Café and the brilliant work that they do in providing a safe community for folks to come together on their journeys. Thank you.

Name: Elizabeth Miller

Organization: None

Comment: My comment is pertaining to the allocation of resources. I am not in the profession of recovery, however I have understanding and have witnessed the methods that impact positively on this challenged community. The Recovery Cafe provides a pivotal need in the mental health community, a sober and healing place of refuge. The percentages of people who Recover from the disease of addiction is abysmal. However, the availability of a community of addicts in recovery increases the chances of recovery exponentially. The Recovery Cafe provides this necessary component and keeps the me mentally ill and those suffering with disease off the streets and communing with abusers. Please grant to this remarkable organization. Thank you.

Name: Rev. Rick Reynolds

Organization: Operation Nightwatch

Comment: I am writing in support of the Recovery Cafe in Seattle. This organization is a valuable partner in the community for our homeless clients who are recovering from chemical dependency disorders. They provide a much-needed service to the community and work well with other programs. They are well-managed, and well-integrated into the broader community.

Name: Leslie Yamada

Organization: Recovery Cafe

Comment: I volunteer at the Recovery Cafe and am always moved by the embracing, supportive , non judgmental atmosphere that pervades the cafe. it provides its members, not only with lunch and dinner, but with a place to be accepted as a fellow human being. All to often, for those who suffer from mental illness and/or addictions the rest of society ignores them as if they do not exist. The Recovery Cafe helps them realize that they do count and can be active in their own lives and a part of their own recovery. Please continue funding the Cafe and other entities that provide important services for this portion of our population.

Name: Randy Brothers

Organization: University Presbyterian Church

Comment: I am a ministry director at University Presbyterian Church. I have helped coordinate young people and adults to experience Recovery Cafe, learn about it's mission, and get involved. I have not only been consistently impressed with it's proven effectiveness, but also it's exceptional quality. Recovery Cafe aligns well with the goals of MIDD II. It leverages many resources into results and is an asset for our community.

Name: Mary Ellen Stone

Organization: KCSARC

Comment: I am pleased to see sexual assault therapy is continued in the MIDD II plan. Community sexual assault programs provide holistic trauma informed services including mental health treatment to victims and their families. Both the holistic venue and specialized treatment are essential to the positive outcomes our agencies produce. With trauma informed mental health treatment, victims are able to reduce their debilitating symptoms and live productive lives.

Name: Ivetta Scott

Organization: HCS-APS

Comment: as an APS investigator, who works with many elderly, who has dementia or could have dementia, I truly appreciate and need GRAT help.

Name: Sylvia Burges

Organization: None

Comment: I strongly support including Recovery Café in the “Reentry and Recovery” strategy area and providing ample funding for the Café.

Name: Molly Kimble

Organization: None

Comment: Please include Recovery Cafe in your program allocations. It is a very effective organization I have personally sponsored for years.

Name: Michelle Bunn

Organization: None

Comment: I believe providing support to The Recovery Cafe will in the end be a cost saving proposition. All one needs to do is travel around the city to see how desperate the need is for these kinds of services.

Name: Brad Harris

Organization: None

Comment: My wife and I have been supporters of the Recovery Cafe for the last seven years. I feel that it provides excellent outreach and assistance in an area that is so critical in the Seattle area. I would strongly urge continued support for the fine work that this group is doing to improve our city. Brad Harris

Name: Victoria Bozzacco

Organization: None

Comment: As an RN, I used GRAT team in an Adult Day Health setting. Their service is a great resource and support to health care providers/caregivers in assessing and managing mental health issues.

Name: David Ketola

Organization: None

Comment: I recommend that Recovery Cafe be funded as part of the Reentry and Recovery" strategy. Myself and many others have experienced the Recovery Cafe as a place of hope, healing and life transformation. Please consider my support for funding to go towards the Recovery Cafe. Thank you so much

Name: Angela Bultemeier

Organization: None

Comment: I fully support the MIDD program and budget and urge you to include the Recovery Cafe in designating budget funding. The Recovery Cafe is a vital source of healing and recovery in building our community. Thank you.

Name: Lynn Poser

Organization: None

Comment: Please include Recovery Cafe in the budget for MIDD funding.

Name: Kathryn Collins

Organization: Christ Our Hope Parish

Comment: We are gateful for your support of the amazing work of the Recovery Cafe, and hope that this continues to be well-funded.

Name: Nathaniel Muller

Organization: None

Comment: I would like to see Recovery Cafe included in the funding.

Name: Cui Openshaw

Organization: None

Comment: I highly recommend recovery cafe. They have been doing a great job. Also the funding should go to organization that help people finding job. Finding the jobs will help them become more independent. It is a win win situation. Corporation should be able get a tax credit if they hire people with disabilities, mental health, drug addiction or alcohol related issues. Building the bridge for employment will be a win win for those people and to the society as a whole.

Name: Laurie Mallett

Organization: None

Comment: As someone very familiar with the benefits of recovery, I urge you to support the Recovery Cafe at every level possible---particularly the financial.

Name: Mishelle Wentz

Organization: TAM WA chapter

Comment: It is imperative that this be made apart of the funding so many people don't want to live as an addict however they got there at some point it's not a fun thing is becomes an illness that is out of control. Myself, I have great insurance and have money to put down for my son....he can get a bed asap and go any place for treatment. My sister on the other hand, has WA. Basic health and is told she has to wait their not sure when help will be available? This is all too common and its appalling!!!!!!

Name: Christa Palmberg

Organization: None

Comment: Please include funding for Recovery Cafe. My family and I have been supporters of the cafe for years. Their work is tremendous. It's transformative for the members who receive services (and find a community!) and it promotes public health and safety.

Name: Liz Hunter

Organization: None

Comment: Please include Recovery Cafe in the MIDD. Recovery Cafe offers a unique supportive community for those who desperately need it. Our community cannot afford to lose this valuable resource.

Name: Jamie T. Shilling

Organization: 1953

Comment: Please include Recovery Cafe in the new MIDD budget. Thank you! Jamie Shilling

Name: Kate Maughan

Organization: None

Comment: I am writing in support of the Recovery Cafe. An amazing group of people helping to provide a place of hope, healing and life transformation for those in need. They do a tremendous job collaborating and partnering with individuals and other organizations that can help assist in their mission in serving their clientele. The "program" is so successful it is being modeled by other cities throughout the country. The Recovery Cafe is most deserving of funding in the "Reentry and Recovery" strategy area. Thank you.

Name: Ed Phippen

Organization: None

Comment: Please include the Recovery Cafe in the MIDD. They provide an important refuge for folks seeking addiction services.

Name: Katy Willis

Organization: None

Comment: I support Recovery Café being included in the MIDD. Recovery Café's inclusion in the MIDD is a critical part of their strategy to ensure that they can continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Madeline Condon

Organization: None

Comment: Recovery Cafe is an amazing organization

Name: Barbara Guzzo

Organization: None

Comment: I would ask that you provide funding for The Recovery Café. The work they do with regarding recovery and reentry is truly amazing. They continue to help countless numbers of women and men who suffer mightily addiction, mental illness, and the related issues (i.e. homelessness). Thank you for your consideration.

Name: Kelly Hickman

Organization: Archdiocese of Seattle

Comment: Please include Recovery Café the MIDD, thank you!

Name: Monica Wood

Organization: None

Comment: Thank you for the good work you do. I am writing to put in a strong word for Recovery Cafe. Everything I know about this place, the staff, members of the community has impressed me. I helped teach a couple of classes there and was touched by the sincerity of the members to grow and change and approach their recovery with integrity and the general sense of compassion, accountability and effectiveness. There seems to be something magical going on there ... and whatever the magic is, it works!! I hope you will continue to include Recovery Cafe in your funding program.

Name: Judith Ryan, SNJM

Organization: St. James Cathedral

Comment: I strongly support including the Recovery Cafe in the MIDD funding. Their wholistic program of empowering individuals in recovery through the support of Community has great success.

Name: Julie Callahan

Organization: The Food Bank @ St. Mary's

Comment: I'm very familiar with the many ways that Recovery Café helps people with broken lives--to pick themselves up and become whole again--so they can become productive members of our community again. This wonderful organization has depended greatly on the past resources they've received from MIDD II Funding. I strongly recommend Recovery Café's inclusion in MIDDII Funding and Programmatic Recommendations. These funds have been, and hopefully will continue to be, a critical part of their strategy to ensure that Recovery Café can continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Ken Kierstead

Organization: None

Comment: I'm writing to advocate particularly for the Recovery Café as a critical resource for recovery care, and effective community re-entry for those who suffer addictions. Recovery Cafe's unique presence and services were affirmed in the community surveys and are critical to continue in the next round of program funding.

Name: Sharon Callahan

Organization: None

Comment: Please include the Recovery Cafe in the funding list for the MIDD II Funding and Programmatic Recommendations. As a supporter of this innovative work for the better good of all, I think the model this institution/ organization employs is one that many could benefit from learning.

Name: Judy Lightfoot

Organization: None

Comment: I strongly support ensuring that Recovery Cafe receives the resources it needs to continue its excellent Reentry and Recovery work in the County.

Name: Barry Eben, Ph.D.

Organization: Retired

Comment: I am a recently retired clinical psychologist. While working at Cornish College of the arts, I referred several students to Recovery Cafe. These students reported substantial benefit from participating in that community, benefit that was clearly apparent in my contacts with them. I urge you to be generous in your support of recovery café, in that it provides a unique and effective atmosphere for people struggling with addiction problems. Barry Eben, Ph.D.

Name: Anne Potter

Organization: None

Comment: I strongly urge you to include the Recovery Café in this program. They do remarkable work in supporting individuals who want to make a change in their lifestyle, providing ongoing assistance with maintaining a clean and sober life. The staff and volunteers are marvelous, helpful and caring.

Name: Krista Harris

Organization: Private citizen

Comment: The Recovery Café is an amazing success story, helping homeless and addicted people be in relationship with caring RC staff and volunteers who help them turn their lives around. The RC is committed to fostering change through relationships, personal support, social services, addiction recovery, and life and job training skills. The programs at RC WORK! The RC model has inspired similar programs in other cities and in other countries. My husband and I have been making annual pledges to RC for seven years. RC is a model of hope. This is a very important and successful Recovery and Reentry program. I STRONGLY SUPPORT its being included in the MIDD II budget so it can continue to help many more people heal and recover from addiction and homelessness in the future.

Name: Alysse Bryson

Organization: None

Comment: Please consider adding Recovery Café to the budget allocations from the MIDD II program. They are doing significant work here in Seattle and it would be amazing to see them grow into multiple locations.

Name: Ann Sakaguchi

Organization: None

Comment: The services provided by the Recovery Cafe are critical for those in recovery and those afflicted with mental health challenges. Please retain funding for the Recovery Cafe in your plan.

Name: Christie Lynk

Organization: None

Comment: I heartly endorse Recovery Cafe for their stunning work in recovery and addition. I volunteered for them and have sent numerous people their way - both as clients and staff. Please support them through the funding available.

Name: Sep and Rita Egrari

Organization: None

Comment: thank you for this important funding. We wanted to voice our support for your funding for Recovery Cafe - we have seen time and again the effectiveness of this recovery model in sustainable, long term healing of community members struggling with addiction/mental health/homelessness. we feel it is cost effective and deeply needed. We need more of this model.

Name: Beth Morgan

Organization: None

Comment: Please include the Recovery Cafe in MIDD. The organization does amazing work by providing a loving community and skills that will help sustain long term recovery from addiction.

Name: Cheryl Berenson RN, MS, MPH

Organization: King County Medical Reserve Corps; NCJW WA State Policy Advocate

Comment: Please include the Recovery Cafe in your funding stream. The Cafe has a unique and successful program for people in recovery in our communities. I am a part of a KC nursing project and do foot care, health screening and referral at the Recovery Cafe once a month. They are a critical organization for those patients who are looking to stay sober! thank you, Cheryl Berenson RN, MS, MPH

Name: Anne Mohundro

Organization: None

Comment: I strongly support the inclusion and funding of the Recovery Cafe. I have been a volunteer once a week there for three years, and have witnessed first hand the incredible help the Cafe provides to those living with mental illness and the many related difficulties they face. The Cafe provides community and normalcy for all its members.

Name: Anna Jenkins

Organization: None

Comment: I want you to continue to support the Recovery Cafe in Seattle. The work it does helps so many people in so many ways!

Name: Chuck Pecka

Organization: None

Comment: Recovery Cafe - I would like to add my voice in support of the services provided by Recovery Cafe. I have seen the incredibly positive impact the Recovery Cafe has had on the lives of its members and the community. I urge King County to continue supporting the Recovery Cafe and the great work they do for individuals in our community that need recovery support and services.

Name: Melisa Barbera

Organization: None

Comment: Please include Recovery Café has in MIDD II in the "Reentry and Recovery" strategy area to receive funding.

Name: Leah

Organization: None

Comment: It is vital that older adult continue to be supported through the use of MIDD II funding, specifically the GRAT program. There is no other available crisis outreach program that specializes in older adult issues. The older adult population is quickly growing in King County and the need for appropriate evaluation and assessment is necessary. Please ensure funding is available to GRAT for continued service provision and growth to accommodate the ongoing needs of our seniors.

Name: Katherine McIntyre

Organization: None

Comment: Please support the Recovery Cafe, it's changed the lives of so many people I know in a positive way.

Name: Donna Tucker

Organization: King County District Court

Comment: Considering the MIDD Policy Goal 1 and 2 to reduce the number of mentally ill and chemically dependent people using costly interventions such as jail and further considering the current opiate crisis along with the highest property crime rates in the nation – it is difficult to understand why there is no recommendation to expand therapeutic courts in King County. The King County Executive's commitment to the people of King County is to invest in what works and to apply proven approaches that produce remarkable results. Studies of therapeutic community courts at the San Francisco Community Justice Center, at the Neighborhood Justice Center in Yarra, Melbourne Australia, and the Red Hook Community Justice Center in New York are all showing successful results. The National Institute on Drug Abuse revised report from April 2014 on the Principles of Drug Abuse Treatment for

the Criminal Justice Populations provides a research-based guide in providing effective treatment for offenders suffering from chemical dependence and/or mental health conditions. The research shows that a large percentage of those admitted to drug abuse treatment cite legal pressure as an important reason for seeking treatment. Most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Individuals under legal pressure also tend to have higher attendance rates and remain in treatment for longer periods, which can also have a positive impact on treatment outcomes. A local treatment educator explained that "forced treatment" does work because dealing with addiction in treatment will ultimately require the individual to deal with really difficult areas in their lives and when entering into treatment without an 'outside force', like the courts or threat of criminal conviction, it is much easier to abandon treatment and walk away. Therapeutic community courts provide not only the incentive but also the guidance and support system needed for drug addicted and mentally ill individuals who are committing crimes to address their underlying issues. Unfortunately, in King County there are many individuals in the criminal justice system with untreated addictions/mental illness who have engaged in misdemeanor and gross misdemeanor criminal activity, while under the influence and/or done to support the addiction. These criminal activities put others in the community at risk for harm to persons or property. For way too long, the only response available has been the use of jail with very little resources to provide real help to address the underlying problems to the criminal behavior. MIDD funding has the ability to recognize this reality and make a change by supporting and/or expanding the existing therapeutic courts and reaching more of those in desperate need, though the development of a therapeutic community court with the King County District Court.

Name: Mary Pat Osterhaus

Organization: None

Comment: Recovery Cafe in Seattle has become an intergral player in the effort to form community with, and support for, indivduals struggling with mental health and addiction. Recovery Cafe is a vital part of providing care, services, and support for recovery to at risk individuals in our community. Please fund the efforts they are making.

Name: Ariel Duncan

Organization: None

Comment: Recovery Cafe provides a valuable resource to our community as a whole, particularly members struggling with mental health issues. Please continue to include their work in your funding. They do their work with such excellence!

Name: Robin Lorenzini

Organization: None

Comment: I highly recommend Recovery Cafe!

Name: Mary Case

Organization: None

Comment: I strongly recommend that Recovery Cafe be funded through MIDD 11. It is a unique organizations that offers safe environment and the opportunity to stay sober while giving the opportunity to better each person's life. No other program does this in quite the same way.

Name: Anne Frantilla

Organization: None

Comment: I am writing in support of the Recovery and Reentry Briefing Paper for Recovery Cafe, B 91, B92. As a long-time volunteer at Recovery Cafe, I can attest to the value of this loving community, meeting people "where they are." Not everyone who comes through leaves in a better place, but for someone who is ready to improve their life, the Cafe offers the best wholistic model I have seen for providing support. I help out with a writing class where people find their "lost" voices and heal through words. I run with the running club, "Sole Train," and hear people attest to how this healthy activity has helped them eat better, calm the voices in their head, and just help them feel better all around. The Cafe addresses a population that has exhausted or never had the support of family and friends. When there is no place else to go, people can come to the Cafe and find immeidate loving care. Health food, a Circle that helps them be accountable, and access to meditation, art, writing classes and more that help heal the whole body, not just "fix" a temporary problem. Members travel long distances to come to the Cafe. As housing gets more expensive and transitional housing fills up, this type of resources in other places (south King County especially) is essential. Please fund Recovery Cafe.

Name: Michelle Dillon

Organization: None

Comment: Please ensure that funding for Recovery Cafe is sustained in the allocation decision for the MIDD tax levy. This organization provides daily stability in the lives of hundreds of individuals in the Seattle Metro area who need assistance during the recovery process. As a volunteer, I see their work in action every day firsthand. Recovery Cafe manages an irreplaceable system of services (daily hot meals, spiritual support in every capacity, and references for additional services) to ensure that our most vulnerable citizens meet and exceed their personal goals for recovery. Without funding from this levy, Recovery Cafe will be less equipped to provide these extraordinary services and community connections every week.

Name: Alexis Nelson

Organization: None

Comment: I have been involved with Recovery Cafe for over 10 years as a staff member and volunteer and, knowing its important work in the Seattle community, urge policymakers to designate funding to the organization as part of the MIDD. Recovery is the cornerstone of healthy communities and needs to be funded alongside effective housing, mental health, medical, and workforce programs. As

stakeholders are aware, drug addiction has significantly increased in Seattle and threatens the stability of residents throughout the city. Recovery Cafe has a long-term record of excellence and would be an excellent investment by the city and its taxpayers. Thank you for your consideration. Best, Alexis Nelson

Name: Molly M McCarthy

Organization: None

Comment: Please make sure to include Recovery Cafe. They have the best program in the county for recovery efforts.

Name: Blair Carleton

Organization: None

Comment: Please oh please include Recovery Cafe, and its amazing results that help so many individuals turn around their lives, by including it in MIDD II. You will be so happy you did, I promise!

Name: Richard Israel

Organization: None

Comment: As a taxpayer, I support the MIDD program. I would like to call out Recovery Café as a worthy part of the Re-entry and Recovery strategy.

Name: Kayla Zobel

Organization: None

Comment: I would like to recommend that Recovery Cafe be included in MIDD II. The organization has a shown itself to be a high-impact organization, especially in relation to the recently declared "State of Emergency" regarding homelessness in Seattle.

Name: Lynette Lewis

Organization: None

Comment: Please include the Recovery Cafe

Name: Paul Kilian

Organization: None

Comment: Please include Recovery Cafe in your funding. They do amazing work creating community amongst those who are in most desperate need of it to literally save their lives.

Name: Wendy Rush

Organization: None

Comment: Please maintain funding for the Recovery Cafe in Seattle. They do important, life changing work using a model that prioritizes loving accountability, community support, and compassion. We need this program!

Name: Sheri Zimmerman

Organization: None

Comment: Please continue support and include funds for Recovery Café. Thank you!

Name: Ben Wiselogle

Organization: None

Comment: The Recovery Cafe plays an important part in servicing those working through addiction. The Recovery Café needs to be included in the MIDD.

Name: Donna Thorson

Organization: None

Comment: I have first hand knowledge how effective The Recovery Cafe is at helping people turn their lives around. Please fund this program as it is doing a good job of getting the addicted off the streets and into productive lives. Thank you.

Name: Lara Okoloko

Organization: Caresnw.com

Comment: I hope that robust funding will be included for recovery café. They provide a valuable service for people with addiction and their families. They are a model that offers low barrier services, which is an important need not meet by many organizations.

Name: Kay Bradford

Organization: None

Comment: As a member of the Recovery Café's Young Professionals boards, I've witnessed how the Cafe is central to destigmatizing and building community with those suffering from addiction, mental health issues and homelessness. I'd recommend funding the “Reentry and Recovery” program so that Recovery Café can be beacon of hope for those suffering in our community and for starting the healing process.

Name: Donna Haggarty-Robbins

Organization: None

Comment: Please include funding support for Recovery Cafe in the MIDD. It provides such essential and compassionate service to those in need in our community. There is nothing quite like Recovery Cafe, and they have saved so many lives and returned people to being productive and happy members of our County.

Name: Hugo Cruz-Moro

Organization: None

Comment: Since relocating to Seattle from Miami FL in 2014, we have been supporting the Recovery Cafe as volunteers, contributors, and have taken part in many of the activities offered to members. As an artist and artist educator with what is reffered to as "long term sibriety" I appreciate and support the RC Cafe in its offering the opportunity for those living on the margins of society, but also in its ability to facilitate a venue for people like myself to give back.

Name: Amy Stolov

Organization: Recovery Cafe

Comment: I am a volunteer at the Recovery Cafe. Please continue to fund this organization at the maximum level that you can. I have seen how the Cafe transforms people's life and have been transformed myself by the process. Thank you

Name: Molly Hancock

Organization: FareStart

Comment: I am in strong support of Recovery Café’s inclusion in the MIDD is a critical part of our strategy to ensure that Recovery Café can continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Charles Heffernan

Organization: Dharma Gate Yoga

Comment: Recovery Cafe is fantastic and deserving of full support.

Name: Michele Moore

Organization: None

Comment: I wish to support Recovery Cafe's inclusion in the MIDD Tax Levy.

Name: Laura Little

Organization: None

Comment: Please include Recovery Cafe in the MIDD II tax levy renewal. This is a vital service for so many in our community.

Name: Catherine Endicott

Organization: None

Comment: As a past Recovery Café volunteer and follower of their work since their inception, I can attest to the success of their programs. Their approach ensures full compliance with behavior changing principles, and, they address many root problems of addiction, which helps lessen the impact on homelessness.

Name: Karen Allman

Organization: None

Comment: The continued support for Recovery Cafe is a crucial issue. Recovery Cafe provides support to help people into recovery (and grow into healthy and productive lives). Recovery Cafe is very active and vital in providing a safe place for vulnerable individuals in our community. Funding their efforts is crucial.

Name: Ted Neill

Organization: None

Comment: Please include the Recovery Cafe in the MIDD II budget. The cafe offers incredibly important services to the recovery community. Thanks.

Name: Julie Chandler

Organization: None

Comment: Please consider including Recovery Cafe in the MIDD and allocation a portion of the funding towards this very worthy and well run organization. I have spent many years watching the growth and operation of this center and been amazed at the positive impact that Recovery Cafe has in our Seattle community.. The outreach, assistance and resources that exist at Recovery Cafe is nothing short of amazing. The stories of healing and hope are an inspiration for all. Those struggling with substance abuse and addition have a true home and partner at Recovery Cafe. An allocation of money provided in the MIDD would be so beneficial for this organization and the impact would be substantial and visible. Thank you for considering my request.

Name: Jessica Matthews

Organization: None

Comment: Recovery Café needs this financial support continue to be a place of hope, healing and life transformation for thousands of people into the future.

Name: Rick Workman

Organization: Lease Crutcher Lewis

Comment: I strongly support the Recovery Cafe' being included in the MIDD based on their exceptional results in improving the lives of so many of our marginalized citizens. As a downtown worker, I have witnessed the dramatic improvements made by the Recovery Cafe'.

Name: Richard Jones

Organization: None

Comment: Please continue public support for Recovery Café and its many important programs. We have too many homeless people in Seattle and many/most of them are homeless due to addiction and other mental health problems. This program makes a difference for this population.

Name: Rev. Colette Mercier

Organization: Amazing Grace Spiritual Center

Comment: I am writing in support of recovery Cafe is inclusion and funding under this appropriation. I have seen firsthand its good work as know that it provides an essential support for those who have made the difficult decision to step onto the path of recovery. I advocate strongly for their inclusion in this funding. There's a welcoming and supportive environment, both physically and in terms of staff and volunteers support, for those who have decided to make this change.

Name: Karina Saunders

Organization: Real Change Homeless Empowerment Program

Comment: Please include Recovery Cafe and Real Change in the MIDD funding!

Name: Joseph Sparacio

Organization: Neighborcare Health

Comment: Neighborcare Health currently operates two program under MIDD I initiatives: 1.g.) Prevention/early intervention mental health and substance abuse services for older adults, and 4.c.) School district based mental health and substance abuse services. This funding has allowed us to provide very specific, focused treatment for older clients as well as population-based strategies in the schools, which can then be complemented by group or individual therapy for those students most in need. We are grateful to the MIDD Oversight Committee for their recognition of the significant, life-saving work being done in these areas and their commitment to include a similar focus in MIDD II funding. As Neighborcare Health continues to refine its behavioral health program to respond to the needs we see in our community, increased access is a continual concern. To that end, we are introducing even further integration of SBIRT, MAT, and brief intervention focused behavioral health into our primary care model, and bringing services to locations such as supportive housing, schools, and our homeless clinic locations. These creative approaches aim to reduce barriers to accessing services and provide care to patients along the entire continuum of need. It is our hope that MIDD II will include flexibility in service provision, such as models other than MHIP, to allow organizations to respond to populations-specific needs more efficiently and effectively.

Name: Ahmed Ali

Organization: Somali Health Board

Comment: Overall, the budget looks fine, however, I think the NEW Community Driven Behavioral Health Grants (SI-IX) should be allocated more funding in providing technical assistance, evaluation and support with community initiated behavioral health programs. I should also point out that due to strong stigma associated with mental/behavioral health within certain ethnic communities, self driven, grassroot efforts such as the Somali Health Board should be given direct access to funding rather than larger organizations that receive findings simply by stating they're culturally competent. Small CBOs with a proven track record of working within the community should be encouraged and financially supported on their work - in order to better serve the community on such needed work. MIDD number SI-IV, peer to peer training is a great model that I see can work really in limited English proficiency communities- it's a pilot, anticipated and hope to see it materialize. I'm also encouraged by the Parent Partners Family Assistance, I'd suggest increasing the funding in that area - $1M, simply because I'm aware of the direct positive impact it has with getting families support their loved and reducing stigmatization.

Name: Abdul Karim Taifour

Organization: None

Comment: Please support services for older adults including GRAT.

Name: Pratima Lakhotia

Organization: None

Comment: Please do not decrease the clubhouse funding of Hero House. It is the only organization in King County that provides a non-clinical way of recovery to mentally ill patients and provides them the ability to get a job. Save Hero House by not decreasing the funding.

Name: Savinay Dangi

Organization: Hero House, Secretary

Comment: Proposed clubhouse funding of $230K for Hero House is 36% reduction from the current budget of 362K. This is extremely low and will make the Hero House in Bellevue unsustainable. Hero House is unique in King County as we are the only organization that provides a non-clinical approach to mental illness recovery and help them get a job. Hero House offers a very diversity rich environment to support the diverse community of King County. Lastly, the proposed decrease of funding for IPS Supported employment will directly impact the ability of recovering patients to get back into employment. We need the funding for Clubhouse and Supported Employment to increase so we can serve more.

Name: Sandy Nisperos

Organization: Asian Counseling and Referral Service

Comment: I support increased $ to MIDD II. AT ACRS we serve the community of non-English speaking Asian/Pacific Islanders who suffer from serious mental illnesses. Many of these people don't have the resources to apply for Medicaid. Due to the MIDD II funding, we can serve this population and get them the services they need such as mental health counseling, medication management , case management.....and more delivered to them in their own Asian language. Please increase the funding for the MIDD II so that we can serve more of the population that needs services. In additon, we help these clients get jobs through our Supported Employment program, so please increase funding for this through the MIDD II.

Name: Deb Lewy

Organization: HERO House

Comment: Hello, Here are my comments on the initial draft MIDD II program and budget recommendations: (1) For clubhouse funding, the county is suggesting $230,000 per year serving 20/30

members per day. This is extremely LOW since at HERO House, we serve this number of members already and our budget for MIDD is currently $362,000 a year. (2) HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a non-clinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program.)3) At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff. (4) For IPS Supported Employment, the county has suggested $950,000 per year. This is $50,000 less than the previous year. In order to expand the IPS program within the county, this shortfall will negatively impact how many individuals we are able to serve. Last year, all 7 IPS programs (including HERO HOUSE) served approximately 1,000 individuals combined in employment. All of the funds were used. The county cannot and should not expect to increase the employment rate among individuals with mental illness by decreasing the funding by $50,0000. Thank you for allowing the feedback and for serving the community of adults who live with mental illness. Deb Lewy President, HERO House Board of Directors

Name: Michelle Vance

Organization: DSHS - APS

Comment: Our main service that we have a close working relationship with is the Geriatric Regional Assessment Team. They have provided excellent services in assessing seniors with a mental health crisis and I feel that this service is essential to APS and the community at whole. Without their assessments, it would be difficult to obtain the information on the cognitive limitations of vulnerable adults and to determine the need for APS to file a guardianship if warranted.

Name: Sue Bunn

Organization: None

Comment: As a geriatric case manager with a masters degree in mental health counseling, I have seen first hand the amazing work done by the GRAT program. It is very clear to me that clients who otherwise would have been hospitalized or a significant threat to themselves or others have been provided stabilizing services not offered by any other program. The GRAT team rocks and should be give a very high funding priority.

Name: Gary Bright

Organization: DSHS/HCS/APS

Comment: I have been an Adult Protective Services worker going into my 16th year, and 10 years in Children's Administration. I have seen a variety of programs come and go over the years with varying results. I wish to give an editorial comment on GRAT and the need to continue this very appropriate program for the King County geriatric population. In contrast to King County, Snohomish County does not have such a program with direct service delivery. Absent GRAT, APS social workers will have to fall

back on RCW 71.05.153 "Emergent detention of persons with mental disorders" to request police to involuntarily take a person to an emergency room for a mental health evaluation. Herein lies the problem: Without good information to show the vulnerable adult is gravely disabled and in a setting impacting their health and welfare, a Mental Health Professional is more likely to release the person after ER contact. GRAT has been extremely helpful networking with APS and other agencies to help establish a need for additional intervention. Early intervention means a cost savings to the immediate medical, long term care and governing health care authorities which provides quality of life to vulnerable adults in King County. Losing GRAT means one less link in the chain of agencies that assist gravely disabled people in need. On my wish list is a request for GRAT to expand their program to include Snohomish County as well. I know, "If wishes were horses, beggars would ride." My wish remains for GRAT to help us here in Snohomish County as well. A case example may help to illustrate: An elderly lady was assigned to me in south King County some years back. There was also an administrative lock on the case. In addition to the extra security required to address the case confidentiality concerns internally, GRAT involvement during this case was extremely helpful as a credible, reliable and relevant source of information gathered from the alleged victim, alleged perpetrator and other non-professional witnesses. GRAT helped with baseline information to provide a positive outcome for this case. The GRAT model is invaluable. As Washington State is one of the top states which heads the nation in quality of care to vulnerable adults, so is King County the model for the rest of this state. Budget constraints aside, there is every reason for GRAT to continue their good work. Please contact me if I can be of further assistance to keep GRAT.

Name: Todd Beller

Organization: None

Comment: I'm glad to participate in this survey. I was employed with the Geriatric Regional Assessment Team from 6/2008 - 6/2013 as their substance abuse specialist. I worked with hundreds of clients impacted with addiction and other co-occuring disorders who would have otherwise not received any support as they were significantly impacted and unable to leave their residence. The GRAT team has a significant impact in the community and offers services for people in crisis as well as clients taking care of people they love (Caregiver support) I implore you to continue this service and continue funding; it's valuable, needed and helps more than you can quantify in a spreadsheet or debate in a legislative session. Thanks, Todd

Name: Kathleen Sullivan, Ph.D.

Organization: Generations with Pride

Comment: The draft shows the work and thoughtfulness of the Advisory Committee and Staff. I would like to again urge you to consider the LGBT senior community. Mental health disparities are compounded with the lack of early detection and prevention programs for this group.

Name: Mark Bernstein

Organization: Aging and Disability Services - Case Management

Comment: The Geriatric Regional Assessment Team is and has been a vital service to our case management program. GRAT's availability, capacity to respond, assess and consult on how to best serve those in our community who find themselves in difficulty and at significant health, physical or emotional risk is a critical part of the continuum of support in helping people in our community.

Name: Amy Sill

Organization: Neighborcare Health

Comment: Very, very helpful resource for our patients! Fred in Seattle is so caring and did all he could to help one of my pts.

Name: Ramona Graham

Organization: Center for Human Services

Comment: MIDD Wraparound should not be reduced because of WISe funding. WISe Programming has requirements and is intensely costly as compared to the MIDD Wraparound. The funding for this program needs to remain the same in order to continue these services to those clients who do not qualify for WISe, but need the support of Wraparound services.

Name: Karen Larsen

Organization: City of Seattle

Comment: GRAT provides excellent mental health assessments for my agency, Aging and Disability Services. Their assessments and expert insight into mental health disabilities give ADS counselors essential information for effective case management. This service cannot be matched. Please, for the sake of the elderly and disabled residents we serve, do not eliminate this important piece of social service care.

Name: Samantha Santor

Organization: City of Seattle HSD, ADS

Comment: I am writing to support continued funding for the GRAT program. We refer to GRAT on a regular basis as they are the only service that goes to see our older/homebound clients in their homes. This is a vital service and many clients will lose access to critical mental health services if funding is cut. Please continue to fund GRAT. The system does not have the capacity to absorb this loss.

Name: Kathi Church

Organization: Aging & Disability Services

Comment: PLEASE PROVIDE FUNDING FOR THE GERIATRIC REGIONAL ASSESSMENT TEAM! (GRAT). GRAT has been invaluable to those of us in the ADS case management program who work with older adult populations, many vulnerable due to cognitive deficits and other mental health issues. GRAT clinicians and their assessments have been critical to inform us and others involved as to options for the client in living independently (or not), what the appropriate services would be given their challenges and strengths, and help inform those at Adult Protective Services when a guardianship is recommended due to capacity issues, etc. If GRAT were to lose funding and were no longer able to serve the clients they do, we at ADS (and our clients) will lose an extremely valuable service.

Name: Rachel Diaz

Organization: Reach

Comment: RE: Treatment on Demand: It's a really great concept but I would like the actual quality of treatment to be addressed. At this point, there really are few treatment options in King County. The one's that exist do not, in general, keep up with best practices as put forth by the federal government. Most treatment facilities are entrenched in only the AA model and that leaves many people out of luck if they do not embrace that model. Many of the providers are rigid in their approaches and clients leave treatment early or relapse immediately. The lack of detox and SUFFICIENT number of days for detox is sorely lacking--many people (alcoholics, opiate users) end up starting treatment while still dealing with post acute withdrawal syndrome and they are not ready to do the hard work. They don't feel better for a good 10 plus days and are half way through treatment by the time their brain really starts to clear. Also, I have yet to hear a client tell me that they worked on coping skills around re-entry to their same housing or living situation. Sorry, but our SU treatment system is quite broken.

Name: Sompasong Keohavong

Organization: ACRS

Comment: I like the proposal. Case load reduction and Non-medicaid PHP funding for behavioral health clients are the two most important issues, I think. This is based on my daily work experience with my clients and my Southeast Asian American community.

Name: Hiede Holmes

Organization: ADS

Comment: I am interested in making certain that the impact that Evergreen's Geriatric Regional Assessment Team be supported in funding. They are often the only contact that vulnerable seniors have available at a time of mental health crisis and their services are invaluable to our case management program in both providing clear assessment of cognitive functioning and also educating and consulting with us on difficult cases. It would be a terrific loss to the community if this service was not to be funded.

Name: Lauren Mirzakhalili

Organization: REACH

Comment: I believe it is absolutely necessary for the city to renew the MIDD program. There are many gaps in our city's services for those experiencing mental illness and/or drug dependency, and I believe there would be serious repercussions if the MIDD program renewal is not put into place.

Name: Alicia Sacko

Organization: DSHS-APS

Comment: Geriatric Regional Assessment Team(GRAT) is a much needed service and should continue to receive funding. The GRAT team is able to evaluate clients quickly and help start services in place for the client. Adult Protective Services uses GRAT services and evaluations on a weekly basis. GRAT is able to reach some of our most vulnerable elderly populations, which would normally not get services.

Name: Christine Illan

Organization: None

Comment: Without the funding for mental health crisis, diversion and recovery support the 10,000+ homeless will continue to grow in King Co.

Name: Tramanh Nguyen

Organization: Asian Counseling and Referral Service

Comment: As a mental health case manager for the past 10 years, I have been through many ups and downs with my clt as the funding fluated, I strongly believe that more funding should be located for non Medicaid and reduce caseload because there are still many people in the community that needs the mental health service but d/t limited of funding we cannot serve everyone who are in needs. I, myself, many years ago had received outpatient mental health treatment and as a result of treatment, I was able to lift myself up, went through grad school and got my MSW and has been serving in the mental health field since 2005, if I didn't get the treatment that I have gotten, I probably not end up where I am today (back then I have made many suicides attempts). Speaking of reducing caseload, right now I have close to 50 caseload and with 40 hrs/week and some of those hours are used for meetings and other necessary trainings, I don't have much time left to meet all of my clts needs, I have to struggle with prioritize my clt's needs and that is very sad because some of them would have making much more progress if they get more support from me. Therefore, pls allocate more funding for non-Medicaid and reduce caseload.

Name: Kim

Organization: DSHS

Comment: GRAT is a great resource please don't take money away from them. We need all the mental health resources we can get. Its very limited and mental health issues are increasing to a hazard. Peoples lives depend on more mental health resources.

Name: Karin Taifour

Organization: None

Comment: I noticed there are only two programs providing support to older adults, the fastest growing population. With issues like dementia, housing, and access to services, our elders are in great need of support. Please consider expanding support to seniors.

Name: Brenda Abbenante

Organization: APS

Comment: Continue with GRAT services as they are a huge benefit to the community.

Name: Tom Lang

Organization: None

Comment: I hope funding will be continued for the GRAT. As the President of an HOA, we were very concerned about one of our elderly owners who called 911 at least 3 dozen times over about 4 months and who had signs of dementia. The advice GRAT offered was most helpful. They came out did an on-site assessment that was also valuable. We needed, and appreciated, that we had someone to call and advise us on how to deal with this owner.

Name: Barbara de Michele

Organization: Issaquah Schools Foundation Healthy Youth Initiative

Comment: I strongly support development of a treatment on demand system. For youth, please consider placing treatment on demand in public schools where access to treatment is currently woefully lacking. Young people who are experimenting or already in addiction have great difficulty accessing appropriate substance abuse counseling and referrals. We have long waiting lists for mental health counseling. School-based treatment on demand would meet these challenges effectively, saving many lives.

Name: Crystal Hanson-Garrett

Organization: DSHS-APS

Comment: This service is invaluable without it, our vulnerable population would not receive much needed services.

Name: Kim Spector

Organization: Northwest Care Managers

Comment: I am writing in support of the GRAT at Evergreen. It has been a life-saver to me and many of my clients over the years. I believe this worthwhile and much-needed program deserves all the support, financial and otherwise, that it needs to serve the people of King County and the greater Seattle area.

Name: Kathy Penn

Organization: Adult Protective Services

Comment: I have used GRAT services to assist in determining whether vulnerable adults need a guardianship in order to protect their interests. This service is very much needed in order for us to timely serve our aging adult population.

Name: Karen Kent

Organization: None

Comment: I believe it is essential that GRAT continue to get MIDD money. It is a program of great value in the community and the only one that deals specifically with isolated older adults in crisis. The population is growing older so there will be more and more need for GRAT.

Name: Abe Liu

Organization: None

Comment: I support the Geriatric Regional Assessment Team (GRAT) efforts to continue to receive MIDD funding (Mental Illness and Drug Dependency levy). I have experienced the value that the GRAT team provides through their support of our family's issues. They fill a need, and should be fully funded!

Name: Angela

Organization: None

Comment: We need to continue to support mental health therapist and government agencies because the Mental Health crisis is growing in our state as well as our country. If we don't help the therapist the provider's the nurses Etc do what they do best things can only get worse.

Name: Lenh Vong

Organization: DSHS APS

Comment: It is critical to continue to have GRAT provide the needed mental health services to all clients in our community to help them access and provide better services etc.

Name: Ashley Kraft

Organization: SHAG Community Life Foundation

Comment: GRAT is a key program to help support our residents, we are at a loss if we do not have this program.

Name: Diane Stone

Organization: Seattle Police Department

Comment: My comment is to attest to the invaluable service of the GRAT program. I work as an advocate for seniors who have been abused, neglected and or exploited. This program has been a phenomenal help to myself and the detectives that investigate the cases. The expertise, hard work, professionalism and compassion shown by the GRAT personnel is invaluable to us and to the older people that they come into contact with and serve. Please, keep this extremely valuable service to our older community up and running! We cannot imagine our job without their expertise and assistance.

Name: Denise Malm

Organization: Wallingford Community Senior Center

Comment: As a social worker at the Wallingford Community Senior Center, I encourage MIDD decision makers to support the Mental Illness and Drug Dependency levy/ funding. In my job, I am noticing an increase of older adults with and without support systems in desperate need of mental health assessments, interventions and services. Too often I see and hear from concerned family members, friends, professionals and neighbors regarding elders with limited resources in critical life and death situations. Personally, I have relied on the Geriatric Regional Assessment Team for help when seniors are in crisis. Professionally, I would not know what to do or who to call (other than 911) when working with an individual who is suicidal, suffering from memory loss or is incoherent. Without this funding, these situations will need to be dealt with by local fire departments, law enforcement and medical facilities.This put a strain on services that are already stretched beyond capacity, ultimately costing the County more in the long run. Furthermore, organization like GRAT have the knowledge and experience with aging populations. Please value seniors in need by fully funding these programs.

Name: Stephen Allar

Organization: APS Region 2

Comment: GRAT is essential to assist our community in making sure that vulnerable adults have their needs being met. All of our society benefits from their critical work.

Name: Jeff Quigley

Organization: DSHS

Comment: Would love to see the GRAT Program funded from the MIDD II program as it is a program which has benefitted the service structure in King Co for many years. Currently, the program is slated to go away due to Evergreen Care Network discontinuing their community service programs.

Name: Rachel Wang Martinez

Organization: None

Comment: As a community health nurse, I have worked in partnership with GRAT many times to provide crucial services to our underserved aging population in crisis. This program is vital to keeping our communities healthy and decreasing the burden of emergency services provided to older adults who benefit from the support provided by GRAT.

Name: Janet Smith

Organization: Northwest Elder Law Group PLLC

Comment: I feel strongly that the Geriatric Regional Assessment Team is a vital resource for frail elders in King County and should continue to be funded. This is a life saving service for elders at risk who live alone, or vulnerable elders who are being exploited by others. Please continue this funding.

Name: Gigi Meinig

Organization: Aging and Disability Services

Comment: I highly recommend the Geriatric Regional Assessment Team (GRAT) be included as a provider in the MIDD process. GRAT is one of the few Behavioral Health (mental health and substance abuse) organizations to serve older adults. In the not so distant future, older adults will increase to 25% of the overall population. As the demographics shift there will be a huge need for practitioners with geriatric experience, knowledge of dementia and understanding of the affects of psychotropic medications on the elderly. GRAT continues to be a leader in the field of geriatrics. Much of their work is done in the client's home. They are connected to the medical community through it's umbrella organization Evergreen Health. As a former contract specialist and agency assessor I always found GRAT's Administrative work to be high quality and appreciated their willingness to maintain flexibility

regarding data collection. I strongly urge you to incorporate the needs of older adults in the MIDD planning process. Thank you.

Name: Amanda Froh

Organization: King County Prosecutor's Office

Comment: I would encourage you to continue funding the Geriatric Regional Assessment Team. These evaluators provide cognitive assessment to elderly and vulnerable adults in crisis (such as those who are victims of the crimes of neglect and financial exploitation), and direct them into services to better their lives. As prosecutors, we often rely on cognitive assessments done by GRAT evaluators of our victims, as they are often first on the scene following discovery of the crisis. Prosecuting crimes against the elderly would be exponentially more difficult without this resource available to law enforcement, social workers, and APS/DSHS.

Name: Kay (Kyung Hwa) Jun

Organization: Sound Generations, formerly Senior Services of Seattle and King County

Comment: My program (I&A for Seniors and younger folks with disabilities) has been working with GRAT closely, with the capacity as an referral agency. There has been huge volume of crisis calls (daily basis) from concerned community members who does not know where to turn. GRAT is the one who was there to go out to the community and help out the senior individuals who's in crisis while no other could reach out that effectively and fast (within 3 days). I'd like to advocate for GRAT in your decision to keep funding the much needed program like GRAT.

Name: Kathy Van Olst

Organization: KCPAO

Comment: The Geriatric Regional Assessment Team provides an incredible service to the community. In the prosecutor's office, there are many elders in the community that are not currently in the mental health system but are experiencing crisis due to evolving cognitive impairments (as victims and offenders). GRAT is the agency where we can refer families whose elders are in crisis to have a competent mental health assessment done in order to plan next steps for these individuals. They are an incredible resource for our community.

Name: Annie Jacobsen

Organization: SHAG Community Life Foundation

Comment: In my 3 years with SHAG as Resident Services Manager we have found the GRAT team to be an invaluable resource and service. The caliber of the team is extraordinary in their efficient, skill and compassion. As a state with below standard services for mentally challenged individuals, they are often falling to unskilled options - housing not meant for the challenges they face as one example. It is often

humiliating for our residents to be a person with a mental health issue being shunned in a community where they simply want to make a home - because of behavior issues or habits. We need to do better by those with mental health challenges and it is of vital importance to have programs like GRAT and DMHP for this reason.

Name: Elizabeth Strewler

Organization: UW School of Social Work

Comment: I write to you today as a concerned citizen and advocate for one of our area's consistently at-risk and underserved communities, our LGBTQ older adult population. Despite being an at-risk group in itself, the LGBTQ community includes many particularly high risk groups, some of whom are: LGBTQ veterans, trans* older adults, LGBTQ older adults of color, those living with HIV, those of limited ability status, those living in poverty, as well as the 'oldest old' and caregivers. In King County, LGBTQ older adults represent about 2.4% of the older adult population and are expected to double by 2030.

Numerous reports and studies, several of them conducted here at the University of Washington, confirm that the LGBTQ aging community faces considerably higher rates of mental health challenges (including suicidality), substance use, and isolation than their heterosexual counterparts. Troublingly, LGBTQ identities and behavioral health challenges continue to be highly stigmatized, even in a progressive region like King County. This continued stigmatization translates to an increased threat of victimization and discrimination for our local LGBTQ older adults, who often face a combination of challenges as they move through their daily life. We know that the LGBTQ aging community can be both resourceful and resilient when provided with the supports and resources they need. At present, our local LGBTQ older adults rely primarily on their informal peer groups and networks for support, few of which are equipped to address the mental health and substance use challenges that so often affect members of this community. This is because programming that could serve them more comprehensively does not yet exist. Several core components of MIDD's programmatic focus areas would directly address the unmet needs of this growing population. As the MIDD moves forward with plans for new prevention, intervention, and systems improvements that will address the behavioral health challenges experienced by King County constituents, I urge you to forge programming specifically tailored to the needs of our LGBTQ aging community. Thank you for your time in taking my public comment into consideration.

Name: Yoon Joo Han

Organization: Asian Counseling and Referral Service

Comment: There is great need for mental health services for minority community members as many are not eligible for Medicaid or health benefit. We would like to see increased amount designated for Non-Medicaid funding for mental health and CD outpatient services. Workload reduction funding has been very helpful in addressing workload of our case managers who carry such a high caseload. Although it is not enough to solve the problem, certainly it has been helpful as it can be used in a creative way for each agency. We would like to see an increase in workload reduction fund and the kind of support to support the infrastructure. I would have liked a focus on cultural competency, whether it is to increase the level of cultural competency in the system or providers' level, or in direct service staff. I am not sure how or whether this MIDD II took equity, social justice and cultural competency into consideration.

There is more need to address these important values and issues that we all share. Thank you for the important work!

Name: Reza Hosseini Ghomi

Organization: None

Comment: I fully support renewal of the MIDD.

Name: Perla Castaneda

Organization: None

Comment: To whom it may concern: I am writing today to urge the MIDD Oversight Committee to recognize and continue to support the ever-growing needs of the aging LGBT community. As a community that is facing pronounced mental health and behavioral health disparities, the aging LGBT community is in dire need of preventative and supplemental services. Despite the growth of the this community, now making up about 2.4% of the older adult population in Seattle/King County, no services exist that address their unique needs. LGBT are at higher risk for poor health as mental health related issues and therefore need specialized resources as well. Poor mental health can lead to other health related issues such as increased drug use and higher risk for suicide. One of the themes that came up in MIDD focus groups was the stigma that is often associated with using mental health care services. This stigma is even more prominent with the LGBT community given stigma surrounding identifying as LGBT is still outstanding. Older adults face these and other hardships, such as mobility issues and economic instability, in attempting to access services. For these reasons, it is critical that programming be dedicated to the older LGBT community in King County. I would like to commend the efforts of the Committee to include our aging community in the initial MIDD recommendations and would ask that we recall that the LGBT aging community should be specifically addressed in these efforts as well. With more efforts in behavioral health services focused in prevention and early intervention, our aging LGBT community can have a better chance of aging in a healthy and dignified manner.

Name: Lisa Nelson

Organization: None

Comment: The treatment on demand should also allow for mobile medical services. The urgent care clinic is a good start, but expand the funding eligibility to help with funding the new mobile medical van.

Name: Michelle Peterson

Organization: HERO House

Comment: It is very important to keep in mind the most important factor that benefits the club house members, and the community -- as it is so eloquently written in the MIDD II Recommendations: "Seattle

Clubhouse is well- positioned to overcome the challenges faced by past programs and fully support those working towards their own long-term, SUSTAINED RECOVERY (emphasis added)."

Name: Sarah Boye

Organization: None

Comment: As someone who has worked closely with the MIDD Wraparound program in multiple capacities, I object to the reduction of this program's budget. An assumption has been made that "Medicaid dollars" (aka WISe program funding) will enhance or supplement the current Wraparound delivery model, and therefore the overall budget for this program could be reduced without changing the service delivery. What this assumption fails to take into account is twofold:

1. The WISe funding model is not sustainable in itself, and does not provide adequate funding for the program design, and
2. MIDD Wraparound dollars provided key program elements which are not at all funded in the WISe model.

One of these key elements funded through the MIDD funding is Flex Funds. Flex Funds help to fill "gaps" in a client's care plan, and address needs that would not be otherwise paid for through categorical services. Examples of this would be sports fees to allow a youth in CD treatment to engage in prosocial activities which the family could not pay for, or items needed to create a safe living space for a child with Autism, or camp fees for a child with profound behavior needs to engage in "typical" summer activities, build skills, and give parents a needed break. Flex Funds are a crucial part of the service delivery model specifically because they are flexible. The child's team can decide to use them in a way that is culturally appropriate and clinically indicated. A second key element of the MIDD Wraparound program includes "following" a youth who has been admitted to a CLIP facility. Under the WISe program model, Wraparound would end when a youth enters long-term residential treatment facility. However with MIDD funding, the Wraparound team could continue to support this family and enhance the treatment and discharge planning of the youth. Our experience has found that this is crucial in ensuring that the expert clinical work done at the CLIP facilities can be effectively "translated" back to the child's family, school, outpatient mental health team, and natural support network. We have received feedback from more than one CLIP facility that they see more parent engagement, increased support network involvement, and an overall better prognosis for the future when Wraparound has maintained involvement throughout a youth's stay. Finally, and perhaps most importantly, MIDD funding allows families who do not have Medicaid to have access to the Wraparound program. In our community we serve families across a socioeconomic spectrum, because mental health, substance abuse, and behavioral needs affect all communities. Reducing this funding would limit access for our non-Medicaid families, and eliminate their opportunity to engage in this research based, team-based planning process. There are many families in our community who do not receive Medicaid, yet have children with profound emotional or behavioral disturbances. Wraparound supports these families in navigating the complex mental health, DDA, Juvenile Justice, Children's Administration, Special Education or Substance Abuse systems. The process also supports the family in developing robust proactive crisis and care plan which reduce the need for hospital or detention stays, and allow youth to remain in appropriate school and home settings. Please consider restoring the MIDD Wraparound budget to its original funding level. This program is unique in that it supports youth up to age 21, and enhances the work of providers across a variety of child-serving systems. By appropriately funding this single program, the efficiency of several

others are increased, and the burden on our hospitals, schools, social workers, and therapists can be distributed across a team of cross-agency supports. Thank you for your consideration.

Name: Kailey Fiedler

Organization: HERO House

Comment: I believe the recommendations are appropriate and help focus on preventative treatment rather than reactive treatment. It is imperative that the Clubhouse Model of Recovery that is accredited by Clubhouse International is at the forefront of MIDD II funding. The clubhouse model has proven outcomes to reduce hospitalization, cost effective in treatment and reduces individuals in jail. This is one area which the county has determined is vital to improving our mental health system.

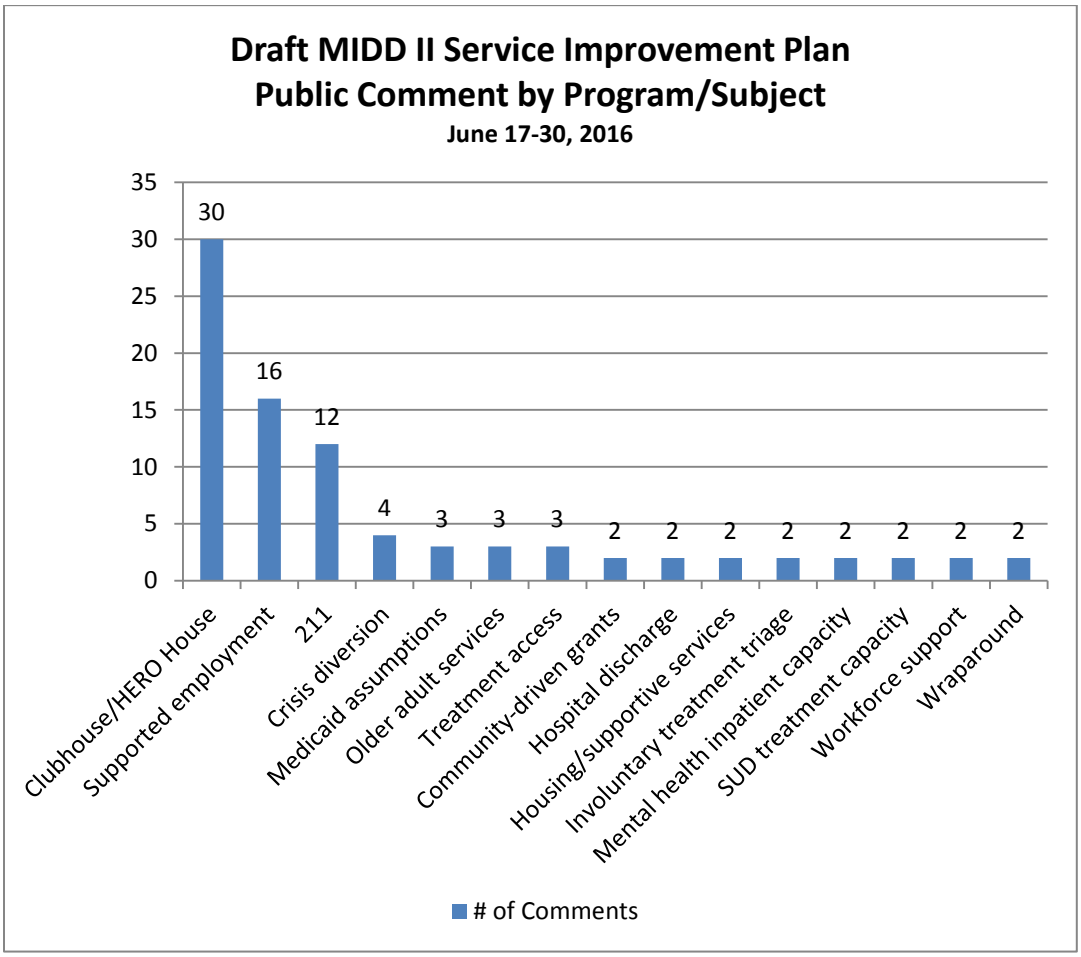
Draft MIDD II Service Improvement Plan

Public Comment Summary: June 17 – 30, 2016

A total of 65 comments on the draft MIDD II Service Improvement Plan were received by King County. The comments were provided online June 17-30 through a survey portal, via email, or in person at the MIDD Oversight Committee meeting on June 23.

The vast majority of comments endorsed or supported particular program(s), in some cases advocating for additional funding. Notably, 46 percent of commenters (30 total) advocated for additional funding for clubhouse/HERO House. About one quarter of public comment participants (16 total) advocated for increased funding for supported employment services. About 18 percent of respondents (12 total) supported MIDD funding for 211 services.

When comments referenced multiple subjects, they were counted under each subject discussed. Programs or subjects mentioned by two or more commenters are shown in the chart below.



Public Comment on Draft MIDD 2 Service Improvement Plan (June 2016)

Name: Kelly Rider, Alison Eisinger, Janet Pope, Paul Lambros, Daniel Malone, Matt King, Bill Hallerman, and John Hickman

Organization: Housing Development Consortium Seattle-King County, Seattle/King County Coalition on Homelessness, Compass Housing Alliance, Plymouth Housing Group, DESC, YMCA Seattle | King | Snohomish, Catholic Community Services, and Catholic Housing Services

Comment: Thank you for the opportunity to comment on the forthcoming draft of the MIDD II Service Improvement Plan (SIP). We appreciate that the current MIDD II proposal would invest a significant amount of funding in permanent supportive housing and related uses. In particular, we are grateful the proposal identifies sufficient funding to create an ongoing allocation of capital funding, compared to the one-time allocation in MIDD I. That said, we are concerned that the proposed funding level does not sufficiently respond to the crisis level of homelessness our County is experiencing. At a time when the One Night Count of unsheltered homeless individuals has increased by 20% over one year, the proposed funding does not bring this proven best practice to scale. Unfortunately, it would create fewer permanently affordable homes over the life of MIDD II than were created over the life of MIDD I due to increased costs and reduced external leveraging resources. We recognize MIDD II is being shaped to respond to a variety of needs our communities are facing. However, we recommend the following actions to better address homelessness among our county's population facing mental illness and substance abuse challenges.

Unallocated Funds: We strongly urge the County to prioritize permanent supportive housing capital dollars in the Service Improvement Plan's policy regarding additional allocations, underspending, and/or recapture of funds. A similar policy is currently in place for the Veterans & Human Services Levy and serves as a best practice for promoting enhanced housing outcomes over time should additional funding opportunities become available. This serves our community well as recipients do not require ongoing funding of capital dollars.

Flexibility of Housing-Related Funds: While we respect the County's need to create predictability and accountability within the Service Improvement Plan, we encourage you to create more flexibility within the housing-related funding allocations. Services and operating dollars in particular are incredibly challenging to identify and have reached a "cliff," where the current service dollars available have already been committed to current sites, leaving a shortage of funding available to commit to new permanent supportive housing sites. Given King County's position among a variety of other funders with varying priorities, flexibility will allow you to best leverage other funding sources to create the desired outcomes. In addition, this would align well with the unallocated funds policy recommended above, allowing the County to increase yearly funds for service dollars above $2 million if recaptured or other funds are identified to allocate toward capital funds.

Thank you for your leadership throughout this important process. We look forward to continuing to work with you and other County leaders to advance a successful MIDD II proposal later this year and to identify the other funding sources necessary to bring our homelessness strategies to scale. [Stakeholder letter submitted to MIDD June 15, 2016]

Name: Corrina Reily

Organization: HERO House

Comment: It has helped me get along with people. I learned how to do the right thing and to be honest and not steal. I have learned how to listen here and how to work well with others.

Name: Carol Bashaw

Organization: HERO House

Comment: HERO House lets me do reception when I'm there. HERO House allows me to have lunch too. I feel a sense of belonging to the clubhouse. Greg or Matt give me rides here and back because I can't get here otherwise.

Name: Alex Odesskiy

Organization: HERO House

Comment: I met a lot of new people. I had a volunteer job for 3 school years. I like the staff and get along well with them. I help out with shopping and go on socials. I also participated in a conference two years ago in Canada. HERO House helps me with my recovery.

Name: Joseph C.

Organization: HERO House

Comment: HERO House is a great place for people who have a mental illness to come and be accepted and feel at home here. It serves as a good foundation to help you sort of get on with life, move forward with life. The socialization aspects are really crucial. Also, the work activities are meaningful and it provides an atmosphere of comradery which is motivational. I'm getting a whole lot more interaction with people so it's really helped me to engage with people and brought me out of my shell. It's been very satisfying socially, which that when I go home, I can focus on other things and not feel isolated. It's eliminated the feeling of isolation, which has allowed me to be more productive.

Name: David Honrath

Organization: HERO House

Comment: It keeps me more active and more stable. I work well with a standard. HERO House helps me keep my body moving. I've met quite a few people at HERO House. Segregated place that lives up to standards. I appreciate HERO House and what it's done for me. I have a better living situation thanks to HERO House. Good things and bad things about work ordered day.

Name: Susan Ericksen

Organization: HERO House

Comment: I like the people here. It's helped me get along with people. I get to help with stuff, like cooking, setting the table, and my self-worth. I like the friends here.

Name: Anthony Gomez

Organization: HERO House

Comment: I'm not drinking and using drugs anymore. HERO House makes me feel like I'm a part of something. I'm able to ask for someone's help to explain things to people what don't want to listen to me. Peer support and advocacy. I feel like I have something to do now. It feels like I'm worth something now. Before, I was depressed, because I felt like I wasn't worth anything, but now I have someplace to go. They accept me for who I am. I get to cook anything I want to for the members if they have it. I'm developing skills and I hope to get a job. It's a new standard on my life.

Name: Michelle Ragan

Organization: HERO House

Comment: HERO House got me a real job. It's the only way I get paid. If I wasn't working, I wouldn’t have any money in my bank account. I've been working for six months. This is my first job in a long time. I like the activities they do. They give me two free shirts I can keep at my work.

Name: Ben Miksch

Organization: Seattle/King County Coalition on Homelessness

Comment: Ben Miksch, representing the Seattle/King County Coalition on Homelessness, spoke on behalf of the groups who signed the letter regarding the MIDD II Service Improvement Plan (Kelly Rider of the Housing Development Consortium Seattle-King County, Janet Pope of Compass Housing Alliance, Daniel Malone of Downtown Emergency Service Center, Bill Hallerman of Catholic Community Services, Alison Eisinger of Seattle/King County Coalition on Homelessness, Paul Lambros of Plymouth Housing Group, Matt King of YWCA Seattle/King/Snohomish, and John Hickman of Catholic Housing Services [included in the packet everyone received for today’s meeting]). He thanked the Oversight Committee for their work which is hugely appreciated by everyone in the community. He described permanent supportive housing, which was supported by MIDD I, as a national best practice for some of the most vulnerable people in our community, who often cannot be served without housing and cannot get housing without supportive services. He expressed the hope of the Coalition on Homelessness that some of the unallocated MIDD dollars be used to raise funding for permanent supportive housing or, given the current draft of the Service Improvement Plan, that money from emerging issues category could be considered for use in supportive housing. His other request was for flexibility of spending: comparing housing to a three-legged stool – capital projects, operations and maintenance, and services – with varying requirements at the federal and local levels, flexibility of spending MIDD dollars would be very helpful in respect to supportive housing.

Name: Alicia Tillery

Organization: Valley Cities Behavioral Health

Comment: Alicia Tillery, Vocational Specialist at Valley Cities Behavioral Health, thanked the MIDD Oversight Committee for their support of Supported Employment. She shared a success story about a consumer from DVR [the state Division of Vocational Rehabilitation] whom she was able to place at a CVA store where he boosted book sales by over 30 percent. Originally, this consumer had been unable to communicate, had no friends, and had never worked, at 25 years of age. But as a result of the job at CVA, his life has turned 180 degrees: his verbal communication has increased, he has friends, he is self-sufficient, his symptoms have decreased, and he is a productive citizen. This is why we are asking for an increase of $250,000 from the present Service Improvement Plan. We need to continue building our success numbers.

Name: Sue Wyder

Organization: Valley Cities Behavioral Health

Comment: Sue Wyder of Valley Cities Behavioral Health thanked the MIDD Oversight Committee for the work they have done on the budget, which she also has some experience with. Her public comment was in support of the Supported Employment Program at Valley Cities Behavioral Health, requesting the MIDD Oversight Committee recommend $250,000 more in funding for this program. She described the spiral effect that follows decreased funding has: low performance leads to low outcomes leads to decreased services from South King County and Auburn to Northgate, the area that Valley Cities serves. A large number of consumers at Valley Cities are motivated to work because of the time that staff spends supporting them. And employment works: it establishes routines, boosts confidence, lifts people out of homelessness and addictions, and they become role models for others. These are signs of what that extra funding can do and we want everyone to have the opportunity to work.

Name: Katharine Wisner

Organization: HERO House

Comment: Katharine Wisner, a consumer giving public comment about Hero House, described the critical importance of Hero House in helping her to live with severe anxiety and panic disorder after leaving a very stressful job last year. At Hero House, she has felt safe and accepted. No one asked questions about her mental health; they asked her to edit the newsletter and answer the phones, so that she felt like she was contributing even while she was still experiencing symptoms, which she while working through her symptoms. Thanks to her involvement in Hero House, some therapy, and other things, she began to feel better and spoke with Isabelle at Hero House about Supported Employment. She is now working part time in something that feels meaningful to her, and she is gaining confidence; her plan is to work full time by the end of the year with the help of Supported Employment. She advocated for funding of the Supported Employment Program at the $1.25 million level rather than the proposed $950,000 level. Working for her is the next step in reclaiming full recovery.

Name: Earl Peterson

Organization: HERO House

Comment: Earl Peterson, a consumer giving public comment about Hero House and the Supported Employment Program, described how Hero House has helped him greatly over the past seven years in his recovery from drug addiction, homelessness and severe depression. To live and be successful in life is important and not easy for anyone. Since joining Hero House, he's been able to attend college and initiate a new charter with the Kiwanis Club to donate funds to Hero House. Other members are regularly employed and also volunteer for nonprofits. More recently, he has committed to a new workshop at the Clubhouse on life goals, sponsored by Hero House. For most in recovery, progress is slow. The improvements he has been able to observe in himself and others within the Clubhouse environment seem directly proportional to the growth of this organization. Helping people be all they can be is the business of this organization; lives are being changed for the better, to be more constructive, clear, with a purpose. My hope is to convey how important funding dollars are to this program.

Name: Greg Davis

Organization: HERO House

Comment: Hi my name is Greg Davis i am a peer support Generalist at HERO House, HERO House is a safe place for people who have special needs we give hope to our members,we offer opportunities for people with special needs to rejoin their communitys.

Name: Matt Valdespino

Organization: HERO House

Comment: Hi, my name is Matt Valdespino and I'm a staff member at HERO House here in Bellevue. I have been working at the Clubhouse for a little over a year and it has been a truly incredibly experience. The work we do helps transform lives every day, and as we have expanded our services over the past year new people from all over the county are being rehabilitated through the unique recovery-through-work model that is unparalleled in Western Washingotn. It is for that reason that I urge you to, at the very least, maintain funding for HERO House at the current level through MIDD II, if not expand it. We are a proven, cost-effective method of psychosocial rehabilitation that helps individuals return to the workforce and re-engage with the community at large: a year of services from HERO House costs roughly the same as a 2 week stay at a psychiatric hospital. If the funding is cut, we will be forced to ration our services to the point where we will have to turn away individuals seeking assistance. This will not only damage that individual's recovery but damage the relationship of trust the members have in our program that if they want to get back to work, we will do everything to get them back to work. It is this trust, based on the strong individual relationships built through member-staff participation in the work ordered day, that distinguishes us from any other program in the area. When members come into the Clubhouse, they know they are dealing with people who will treat them as individuals and work to support them based on their goals, their personalities, and their strengths. Our diverse staff is representative of the community at large, with eight languages between our staff members and even more from our active members. By supporting HERO House, the county is supporting a holistic approach

to recovery that engages the strengths of individuals with mental illnesses rather than fixating on their weaknesses. I urge you, on the behalf of adults living with mental illness throughout King County who have not given up on reaching their full potential, to keep supporting our wonderful program.

Name: Olga Yarmoshik

Organization: HERO House

Comment: I am so thankful for MIDD funding as it vitally helped our program - HERO House to survive and prosper. My hope is that everyone could see the importance of continuing to fund this unique program at current level the least. Our clubhouse is currently the only clubhouse in King County that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery from mental illness. Members have opportunity to be active part to reach their goals, whether it is employment education, skills, meaningful life, connection to others and most importantly increased self esteem and confidence. Members and staff run the program side by side, resulting in many of the members returning to work, being less isolated and finding meaning in life. Over the past 10 years I have witnessed dozens of members going to work for the first time in very long time or even in their lifetime. These members are being able to be successful because of the many layers of support provided by HERO House program - prevocational building of skills and confidence, support from peers, encouragement from staff and opportunities to participate in social activities in safe and familiar environment. For members that are not interested in employment there is everyday support dealing with personal advocacy, community resources, and opportunity to participate in meaningful work of running the clubhouse. Clubhouse is effective and cost efficient option for those recovering from mental illness. Please do continue to fund our agency.

Name: Gail Kowall

Organization: HERO House

Comment: Would like to ask for King County/MIDD 11 to continue the current funding level of Hero House at $362,489 per year. Ask for funding of SE at $1,250,000-250k above previous MIDD 11 level Thank you

Name: Riley Holbrook

Organization: HERO House

Comment: HERO House has given me access to computers, found clothing in which to go to interviews. Provide cheap lunches and free pastries. Normally, I come to the morning meeting and sign up for 1-2 tasks and meet with Isabelle who is an employment generalist and go on a wellness walk with Corey. I got a job at PCC because of HERO House, developed friendships, volunteer at an organic farm, which is part of my chosen career.

Name: Kuong Quach

Organization: HERO House

Comment: I started 2 years ago. I heard about HERO House from my roommate who said HERO House is good for getting out of the house and getting a job. Kaz helped me get a job at Ross. I am proud to have work. It makes me happy to come here and it makes my recovery stable. Because of HERO House I have something to do every day. Also I get to socialize with the members. HEROHouse refreshes my job skills.

Name: Monika Swanson

Organization: HERO House

Comment: HERO House has given me a place to go each day so I don't isolate. I have found a place where I get a sense of belonging. I also get to do things that help me gain both social and job skills. I also find that I get support and encouragement in all my situations.

Name: Susie Willard

Organization: HERO House

Comment: HERO House helps me stay out of trouble and gives me something to occupy my time. HERO House has also been instrumental in assisting me to gain friendships. The computer skills I have learned will be helpful when I become employed.

Name: Kellen Ryan

Organization: HERO House

Comment: Helped me develop a sense of belonging. Helped me find and retain a part-time job. Helped me develop friendships. Helping me grow as a person (inter/intrapersonal growth). Share feelings

Name: Sei Obara

Organization: HERO House

Comment: There's a lot of social activities at HERO Hosue. I like being with people and in a friendly environment. HERO House helps me with resumes and applications for getting a job. It gives me time to reflect on my own self. I run the snackbar and help set up the Daily Dish. I also am the Lunch List attendant when I'm here.

Name: Jeffrey Parr

Organization: HERO House

Comment: It helps me in three ways: I'm not staying at home; it's a place in the community that I feel I'm doing something productive for the community if not for myself; it keeps me off the streets. We're learning to be training to go out and work and be part of the community, instead of sitting at home vegitating.

Name: Earl Peterson

Organization: HERO House

Comment: I have something to do to keep my mind off the problems in Seattle and the communities, and the chaos that spreads. It's like an oasis in the sewer, like a protective bubble.

Name: Michael Given

Organization: Hero House

Comment: I do a lot more in the computer, more than I did before. I've learned at HERO House how to do 3-D photos. I make the member cards for HERO House. In the past, I did a lot of movies, but never have people to help me. I do a lot of slide shows. HERO House helps those with mental illness to function better. It gave me the space to learn and people to help me. I was working as a drafter. I'm working with employment services to try to get back to work and to improve my CAD skills.

Name: Ann Allen

Organization: Harborview Medical center

Comment: This is a service that is vital to getting people with serious and acute mental illness out of jail. I provided the service for my agency at one point, please consider our efforts to get treatment for those in need.

Name: Idabelle Fosse

Organization: Sound Generations

Comment: Having read through the materials, I would like to comment on some of the themes that you outlined. Given the lack of access to hospitalizations, I think that the continuum of care would benefit greatly from using a system of crisis homes that are more effective and less expensive to run than trying to add more hospital beds. This idea would also help discharge planners from hospitals access a supportive transitional living environment for clients who need more services in order to become stabilized. San Diego has (or used to have) an excellent model for this. We need more services for folks who are homebound because of their mental illness, and need help to access services in order to prevent their becoming homeless, And lastly, we need more services that will help support older adults

with mental illness remain in their homes. The specific needs of older adults with mental illness is not addressed in any of the programming that is listed.

Name: Ursula Whiteside

Organization: NowMattersNow.org

Comment: Please include $200,000 to support King County 2-1-1 in the MIDD process. 2-1-1 is a foundational and critical part of the behavioral health system and deserves to be fully funded.

Name: Kristin Middleton

Organization: None

Comment: Please include $200,000 to support King County 2-1-1 in the MIDD process. 2-1-1 is a foundational part of the behavioral health system and deserves to be funded.

Name: Janice Tufte

Organization: Hassanah Consulting

Comment: Please fund MIDDII and fully fund 2-1-1 both organizations help many with a hands up, resources

Name: Mindy Brown

Organization: OESD 114

Comment: 211 is very important to the clients we serve. Without resources available to our families, they will never see the bigger picture that they could be part of.

Name: Gary Davis

Organization: None

Comment: I urge the King County Council to include $200,000 in support of King County 2-1-1 in the MIDD process. 2-1-1 saves lives, money, and critical time in serving our neighbors in need of crucial behavioral health care and is a vital resource in accomplishing the MIDD goals. Thank you for your advocacy for 2-1-1.

Name: Jason Austin

Organization: None

Comment: Please fully fund the $200,000 proposal to King County 2-1-1. 2-1-1 is a foundational element of King County behavior health safety net and should be strengthened to better meet the needs of King County residents.

Name: Dennis Raymond

Organization: None

Comment: Funding is needed for the 211 line in King County. This is a vital service for those needing social services, and don't know who to contact.

Name: Cynthia Drover

Organization: None

Comment: Please set aside 200,000 for 2-1-1. As a professional human service worker with direct contact with clients, I have utilized this resource many times when asked for resource and referral.

Name: Bonnie Thane

Organization: Olympic Educational Service District 114

Comment: Please include $200,000 to support King County 2-1-1 in the MIDD process. 2-1-1 is a foundational part of the behavioral health system and deserves to be funded. This service is VITAL to our community. Thank you.

Name: Lori VanderBilt

Organization: None

Comment: 211 is critical to our infrastructure. I have volunteered for the crisis line, offered it as a resource as a therapist, and donated money to support it! Please keep it going--so many people in desperate straits rely on it daily for resources!

Name: Jerilyn Anderson

Organization: 14834 119th Pl NE

Comment: The 2-1-1 service is underwritten financially by other line items in the Crisis Clinic budget. It is a value of it's own, serving so many thousands of residents. It should be funded sufficiently on its own so it can continue to provide this essential referral service for our community.

Name: Tanya McGee

Organization: Sound Generations

Comment: Working for 12 years with Senior Services now Sound Generations, I interact daily with client's 60 and over and clients 18-59yrs old who are struggling with depression and other mental health issues. Most are unable to access free or low cost mental health services and are struggling to maintain households, relationships, and get safe and secure placements when they are in a crisis. I also talk frequently with caregivers of client's with mental health needs and the caregivers are overwhelmed with navigating mental health systems; especially involuntary commitment. More wrap around services, care coordination, and crisis diversion services (like GRAT) are needed for older adults and younger disabled client's. I see firsthand that many clients could be assisted if there was more funding, more intensive supports, and more creative housing environments. The alternative being costly hospitalizations where no specialized treatment is being received, becoming homeless, or living in unsafe living environments frequently calling 911 and going in and out of the hospital with no follow up or care plans. I have several client's that are not in a mental health crisis, but have undiagnosed mental health conditions and need care coordination including home visits, and assistance to get connected to a doctor. I have researched current options but so far can't find the assistance they need to live safely in the community. Washington State is one of the best places to live. It needs to be one of the best places to live to access mental health services also. There are so many great ideas for the MIDD funding….all of them should be funded.

Name: Debbie Fuller

Organization: Mom

Comment: This specific funding needs to be addressed for its Unique ability to address very Basic and REAL needs. You can have Housing ,Food, Education, etc. needs met but if a Mom needs her hair cut to feel REAL to herself or a front door needs repair so a family entering doesn't have to be reminded that their Dad slammed their Mom's head into that space....THIS is the Funding that is not OUT THERE....THIS is the funding that precedes ALL the other interventions. ....this is the funding that is the platform for CHANGE.....lasting/fundamental /genuine Change! Please HEAR THIS !

Name: Tina Budell

Organization: None

Comment: I have read through the draft and am still thinking there is more focus on overhead and oversight than getting more treatment centers open. I have a friend who's brother is struggling with addiction and can't get into treatment. He is waiting to hopefully get in at Yakima, he is from federal way and has been a homeless addict in and around Seattle to Tacoma. He has been in the methadone program to no success and keeps slipping back to heroin due to ease of access. The clinics don't always work for people who are working and need access quickly, the waiting months to get in a treatment center if you are low income is counter productive to offering poor and lower income people with REAL options for getting help and getting treatment for their addictions. As a person who's own older brother struggled with addiction for over 20 years of his life and became homeless and addicted I know first hand the struggle for addicts who are ready to get help. The waiting game only makes it easier to go

back to the drugs and lifestyle that they desperately want to leave behind. The idea that all this reporting is going to make the addiction problem in our county/state/country go away is foolish and a waste of tax dollars. We need more treatment centers, we need intake centers that can take an addict in when they are ready and get this on the road to recovery that day, not 6 weeks later. Watching your loved one spiral into a drugged out zombie is heart breaking and destroys families, not just the addict. While my brother was trying to get into treatment was relapsed and stole jewelry from my mother who was in the hospital fighting for her life in her struggle with cancer. Had my brother been able to get in treatment when he realized he was ready and tired of being a drain on the family, he might not have been homeless for 7 years and addicted for over 20 years. Your plan needs to think about not just the future, it needs to have a concrete plan for NOW. How do we get these folks into treatment NOW, not 6 weeks from now and in a different part of the state.

Name: Gail Stone

Organization: King County

Comment: Thank you for the herculean effort. It is clearly the result of a sustained, deep fact-finding and challenging moral discussions. Please accept my comment on one item in particular. MIDD II Number: CD-14, ITA Triage: Too long ago to admit in public, a group of CJ actors, DCHS, state and local hospitals came together to address the escalating, intractable problem of people waiting in jail unconstitutionally long periods of time for an evaluation bed to open up at Western State Hospital. While this is clearly the State's obligation, it wasn't happening and wasn't going to be happening in the foreseeable future. The group developed the triage model in CD-14. Harborview Medical Center generously stepped into the gap and committed staff to do jail-based evaluations, cutting the wait time significantly and, unexpectedly, resulting in better outcomes for people needing evaluation. The rest of the group committed to find ways to fund this service, which Harborview continued to provide until they simply couldn't sustain within current capacity. Our workgroup hasn't found any other funding source. This program works, Harborview has the expertise and the geographic proximity to make it successful. On behalf of our workgroup, thank you for including the ITA Triage project in the MIDD II SIP, and please keep it in as you wrestle with the difficult choices before you.

Name: Jobyna Nickum

Organization: Enumclaw Senior Center

Comment: As a direct service provider, for 25 years in rural South East King County, providing person to person assistance to older adults, I am submitting the following comments/input on the MIDD II Service Improvement Plan: GRAT: Geriatric Regional Assessment Team is an extremely valuable resource for King County for our most at risk elders. Continued funding is essential. Would recommend a South King County based GRAT team to better address growing senior population. Mental Health Services/Case Management Model: I urge King County- MIDD II SIP to develop/support innovative strategies to address the growing "silver tsunami" that we are woefully unprepared for: the mental health needs of older adults Strategies and programs regarding older adults and homelessness Strategies and programs regarding older adults and heroin and opiate addiction

Name: Harry J. Mccarthy

Organization: Retired King County Superior Court judge

Comment: The single most important thing MIDD can do is to lobby strongly for many more residential mental health facilities, both inpatient and outpatient, in King County. We have all heard for years that both the King County jail and the juvenile detention facility are the de facto residences for the mentally ill. Indeed, the King County jail houses more mentally ill people than any facility other than Western State Hospital. Unless and until the Legislature commits to many more community mental health facilities, the mentally ill will continue to be incarcerated in our jails. That intolerable situation must end before any meaningful treatment and counseling can begin . We have been lobbying for this for many years with no change. Frankly, it leaves us who have been fighting for changes in the care for the mentally ill somewhat doubtful that the legislature will make the necessary commitment, particularly in light of their long standing failure to fund public education, their first duty.

Name: Amanda Clark

Organization: League of Women Voters, Seattle-King Co.

Comment: The League of Women Voters of Seattle-King County urges King County to support and fund the King County Mental Illness and Drug Dependency (MIDD) Improvement Plan for inclusion in the 2017-2018 biennial budget. The League of Women Voters of Washington supports measures to expand and fund drug abuse prevention education and drug abuse treatment programs as a means to reduce the demand for drugs. In particular, we support integrated services as appropriate, including long-term treatment, counseling and mental health services, to all drug abusers and to meet the needs of individuals with co-occurring disorders. As a community, we are all stronger by supporting the mental health of all of our citizens. Thank you for your continued support for drug dependency programs in King County through MIDD.

Name: Mike Heinisch

Organization: Kent Youth and Family Services

Comment: Comments submitted on the draft MIDD II SIP issued for public comment June 17, 2016
First off, thank you for the opportunity to provide comment once again as well as compliments on the thoroughness and thoughtfulness that went into development of the draft. It is clear through reading it that a great amount went into it's development, as with the entire planning process design of MIDD II development.

- I note very positively recognizing the challenges of King County MH providers sustaining a qualified, expert workforce and applaud the explicit inclusion of provider Economic Adjustments to the extent of referencing the situation as a workforce crisis.

- I am very much supportive of creating community driven grants and the opportunity this initiative presents for locally responsive, culturally competent MH services.

- I am supportive of expanding crisis diversion and mobile crisis services through the establishment of a crisis center in South King County. You will find tremendous support throughout the first responders and municipalities in SKC for this initiative.

- The draft SIP clearly calls out the BH Medicaid rate, "20-25% lower than pre ACA adoption, making it even more for providers to operate" (dovetailing legitimately and, in part, fueling the workforce capacity and sustainability cited elsewhere in the report. It has been obvious for years, well before ACA era, as the draft SIP states, "the system continues to be significantly underfunded."

- I applaud the recommended revision to the MIDD policy goals as well as the new Strategic Framework of MIDD II.

- I appreciate the recognition of the need that results in the expansion of Family Treatment Court to South King County.

- I ask you to be cautious with assumptions on Medicaid, the likely MIDD savings projections (whatever amount however cited as $4.8M in the draft SIP). Continue to think thoroughly through any assumptions and recommendations from any consultant(s) contracted to work with the County staff on Medicaid assumptions.

In general the array of NEW MIDD II projects/programs is very much reflective of the current BH care environment. Well done on crafting them with the extensive community and key stakeholders input.

Name: Laura Collins

Organization: None

Comment: Re: MIDD Initiative CD-14: Involuntary Treatment Triage Project which serves mentally ill individuals who have committed a serious misdemeanor and are found not competent to assist in their defense. This project provides a safer, more efficient and local evaluation process for these individuals, and has demonstrated great impact in multiple spheres – including diversion from costly ER visits and State hospital admissions, improved utilization of local resources and ensures compliance with the requirements of the civil commitment evaluation process outlined in RCW 10.77. This project has brought the required evaluation process back in-line with the Statute, which requires that these persons be evaluated for possible long term civil commitment (90 day inpatient treatment) vs. a shorter 72 hour commitment. If funded, this program will hire the providers that are qualified to file and testify for the possible 90 day commitment as required by law. Without this project, these individuals will continue to be evaluated for the 72 hour commitment only. Prior to December 2013, these individuals were either referred to Western State Hospital or Harborview's Emergency Department for these evaluations. Both processes were costly, risking longer lengths of stay (at Western State) and safety of patients and staff by treating these persons in an unpredictable emergency department environment of highly vulnerable patients. This project would bypass transfers to Western State or the Emergency Department, by allowing the evaluation to take place in the jail – a more safe and cost effective process. The other strong benefit of this project is its promotion of local care – both inpatient and outpatient. This project includes in the evaluation a thorough coordination with both existing and new outpatient providers, and encourages the development of a safe outpatient alternative plan that can prevent unnecessary hospitalizations. One discovery Harborview made when piloting this process, was that a majority of these individuals were already connected with care, and with some extra leg-work, the evaluators were

able to ensure that connection was in place in creating an outpatient plan. For the individuals who were believed to require inpatient level of care, this process ensured the admission to a local psychiatric facility (rather than the State hospital), in turn promoting shorter lengths of stay by keeping these persons in their own community. Moreover with this local process This supports fewer State Hospital admissions. In the original pilot of this project, it was found that a very small percentage (10%) of these individuals were actually ultimately placed on the long term (90 day) commitment and only 4% ultimately transferred to Western State Hospital. Please support the funding of the Involuntary Treatment Triage Project! Thank you, Laura Collins

Name: Jennifer Phillips

Organization: None

Comment: It appears that some of the new initiatives proposed may address what we've experienced as parents of a teen with mental illness. But I didn't find the details explained in the report or missed if there were fuller descriptions. As part of preventing ED visits/hospitalizations, our personal experience is that much clearer and quickly responsive gap services are needed. She has a behavioral health team but we've repeatedly been in a situation where we see several warning signs that mean a 911 call or journey to the ED is imminent and yet the ability to get a very rapid intervention to try preventing this is non-existent. There's no where else we can take her in these situations. And we've also been left without intensive outpatient services upon her discharge, basically teetering on the edge of crisis during fragile weeks after hospitalization. I'm not sure if a behavioral health urgent care center would be a twist on an ED but will be curious to learn more. Information about what is available in services and how to match to needs also feels fractured. Hope this is part of the next wave of improvements, so professionals can more easily advise patients/families on options. Also couldn't tell from the report whether those with developmental and intellectual disabilities and/or parents and guardians were consulted as part of this process. Hoping yes. This also is a dimension to our situation and it creates complicated situations in receiving services. Thanks.

Name: Bradley K Benson

Organization: Member NAMI

Comment: My son 25 year old Chad R Benson was diagnosed type 1 bipolar and schizophrenic at 19 years old. Chad has been hospitalized twice and taken into custody twice by the police for manic mental events. Chad has been stable and medically compliant for nearly three years. Any all programs that support mental health awareness and services in our city, state and nation deserve attention. Washington state ranks 49th in the nation for mental health services. Washington state has the fastest growing economy and population in the nation. One in Five people in our city, state and nation suffer from a mental illness. Prisons and two week inpatient treatment facilities are not the answer. For the sake of our city, state and nation vote to improve the services of our most misunderstood citizens.

Name: Tsegaye Gebru

Organization: Horn Of Africa Services

Comment: Every SINGLE day we are using 211 for our clients to find several resources. I am not sure how to put in word but it is very critical that 211 is fully funded. We can not do the work we are doing for over 4000 client we are serving at HOAS without 211. Thank you

Name: Elizabeth Krijger

Organization: None

Comment: Thank you so much for all the effort you are putting into the well being of our community. I especially appreciate the emphasis on prevention. While looking over the MIDD II proposal, I noticed the inclusion of housing and treatment, but didn't see anything on specific life skill development that would enable people to have more satisfying & productive lives. If it's not already included, I encourage you to consider inclusion of services that can provide life skill training, such as community-based occupational therapy.

Name: Christopher S

Organization: HERO House

Comment: I think HERO House benefits me in terms of being more social, accepting my mental illness, and helping me find a job, employment-wise. I've been out of work for three years, and I imagined one day I would go back to work. HERO House is an integral part of making that happen. I'm developing job skills with my activities at HERO House. I've spoken at a few NAMI meetings and other community type organizations as a HERO House representative. These opportunities have helped me regain confidence in myself. Because it's a non-clinical environment, I like that. I like the clubhouse environment, because it's a real friendly atmosphere, people are equal, people are treated like peers to the staff.

Name: Denise

Organization: n/a

Comment: we must continue to keep funding MIDD II! this is more important than throwing away money on "dumb" projects, like bertha, for instance! those with a mental illness and/or addiction problems, need continuous help! not only with initial hospitalizations, but also continuously follow-up treatment .... no matter how many months and/or years it takes to have the clients get well .... and healthy .... and back to being contributing members of society again!

Name: Michael J. Brown

Organization: HERO House

Comment: I graduated not knowing that there was a resource in mental health as personal and community oriented as HERO House. The work that clubhouse does is unprecedented in making people with mental illnesses feel wanted, needed, and included, which is something that society is not good at. I've seen mental illness in my family a lot and I only wish that I had known about organizations like HERO House as a resource for everyone I know with mental illness. Every resource here is used sparingly and wisely. There is no waste here. We'd love to stick around longer and be able to grow to be a front runner in mental health in King County. I work as a Program Generalist at HERO House and as such I am intimately involved in the workings of the everyday clubhouse. The King County/MIDD II current funding level of HERO House at $362,489 per year is essential to our running smoothly and not a cent is wasted. Here are a few of the ways I believe that we merit such funding.

1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program.

2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff.

3. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective.

4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system.

Although I am in wise a SE specialist I do know that there are a few of the specifics that we are seeking in regards to funding of Supported Employment at $1,250,000.

1. If funded at 950K this would be a decrease by 210K compared to the previous year's funding level. If funding at the 950k level currently proposed, this successful employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding.

Name: Elizabeth Archambault

Organization: The DoVE Project

Comment: My comment is more general. At DoVE, our mission is domestic violence. Many of our clients need therapists to be sure and many cannot afford private therapists and cannot, for many reasons, go to VYFS (past trauma, their abuser goes there, abuser's "people" are there). This is very limiting. Last year after the most recent youth suicide, I had community members coming up to me saying that their teens were sitting around tables with their friends saying "What if it's me next?" It was like there was no control over suicide and that was horrifying to parents. So. Two things happened. We started sending teens (as prevention) and adults (as intervention) to Axiom Equine Assisted Education (not exactly therapy -- and with great results). We have sent approximately 30 folks through and we get requests for this weekly even though the money for this program is gone. Also, because of the bleak situation on the island, a family foundation approached us in December and gave us $15000 to develop and implement a plan where we pay for islanders to attend therapy with a therapist (private) of their choice. This also covered substance abuse counselling. This program was crazy popular and half way through the year, the money is gone and we have more people asking us for it. My point here is that on Vashon different methods can work. We must be innovative because there is no other choice. I hope that MIDD can allow room for innovative projects that help the overall health of the community in the ways that they need and want.

Name: Kailey Fiedler

Organization: HERO House

Comment: HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program.This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding. We are asking for funding of SE at $1,250,000---250k above previous MIDD 1 level. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system. I am asking For King County/MIDD II to at least continue the current funding level of HERO House if not, increase the funding.

Name: Ramona K. Graham

Organization: Center for Human Services

Comment: I am gravely concerned about two issues in the SIP. One, Wraparound serves are being considered for a cut, which will affect those youth in King County who are in Crisis. By cutting the MIDD wraparound, the flex funds that are vitally important to this EBP will not cover the MIDD Wraparound families needs and WISe does not include these funds at all. Two, the North end of the county is being overlooked for many of the SIP services especially the services for children and youth. The North part of the county also has needs and it would be a huge blow to our community to be excluded.

Name: Guy Andrews

Organization: None

Comment: 1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program. 2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff. 3. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective. 4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system.

Name: Caprice Andrews

Organization: None

Comment: The ASK: Funding of SE at $1,250,000---250k above previous MIDD 1 level.

1. If funded at 950K this would be a decrease by 210K compared to the previous year's funding level. If funding at the 950k level currently proposed, this successful employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding.

On Clubhouse: The ASK: For King County/MIDD II to continue the current funding level of HERO House at $362,489 per year.

1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program.

HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education program.

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3. One year of recovery at HERO House costs the same as a 2 week psychiatric hospital stay: Clubhouse is cost effective.

4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House which is double the average employment rate for people in the public mental health system.

Name: Kaz Uchimura

Organization: HERO House

Comment: I am an Employment Generalist at HERO House (Non profit organization working with people who got mental health challenges) and follow IPS (Individual Placement and Support) model for our members' job placements. We also follow the fidelity scales supported by King County, Mental Health, Chemical Abuse and Dependency Services Division. Now I would like to share my opinions about the draft MIDD II Service Improvement Plan.

1. If funded at 950K this would be a decrease by 210K compared to the previous year's funding level. If funding at the 950k level currently proposed, this successful employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance based payment program, when we cut performance based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retention because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding. I truly believe that Supported Employment program works well with individuals who have mental health challenges not only they start earning money, but also they find their desired goal in employment. I placed 7 members at work since last November and would like to work with more individuals who are willing to get back to work and we will appreciate your support. Thank you.

Name: Beratta Gomillion

Organization: Center for Human Services

Comment: There is a major flaw in the thinking behind reducing Wraparound funds. WISe program funds will not adequately fund the deficit created by the reduction proposed. This must be reconsidered immediately. Thank you.

Name: Ashley Fontaine

Organization: NAMI Seattle

Comment: I fully support the addition of seats to the MIDD Oversight Committee, especially those which ensure the voices of traditionally underrepresented groups are heard. Behavioral Health Workforce Shortage, Behavioral Health on Demand, Behavioral Health Urgent Care Walk in Clinic – We have to find a way to address our workforce shortage in King County. While the behavioral health walk in clinic does not directly address this issue, it has the potential to mitigate a huge barrier to treatment: waiting. When someone is seeking help and ready to walk through that door, we have to have a mechanism to keep that door open. A walk in clinic is a vital middle-of-the-road entry point and will support our commitment to recovery by helping create a "no wrong door" approach to care. Community Driven Grants - I am extremely happy to see that creating community-driven grants so geographic and culturally diverse communities can customize behavioral health services for their unique needs is a listed priority for MIDD II. Clubhouse - the Clubhouse model needs ongoing support from MIDD and should not have funding reduced. Currently, Hero House is the only place in King County accredited by Clubhouse International, and acts as a model for other Clubhouses in the county. We desperately need a clubhouse on the west side of the county, to provide employment training and support, social engagement and friendship, and a sense of purpose for people working the path to recovery. We know that employment is a crucial component of recovery for so many people, and we know that social isolation can contribute significantly to negative mental health outcomes. Clubhouses provide much needed services outside the clinical/medical model - we need more this type of community based care, and we need to ensure that Clubhouses are not subjected to the changing whims of Medicaid funding. First Episode Psychosis Programs - Multiple research studies from around the world show that the longer psychosis goes untreated, the more serious it becomes. Other states, including our neighbor Oregon, have implemented FEP programs with great success. While Washington has its first FEP program pilot underway in Yakima, we need FEP here in the most densely populated county in our state. I interact with countless families whose lives have been turned upside down by psychosis in their teens and young adults, who are frustrated that this type of programming isn't available to them. This is a prime opportunity to pair MIDD funds and Best Starts for Kids funds to create a robust FEP program. Early interventions like FEP programs are a game changer that can dramatically improve the trajectory for young people experiencing psychosis.

Name: Deborah Lewy

Organization: HERO House

Comment: On SEP: The ASK: We are asking that funding of SE be at $1,250,000 which is 250k above previous MIDD 1 level.

1. If funded at the only 950K, this would be a decrease by 210K compared to the previous year's funding level. If only funded at 950K, our SEP employment program would need to reduce enrollments and turn people away who are seeking jobs as part of their recovery journeys. Jobs are critical for our members to feel like they are back in the community; it increases their self esteem and lowers society's costs for supporting them.

2. Performance/Cuts: This program routinely outperforms performance benchmarks for job placements and job retention expectations. In a performance-based payment program, when we cut

performance-based payments, we decrease performance. With this funding, we are likely to employ and retain less people at work. In total we've received $1,375 in cuts per employed person for the same job placements and job retentions because we are achieving them in greater numbers today. We cannot continue to provide the same level of services or expand this high performing program with less funding.

On Our Clubhouse: The ASK: We are asking for King County/MIDD II to continue the current funding level of HERO House at $362,489 per year.

1. HERO House is a unique organization in King County because it is the only clubhouse that is accredited by Clubhouse International and it also includes the IPS Supported Employment Program. HERO House provides a nonclinical approach to recovery which puts people back to work and keeps them there. We increase access to community services through our clubhouse supports such as bus passes, the SE program, and our education and training programs.

2. At HERO House, our staff represents the community we serve at large. Our staff provides support in more than eight languages. This creates a diverse culture and is reflected in our continued growth for members and staff.

3. One year of recovery at HERO House costs the same as a 2-week psychiatric hospital stay: Clubhouse has been shown to be cost-effective.

4. Forty-two percent employment rates are achieved at Accredited Clubhouses, like HERO House, which is double the average employment rate for people in the public mental health system.

We sincerely hope you continue to support HERO House and our funding needs over the next years, helping adults in King County with mental illness get back on track and recover their lives and jobs.

2015/2016 FISCAL NOTE

Ordinance/Motion:
Title: Mental Illness and Drug Dependency Service Improvement Plan
Affected Agency and/or Agencies: KC DCHS, DPH, PSB, PAO, DJA, Superior Court, Sheriff, DAJD, DPD, District Court
Note Prepared By: DCHS Staff
Date Prepared: 8/18/2016
Note Reviewed By: Steve Andryszewski
Date Reviewed: 8/18/2016

Description of request:

This request proposes to fund the Service Improvement Plan

Revenue to:

Agency	Fund Code	Revenue Source	2015/2016	2017/2018	2019/2020
DCHS	1135	Local		134,073,353	142,679,937
Housing and Community Development	2460	Interfund Transfer		11,517,354	11,805,288
Prosecuting Attorney's Office	10	Interfund Transfer		1,032,171	1,057,975
Public Health	1800	Interfund Transfer		3,717,318	3,810,251
Judicial Administration	10	Interfund Transfer		468,282	479,989
Superior Court	10	Interfund Transfer		1,803,582	1,848,671
Sheriff	10	Interfund Transfer		350,628	359,394
Jail Health Services	10	Interfund Transfer		241,264	247,296
Adult and Juvenile Detention	10	Interfund Transfer		712,779	730,598
TOTAL			**0**	**153,916,731**	**163,019,400**

Expenditures to:

Agency	Fund Code	Department	2015/2016	2017/2018	2019/2020
DCHS - BHRD	1135	DCHS		-116,304,254	-119,211,860
District Court - MIDD	1135	District Court		-2,773,528	-2,740,365
Prosecuting Attorney's Office - MIDD	1135	PAO		-3,007,410	-3,082,595
Judicial Administration - MIDD	1135	DJA		-3,327,127	-3,410,305
Superior Court - MIDD	1135	Superior Court		-3,804,053	-3,899,154
Department of Public Defense - MIDD	1135	DPD		-5,405,835	-5,540,981
DCHS - HCD	2460	DCHS		-11,517,354	-11,805,288
Prosecuting Attorney's Office	10	PAO		-1,032,171	-1,057,975
Public Health	1800	DPH		-3,717,318	-3,810,251
Judicial Administration	10	DJA		-468,282	-479,989
Superior Court	10	Superior Court		-1,803,582	-1,848,671
Sheriff	10	Sheriff		-350,628	-359,394
Adult and Juvenile Detention	10	DAJD		-712,779	-730,598
Jail Health Services	10	JHS		-241,264	-247,296
TOTAL			**0**	**-154,465,585**	**-158,224,724**

Expenditures by Categories

	Fund Code	Department	2015/2016	2017/2018	2019/2020
Wages and Benefits	1135	DCHS		-4,874,040	-4,995,891
Supplies	1135	DCHS		-105,500	-108,138
Contracts	1135	DCHS		-86,972,166	-89,146,470
Intergovernmental Services	1135	DCHS		-4,509,170	-4,621,899
Interfund Transfers	1135	DCHS		-19,843,378	-20,339,463
Contracts	2460	DCHS		-11,517,354	-11,805,288
Wages and Benefits	1135	PAO MIDD		-2,874,445	-2,946,306
Intragovernmental Services	1135	PAO MIDD		-132,965	-136,289
Wages and Benefits	10	PAO		-1,032,171	-1,057,975
Wages and Benefits	1135	Superior Court MIDD		-2,932,857	-3,006,178
Supplies	1135	Superior Court MIDD		-46,800	-47,970
Services -Other Charges	1135	Superior Court MIDD		-555,772	-569,666
Intragovernmental Services	1135	Superior Court MIDD		-268,624	-275,340
Wages and Benefits	10	Superior Court		-1,765,582	-1,809,721
Services -Other Charges	10	Superior Court		-38,000	-38,950
Wages and Benefits	1135	DJA MIDD		-2,652,434	-2,718,745
Services -Other Charges	1135	DJA MIDD		-549,662	-563,404
Intragovernmental Services	1135	DJA MIDD		-125,031	-128,157
Services -Other Charges	10	DJA		-468,282	-479,989
Wages and Benefits	1135	District Court MIDD		-2,400,619	-2,460,634
Supplies	1135	District Court MIDD		-13,912	-14,260
Services -Other Charges	1135	District Court MIDD		-67,226	-68,907
Intragovernmental Services	1135	District Court MIDD		-191,771	-196,565
Contracts	1135	District Court MIDD		-100,000	0
Wages and Benefits	1800	Public Health		-166,000	-170,150
Contracts	1800	Public Health		-3,267,213	-3,348,893
Intragovernmental Services	1800	Public Health		-284,105	-291,208
Wages and Benefits	10	DAJD		-712,779	-730,598
Wages and Benefits	10	JHS		-241,264	-247,296
Wages and Benefits	1135	DPD MIDD		-5,246,483	-5,377,645
Intragovernmental Services	1135	DPD MIDD		-159,352	-163,336
Wages and Benefits	10	Sheriff		-290,628	-297,894
Supplies	10	Sheriff		-60,000	-61,500
TOTAL			**0**	**-154,465,585**	**-158,224,724**

Does this legislation require a budget supplemental? No

Notes and Assumptions:
This Fiscal Note assumes funding allocations proposed in the Service Improvement Plan are adopted.

KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

September 8, 2016

Ordinance

Proposed No. 2016-0428.1 **Sponsors** Kohl-Welles

AN ORDINANCE revising the King County mental illness and drug dependency policy goals; amending Ordinance 15949, Section 3, as amended, and adding a new section to K.C.C. chapter 4A.500.

PREAMBLE:

In 2005, recognizing the need for additional mental health and chemical dependency programs, the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new programs.

The one-tenth of one percent sales and use tax supporting new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services, known as the mental illness and drug dependency ("MIDD") sales and use tax, generates between fifty and sixty-five million dollars annually for King County.

King County council levied the one-tenth of one percent MIDD sales and use tax in Ordinance 15949, which was enacted November 26, 2007.

The intent of the sales tax is to support new or expanded mental health and substance abuse programs, now referred to as behavioral health programs, reflective of the integration of mental health and substance use disorder programs and services; and the operation of the county's therapeutic court programs.

In March 2014, the Washington state Legislature passed Senate Bill 6312, which became Chapter 225, Laws of Washington 2014, calling for the integrated purchasing of mental health and substance abuse treatment services. Implementation of this law has brought about changes to how mental health and substance abuse treatment services are described and administered and delivered in King County. An integrated behavioral health system allows more flexibility to deliver holistic care especially for individuals with co-occurring mental health and substance use disorders. One change initiated by behavioral health integration is the evolution of terminology used to define and describe the mental health and substance use disorder systems. King County uses "behavioral health" when referencing mental health and substance use disorder systems, reflecting the joining of systems through behavioral health integration.

The MIDD sales tax-funded initiatives, programs and services supported by taxes levied under K.C.C 4A.500.300 continue the county's work to transform the approach to health and human services by improving health and well-being and creating conditions that allow residents of King County to achieve their full potential.

Much has changed locally, at the state level and nationally in the realm of behavioral health the eleven years since the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new program and enhance the state's chemical dependency and mental health treatment services, and in the nine years since King County subsequently authorized the MIDD one-tenth of one percent sales and use tax levied under K.C.C. 4A.500.300: the formerly separate mental health and chemical dependency services are integrated into one behavioral health system; the nation and region experienced a severe economic downturn and recovery; the federal Affordable Care Act was enacted; and there have been several changes in state laws impacting behavioral health services. Throughout all of these change events, King County's MIDD work became a platform for cross system engagement and improvement, collaboration and policy dialogue between the criminal justice, and health and human services sectors.

King County, its behavioral health and community stakeholders and the MIDD oversight committee embraced the opportunity to review and learn from the MIDD work accomplished between 2008 and 2016, and plan for a robust, forward-looking MIDD for the next service period. The collaborative efforts over a nearly two-year period from a wide range of stakeholders including representatives from communities, provider agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, staff and elected

officials from jurisdictions in King County, council staff and many others thoughtfully informed the recommendations to modify the policy goals for MIDD for 2017 through 2025.

The 2007 through 2016 MIDD policy goals were the foundational expression of what policymakers expected MIDD-funded programs to achieve, or work towards achieving. The policy goals provided the essential framing for all elements of the MIDD, including the 2008 through 2016 MIDD implementation and evaluation plans. The primary focus of the MIDD evaluation was to determine progress of MIDD-supported programs toward meeting the five policy goals.

Calling for proposed modifications to the MIDD policy goals through Ordinance 17998, the council recognized that the behavioral health and criminal justice environments have changed since 2007 when the MIDD policy goals were established via Ordinance 15949 and that revised policy goals may be necessary. As required by Ordinance 17998, modifications to the adopted MIDD policy goals were submitted to the council in the Comprehensive Historical Assessment Report on June 30, 2016.

The recommended revised MIDD policy goals use a person-centered language that strives to avoid using dehumanizing terms for individuals and groups that demean or create barriers to inclusion. This approach also aligns with RCW 44.04.280, a statute that directed the state code reviser to avoid disrespectful language used in reference to individuals with disabilities. Recommended changes to the MIDD policy goals including

preserving the outcome driven focus of the goals, while focusing on meeting the needs of people rather than on meeting system needs and improving and supporting culturally-appropriate services. Proposed changes to the policy goals reflect recent advancements in recovery-oriented approaches to care, and actively support King County's equity and social justice aims.

At the same time as MIDD policy goals are proposed for amendment, the executive recognizes that MIDD-funded initiatives, programs and services alone cannot achieve policy goals. Due to the interrelatedness of the criminal justice, behavioral health, and housing systems, changes in any one of those systems or funding to those systems will impact MIDD-funded initiatives, programs and services.

Additional implementation planning is needed for proposed new and revised MIDD-funded initiatives, programs and services, of which many include community engagement components that need to be carried out in collaboration with providers and communities.

The initial MIDD evaluation plan adopted by the council in 2008 served as the blueprint for conducting the evaluation and assessment of MIDD through 2016. It was developed in conjunction with the initial MIDD implementation plan, after the individual MIDD strategies, programs and services were established in the council accepted MIDD Action Plan via Motion 12598.

Once the council makes MIDD funding and programmatic decisions with adoption of the county's 2017/2018 Biennial Budget Ordinance, a detailed MIDD evaluation plan for 2017 through 2025 will be prepared and transmitted to the council in 2017. Further, it is necessary to develop a MIDD evaluation plan for 2017-2025 that is built on the recommendations contained in the MIDD comprehensive historical assessment report (Proposed Motion 2016-0354), which calls for stakeholder involvement in the development of an updated MIDD evaluation plan.

Much has changed in the eight years since the initial MIDD implementation and evaluation plans were completed, including behavioral health integration and technological advances. Yet the purpose for evaluating MIDD remains the same, which is providing the public and policy makers with the tools to evaluate the effectiveness of the MIDD strategies in meeting the established MIDD policy goals, as well as to ensure transparency and accountability

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. Ordinance 15949, Section 3, as amended, is hereby added to K.C.C. chapter 4A.500.

SECTION 2. Ordinance 15949, Section 3, as amended, is hereby amended to read as follows:

A. It is the policy of the county that citizens and policy makers be able to measure the effectiveness of the investment of these public funds. The county requires appropriate oversight, accountability and reporting on the status and progress of the

programs supported with the sales tax funds. The programs supported with these funds shall be designed to achieve the following policy goals:

1. ((~~A reduction of the number of mentally ill and chemically dependent using costly interventions like~~)) Divert individuals with behavioral health needs from costly interventions such as jail, emergency rooms and hospitals;

2. ((~~A reduction of the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency~~)) Reduce the number, length and frequency of behavioral health crisis events;

3. ((~~A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults;~~)) Increase culturally-appropriate, trauma-informed behavioral health services;

4. ((~~Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement~~)) Improve the health and wellness of individuals living with behavioral health conditions; and

5. Explicit linkage with, and furthering the work of, ((~~other council directed efforts including, the adult and juvenile justice operational master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Services Improvement Plan and the county Recovery Plan~~)) King County and community initiatives.

B. To ensure the oversight, implementation and evaluation of the Mental Illness and Drug Dependency ((~~Action~~)) Service Improvement Plan is consistent with the county's policy goals outlined in subsection A. of this section and to ensure fulfillment of the requirements of RCW 82.14.460 which enables the sales tax, the ((~~office of performance, strategy and budget, the departments of community and human services,~~

~~public health and adult and juvenile detention, superior court, district court, the prosecuting attorney, the public defender and the sheriff are requested, with assistance from council staff, to~~)) executive, in collaboration with the mental illness and drug dependency advisory committee and community stakeholders, shall develop and submit for council review and approval an ((~~oversight,~~)) implementation and evaluation plan for the Mental Illness and Drug Dependency ((~~Action~~)) Service Improvement Plan accepted by council by ((~~Motion 12598~~)) (Proposed Ordinance 2016-xxxx).

C. The ((~~oversight~~)) implementation and evaluation plan shall have ((~~three~~)) the following parts:

1. Part One: ((~~Oversight Plan. Part one of the oversight, implementation and evaluation plan shall be an oversight plan. Part one, the oversight plan, shall propose an oversight group that will be responsible for the ongoing oversight of the mental illness and drug dependency action plan. The oversight group shall include representation from other county, state and community agencies and entities involved in the mental health, substance abuse, domestic violence and sexual assault, homeless, justice, public health and hospital systems. The oversight plan shall also identify the proposed role of the oversight group and how the oversight group will link and coordinate with other existing county groups such as the Criminal Justice Council, the Committee to End Homelessness and the veterans and human services levy oversight groups. Part one of the oversight, implementation and evaluation plan shall be submitted to the council by April 1, 2008, for council review and approval by motion. Twelve copies of the part one oversight plan shall be filed with the clerk of the council, for distribution to all councilmembers and to the lead staff the law, justice and human services committee or its successor;~~

~~2. Part OneTwo:~~)) Implementation Plan. Part ((~~two~~)) one of the ((~~oversight,~~)) implementation and evaluation plan is an implementation plan. ((~~Part two, t~~))The implementation plan((~~,~~)) shall describe the implementation of the initiatives, programs and services outlined in the Mental Illness and Drug Dependency ((~~Action~~)) Service Improvement Plan. ((~~This~~)) The description shall include: a schedule of the implementation of initiatives, programs, and services outlined in the Mental Illness and Drug Dependency ((~~Action~~)) Service Improvement Plan as approved by the council under Ordinance xxxx (Proposed Ordinance 2016-xxxx); a discussion of needed resources, including staff, information and provider contracts; outcome and performance measures; procurement and contracting information; community engagement efforts; and ((~~milestones for implementation of the programs. The implementation plan shall address how adult drug diversion court, one of the county's therapeutic courts, may also utilize sales tax revenue for program expansion. Additionally, because the council recognizes that there is a strong correlation between sexual assault and domestic violence victimization and subsequent mental health problems, substance abuse, homelessness, incarceration and usage of the emergency medical system, the implementation plan shall include a proposal on how to integrate programs that support specialized mental health or substance abuse counseling, therapy and support groups for victims of sexual assault, victims of domestic violence and children exposed to domestic violence, provided by or in collaboration with recognized sexual assault and domestic violence services providers~~)) how the initiative, program or service advances the county's mental health and chemical dependency policy goals. An ((~~revised 2008~~)) updated 2017-2018 biennial spending plan and financial plan for the mental illness and drug dependency fund shall be

included in ((~~part two~~)) the implementation plan that is transmitted to the council. Part ((~~two~~)) one shall be developed in collaboration with the ((~~oversight group~~)) mental illness and drug dependency advisory committee and community stakeholders. Part ((~~two~~)) one of the ((~~oversight,~~)) implementation and evaluation plan shall be submitted to the council by ((~~June 1, 2008~~)) August 3, 2017, for council review and approval by motion. Twelve copies of the part ((~~two~~)) one implementation plan to the council shall be filed with the clerk of the council, for distribution to all councilmembers and to the lead staff of the ((~~law, justice~~)) health, housing and human services committee, or ((~~their~~)) its successor((~~s~~)); and

((~~3.~~)) 2. Part ((~~Three~~)) Two: Evaluation Plan. Part ((~~three~~)) two of the ((~~oversight,~~)) implementation and evaluation plan is an evaluation plan. ((~~Part three, t~~))The evaluation plan((~~,~~)) shall describe an evaluation and reporting plan for the ((~~programs funded with the sales tax revenue~~)) mental illness and drug dependency sales tax-funded initiatives, programs, and services supported by revenue levied under K.C.C 4A.500.300. Part ((~~three~~)) two shall specify: process and outcome evaluation components; a proposed schedule for evaluations; performance measurements and performance measurement targets; and data elements that will be used for reporting and evaluations. Performance measures shall include, but not be limited to: the amount of funding contracted to date, the number and status of request for proposals to date, individual program status and statistics such as individuals served, data on utilization of the justice and emergency medical systems and resources needed to support the evaluation requirements identified in this subsection C.((~~3.~~))2. The evaluation plan shall describe overarching principles, evaluation framing questions and approaches that will

guide mental illness and drug dependency evaluation and performance measurement for 2017 through 2025. Part ((~~three~~)) two shall be developed in collaboration with the ((~~oversight group~~)) mental illness and drug dependency oversight committee and community stakeholders. Part ((~~three~~)) two of the ((~~oversight,~~)) implementation and evaluation plan shall be submitted to the council by August ((~~1, 2008~~)) 3, 2017, for council review and approval by motion. Twelve copies of the part ((~~three~~)) two evaluation plan to the council shall be filed with the clerk of the council, for distribution to all councilmembers and to the lead staff the ((~~law, justice~~)) health, housing and human services committee or their successors.

D.1. In addition to reviewing and approving the parts one((~~,~~)) and two ((~~and three~~)) of the ((~~oversight,~~)) implementation and evaluation plan outlined in subsection C. of this section, in coordination with the ((~~oversight group~~)) mental illness and drug dependency advisory committee, the executive shall submit ((~~four quarterly progress reports and~~)) an ((~~one~~)) annual ((~~summary~~)) mental illness and drug dependency evaluation summary report each year for the initiatives, programs and services supported with the sales tax revenue ((~~to the council~~)). The annual summary evaluation report shall be submitted to the council by August 1 each year for council review and approval by Motion, starting in August 2018. The ((~~quarterly~~)) annual report((~~s~~)) shall include at a minimum:

a. performance measurement statistics;

b. program utilization statistics;

c. request for proposal and expenditure status updates; ((~~and~~))

d. progress reports on evaluation implementation;

e. geographic distribution of the sales tax expenditures across the county, including collection of residential ZIP code data for individuals served by the programs and strategies; ((~~and~~))

f. updated performance measure targets for the following year of the mental illness and drug dependency initiatives, programs and services;

g. recommendations on either program changes or process changes, or both, to the funded programs based on the measurement and evaluation data; and

h. summary of cumulative calendar year data.

2.((~~a. The quarterly reports to the council are due to the council March 1, June 1, September 1 and December 1 for council review for years one and two and thereafter, every six months.~~

~~b.(1) The annual report to the council shall be submitted to the council by April 1, for council review and acceptance by motion. The annual report shall also include:~~

~~(a) a summary of quarterly report data;~~

~~(b) updated performance measure targets for the following year of the programs;~~

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

~~(d) recommended revisions to the evaluation plan and processes; and~~

~~(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. New or revised performance measures and performance~~

~~measurement targets for the strategies shall be identified and included in the April 1, 2009, annual report and in each annual report thereafter.~~

~~3.~~)) Twelve copies of the quarterly reports and the annual report to the council shall be filed with the clerk of the council, for distribution to all councilmembers and to the lead staff of the ((~~law, justice~~)) health, housing and human services committee, or its successor.

E. Concurrent with the executive's ((~~2009~~)) 2017/2018 biennial budget proposal ((~~, and~~)) for each ((~~subsequent year~~)) biennia that the mental illness and drug dependency sales and use tax ((~~exists~~)) is levied, the executive shall submit a report on program expenditures and revenue as part of the county's ((~~annual~~)) biennial budget review process. The information submitted with the executive's budget shall include an ((~~annual~~)) updated and financial plan and a detailed spending plan for the tax funding, as well as revenue information. The ((~~elements of an annual~~)) mental illness and drug dependency spending plan ((~~, at a minimum,~~)) shall include((~~:~~

~~1. A~~))a detailed list of ((~~funded activities along with~~)) mental illness and drug dependency sales tax-funded initiatives, programs and services supported by revenue levied under K.C.C 4A.500.300 and a budget (~~and revenue for each activity;~~

~~2. A reasonable estimate of cost per unit of service of activities;~~

~~3. The anticipated number of service units to be provided for each activity or item;~~

~~4. How many individuals are estimated to be served in each activity;~~

~~5. Whether the activity is to be completed by the county or by a contracted provider; and~~

~~6. Full time equivalent or term-limited temporary employee impact if service is provided by the county~~)).

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

J. Joseph McDermott, Chair

ATTEST:

_____

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: None

2015/2016 FISCAL NOTE

Ordinance/Motion:
Title: Mental Illness and Drug Dependency - Policy Goals
Affected Agency and/or Agencies: KC DCHS
Note Prepared By: DCHS Staff
Date Prepared: 8/18/2016
Note Reviewed By: Steve Andryszewski
Date Reviewed: 8/18/2016

Description of request:

This request proposes to revise the MIDD policy goals

Revenue to:

Agency	Fund Code	Revenue Source	2015/2016	2017/2018	2019/2020
TOTAL			**0**	**0**	**0**

Expenditures to:

Agency	Fund Code	Department	2015/2016	2017/2018	2019/2020
TOTAL			**0**	**0**	**0**

Expenditures by Categories

	Fund Code	Department	2015/2016	2017/2018	2019/2020
TOTAL			**0**	**0**	**0**

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ATTACHMENT 5

August 24, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

I am pleased to transmit to you the Mental Illness and Drug Dependency (MIDD) Service Improvement Plan for King County Council approval, per Ordinance 17998. There are three proposed ordinances included with this transmittal letter relating to MIDD:

1. A proposed ordinance approving the MIDD Service Improvement Plan
2. A proposed ordinance revising the MIDD policy goals
3. A proposed ordinance renaming and revising the MIDD Oversight Committee.

MIDD Service Improvement Plan: The MIDD Service Improvement Plan makes operational, programmatic, funding and policy recommendations for the investment of revenue generated by King County's MIDD sales tax. As required by Ordinance 17998, this report was developed with input from the MIDD Oversight Committee and was informed by an unprecedented level of community feedback.

The MIDD Service Improvement Plan outlines a comprehensive approach to creating improvements across the continuum of the behavioral health[1] system by continuing successful MIDD 1 (2008-2016) programs and adding 21 recommended new initiatives. Improvements will be achieved by building on the groundbreaking partnership between health and human services, criminal justice, King County government and community providers that is the hallmark of King County's MIDD. The recommended initiatives, policies and processes that comprise MIDD and are reflected in the MIDD Service Improvement Plan are:

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

- Informed by community and MIDD Oversight Committee input.
- Grounded in King County's Equity and Social Justice work.
- Driven by outcomes.
- Guided by the behavioral health continuum of care.
- Aligned with other King County policy initiatives.

MIDD initiatives prioritize funding services and programs to keep people out of, or from returning to, jail and the criminal justice system, including upstream prevention and diversion activities. These include initiatives like:

- Law Enforcement Assisted Diversion (LEAD)
- Housing Capital and Rental Assistance
- Crisis Diversion and Mobile Crisis Services, including expanding to South King County
- Recovery Café.

MIDD invests in a treatment on demand system that delivers treatment to people who need it, how they need it, and when they need it so crises can be avoided or shortened. These include initiatives like:

- Behavioral Health Urgent Care Walk In Clinic Pilot
- Next Day Appointments
- Peer Bridger and Peer Support.

In addition to these important improvements, I am also recommending that through MIDD, King County create a grants process that will enable geographic and culturally diverse communities to meet their unique behavioral health service needs.

MIDD Policy Goals: Ordinance 15949 established five policy goals for King County's MIDD sales and use tax. These goals have guided and informed all aspects of the MIDD policy and services work since 2007, including the MIDD Implementation and Evaluation Plans. While much has changed locally, at the state level, and nationally in the realm of behavioral health in the nine years since King County subsequently authorized the one-tenth of one percent MIDD sales and use tax, the policy goals have remained unchanged.

Ordinance 17998 called for recommended revisions to the MIDD policy goals. Legislation included in this transmittal proposes changes to the MIDD's adopted policy goals as outlined in the Service Improvement Plan and also the Comprehensive Historical Assessment Report submitted to the Council on June 30, 2016. These proposed revised MIDD policy goals maintain focus on achieving results for MIDD program participants and address improvements in access to services.

MIDD Oversight Committee: Ordinance 17998 calls for review of the MIDD Oversight Committee purpose, role and composition. The MIDD Service Improvement Plan includes a number of recommended improvements to the MIDD Oversight Committee, including adding seats to the Committee to bring greater depth and breadth of subject matter expertise and experiences to the group. A pivotal recommendation is the convening of a Consumers and Communities Ad Hoc Work Group by the MIDD Oversight Committee comprised of individuals with lived experience of the behavioral health system (consumers) and individuals who are part of communities with marginalized identities or experiences. Two members of the Consumers and Communities Ad Hoc Work Group would be added to the MIDD Oversight Committee to bring the perspectives of consumers and communities to the Oversight Committee. Changing the name of the MIDD Oversight Committee to the MIDD Advisory Committee is also included in the Service Improvement Plan, commensurate with their unchanged duties as an advisory body to the Executive and Council. Proposed legislation to make these, and other recommended changes to the Oversight Committee, is included with this transmittal.

Ordinance 17998 called for the transmittal of the MIDD Service Improvement Plan in December of 2016. In order to support the King County Council's desire for expanded review and input on the MIDD Service Improvement Plan, this plan is submitted three months earlier than required. The impact of this changed timeline is that MIDD implementation and evaluation plans require further development.

The MIDD Service Improvement Plan I am transmitting to you today reflects my programmatic and funding priorities for MIDD, as informed by MIDD Oversight Committee and community input. It also balances the needs of King County government in the face of a declining General Fund. I am especially pleased to transmit a MIDD spending plan that provides economic adjustments for providers for the 2017-2018 biennium. I look forward to working with you during the Council's upcoming fall biennial budget process as you consider the MIDD Service Improvement Plan and the 2017-2018 MIDD budget. Please note that we anticipate slight modifications to the bottom line MIDD budget and individual initiatives between now and when I transmit the proposed 2017-2018 biennial budget to you due to final balancing and technical adjustments.

The MIDD continues the County's work in transforming the approach to health and human services by improving health and well-being and creating conditions that allow residents of King County to achieve their full potential. Our MIDD sales tax provides King County with an important tool to make progress on both the Justice and Safety and Health and Human Potential goals of the King County Strategic Plan. This legislation is also consistent with the Financial Stewardship goal of the Strategic Plan, reflecting continued sound financial management, and will help maintain King County's long-term fiscal strength.

This report, including the appendices, required an estimated 7,701 staff hours to complete at a cost of $559,230.

If you have any questions or comments, please contact Adrienne Quinn, Department of Community and Human Services Director, at 206-263-9100.

Sincerely,

Dow Constantine
King County Executive

Enclosures

cc: King County Councilmembers
ATTN: Carolyn Busch, Chief of Staff
Anne Noris, Clerk of the Council
Carrie S. Cihak, Chief of Policy Development, King County Executive Office
Dwight Dively, Director, Office of Performance, Strategy and Budget
Adrienne Quinn, Director, Department of Community and Human Services

Financial Plan July, 2016
MIDD /000001135

Category	2013/2014 Actuals[1]	2015/2016 Adopted Budget[2]	2015/2016 Current Budget[3]	2015/2016 Biennial-to-Date Actuals[4]	2015/2016 Estimated[5]	2017/2018 Projected[6]	2019/2020 Projected[6]
Beginning Fund Balance	**23,962,347**	**15,773,536**	**16,257,983**	**16,257,983**	**16,257,983**	**11,869,049**	**11,317,521**
Revenues							
Local Sales Tax	100,493,041	111,109,079	120,247,632	92,192,601	120,379,332	133,955,400	142,561,984
Other	139,899	112,336	112,336	333,095	366,105	117,953	123,143
Total Revenues	**100,632,940**	**111,221,415**	**120,359,968**	**92,525,696**	**120,745,437**	**134,073,353**	**142,685,127**
Expenditures							
Wages and Benefits (51000)	(21,126,899)	(23,437,231)	(24,533,745)	(19,274,346)	(24,354,116)	(26,180,675)	(26,835,192)
Supplies & Capital	(103,230)	(107,668)	(107,668)	(80,782)	(107,668)	(115,743)	(118,637)
Services (53000)	(83,243,300)	(86,238,855)	(99,272,708)	(68,311,590)	(96,082,708)	(103,394,343)	(105,979,202)
Intergovernmental Services (55000)	(3,863,875)	(3,584,465)	(4,567,098)	(5,825,604)	(4,567,098)	(4,909,630)	(5,032,371)
Other Balances		(22,781)	(22,781)	(3,661)	(22,781)	(24,490)	(25,102)
Total Expenditures	**(108,337,304)**	**(113,391,000)**	**(128,504,000)**	**(93,495,983)**	**(125,134,371)**	**(134,624,881)**	**(137,990,503)**
Estimated Under expenditures							
Other Fund Transactions[7]							
GAAP Adjustments							
Total Other Fund Transactions	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Ending Fund Balance	16,257,983	13,603,951	8,113,951	15,287,696	11,869,049	11,317,521	16,012,145
Reserves							
Expenditure Reserve (s)		(3,658,569)					
Services Stabilization Pool Reserve[8]			(895,000)	(895,000)	(895,000)		
Revenue Reserve(s)[9]	(5,275,885)	(5,833,227)	(6,313,001)	(6,313,001)	(6,319,915)		
Rainy Day Reserve (60 days)[10]					(4,654,134)	(11,218,740)	(11,499,209)
Total Reserves	**(5,275,885)**	**(9,491,796)**	**(7,208,001)**	**(7,208,001)**	**(11,869,049)**	**(11,218,740)**	**(11,499,209)**
Reserve Shortfall	-	-	-	-	-	-	-
Ending Undesignated Fund Balance	**10,982,098**	**4,112,155**	**905,950**	**8,079,695**	**-**	**98,781**	**4,512,937**

Financial Plan Notes

[1] 2013/2014 Actuals reflect year end information from EBS and are consistent with the Budgetary Fund Balance figures published by FBOD.

[2] 2015/2016 Adopted Budget is based on ordinance 17941.

[3] 2015/2016 Current Budget includes March 2016 Mental Health Sales Tax Forecast and supplemental appropriations per ordinance #17941 for $113,391,000, # 18110 for $9,943,000, ordinance # 18155 for $2,322,000, ordinance # 18223 for $378,000 and ordinance #18319 for $2,480,000.

[4] 2015/2016 Biennial-to-Date Actuals reflects actual revenues and expenditures as of 7/31/2016, using EBS report GL 010.

[5] 2015/2016 Estimated reflects updated revenue and expenditure estimates as of 7/31/2016.

[6] Out year projections assume revenue growth per OEFA guidance and the proposed MIDD II Service Improvement Plan is renewed past 2017.

[7] Other fund transactions include accounting adjustments to balance to budgetary fund balance.

[8] The Services Stabilization Pool is designated to fund MIDD I services during transition to MIDD II services to avoid service disruptions for vulnerable populations.

[9] Revenue Reserve is equal to 5.25% of MIDD tax receipts.

[10] The MIDD fund will move to a Rainy Day Reserve as of 2017 which represents a 60 day expenditure reserve.

This plan was updated by DCHS Staff on 8/24/2016.

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Mental Illness and Drug Dependency (MIDD)
Community Conversations & Focus Group Themes

County staff have conducted a robust outreach and engagement process around MIDD renewal. From September through December 2016, King County invited communities to participate in five regional Community Conversations on MIDD[1]. Between October 2015 and February 2016, county staff held 13 focus groups involving specific communities, populations, or sub-regional areas. The purpose of these engagement efforts was to hear ideas about services and programs for people living with mental illness and substance use disorders. The conversations were intentionally designed so that community members could have a role in informing the County's decisions around its investments for children and youth and investments for mental health and substance use disorder services and programs. For the Community Conversations, participants engaged in small discussions based on birth to young adult age groups and MIDD Strategy Areas. A summary of their thoughts on MIDD Strategy Areas are below. Conversations were flexible and welcome to all ideas to allow participants to fully engage.

Community Conversations September – December 2016		
MIDD Strategy Area Table	**What's working?**	**What's not working or needed?**
Prevention & Early Intervention	• Wraparound • Peer Mentors/Counselors • School-based Services • Trauma Informed Care • Suicide Prevention	• Family/In-home Support • Youth-Young Adult Support • Culturally Diverse Resources • Crisis Line Texting • Provider Trainings
Crisis Diversion	• Mental Health First Aid Training • Police De-escalation Training • Crisis Clinic • Crisis Solution Services • Children's Crisis Outreach Response System/Geriatric Regional Assessment Team	• Waiting for Services • Mental Health Aftercare for Young Adults • Mobile Van for Mental Health • Respite Housing/ Crisis beds • Culturally Sensitive Services
Recovery & Reentry	• Non-Medicaid services • Wraparound • Recovery Café • Peer/Mentoring Support • Clubhouses	• Non-Medicaid Services, more needed • Restorative Justice • Recovery House/Oxford House • Treatment on Demand • Recovery High Schools
System Improvement	• Harm Reduction Programs • Specialty Population Behavioral Health Services • MIDD Mental Health/Substance Use Disorder funds • Staff Trainings • Behavioral Health/Physical Health Integration	• High Staff Turnover and Burnout • Caregiver/Parent Resources are lacking • Lack of services in south and rural county areas • Culturally Competent Services • Facility-based Mental Health/Substance Use Disorder services limit access

[1] *Community Conversations were held in partnership with King County staff planning for what became Best Starts for Kids.*

Focus Groups: Groups ranged in size from as few as four to over 100. Groups included:

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

A summary of themes from the focus groups on MIDD and behavioral health services are below.

1. **Culturally specific organizations and groups need to be a central part of development and delivery of programs and services.**

2. **Stigma is a barrier to seeking services.**

3. **Outreach and engagement services are needed. Outreach is needed to educate people about available resources. Engagement is important to develop trust to increase commitment and active involvement in services.**

4. **More affordable housing/housing programs are needed.**

5. **Non-Medicaid services are necessary to fill a significant gap in the service system since many people still do not qualify for Medicaid.**

Primary Needs and Gaps Identified by Respondents to the Mental Illness and Drug Dependency (MIDD) Review and Renewal Survey September 2015 – February 2016

As part of the Mental Illness and Drug Dependency (MIDD) renewal work by King County, an electronic survey was made available between September 2015 and February 2016. The purpose of the survey was to gather feedback on a number of aspects of MIDD. The County received 362 responses.

One question specifically asked respondents to describe in narrative the specific mental health or substance abuse service gaps in their communities where new or expanded mental health, substance abuse, or therapeutic court services could make a difference.

Narrative responses to this question from 262 survey participants identified the following as the top 12 areas of need. Please note that not all survey respondents elected to answer this question.

MIDD SURVEY: TOP AREAS OF NEED OR SERVICE GAPS

1. **Outpatient mental health and substance abuse treatment access, including funding for people who do not have Medicaid**

2. **Housing, including housing supports and improved services for homeless individuals**
3. **Services for youth, especially in schools, including prevention**
4. **Culturally and linguistically competent services**
5. **Support for families**
6. **Inpatient substance use disorders treatment capacity/access**
7. **Crisis services and diversion, including mobile crisis teams**
8. **Support for people with behavioral health needs whose private insurance is insufficient or too expensive**
9. **Improved coordination and continuity of care**
10. **Inpatient mental health treatment capacity/access**
11. **Workforce challenges including high caseloads and turnover and low salaries**
12. **Hospital re-entry services including stepdown options**

Additional information from the survey will be made available as it is reviewed.

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King County

Metropolitan King County Council
Regional Policy Committee

STAFF REPORT

Agenda Item:	8	**Name:**	Scarlett Aldebot-Green Wendy K. Soo Hoo
Proposed No.:	2016-B0170	**Date:**	September 14, 2015

SUBJECT

A briefing on the Veterans and Human Services Levy 2015 Annual Report (Proposed Motion 2016-0346) and accomplishments of the 2012-2017 Veterans and Human Services Levy.

SUMMARY

This briefing will focus on accomplishments of the 2012-2017 Veterans and Human Services Levy (VHSL) and a summary of the annual progress report on the implementation of the King County Veterans and Human Services Levy Service Improvement Plan as required by Ordinance 17200. A motion (Proposed Motion 2016-0346) accepting the annual progress report was referred to the Health, Housing and Human Services Committee.

This is the fourth annual report for the 2012-2017 Veterans and Human Services Levy (VHSL). This report documents King County's implementation of the activities and strategies identified in the Veterans and Human Services Levy Service Improvement Plan. The transmitted report contains a description of services and the status of activities, individual program statistics by strategy and activity, a report from the VHSL boards, and an evaluation report.

BACKGROUND

The Renewed Levy: In 2011, King County voters approved a renewed Veterans and Human Services Levy, which provides approximately $18 million per year ($0.05 per $1,000 assessed valuation plus annual increases by the percentage increase in the consumer price index or 1 percent, whichever is greater, with a maximum increase of 3 percent) for six years starting in 2012. Fifty percent of the levy proceeds is dedicated to these services for veterans, military personnel and their families, and fifty percent is dedicated to improving health, human services and housing for a wider array of people in need.

The levy's purpose is to provide revenue that supports health and human services such as housing assistance, mental health counseling, substance abuse prevention and treatment, and employment assistance, as well as capital facilities and improved access to and coordination of services for veterans, military personnel and their families.

Levy proceeds are to be used to pay the costs associated with provision of regional health and human services to a wide range of people in need of such services, including, but not limited to:

- Services that increase self-sufficiency for veterans, military personnel and their families
- Services that reduce involvement in the criminal justice system
- Services that reduce emergency medical costs
- Services for children and youth, the elderly, the unemployed and underemployed
- Services specific to veterans' needs such as treatment for posttraumatic stress disorder and specialized employment assistance
- Costs associated with strengthening and improving health and human services system and infrastructure to provide greater access to services and engender better coordination and integration of regional health and human services addressing the needs of veterans, military personnel and their families

The services provided under the VHSL also include a range of regional health and human services and related capital facilities including, but not limited to, housing assistance, homelessness prevention, mental health counseling substance abuse prevention and treatment and employment assistance.

Oversight: As with the first levy, the current Veterans and Human Services levy is overseen by two community boards: the Veterans Citizen Oversight Board (VCOB) and the Regional Human Services Citizen Oversight Board (RHSCOB). The two boards play an integral role in reviewing the plans for expenditure of levy proceeds and monitoring progress of service and program implementation.

Reporting: Ordinance 17200 requires regular reporting to the King County Executive and the County Council on the VHSL's performance evaluation and financial status information. Ordinance 17200 specifies that an annual report shall be transmitted to the Council by June 30 each year of the levy. Performance reports are included with each annual report.

Ordinance 17200 also outlines the specific reporting requirements of the VHSL annual reports, calling for:

- A description of services procured and delivered to date and the status of service and project and activity implementation
- An updated, detailed financial plan
- Individual program statistics for by strategy, sub-strategy, activity or program
- The geographic distribution of levy resources across the county, including numbers of individuals served by jurisdiction

- A report or reports from the Citizen Oversight Boards regarding their assessment of progress and any recommendations they may have for improvement of levy program operations and result
- Detailed explanation of any revisions to the adopted service improvement plan strategies, activities or should any strategy or activity be eliminated or added, and should there be any changes to allocation plan's funding amounts for any strategy or activity greater than 15 percent; and
- An evaluation report that identifies outcome and output targets and assesses performance by the county and its contractors strategy, sub-strategy, activity and program in meeting the identified outcome and output targets.

Funding Requirements: Ordinance 17200 identifies explicit amounts of funds that are required to be set aside from the VHSL for certain purposes. The set aside amounts and areas are as follows:

- Up to $2.5 million per year may be set aside for housing capital, including funding of transitional housing for homeless youth and young adults

- At least $2 million per year is required to be set aside from the portion of the levy proceeds used for services for veterans, military personnel in need and their families to be used in maintaining the expansion of and improving current county veterans program services

- At least $2.5 million is required to be set aside from the portion of the total levy proceeds used for services for veterans, military personnel in need and their families to be expended on strategies, sub-strategies, programs and activities related to veterans justice programs including the veterans incarcerated program, veterans legal assistance, the veterans treatment court or other emerging veterans justice programs; and

- At least $1 million per year is required to be set aside from the portion of the levy proceeds not specifically designated for services for veterans, military personnel in need and their families to be invested in early intervention and prevention programs that have demonstrated effectiveness in reducing dependency and criminal justice problems in the long run.

In addition, Ordinance 17200 limits the county's administrative expenses for managing and administering the levy proceeds to five percent, excluding evaluation and board support expenses.

The Service Improvement Plan: In December 2011, the Council passed Ordinance 17236 adopting the VHSL service improvement plan for 2012 through 2017. The service improvement plan (SIP) provides guidance on the goals, investments and implementation of the King County VHSL. The SIP outlines the 2012-2017 levy goals as follows:

2012-2017 Levy Goals
1. Prevent and reduce homelessness. 2. Reduce unnecessary criminal justice and emergency medical system involvement. 3. Increase self-sufficiency of veterans and vulnerable populations.

The 2012-2017 SIP also requires the Department of Community and Human Services to work in cooperation with other county departments and branches of government and with the levy oversight boards to ensure that the goals and strategies of the levy are achieved.

The SIP describes VHSL priority populations and investment areas, specifying them as follows:

1. Veterans, military personnel, and their families who are struggling with mental and physical health problems, unstable housing or homelessness, or unemployment and in need of supports that will help them build on their strengths and respond to the unique challenges they face.

2. Residents who are currently experiencing instability in their lives resulting in involvement in the homelessness, criminal justice, or emergency medical systems.

3. Families and individuals for whom prevention and early interventions will help lay the foundation for a successful future and prevent involvement in crisis systems.

Similar to the first levy, the plan states that while many activities are focused on families and individuals who have already become involved in costly public systems, the renewed levy SIP recognizes that it is also important to target those who are at-risk of such involvement. The levy will also continue to invest in proven interventions for mothers and children at the very earliest point of their lives, prenatal to age three.

The plan notes that further targeting of people and communities to be served with levy resources occurs at the level of the specific program activity. Similar to the first SIP, need continues to be a key factor in allocations and activities.

Levy Strategy Areas: The levy funds are dispersed into the four strategy areas outlined in the box below:

Veterans and Human Services Levy Strategy Areas 2012-2017
1. Supporting veterans and their families to build stable lives and strong relationships 2. Ending homelessness through outreach, prevention, permanent supportive housing and employment 3. Improving health through the integration of medical and behavioral health services 4. Strengthening families at risk

2015 ANNUAL REPORT HIGHLIGHTS

Specific highlights of the 2015 Veterans and Human Services Levy Annual Report include:

Strategy 1: Supporting Veterans and their Families[1]

- The King County Veterans Program served 2,532 veterans and family members, more than 900 of whom were homeless when they contacted the program. The program helped 1,527 veterans and family members get or maintain housing.

- The Veterans Call and Service Center connected 874 veterans to veteran-specific resources. Outreach specialists were dispatched by the call center to engage 462 homeless veterans – almost 23 percent were women veterans.

- The Vet Corps program's 15 peer mentors served on college campuses across the county in 2015, helping 61 stay in education or training in 2015.

- The Post-Traumatic Stress Disorder (PTSD) program provided confidential counseling services free of charge to 250 veterans with war readjustment and PTSD treatment needs.

- In 2015, the Veterans Incarcerated Program screened 328 veterans who were incarcerated and provided re-entry case management to 242 who were were incarcerated or at risk of incarceration. Seventy percent of the veterans referred to treatment or educational programs followed through with those services.

- The Veterans Program enabled 51 family members and caregivers of veterans to see a mental health provider at no cost – 94 percent of those served reported an improved quality of life.

Strategy 2: Ending Homelessness[2]

- The levy's REACH program served 634 homeless people in 2015 and 63 moved into or kept stable housing. According to the report, this was fewer than anticipated because of limited availability of appropriate housing.

- The Emergency Services Patrol (ESP) patrolled downtown Seattle streets for individuals with chronic substance use disorders. ESP served 7,811 persons

[1] Veterans & Human Services Levy 2015 Annual Report, pgs. 5-6.
[2] Veterans & Human Services Levy 2015 Annual Report, pgs. 9-10.

and transported 5,508 to the Dutch Shisler Sobering Center, which serves as an entry point for other health housing and recovery support services.

- The mobile medical outreach van regularly visited meal sites and shelters, serving 837 individuals in 2015. Staff also helped 59 enroll for medical benefits.

- In 2015, the South King County homeless outreach program (PATH) assessed the needs of 142 long-term homeless individuals, 66 percent of whom accessed community services and housing as a result.

- The levy funded creation of 168 units of low-income housing with each dollar leveraging nearly $17 of other public and private funding.

- The Housing Stability Program helped 511 households (1,273 individuals) to maintain or secure housing.

- The Forensic Assertive Community Treatment (FACT) program served 63 individuals referred from the Regional Mental Health Court, including 13 new participants, to help them find housing – of those housed, 72 percent were able to retain housing or move to other permanent housing. The Forensic Intensive Supportive Housing (FISH) program served 69 homeless individuals referred by the Mental Health Court in 2015 – of those housed, 81 percent were able to retain housing or moved to other permanent housing.

- Community Employment Services enrolled and served 382 homeless individuals in 2015 – a total of 219 found jobs, increasing their household income by roughly 180 percent. The average starting wage was $13 per hour.

- The King County Veterans Internship/Fellowship Program received nearly 300 applications for 16 six-month positions, beginning in late 2015.

Strategy 3: Improving Health[3]

- In 2015, screenings of 1,818 low-income adults during primary care appointments identified 1,322 with depression, anxiety and/or substance abuse. Of these, 56 percent received at least two visits with a mental health provider in the primary care setting.

- The Program to Encourage Active, Rewarding Lives (PEARLS) provided in-home counseling to 109 older veterans and spouses of veterans who had disabilities and were experiencing minor depression.

[3] Veterans & Human Services Levy 2015 Annual Report, pgs. 13-14.

- The levy supported 64 workshops on veterans' issues and trauma-informed care, training 1,085 treatment professionals and 1,455 service providers and employers. The majority (79 percent) of trainees said they were better able to identify trauma-related issues – 85 percent said they were better able to refer veterans for services.

- The levy allowed for identification of 1,503 individuals, including 458 veterans, as high users of emergency services. The program screened 407 individuals referred by service providers and identified 203 who met the criteria for housing. A total of 94 individuals, including 30 veterans, moved into permanent supportive housing in 2015. The report indicates that "housing placements resulted in almost $615,000 in reduced use of emergency services."

Strategy 4: Strengthening Families at Risk[4]

- In 2015, the levy supported Nurse Family Partnership (NFP) services for 100 of the program's 1,305 low-income, first-time parents from pregnancy to age 2 of the child. Two-thirds were living in South King County. Fourteen parents gained employment or an education credential.

- The Healthy Start program provided home visits to 369 young, first-time, mostly low-income parents making up 150 families in East and North King County in 2015.

- In 2015, 2,090 pregnant and parenting mothers received screening at their primary care clinic for depression, anxiety and substance abuse – of 843 who showed symptoms, 628 had at least two visits with a mental health provider at the clinic, with 69 percent showing improvement as a result.

- In 2015, 98 Play & Learn groups served a total of 4,046 families. Forty-five new facilitators were trained. Eighty percent of participants said they read or told stories to their child more often because of what they learned.

- Passage Point helped 62 households to transition from prison and, where possible, to reunite with their children. Twelve households moved into permanent housing and one moved into transitional housing.

Performance and Evaluation Report[5]

As required by Ordinance 17200, an evaluation report that identifies outcome and output targets, and assesses performance by the county and its contractors by strategy, sub-strategy, activity and program in meeting the identified outcome and output targets

[4] Veterans & Human Services Levy 2015 Annual Report, pgs. 17-18.
[5] Veterans & Human Services Levy 2015 Annual Report, pgs. 19-27.

is also required. The Executive has included this information in the annual report starting on page 19.

Evaluation and levy staff collected and analyzed year-end data and reports from 40 levy activities in 2015. A summary of performance data finds that of 40 activities (and 92 individual service measures) finds:

- All but five activities achieved 85 percent of their targets
- The five that did not achieve 85 percent achieved at least 65 percent of their targets.

The majority of individuals served lived in south King County (41 percent) or Seattle (40 percent), with lower percentages living in east King County (16 percent) or north King County (3 percent).

The report also provides cumulative data on clients served by strategy for 2012 through 2015:

- Strategy 1 (Supporting Veterans): 22,890 individuals served
- Strategy 2 (Ending Homelessness): 38,350 individuals served
- Strategy 3 (Improving Health): 30,764 individuals served
- Strategy 4 (Strengthening Families): 58,819 individuals served

Annual Financial Report[6]

The annual report is required to include the following detailed financial information:

- Total actual and projected revenue and expenditures for the veterans and regional human services funds for each year of the levy and cumulatively for the life of the current levy;
- The total amount of funding expended to date by strategy, sub-strategy, activity or program;
- The total amount of funding contracted to date by strategy, sub-strategy, activity or program;
- Explanations of all changes from the previous year's financial plan and changes from the projected budget; and
- All levy operation and administration costs, including all full-time equivalents and term-limited temporaries supported by the levy, the number of contracts administered from levy funds.

The financial data submitted with the 2015 annual report (including Exhibit A to the annual report) contains all required information.

[6] Veterans & Human Services Levy 2015 Annual Report, pgs. 28-30.

ANALYSIS

The annual Veterans and Human Services Levy progress report submitted by the Executive meets the criteria set forth in Ordinance 17200. Required programmatic, financial, evaluation, and performance management data was provided.

ATTACHMENTS

1. Veterans and Human Services Levy, 2015 Annual Report

INVITED

1. Leonardo Flor, Veterans and Human Services Levy Renewal Manager, Department of Community and Human Services
2. Adrienne Quinn, Director, Department of Community and Human Services

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VETERANS & HUMAN SERVICES LEVY

2015 ANNUAL REPORT

King County

Attachment A

The Veterans and Human Services Levy for 2012–2017 was approved by King County voters in 2011 to build on the success of the 2006–2011 levy. Costing about $17 a year for the average homeowner, it provides approximately $18 million each year to help people in need.

HIGHLIGHTS

Look what your contribution to the levy did in 2015:

- 82% of King County Veterans Program clients with housing goals achieved them.
- $1 from the levy leveraged $17 in other funding for low-income housing.
- 97% of Healthy Start parents increased their parenting skills.

CITIZEN OVERSIGHT

In 2015, the Veterans Citizen Oversight Board and the Regional Human Services Citizen Oversight Board donated more than 200 hours of their time to review the work of the 40 levy-funded programs. Throughout the year, members monitored levy fund expenditures and made recommendations that helped shape planned changes for two levy programs.

To deepen their knowledge, the oversight boards received training on Supporting Young Children Exposed to Trauma and on Military Sexual Trauma. The boards also were briefed on King County's Best Starts for Kids and Regional Veterans Initiative.

FUNDING SPLIT. Levy revenue is divided equally into two parts:

- The Veterans Levy Fund serves veterans, military personnel and their families.
- The Human Services Fund assists other individuals and families in need.

Each fund has a citizen oversight board to ensure that the funds are used effectively.

GOALS. The levy's goals support King County's Strategic Plan, and the "Fair and just" principle of the Equity and Social Justice Initiative. The three levy goals are:

- Prevent and reduce homelessness
- Reduce unnecessary criminal justice and emergency medical system involvement
- Increase self-sufficiency of veterans and vulnerable populations.

STRATEGIES. The levy's Service Improvement Plan sets out four overarching strategies to achieve these goals:

1. Supporting veterans and their families to build stable lives and strong relationships
2. Ending homelessness through outreach, prevention, permanent supportive housing and employment
3. Improving health through the integration of medical and behavioral health services
4. Strengthening families at risk.

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Dear Friend:

We are very pleased to bring you the 2015 Annual Report of the Veterans and Human Services Levy, the fourth year of the 2012–2017 levy. Last year we served almost 37,500 county residents including 7,550 veterans, and made strong progress on the levy's three goals. Levy accomplishments supported the goals of the King County Strategic Plan, especially "Provide opportunities for all communities and individuals to realize their full potential," as well as the "Fair and just" principle of the King County Equity and Social Justice Initiative. Here are a few examples of 2015 achievements in each of the levy's goal areas.

REDUCING HOMELESSNESS:

- Helped 1,527 veterans obtain or maintain housing (Activity 1.1)
- Provided capital funds to create 168 apartments for low-income residents (Activity 2.2).

REDUCING UNNECESSARY USE OF THE CRIMINAL JUSTICE AND EMERGENCY MEDICAL SYSTEMS:

- Achieved cost offsets of an estimated $615,000 through housing placements (Activity 3.6)
- Provided intensive services for 132 homeless individuals with a mental illness who were involved in the criminal justice system (Activity 2.5).

INCREASING SELF-SUFFICIENCY:

- Provided 109 older veterans and spouses who had disabilities and minor depression with in-home counseling to regain as much independence as possible (Activity 3.4)
- Responded to 99,112 calls to the 2-1-1 line, offering referrals to community services that could assist with move-in costs, emergency shelter and other needs (Activity 4.5).

The included Performance Reports show how we track the success of levy-funded programs. Most met their service goals this year. We are also including a report on pages 20–23 that looks back at some of the levy's achievements over the years. This is available online at kingcounty.gov/VHSLevyAchievements.

While the levy-funded services have been effective, we know the needs continue in our communities. The 2016 One Night Count identified 4,500 homeless people without shelter, an increase of more than 700 people from the 2015 One Night Count. Many veterans returning to our communities need assistance, as does our growing population of aging veterans. By 2025, 31 percent of the county's veterans and non-veterans are expected to be age 55 or older, with their service needs only expected to grow as they age. We need to be mindful of these trends as we continue to shape levy services to meet our neighbors' needs.

Thank you for your interest in and continued support of the levy. As you read the stories of people you have helped and review the data in this report, please know that we could not achieve this progress without you!

Sincerely,

Francisco F. Ivarra, Chair
Veterans Citizen
Oversight Board

David Ramsay, Chair
Regional Human Services
Citizen Oversight Board

STRATEGY 1

Supporting Veterans and Their Families to Build Stable Lives and Strong Relationships

Team Clears the Way to Better Life for 41-year-old Vet

Mato, a 41-year-old Army veteran, saw only roadblocks ahead—especially after being booked into the Maleng Regional Justice Center. But it was there he met the Veterans Incarcerated Program's Reentry Case Management (VRCM) team, one of four levy-funded programs that worked together to help Mato get on his feet. The team, managed by the Washington Department of Veterans Affairs (WDVA), explained they could offer him short-term case management for re-entering the community.

Mato's re-entry needs were basic: housing, food, clothing, health care and transportation. The VCRM team got to work while he was still incarcerated, and enrolled him in the U.S. Department of Veterans Affairs (VA) Healthcare System. They also connected with a VA specialist, who found him housing. Then another roadblock arose: Mato was unexpectedly transferred to the Department of Corrections (DOC) Monroe facility for another six months. Undaunted, the VRCM team contacted the DOC community corrections officer and updated Mato's re-entry plan.

Upon Mato's release, the team launched his plan, starting with a levy-supported emergency shelter bed, a clothing gift card, a backpack for his belongings, and an ORCA card for the bus to VA appointments. The team linked him with the King County Veterans Program (KCVP), who enrolled him in the levy's community employment program with the YWCA.

Now Mato is in transitional housing, attending South Seattle College, meeting his legal obligations—and can see a promising road to stability.

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SUPPORTING VETERANS AND THEIR FAMILIES TO BUILD STABLE LIVES AND STRONG RELATIONSHIPS

King County is home to approximately 122,000 veterans and military personnel. Levy funding has helped veterans and their families rebuild strong lives and find services that meet their unique needs. In 2015, Strategy 1 activities helped 5,384 veterans and family members, almost 400 more than in 2014, get medical and behavioral health services, find stable housing and employment, and re-establish or continue a productive life in our communities.

ACTIVITY 1.1

King County Veterans Program

The King County Veterans Program (KCVP) has served low-income, homeless, disabled, and at-risk veterans and their families since the 1950s. Levy funding has enabled KCVP to expand to serve National Guard and Reserves members, and the families of active duty military who were not eligible for other military services. KCVP has supported immediate needs and long-term self-sufficiency. In 2015, KCVP:

- Served 2,532 veterans and family members, more than 900 of whom were homeless when they contacted KCVP.
- Helped 1,527 get or maintain housing.
- Provided $815,411 in emergency financial assistance, 68 percent of which was for housing and utilities.
- Provided case management for 1,829 veterans and family members.
- Helped 80 percent become more self-reliant and 82 percent get jobs.

ACTIVITY 1.2

Veteran Outreach and Engagement

Three levy-funded programs focused on reaching out to veterans in need and helping them connect with housing services, health care and other benefits to rebuild their lives.

Enhanced outreach to women veterans and veterans of color. In 2015, the program's outreach specialists visited shelters and tent cities, and were "dispatched" from the Call Center (see below) to engage 462 homeless veterans. Almost 23 percent were women veterans. The program used the Common Assessment tool (VI-SPDAT)[1], helped 79 percent get benefits with the VA or get housing, and assisted 30 percent with job searches.

Veteran information and referral. The King County Veterans Call and Service Center served 881 veterans in 2015, connecting 874 to veteran-specific resources and referrals. The Call Center number was used by Operation: WelcomeOneHome, as part of action to end veteran homelessness. Center staff participated in veteran-focused resource fairs and workshops, as well.

Homeless Veteran Street Outreach. In 2015, the program conducted outreach in shelters and with veterans living on the streets, completed assessments for 166 homeless veterans and families, and helped 39 households get housing. Referrals successfully linked 86 percent with services.

86% Street outreach assessed **166 homeless vets**, connecting **86 percent** with services.

ACTIVITY 1.3

Veterans Employment and Training

The Vet Corps program's 15 peer mentors served on college campuses across the county in 2015, assessing 114 veterans and helping 61 stay in education or training. A newly created emergency fund provided up to $300 for veteran student needs for books, transportation, housing or campus fees. Levy funding leveraged $260,675 from federal, local and state sources, more than doubling the program's levy budget.

1 The Vulnerability Index–Service Prioritization Decision Assistance Tool (VI-SPDAT) is an evidence-informed tool used nationwide to help determine who is eligible for and in greatest need of housing and support, and the best option to help them.

ACTIVITY 1.4

Post-Traumatic Stress Disorder (PTSD) / Military Sexual Trauma (MST) Treatment

In 2015, the PTSD program provided confidential counseling services free of charge to 250 veterans with war readjustment and PTSD treatment needs, and their family members. Ninety-three percent reported their life had improved since starting services. The program also offered continuing education for direct service providers, and for college and university counseling staff serving veterans. In addition, 169 service providers completed one of 13 trainings to increase their understanding of MST and awareness of referral resources. After the training, 47 percent said they had referred an MST survivor to benefits.

ACTIVITY 1.5

Veterans Justice

The levy provided funding for three programs for veterans involved with the justice system.

Veterans Incarcerated Program (VIP). In 2015, the program screened 328 veterans who were incarcerated and provided short-term re-entry case management[2] to 242 who were incarcerated or at risk of incarceration. Seventy percent of the veterans the program referred to treatment or educational programs followed through with those services. The program's housing referrals were 79 percent successful. Thanks to a County Council action in early 2015, the program was able to begin working with veterans earlier in their incarceration.

Veterans Legal Assistance Program. The program served 201 new veterans in King County and resolved 108 cases. Through its partnership with the VA and a new partnership with King County Regional Justice Detention Center, the program provided free legal services to veterans at a VA clinic and at the jail.

Emerging programs for justice-involved veterans. Of 86 justice-involved veterans whom the levy-funded Veterans Court Clinician screened in 2015, 65 opted into the program, almost double the number opting into the program in 2014. The program helped 62 veterans access services from the VA and other providers. A total of 30 "graduated" from the Seattle Veterans Treatment Court or King County District Court Regional Veterans Court, meaning they had participated in behavioral health treatment and had no new law violations over the roughly two years they were in the court.

> "Highly recommend this program for turning negative circumstances into positive outcomes."
> *– Veterans Treatment Court participant*

ACTIVITY 1.6

Support for Military Families

Recognizing the sacrifices made by families and their importance, the levy supported two programs that helped military and veteran families stabilize their lives. These families are often overlooked by traditional veterans' services.

Military family outreach. In 2015, the program conducted outreach to homeless military families in shelters and to follow up on Call Center requests (see 1.2, above), and conducted 170 assessments using the VI-SPDAT. Case management was key to helping 166 families find emergency, transitional, permanent supportive or market rate housing.

Military family counseling. The program enabled 51 family members and caregivers of veterans to be seen by a mental health provider at no cost, whether or not the veteran was receiving services. This connection was especially important for families of a veteran with PTSD, who can experience a secondary form of that trauma. Ninety-four percent of those served reported an improved quality of life.

2 VIP used a best practice for transition of people with co-occurring disorders in the criminal justice system called the APIC Model (for the steps: Assess, Plan, Identify, Coordinate), along with Motivational Interviewing, an evidence-based practice.

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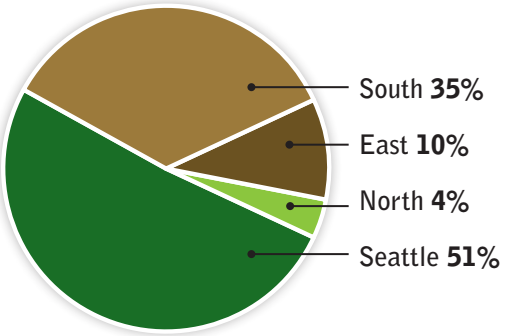
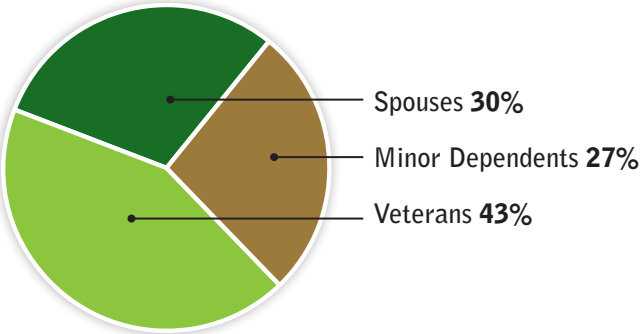
Location of King County Residents Served by Strategy 1



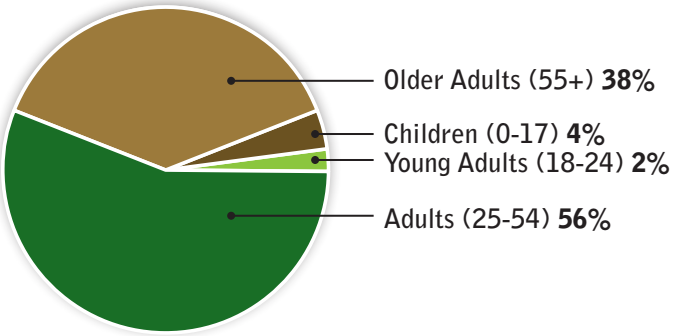
Veterans and families served by Strategy 1 lived throughout the county, with the largest proportion in Seattle and South King County.

PTSD Clients Served



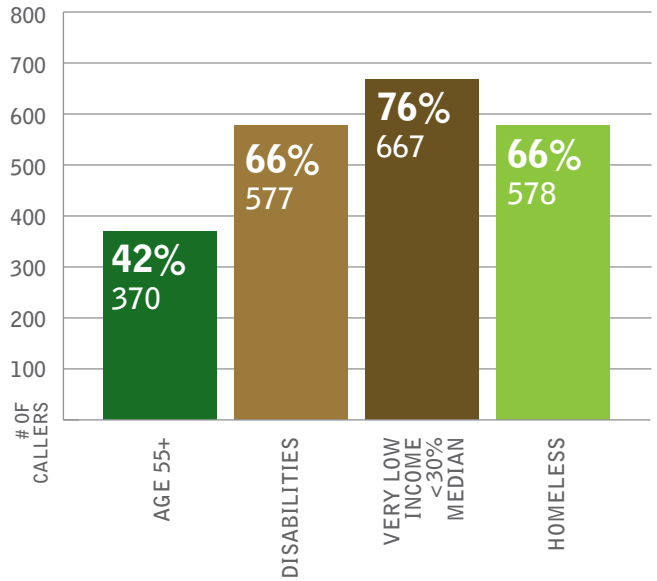
The PTSD / MST program (Activity 1.4) served more veteran family members than veterans.

Age of Veterans and Families Served



More than half of those served by Strategy 1 were age 25 to 54; more than a third were 55 or older.

Selected Characteristics of Callers to Veterans Call Center



Three-quarters of callers to the Veterans Call Center (Activity 1.2) had very low incomes.

STRATEGY 2

Ending Homelessness through Outreach, Prevention, Permanent Supportive Housing and Employment

Phone Call Leads Single Mom to Stable Home

The solution to a big problem often starts with a simple act—in this case, picking up the phone. Lucy was a single mother with one child. She was homeless. She had a job, but with low pay, so had taken out payday loans to fill gaps in her budget. When she got a Section 8 voucher, she thought her troubles were over since the voucher would cover rent and utilities above 30 percent of her income. However, when her prospective landlord learned of Lucy's low credit score, he required a higher-than-normal deposit. Lucy could not pay it and did not want to increase her loans or fall behind on payments.

Then things got worse: Lucy's hours were cut back at work. She was desperate. Lucy heard that the 2-1-1 Community Information Line could steer people in need to local services, so she called. The levy-funded 2-1-1 Line's staff referred Lucy to the Housing Stability Program, a levy-funded program that helps low-income King County residents get into or keep their housing.

The Housing Stability staff assessed Lucy's needs and explained how they could help. She found an apartment she could afford in Redmond. This time, Lucy was able to get the apartment because the Housing Stability Program paid all her move-in fees.

Lucy's call and one-time help from a levy program worked. She has been able to keep up with her payday loan payments *and* her rent. Lucy is thrilled to have a stable home for her child and is working to make their lives better day by day.

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ENDING HOMELESSNESS THROUGH OUTREACH, PREVENTION, PERMANENT SUPPORTIVE HOUSING AND EMPLOYMENT

Homelessness remains a challenge in our county. The 2015 King County One-Night Count found 3,772 people without homes or shelter in our communities. In 2015, levy Strategy 2 continued to focus on making homelessness rare, brief and one-time, and served 8,384 homeless people, over 800 more than in 2014. Of those served in 2015, 1,279 were veterans or their family members.

ACTIVITY 2.1

Outreach and engagement

Many who struggle with homelessness also face health problems and substance abuse, too often relying on expensive emergency services instead of available community services. Levy funds helped four programs reach homeless individuals, gain their trust, and connect them with meals and health care.

Homeless street outreach. The REACH program[3] served 634 homeless people in 2015, of whom 63 moved into or kept stable housing—fewer than anticipated because of the limited availability of appropriate housing. Outreach nurses provided medical services for 523 homeless individuals and connected them to other services. REACH also launched "Lunch and Learn," where up to 12 people gathered weekly to enjoy a family-style meal with peers and discuss such topics as coping with stress.

Dutch Shisler Sobering Center and Emergency Service Patrol (ESP). The ESP continued to patrol downtown Seattle streets for individuals with chronic substance use disorders and to transport them to the Dutch Shisler Sobering Center or other providers. In 2015, ESP served 7,811 persons and transported 5,508 to the Sobering Center. The Sobering Center served as an entry point for other health, housing and recovery support services.

Mobile medical outreach. The mobile medical van brought a health care team to meal sites and other programs for the homeless, serving 837 individuals in 2015. Of 478 who needed mental health treatment, 24 percent went to at least one mental health provider visit. Staff also helped 59 enroll for medical benefits. The program added a chemical dependency clinician to the van's team and doubled the number of dental clinics per month. Levy funding leveraged more than $600,000 in other revenue, a 200 percent increase in the budget.

> Levy funding leveraged more than **$600,000** from other sources for Mobile Medical Outreach.

South King County homeless outreach (PATH). In 2015, the outreach team engaged and assessed the needs of 142 long-term homeless individuals, 66 percent of whom accessed community services, resources and housing as a result. Local jurisdictions and county staff often called on PATH staff for outreach in encampments and problem situations. Levy funds helped leverage $170,000 in other funding—a 200 percent increase in PATH's levy budget.

ACTIVITY 2.2

Capital funds for permanent housing

In 2015, the levy funded creation of 168 units of low-income housing. Each levy dollar leveraged nearly $17 of other public and private funding. August Wilson Place in Bellevue was completed, with 45 levy-funded units, including three for veterans. Construction began on two buildings that will provide 74 units for low-income and homeless adults.

ACTIVITY 2.3

Housing Stability Program

In 2015, the Housing Stability Program helped 511 households made up of 1,273 individuals to maintain or secure housing. Of the households, 139 included veterans. The program provided one-time emergency assistance for housing costs, and helped clients create a budget and action plan to stabilize their housing.

3 REACH used several best-practice models and clinical strategies: Recovery-Oriented Care, Motivational Interviewing, Harm Reduction, Stages of Change, Trauma-Informed Care, and Integrated Treatment.

ACTIVITY 2.4

Support services for permanent housing

Offering supportive services for chronically homeless people who enter housing helped them manage their health issues and achieve a more stable life. The levy supported two programs providing these services.

Housing Health Outreach Team (HHOT). In 2015, HHOT served 927 individuals, 100 more than in 2014, with 98 percent maintaining their housing for at least one year. HHOT reduced emergency system use by linking 392 individuals to primary care and helping 620 improve self-management of chronic health conditions.

On-site support services. The levy provided supportive services[4] in 2015 for 1,007 formerly homeless households now housed in 782 units at 14 housing sites. Of the units, 146 were dedicated to housing veterans. Eighty-four percent maintained their housing for at least one year. A total of 104 also gained at least part-time employment.

ACTIVITY 2.5

Criminal justice initiatives

The levy supported two initiatives that located supportive housing for homeless individuals who had a mental illness and were involved in the criminal justice system.

Forensic Assertive Community Treatment (FACT) program.[5] In 2015, the program served 63 individuals referred from Regional Mental Health Court, including 13 new participants, to help them find housing and begin to stabilize their lives. Four participants graduated to a lesser level of care, and 18 others exited the program. Of those housed, 72 percent were able to retain it or move to other permanent housing.

Forensic Intensive Supportive Housing (FISH) program.[6] The program served 69 homeless individuals referred by the Mental Health Court in 2015, including three new participants; 16 individuals exited, and one graduated. The program connected them to housing and provided supportive services. Eighty-one percent of those housed retained or moved to other permanent housing.

ACTIVITY 2.6

Employment and training

The levy supported three programs to help veterans, homeless and low-income residents move toward self-sufficiency.

$13/hr. Community Employment Services clients found jobs averaging $13/hr.

Community employment services. The program enrolled and served 382 homeless individuals in 2015, of whom 24 percent were veterans. A total of 219 found jobs, increasing their household income by roughly 180 percent. The average starting wage was $13 per hour.

Career Connections. The program served 260 homeless individuals in 2015, of whom 69 were veterans. Participants received assessments of their skills and barriers to employment, and created an action plan. A total of 151 completed training or job readiness milestones, and 90 obtained jobs.

King County Veterans Internship/Fellowship Program. The program received nearly 300 applications for 16 six-month positions, which began in late 2015. The program expanded to provide higher-paying fellowships, along with internships that offered substantive and hands-on experiences in a variety of fields.

ACTIVITY 2.7

Youth/Young Adult Homelessness Plan

The Clear Path to Employment program served 115 homeless young adults in 2015 through job readiness and search assistance, internships, case management and connections to housing services. A total of 85 completed internships or were involved in pre-employment training, and 38 found jobs.

4 The program used the Housing First and Harm Reduction best practice approaches.
5 FACT used the Assertive Community Treatment (ACT) evidence-based model.
6 FISH used evidence-based Integrated Dual Disorder Treatment (IDDT); however not all participants functioned at a high enough level to apply IDDT.

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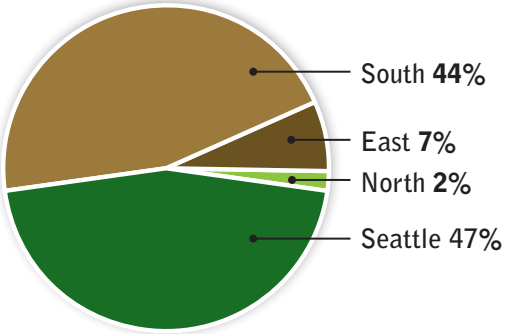
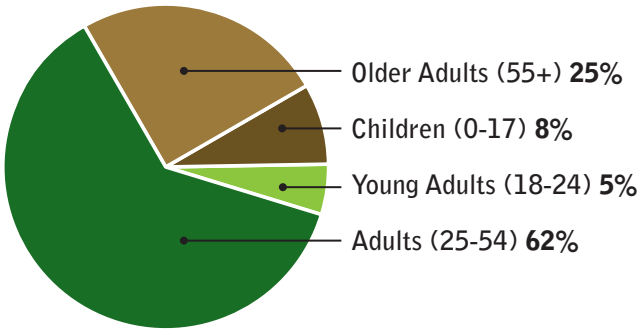
Location of King County Residents Served by Strategy 2



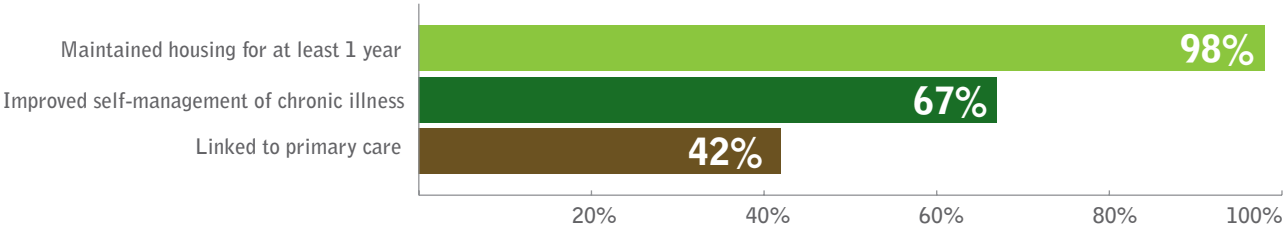
Close to equal proportions of residents served by Strategy 2 lived in South King County and Seattle.

Age of People Served by Strategy 2



More than half of those served by Strategy 2 were adults age 25 to 54; a quarter were 55 or older.

Housing Health Outreach Team Client Successes, 2015



Individuals served for a year by HHOT (Activity 2.4) stabilized their lives.

STRATEGY 3

Improving Health through the Integration of Medical and Behavioral Health Services

Vet Gets Help Climbing Out of Depression "Black Hole"

How do you get out of a "black hole" of depression, family discord, and financial hardship? For Jaime, a 36-year-old Army vet who saw combat during Operation Iraqi Freedom (OIF), climbing out started with a referral to counseling at his medical clinic.

Jaime lived in South King County with his wife and 5-year-old daughter. Though he had a B.A. in technology management, he had been unable to find work. Unemployment caused stress and marital conflict. His daughter started to act out. These pressures added to the depression, anxiety, and recurrent suicidal and homicidal thoughts Jaime had struggled with for years. He was self-medicating with alcohol and marijuana.

Jamie's primary care provider at HealthPoint referred him to the coordinator of their levy-funded behavioral health integration program. Jaime and his wife each received supportive counseling. The Care Coordinator referred Jaime to the King County Veterans Program (KCVP) for job search and emergency financial help. KCVP helped him pay past due bills, assessed his job skills, and gave him a letter of reference.

With more confidence, Jaime went on interviews, and—success!—landed a high-paying job. Now he checks in by phone with the Care Coordinator, has stopped drinking, and is working to quit marijuana. He and his wife are communicating better, and their daughter is happier. Jaime is now emerging into the light and fresh air of a good life.

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IMPROVING HEALTH THROUGH THE INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH SERVICES

Strategy 3 supports the levy goal to reduce unnecessary use of the emergency medical system, and includes both direct services and systems improvements. With integrated primary care and behavioral health services, individuals can become more stable in their communities. In 2015, the activities served a total of 6,642 people, including 726 veterans and their family members.

ACTIVITY 3.1

Behavioral health integration

Integrating behavioral health care into primary care clinics[7] reaches people who might not seek mental health services and reduces the stigma of using these services. A 2008 study estimated a net savings from integration of roughly $1,300 per program participant per year.[8] The levy funded integration programs for low-income adults and for veterans and family members.

Behavioral health integration. In 2015, screenings of 1,818 low-income adults during primary care appointments identified 1,322 with depression, anxiety and/or substance abuse. Of these, 56 percent received at least two visits with a mental health provider in the primary care setting. In follow-up screenings, nearly half showed improvement in their depression or anxiety symptoms.

Behavioral health integration for veterans. In 2015, 672 veterans and family members were screened for depression, anxiety and/or substance abuse in a primary care clinic. Of 225 identified with behavioral health needs, 164 had at least two visits with a provider. In follow-up screenings, 48 percent showed improvement. Care coordinators received training on veteran culture and the services available in King County.

48% Forty-eight percent of veterans attending behavioral health visits showed reduced depression, anxiety and/or substance abuse.

ACTIVITY 3.2

Veteran and trauma competency training

In 2015, this program held 64 workshops on veterans' issues and trauma-informed care, which trained 1,085 treatment professionals and 1,455 service providers and employers. Twenty of the workshops were customized for 13 local employers and agencies. As a result, 79 percent of trainees said they were better able to identify trauma-related issues, and 85 percent to refer veterans for services.

ACTIVITY 3.3

Health care reform system design and implementation

In 2015, this activity supported efforts to enroll low-income individuals in health insurance, and to expand partnerships among health, housing and social services to move from a crisis focus to a wellness and prevention focus. A 2015 report[9] on the results from the first two years of health care reform found that the percentage of uninsured King County adults dropped from 16 percent to 10 percent.

ACTIVITY 3.4

Depression intervention for seniors

In 2015, the Program to Encourage Active, Rewarding Lives (PEARLS)[10] provided in-home counseling to 109 older veterans and spouses of veterans who had disabilities and were experiencing minor depression. Ninety-six percent showed decreased depression symptoms after participating. The program expanded outreach in 2015 to community sites, such as libraries and grocery stores.

7 Integrating mental health services with primary care community clinics is an evidence-based approach called IMPACT Model or collaborative stepped care.

8 Cited in J. Unützer, H. Harbin, M. Schoenbaum, and B. Druss, *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes* (Washington, DC: Centers for Medicare & Medicaid Services) 2013, p. 6.

9 Public Health – Seattle & King County, "Access to Health Care After the Affordable Care Act," July 2015.

10 PEARLS is an evidence-based program to reduce depression and improve quality of life in older adults living in the community.

ACTIVITY 3.5

Facilitation of ongoing partnerships

This activity helped support the work of the Regional Veterans Initiative, which focused in 2015 on reducing homelessness among veterans. A total of 1,045 homeless veterans were identified and assessed, and 845 entered permanent housing.

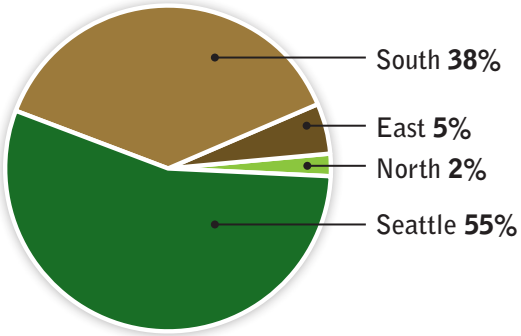
This activity also supported integrating physical and behavioral health as part of the King County Health and Human Services Transformation Plan and state integration requirements. It helped the Integration Design Committee, a multi-sector community-based partnership, design a regional model that will lead to better health and improved outcomes for those receiving these services.

ACTIVITY 3.6

Client care coordination

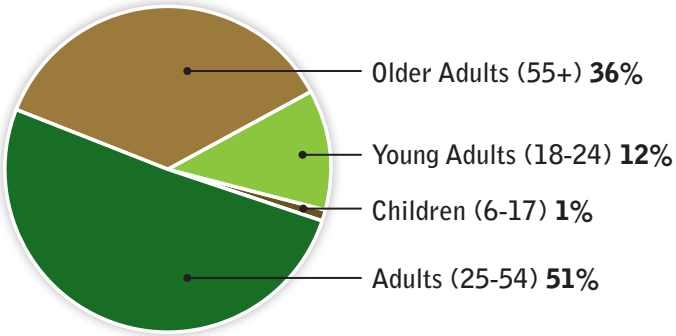
In 2015, the program identified 1,503 individuals, including 458 veterans, as being high users of emergency services, highly vulnerable if remaining on the street, and, therefore, at the top of the list for housing referrals. The program screened 407 individuals referred by service providers, and identified 203 who met the criteria for housing. A total of 94 individuals, 30 of whom were veterans, moved into permanent supportive housing in 2015. Housing placements resulted in almost $615,000 in reduced use of emergency services.

Location of King County Residents Served by Strategy 3



Most of the residents served by Strategy 3 lived in Seattle or South King County.

Ages of People Served by Strategy 3



While Strategy 3 served mainly adults age 25 or older, it also served a sizable percentage of young adults.

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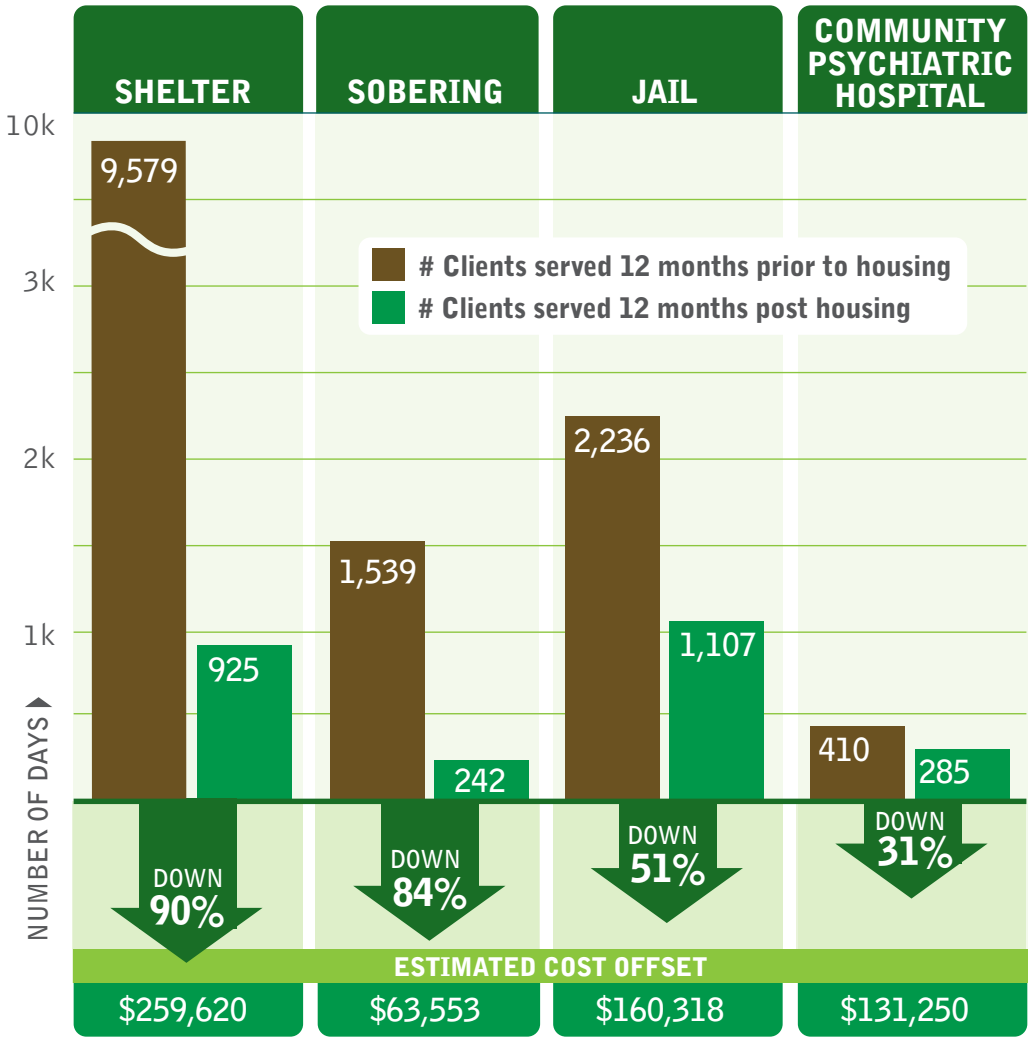
Having a Home Makes a Difference

The Client Care Coordination data tells the story.



Housing programs supported by the levy helped vulnerable individuals reduce their use of costly emergency services.

STRATEGY 4

Strengthening Families at Risk

Mother and Facilitator Persist to Find a Solution

Persistence is an important trait, as a parent and a Kaleidoscope Play & Learn staff facilitator found. Silvia brought her three-year-old daughter, Lety, to one of the 98 Play & Learn groups receiving levy funding. This group was offered in Spanish by the Center for Human Services at its Shoreline Family Center. After several weeks, Silvia took the facilitator aside and confided her worry that Lety was not speaking enough for her age. Silvia spoke Spanish with Lety, but Lety also spent a few days a week with her paternal, Cantonese-speaking grandmother. Could the different languages be causing a problem?

The facilitator explained that while her own children did fine in a bilingual home, an early intervention program could assess Lety's development. She helped Silvia make an appointment. The early intervention therapist conducted part of the assessment at the Play & Learn group, using an interpreter. With Silvia's permission, the facilitator shared with the therapist what she had observed of Lety's speech and behaviors over time.

The therapist found that Lety did have a language delay, though not related to her multilingual upbringing, and recommended Shoreline Schools' developmental preschool. Silvia enrolled Lety at the preschool. Silvia and Lety are also continuing at Play & Learn, and enjoy its supportive community. Silvia has high praise for Play & Learn, and thanks the day she and the facilitator decided to take extra steps to make sure Lety got the help she needed.

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STRENGTHENING FAMILIES AT RISK

Strategy 4 focused on prevention and early intervention to help families and individuals avoid or reduce crises and build strong lives. In 2015, Strategy 4 helped 16,673 county residents, of whom 161 were veterans. Levy programs served young parents, people returning to the community after prison, and people seeking services of all kinds.

ACTIVITY 4.1

Home visiting

The levy provided funds to two evidence-based programs to help low-income, first-time parents in pregnancy or with very young children to stabilize their lives and support their child's healthy development in the crucial first few years of life.

Nurse Family Partnership (NFP).[11] In 2015, the levy supported NFP services for 100 of the program's 1,305 low-income, first-time parents from pregnancy to age 2 of the child. Two-thirds were living in South King County, with the majority "couch surfing" with friends or relatives. Fourteen parents gained employment or an education credential.

Healthy Start.[12] In 2015 the program provided home visits to 369 young, first-time, mostly low-income parents making up 150 families in East and North King County. Ninety-seven percent increased their parenting skills or delayed a subsequent birth, allowing time for the family to become more stable. Levy support helped leverage funding from several cities and foundations.

ACTIVITY 4.2

Maternal depression reduction

In 2015, 2,090 pregnant and parenting mothers received screening at their primary care clinic for depression, anxiety and substance abuse. Of 843 who showed symptoms, 628 had at least two visits with a mental health provider at the clinic, with 69 percent showing improvement as a result. Building the mothers' self-care skills and helping them connect with support systems were important factors in their success.

ACTIVITY 4.3

Parent education and support

The levy supported two programs that helped parents learn how to promote their child's healthy development and learning.

> The mom says she has a better understanding now of her own as well as her child's needs.
>
> – *PFR trainee*

Promoting First Relationships (PFR) Train the Learner Program.[13] In 2015, 14 staff from seven different social service agencies completed PFR training, and three trained as Agency Trainers. After a two-day workshop and a video-discussion series, trainees used PFR for 10 weeks to help a family support their child's social/emotional development and increase their parenting skills.

Family, Friend and Neighbor Play & Learn Groups.[14] In 2015, there were 98 Play & Learn groups that served a total of 4,046 families. Forty-five new facilitators were trained. The groups with the most growth met in libraries and schools, or offered multiple languages. Eighty percent of participating parents and caregivers said they read or told stories to their child more often because of what they had learned. Levy funding leveraged additional funding from school districts.

11 NFP is an evidence-based program to improve birth outcomes, reduce child abuse and neglect, improve school readiness, and increase family self-sufficiency.

12 Healthy Start is an accredited affiliate of Parents as Teachers (PAT), an evidence-based program to prevent child abuse and neglect, promote health, and increase parental involvement.

13 PFR is an evidence-based program to promote healthy child/caregiver relationships.

14 The Kaleidoscope Play & Learn program has received Promising Practice status from the University of Washington's Evidence Based Practices Institute.

ACTIVITY 4.4

Passage Point

In 2015, the program helped 62 households to transition from prison to stability and, where possible, to reunite with their children. The program provided employment support and family therapy onsite, and transportation to offsite appointments. Twelve households graduated to permanent housing; one moved into transitional housing.

ACTIVITY 4.5

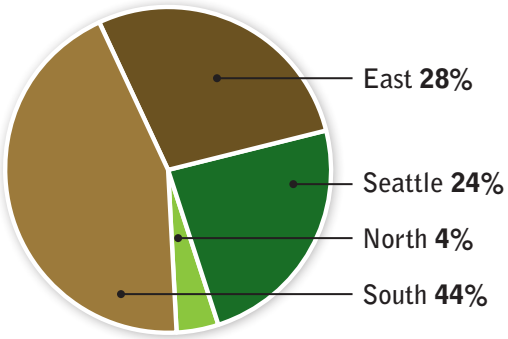
Information and Referral

The levy supported two programs that helped residents find local services they needed.

2-1-1 Community Information Line. In 2015, the program responded to 99,112 calls and made referrals to community services, most often related to housing. More than 1,300 calls were conducted in Spanish by a bilingual staff member, and more than 2,200 other calls were handled in more than 50 other languages by an interpreter service. In 2015, King County 2-1-1 was chosen as a central access point for those age 60 or older, approximately 15 percent of callers.

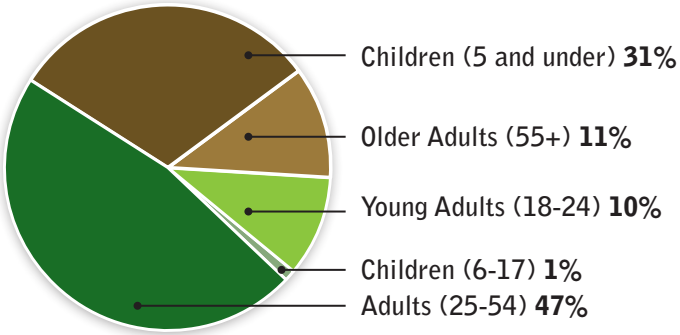
Cultural Navigator. In 2015, the program's three service sites in Kent, Bellevue and Redmond helped 1,904 individuals from 778 primarily immigrant, refugee and low-income households to access local resources to maintain their self-sufficiency. Navigators provided services in Chinese, Spanish, Russian and Southeast Indian languages. The program also provided technical assistance to 258 agencies. Levy funding leveraged more than $96,000 from three Eastside cities, doubling the program's levy budget and increasing program capacity.

Location of King County Residents Served by Strategy 4



The largest percentage of those served by Strategy 4 lived in South King County, with nearly equal percentages in East King and Seattle.

Ages of People Served by Strategy 4



Children accounted for almost a third of those served by Strategy 4.

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2015 Performance and Evaluation Report

The 2012–2017 levy Service Improvement Plan identified outcome and output targets for each levy activity. Activity managers reported twice a year on their progress.

PERFORMANCE MEASUREMENT AND EVALUATION ACTIVITIES IN 2015

- Worked closely with contractors and program managers to develop targets and analyze performance.
- Updated the 2012–2017 Levy Evaluation Framework for 2015.
- Prepared the 2015 Mid-Year Performance Update. As needed, developed corrective action plans with project directors.
- Played a key role in developing regional indicators and performance dashboards for housing, employment and education, and veterans' programs.
- Analyzed year-end data and reports for the nearly 40 levy activities.
- Updated the Communities Count indicators related to housing, food, income, early childhood and equity.

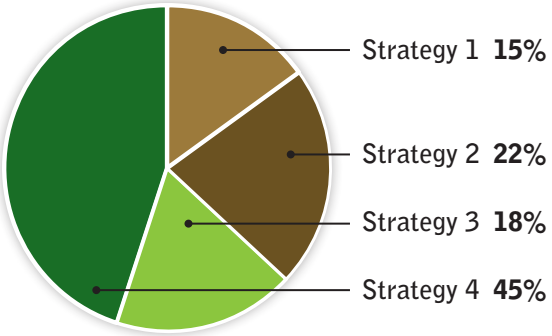
LEVY BY THE NUMBERS

The next four pages offer a look back at key levy accomplishments since 2007.

2015 PERFORMANCE REPORT

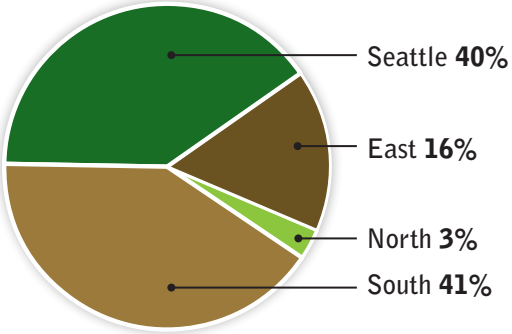
The 2015 Performance Management Report (pp. 24–27) is organized by the four levy strategies and shows each activity's results compared to its targets. All but five of the activities achieved at least 85 percent of their targets. Recognizing the levy's stewardship of public resources, this year's performance report includes a column on effectiveness—what difference the activity made in the lives of those served.

People Served in 2015, by Strategy



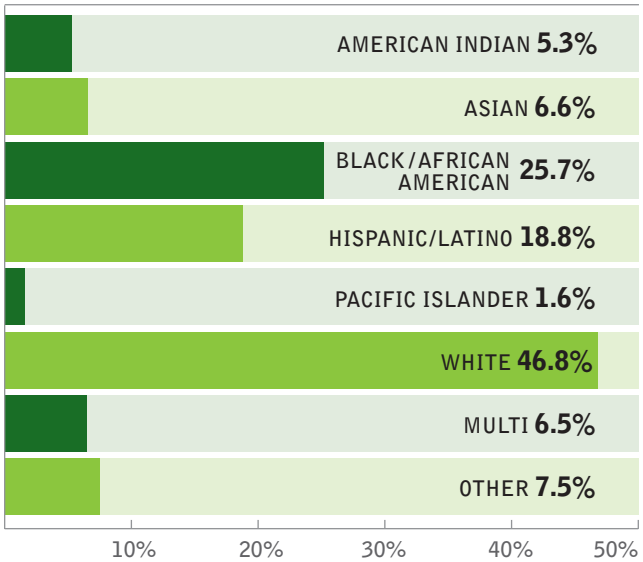
Strategy 4 served the most people in 2015.

Location of People Served in 2015



The levy served people across King County.

Percent Served in 2015 by Race/Ethnicity



The largest racial/ethnic groups of those served in 2015 were white, black/African American and Hispanic/Latino.

THE LEVY BY THE NUMBERS

A LOOK BACK

HIGHLIGHTS:

OVER $7,000,000 in cost offsets achieved through housing placements

2,000+ low-income housing units created since 2006

80% increase in self-sufficiency after clients were linked to services

In 2005, King County voters approved a property tax measure creating regional health and human services funds to assist veterans and their families and others in need. In 2011, voters then renewed the levy through 2017. The tax of 5 cents per $1,000 of assessed property value generates about $18 million annually and supports a broad array of services.

Guided by a Service Improvement Plan and with oversight from two citizen boards, the levy's revenues are divided equally between services for veterans and their families, and services for others in need. Services are aligned to help achieve the three primary goals of the levy, which are:

- Prevent and reduce homelessness
- Reduce unnecessary criminal justice and emergency medical system involvement
- Increase self-sufficiency of veterans and vulnerable populations.

The 40 activities funded to help meet these goals are grouped into four overarching strategies:

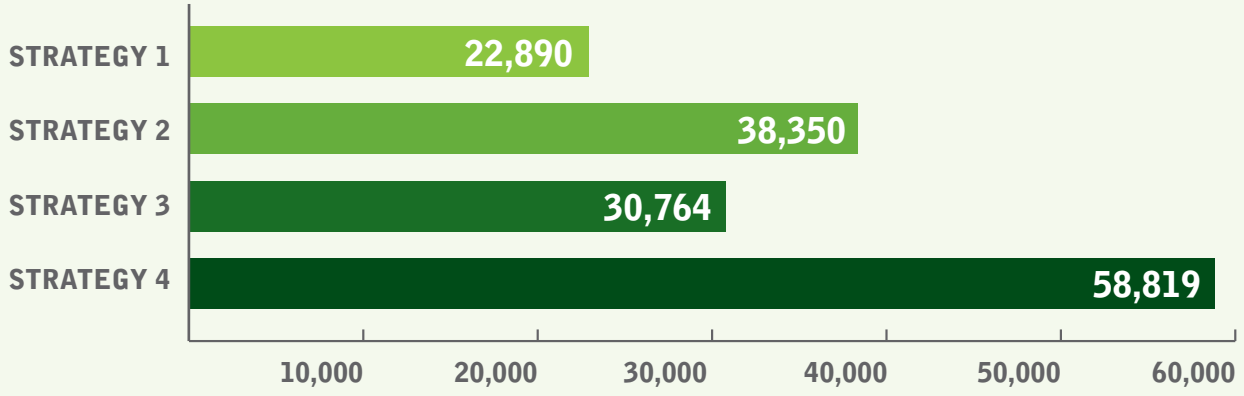
STRATEGY 1: SUPPORTING VETERANS

STRATEGY 2: ENDING HOMELESSNESS

STRATEGY 3: IMPROVING HEALTH

STRATEGY 4: STRENGTHENING FAMILIES

CLIENTS SERVED BY STRATEGY 2012–2015



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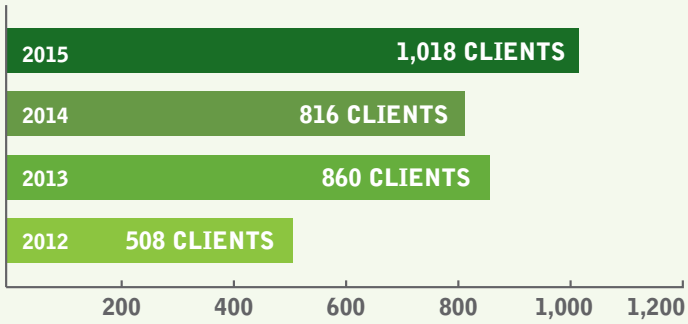
GOAL 1: PREVENT AND REDUCE HOMELESSNESS

The Veterans and Human Services Levy has supported efforts to end homelessness in King County since 2006. Many of these efforts share a common objective: maintaining clients in housing, or moving or "exiting" people to other permanent housing.

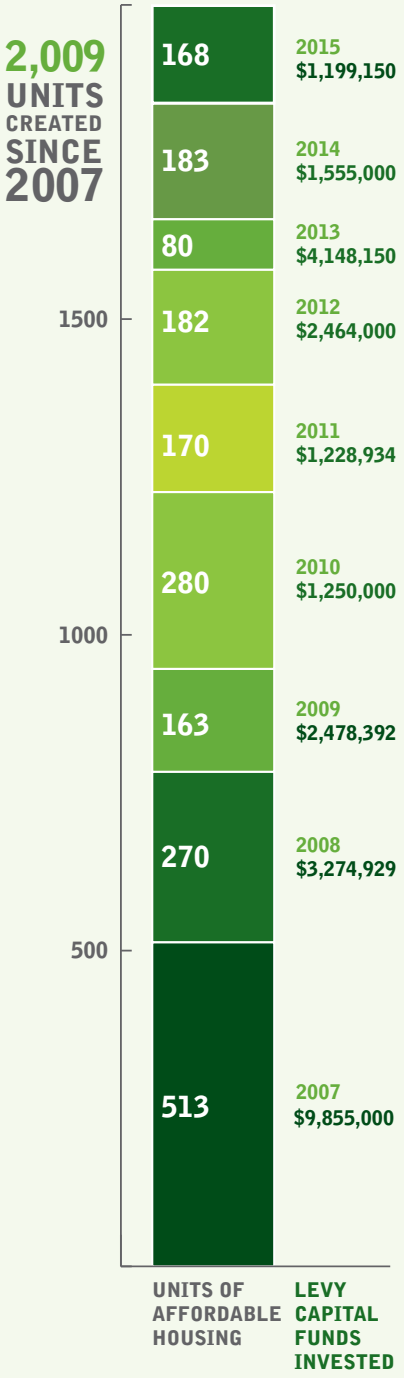
Each year since 2012, the levy has helped almost 88 percent of clients in levy-funded housing programs either maintain their housing or enter permanent housing.

CLIENTS IN LEVY FUNDED HOUSING PROGRAMS MAINTAIN OR EXIT TO PERMANENT HOUSING



800 AVERAGE NUMBER OF FORMERLY HOMELESS CLIENTS THAT MAINTAINED PERMANENT HOUSING EACH YEAR

About 40 percent of the levy's annual revenue is dedicated to preventing and reducing homelessness through outreach, prevention, and permanent supportive housing and employment activities. Fifteen of the levy's activities support this goal.



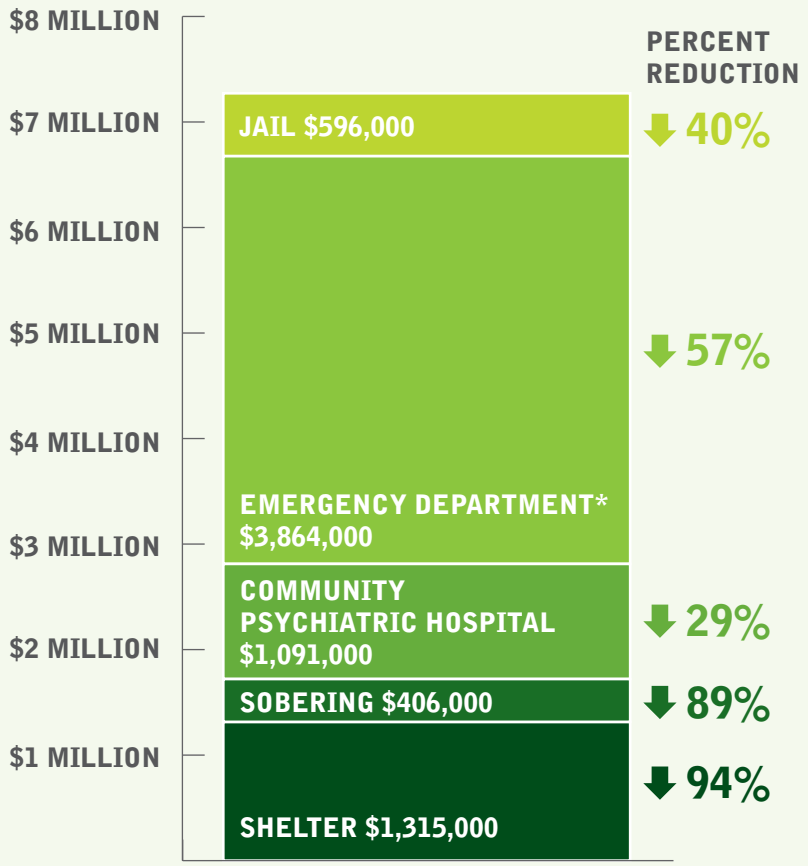
Every year since 2006, the levy has awarded funds to developers of low-income housing to increase the availability of housing in King County. Levy support helped steadily increase the number of units.

GOAL 2: REDUCE UNNECESSARY CRIMINAL JUSTICE AND EMERGENCY MEDICAL INVOLVEMENT

The levy's second goal focuses on reducing emergency medical and criminal justice involvement by stabilizing homeless individuals, particularly those with disabling conditions, in housing with supportive services.

Since 2012 an average of 780 clients were stabilized in programs each year reducing their emergency medical and criminal justice involvement.

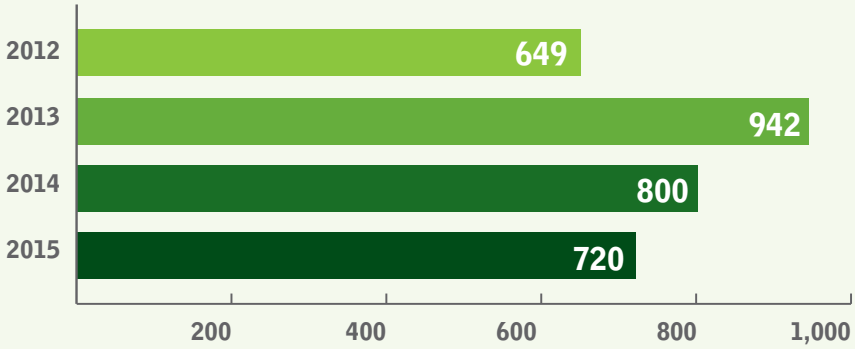
REDUCED USE OF SERVICES AND COST OFFSETS 2012-2015



One levy-funded activity, Client Care Coordination (CCC), maintained a database of homeless individuals who were high users of public services and tracked their use of these services one year before and one year after they were housed. The clients' use of services declined after they were placed in housing. The CCC calculated the cost offsets associated with this decline and found that since 2012, estimated cost offsets were over $7 million.

*Emergency Department data is not available for 2015.

NUMBER OF CLIENTS STABILIZED



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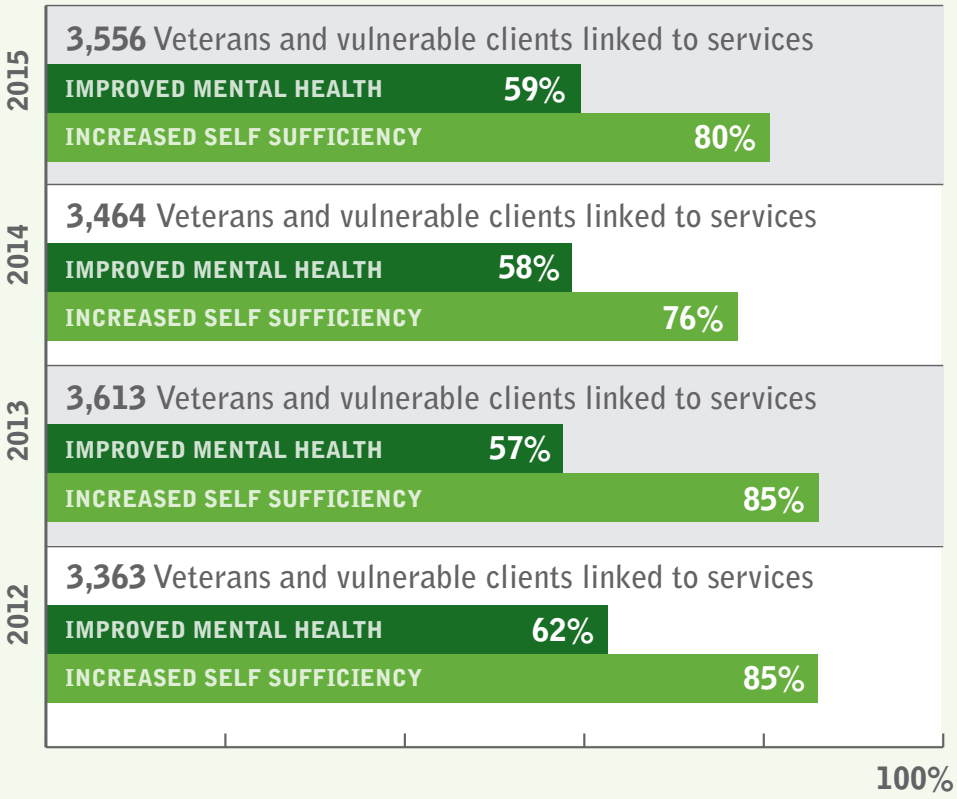
GOAL 3: INCREASE SELF-SUFFICIENCY OF VETERANS AND VULNERABLE POPULATIONS

The levy supports an array of programs designed to assist individuals to become more stable and self-sufficient in their communities. Eight levy-funded outreach programs identify and link vulnerable individuals to services, helping over 3,000 veterans and other vulnerable individuals find the help they need each year.

Five levy-supported mental health programs such as Post-traumatic Stress Disorder (PTSD) counseling, the Mental Health Integration Program embedded in community health clinics and in-home treatment of mild depression in older adults, have been successful in improving clients' lives. The same is true of the King County Veterans Program's intensive case management service that regularly assesses veterans' progress in meeting personal goals and their movement toward self-sufficiency.

Since 2013, 86 percent of individuals engaged were successfully linked to services.

LEVY IMPACT ON CLIENTS' LIVES, BY YEAR



Every year since 2012, levy services have improved the lives of veterans, their families and others in need.

2015 Performance Management Reports

LEVY ACTIVITY		Household members 2015*	HOW MUCH SERVICE WAS PROVIDED AND HOW WELL DID LEVY SERVICES DO?					
			Service Measures	2015 Targets	Actual 2015 Performance	% Target Reached**		What difference did the service make in the lives of clients?
STRATEGY 1: SUPPORTING VETERANS								
1.1.A	KCVP - satellite site outreach	2,532	Satellite site service contacts	750	653	↑	87%	Clients of satellite services are linked to KCVP case management at Renton.
1.1.B	KCVP - contracted shelter services		Emergency shelter bed nights / Transitional housing bed nights	13,505	11,869	↑	88%	69% of KCVP homeless clients provided shelter were able to transition to permanent housing or treatment.
1.1.C	King County Veterans Program (KCVP) financial assistance		Financial assistance recipients	1,800	1,471	→	82%	82% of veterans with housing goals achieved them. 93% of those seeking employment were able to secure jobs. 80% of all clients were able to increase their self-sufficiency.
			Total levy and State RCW assistance	$892,875	$815,411	↑	91%	
1.1.D	KCVP - employment, and case management		New client assessments	1,800	2,458	↑	137%	
			New case plans created	1,650	1,829	↑	111%	
1.2.A	Enhanced outreach to women veterans and veterans of color	337	Number of clients engaged in outreach	420	462	↑	110%	79% of veterans were able to successfully secure benefits or housing.
			Clients applying for benefits/services	330	346	↑	105%	
1.2.B	Veteran information and referral	881	Number of information and referral clients	900	881	↑	98%	97% of clients referred, successfully linking to services.
			Number of clients receiving referrals to services	850	874	↑	103%	
1.2.C	Homeless veteran street outreach	166	Number of veterans engaged and assessed	183	166	↑	91%	86% of clients receiving referral were linked with services. 39 successful housing placements.
1.3	Veteran employment and training	142	Number of veterans assessed	108	114	↑	106%	61 of 86 veterans were able to stay in school or keep their job due to Vet Corps support.
			Number of veterans placed in jobs or education training	86	61	→	71%	
1.4	Contracted PTSD Treatment / Military Sexual Trauma treatment	780	Hours of individual and group counseling	2,600	3,281	↑	126%	93% clients demonstrated increased resolution of PTSD trauma. 47% of the trainees reported making a MST client referral to benefits and services post training.
			Number of clients in counseling (unduplicated)	260	250	↑	96%	
			Professionals trained in MST identification and referral	84	169	↑	201%	
1.5.A	Veterans Incarcerated Program (VIP)	328	Number of veterans screened	360	328	↑	91%	70% of referrals to treatment or education were successful. 79% of referrals to housing were successful.
			Number of veterans enrolled (with 2014 carryover)	155	242	↑	156%	
1.5.B	Veterans Legal Assistance Program	201	Initial case assessments	200	201	↑	101%	108 veterans needing legal assistance had their cases successfully resolved.
			Case referrals for services to outside counsel	150	112	→	75%	
1.5.C	Emerging programs for justice involved veterans - Veterans Court	86	Number of veterans screened	90	86	↑	96%	30 veterans graduated from treatment court in 2015, having met all of their goals over the two-year program.
			Number of veterans opting in to program	30	65	↑	217%	
			Veterans accessing services from the VA and other providers	15	62	↑	413%	
1.6.A	Military family outreach	170	Number of households completing assessment	150	170	↑	113%	94% of families reduced the impact of deployment of a spouse or partner.
			Number of referrals made	75	74	↑	99%	
			Number of referred clients connected to services	60	166	↑	277%	
1.6.B	Military family counseling	139	Number of hours of counseling	350	531	↑	152%	93.5% of family members and caregivers had improved quality of life and reduced PTSD.
			Number of military family members served	55	51	↑	93%	
TOTAL STRATEGY 1 CLIENTS SERVED 2015: 5,762								

* Includes all members of a family and may be larger or smaller than "clients served" depending on the data source.
** ↑ Indicates meeting 85% or more of target; → Indicates 65% – 85%; no activity met less than 65% target.

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LEVY ACTIVITY		Household members 2015*	HOW MUCH SERVICE WAS PROVIDED AND HOW WELL DID LEVY SERVICES DO?					
			Service Measures	2015 Targets	Actual 2015 Performance	% Target Reached**		What difference did the service make in the lives of clients?
STRATEGY 2: ENDING HOMELESSNESS								
2.1.A	Homeless street outreach (REACH)	634	Number of clients engaged by REACH	380	634	↑	167%	70% of clients needing treatment or services were linked. However, there is limited access to appropriate permanent housing.
			Clients enrolled in treatment/services/health care	365	523	↑	143%	
			Clients moved into or remained stabilized in housing	80	63	→	79%	
2.1.B	Dutch Shisler Sobering Center Emergency Service Patrol	2,529	Number of persons contacted (duplicated)	5,000	7,811	↑	156%	1,819 individuals were transported to either detox, Crisis Solution Center or housing, protecting them from harm on the streets.
			Number of clients (duplicated) transported to Sobering Center	3,600	5,508	↑	153%	
2.1.C	Mobile medical outreach	837	Clients receiving services from mobile medical van	700	837	↑	120%	837 individuals received health care, 59 enrolled in medical benefits, 113 had at least one visit with a mental health professional.
			Total visits for medical care or psychiatric social worker	1,150	1,889	↑	164%	
2.1.D	South King County homeless outreach (PATH)	142	Number of clients engaged in service	125	142	↑	114%	66% of homeless clients were linked to housing or support services.
2.2	Capital funds for permanent housing		Housing units funded in 2015	N/A	168		N/A	2,009 units created since 2007.
2.3	Housing Stability Program	1,273	Number of unduplicated non-veteran households	143	372	↑	260%	95% retention of housing at 6 months.
			Number of unduplicated veteran households	136	139	↑	102%	
2.4.A	Health Housing Outreach Team (HHOT)	927	Number of clients linked to primary care	400	392	↑	98%	98% of HHOT clients are able to maintain housing for at least a year.
			Number of clients served	700	927	↑	132%	
			Number of clients self-managing chronic condition	315	620	↑	197%	
2.4.B	On-site support services	1,137	Case management/Housing support hours	57,112	63,900	↑	112%	83.7% of the households served retained their housing or moved to other permanent housing.
			Total number of households served	N/A	1,007		N/A	
2.5.A	Forensic Assertive Community Treatment program (FACT)	63	Clients engaged in services but not housed	16	15	↑	94%	72% of those housed were able to retain it or move to other permanent housing.
			Clients moved into or maintained in supportive housing	44	48	↑	109%	
2.5.B	Forensic Intensive Supportive Housing program (FISH)	69	Clients moved into or maintained in supportive housing	51	58	↑	114%	81% of those housed were able to retain it or move to other permanent housing.
			Total clients served	64	69	↑	108%	
2.6.A	Community employment services	382	Number of homeless clients enrolled	301	382	↑	127%	Average employed household increased income by 180%, from $9,700 to $27,336.
			Number of job placements	189	219	↑	116%	
2.6.B	Career Connections	260	Number of clients completing job readiness and training	150	151	↑	101%	90% of job placements resulted in increased self-sufficiency.
			Number of clients served	150	260	↑	173%	
			Number of clients obtaining new jobs	85	90	↑	106%	
2.6.D	King County Internship Program for Veterans	16	Number of clients assessed	50	282	↑	564%	After a revamp in Spring 2015, new interns entered when program relaunched in Fall 2015.
			Number of clients entering internship program	16	16	↑	100%	
2.7	Youth/Young Adult Homelessness Plan	115	Number of clients served	100	115	↑	115%	38 homeless youth secured jobs.
			Number of job placements or pre-employment training	90	85	↑	94%	
TOTAL STRATEGY 2 CLIENTS SERVED 2015: 8,384								

* Includes all members of a family and may be larger or smaller than "clients served" depending on the data source.
** ↑ Indicates meeting 85% or more of target; → Indicates 65% – 85%; no activity met less than 65% target.

LEVY ACTIVITY		Household members 2015*	HOW MUCH SERVICE WAS PROVIDED AND HOW WELL DID LEVY SERVICES DO?					
			Service Measures	2015 Targets	Actual 2015 Performance		% Target Reached**	What difference did the service make in the lives of clients?
STRATEGY 3: IMPROVING HEALTH								
3.1.A	Behavioral health integration	1,818	Number of persons screened	2,000	1,818	↑	91%	49% of clients in treatment reduced depression or anxiety symptoms.
			Total number of all clients receiving treatment	1,500	1,322	↑	88%	
3.1.B	Behavioral health integration for veterans	672	Veterans or dependents screened for PTSD/MH issues	450	672	↑	149%	48% reduced mental health symptoms--impressive for a low-income, chronically mentally ill population.
			Number of veterans or their dependents enrolled	225	225	↑	100%	
3.2	Veteran and trauma competency training	2,540	Number of mainstream providers trained	748	1,455	↑	195%	More providers trained than expected - all targets exceeded.
			Number of professionals trained	752	1,085	↑	144%	
			Number of training sessions	64	64		100%	
3.4	Depression intervention for seniors (PEARLS)	109	Older adults/veterans who completed the PEARLS program	82	86	↑	105%	96% of measured clients achieved reduced depression/anxiety.
			Older adults/veterans enrolled in the PEARLS program	110	109	↑	99%	
3.6	Client Care Coordination (CCC)***	1,503	Number of clients with high system utilization/ vulnerability and referred for possible tenancy	225	203	↑	90%	94 individuals moved into Client Care designated housing units.
			Number of persons in the database meeting system utilization/ vulnerability requirements	1,000	1,503	↑	150%	
TOTAL STRATEGY 3 CLIENTS SERVED 2015: 6,642								

* Includes all members of a family and may be larger or smaller than "clients served" depending on the data source.
** ↑ Indicates meeting 85% or more of target; ➡ Indicates 65% – 85%; no activity met less than 65% target.
*** Number of household memberes is lower than reported for 2014 due to improved reporting methods.

LEVY ACTIVITY		Household members 2015*	HOW MUCH SERVICE WAS PROVIDED AND HOW WELL DID LEVY SERVICES DO? Service Measures	2015 Targets	Actual 2015 Performance	% Target Reached**	What difference did the service make in the lives of clients?
STRATEGY 4: STRENGTHENING FAMILIES							
4.1.A.1	Nurse Family Partnership (NFP)	174	Number of persons enrolled	100	100	↑ 100%	Levy funded NFP clients exceeded all national NFP standards and had lower attrition rate than national performance.
4.1.A.2	NFP employment	45	Number of persons enrolled in Employment and Education Resources (EER)	40	45	↑ 113%	14 NFP parents either gained employment or earned an education credential in 2015.
			Number of persons entering education or training	30	39	↑ 130%	
4.1.B	Healthy Start	369	Number of new persons/households assessed	300	369	↑ 123%	97% of parents increased their positive parenting skills or delayed birth of their second child.
			Clients receiving home visits	300	370	↑ 123%	
			Number of home visits	1,400	1,490	↑ 106%	
4.2	Maternal depression reduction	2,403	Number of persons screened	2,800	2,090	➡ 75%	69% of measured clients showed decreased depression and anxiety, exceeding national standards.
			Total number of clients receiving treatment	400	628	↑ 157%	
			Number of persons who screened positive for depression	400	843	↑ 211%	
4.3.A	Parent education and support - Promoting First Relationships (PFR)	14	Number of agency learners delivering PFR intervention	12	14	↑ 117%	100% of families were able to demonstrate increased ability to support their child's healthy development.
			Number of community members showing improved skills and knowledge	12	14	↑ 117%	
4.3.B	Family, Friend and Neighbor Play & Learn Groups	8,665	Number of facilitators educated in play and learn	32	45	↑ 141%	80% of parents improved caregiver, parenting skills. There were 21 new groups in 2015.
			Number of play and learn groups	90	98	↑ 109%	
4.4	Passage Point	126	Number of new households and carryover enrolled	60	62	↑ 103%	90% remained stable for 6 months. Twelve households moved into housing.
4.5.A	2-1-1 Community Information Line	2,973	Number of callers	3,300	2,973	↑ 90%	99,112 calls received. Targets prorated to portion supported by Levy.
4.5.B	Cultural Navigator	1,904	Number of clients receiving information and referral	1,000	1,904	↑ 190%	97% of clients were able to access resources.
			Number of agencies receiving technical assistance	250	258	↑ 103%	
TOTAL STRATEGY 4 CLIENTS SERVED 2015: 16,673							

* Includes all members of a family and may be larger or smaller than "clients served" depending on the data source.
** ↑ Indicates meeting 85% or more of target; ➡ Indicates 65% – 85%; no activity met less than 65% target.

2015 Financial Reports

Veteran Levy Funds by Strategy

Service Improvement Plan (SIP) Strategy		2015 Adopted SIP Budget	Supplemental & Budget Ordinance 17941 & 18110	Adjustments†	Total Operating Budget	2015 Expenditure
STRATEGY 1: SUPPORTING VETERANS AND THEIR FAMILIES TO BUILD STABLE LIVES AND STRONG RELATIONSHIPS						
1.1	King County Veterans Program	$2,485,000	$–	$(210,000)	$2,275,000	$2,114,586
1.2	Outreach and engagement					
A	Enhanced outreach to women veterans and veterans of color	$300,000	$–	$(50,000)	$250,000	$250,000
B	Veteran information and referral	$100,000	$–	$–	$100,000	$100,000
C	Homeless veterans street outreach	$84,000	$–	$–	$84,000	$84,000
1.3	Veterans employment and training	$200,000	$–	$–	$200,000	$200,000
1.4	Contracted PTSD treatment/Military Sexual Trauma	$400,000	$–	$152,000	$552,000	$552,000
1.5	Veterans justice					
A	Veterans Incarcerated Program	$100,000	$–	$–	$100,000	$100,000
B	Veterans Legal Assistance Program	$20,000	$–	$60,000	$80,000	$80,000
C	Emerging programs for justice involved veterans	$330,000	$–	$–	$330,000	$330,000
1.6	Support for military families					
A	Military family outreach	$174,000	$–	$–	$174,000	$174,000
B	Military family counseling	$100,000	$–	$–	$100,000	$100,000
Total Strategy 1		$4,293,000	$–	$(48,000)	$4,245,000	$4,084,586
STRATEGY 2: ENDING HOMELESSNESS THROUGH OUTREACH, PREVENTION, PERMANENT SUPPORTIVE HOUSING & EMPLOYMENT						
2.1	Outreach and engagement					
A	Homeless street outreach	$86,000	$–	$–	$86,000	$86,000
B	Sobering/Emergency Services Patrol	$45,000	$–	$–	$45,000	$45,000
C	Mobile medical outreach	$90,000	$–	$–	$90,000	$90,000
D	South King County homeless outreach	$15,000	$–	$–	$15,000	$15,000
2.2	Housing capital	$725,000	$–	$–	$725,000	$725,000
2.3	Housing Stability Program	$400,000	$–	$15,000	$415,000	$415,000
2.4	Support services for housing					
A	Housing Health Outreach Team	$75,000	$–	$–	$75,000	$75,000
B	On–site support services	$450,000	$–	$–	$450,000	$450,000
2.5	Criminal Justice Initiatives					
A	FACT	$63,000	$–	$(1,250)	$61,750	$61,750
B	FISH	$210,000	$–	$(13,500)	$196,500	$196,500
2.6	Employment and training					
A	Community employment services	$120,000	$–	$–	$120,000	$120,000
B	Career Connections	$120,000	$–	$–	$120,000	$120,000
C	Aerospace and Veteran Employment Training Initiative	$–	$–	$–	$–	$–
D	King County Internship Program for Veterans	$–	$100,000	$–	$100,000	$100,000
2.7	Youth/Young Adult Homelessness Plan	$–	$–	$–	$–	$–
Total Strategy 2		$2,399,000	$100,000	$250	$2,499,250	$2,499,250
STRATEGY 3: IMPROVING HEALTH THROUGH THE INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH SERVICES						
3.1	Behavioral health integration					
A	Behavioral health integration	$–	$–	$–	$–	$–
B	Behavioral health integration–veterans	$600,000	$–	$–	$600,000	$600,000
3.2	Veteran and trauma competency training	$200,000	$–	$–	$200,000	$200,000
3.3	Health care reform system design and implementation	$25,000	$–	$–	$25,000	$25,000
3.4	Depression intervention for seniors	$178,000	$–	$–	$178,000	$178,000
3.5	Facilitation of ongoing partnerships	$70,000	$62,000	$107,750	$239,750	$132,000
3.6	Client care coordination	$40,000	$–	$–	$40,000	$40,000
Total Strategy 3		$1,113,000	$62,000	$107,750	$1,282,750	$1,175,000
STRATEGY 4: STRENGTHENING FAMILIES AT RISK*						
Evaluation 5		$257,500	$–	$–	$257,500	$257,500
Total Program		$8,062,500	$162,000	$60,000	$8,284,500	$8,016,336
Admin 6		$428,040	$–	$–	$428,040	$428,040
Board Support 7		$70,264	$–	$–	$70,264	$70,264
GRAND TOTAL		$8,560,804	$162,000	$60,000	$8,782,804	$8,514,640
Percent Expended						**97%**

† Includes reallocations to ensure maximum expenditure
* Strategy 4 receives no Veterans Levy funds.

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Human Services Levy Funds by Strategy

Service Improvement Plan (SIP) Strategy		2015 Adopted SIP Budget	Supplemental & Budget Ordinance 17941 & 18110	Adjustments†	Total Operating Budget	2015 Expenditure
STRATEGY 1: SUPPORTING VETERANS AND THEIR FAMILIES TO BUILD STABLE LIVES AND STRONG RELATIONSHIPS*						
STRATEGY 2: ENDING HOMELESSNESS THROUGH OUTREACH, PREVENTION, PERMANENT SUPPORTIVE HOUSING & EMPLOYMENT						
2.1	Outreach and engagement					
A	Homeless street outreach	$190,000	$–	$–	$190,000	$190,000
B	Sobering/Emergency Services Patrol	$100,000	$–	$–	$100,000	$100,000
C	Mobile medical outreach	$210,000	$–	$–	$210,000	$210,000
D	South King County homeless outreach	$65,000	$–	$–	$65,000	$65,000
2.2	Housing capital	$830,000	$–	$–	$830,000	$830,000
2.3	Housing Stability Program	$400,000	$–	$–	$400,000	$400,000
2.4	Support services for housing					
A	Housing Health Outreach Team	$240,000	$–	$–	$240,000	$240,000
B	On–site support services	$850,000	$–	$–	$850,000	$850,000
2.5	Criminal Justice Initiatives					
A	FACT	$142,000	$–	$–	$142,000	$142,000
B	FISH	$480,000	$–	$(31,500)	$448,500	$448,500
2.6	Employment and training					
A	Community employment services	$550,000	$–	$–	$550,000	$550,000
B	Career Connections	$300,000	$–	$–	$300,000	$300,000
C	Aerospace and Veteran Employment Training Initiative	$–	$–	$–	$–	$–
D	King County Internship Program for Veterans	$–	$–	$–	$–	$–
2.7	Youth/Young Adult Homelessness Plan	$–	$250,000	$–	$250,000	$250,000
Total Strategy 2		$4,357,000	$250,000	$(31,500)	$4,575,500	$4,575,500
STRATEGY 3: IMPROVING HEALTH THROUGH THE INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH SERVICES						
3.1	Behavioral health integration					
A	Behavioral health integration	$625,000	$579,000	$–	$1,204,000	$1,204,000
B	Behavioral health integration–veterans	$–	$–	$–	$–	$–
3.2	Veteran and trauma competency training	$50,000	$–	$–	$50,000	$50,000
3.3	Health care reform system design and implementation	$245,000	$–	$–	$245,000	$245,000
3.4	Depression intervention for seniors	$178,000	$–	$–	$178,000	$178,000
3.5	Facilitation of ongoing partnerships	$70,000	$–	$–	$70,000	$70,000
3.6	Client care coordination	$100,000	$–	$–	$100,000	$100,000
Total Strategy 3		$1,268,000	$579,000	$–	$1,847,000	$1,847,000
STRATEGY 4: STRENGTHENING FAMILIES AT RISK						
4.1	Home Visiting					
A	Nurse Family Partnership	$470,000	$–	$90,700	$560,700	$562,100
B	Healthy Start	$270,000	$–	$–	$270,000	$270,000
4.2	Maternal depression reduction	$625,000	$–	$–	$625,000	$625,000
4.3	Parent education and support	$260,000	$–	$(59,200)	$200,800	$200,800
4.4	Passage Point	$415,000	$–	$–	$415,000	$415,000
4.5	Information and referral					
A	2–1–1 Community Information Line	$50,000	$–	$–	$50,000	$50,000
B	Cultural Navigator	$70,000	$–	$–	$70,000	$70,000
Total Strategy 4		$2,160,000	$–	$31,500	$2,191,500	$2,192,900
Evaluation 5		$287,500	$–	$–	$287,500	$276,984
Total Program		$8,072,500	$829,000	$–	$8,901,500	$8,892,384
Admin 6		$423,040	$–	$–	$423,040	$423,040
Board Support 7		$65,264	$–	$–	$65,264	$51,146
GRAND TOTAL		$8,560,804	$829,000	$–	$9,389,804	$9,366,570
Percent Expended						**100%**

† Includes reallocations to ensure maximum expenditure
* Strategy 1 receives no Human Services Levy funds.

Combined Levy Funds by Strategy

Service Improvement Plan (SIP) Strategy		2015 Adopted SIP Budget	Supplemental & Budget Ordinance 17941 & 18110	Adjustments†	Total Operating Budget	2015 Expenditure
STRATEGY 1: SUPPORTING VETERANS AND THEIR FAMILIES TO BUILD STABLE LIVES AND STRONG RELATIONSHIPS						
1.1	King County Veterans Program	$2,485,000	$–	$(210,000)	$2,275,000	$2,114,586
1.2	Outreach and engagement					
A	Enhanced outreach to women veterans and veterans of color	$300,000	$–	$(50,000)	$250,000	$250,000
B	Veteran information and referral	$100,000	$–	$–	$100,000	$100,000
C	Homeless veterans street outreach	$84,000	$–	$–	$84,000	$84,000
1.3	Veterans employment and training	$200,000	$–	$–	$200,000	$200,000
1.4	Contracted PTSD treatment/Military Sexual Trauma	$400,000	$–	$152,000	$552,000	$552,000
1.5	Veterans justice					
A	Veterans Incarcerated Program	$100,000	$–	$–	$100,000	$100,000
B	Veterans Legal Assistance Program	$20,000	$–	$60,000	$80,000	$80,000
C	Emerging programs for justice involved veterans	$330,000	$–	$–	$330,000	$330,000
1.6	Support for military families					
A	Military family outreach	$174,000	$–	$–	$174,000	$174,000
B	Military family counseling	$100,000	$–	$–	$100,000	$100,000
Total Strategy 1		$4,293,000	$–	$(48,000)	$4,245,000	$4,084,586
STRATEGY 2: ENDING HOMELESSNESS THROUGH OUTREACH, PREVENTION, PERMANENT SUPPORTIVE HOUSING & EMPLOYMENT						
2.1	Outreach and engagement					
A	Homeless street outreach	$276,000	$–	$–	$276,000	$276,000
B	Sobering/Emergency Services Patrol	$145,000	$–	$–	$145,000	$145,000
C	Mobile medical outreach	$300,000	$–	$–	$300,000	$300,000
D	South King County homeless outreach	$80,000	$–	$–	$80,000	$80,000
2.2	Housing capital	$1,555,000	$–	$–	$1,555,000	$1,555,000
2.3	Housing Stability Program	$800,000	$–	$15,000	$815,000	$815,000
2.4	Support services for housing					
A	Housing Health Outreach Team	$315,000	$–	$–	$315,000	$315,000
B	On–site support services	$1,300,000	$–	$–	$1,300,000	$1,300,000
2.5	Criminal Justice Initiatives					
A	FACT	$205,000	$–	$(1,250)	$203,750	$203,750
B	FISH	$690,000	$–	$(45,000)	$645,000	$645,000
2.6	Employment and training					
A	Community employment services	$670,000	$–	$–	$670,000	$670,000
B	Career Connections	$420,000	$–	$–	$420,000	$420,000
C	Aerospace and Veteran Employment Training Initiative	$–	$–	$–	$–	$–
D	King County Internship Program for Veterans	$–	$100,000	$–	$100,000	$100,000
2.7	Youth/Young Adult Homelessness Plan	$–	$250,000	$–	$250,000	$250,000
Total Strategy 2		$6,756,000	$350,000	$(31,250)	$7,074,750	$7,074,750
STRATEGY 3: IMPROVING HEALTH THROUGH THE INTEGRATION OF MEDICAL AND BEHAVIORAL HEALTH SERVICES						
3.1	Behavioral health integration					
A	Behavioral health integration	$625,000	$579,000	$–	$1,204,000	$1,204,000
B	Behavioral health integration–veterans	$600,000	$–	$–	$600,000	$600,000
3.2	Veteran and trauma competency training	$250,000	$–	$–	$250,000	$250,000
3.3	Health care reform system design and implementation	$270,000	$–	$–	$270,000	$270,000
3.4	Depression intervention for seniors	$356,000	$–	$–	$356,000	$356,000
3.5	Facilitation of ongoing partnerships	$140,000	$62,000	$107,750	$309,750	$202,000
3.6	Client care coordination	$140,000	$–	$–	$140,000	$140,000
Total Strategy 3		$2,381,000	$641,000	$107,750	$3,129,750	$3,022,000
STRATEGY 4: STRENGTHENING FAMILIES AT RISK						
4.1	Home Visiting					
A	Nurse Family Partnership	$470,000	$–	$90,700	$560,700	$562,100
B	Healthy Start	$270,000	$–	$–	$270,000	$270,000
4.2	Maternal depression reduction	$625,000	$–	$–	$625,000	$625,000
4.3	Parent education and support	$260,000	$–	$(59,200)	$200,800	$200,800
4.4	Passage Point	$415,000	$–	$–	$415,000	$415,000
4.5	Information and referral					
A	2–1–1 Community Information Line	$50,000	$–	$–	$50,000	$50,000
B	Cultural Navigator	$70,000	$–	$–	$70,000	$70,000
Total Strategy 4		$2,160,000	$–	$31,500	$2,191,500	$2,192,900
Evaluation 5		$545,000	$–	$–	$545,000	$534,484
Total Program		$16,135,000	$991,000	$60,000	$17,186,000	$16,908,720
Admin 6		$851,080	$–	$–	$851,080	$851,080
Board Support 7		$135,528	$–	$–	$135,528	$121,410
Veterans Total		$8,560,804	$162,000	$60,000	$8,782,804	$8,514,640
Human Services Total		$8,560,804	$829,000	$–	$9,389,804	$9,366,570
GRAND TOTAL		$17,121,608	$991,000	$60,000	$18,172,608	$17,881,210
Percent Expended						**98%**

† Includes reallocations to ensure maximum expenditure

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THE VETERANS AND HUMAN SERVICES LEVY IS CARRIED OUT IN PARTNERSHIP WITH:

Abused Deaf Women's Advocacy Services
African American Elders Project
Area Agency on Aging – City of Seattle Aging and Disability Services
Atlantic Street Center
Auburn Youth Resources
Catholic Community Services
Catholic Housing Services
Center for Human Services
Child Care Resources
Children's Home Society of Washington
Chinese Information and Service Center
City of Seattle
Community Health Plan
Community House Mental Health Agency
Community Psychiatric Clinic
Compass Housing Alliance
Congregations for the Homeless
Country Doctor Community Health Centers
Crisis Clinic
Downtown Action to Save Housing (DASH)
Downtown Emergency Services Center
Eastside Interfaith Social Concerns Council
El Centro de la Raza
Encompass
Evergreen Treatment Services
First Place
Foundation for the Challenged
Friends of Youth
Harborview Medical Center
Health Care for the Homeless Network
HealthPoint
Hopelink
Imagine Housing
International Community Health Services
International Drop-in Center
Kindering
King County Behavioral Health Safety Net Consortium
Low-Income Housing Institute
Muckleshoot Indian Tribe
Multi-Service Center
Navos
Neighborcare Health
Neighborhood House
Northshore Youth & Family Services
Northwest Justice Project
Pioneer Human Services
Plymouth Housing Group
Projects for Assistance in Transition from Homelessness (PATH)
Provail
Public Health – Seattle & King County
Puget Sound Educational Service District
Renton Area Youth & Family Services
Renton Housing Authority
Salvation Army – Seattle
SeaMar Community Health Centers
Seattle Indian Health Board
Seattle Jobs Initiative
Senior Services (now Sound Generations)
Solid Ground
Sound Mental Health
South King County Early Intervention Program
Terry Home
Therapeutic Health Services
TRAC Associates
United Indians of All Tribes
United Way of King County
University of Washington
Valley Cities Counseling and Consultation
Vashon HouseHold
Vashon Youth & Family Services
Veterans Training Support Center
Washington State Department of Veterans Affairs
Wellspring Family Services
Wonderland Development Center
YouthCare
Youth Eastside Services
YMCA
YWCA of Seattle–King County–Snohomish County

For a list of partners awarded levy funds by strategy, go to **kingcounty.gov/VHSLevyPartners.**

What do you think?
Please give us your comments on the levy programs and how your money is being spent. Go to **kingcounty.gov/VHSLevyInput.**

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EXHIBIT 1

VETERANS AND HUMAN SERVICES LEVY 2015 ANNUAL FINANCIAL REPORT

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2015 / 2016 Biennial Financial Plans

Veterans and Family Levy Fund 1141

Human Services Levy Fund 1142

Financial Plans Narrative

Changes to Service Improvement Plan

2012 – 2017 Updated Service Improvement Plan Allocation Table

2015/2016 Financial Plan - 4th Quarter 2015, Quarterly Monitoring
Veterans Services Levy Fund/000001141

Category	2013/2014 Actuals[1]	2015/2016 Adopted Budget[2]	2015/2016 Current Budget[3]	2015/2016 Biennial-to-Date Actuals[4]	2015/2016 Estimated[5]	2017/2018 Projected[6]	2019/2020 Projected[6]
Beginning Fund Balance	**3,898,587**	**1,765,400**	**2,361,096**	**2,361,096**	**2,361,096**	**1,716,410**	**2,052,612**
Revenues							
Veterans and Family Levy Millage	16,653,440	17,679,651	17,634,704	8,721,859	17,634,704	19,704,965	21,518,274
Interest Earnings	69,934	22,608	22,608	19,464	22,608	22,608	22,608
Veterans Service Shared Resources[7]		90,698	90,698				
Total Revenues	**16,723,374**	**17,792,957**	**17,748,010**	**8,741,323**	**17,657,312**	**19,727,573**	**21,540,882**
Expenditures							
Salaries, Wages & Benefits	(2,930,217)	(3,635,538)	(3,635,538)	(1,408,932)	(3,635,538)	(3,893,661)	(4,193,473)
Supplies and Other	(182,745)	(251,568)	(251,568)	(131,787)	(251,568)	(251,568)	(251,568)
Central Rates	(1,373,501)	(1,533,415)	(1,712,415)	(812,461)	(1,712,415)	(1,852,833)	(2,004,765)
Contracted Services	(12,568,337)	(11,133,717)	(11,133,717)	(6,002,684)	(11,133,717)	(11,734,938)	(12,462,504)
Participants Costs	(1,206,065)	(1,165,762)	(1,165,762)	(685,969)	(1,165,762)	(1,228,713)	(1,304,893)
Total Expenditures	**(18,260,865)**	**(17,720,000)**	**(17,899,000)**	**(9,041,833)**	**(17,899,000)**	**(18,961,713)**	**(20,217,204)**
Estimated Underexpenditures							
Other Fund Transactions							
Transfer to KCVP Shared Resources[7]					(402,998)	(429,658)	(461,920)
Total Other Fund Transactions	**-**	**-**	**-**	**-**	**(402,998)**	**(429,658)**	**(461,920)**
Ending Fund Balance	2,361,096	1,838,357	2,210,106	2,060,586	1,716,410	2,052,612	2,914,370
Reserves							
Reserve for Encumbrances/Committed Projects[8]					(80,000)		
Cash Flow Reserve(s)							
Rate Stabilization Reserve(s)							
Rainy Day Reserve (60 days)[9]		(1,476,666)	(1,491,584)	(753,486)	(1,525,166)	(1,615,948)	(1,723,260)
Total Reserves	**-**	**(1,476,666)**	**(1,491,584)**	**(753,486)**	**(1,605,166)**	**(1,615,948)**	**(1,723,260)**
Reserve Shortfall	-	-	-	-	-	-	-
Ending Undesignated Fund Balance	**2,361,096**	**361,691**	**718,522**	**1,307,100**	**111,244**	**436,664**	**1,191,110**

Financial Plan Notes

[1] 2013/2014 Actuals reflect year end information from EBS and are consistent with the Budgetary Fund Balance figures published by FBOD.

[2] 2015/2016 Adopted Budget is based on ordinance 17941.

[3] 2015/2016 Current Budget includes supplemental appropriations approved through Council ordinances.

[4] 2015/2016 Biennial-to-Date Actuals reflects actual revenues and expenditures as of 12/31/2015, using EBS report GL 10.

[5] 2015/2016 Estimated reflects updated revenue and expenditure estimates as of 12/31/2015, and the impact of any proposed, but not approved supplementals.

[6] Outyear projections assume revenue and expenditure growth off of the 2015/2016 estimated column, based PSB's July 2016 planning assumptions. Exceptions include one-time projects incurred in 2015-2016.

[7] Budgeted revenues and expenditures now included in the total amount transferred to the shared KCVP fund (other fund transactions).

[8] Expenditure reserve for committed 2016 NW Justice Center Project.

[9] Rainy Day Reserve is calculated based on 60 days of actual expenditures.

[10] This plan was updated by Sam Ezeonwu on 03/15/2016.

2015/2016 Financial Plan - 4th Quarter 2015, Quarterly Monitoring
Human Services Levy Fund/000001142

Category	2013/2014 Actuals[1]	2015/2016 Adopted Budget[2]	2015/2016 Current Budget[3]	2015/2016 Biennial-to-Date Actuals[4]	2015/2016 Estimated[5]	2017/2018 Projected[6]	2019/2020 Projected[6]
Beginning Fund Balance	**2,546,724**	**1,423,244**	**1,645,863**	**1,645,863**	**1,645,863**	**1,005,145**	**1,415,964**
Revenues							
Veterans and Family Levy Millage	16,653,440	17,679,650	17,634,704	8,708,575	17,634,704	19,704,965	21,518,274
Interest Earnings	69,696	11,578	11,578	14,871	11,578	11,578	11,578
Total Revenues	**16,723,136**	**17,691,228**	**17,646,282**	**8,723,446**	**17,646,282**	**19,716,543**	**21,529,852**
Expenditures							
Salaries, Wages & Benefits	(820,969)	(1,129,586)	(1,129,586)	(631,644)	(1,129,586)	(1,209,787)	(1,302,940)
Supplies and Other	(40,110)	(168,746)	(168,746)	(14,806)	(168,746)	(168,746)	(168,746)
Central Rates	(695,723)	(754,822)	(754,822)	(130,390)	(754,822)	(816,717)	(883,688)
Contracted Services	(16,067,195)	(15,654,846)	(16,233,846)	(8,589,730)	(16,233,846)	(17,110,474)	(18,171,323)
Total Expenditures	**(17,623,997)**	**(17,708,000)**	**(18,287,000)**	**(9,366,570)**	**(18,287,000)**	**(19,305,724)**	**(20,526,697)**
Estimated Underexpenditures							
Other Fund Transactions							
Total Other Fund Transactions	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Ending Fund Balance	1,645,863	1,406,472	1,005,145	1,002,739	1,005,145	1,415,964	2,419,119
Reserves							
Expenditure Reserve (s)							
Cash Flow Reserve(s)							
Rate Stabilization Reserve(s)							
Rainy Day Reserve (60 days)[7]		(1,475,666)	(1,523,916)	(780,548)	(1,523,916)	(1,608,810)	(1,710,558)
Total Reserves	**-**	**(1,475,666)**	**(1,523,916)**	**(780,548)**	**(1,523,916)**	**(1,608,810)**	**(1,710,558)**
Reserve Shortfall	-	69,194	518,771	-	518,771	192,846	-
Ending Undesignated Fund Balance	**1,645,863**	**-**	**-**	**222,191**	**-**	**-**	**708,561**

Financial Plan Notes.

[1] 2013/2014 Actuals reflect year end information from EBS and are consistent with the Budgetary Fund Balance figures published by FBOD.

[2] 2015/2016 Adopted Budget is based on ordinance 17941.

[3] 2015/2016 Current Budget includes supplemental appropriations approved through Council ordinances 18110.

[4] 2015/2016 Biennial-to-Date Actuals reflects actual revenues and expenditures as of 12/31/2015, using EBS report GL 10.

[5] 2015/2016 Estimated reflects updated revenue and expenditure estimates as of 12/31/2015, and the impact of any proposed, but not approved supplementals.

[6] Outyear projections assume revenue and expenditure growth off of the 2015/2016 estimated column, based PSB's July 2016 planning assumptions. Exceptions include planned changes in expenditure patterns, such as transfer to Public Health for NAVOS project.

[7] Rainy Day Reserve is calculated based on 60 days of actual expenditures.

[8]This plan was updated by Sam Ezeonwu on 03/15/2016.

As required by Ordinance 17200 an updated detailed financial plan for the Veterans and Family Levy and Human Services Levy is included as part of the 2015 annual report package. The package includes the following:

1) **Actual and projected revenue and expenditures for the veterans and regional human services funds for each year of the levy and cumulatively for the life of the current levy:**

   The adjusted Service Improvement Plan budget for the Veterans and Human Services (VHS) Levy for 2015 was $18,174,008 of which $8,782,804 was Veterans Levy funding and $9,391,204 was Human Services Levy funding. This amount includes $991,000 in supplemental funding received of which $162,000 was Veterans Levy supplemental funding and $829,000 was Human Services Levy supplemental funding. Of the Veterans Levy funding, $162,000 was included in the 2015 supplemental budget ordinance. Of the Human Services Levy funding, a total of $829,000 was included in the 2015 supplemental budget ordinance.

2) **Total amount of funding expended to date by strategy, substrategy, activity or program:**

   Of the $18,174,008 adjusted budget, a total of $17,881,210 was expended. A total of $292,798 (two percent) was not expended of which $268,164 was Veterans Levy funding and $24,634 was Human Services Levy funding. Recommendations for use of these funds will be submitted in the 2016 supplemental budget ordinance. See pages 28-30 of the Veterans and Human Services Levy: 2015 Annual Report for details on expenditure by strategy, substrategy, activity or program.

3) **Total amount of funding committed to date by strategy, substrategy, activity or program:**

   A total of $18,174,008 in funding was committed of which $8,782,804 was Veterans Levy funding and $ 9,391,204 was Human Services Levy funding. This includes funds committed by Letter of Award, Contract and/or Memorandum of Agreement (MOA), the Service Improvement Plan, as well as funds committed to enhance the services provided by the King County Veterans Program. See pages 28-30 of the Veterans and Human Services Levy: 2015 Annual Report for details.

4) **Explanation of changes from the previous year's financial plan and changes from the projected budget:**

The 2015 Budget Ordinance included supplemental funding totaling $991,000 of which $162,000 was Veterans Levy Supplemental funding and $829,000 was Human Services supplemental funding.

5) All levy operation and administrative costs:

Levy operation and administrative costs are listed on pages 28-30 of the Veterans and Human Services Levy: 2015 Annual Report.

6) Administration and fiscal staff:

As of December 31, 2015, the administration and fiscal staff supported by the Levy totaled seven (7.0) full-time equivalents.

7) 2015 Contracts:

As of December 31, 2015 the Community Services Division (CSD) had the following contracts in place: two internal Memoranda of Agreement with King County agencies and 60 subcontracts with community providers.

8) Additional Financial Management Practices Update

To better track expenditures of 2012-2017 VHS Levy funds, the CSD implemented improved procedures that include timely monitoring of contract and program expenditure variances. VHS Levy Service Improvement Plan (SIP) expenditure variances are reviewed and analyzed on a monthly basis by the levy fiscal staff and program administrators. On a quarterly basis, SIP expenditure variances are discussed and analyzed with input from program and contract managers from the responsible County agencies. As reported above, a total of $292,798 (two percent) of committed funds were not expended during 2015 of which $268,164 was Veterans Levy funding and $24,634 was Human Services Levy funding.

			2012		2013		2014		2015		2016		2017		Outcome	Council
Date	**Activity**	**Description of Change**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**		**Notification**
2/13	1.5 A Veterans Incarcerated Program	$50,000 of annual SIP allocation moved from 1.5 A to 1.5C Emerging programs for justice-involved vets	$ 50,000		$ 50,000		$ 50,000		$ 50,000		$ 50,000		$ 50,000		SIP Allocation Table revised. See columns 2012-2017 fpr Activities 1.5 A & C. Plans were modified.	Through 2012 Levy Annual Report
9/12	1.2 A Enhanced Outreach to Women Veterans and Veterans of Color	2012 Supplemental Budget Ordinance appropriation	$ 75,000												SIP Allocation Table revised. See columns 2012-2017 for Activities 1.4, 1.6 B; 2.1 C; 2.2; 2.4 B; 2.6 A, 2.6 C and 2.6 D. Plans either exit or were created.	Through 2012 Supplemental Budget Ordinance
	1.4 PTSD Treatment /MST Counseling	"	$ 50,000		$ 200,000		$ 200,000									
	2.1 C Mobile Medical Unit	"	$ 115,000	$ 260,000												
	2.2 Housing Capital & Services	"	$ 2,300,000													
(1)	2.4 B Housing /Supportive Services - Youth & Young Adult (YYA)	"		$ 173,127	$ 210,000	$ 435,873										
	2.6 A Community Employment Services - Friends of Youth	"		$ 35,000												
	2.6 C Aerospace & Veterans Employment Training (new activity)	"	$ 237,294	$ 79,098	$ 635,184	$ 136,728	$ 627,522	$ 134,174								
	2.6 D Veterans Internship Program (new activity)	"	$ 33,333		$ 100,000		$ 66,667									
11/13	1.6 B Military Family Counseling	2012 Supplemental Budget Ordinance & 2013/2014 Budget Ordinance			$ 100,000										SIP Allocation Table revised. See columns 2012-2017 for Activities 1.6 B; 2.4 C; 2.7; and 3.4. Plans either exist or were created.	Notified through 2012 Supplemental Budget Ordinance
(2)	2.4 **C** Bridge Program for YYA	"				$ 100,000										
	2.7 YYA Homelessness Plan Private Fund Match (new activity)	"				$ 136,000		$ 144,000								
	3.4 Depression Intervention for Seniors	"				$ 66,000										
11/14	3.5 Facilitation of Community Partnerships/ PAO Family Advocate for Involuntary Treatment Act clients	Striker Amendment to 2013 Budget Ordinance & transfer of unspent 2012 funds to GL						$ 81,000							SIP Allocation Table revised. See column 2014, Activity 3.5: Facilitation of Community Partnerships.	Notified through Ordinance 17696

(1) A total of $101,873 of the $275,000 in Veterans Levy supplemental funds allocated in 2012 to Activity 2.4 B Youth and Young Adult was carried over to 2013 for Auburn Youth Resources.
(2) A total of $100,000 allocated to 2.4 C Bridge Program for YYA is included under 2.4 B Onsite supportive services in the 2013 Levy Annual Report, Financial Report: Human Services Levy, Supplemental and Budget Ordinance column.

			2012		2013		2014		2015		2016		2017		Outcome	Council
Date	**Activity**	**Description of Change**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**		**Notification**
11/14 (cot'd)	3.5 Facilitation of Community Partnerships/ Regional Veterans Initiative (RVI)	Unspent 2012 VL funds ($326,902) and unspent 2013 VL funds ($61,545) reallocated to 3.5 for RVI					$ 388,447								SIP Allocation Table revised. See columns 2014 Activity 3.5: Facilitation of Community Partnerships.	Through Ordinance 17696
	4.5 A 2-1-1 Community Information Line	Unspent 2013 funds reallocated						$ 12,875							SIP Allocation Table revised. See column 2014 for Activity 4.5.A	Through 2014 Levy Annual Report
12/15	4.3 Parent Education & Support	$59,200 identified as unexpendable. Transferred to 4.1.A Nurse Family Partnership (NFP) for Employment & Education Resouces(EER) services						$ (59,200)		$ (59,200)		$ (59,200)		$ (59,200)	SIP Allocation Table revised. See column 2014 for Activity 4.3	Through 2014 Levy Annual Report
11/14 & 12/14	4.1.A Nurse Family Partnership / Employment & Education Resources (EER)	Unspent 2013 HS funds reallocated ($60K), 2.5.B FISH 2014 HS funds ($24,500)identified as being unspent by year end reallocated, and $59,200 annually of SIP allocation reallocated from 4.3 Promoting First Relationships for EER services.						$ 143,700		$ 59,200		$ 59,200		$ 59,200	SIP Allocation Table revised. See columns 2014-2017 for Activities 4.1.B and 4.3. Plans revised.	Through 2014 Levy Annual Report
12/14	2.5.B FISH	$60K identified as unexpendable by 2014 year-end. Reallocated $32,500 to 2.6.B Career Connections & $24,500 to 4.1.A NFP/EER services.					$ (18,000)	$ (42,000)							SIP Allocation Table revised. See columns 2014-2017 for Activities 4.1.B and 4.3. Plans revised.	Through 2014 Levy Annual Report
12/14	2.6.B Career Connections	Received $32.5K of 2014 allocation for 2.5.B FISH that was identified as being unspent by year-end.					$ 15,000	$ 17,500							SIP Allocation Table revised. See columns 2014-2017 for Activities 4.1.B and 4.3. Plans revised.	Through 2014 Levy Annual Report
12/14	3.6 Client Care Coordination	$16K identified as unexpendable by year end was reallocated to 1.5.B Northwest Justice Project					$ (16,000)								SIP Allocation Table revised. See columns 2014-2017 for Activities 4.1.B and 4.3. Plans revised.	Through 2014 Levy Annual Report
12/14	1.5.B Northwest Justice Project	Received $19K of 2014 allocation from Client care Coordination ($16K) and 2.5.B FISH ($3K) that was identified as being unspent by year-end.					$ 19,000								SIP Allocation Table revised. See columns 2014-2017 for Activities 4.1.B and 4.3. Plans revised.	Through 2014 Levy Annual Report
1/15	2.7 Youth/Young Adult Homelessness Plan	Council request to add $250,000 from fund balance to Clear Path to Employment program for Y/YA								$ 250,000					SIP Allocation Table Revised. See columns for 2015.	Through Ordinance 17941/ 18110
	2.6.D KC Internship Program for Veterans	Council request to add $100,000 from fund balance to continue veterans internship/fellowship program							$ 100,000						SIP Allocation Table Revised. See columns for 2015.	Through Ordinance 17941/ 18110
	1.5.B Northwest Justice Project	$60,000 in unspent 2014 funds provided to NJP due to loss of grant funding							$ 60,000						SIP Allocation Table Revised. See columns for 2015.	Through 2015 Levy Annual Report

			2012		2013		2014		2015		2016		2017		Outcome	Council
Date	**Activity**	**Description of Change**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**	**Veterans**	**Human Services**		**Notification**
12/15	3.1.A Behavioral Health Integration	Budget Office requested $579,000 for PHSKC subcontractor Navos Primary Care Program providing mental health services due to budget shortfall								$ 579,000					SIP allocation table revised. See columns for 2015.	Through Ordinance 17941/18110
	1.1 King County Veterans Program	Identified $210,000 that would be unspent by year-end 2015 and reallocatedit to 1.4.B, 2.3 and 3.5.							$ (210,000)						SIP allocation table revised. See columns for 2015.	Through 2015 Levy Annual Report
	1.2.A Enhanced Outreach to Women Veterans & Veterans of Color	Identified $50,000 that would be unspent by year-end 2015 due to subcontractor underperformance and reallocated to 3.5.							$ (50,000)						SIP allocation table revised. See columns for 2015.	Through 2015 Levy Annual Report
	2.5.A FACT	Identified $1,250 that would be unspent by year-end 2015 and reallocated to 3.5.							$ (1,250)						SIP allocation table revised. See columns for 2015.	Through 2015 Levy Annual Report
	2.5.B FISH	Identified $45,000 ($13,500 Vets Levy & $31,000 HS) that would be unspent by year-end 2015 and reallocated to 3.5 and 4.1 EER/NFP.							$ (13,000)	$ (31,500)					SIP allocation table revised. See columns for 2015.	Through 2015 Levy Annual Report
	2.3 Housing Stability Program / Landlord Liaison Program	$15K of unspent KCVP funds provided to 2.3 HSP/LLP to assist in ending Veterans Homelessness							$ 15,000						SIP Allocation Table Revised. See columns for 2015.	Through 2015 Levy Annual Report
	3.5 Facilitating Community Partnerships	$62K of unspent 2013 funds allocated to Facilitating Community Partnerships to assist in ending veterans homelessness							$ 62,000						SIP Allocation Table Revised. See columns for 2015.	Through Ordinance 17941 / 18110
	3.5 Facilitating Community Partnerships	$107,750 in unspent funds ($43K from KCVP, $50K from 1.2.A, $13,500 from 2.5.B FISH, $1,250 from 2.5.A FACT) provided to 3.5 Facilitating Community Partnerships for Ending Veterans Homelessness							$ 107,750						SIP Allocation Table Revised. See columns for 2015.	Through 2015 Levy Annual Report
	4.1.A Nurse Family Partnership / Employment & Education Resources (EER)	$31,500 in unspent 2015 funds (from 2.5.B FISH) for employment / education services provided by EER								$ 31,500					SIP Allocation Table Revised. See columns for 2015.	Through 2015 Levy Annual Report

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

		2012	2013	2014	2015	2016	2017
Strategy 1: Supporting veterans and their families to build stable lives and strong relationships							
1.1	King County Veterans Program						
	Veterans	$2,485,000	$2,485,000	$2,485,000	$2,485,000	$2,485,000	$2,485,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$2,485,000	$2,485,000	$2,485,000	$2,485,000	$2,485,000	$2,485,000
1.2	Outreach and engagement						
A	*Enhanced outreach to women veterans and veterans of color*						
	Veterans	**$375,000**	$300,000	$300,000	$300,000	$300,000	$300,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$375,000	$300,000	$300,000	$300,000	$300,000	$300,000
B	*Veteran information and referral*						
	Veterans	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
C	*Homeless veterans street outreach*						
	Veterans	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$84,000	$84,000	$84,000	$84,000	$84,000	$84,000
1.3	Veterans employment and training						
	Veterans	$125,000	$200,000	$200,000	$200,000	$200,000	$200,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$125,000	$200,000	$200,000	$200,000	$200,000	$200,000
1.4	Contracted PTSD treatment/Military Sexual Trauma						
	Veterans	**$450,000**	**$600,000**	**$600,000**	$400,000	$450,000	$450,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$450,000	$600,000	$600,000	$400,000	$450,000	$450,000
1.5	Veterans justice						
A	*Veterans Incarcerated Program*						
	Veterans	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
B	*Veterans Legal Assistance Program*						
	Veterans	$20,000	$20,000	**$39,000**	**$80,000**	$20,000	$20,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$20,000	$20,000	$39,000	$80,000	$20,000	$20,000

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

		2012	2013	2014	2015	2016	2017
C	*Emerging programs for justice involved veterans*						
	Veterans	$150,000	$305,000	$305,000	$330,000	$345,000	$345,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$150,000	$305,000	$305,000	$330,000	$345,000	$345,000
1.6	Support for military families						
A	*Military family outreach*						
	Veterans	$174,000	$174,000	$174,000	$174,000	$174,000	$174,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$174,000	$174,000	$174,000	$174,000	$174,000	$174,000
B	*Military family counseling*						
	Veterans	$0	$100,000	$100,000	$100,000	$100,000	$100,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$0	$100,000	$100,000	$100,000	$100,000	$100,000
	Veterans	**$4,063,000**	**$4,468,000**	**$4,487,000**	**$4,353,000**	**$4,358,000**	**$4,358,000**
	Human Services	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Total Strategy 1	**$4,063,000**	**$4,468,000**	**$4,487,000**	**$4,353,000**	**$4,358,000**	**$4,358,000**
	Percent of Total Program	**22%**	**26%**	**26%**	**25%**	**26%**	**25%**
Strategy 2: Ending Homelessness through outreach, prevention, permanent supportive housing and employment							
2.1	Outreach and engagement						
A	*Homeless street outreach*						
	Veterans	$86,000	$86,000	$86,000	$86,000	$86,000	$86,000
	Human Services	$190,000	$190,000	$190,000	$190,000	$190,000	$190,000
	Total	$276,000	$276,000	$276,000	$276,000	$276,000	$276,000
B	*Sobering/Emergency Services Patrol*						
	Veterans	$45,000	$45,000	$45,000	$45,000	$45,000	$45,000
	Human Services	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
	Total	$145,000	$145,000	$145,000	$145,000	$145,000	$145,000
C	*Mobile medical outreach*						
	Veterans	$205,000	$90,000	$90,000	$90,000	$90,000	$90,000
	Human Services	$470,000	$210,000	$210,000	$210,000	$210,000	$210,000
	Total	$675,000	$300,000	$300,000	$300,000	$300,000	$300,000
D	*South King County homeless outreach*						
	Veterans	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
	Human Services	$65,000	$65,000	$65,000	$65,000	$65,000	$65,000
	Total	$80,000	$80,000	$80,000	$80,000	$80,000	$80,000

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

		2012	2013	2014	2015	2016	2017
2.2	Housing capital						
	Veterans	$2,925,000	$625,000	$625,000	$725,000	$860,000	$960,000
	Human Services	$700,000	$700,000	$700,000	$830,000	$1,000,000	$1,200,000
	Total	$3,625,000	$1,325,000	$1,325,000	$1,555,000	$1,860,000	$2,160,000
2.3	Housing Stability Program						
	Veterans	$400,000	$400,000	$400,000	$400,000	$400,000	$400,000
	Human Services	$400,000	$400,000	$400,000	$400,000	$400,000	$400,000
	Total	$800,000	$800,000	$800,000	$800,000	$800,000	$800,000
2.4	Support services for housing						
A	*Housing Health Outreach Team*						
	Veterans	$75,000	$75,000	$75,000	$75,000	$75,000	$75,000
	Human Services	$165,000	$165,000	$165,000	$240,000	$240,000	$290,000
	Total	$240,000	$240,000	$240,000	$315,000	$315,000	$365,000
B	*On-site support services*						
	Veterans	$300,000	$611,873	$340,000	$450,000	$525,000	$720,000
	Human Services	$1,010,000	$1,134,000	$815,000	$850,000	$950,000	$1,000,000
	Total	$1,310,000	$1,745,873	$1,155,000	$1,300,000	$1,475,000	$1,720,000
2.5	Criminal Justice Initiatives						
A	*FACT*						
	Veterans	$63,000	$63,000	$63,000	$63,000	$63,000	$63,000
	Human Services	$142,000	$142,000	$142,000	$142,000	$142,000	$142,000
	Total	$205,000	$205,000	$205,000	$205,000	$205,000	$205,000
B	*FISH*						
	Veterans	$210,000	$210,000	$192,000	$210,000	$210,000	$210,000
	Human Services	$480,000	$480,000	$438,000	$480,000	$480,000	$480,000
	Total	$690,000	$690,000	$630,000	$690,000	$690,000	$690,000
2.6	Employment and training						
A	*Community employment services*						
	Veterans	$120,000	$120,000	$120,000	$120,000	$120,000	$120,000
	Human Services	$550,000	$550,000	$550,000	$550,000	$550,000	$550,000
	Total	$670,000	$670,000	$670,000	$670,000	$670,000	$670,000
B	*Career Connections*						
	Veterans	$120,000	$120,000	$135,000	$120,000	$120,000	$120,000
	Human Services	$300,000	$300,000	$317,500	$300,000	$300,000	$300,000
	Total	$420,000	$420,000	$452,500	$420,000	$420,000	$420,000

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

		2012	2013	2014	2015	2016	2017
C	*Aerospace and Veteran Employment Training Initiative*						
	Veterans	$237,294	$635,184	$627,522	$0	$0	$0
	Human Services	$79,098	$136,728	$134,174	$0	$0	$0
	Total	$316,392	$771,912	$761,696	$0	$0	$0
D	*King County Internship Program for Veterans*						
	Veterans	$33,333	$100,000	$66,667	$100,000	$0	$0
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$33,333	$100,000	$66,667	$100,000	$0	$0
2.7	Youth/Young Adult Homelessness Plan Private Fund Match						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$0	$136,000	$144,000	$250,000		
	Total						
	Total Vets	**$4,834,627**	**$3,196,057**	**$2,880,189**	**$2,499,000**	**$2,609,000**	**$2,904,000**
	Total HS	**$4,651,098**	**$4,708,728**	**$4,370,674**	**$4,607,000**	**$4,627,000**	**$4,927,000**
	Total Strategy 2	**$9,485,725**	**$7,904,785**	**$7,250,863**	**$7,106,000**	**$7,236,000**	**$7,831,000**
	Percent of Total Program	**52%**	**45%**	**42%**	**41%**	**43%**	**45%**
Strategy 3: Improving health through the integration of medical and behavioral health services							
3.1	Behavioral health integration						
A	*Behavioral health integration*						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$625,000	$625,000	$625,000	$1,204,000	$625,000	$625,000
	Total	$625,000	$625,000	$625,000	$1,204,000	$625,000	$625,000
B	*Behavioral health integration-veterans*						
	Veterans	$600,000	$600,000	$600,000	$600,000	$600,000	$600,000
	Human Services	$0	$0	$0	$0	$0	$0
	Total	$600,000	$600,000	$600,000	$600,000	$600,000	$600,000
3.2	Veteran and trauma competency training						
	Veterans	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000
	Human Services	$50,000	$50,000	$50,000	$50,000	$50,000	$50,000
	Total	$250,000	$250,000	$250,000	$250,000	$250,000	$250,000
3.3	Health care reform system design and implementation						
	Veterans	$0	$25,000	$25,000	$25,000	$25,000	$25,000
	Human Services	$0	$245,000	$245,000	$245,000	$245,000	$245,000
	Total	$0	$270,000	$270,000	$270,000	$270,000	$270,000

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

		2012	2013	2014	2015	2016	2017
3.4	Depression intervention for seniors						
	Veterans	$112,000	$112,000	$178,000	$178,000	$178,000	$178,000
	Human Services	$112,000	$178,000	$178,000	$178,000	$178,000	$178,000
	Total	$224,000	$290,000	$356,000	$356,000	$356,000	$356,000
3.5	Facilitation of ongoing partnerships						
	Veterans	$70,000	$70,000	$458,447	$132,000	$70,000	$70,000
	Human Services	$70,000	$70,000	$151,000	$70,000	$70,000	$70,000
	Total	$140,000	$140,000	$609,447	$202,000	$140,000	$140,000
3.6	Client care coordination						
	Veterans	$40,000	$40,000	$24,000	$40,000	$40,000	$40,000
	Human Services	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
	Total	$140,000	$140,000	$124,000	$140,000	$140,000	$140,000
	Total Vets	**$1,022,000**	**$1,047,000**	**$1,485,447**	**$1,175,000**	**$1,113,000**	**$1,113,000**
	Total HS	**$957,000**	**$1,268,000**	**$1,349,000**	**$1,847,000**	**$1,268,000**	**$1,268,000**
	Total Strategy 3	**$1,979,000**	**$2,315,000**	**$2,834,447**	**$3,022,000**	**$2,381,000**	**$2,381,000**
	Percent of Total Program	**11%**	**13%**	**16%**	**18%**	**14%**	**14%**
Strategy 4: Strengthening families at risk							
4.1	Home visiting						
A	*Nurse Family Partnership*						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$470,000	$470,000	$613,700	$560,700	$529,200	$529,200
	Total	$470,000	$470,000	$613,700	$560,700	$529,200	$529,200
B	*Healthy Start*						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$270,000	$270,000	$270,000	$270,000	$270,000	$270,000
	Total	$270,000	$270,000	$270,000	$270,000	$270,000	$270,000
4.2	Maternal depression reduction						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$625,000	$625,000	$625,000	$625,000	$625,000	$625,000
	Total	$625,000	$625,000	$625,000	$625,000	$625,000	$625,000
4.3	Parent education and support						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$260,000	$260,000	$200,800	$200,800	$200,800	$200,800
	Total	$260,000	$260,000	$200,800	$200,800	$200,800	$200,800

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

		2012	2013	2014	2015	2016	2017
4.4	Passage Point						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$415,000	$415,000	$415,000	$415,000	$415,000	$415,000
	Total	$415,000	$415,000	$415,000	$415,000	$415,000	$415,000
4.5	Information and referral						
A	*2-1-1 Community Information Line*						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$50,000	$50,000	$62,875	$50,000	$50,000	$50,000
	Total	$50,000	$50,000	$62,875	$50,000	$50,000	$50,000
B	*Cultural Navigator*						
	Veterans	$0	$0	$0	$0	$0	$0
	Human Services	$70,000	$70,000	$70,000	$70,000	$70,000	$70,000
	Total	$70,000	$70,000	$70,000	$70,000	$70,000	$70,000
	Total Vets	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Total Human Services	**$2,160,000**	**$2,160,000**	**$2,257,375**	**$2,191,500**	**$2,160,000**	**$2,160,000**
	Total Strategy 4	**$2,160,000**	**$2,160,000**	**$2,257,375**	**$2,191,500**	**$2,160,000**	**$2,160,000**
	Percent of Total Program 5	**12%**	**12%**	**13%**	**13%**	**13%**	**13%**
	Evaluation						
	Veterans	$257,500	$257,500	$257,500	$257,500	$257,500	$257,500
	Human Services	$282,500	$287,500	$287,500	$287,500	$287,500	$287,500
	Total	$540,000	$545,000	$545,000	$545,000	$545,000	$545,000
	Total Program-Veterans	$10,177,127	$8,968,557	$9,110,136	$8,284,500	$8,337,500	$8,632,500
	Total Program-Human Services	$8,050,598	$8,424,228	$8,264,549	$8,933,000	$8,342,500	$8,642,500
	Total Program 5	**$18,227,725**	**$17,392,785**	**$17,374,685**	**$17,217,500**	**$16,680,000**	**$17,275,000**
	Admin **6**						
	Veterans	$391,464	$395,620	$421,171	$428,040	$442,316	$457,960
	Human Services	$369,063	$365,620	$420,906	$423,040	$437,316	$448,002
	Total6	$760,527	$761,240	$842,077	$851,080	$879,632	$905,962
	Board Support 7						
	Veterans	$71,319	$60,583	$62,853	$70,264	$66,507	$68,736
	Human Services	$58,720	$60,583	$62,853	$65,264	$66,507	$68,694
	Total **7**	$130,039	$121,166	$125,706	$135,528	$133,014	$137,430
Veterans Total		**$10,639,910**	**$9,424,760**	**$9,594,160**	**$8,782,804**	**$8,846,323**	**$9,159,196**
Human Services Total		**$8,478,381**	**$8,850,431**	**$8,748,308**	**$9,421,304**	**$8,846,323**	**$9,159,196**
GRAND TOTAL		**$19,118,291**	**$18,275,191**	**$18,342,468**	**$18,204,108**	**$17,692,646**	**$18,318,392**

2012 - 2017 Veterans and Human Services Levy Service Improvement Plan

	2012	2013	2014	2015	2016	2017
VL-Original SIP II	$7,829,283	$8,077,703	$8,305,635	$8,560,804	$8,846,323	$9,159,196
VL-2012 Supplemental Reprograming of SIP I Unspent Balance	**$2,810,627**	**$1,347,057**	**$1,288,525**	**$222,000**	**$0**	**$0**
VL-SIP II plus 2012 Supplemental Reprograming of SIP I Unspent Balance	**$10,639,910**	**$9,424,760**	**$9,594,160**			
HSL-Original SIP II	$7,829,283	$8,077,703	$8,305,635	$8,560,804	$8,846,323	$9,159,196
HSL-2012 Supplemental Reprograming of SIP I Unspent Balance	**$649,098**	**$772,728**	**$442,673**	**$860,500**	**$0**	**$0**
HSL-SIP II plus 2012 Supplemental Reprograming of SIP I Unspent Balance	**$8,478,381**	**$8,850,431**	**$8,748,308**			

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King County

Metropolitan King County Council
Regional Policy Committee

STAFF REPORT

Agenda Item:	9	**Name:**	Wendy K. Soo Hoo
Proposed No.:	2016-0419	**Date:**	September 14, 2016

SUBJECT

Proposed Motion 2016-0419 would request two reports from the Executive to inform Council deliberations on possible renewal of the Veterans and Human Services Levy.

SUMMARY

Proposed Motion 2016-0419 requests two reports from the Executive to inform Council deliberations on possible renewal of the Veterans and Human Services Levy. The motion asks the Executive transmit a report that assesses the effectiveness of the current levy strategies, services and programs in meeting the goals of the levy, and that analyzes and makes recommendations on various policy considerations, including specific populations and their service needs.

The second report would focus on costs of providing housing, including shelter, such that no veteran residing in King County who seeks housing or shelter would remain unhoused.

The reports would be due January 19, 2017. If the Council wished to place a ballot measure on the August 2017 ballot, action would need to be taken on a levy ordinance in early May 2017.

Proposed Motion 2016-0419 must be acted on by the Regional Policy Committee before the Health, Housing and Human Services Committee can begin deliberations.

BACKGROUND

The first Veterans and Human Services Levy: In November 2005, King County voters passed the first Veterans and Human Services Levy to generate at least $13 million per year for a wide range of programs to assist veterans, military personnel and their families, and individuals and families in need.

The Renewed Levy: In August 2011, King County voters approved a renewed Veterans and Human Services Levy (VHSL), which provides approximately $15 million

to $18 million per year ($0.05 per $1,000 assessed valuation plus annual increases by the percentage increase in the consumer price index or 1 percent, whichever is greater, with a maximum increase of 3 percent) for six years starting in 2012. Fifty percent of the levy proceeds is dedicated to services for veterans, military personnel and their families, and fifty percent is dedicated to improving health, human services and housing for a wider array of people in need.

The levy's purpose is to provide revenue that supports health and human services such as housing assistance, mental health counseling, substance abuse prevention and treatment, and employment assistance, as well as capital facilities and improved access to and coordination of services for veterans, military personnel and their families.

Levy proceeds are to be used to pay the costs associated with provision of regional health and human services to a wide range of people in need of such services, including, but not limited to:

- Services that increase self-sufficiency for veterans, military personnel and their families;
- Services that reduce involvement in the criminal justice system;
- Services that reduce emergency medical costs;
- Services for children and youth, the elderly, the unemployed and underemployed
- Services specific to veterans' needs such as treatment for posttraumatic stress disorder and specialized employment assistance; and
- Costs associated with strengthening and improving health and human services system and infrastructure to provide greater access to services and engender better coordination and integration of regional health and human services addressing the needs of veterans, military personnel and their families

The services provided under the VHSL also include a range of regional health and human services and related capital facilities including, but not limited to, housing assistance, homelessness prevention, mental health counseling substance abuse prevention and treatment and employment assistance.

Oversight: As with the first levy, the current VHSL is overseen by two community boards: the Veterans Citizen Oversight Board (VCOB) and the Regional Human Services Citizen Oversight Board (RHSCOB). The two boards play an integral role in reviewing the plans for expenditure of levy proceeds and monitoring progress of service and program implementation.

Funding Requirements: Ordinance 17200, which was passed in August 2011 after the voters had approved renewal of the VHSL, called for development of a Service Improvement Plan (SIP) and identifies explicit amounts of funds that are required to be set aside from the VHSL for certain purposes. The set aside amounts and areas are as follows:

- Up to $2.5 million per year may be set aside for housing capital, including funding of transitional housing for homeless youth and young adults

- At least $2 million per year is required to be set aside from the portion of the levy proceeds used for services for veterans, military personnel in need and their families to be used in maintaining the expansion of and improving current county veterans program services

- At least $2.5 million is required to be set aside from the portion of the total levy proceeds used for services for veterans, military personnel in need and their families to be expended on strategies, sub-strategies, programs and activities related to veterans justice programs including the veterans incarcerated program, veterans legal assistance, the veterans treatment court or other emerging veterans justice programs; and

- At least $1 million per year is required to be set aside from the portion of the levy proceeds not specifically designated for services for veterans, military personnel in need and their families to be invested in early intervention and prevention programs that have demonstrated effectiveness in reducing dependency and criminal justice problems in the long run.

In addition, Ordinance 17200 limits the county's administrative expenses for managing and administering the levy proceeds to five percent, excluding evaluation and board support expenses.

The Service Improvement Plan: In December 2011, the Council passed Ordinance 17236 adopting the VHSL Service Improvement Plan for 2012 through 2017. The Service Improvement Plan (SIP) provides guidance on the goals, investments and implementation of the King County VHSL. The SIP outlines the 2012-2017 levy goals as follows:

2012-2017 Levy Goals (Ordinance 17236)
1. Prevent and reduce homelessness.
2. Reduce unnecessary criminal justice and emergency medical system involvement.
3. Increase self-sufficiency of veterans and vulnerable populations.

The 2012-2017 SIP also requires the Department of Community and Human Services to work in cooperation with other county departments and branches of government and with the levy oversight boards to ensure that the goals and strategies of the levy are achieved.

The SIP describes VHSL priority populations and investment areas, specifying them as follows:

1. Veterans, military personnel, and their families who are struggling with mental and physical health problems, unstable housing or homelessness, or unemployment and in need of supports that will help them build on their strengths and respond to the unique challenges they face.

2. Residents who are currently experiencing instability in their lives resulting in involvement in the homelessness, criminal justice, or emergency medical systems.

3. Families and individuals for whom prevention and early interventions will help lay the foundation for a successful future and prevent involvement in crisis systems.

Similar to the first levy, the plan states that while many activities are focused on families and individuals who have already become involved in costly public systems, the renewed levy SIP recognizes that it is also important to target those who are at-risk of such involvement.

Levy Strategy Areas: The levy funds are dispersed into the four strategy areas outlined in the box below:

Veterans and Human Services Levy Strategy Areas 2012-2017 (Ordinance 17236)
1. Supporting veterans and their families to build stable lives and strong relationships 2. Ending homelessness through outreach, prevention, permanent supportive housing and employment 3. Improving health through the integration of medical and behavioral health services 4. Strengthening families at risk

Proposed Motion 2016-0419 requests the executive to transmit a response to inform the Council's deliberations regarding the possible renewal of the VHSL. The proposed motion requests that the Executive submit an assessment report to be developed in consultation with stakeholders that includes:

1. An assessment of the effectiveness of the current strategies, services and programs in achieving the current levy-funded goals with the aim of identifing potential changes to improve the levy's effectiveness, stewardship and equity and social justice impact.

2. Analysis and recommendations on the following:

    - Potential changes to the levy's three goals and/or strategies and whether the VHSL should incorporate any new goals and/or strategies – and whether strategies addressing specific populations or service needs should be considered, including:
        - Older adults;
        - Civil legal services;
        - Affordable housing and homelessness;
        - Criminal justice-system involved persons;
        - Populations whose circumstances warrant specialized approaches, including sexually exploited youth, victims of human trafficking, and low-income residents living in rural communities; and
        - Survivors of or people experiencing domestic violence.
    - How a renewed VHSL would align and coordinate with the Best Starts for Kids Levy and the Mental Illness and Drug Dependency Sales Tax, as well as other funding streams; and

- Whether a renewed levy should retain or revise the current oversight structure

3. An assessment of the state of funding for basic human services throughout King County in light of changing public and private funding practices.

4. In addition to the assessment report described above, the motion requests a report on the costs and potential timeline for providing housing or shelter, such that no veteran residing in King County who seeks housing or shelter would remain unhoused. This report should also assess the options of reallocating existing levy proceeds, raising additional revenue, or a combination of both.

The assessment report and the additional report are requested by January 19, 2017, with copies being transmitted to Councilmembers, the Council's Chief of Staff and Policy Staff Director, and the lead staff for the Health, Housing and Human Services Committee and the Regional Policy Committee.

Anticipated Process for Potential VHSL Renewal

Staff currently anticipate the potential renewal of the VHSL would involve at least three pieces of legislation:

- Proposed Motion 2016-0419, calling for an analysis and report to inform deliberations on the levy ordinance and development of a new SIP

- A levy ordinance (likely referral to the Budget and Fiscal Management Committee) placing the measure before the voters

    - Assuming an August 2017 ballot measure, the last regular council meeting for action with minimum processing time would be May 1.
    - Assuming November 2017 ballot measure, the last regular council meeting for action with minimum processing time would be July 17.

- An ordinance adopting the implementation plan (mandatory referral to Regional Policy Committee and likely referral to the Health, Housing and Human Services Committee), assuming Council passage of the levy ordinance. Action on the implementation plan would likely occur post-election if the levy is approved by the voters.

Councilmembers may be interested in exploring ways to limit service discontinuity during the renewal process for all or some providers. In part, this will depend on whether the renewal strategies and programs are similar to presently funded strategies and programs, as well as the timing of deliberations on the implementation plan by both the Regional Policy Committee and the County Council.

Election Deadlines for August and November 2017[1]

	8/1[2]	**11/7**[3]
Last regular council meeting with maximum processing time (25 days)	4/17/17	7/3/17
Last regular council meeting with minimum processing time (10 days)	5/1/17	7/17/17
Last regular council meeting to pass as emergency	5/8/17	7/31/17
Last special council meeting to pass as emergency	5/12/17	8/1/17
Election Division deadline for receiving effective ordinance	5/12/17	8/1/17

STRIKING AMENDMENT

At the direction of two of the motion's sponsors, staff has drafted a striking amendment that makes the following changes:

- Removes references to assessing the effectiveness of services and programs.
- Makes clarifications in Subsection A.2.e.
- Clarifies language in the Subsection A.3. regarding an assessment of funding trends and major initiatives for basic human services in King County.

ATTACHMENTS

1. Proposed Motion 2016-0419
2. Striking amendment, S1
3. Council Clerk's Elections Date Memorandum

INVITED

1. Adrienne Quinn, Director, Department of Community and Human Services
2. Leonardo Flor, Veterans and Human Services Levy Renewal Manager, Department of Community and Human Services

[1] These are based on the Clerk's Elections Date Memorandum (attached).

KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

September 8, 2016

Motion

Proposed No. 2016-0419.1 **Sponsors** Dembowski, von Reichbauer, Balducci and Kohl-Welles

A MOTION requesting the executive's response informing council deliberations regarding possible renewal of the veterans and human services levy.

WHEREAS, in November 2005, King County voters passed the first veterans and human services levy to generate funding for a wide range of programs to assist veterans, military personnel and their families and individuals and families in need, and

WHEREAS, in August 2011, voters in King County voted to renew the veterans and human services levy for another six years, and

WHEREAS, the goals of the existing veterans and human services levy are to reduce homelessness and emergency medical costs, to reduce criminal justice system involvement and to increase self-sufficiency by means of employment, and

WHEREAS, fifty percent of the existing levy's proceeds are allocated to provision of regional health and human services for veterans, military personnel and their families and fifty percent is allocated to provision of regional health and human services to a wide range of people in need of those services. The allocation has been beneficial in delivering services to populations in need of such services, and

WHEREAS, the veterans and human services levy will expire on December 31, 2017, and

WHEREAS, the veterans and human services levy is a voter-approved, six-year levy lid lift, renewal of which requires voter approval of a ballot measure, and

WHEREAS, the U.S. Department of Veterans Affairs estimates that King County remains home to more than one hundred and ten thousand veterans and military servicemembers, and

WHEREAS, All Home estimates that eight hundred sixty-seven veterans remain homeless in King County in 2016, and

WHEREAS, veterans, servicemembers, their families and other populations within King County have benefitted from services funded by the veterans and human services levy;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The King County council is considering whether to submit to the qualified electors for their approval in 2017 a ballot measure to renew the veterans and human services levy. The council requests that the executive submit for council review an assessment report of the veterans and human services levy-funded goals, strategies, services and programs. The assessment report submitted to the council shall be developed in consultation with stakeholders and shall include:

1. An assessment of the effectiveness of the of the veterans and human services levy-funded goals outlined in Ordinance 17236, and the effectiveness of the existing strategies, services and programs in meeting the three policy goals. The assessment report shall include an explanation of the methodology used to make the determination of effectiveness. The purpose of the review is to identify potential changes to improve the

levy's effectiveness, improve the levy's stewardship of resources and improve the levy's equity and social justice impact;

2. Analysis and recommendations that address the following:

a. whether the council should revise, eliminate, or retain the veterans and human services levy's three goals, enumerated in Ordinance 17236: to prevent and reduce homelessness; to reduce unnecessary criminal justice and emergency medical system involvement; and to increase self-sufficiency of veterans and vulnerable populations;

b. whether a renewed levy should incorporate any new goals not specified in the current levy's service improvement plan;

c. how a renewed levy would align and coordinate with the best starts for kids levy and the mental illness and drug dependency sales tax, as well as other federal, state and local funding streams and programs, so as to integrate, align and avoid duplication of effort;

d. whether a renewed levy should retain some or all of the existing levy's four strategies, which are to: support veterans and their families to build stable lives and strong relationships; end homelessness through outreach, prevention, permanent supportive housing and employment; improve health through the integration of medical and behavioral health services; and strengthen families at risk;

e. whether a renewed levy should incorporate any new strategies not specified in the current levy's service improvement plan. The analysis and recommendations shall specifically address: whether a renewed levy should include a strategy or strategies to serve older adults; a strategy or strategies to increase integration of civil legal services for

levy-funded programs or persons served by the levy; a strategy or strategies to increase investments in affordable housing generally and reduction of homelessness specifically; a strategy or strategies to enhance reentry services for criminal justice system-involved and incarcerated persons; strategy or strategies to tailor services for particular populations whose circumstances warrant specialized approaches, including sexually exploited youth, victims of human trafficking and low-income residents living in rural communities; and a strategy or strategies to provide investments in services for survivors of domestic violence and people experiencing domestic violence; and

f. whether a renewed levy should retain or revise the current levy's citizen oversight board structure; and

3. An assessment of the state of funding for basic human services throughout King County, sometimes referred to as the "social safety net," in light of changing priorities of public and private funders, specifically the move away from flexible funding based on community needs and toward targeted funding of specific causes. The report should include options and recommendations for use of proceeds from a renewed veterans and human services levy to fill gaps in the social safety net.

B. In addition to the report requested in section A. of this motion, the council requests that the executive prepare and deliver an additional report at the same time as the assessment report requested herein, to assess the costs of providing housing, including shelter where and when needed, for every King County veteran in need of housing or shelter, such that no veteran residing in King County who seeks housing or shelter, shall remain unhoused. This additional report should also assess whether funding to support these costs should be assembled by re-allocating existing levy proceeds, or whether

additional revenues should be raised, or a combination of both. The report should also provide a potential timeline to accomplish the goal of housing every veteran who seeks housing or shelter.

C. The executive shall file the veterans and human services levy assessment report and the additional report requested by this motion by January 19, 2017, in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembmers, the council chief of

staff, the policy staff director and the lead staff for the health, housing and human services committee and the regional policies committee, or their successors.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

J. Joseph McDermott, Chair

ATTEST:

_____

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: None

1

September 2, 2016

Sponsor: Balducci/Dembowski

WSH

Proposed No.: 2016-0419

STRIKING AMENDMENT TO PROPOSED MOTION 2016-0419, VERSION 1

On page 1, beginning on line 4, strike everything through page 6, line 95, and insert:

"WHEREAS, in November 2005, King County voters passed the first veterans and human services levy to generate funding for a wide range of programs to assist veterans, military personnel and their families and individuals and families in need, and

WHEREAS, in August 2011, voters in King County voted to renew the veterans and human services levy for another six years, and

WHEREAS, the goals of the existing veterans and human services levy are to reduce homelessness and emergency medical costs, to reduce criminal justice system involvement and to increase self-sufficiency by means of employment, and

WHEREAS, fifty percent of the existing levy's proceeds are allocated to provision of regional health and human services for veterans, military personnel and their families and fifty percent is allocated to provision of regional health and human services to a wide range of people in need of those services. The allocation has been beneficial in delivering services to populations in need of such services, and

WHEREAS, the veterans and human services levy will expire on December 31, 2017, and

WHEREAS, the veterans and human services levy is a voter-approved, six-year levy lid lift, renewal of which requires voter approval of a ballot measure, and

WHEREAS, the U.S. Department of Veterans Affairs estimates that King County remains home to more than one hundred and ten thousand veterans and military servicemembers, and

WHEREAS, All Home estimates that eight hundred sixty-seven veterans remain homeless in King County in 2016, and

WHEREAS, veterans, servicemembers, their families and other populations within King County have benefitted from services funded by the veterans and human services levy;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The King County council is considering whether to submit to the qualified electors for their approval in 2017 a ballot measure to renew the veterans and human services levy. The council requests that the executive submit for council review an assessment report of the veterans and human services levy-funded goals, strategies, services and programs. The assessment report submitted to the council shall be developed in consultation with stakeholders and shall include:

1. An assessment of the effectiveness of the veterans and human services levy in achieving the three goals outlined in Ordinance 17236 and the effectiveness of the existing strategies in meeting the three policy goals. The assessment report shall include an explanation of the methodology used to make the determination of effectiveness. The purpose of the report is to identify potential changes to improve the levy's effectiveness,

improve the levy's stewardship of resources and improve the levy's equity and social justice impact;

2. Analysis and recommendations that address the following:

a. whether the council should revise, eliminate, or retain the veterans and human services levy's three goals, enumerated in Ordinance 17236: to prevent and reduce homelessness; to reduce unnecessary criminal justice and emergency medical system involvement; and to increase self-sufficiency of veterans and vulnerable populations;

b. whether a renewed levy should incorporate any new goals not specified in the current levy's service improvement plan;

c. how a renewed levy would align and coordinate with the best starts for kids levy and the mental illness and drug dependency sales tax, as well as other federal, state and local funding streams and programs, so as to integrate, align and avoid duplication of effort;

d. whether a renewed levy should retain some or all of the existing levy's four strategies, which are to: support veterans and their families to build stable lives and strong relationships; end homelessness through outreach, prevention, permanent supportive housing and employment; improve health through the integration of medical and behavioral health services; and strengthen families at risk;

e. whether a renewed levy should incorporate any new strategies not specified in the current levy's service improvement plan. The analysis and recommendations shall specifically address: whether a renewed levy should include a strategy or strategies to serve older adults; a strategy or strategies to increase integration of civil legal services for

levy-funded programs or persons served by the levy; a strategy or strategies to increase investments in affordable housing generally and reduction of homelessness specifically; a strategy or strategies to enhance reentry services for criminal justice system-involved and incarcerated persons; a strategy or strategies to tailor services for particular populations whose circumstances warrant specialized approaches, including sexually exploited youth, victims of human trafficking, low-income residents living in rural communities and survivors of domestic violence and people experiencing domestic violence; and

f. whether a renewed levy should retain or revise the current levy's citizen oversight board structure; and

3. An assessment of funding trends and major initiatives for basic human services throughout King County, in light of changing priorities of public and private funders, specifically the move away from flexible funding based on community needs and toward targeted funding of specific causes. The assessment should include options and recommendations for areas of strategic focus in a renewed veterans and human services levy to promote broad human services availability based on community need, and system sustainability in light of the trends and major initiatives that the assessment identifies.

B. In addition to the report requested in section A. of this motion, the council requests that the executive prepare and deliver an additional report at the same time as the assessment report requested in this motion, to assess the costs of providing housing, including shelter where and when needed, for every King County veteran in need of housing or shelter, such that no veteran residing in King County who seeks housing or shelter, shall remain unhoused. The additional report should also assess whether funding

to support these costs should be assembled by reallocating existing levy proceeds, or whether additional revenues should be raised, or a combination of both. The report should also provide a potential timeline to accomplish the goal of housing every veteran who seeks housing or shelter.

C. The executive shall file the veterans and human services levy assessment report and the additional report requested by this motion by January 19, 2017, in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembmers, the council chief of staff, the policy staff director and the lead staff for the health, housing and human services committee and the regional policies committee, or their successors."

EFFECT:

- Removes references to assessing the effectiveness of services and programs.
- Makes clarifications in Subsection A.2.e.
- Clarifies language in the Subsection A.3. regarding an assessment of funding trends and major initiatives for basic human services in King County.

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King County

MEMORANDUM

May 5, 2016

TO: All Councilmembers
All Council Staff
FM: Anne Noris, Clerk of the Council
RE: Deadlines for Adoption of Ballot Measures in 2017

The deadlines for adoption of ballot measures for 2017 elections are as follows:

2017 Election Dates

	2/14[1]	4/25[1]	8/1[2]	11/7[3]
Last regular council meeting with maximum processing time (25 days)	11/2116	1/30/17	4/17/17	7/3/17
Last regular council meeting with minimum processing time (10 days)	12/5/16	2/13/17	5/1/17	7/17/17
Last regular council meeting to pass as emergency	12/12/16	2/21/17	5/8/17	7/31/17
Last special council meeting to pass as emergency	12/16/16	2/24/17	5/12/17	8/1/17
Election Division deadline for receiving effective ordinance	12/16/16	2/24/17	5/12/17	8/1/17

Special Council meetings can be scheduled with a minimum of 25 hours advance notice.

*Council summer recess is from August 7 through 20 (assumed-first two weeks in August)

1. Based on effective ordinance filed with Elections 60 days before the election. RCW 29A.04.321
2. Based on effective ordinance filed with Elections no later than the Friday immediately before the first day of regular candidate filing, which is the Monday two weeks before Memorial Day (May 29). RCW 29A.24.050; RCW 29A.04.321
3. Based on effective ordinance filed with Elections no later than the primary. RCW 29A.04.321.

Note: This schedule does not apply to Charter amendments. Because Charter § 800 provides that ordinances proposing amendments to the Charter are not subject to executive veto, such ordinances have an effective date (10 days after enactment by the Council) that differs from the effective date of an ordinance that is subject to executive veto.

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King County

Metropolitan King County Council
Regional Policy Committee

STAFF REPORT

Agenda Item:	10	**Name:**	Mike Reed
Proposed No.:	2016-B0171	**Date:**	September 14, 2016

SUBJECT:

A briefing on Proposed Ordinance 2016-0386 setting solid waste rates for 2017-2018.

SUMMARY:

Proposed Ordinance 2016-0386, as transmitted by the Executive, would set the 2017-2018 Basic Fee for solid waste disposal at $137.75, up 14.6% from the current rate of $120.17. Increases are also proposed to the self-haul minimum fee—up from the current $19.22 per entry to 22.08 per entry, a 14.8% increase. Other increases include the Regional Direct Fee—up 13% to $117/ton; the Special Waste Fee—up 14% to $165/ton, and the Special Waste Extra Handling Fee, up 10% to $193/ton.

The previous rate increase was approved by Council in 2012, for the 2013-2014 period; a projected 2015-2016 rate increase was deferred, in light of challenging economic conditions and a number of related fiscal developments. Since the last rate increase, most of the participating cities in the regional solid waste system have executed extended agreements committing them to the system through 2040; the County has deferred plans for the construction of a Northeast station; and participants have discussed plans to manage service demand to avoid short term station queueing challenges. The 2010 Cedar Hills Site Development Plan is proceeding, with remaining disposal cells being developed for use. Tonnage appears to be returning, though levels remain below pre-recession levels, and a modest tonnage decline is anticipated for the coming biennium. The new Factoria Recycling and Transfer Station is open and operating, though the hazardous waste building has not yet been completed.

The legislation has been referred to the Budget and Fiscal Management (BFM) Committee. The committee was briefed on the Executive's proposal on August 28, 2016. BFM is anticipated to act on the legislation at its September 14, 2016 meeting.

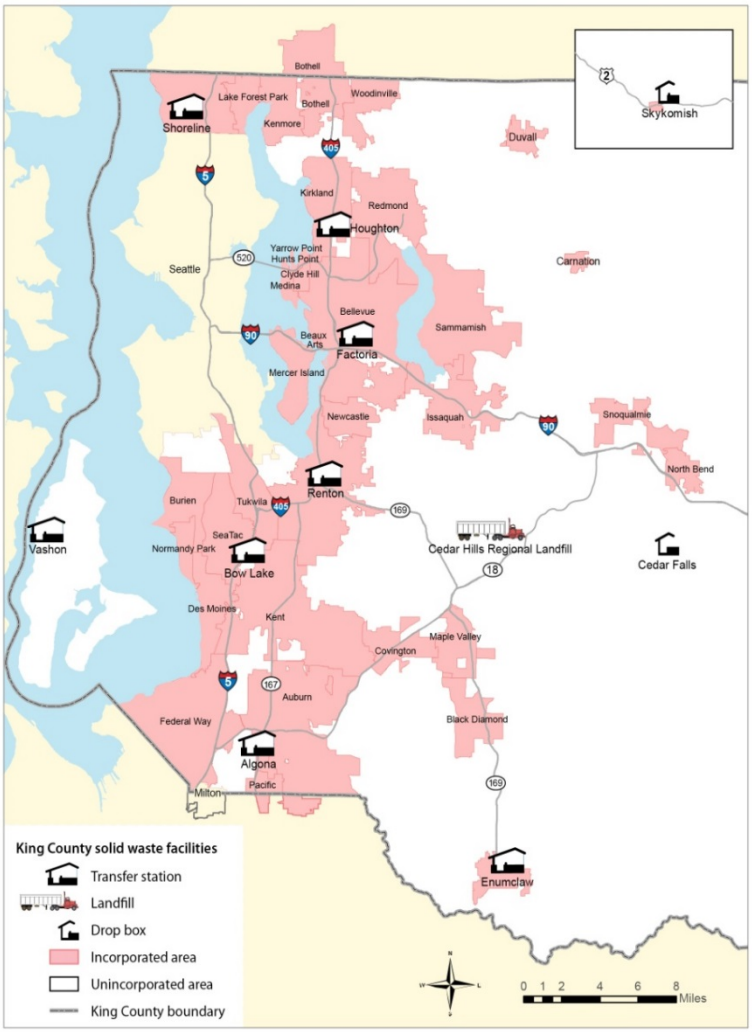
This briefing is being provided to RPC members and with regard to the committee's role as the Solid Waste Interlocal Forum.

BACKGROUND:

The Regional Solid Waste System

The regional solid waste system is a cooperative, integrated system, with participation by 37 cities, solid waste haulers, and the County. King County receives solid waste at its eight transfer stations and two drop boxes from solid waste haulers, who collect it curbside from households in cities and in the unincorporated area. Cities manage solid waste disposal within their jurisdictions, and contract with solid waste haulers, to provide service within the city[1].

Since the 1960s, the County has operated this network of transfer stations and drop boxes, now collectively receiving and processing over 800,000 tons of mixed municipal solid waste annually. These transfer stations, as well as drop boxes serving more remote locations, are distributed throughout the region, as shown on the graphic below:



A basic fee is charged to discharge waste at the transfer stations. The fee has been set at $120.17 per ton of waste since 2013. The proposed rate for 2017-2018 is $137.75.

[1] RCW 35.21.120

The basic fee and other rates are developed based on a rate study entitled Executive Proposed Solid Waste Disposal Fees for 2017-2018 ("rate study") (Attachment A to Proposed Ordinance 2016-0386).

The transfer stations and drop boxes also accept waste delivery from self-haulers—residents and small businesses who accumulate small loads of garbage and deliver it to transfer stations or drop boxes for disposal. The current rate of $19.22 per carload is proposed to increase to $22.08 per carload (tax and Moderate Risk Waste fee are added).

The Transfer System network receives and consolidates these waste loads, transfers them onto trailers and transports them by truck to the Cedar Hills Regional Landfill, a 920 acre facility located in Maple Valley, about 20 miles southeast of Seattle. The landfill is owned by King County. A rental fee is paid for its use for landfill purposes by the Solid Waste Fund to the County's General Fund. The site has been operating as a landfill since 1965.

In 2010, the Council acted to modify the facility's Site Development Plan, resulting in the expansion of landfill capacity by 56 acres thereby extending its useful life from 2018 to 2025. The opening of a new "Area 8" will begin during this rate period. The Division has undertaken an update of the Site Development Plan, which is expected to recommend strategies for further extending the life of the Landfill. The results of this review may have significant fiscal impacts since disposal at the Landfill is considered significantly less expensive than available alternatives. The Council has approved policies to maximize the life of the landfill. Additionally, the Division, as required by federal law, is accumulating funding in the Landfill Reserve Fund for monitoring and maintaining the landfill for a minimum 30-year period following its closure. The date of that closure has implications for the amount of time available to accumulate the needed monitoring/maintenance funding—a later closure date results in lesser annual amounts needed to achieve funding targets.

Waste delivered from transfer stations to Cedar Hills is buried in "cells"—multi-acre disposal areas that are engineered to hold the waste permanently while managing the accumulated volumes to assure that leachate runoff and methane gas are appropriately captured and addressed. A limited number of waste haulers deliver waste directly to Cedar Hills; they pay a "regional direct" rate which is currently $103.50 per ton and proposed to be raised to $117 per ton.

Transfer Station Network Upgrade

The County has been working to upgrade the transfer network since the 2007 approval of the Solid Waste Transfer and Waste Management Plan, which provided for:

- Upgrading the Bow Lake and Factoria transfer stations in place;
- Replacing the Algona station with a new Southwest Recycling and Transfer Station at a site to be determined;
- a new Northeast Recycling and Transfer Station at a site to be determined, closing the Houghton station upon availability of replacement capacity;
- Closing the Renton Transfer Station when all upgrades are completed; and
- Retaining the Shoreline, Enumclaw and Vashon Recycling and Transfer Stations, which had been recently upgraded or constructed.

System Developments Impacting Rates

Since the 2012 approval of 2013-2014 rates, there has been extensive discussion of the proposed system upgrade. In noting a substantial drop in the volumes of tonnage being processed through the system—as well as decreases in future tonnage projections—the Council directed review of the proposed transfer system buildout. That review process focused on the proposed new Northeast transfer station. The resulting report addressed potential options, including deferral of a new Northeast station, but noted potentially extensive queueing at the Factoria Recycling and Transfer Station if the Houghton Transfer Station, located in Kirkland, were closed and not replaced. The northeast service area is currently served by the Houghton Transfer Station, which processes about 160,000 tons annually. The Solid Waste Transfer and Waste Management Plan proposed closure of the Houghton station upon availability of replacement capacity; interim communications have focused on a closure date in the 2021-2023 period.

It is noted that the City of Bellevue, which generates about 8 to 10% of the annual system tonnage, has indicated plans to leave the system in 2028, at the end of the current interlocal agreement—removing about 60,000-70,000 tons from the Northeast King County portion of the system.

As a result of that initial review, Council recommended further review of the potential for strategies to manage the self-haul customer demand at the Factoria station, using techniques such as extended station hours, peak hour fee increases, bulky item collection, and similar strategies. The current rate proposal includes funding and staffing for testing a “demand management” pilot project.

Since the Council’s 2012 consideration of the 2013-2014 rate proposal, most participant cities have signed extended and revised interlocal agreements committing them to the system through 2040, allowing for bond repayment terms extending over a longer period, and therefore at a more modest periodic rate. All of the transfer stations rebuilt or replaced through the upgrade process are expected to have life spans of at least 30 – 40 years.

Major system direction is established by the Comprehensive Solid Waste Management Plan. The last completed plan was prepared in 2001. An ongoing joint planning effort, involving the Solid Waste Division, the Metropolitan Solid Waste Advisory Committee, and the Solid Waste Advisory Committee, has approached, but not completed, an updated plan.

Schedule of Proposed Fees

Below are the existing / proposed fees recommended in Proposed Ordinance 2016-0386:

Passenger cars	~~$19.22~~ $22.08 per entry (14.8% increase)
Other Vehicles	~~$120.17~~ $137.75 per ton (14.6% increase)
Charitable organizations	~~$92.55~~ $106.07 per ton (14.6% increase)
Minimum	~~$19.22~~ $22.08 per vehicle (14.8% increase)
Charitable organizations	~~$15.08~~ $16.97 per entry (12.5% increase)

Solid Waste Facilities without Scales

Compacted wastes	~~$35.31~~	$39.95 per cubic yard (13.1% increase)
Uncompacted wastes	~~$20.70~~	$23.42 per cubic yard (13.1% increase)
Minimum charge	~~$19.67~~	$22.08 per vehicle (14.8% increase)

Cedar Hills disposal

Regional Direct	~~$103.50~~	$117.00 per ton (13% increase)
Other vehicles	~~$120.17~~	$137.75 per ton (14.6% increase)

Special Waste

Special Waste fee	~~$145.00~~	$165.00 per ton (13.8% increase)
Special Waste fee Minimum charge	~~$23.20~~	$26.45 per entry (14% increase)
Special Waste fee Extra handling	~~$175.00~~	$193.00 per ton (10.3% increase)
Special Waste fee Extra handling-minimum charge	~~$28.00~~	$30.86 per entry (10.21% increase)

ANALYSIS

For 2016, the current fee structure is expected to generate $104,865,887. The proposed increase described above would generate $116,461,232 in 2017, an 11% increase in revenue over 2016. Over 90% of the fee revenue is generated by the Basic Fee charged to commercial and self-haulers for waste acceptance at transfer stations. The increase in the Basic Fee, from $120.17 currently to $137.75 in 2017 and 2018, represents a 14.6% increase over the current rate.

System tonnage is anticipated to decline somewhat in 2017. Over the last two years, the North transfer station of the Seattle Public Utilities solid waste system has been closed for reconstruction; many self-haulers who ordinarily would use the Seattle North station have instead brought their loads to the County's Shoreline Recycling and Transfer Station. In 2013, the Shoreline station received 43,000 tons of waste; in 2015, it received 65,000 tons, a 51% increase. When the Seattle North construction project is completed in 2016, part or all of the Seattle North service population may return to the Seattle facility. The rate study prepared by the Division projects a First Northeast 2017 tonnage level of 52,000. System-wide, the rate study projects a decline in Basic Fee tons from 856,100 (2016) to 829,467 (2017).

The Executive notes that the proposed rate, if approved, would place King County Basic Fee at a level within the general range of fees charged by major solid waste utilities within the state:

Table 1. Proposed Fee compared to Peer Jurisdictions

Jurisdiction	**Basic Fee** (as of 2016)
Clark County	$87.56
King County proposed	$137.75
Pierce County	$145.84
Seattle City	$145.00
Snohomish County	$105.00
Spokane County (includes city)	$101.00
Thurston County	$119.00

The Executive has disaggregated the elements of the proposed increase, by dollars and by rate impact, in Table 1 below:

Table 2. Components of the 2017-2018 Rate Increase

	2017-18 Expenditures ($ in millions)	2017-2018 Rate Impact ($ per ton)	New FTEs/TLTs required
Current Basic Fee		$120.17	
Sustain Current Services			
Cover Inflationary Increases	$12.5 M	$5.49	10.25 / 0
Debt Service for New Transfer Stations	$7.1 M	$3.10	
Replace Aging Equipment	$ 6.8 M	$2.98	
Fortify Cedar Hills Landfill Reserve Fund	$3.6 M	$1.59	
Maintain Closed Landfills	$2.5 M	$1.07	
Subtotal Sustain Current Services	*$32.5 M*	*$14.23*	*10.25 / 0*
Ensure Service Reliability	$3.6 M	$1.58	1 / 3
Address County Strategic Priorities	$1.1 M	$0.46	1 / 0
Position for the Future	$2.0 M	$0.88	0 / 10
Adjustment for Increased Recycling Rate	$0.7 M	$0.43	
Total		**$137.75**	**12.25 / 13**

In sum, the recommended rate increase would support 12.25 new FTEs, primarily to "sustain current services" and 13 new TLTs, primarily to "position for the future". These additional positions would likely be proposed to be added in the Executive's proposed 2017/2018 biennial budget.

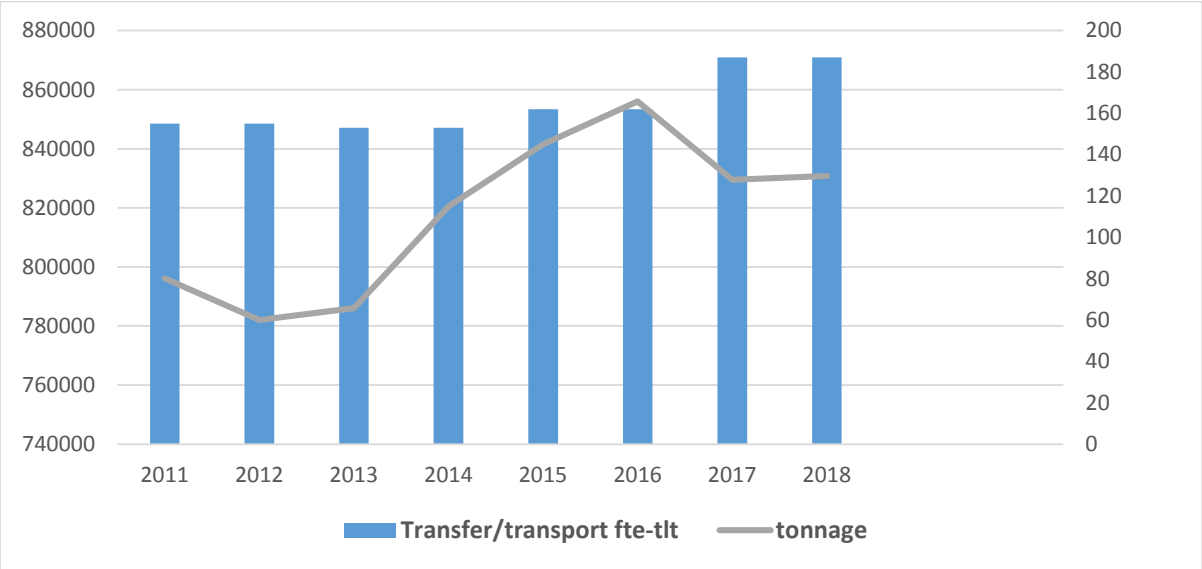
In describing the proposed new FTEs, the rate study defines four major categories of expenditure to: Sustain Current Services; Replace Aging Equipment; Fortify Cedar Hills Landfill Reserve Fund; and Maintain Closed Landfills.

Sustain Current Services

A number of the increased expenditures in this category will be familiar to the Council. In response to a proviso, the Executive, earlier this year, provided a report on closed landfills, noting that six landfills for which the County has responsibility are beyond their minimum monitoring date—but that there are continuing needs for managing environmental systems at the landfills, and the State Department of Ecology has not indicated any near-term date for termination of monitoring responsibility. This appears to represent a mandate for continuing expenditures to manage these custodial facilities.

This category also describes the need to pay for inflationary increases, and to replace aging equipment. It further refers to the need to pay for FTEs required to process increased tonnage at transfer stations. Specifically, the study refers to 10.25 new positions to "provide additional support at transfer stations and for transportation services to respond to increased solid waste tonnage, new station design, and expanded recycling services." However, as the table below demonstrates, system tonnage is anticipated to decline over the coming biennium:

Table 3. Growth of Transportation and Transfer Staff v. System Tonnage
(2017-2018 staffing based on proposed rate)



Transfer staff are those located at system transfer stations, responsible for cashiering, operating waste-moving equipment, assisting customers, and similar functions. Transportation staff drive loaded tractor/trailers from transfer stations to Cedar Hills.

Resource Recovery

In the 2015-2016 budget, the Executive requested, and the Council approved, 9 new positions designated to sort through waste piles at transfer stations, pulling out recyclable wood, metal and cardboard. These positions were to be located at Shoreline, Enumclaw

and Bow Lake transfer stations. Questions were raised at the time regarding the cost-benefit of these positions, and Council included a proviso in the budget with a requirement for consideration of a "self-haul surcharge" as an alternative approach to attaining progress in self-haul recycling and resource recovery. Such a surcharge would be placed on self-haulers who choose not to sort their loads. About 80% of the transfer station tons are the pre-sorted household/business volumes; the remainder are self-haul tons that are often not pre-sorted.

Transportation Services

The rate study also refers to additional support for "transportation services", as noted. In early discussions regarding the transfer station upgrade project, one of the key reasons offered for constructing new transfer stations was the placement of "compactors" that would compress waste loads for placement in trailers bound for Cedar Hills, with the expectation of substantial reduction in the numbers of tractor/trailer trips required from transfer stations. The Factoria Recycling and Transfer Station, largely completed, is making operational use of the new compactor at the station; June 2016 numbers show a 10% increase in tonnage over June 2015, but a 17% decline in numbers of loads leaving for Cedar Hills from that transfer station, from 533 to 443 trips. A similar decline was seen upon the completion of the Bow Lake Recycling and Transfer Station several years ago.

Self-Haul/Recycling

Self-haulers include clients who generate waste in different ways, including residents with large loads who are doing a major clean-up project, or who may not subscribe to curbside service; landscapers; home rehabilitation contractors; and others. According to the most recent waste monitoring survey,[2] 11% of visitors to transfer station indicate that it is cheaper, or it saves them money. Thirty-two percent of self-haul customers report that they do not subscribe to curbside garbage service at home.[3] Concurrently, self-haulers are among the lowest recycling waste generators; in 2011, they generated 208,815 tons of garbage, of which 9,630 tons were recycled (4.6%). Meanwhile, single family residents generated 376,537 tons of garbage in 2011, of which 248,727 were recycled (66%)[4].

The Executive is proposing increasing self-haul fees from $19.22 to $22.08 per entry (plus tax/MHW fee)—an increase of 14.8%. This increased rate will continue to leave the self-haul fee below that of local jurisdictions, except Snohomish County. Seattle's minimum self-haul fee is $30; Pierce County's minimum fee is $26.73 (plus tax). Snohomish County's self-haul fee is $20, which includes tax. Concurrently, many self-haul users of King County transfer facilities do not live in jurisdictions that are system participants. According to the Transfer Plan Review Final Report[5], 10% of Bow Lake weekend users are Seattle residents (Seattle is not a participant in the regional system); 61% of First Northeast (Shoreline) weekday users are Seattle residents (some proportion may return to the Seattle system upon completion of the Seattle North station, though Seattle minimum fees there are substantially higher, and cues may be longer); and 9% of First Northeast weekday users are from Snohomish County.

[2] http://your.kingcounty.gov/solidwaste/about/documents/waste-characterization-study-2011.pdf
[3] http://your.kingcounty.gov/solidwaste/about/documents/waste-characterization-study-2011.pdf p38
[4] http://your.kingcounty.gov/solidwaste/about/Planning/documents/2013-swd-comp-plan.pdf p3-19
[5] https://your.kingcounty.gov/solidwaste/about/Planning/documents/transfer-plan-review-part-2-report-final.pdf

Demand Management Pilot

As noted earlier, this proposed rate adjustment supports a demand management project intended to assess strategies to limit the extent of queueing, primarily at the Factoria Recycling and Transfer Station. This project is a follow-on to system discussions regarding potential wait-time impacts at the Factoria station, in the instance that the Houghton Transfer Station were closed and not replaced. The rate study indicates that the demonstration project is anticipated for 2018.

However, there are uncertainties regarding the project. As noted by the rate study, there is a question as to whether the review will involve a closure of the Houghton station during implementation. Station closure would clearly be disruptive to current facility users, both commercial and self-haulers. Certainly, discussions and outreach to the affected users would be required. Without a facility closure, however, it is unclear how the agency could assess the effectiveness of various alternatives, in terms of the choices of Houghton users to access alternative service options—as well as potential queueing impacts on next-closest transfer stations.

The rate study indicates that ten TLTs will be assigned to the demand management pilot program. Discussion of the actual function of these staff is limited; it is indicated that temporary staff would be added to assist customers at the Shoreline station. Presumably, these additional staff would be intended to mitigate impacts of additional queueing times at Shoreline, by helping to move customers more quickly through the unloading process. It is noted that the Executive is projecting reduced self-haul usage at Shoreline with the opening of the Seattle North station. The Rate Study notes that the self-haul fee at Factoria would be increased, and operating hours would be extended. The fee increase should not require additional staffing, though the extended operating hours may.

The demand management pilot will either A) demonstrate the viability of demand management strategies, or B) fail to demonstrate their viability. If the strategies are not proven viable, the region would need to assess its options, including whether to proceed with a North Recycling and Transfer Station, or how long to continue serving the disposal needs of the Houghton service area with the existing station.

By way of context, it is important to note the concerns of the County Auditor in the 2011 Performance Audit of Solid Waste Transfer Station Capital Projects. The Auditor expressed concern about the potential for "overbuilding" the transfer network upgrade:

> "An additional risk is that current rate payers could be financing more infrastructure than would be needed in the future, especially if cities drop out of the system after 2028 when the current interlocal agreement with the 37 city partners to the County's solid waste system expires." [6]

Since the 2011 Performance Audit, all but five of the city participants in the system have signed extended agreements, through 2040, as noted earlier.

[6] ttp://www.kingcounty.gov/~/media/operations/auditor/documents/2011Documents/SWD_Report_Final.ashx?la=en

In the meantime, the South County transfer station replacement project will have taken over a decade to site, design, permit, construct and open. A siting process in Northeast King County may encounter obstacles as well.

Landfill Reserve Fund

Staff has previously noted an opportunity for additional rate savings that was identified in the County Auditor's 2011 Performance Audit, having to do with the investment strategy of the Landfill Reserve Fund. The Audit noted,

> "Finally, as previously noted, part of the Landfill Reserve Fund (LRF) balance has an investment horizon extending to the year 2058. Nevertheless, the fund is invested in the same investment pool as other funds, whose overall liquidity objectives and needs are shorter term, for example, less than one year. It may be to the benefit of the Landfill Reserve Fund to have an alternative investment strategy. As an example, increasing the real (before inflation) rate of return on the LRF balance by a full one-percent could result in lowering the tipping fee by $.87 per ton in 2012. At the estimated 826,000 tons of waste for 2012, this would translate into a savings to rate payers of $717,000."

This LRF investment strategy revision has not yet been completed, though the Division has pursued a strategy review. Implementation of this recommendation during the 2017-2018 biennium has the potential to generate additional revenue for the Division. The Executive's proposed rate does not assume implementation of this recommendation in 2017/2018 – implementation of the recommendation would have the potential to generate additional revenue for the Division.

Debt Service for New Transfer Stations

The 2012 Rate Study, in support of the approved 2013-2014 rate proposal, discussed the projected repayment of bonded indebtedness that the Division than anticipated. At the time, there were a number of conditions that have since changed. The Council has directed a deferral in expenditures for the Northeast Recycling and Transfer Station, pending demonstration of need; the Executive has included funding for a demand management pilot in this proposed rate. Additionally, in 2012, there was an expectation of further progress in the replacement of the Algona Transfer Station with a new South Recycling and Transfer Station.

Table 4. 2012 Rate Study: Anticipated Station Upgrade Project Schedule

	2013	2014	2015	2016	2017	2018	2019
Bow Lake	open						
Factoria	Design and permit	construction		open			
South County	Siting	Design and permit		Construction			
Northeast	siting		Design and permit		construction		open
Algona						close	
Houghton							close
Renton						Close or modify operations	

However, progress in siting the South County facility has been delayed. After an extended effort to move forward in siting the facility, in February of this year, the Division issued a new "Notice of Availability of Draft EIS". A final EIS is anticipated for October of 2016. It is not clear that siting decisions will be completed this year, or precisely when design and permitting efforts, and subsequent construction activity--will begin. Initial project expenditures for the South County project began in about 2008, according to the 2006 rate study. By the time of completion, it is likely that the project would have taken over a decade from start to finish.

Table 5. 2012 Rate Study: Anticipated Transfer Station Upgrade Schedule

Comparison of Projected Northeast and South County Transfer Station Expenditures, 2012 v. 2016					
	2016	2017	2018	2019	2020
Northeast 2012	3,991,918	7,441,963	22,436,238	24,124,598	7,622,063
Northeast 2016	0	0	0	0	0
South County 2012	22,068,323	23,737,848	7,636,261		
South County 2016	798,000	2,509,510	6,275,223	6,441,625	34,153,561

The outcome of the process described above has been a delay in project expenditures, and in the case of Northeast, a deferral pending demonstration of need. As a result, anticipated bond sales have been delayed, and bond repayment has been rescheduled.

In addition to the rescheduling described above, most participating cities in the system have executed an extended and amended Interlocal Agreement committing to the regional solid waste system, continuing through 2040. This has had the effect of allowing bond sales that may be repaid over several decades, rather than having to be repaid by 2028, reducing the required level of annual payments.

The table below demonstrates the projected bond repayment schedule system wide, anticipated in 2012, compared to the bond repayment schedule as currently projected. In 2018, for example, the difference between the amount that had been projected for repayment, and the amount currently anticipated, is $14,414,424.

Table 6. Payments on Bonded Indebtedness: 2012 Projections v 2016 Projections

	2016	2017	2018	2019	2020
2012 Rate Study	21,704,322	24,753,779	28,014,087	30,710,638	31,481,491
2016 Rate Study	11,478,095	13,732,413	13,599,663	13,602,163	16,478,047

Cedar Hills

The Rate Study recommends $3.6 million to "Fortify the Cedar Hills Landfill Reserve Fund". One function of the Landfill Reserve Fund is to accumulate funding necessary to support monitoring and maintenance activities at the landfill for a 30-year period after its closure date. Over the last few years, the anticipated closure date has been moved

progressively further into the future, as waste volume projections have declined compared to earlier projections, and as landfill settlement patterns have become more defined. The agency has referred to closure dates of 2028 until recently.

For the first time, the current rate study reverses the trend of recent years, and identifies a closure date of 2027. This is noteworthy, in that it allows fewer years to accumulate needed post-closure maintenance/monitoring funding.

In the 2015-2016 budget, the Council approved an effort to update to the 2010 Cedar Hills Site Development Plan. That Plan had established county policy to acknowledge an in-county landfill as the least expensive disposal option, and to extend the life of the landfill to the extent possible. The Revised Site Development Plan was anticipated at the end of December 2015, later projected at July, 2016. The intent of the Revised Plan was to recommend strategies to further extend the life of the landfill; the rate study refers to "cost-effective capacity through 2040."

Timing

The proposed rate would become effective in January 2017. For the unincorporated area, such residential collection rates require approval by the Washington Utilities and Transportation Commission, therefore requiring action by the Council at least 90 days in advance to allow necessary WUTC review time before the January effective date. RCW 36.58.045 requires that:

"Each county imposing the fee authorized by this section shall notify the Washington utilities and transportation commission and the affected solid waste collection companies of the amount of the fee ninety days prior to its implementation."

Cities incorporate the rate adjustment into their rates; the Executive seeks to allow them a 3-month period to accomplish the adjustment before the start of 2017. Additionally solid waste haulers, who pay the basic rate for deposit of waste at transfer stations, adjust their monthly rates paid by homeowners for residential collection based on this basic rate. If the Council's action were delayed beyond September, the new rate would not be able to go into effect at the start of the year.

ATTACHMENTS

1. Proposed Ordinance/Motion 2016-0386 with
   Attachment A: Executive Proposed Solid Waste Disposal Fees for 2017-2018 (and its attachments)
2. Fiscal Note
3. Transmittal Letter

INVITED

Pat McLaughlin, Director, Solid Waste Division (SWD), Department of Natural Resources and Parks (DNRP)
Meg Moorehead, Strategy, Communications & Performance Manager, SWD, DNRP

KING COUNTY

Signature Report

August 22, 2016

Ordinance

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Proposed No. 2016-0386.1 **Sponsors** Upthegrove

AN ORDINANCE relating to solid waste fees charged at recycling and transfer facilities and at the Cedar Hills regional landfill; and amending Ordinance 12586, Section 2, as amended, and K.C.C. 10.12.021.

STATEMENT OF FACTS:

1. The solid waste division of the department of natural resources and parks provides essential public services that protect human health, the environment, and the quality of life in our region.

2. The solid waste division operates the Cedar Hills regional landfill, eight transfer stations, and two drop boxes. It also provides innovative programs to help customers recycle and prevent waste.

3. The solid waste division is an enterprise fund, supporting almost all (ninety-five percent) of its services with a basic fee charged for each ton of municipal solid waste received at county facilities.

4. The solid waste basic fee for 2013-2014 took effect on January 1, 2013, with a further increase scheduled for the 2015-2016 rate period.

5. By achieving efficiencies and refocusing priorities, the division made the two-year rate last four years, so that customers will pay twenty-two

million dollars less in 2015 and 2016 than if fees had increased as scheduled.

6. A fee increase can no longer be deferred if the solid waste division is to sustain current services, repay debt on previously approved transfer station projects, reinforce service reliability, and test demand management methods at transfer stations.

7. The proposed new basic fee is less than the 2017 fee projected in the last rate proposal and in line with rates charged by comparable solid waste service providers in the region.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. A. This ordinance proposes changes to the fees currently charged for solid waste disposal at solid waste transfer stations and drop boxes and at the Cedar Hills regional landfill.

B. These fees are established and assessed pursuant to RCW 36.58.040, RCW 70.93.070 and K.C.C. 10.08.040.

SECTION 2. Ordinance 12586, Section 2, as amended, and K.C.C. 10.12.021 are each hereby amended as follows:

A. All persons using county-operated solid waste transfer stations and drop boxes shall pay the service fees in the following schedules:

1. Solid waste disposal:

Passenger cars	$((~~19.22~~)) 22.08 per entry
Other vehicles	$((~~120.17~~)) 137.75 per ton
Charitable organizations	$((~~92.55~~)) 106.07 per ton

Minimum	$((~~19.22~~)) 22.08 per vehicle
Charitable organizations, minimum charge	$((~~15.08~~)) 16.97 per entry

2. Deposit of source-separated yard waste at yard waste collection areas, clean wood at clean wood collection areas, or any combination thereof:

Passenger cars	$12.00 per entry
Other vehicles	$75.00 per ton
Minimum charge	$12.00 per vehicle

3. Deposit of white goods at white goods collection areas:

White goods without regulated refrigerants	$10.00 per unit
White goods with regulated refrigerants	$30.00 per unit

B. Service fees for the use of solid waste facilities without scales shall be based upon the cubic yard or fraction thereof as follows:

1. Solid waste disposal:

Passenger cars	$((~~19.67~~)) 22.08 per entry
Other vehicles:	
Compacted wastes	$((~~35.31~~)) 39.95 per cubic yard
Uncompacted wastes	$((~~20.70~~)) 23.42 per cubic yard
Minimum charge	$((~~19.67~~)) 22.08 per vehicle

2. Deposit of source-separated yard waste at yard waste collection areas, clean wood at clean wood collection areas, or any combination thereof:

Passenger cars	$12.00 per entry
Other vehicles:	
Compacted wastes	$21.75 per cubic yard

Uncompacted wastes	$12.75 per cubic yard
Minimum charge	$12.00 per vehicle

C. Service fees at the Cedar Hills regional landfill shall be:

Cedar Hills Regional Direct	$((~~103.50~~)) 117.00 per ton
Other vehicles	$((~~121.75~~)) 137.75 per ton

Disposal by other vehicles is at the discretion of the division director.

D. A moderate-risk waste surcharge shall be added to all solid waste disposed by nonsolid waste collection entities using county operated solid waste facilities. The fee schedule is as follows:

1. For facilities with scales:

Self-haulers	$4.73 per ton
Minimum charge	$1.81 per entry
Passenger cars	$1.81 per entry

2. For facilities without scales:

Compacted	$1.04 per cubic yard
Uncompacted	$0.59 per cubic yard
Minimum charge	$1.81 per entry
Passenger cars	$1.81 per entry

E. As determined by the division director, a special waste fee shall be charged for special waste including asbestos-containing waste material and other wastes requiring clearances in accordance with King County Board of Health Code Title 10 or rules adopted by the department.

Special waste fee	$((~~145.00)) 165.00~~ per ton

Special waste fee minimum charge	$((~~23.20)~~) 26.45 per entry
Special waste fee, extra handling	$((~~175.00~~)) 193.00 per ton
Special waste fee, extra handling minimum charge	$((~~28.00)~~) 30.86 per entry

F. In the absence of exact weights or measurements, the estimate of the solid waste division director is binding upon the user.

G. The solid waste division director may establish fees for handling and processing of recyclable materials for which no other fee has been established

by ordinance. Consistent with WRR-1, WRR-2, WWR-4 and WRR-36, the fees need not recover the full cost of handling and processing.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

J. Joseph McDermott, Chair

ATTEST:

_____

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: A. Executive Proposed Solid Waste Disposal Fees for 2017-2018

Executive Proposed Solid Waste Disposal Fees for 2017-2018

June 30, 2016

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Executive Proposed Solid Waste Disposal Fees for 2017 and 2018

Executive Summary

The King County Solid Waste Division operates eight transfer stations, the Cedar Hills regional landfill, and waste prevention and recycling programs for the unincorporated area and 37 partner cities. The division is proposing an increase in its basic rate (tipping fee) from $120.17 to $137.75 per ton for 2017 and 2018. Other King County solid waste rates and fees are unchanged except for those set as a percent of the basic rate. The system wide average effect on single-family curbside customers would be about $0.94 per month, representing a five percent increase on a $20 monthly bill, which is in the mid-range of bills charged in partner cities and the unincorporated area.

The current rate was adopted for 2013-2014, with an increase scheduled for 2015-2016. While the impacts of the recent recession were reverberating through the economy, the Solid Waste Division pursued efficiencies and deferred facility maintenance and equipment replacement to make the two-year rate last four years, and give the economy and consumers time to more robustly and sustainably recover. Had rates increased as planned in 2015, customers would have paid $22 million more during the 2015-2016 biennium. The cost of current services has increased over the past four years and further deferral of investments in equipment and operations would have significant adverse impacts to the solid waste system. The proposed 2017-2018 rate will provide revenue needed to sustain current services, help catch-up on deferred system investments, and adapt to a rapidly changing industry.

The new rate will primarily fund the increased cost of current services, including waste transfer, disposal, and waste prevention and recycling programs, while maintaining fundamental support services, such as human resources, finance, and system-wide planning conducted in conjunction with partner cities. The rate also repays new debt for construction of previously approved new transfer stations at Factoria and South County.

In addition to sustaining current services, new spending is proposed to:

- **Enhance service reliability** including upgrading the transfer station cashiering system, improving wastewater systems at Cedar Hills to ensure continued regulatory compliance, education costs and operational changes required to implement new recycling requirements for transfer station self-haulers, and completing new development in Area 8 to extend the life of Cedar Hills.
- **Implement the Equity and Social Justice (ESJ) Initiative and the Strategic Climate Action Plan** through the “Recicla Más. ¡Es Facilísmo!” program, installing Spanish language signs at transfer stations and establishing an opportunity fund for

staff-generated actions to advance ESJ goals. Initiatives like piloting compressed natural gas/diesel hybrid technology within the division fleet support the goals of the Strategic Climate Action Plan.

- **Position for the Future** by conducting a demand management pilot project in 2018 to test changes to services, hours, and prices at existing transfer stations. If the demand management pilot program meets its goals, it could alleviate the pressure to build new transfer stations or alternatively, reduce the costs of a new station currently estimated at $97 million, reducing future rate increases.

The proposed 2017-2018 basic fee of $137.75 per ton is slightly lower than the $140.00 per ton fee projected for 2017 in the last rate proposal. It is also in line with rates for comparable solid waste providers in the region – lower than Pierce County, but higher than Snohomish County.

Introduction

King County has provided reliable, environmentally responsible solid waste services for fifty years. Since introducing recycling programs in the 1980s, King County has been a leader in diverting waste from the landfill with residents and businesses recycling 54 percent of their waste in 2013, the last year for which State-collected data is available. The *2015 Strategic Climate Action Plan* set higher goals – striving for a recycling rate of 70 percent by 2020 as a crucial step toward the long-term goal of zero waste of resources by 2030.

Interlocal agreements require the division to provide disposal for signatory cities through 2040, yet low-cost capacity at the Cedar Hills Regional Landfill (Cedar Hills) is finite. The adopted 2001 *Comprehensive Solid Waste Management Plan* (Comp Plan) states, "the policy of King County shall be to monitor and analyze conditions impacting the appropriateness, feasibility, and timing of waste export on a continuous basis." The 2006 *Solid Waste Transfer and Waste Management Plan* calls for waste to be exported when Cedar Hills reaches capacity and for the division to maximize the capacity of Cedar Hills "subject to environmental constraints, relative costs to operate, and stakeholder interests." Development of Cedar Hills Area 8, approved in the *2010 Cedar Hills Project Program Plan*, provides capacity into 2027. Cost-effective capacity through 2040 could be provided through development beyond Area 8.

After avoiding a previously planned rate increase for 2015-2016, the division is proposing a rate increase effective January 1, 2017, to continue providing safe, sustainable, and environmentally sound management of the region's solid waste, and to reach the county's goals for recycling. Under this proposal, the basic fee would increase from $120.17 per ton to $137.75 per ton for the two-year period of 2017 and 2018, which is consistent with the rate forecast in 2012. The system-wide average effect on single-family curbside customers would be about $0.94 per month, representing a five percent increase on a $20 monthly bill, which is in the mid-range of bills charged in partner cities and the unincorporated area.

Proposed Fees

The following fees are proposed to change on January 1, 2017:

- **Basic Fee:** A fee charged to commercial curbside collection companies and to residential and business self-haulers who bring solid waste to division transfer facilities. The basic fee accounts for more than 95 percent of revenues. The division proposes an increase in the basic fee from $120.17 to $137.75 per ton for 2017 and 2018.

  As a consequence of the increase in the basic fee, the other fees that are meaningfully impacted by the increase in the basic fee are the Regional Direct

Fee, the Special Waste Fee, and Special Waste Extra Handling Fee. Collectively, these fees make up approximately one percent of total revenue.

- **Regional Direct Fee:** A discounted fee charged to commercial collection companies that haul solid waste to Cedar Hills from their own facilities, thus bypassing division transfer stations. The fee is approximately 85 percent of the basic fee; this fee will increase by approximately 13 percent, to $117 per ton.

- **Special Waste Fee:** Special wastes are non-hazardous waste materials that require special handling and/or record-keeping. Special waste must be cleared through the division's waste clearance program. The special waste fee will increase by approximately 14 percent to $165 per ton.

- **Special Waste Extra Handling Fee**: Some special wastes, such as asbestos, are more expensive to manage due to handling and record-keeping requirements beyond the waste clearance process. The special waste extra handling fee will increase by 10 percent to $193 per ton.

All other King County solid waste rates and fees will be unchanged. **Table 1** compares current and proposed fees charged by the division.

Table 1: Comparison of current and proposed tipping fees

	Last Change	Current Fee ($)	Proposed Fee ($)	Change in Fee ($)	Percent Change
Basic	**2013**	**120.17**	**137.75**	**17.58**	**15%**
Regional Direct	**2013**	**103.50**	**117.00**	**13.50**	**13%**
Yard Waste and Clean Wood	**2013**	**75.00**	**75. 00**	**---**	**---**
Special Waste	**2013**	**145.00**	**165.00**	**20.00**	**14%**
Special Waste - extra handling	**2013**	**175.00**	**193.00**	**18.00**	**10%**
Appliances CFC	**2013**	**30.00**	**30.00**	**---**	**---**
Appliances Non-CFC	**2013**	**10.00**	**10.00**	**---**	**---**
Unsecured loads	**2013**	**25.00**	**25.00**	**---**	**---**

The proposed 2017-2018 rate of $137.75 per ton is lower than projected in the last rate proposal (**Figure 1**). It is in line with rates for comparable solid waste providers in the region – lower than Pierce County and Seattle, but higher than Snohomish County (**Table *2***).

Figure 2: 2017-2018 Rate proposal compared to 2013-2014 rate proposal projections

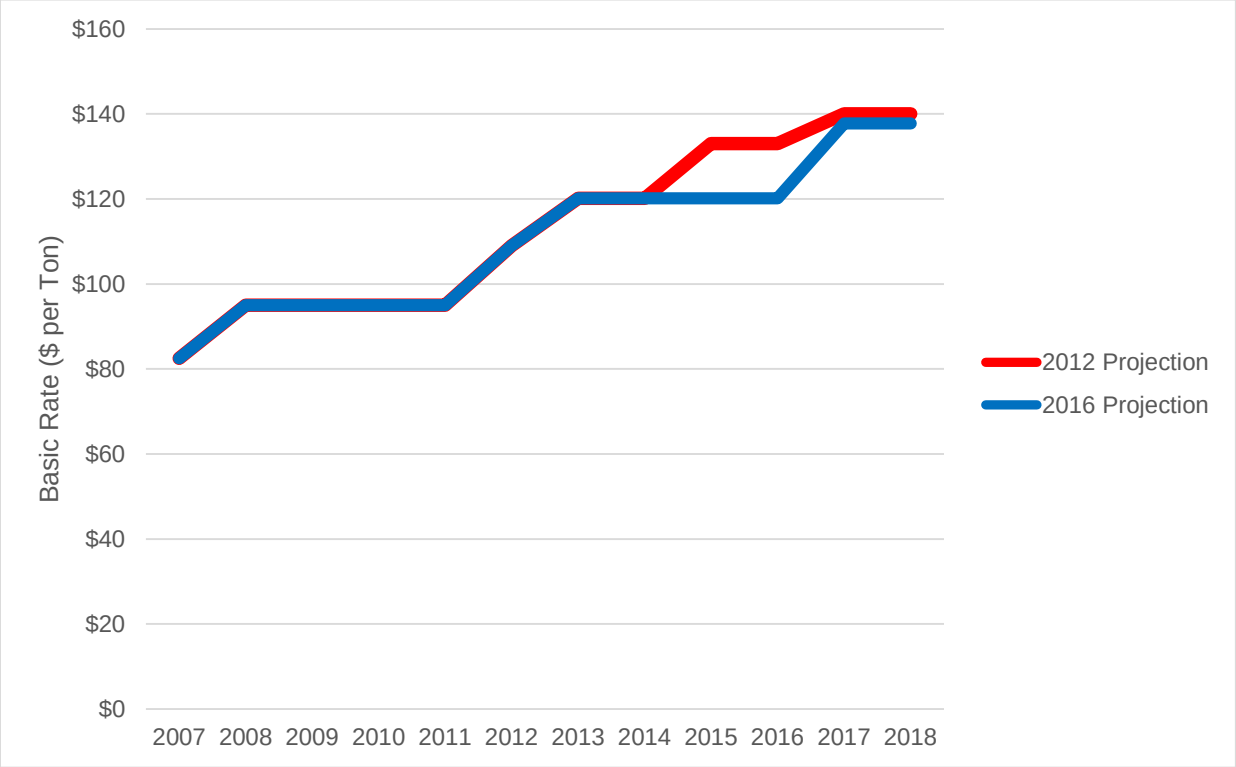

Table 2: Proposed King County solid waste fee compared to peer jurisdictions

Jurisdiction	Basic Fee[1]
Clark County	$87.56
King County proposed	$137.75
Pierce County	$145.84
Seattle City	$145.00
Snohomish County	$105.00
Spokane County (includes city)	$101.00
Thurston County	$119.00

[1] As of 2016

Financial Context

The division uses an enterprise fund, managing nearly all of its expenses with revenues earned through fees (called tipping fees) paid for disposal of waste at its transfer facilities and Cedar Hills. Services supported by the fees include:

- Transfer - Build and operate convenient and efficient transfer stations and drop boxes where many small loads of waste and recyclables are combined into larger loads. Transport waste from stations to Cedar Hills.
- Disposal - Develop and operate Cedar Hills where more than 880,000 tons of solid waste is disposed each year and landfill gas is used to produce energy and fuel. Monitor and maintain seven closed landfills to meet regulatory requirements.
- Recycling - Conduct waste prevention and recycling programs for curbside customers and at transfer stations to protect the environment and quality of life.
- Support Services - Meet customer needs and provide support functions needed to operate the solid waste system including human resources, finance, and system-wide planning.

Beginning in late 2007, a nationwide financial crisis triggered a precipitous, years-long decline in the amount of waste being disposed. Tonnage and rate revenue declined substantially, resulting in service reductions including suspension of recycling services at transfer stations, delaying regular facility maintenance, and deferring equipment replacement, in a bid to reduce expenses and mitigate a need to increase rates.

A rate increase that partially restored service and maintenance levels was adopted for 2013-2014, with a second increase planned for 2015-2016. By pursuing further efficiencies, the division was able to manage a seven percent increase in waste tonnage, wage and services inflation, and new debt service for transfer station construction without the planned 2015-2016 rate increase. Had rates increased as planned in 2015, customers would have paid $22 million more during the 2015-2016 biennium. A fee increase can no longer be deferred if the division is to sustain its current services, enhance service reliability, and keep up with a rapidly changing industry.

Additional revenue from the fee increase will sustain current services, ensure service reliability, fund county strategic priorities, and position the division for the future. The rate proposal also accounts for the County's increasing recycling rate which is projected to reduce solid waste disposal tons and associated disposal fees. **Table 3** summarizes the projected spending, per ton rate impact, and new required positions related to the rate proposal. In total, the rate proposal will increase the basic fee by $17.58 per ton from $120.17 to $137.75 with approximately 80 percent of the rate increase directed to fund the rising costs of current services.

Table 3: Components of 2017-2018 Rate Increase

	2017-18 Expenditures ($ in millions)	2017-2018 Rate Impact ($ per ton)	New FTEs/TLTs required
Current Basic Fee		$120.17	
Sustain Current Services			
Cover Inflationary Increases	$12.5 M	$5.49	10.25 / 0
Debt Service for New Transfer Stations	$7.1 M	$3.10	
Replace Aging Equipment	$ 6.8 M	$2.98	
Fortify Cedar Hills Landfill Reserve Fund	$3.6 M	$1.59	
Maintain Closed Landfills	$2.5 M	$1.07	
Subtotal Sustain Current Services	*$32.5 M*	*$14.23*	*10.25 / 0*
Ensure Service Reliability	$3.6 M	$1.58	1 / 3
Address County Strategic Priorities	$1.1 M	$0.46	1 / 0
Position for the Future	$2.0 M	$0.88	0 / 10
Adjustment for Increased Recycling Rate	$0.7 M	$0.43	
Total		**$137.75**	**12.25 / 13**

The new spending categories within the 2017-2018 rate proposal include:

Sustain Current Services by funding current services and their increased cost including waste disposal at the Cedar Hills Regional Landfill, operation of eight transfer stations and two drop boxes, maintenance of closed landfills, waste prevention and recycling programs, and paying for support services (such as human resources, finance, and system wide planning) that are fundamental to system operations. Functions and projects include:

- **Cover Inflationary Increases.** Pay primarily for inflationary increases in division activities, rent, taxes, insurance, FTEs required to process increased tonnage and other factors.
- **Debt Service for New Transfer Stations** including the new Factoria transfer station, the planned South County transfer station, and other projects. Construction of new recycling and transfer stations is financed through General Obligation (GO) bonds. The new Factoria and South County stations will be under development during the 2017-2018 rate period, in accordance with the 2006 Solid Waste Transfer Plan. No funding is allocated for a new Northeast Station, which remains an option for 2019 or beyond.

- **Replace Aging Equipment.** Begin to catch up on replacing equipment through the Capital Equipment Recovery Fund. The rate proposal will allow the division to accelerate replacement of equipment to normal life-cycles, reduce ongoing maintenance costs, and improve efficiency of the waste management system.
- **Fortify Cedar Hills Landfill Reserve Fund.** Increase the contribution to pay for landfill capacity to meet disposal needs into 2027, and maintain sufficient balances to meet regulatory requirements. As approved in the *2010 Cedar Hills Site Development Plan*, new disposal capacity called Area 8 is being developed. To cover increased landfill development costs associated with development of Area 8 and to maintain reserve funding requirements, contributions to the Landfill Reserve Fund need to increase from the amount in the last rate proposal.
- **Maintain Closed Landfills.** Pay for ongoing monitoring and maintenance of 7 closed landfills to meet regulatory requirements. Current federal and state regulations prescribe a strict monitoring and maintenance regime for up to 30 years after a landfill closes. Funds for monitoring and maintenance during the regulatory period must be set aside in the landfill Post-Closure Maintenance Fund (PCMF). Six of the seven closed landfills that the division monitors and maintains are beyond the regulatory period during which funds must be set aside in a separate fund. However, pollutants at those sites still exceed levels at which monitoring can be discontinued. There is no known date when monitoring and maintenance will no longer be necessary. Funds to monitor and maintain closed landfills that are beyond their regulatory period are included as an ongoing operational cost and are increased from the last rate proposal

Ensure Service Reliability by funding upgrades to the transfer station cashiering system; new rate structure to sustain revenue while recycling rates increase; improving wastewater systems at Cedar Hills to ensure continued regulatory compliance; purchasing an additional tipper; and other means.

Address County Strategic Priorities by funding efforts to implement Equity and Social Justice (opportunity fund); Best Run Government (employee engagement and business planning); and Strategic Climate Action Plan (compressed natural gas pilot project study) initiatives.

Position for the Future by funding a transfer station demand management pilot program in 2018 to explore methods for reducing customer wait times, encouraging use of stations during off-peak hours, and shifting use to less busy stations.

Demand management strives to make better use of existing transfer stations by moving customers more swiftly through the station or reducing the number of customers in a station at one time. Analytical models have been developed to explore methods for reducing customer wait times, encouraging use of stations during off-peak hours, and

shifting use to less busy stations. The proposed rate includes a 2018 demand management pilot project to test the practical effectiveness of the modeled actions at urban transfer stations. If the demand management pilot program meets its end goals, it could alleviate the pressure to build new transfer stations or, alternatively, reduce the costs of new facilities currently estimated at $97 million, reducing future rate increases.

Consistent with the modeling results of a 2015 transfer station study, the scope of the demand management pilot program focuses on the Factoria and Shoreline Recycling and Transfer Stations. The pilot project would run for 12 months beginning in 2018. During the pilot project, the per-ton fee for self-haulers at the Factoria station would be increased during peak hours on weekdays and on weekends. The current assumed peak hours are a four-hour period between 11 a.m. and 3 p.m. Operating hours would be extended on weekdays until 10 p.m. and on weekends until 7:30 p.m.. Additionally, temporary staff would be added to assist customers at the Shoreline station. The use of the Houghton station during the pilot remains under evaluation.

The Metropolitan Solid Waste Management Advisory Committee (MSWMAC) suggested that demand management be tested at all urban stations for a 12-month period to provide an equitable distribution of potential impacts of the pilot measures to the County solid waste system users. While the proposed scope for the pilot project will not affect all transfer stations, it is designed to provide information on equity, service levels and effectiveness that may be incorporated at other stations in the future. Adding additional stations to the pilot is possible, however, it would present a significant cost increase to the study and may not add significant benefit to the ability to evaluate the measures.

Revenue from peak pricing was not included in this rate proposal due to the uncertainty of the pilot results at this time. Following the conclusion of the pilot in 2018, the division will evaluate the effectiveness of demand management and consider including peak pricing revenue in future rate proposals.

Additional Regular and Temporary Positions

The proposed rate increase will fund 12.25 FTEs and 13 temporary TLT positions for a total of 25.25 new positions in 2017-2018. Many of the new positions (10 TLTs) will be assigned to the demand management pilot program. An additional 10.25 positions will provide additional support at transfer stations and for transportation services to respond to increased solid waste tonnage, new station design and expanded recycling services. Two FTE positions and one TLT position would support new stormwater engineering requirements, county strategic priorities related to improved employee engagement and business planning, and the division's planned rate restructure. Two TLT positions will be added to manage the post-closure landfills and Cedar Hills landfill capital projects.

Determining the Rate

The basic fee is calculated using the tonnage forecast, projected costs, projections of revenue from all sources (including the fund balance), and fund balance requirements. The rate model comprises five economic and financial components:

- Tonnage
- Landfill Reserve Fund
- Construction
- Capital Equipment Recovery Program
- Operating Fund

Fees are calculated to ensure that revenues are sufficient to reliably:

- Cover the cost of operations and services,
- Fund capital investment projects and landfill closure and maintenance, and
- Maintain a target Operating Fund balance.

The division's expenditures over the rate period are estimated, including operating and support service costs and transfers to reserve funds. Anticipated revenues from all non-fee sources, such as grants, interest income, landfill gas sales, and available fund balance are subtracted from the total expenditures to arrive at the fee revenue that will be needed to support the system over the rate period. That amount is divided by the forecasted tonnage to determine a per-ton basic fee. Other fees are determined using both the basic fee as a foundation and factors specific to the fee categories. The fee is then adjusted to account for non-tip fee revenue and use of available fund balance for a final basic fee.

Financial Assumptions

Key financial assumptions in the division's rate model include inflation, interest, and the potential date of closure for Cedar Hills. Forecasts for inflation are used in the rate model to help estimate future operational and capital costs, while forecasts for interest earnings are used to calculate revenue that will be earned on fund balances. For more information, see http://www.kingcounty.gov/business/Forecasting/Forecasts.aspx.

Table 4: Financial Assumptions

Projected Wage and Services Inflation (OEFA March 2016 CPI-U Forecast)

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 to 2040
2.41%	2.71%	2.72%	3.01%	3.06%	3.04%	2.98%	2.96%	2.91%	2.50%

Projected Investment Pool Nominal Rate of Return (OEFA March 2016 CPI-U Forecast)

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 to 2040
0.80%	1.10%	1.52%	2.07%	2.50%	2.83%	3.08%	3.28%	3.44%	3.00%

The closure date for Cedar Hills determines how much time is available to collect the required funds in the LRF for thirty years of post-closure maintenance. Under current policy, Cedar Hills will close in 2027.

Tonnage Forecast

A fundamental input to the rate model is the projected amount of waste that will be disposed at division facilities during the rate period. The tonnage forecast predicts waste generation over a 20-year period. The forecast relies on established statistical relationships between waste generation and economic and demographic variables that affect it, such as population, employment rates, and income. Although 2016 has started strong, tonnage is expected to decrease when the City of Seattle reopens its North Transfer and Recycling facility sometime this year. Over time, increased waste generation will replace tonnage lost to the Seattle system, returning to current levels by 2019 (Table 1, Appendix A).

Increases in the recycling rate (forecast to reach 57 percent by 2018) will slow increases in waste tonnage. Resource recovery (recycling that takes place after waste is delivered to division transfer stations) is expected to increase dramatically as new recycling and transfer stations are built with the ability to handle more recyclable materials and station-based resource recovery is expanded. Increased curbside recycling is expected in response to new programs. Appendix A describes the tonnage forecasting process and gives the tonnage forecast through 2036.

Table 5: 2017-2018 tonnage forecast by site

Transfer Station	2017	2018
Factoria	122,230	122,424
Houghton	153,495	153,740
Renton	66,049	66,154
Algona	143,138	143,367
Bow Lake	244,459	244,849
Shoreline	52,098	52,181
Enumclaw	21,593	21,627
Vashon	7,328	7,340
Cedar Falls Drop Box	3,811	3,817

Skykomish[2]	1,100	1,100
Subtotal	**810,467**	**811,759**
Cedar Hills Regional Direct		
Regional Direct	6,500	6,500
Special Waste	1,500	1,500
Other Waste	19,000	19,000
Subtotal	27,000	27,000
Total Disposed	**837,467**	**838,759**
Yard waste (transferred to a composting facility)	13,500	16,500

Revenue Projections

The division generates about 95 percent of its revenues from tipping fees collected at its transfer facilities and Cedar Hills. Most of the remaining five percent is received from the Local Hazardous Waste Management Program (LHWMP), which pays for the handling of household hazardous waste. Other minor revenue sources include:

- Interest earned on fund balances,
- Income from rental properties,
- Fees for construction and demolition waste,
- Revenue from the sale of recyclable materials received at division transfer facilities,
- Fees on recyclables collected in unincorporated areas,
- Grants to help clean up litter and illegal dumping and to support waste prevention and recycling,
- Revenue from the sale of landfill gas from Cedar Hills.

Revenue from most sources can vary considerably due to economic and market conditions.

[2] Solid waste collected at the Skykomish drop box is transported to the Houghton transfer station for disposal. Projected tons for Skykomish are shown for illustrative purposes, but are counted in the Houghton tonnage figures.

Expenditure Projections

The division's annual spending over the planning horizon is estimated based on operational factors as well as forecasts for inflation, which are consistent with other County agencies. Expenditures can be divided into broad categories: operating costs, recycling programs, support service costs, debt service, and transfers to other funds.

Operating Costs: Disposal and Transfer

Operating costs, the day-to-day expenses for transfer, transport, and landfill operations, constitute the majority of all division spending. Maintenance of equipment and facilities, management of landfill gas and wastewater, business and occupation (B&O) tax, and Cedar Hills' rent are also included here.

Recycling

This includes grants to the cities and other division waste prevention and recycling programs.

Support Services

This cost category includes functions that support direct services, such as engineering, finance, management, and system-wide planning.

Debt Service

Debt service is the payment of interest and principal on bonds and loans. GO bonds backed by the full faith and credit of the county's General Fund have been issued to pay for development of major transfer facility capital projects. It is anticipated that with approval of the King County Council, GO bonds will continue to be issued for transfer facility capital projects. More information on the Capital Improvement Program is provided in Appendix C: Capital Improvement Program. Capital projects at Cedar Hills are not funded through debt financing, but through the LRF.

Transfers to Other Funds

Transfers from the Solid Waste Operating Fund to reserve funds were established to ensure that the division can meet future expenses, including those mandated by law. Contributions to reserve funds are routinely evaluated to ensure that they are adequate to meet short- and long-term needs. Paying into reserve funds stabilizes the impact of certain expenses on rates by spreading the costs over a longer time period and ensures that customers who use the system pay the entire cost of disposal. The four reserve funds are discussed below.

Construction Fund

The division deposits bond proceeds and contributions from the operating fund into the construction fund to finance new construction and major maintenance of properties owned by the division. Contributions from the operating fund reduce the need to borrow.

Capital Equipment Recovery Program

The CERP is codified in KCC 4.08.280. Its purpose is to provide adequate resources for replacement and major maintenance of solid waste rolling stock (primarily hauling trucks

and trailers) and compactors. New equipment is purchased from the operating fund, but after the initial purchase, replacements are funded from the CERP.

By accumulating funds in the CERP, the division ensures that it is able to cover the variable expenditures that come with replacing needed equipment even while revenue fluctuates. Contributions to the CERP are calculated by projecting future replacement costs, salvage values, and equipment life. Contributions are adjusted to reflect changes in facilities and operations that affect equipment needs. The contributions earn interest in an account until needed. The CERP is discussed in detail in Appendix E: Capital Equipment Recovery Program.

Landfill Reserve Fund

The LRF, codified in KCC 4.08.045, covers the costs of four major accounts maintained for Cedar Hills.

- The *new area development account* covers the costs for planning, designing, permitting, and building new disposal areas, ensuring sufficient funds for these capital projects.
- The *facility improvements account* covers a wide range of capital investments required to sustain landfill infrastructure and operations, such as the landfill gas and wastewater systems.
- Mandated by federal law, the *closure account* covers the cost of closing operating areas (cells) within the landfill that have reached capacity.
- The *post-closure maintenance account*, mandated by federal law, accumulates funds for 30 years of post-closure maintenance of Cedar Hills.

Post-Closure Maintenance Fund

In accordance with federal regulation 40 CFR 258.61, the PCMF pays for the maintenance and environmental monitoring of closed and custodial landfills in the county for thirty years after closure. Custodial landfills beyond their mandated post-closure period continue to be monitored and maintained through this fund until pollution levels drop below mandated levels. Once Cedar Hills closes, the balance of the LRF will be transferred to the PCM for Cedar Hills' 30-year closure care period.

<u>Target Fund Balance</u>

The current policy is to retain an average balance in the operating fund sufficient to cover 30 days of direct operating costs.

Appendix A: Tonnage Forecast Through 2036

Short-term Forecasting

Since 2007, there has been greater uncertainty and unpredictability in variables that inform the division's short-term (up to five years) forecast. The division's short-term forecasting method involves:

- Monitoring daily solid waste tons delivered to the division's facilities.
- Monitoring regional and state-wide economic forecasts (Dick Conway, King County economic forecast, Washington State Economic and Revenue Forecast Council).
- Monitoring state-wide tax revenue streams, particularly in the home improvement sector, furniture store sales, clothing sector, and other key markets.
- Communicating with other jurisdictions about trends in their service areas.

The information gained through these measures is used to forecast short-term tonnage and subsequent revenues for use in critical budgeting, expenditure control, and management of capital projects over the three-to-five year period. By the end of the 2017-2018 budget cycle there will be enough post-recession data to adjust the forecasting model to reflect any long-term changes resulting from the recession.

Long-term Forecasting

The planning forecast model to predict solid waste generation over the long-term (six to 20 years) relies on established statistical relationships between waste generation and various economic and demographic variables that affect it, such as:

- Population in the service area
- Employment rates
- Household size (persons/household)
- Per capita income (adjusted for inflation)

For the long-term planning forecast the following trends are expected:

- Population is expected to grow at a rate of 0.9 percent per year. Population growth is directly correlated with increased waste generation.
- Employment is expected to increase by 1.3 percent per year. Increased employment is generally accompanied by an increase in consumption and waste generation.
- Household size is expected to decrease by 0.3 percent per year. Since "household," regardless of the number of residents, implies a certain minimum level of maintenance, mail, purchasing, etc. A decrease in household size tends to increase waste generation per capita.
- Per capita income is expected to increase by 1.8 percent per year. As with employment activity, increases in income typically lead to an increase in spending, hence more consumption and more waste generation.

For additional information on long-term forecasting, see 2000 King County Comprehensive Solid Waste Management Plan, Technical Appendix (vol. I).

In response to the King County Auditor's report recommendations (2015), the division conducted sensitivity analyses around key assumptions that affect the long-term forecast trends, including changes to the recycling rate projection.

The tonnage forecast is developed in two steps, with waste disposal and waste diversion calculated separately. In the first step, an econometric model is used to relate historical data for waste disposal and recycling to past demographic and economic trends in the region. Once these relationships are established, the model can be used to project future waste generation based on expected trends over the planning period. This produces a baseline disposal forecast, which assumes that the percentage of waste recycled remains constant.

In the second step, goals for waste prevention and recycling are used to calculate how much additional material is expected to be diverted from disposal given the same demographic and economic trends. This information is then used to adjust the baseline forecast. Recycling data are provided by the curbside collection companies, the division's own transfer facilities, and annual surveys by the Washington State Department of Ecology. Table 1-A shows the tonnage forecast through 2036 (as of February 17, 2016).

Table 1-A Tonnage Forecast Through 2036

Year	Basic Fee Tons	Regional Direct	Special Waste	Tons Disposed	Yard Waste	Total System Tons
2015	861,621	6,384	1,797	869,802	11,723	881,525
2016	856,100	6,500	1,500	864,100	12,000	876,100
2017	829,467	6,500	1,500	837,467	13,500	850,967
2018	830,759	6,500	1,500	838,759	16,500	855,259
2019	853,700	6,500	1,500	861,700	16,500	878,200
2020	892,440	6,500	1,500	900,440	16,500	916,940
2021	923,737	6,500	1,500	931,737	16,500	948,237
2022	955,775	6,500	2,000	964,275	16,500	980,775
2023	984,579	6,500	2,000	993,079	16,500	1,009,579
2024	1,012,137	7,000	2,000	1,021,137	16,500	1,037,637
2025	1,037,527	7,000	2,000	1,046,527	16,500	1,063,027
2026	1,058,236	7,000	2,000	1,067,236	16,500	1,083,736
2027	1,079,391	7,000	2,000	1,088,391	16,500	1,104,891
2028	1,095,594	7,000	2,000	1,104,594	16,500	1,121,094

2029	1,084,134	7,000	2,000	1,093,134	16,500	1,109,634
2030	1,053,320	7,000	2,500	1,062,820	16,500	1,079,320
2031	1,067,169	7,000	2,500	1,076,669	16,500	1,093,169
2032	1,088,121	8,000	2,500	1,098,621	16,500	1,115,121
2033	1,104,791	8,000	2,500	1,115,291	16,500	1,131,791
2034	1,121,604	8,000	2,500	1,132,104	16,500	1,148,604
2035	1,138,603	8,000	2,500	1,149,103	16,500	1,165,603
2036	1,155,889	8,000	2,500	1,166,389	16,500	1,182,889

Appendix B: Rate Model Through 2036

Attachment A

	2015	2016	2017	2018	2019	2020	2021
Basic Fee	**120.17**	**120.17**	**137.75**	**137.75**	**142.00**	**142.00**	**145.00**
Total System Tons	881,525	876,100	850,967	855,259	878,200	916,940	948,237
Revenues							
Disposal Fees	105,553,760	104,865,887	116,461,232	116,889,485	123,957,116	129,454,499	136,759,235
Interest Earnings	177,968	262,350	238,837	214,029	241,587	275,460	284,859
Grants	250,000	250,000	213,000	213,000	215,897	219,146	222,499
Landfill Gas	1,873,000	1,873,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Recycling	563,024	403,024	-	-	-	-	-
Rental Incomes	716,790	1,372,440	620,873	625,783	625,783	625,783	644,932
C&D	50,000	200,000	677,195	696,157	696,157	696,157	717,459
Other Revenue	107,023	107,023	385,000	385,000	395,472	407,376	419,841
Total Revenue	**109,291,564**	**109,333,723**	**119,596,137**	**120,023,453**	**127,132,012**	**132,678,421**	**140,048,825**
Operating Expenditures							
Public Health Transfer	948,084	941,869	912,839	914,247	964,801	1,008,176	1,075,139
Capital program debt service	8,774,601	11,478,095	13,732,413	13,599,663	13,602,163	16,478,047	16,623,547
Landfill Reserve Fund	12,458,793	14,484,649	25,073,066	15,505,430	16,362,804	17,613,100	18,782,980
Capital Equipment Recovery Program	3,500,000	3,500,000	6,900,000	6,900,000	6,900,000	6,900,000	6,300,000
Construction Fund			3,000,000	-	-	-	1,000,000
Cedar Hills Rent	2,885,000	2,928,000	2,972,000	3,017,000	3,062,000	3,108,000	3,155,000
Post-closure Reserve Fund	-	-	1,225,000	1,225,000	1,258,320	1,296,195	1,335,859
City mitigation			22,080	22,715	460,680	496,572	530,104
CHRLF Environmental Liability Policy			405,000	415,976	427,290	440,151	453,620
Overhead / Fund Management	2,304,974	9,652,579	10,460,983	10,694,476	10,985,366	11,316,025	11,662,295
SWD Admin / SW Directors Office	7,032,331	939,001	981,631	1,011,080	1,041,412	1,072,655	1,104,834
Human Resources		1,054,460	1,079,872	1,109,137	1,139,306	1,173,599	1,209,511
Legal Support	452,014	552,014	565,318	580,638	596,431	614,384	633,184
P&C / Strategy, Comms & Performance	1,915,097	2,650,906	3,356,678	3,305,803	3,395,721	3,497,932	3,604,969
Finance & IT / Enterprise Services	7,357,412	3,801,335	4,121,544	4,233,238	4,348,382	4,479,268	4,616,334
Contract Management		435,984	446,491	458,591	471,065	485,244	500,092
Project Management		1,501,875	1,538,070	1,579,752	1,622,721	1,671,565	1,722,715
Recycling & Environmental Services	6,216,649	7,483,135	8,082,818	8,226,862	8,450,633	8,704,997	8,971,369
WPR City Grants	1,136,309	1,138,228	1,165,659	1,197,249	1,229,814	1,266,831	1,305,596
Engineering / Facility Engineering & Science	5,986,644	2,868,993	3,474,749	3,568,914	3,665,989	3,776,335	3,891,891
Transfer & Transport Operations	28,863,355	28,626,769	30,576,547	33,255,171	34,159,712	35,187,919	36,264,669
Disposal Operations	14,162,058	13,288,032	14,919,654	14,290,022	14,678,711	15,120,540	15,583,229
Waste Export							
B & O Tax	1,583,306	1,572,988	1,746,918	1,753,342	1,859,357	1,941,817	2,051,389
Total SWD Cost	**105,576,628**	**108,898,912**	**136,759,330**	**126,864,306**	**130,682,676**	**137,649,353**	**142,378,327**
Ending Fund Balance	36,663,779	38,555,692	22,984,586	17,790,008	15,930,452	12,701,529	12,167,329

Target Fund Balance (30-day reserve)	7,287,925	7,308,323	8,068,237	8,284,481	8,517,547	8,976,833	9,223,662
	2022	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**
Basic Fee	**145.00**	**149.00**	**149.00**	**151.00**	**151.00**	**153.00**	**153.00**
Total System Tons	980,775	1,009,579	1,037,637	1,063,027	1,083,736	1,104,891	1,121,094
Revenues							
Disposal Fees	141,481,399	149,658,613	153,855,332	159,750,921	164,226,746	169,661,758	172,130,568
Interest Earnings	274,116	279,021	285,593	347,898	451,890	606,518	502,313
Grants	225,881	229,247	232,639	236,024	238,975	241,962	244,986
Landfill Gas	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Recycling	-	-	-	-	-	-	-
Rental Incomes	664,538	684,341	704,598	725,101			
C&D	739,270	761,300	783,835	806,645	826,811	847,481	868,668
Other Revenue	432,605	445,496	458,683	472,031	483,831	495,927	508,325
Total Revenue	**144,817,809**	**153,058,018**	**157,320,680**	**163,338,620**	**167,228,252**	**172,853,645**	**175,254,860**
Operating Expenditures							
Public Health Transfer	1,112,686	1,180,072	1,213,413	1,279,772	1,305,096	1,364,241	1,384,550
Capital program debt service	19,491,156	19,499,706	19,508,581	19,429,831	19,422,081	19,422,031	16,409,481
Landfill Reserve Fund	20,029,860	21,242,895	22,489,637	23,719,550	24,793,643	19,876,189	
Capital Equipment Recovery Program	6,300,000	6,100,000	6,100,000	4,100,000	4,100,000	4,100,000	4,100,000
Construction Fund	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Cedar Hills Rent	3,202,000	3,250,000	3,299,000	3,287,583			
Post-closure Reserve Fund	1,376,469	1,417,488	1,459,446	1,501,915	1,539,463	1,577,950	1,617,399
City mitigation	565,562	266,659	387,912	409,214	431,455	451,008	469,165
CHRLF Environmental Liability Policy	467,410	481,339	495,587	510,008	522,758	535,827	549,223
Overhead / Fund Management	12,016,829	12,374,931	12,741,229	13,111,998	13,439,798	13,775,793	14,120,188
SWD Admin / SW Directors Office	1,137,979	1,172,119	1,207,282	1,243,501	1,280,806	1,319,230	1,358,807
Human Resources 720129	1,246,280	1,283,419	1,321,408	1,359,861	1,393,858	1,428,704	1,464,422
Legal Support	652,432	671,875	691,762	711,893	729,690	747,932	766,631
Strategy, Comms. & Performance	3,714,560	3,825,253	3,938,481	4,053,091	4,154,418	4,258,278	4,364,735
Enterprise Services	4,756,671	4,898,419	5,043,413	5,190,176	5,319,930	5,452,929	5,589,252
Contract Management	515,295	530,651	546,358	562,257	576,314	590,721	605,490
Project Management	1,775,085	1,827,983	1,882,091	1,936,860	1,985,282	2,034,914	2,085,787
Recycling & Environmental Services	9,244,099	9,519,573	9,801,353	10,086,572	10,338,736	10,597,205	10,862,135
WPR City Grants	1,345,286	1,385,376	1,426,383	1,467,891	1,504,588	1,542,203	1,580,758
Facility Engineering & Science	4,010,205	4,129,709	4,251,948	4,375,680	4,485,072	4,597,198	4,712,128
Transfer & Transport Operations	37,367,115	38,480,655	39,619,683	40,772,615	41,791,931	42,836,729	43,907,647
Disposal Operations	16,056,959	16,535,456	17,024,906	17,520,330	17,958,339	14,116,735	
Waste Export						14,911,346	66,547,864
B & O Tax	2,122,221	2,244,879	2,307,830	2,396,264	2,463,401	2,544,926	2,581,959
Total SWD Costs	**149,506,160**	**153,318,457**	**157,757,701**	**160,026,863**	**160,536,660**	**169,082,090**	**186,077,619**
Ending Fund Balance	9,328,848	9,068,409	8,631,388	11,943,145	18,634,737	22,406,293	11,583,534

Target Fund Balance (30-day reserve)	9,696,448	9,913,417	10,165,332	10,401,843	10,346,453	11,441,028	14,462,632

	2029	2030	2031	2032	2033	2034	2035	2036
Basic Fee	**169.00**	**169.00**	**171.00**	**171.00**	**180.00**	**180.00**	**184.00**	**184.00**
Total System Tons	1,109,634	1,079,320	1,093,169	1,115,121	1,131,791	1,148,604	1,165,603	1,182,889
Revenues								
Disposal Fees	188,185,336	183,191,383	193,200,441	197,204,416	204,717,287	207,734,031	216,636,683	219,862,659
Interest Earnings	404,496	425,401	413,457	445,906	477,937	495,113	523,174	559,696
Grants	248,049	251,149	254,289	257,467	260,686	263,944	267,243	270,584
Landfill Gas	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Recycling	-	-	-	-	-	-	-	-
Rental Incomes								
C&D	890,385	912,644	935,460	958,847	982,818	1,007,388	1,032,573	1,058,387
Other Revenue	521,033	534,059	547,411	561,096	575,123	589,501	604,239	619,345
Total Revenue	**191,249,299**	**186,314,636**	**196,351,058**	**200,427,732**	**208,013,850**	**211,089,978**	**220,063,913**	**223,370,672**
Operating Expenditures								
Public Health Transfer	1,404,441	1,365,494	1,417,868	1,446,777	1,505,448	1,528,143	1,589,866	1,613,782
Capital program debt service	15,707,431	15,707,331	15,706,681	15,704,681	15,706,646	15,705,471	14,564,311	14,565,791
Landfill Reserve Fund								
Capital Equipment Recovery Program	2,200,000	2,200,000	2,200,000	2,200,000	2,300,000	2,300,000	2,300,000	2,300,000
Construction Fund	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,500,000	1,500,000
Cedar Hills Rent								
Post-closure Reserve Fund	1,657,834	1,699,279	1,741,761	1,785,305	1,829,938	1,875,687	1,922,579	1,970,643
City mitigation	475,905	474,275	492,466	515,070	535,957	557,638	580,161	603,611
CHRLF Environmental Liability Policy	562,954	577,027	591,453	606,239	621,395	636,930	652,854	669,175
Overhead / Fund Management	14,473,193	14,835,023	15,205,898	15,586,046	15,975,697	16,375,089	16,784,466	17,204,078
SWD Admin / SW Directors Office	1,399,571	1,441,558	1,484,805	1,529,349	1,575,229	1,622,486	1,671,161	1,721,296
Human Resources 720129	1,501,032	1,538,558	1,577,022	1,616,448	1,656,859	1,698,280	1,740,737	1,784,256
Legal Support	785,796	805,441	825,577	846,217	867,372	889,057	911,283	934,065
Strategy, Comms. & Performance	4,473,854	4,585,700	4,700,343	4,817,851	4,938,298	5,061,755	5,188,299	5,318,006
Enterprise Services	5,728,983	5,872,208	6,019,013	6,169,488	6,323,725	6,481,818	6,643,864	6,809,961
Contract Management	620,627	636,142	652,046	668,347	685,056	702,182	719,737	737,730
Project Management	2,137,931	2,191,380	2,246,164	2,302,318	2,359,876	2,418,873	2,479,345	2,541,328
Recycling & Environmental Services	11,133,688	11,412,030	11,697,331	11,989,764	12,289,509	12,596,746	12,911,665	13,234,457
WPR City Grants	1,620,277	1,660,784	1,702,303	1,744,861	1,788,482	1,833,194	1,879,024	1,926,000
Facility Engineering & Science	4,829,932	4,950,680	5,074,447	5,201,308	5,331,341	5,464,624	5,601,240	5,741,271
Transfer & Transport Operations	45,005,338	46,130,472	47,283,734	48,465,827	49,677,473	50,919,410	52,192,395	53,497,205
Disposal Operations								
Waste Export	67,503,885	67,272,713	69,853,001	73,059,195	76,021,934	79,097,163	82,291,984	85,618,153
B & O Tax	2,822,780	2,747,871	2,898,007	2,958,066	3,070,759	3,116,010	3,249,550	3,297,940
Total SWD Costs	**187,045,451**	**189,103,966**	**194,369,920**	**200,213,159**	**206,060,995**	**211,880,558**	**217,374,521**	**223,588,747**
Ending Fund Balance	15,787,382	12,998,052	14,979,190	15,193,763	17,146,618	16,356,039	19,045,431	18,827,355

Target Fund Balance (30-day reserve)	14,689,249	14,853,995	15,274,670	15,744,525	16,203,892	16,671,906	17,068,643	17,568,566

Appendix C: Capital Improvement Program

Summary

The Capital Improvement Program (CIP) funded by this rate continues implementation of the transfer system renovation plan as set forth in the collaboratively developed *2006 Solid Waste Transfer and Waste Management Plan* (*Transfer Plan*), which was approved by the King County Council in 2007. Since 2007, the division has altered the sizing and timing of projects due to tonnage changes and with consideration of potential rate impacts. Following the 2014 *Transfer Plan Review Part II* recommendations, the rate assumes no spending for a new Northeast Recycling and Transfer Station, which remains an option for 2019 and beyond. The division will examine demand management as a strategy to further minimize the need for CIP projects (Appendix D: Demand Management.

Background

The division works with its advisory committees to determine how best to modernize the transfer system. As part of this process, the division completed construction of new recycling and transfer stations at Shoreline and at Bow Lake. These newer facilities provide more services while processing greater volumes of waste with less traffic congestion, easily accommodating modern garbage trucks and safely separating commercial traffic from self-haul customers. Flexible design ensures adaptability to changes in regional waste generation and in the solid waste industry for decades to come. The buildings achieved the highest possible rating for environmental design and construction – LEED Platinum.

The remaining urban transfer stations, built in the 1960s, are outdated and operating over capacity. The region has experienced major population growth. Commercial collection trucks are larger, making it difficult and inefficient to safely unload them at older transfer stations. Space constraints limit the number of recycling containers and the range of materials that each site can accommodate, resulting in disposal of recyclable materials like yard waste.

The division recently completed a resource recovery pilot project to remove recyclables from targeted garbage loads at the Shoreline Recycling and Transfer Station. Results indicate resource recovery is a cost-effective method for improving the recycling rate and making efficient use of the transfer stations. The division has expanded the resource recovery pilot to the Bow Lake and Enumclaw stations and will plan for integrating larger-scale resource recovery into the county system. Resource recovery at division facilities may not be enough to meet county goals and may require consideration of a dedicated new facility. The division and its partners are still evaluating how much new transfer capacity to build versus modifying service options and using existing stations more intensively.

Ongoing work of the CIP includes:

Factoria: The newly completed main recycling and transfer building at Factoria has begun operations. Deconstruction of the old transfer building will follow in 2016, with

project completion in 2017 with the opening of a new Household Hazardous Waste collection building.

South County: Environmental review under SEPA is ongoing for potential sites for the new facility.

The CIP also includes smaller projects, such as the removal of creosote pilings from the Duwamish River at the division's Harbor Island property, modernization of the environmental controls at the Duvall closed landfill, and replacement of stormwater pumps at Cedar Hills that are nearing the end of their useful life.

Table 1-C Capital Improvement Program - Revenues, expenditures, and fund balances

	2016	*2017*	*2018*	*2019*	*2020*	*2021*	*2022*	*2023*	*2024*
Interest earnings rate	0.70%	0.80%	1.10%	1.52%	2.07%	2.50%	2.83%	3.08%	3.28%
inflation	2.12%	2.41%	2.71%	2.72%	3.01%	3.06%	3.04%	2.98%	2.96%
cumulative inflation	2.12%	4.53%	7.24%	9.96%	12.97%	16.03%	19.07%	22.05%	25.01%
Beginning fund balance	36,957,193	16,779,970	33,674,623	29,366,836	22,641,637	28,141,546	(8,037,706)	11,368,177	12,484,003
Revenues									
Operating fund transfer		3,000,000	-	-	-	1,000,000	1,000,000	1,000,000	1,000,000
Interest earned	187,424	201,014	344,831	392,283	520,222	248,196	46,469	361,753	421,723
Borrowing - Bonds	-	32,000,000	-	-	40,000,000	-	40,000,000		
Other revenue			8,000,000						
Total	*187,424*	*35,201,014*	*8,344,831*	*392,283*	*40,520,222*	*1,248,196*	*41,046,469*	*1,361,753*	*1,421,723*
Expenditures (with applied inflation or cumulative inflation)									
Bow Lake	$12,538	-	-	-	-	-	-		
Factoria	16,942,959	11,935,935	919,750	156,812	-	-	-	-	-
South County	798,000	2,509,510	6,275,223	6,441,625	34,153,561	36,260,929	19,583,648	-	
Northeast									
Cedar Falls	257,375	602,205	-	-	-	-	-		
Harbor Island	370,000	213,346	3,035,216	-	-	-	-		
Algona deconstruction	-	-	-	-	22,620	297,064	1,818,126	-	
Other projects (placeholder after 2022)	631,775	309,000	318,270	218,545	225,102	231,855	238,810	245,927	253,206
Closed/custodial LF projects	1,352,000	2,736,365	2,104,159	300,500	619,030	637,601	-	-	
Total	*20,364,647*	*18,306,361*	*12,652,619*	*7,117,482*	*35,020,313*	*37,427,448*	*21,640,585*	*245,927*	*253,206*
Ending fund balance	**16,779,970**	**33,674,623**	**29,366,836**	**22,641,637**	**28,141,546**	**(8,037,706)**	**11,368,177**	**12,484,003**	**13,652,519**

Appendix D: Capital Equipment Recovery Program

The division's CERP model applies life-cycle costing considerations to the division's capital equipment and is used to determine the timing of asset replacement. The CERP fund was codified in 1981 (KCC 4.08.280) to ensure the timely and economical replacement of equipment. The fund serves three main purposes:

- Accumulate the financial resources for the replacement of the division's rolling stock and stationary compactors on a timely and cost-effective basis;
- Stabilize the monetary effects of equipment purchases on the operating fund; and
- Provide stability in the operating budget against the effects of dramatic tonnage decreases.

CERP Inventory

By code, the CERP fund explicitly includes the division's "rolling stock and stationary compactors." However, since the establishment of the CERP fund, business practice and equipment technology have advanced and the division's capital equipment now includes significant fixed assets that are not "rolling stock" or "stationary compactors," but that do have direct operational use, such as power units for the landfill tippers. These major assets are included in the CERP model.

CERP Fund

New equipment is purchased from the division's operating fund. After the initial acquisition, an annual contribution is made to the CERP fund for the eventual replacement or major overhaul in lieu of replacement. All auction, salvage, and buyback income from disposal of division equipment is treated as CERP fund revenue.

CERP Fund Contributions

For each CERP inventory asset, an annual payment to the CERP fund is calculated based on assumptions about the asset's life and net future replacement cost (total estimated replacement cost minus estimated salvage/trade-in/buyback income). These annual payments ensure that adequate funds are available to purchase the replacement for that piece of equipment in the scheduled year.

Funding Policy

Since 2012, the division has based contributions to the CERP on a four-year average of the estimated replacement value of equipment due to be replaced within that timeframe. The estimated replacement value is adjusted for capitalized repairs and factors for inflation and salvage value. The fund balance is maintained between 15 percent and 20 percent of total CERP inventory replacement value. Contributions rise and fall based on expected expenditures, which would increase by 75 percent in 2017 if the division is to bring all capital equipment back into normal lifecycles.

Budgeting

Budget planning for equipment purchases, rebuilds, and replacements occurs early each year. Since the 2007, the division has deferred CERP spending wherever possible, a strategy that is no longer sustainable.

Budget planning for CERP is primarily focused on plans for the following year's budget request. However, it may include the review of purchase plans for the current year's adopted budget and a look ahead to the purchase of some items that can require up to two years' lead-time.

The initial purchase of a new asset (expansion of fleet or new type that is not replacing an outgoing asset) and all equipment repair costs are paid from the operating fund. CERP only pays to replace or rebuild existing equipment.

Life-Cycle Costing Model

The model used for life-cycle costing analysis is a Mean Annual Cost Equivalent (MACE) model, based on one published by the American Public Works Association.

The main components of the SWD MACE Model are:

- Interest rate and inflation assumptions
- Purchase/In-Service dates
- Estimated lifespan
- Estimated salvage values
- Repair and maintenance costs
- Meter readings

Interest and inflation rates are obtained from King County's Office of Economic and Financial Analysis (OEFA). All other equipment data is obtained from the division's CCG Faster database. The use of the CCG Faster software, and therefore accumulation of equipment history data, began in February 2003. Cost and usage data of equipment acquired and placed in service prior to this date, which represents 48 percent of the total inventory, is not represented.

MACE Model Function

The goal of using MACE in the economics of equipment replacement is to minimize the total costs of ownership. MACE considers the alternative-use or time value of money; a dollar spent ten years from now is not equivalent to a dollar spent today. This permits comparisons of alternatives that cover multiple time frames; it reduces expenditures over time to values which can be easily compared. For example, discounting permits comparison of a two-year replacement cycle with a four-year cycle.

This model is focused on yearly periods and because of the discount factor, it can be used for mileage or hour usage if these are converted to time equivalents.

The best estimates available are incorporated in the use of this model.

NOTE: MACER means the mean annual cost equivalent for replacement period R. See formula below.

$$MACE_R = \left[P - \frac{S_R}{(1+i)^R} + \sum_{t=1}^{R} \frac{X_t}{(1+i)^t} \right] \left[\frac{i\,(1+i)^R}{(1+i)^R - 1} \right]$$

where: i = discount rate

P = purchase price at t=0

t = year (numeral indicator)

S = resale or salvage value

R = year of replacement

X = sum of the year's costs (excluding depreciation, alternative cost of capital and inflation)

Asset Life Expectancies

An asset's life expectancy is based on the Original Equipment Manufacturer (OEM) suggested life, which is then adjusted for the division's working conditions and consideration of MACE for that asset. For example, a long-haul tractor's OEM suggested life is one million miles for normal usage. However, the division's use of this type of vehicle is short-haul with heavy urban traffic, plus regular off-road driving at Cedar Hills. Based on assessment of the model for life-cycle costs and actual annual usage of 40,000 miles, the division's life expectance for long-haul tractors is about 400,000 miles or 10 years.

Some assets may be rebuilt, which will extend their life beyond the OEM suggested life. For example, the original life expectation for a bulldozer is 10,000 hours or 60 months; the expected life extension for a power train overhaul is 10,000 hours, or an additional 60 months. Other assets expected to have an extended life after rebuild work are excavators, refuse trailers, pre-load compactors, and hydraulic power units for tippers. Rebuilding a piece of equipment a second time has not proven cost-effective for extending useful life and, as a result, the division is resetting many of the units to historical replacement schedules.

CERP Process

The division's CERP manual documents processes, procedure, and definitions. The figure below summarizes the process for inventory purchase and replacement.

Figure 1-E: CERP Inventory Purchase and Replacement Process

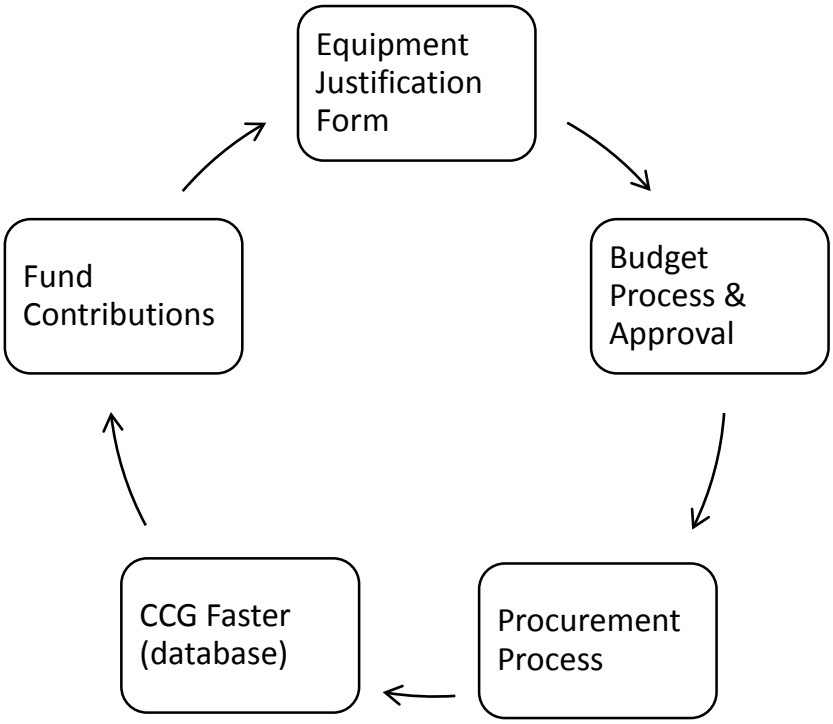

Table 1-F. Average per ton contribution by account 2017

New area development	$ 5.92
Facility improvements	$ 2.08
Closure	$ 6.52
Post-closure	$ 3.48
Total	**$ 18.00**

Table 2-F. Total landfill reserve fund

Year	Status	Cedar Hills Disposal Tonnage	Revenue[3]	Expenditures	Year-end Balance
2016	budgeted	864,100	14,088,081	28,444,784	26,810,229
2017	forecast	837,467	24,623,584	18,761,050	32,672,763
2018	forecast	838,759	14,679,617	20,910,302	26,442,078
2019	forecast	861,700	15,223,682	8,902,236	32,763,524
2020	forecast	900,440	16,042,937	27,210,281	21,596,180
2021	forecast	931,737	16,721,827	14,285,831	24,032,177
2022	forecast	964,275	17,390,982	6,161,766	35,261,393
2023	forecast	993,079	18,039,143	5,756,383	47,544,153
2024	forecast	1,021,137	18,717,799	2,336,518	63,925,435
2025	forecast	1,046,527	19,389,916	4,614,283	78,701,068
2026	forecast	1,067,236	19,878,382	4,862,757	93,716,693
2027	forecast	834,698	15,783,188	7,599,598	101,900,283
2028	closing		700,749	21,177,244	81,423,789
2029	closed		610,936	309,285	81,725,440[4]

[3] Interest revenue is based on the King County Auditor's report recommendation (2011).
[4] Ending balance will be transferred to the Post-Closure Maintenance Fund for ongoing monitoring and maintenance.

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2017/2018 FISCAL NOTE

Ordinance/Motion: 2016-XXXX
Title: 2017-2018 Solid Waste Rate Proposal
Affected Agency and/or Agencies: Solid Waste Division, Department of Natural Resources and Parks
Note Prepared By: Eben Sutton, Enterprise Services Manager, Solid Waste Division
Date Prepared: July 13, 2016
Note Reviewed By: John Walsh, Budget Analyst, Performance, Strategy and Budget
Date Reviewed: July 14, 2016

Description of request:

This proposal would allow the Solid Waste Division to increase disposal fees for the two-year period from 2017 to 2018. The Solid Waste Division has not had increased rates to the majority of fees since the current rate went into effect on January 1, 2013. All proposed rate increases would be implemented on January 1, 2017 if adopted. The rates are comparable with solid waste providers in the region.

Revenue to:

Agency	Fund Code	Revenue Source	2017/2018	2019/2020	2020/2021
Solid Waste Division	000004040	34371 - Disposal Fees	29,422,268	38,931,001	47,615,675
TOTAL			**29,422,268**	**38,931,001**	**47,615,675**

Expenditures from:

Agency	Fund Code	Department	2017/2018	2019/2020	2020/2021
TOTAL			**0**	**0**	**0**

Expenditures by Categories

	2017/2018	2019/2020	2020/2021
TOTAL	**0**	**0**	**0**

Does this legislation require a budget supplemental? **No**

Notes and Assumptions: **Revenues:** Under the proposal, the Basic Fee for disposal of municipal solid waste would increase from $120.17 to $137.75 per ton, the Regional Direct Fee would increase from $103.50 to $117.00 per ton, the Yard Waste Fee would remain at $75.00 per ton, the Special Waste Fee would increase from $145.00 to $165.00 per ton, and the Special Waste Extra Handling fee would increase from $175.00 to $193.00 per ton effective January 1, 2017.

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ATTACHMENT 3

July 18, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

This letter transmits an ordinance that will increase the King County Solid Waste Division basic fee for the disposal of municipal solid waste for the first time since 2013. The proposed fee is lower than was originally projected in the last rate plan for 2017-2018; the average effect on single-family curbside customers would be about $0.94 cents per month, representing a five percent increase on a $20 monthly bill. The Executive Proposed Solid Waste Disposal Fees for 2017-2018 document is attached.

The proposed basic fee of $137.75 per ton will enable the division to sustain current services, repay debt for previously approved transfer station projects, reinforce service reliability, and conduct a transfer station demand management pilot project.

Specifically, the ordinance will accomplish the following:

- Fund the increased cost of current services including waste transfer and transport, continued operation and new development at the Cedar Hills landfill, implementation of waste prevention and recycling programs, and payment for central support services such as human resources, finance, and systemwide planning;
- Repay general obligation bonds for construction of previously approved new transfer stations at Factoria and South County;
- Continue reliable service delivery by upgrading the transfer station cashiering system, improving wastewater systems at Cedar Hills Regional Landfill, and adding recycling requirements for transfer station self-haulers;
- Conduct a demand management pilot project in 2018 to test whether changes to services, hours, and prices at existing transfer stations can meet customer needs while avoiding capital investments for a new Northeast transfer station.

The legislation also furthers the goals of key County plans and initiatives as follows:

- The legislation furthers the King County Strategic Plan goal of Environmental Sustainability by providing safe, reliable, and environmentally responsible disposal of solid waste in compliance with federal, state, and local regulations.
- The legislation furthers the Strategic Plan Financial Stewardship goal by enabling the division to make changes, such as transfer station efficiencies and extending the life of the landfill, which will keep rates lower for all customers over the long-term.
- The legislation furthers the Strategic Climate Action Plan goal of achieving a 70 percent recycling rate by improving recycling requirements for transfer station self-haulers and continuing a pilot project to test compressed natural gas trucks in the division's fleet.

The Department of Natural Resources and Parks has briefed the Metropolitan Solid Waste Management Advisory Committee and the Solid Waste Advisory Committee on the legislation.

Thank you for considering this ordinance. This important legislation will enable the Solid Waste Division to continue to provide safe, reliable, efficient, and environmentally sustainable solid waste transfer and disposal service to ratepayers.

If you have any questions about this ordinance, please contact Pat D. McLaughlin, Division Director of the Solid Waste Division of the Department of Natural Resources and Parks, at 206-477-4501.

Sincerely,

Dow Constantine
King County Executive

Enclosures

cc: King County Councilmembers
ATTN: Carolyn Busch, Chief of Staff
Anne Noris, Clerk of the Council
Carrie S. Cihak, Chief of Policy Development, King County Executive Office
Dwight Dively, Director, Office of Performance, Strategy and Budget
Christie True, Director, Department of Natural Resources and Parks (DNRP)
Pat D. McLaughlin, Division Director, Solid Waste Division, DNRP