King County Executive
RON SIMS

April 22, 2002

The Honorable Cynthia Sullivan
Chair, Metropolitan King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Sullivan:

King County Council passed Ordinance #13974 on October 16, 2000. Section 6 of the ordinance requires the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) of the Department of Community and Human Services (DCHS) to report annually to the King County Council on an evaluation of adult mental health consumers and their progress toward recovering from mental illness. The first of these reports, which will establish baseline measures, is due April 30, 2002.

Of necessity, MHCADSD focused much of this past year on modifying the mental health system because of significant budget cuts. Mental health providers reorganized their operations and reduced levels of staffing due to diminished levels of funding. As a result, MHCSDSD temporarily delayed implementing strategies for putting the Recovery Model into place.

However, MHCADSD is currently moving forward on several initiatives that will both promote the model and provide practical steps for putting it into practice. Unfortunately, it appears that more budget cuts lie ahead for MHCADSD. Although reduced funding presents numerous challenges, it also provides impetus to assist clients to reduce their dependence on the mental health system. MHCADSD will be working closely with the mental health community in the coming months to establish the framework for the recovery model that is achievable under our current revenue picture.

As you will see in the enclosed report, many consumers made strides in improving their levels of functioning, the types of housing in which they live, and how productively they spend their time.

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The Honorable Cynthia Sullivan
April 22, 2002
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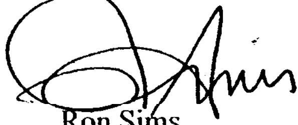
I am encouraged that these improvements can be built upon, and that we can look forward to further improvement as the model develops.

Sincerely,



Ron Sims
King County Executive

Enclosure

cc: Metropolitan King County Councilmembers
ATTN: David deCourcy, Chief of Staff
Shelley Sutton, Policy Staff Director
Anne Noris, Clerk of the Council
Barbara J. Gletne, Director, Department of Community and Human Services

KING COUNTY ORDINANCE #13974

FIRST ANNUAL REPORT TO METROPOLITAN KING COUNTY COUNCIL

King County Department of Community & Human Services
Mental Health, Chemical Abuse and Dependency Services Division
April 2002

KING COUNTY DEPARTMENT OF COMMUNITY AND HUMAN SERVICES

Mental Health, Chemical Abuse and Dependency Services Division

King County Ordinance #13974
First Annual Report: **Recovery Model**

BACKGROUND

The Metropolitan King County Council passed Ordinance #13974 on October 16, 2000. This ordinance is designed to promote recovery as an achievable outcome for adult consumers of the publicly-funded mental health system in King County. The ordinance recognized that recovery is both a treatment philosophy and a process characterized by consumers moving toward participation in age-appropriate roles, including living independently, working, and having less dependence on the mental health system.

As a first step, the ordinance required the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

- to submit a report in April 2001 that described steps the Division would take in redirecting the system toward recovery outcomes.
- to submit a written annual report to the Council that describes the performance of the mental health system toward achieving recovery outcomes, with calendar year 2001 as the evaluation baseline period.

This report addresses the second requirement.

REPORTING REQUIREMENTS

The ordinance stipulates the population MHCADSD is expected to evaluate on an annual basis. The population of interest is consumers who:

- received outpatient benefits or residential services during the previous calendar year, and
- were aged 21-59 years during the reporting period, and
- completed at least one benefit period during calendar year 01/01/2001—12/31/2001

The ordinance provides definitions of "recovery categories". These definitions are:

- Dependence and dependent: experiences significant disability, is not employable, is served by the MH system, has a Global Assessment of Functioning (GAF)[1] score of 50 or below.
- Less dependence and less dependent: some disability, progress toward recovery, improved self-esteem, enhanced quality of life, a GAF score between 51 and 80[2].

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[1] The Global Assessment of Functioning (GAF) is a widely used scale that describes functioning across a range of life domains. The GAF provides an index, and scores range from 0-100. Attachment 1 is the Global Assessment of Functioning (GAF) Scale

[2] GAF scores are the sole measure for "Dependence" and "Less Dependence."

- Recovered:
  - is engaged in volunteer work, or pursuing educational or vocational activities, or employed full or part-time, or engaged in other culturally appropriate activities, and
  - lives in independent or supported housing, and
  - is discharged or receiving infrequent maintenance services,[3] and
  - has a GAF score of 81 or above

OUTCOMES:

In addition to evaluating consumers' recovery status, the ordinance requires MHCADSD to specifically evaluate certain outcome measures. These outcomes, which are central to principles of recovery and indicate involvement in adult life roles, are:

- level of functioning
- employment
- housing

MHCADSD was able to use the existing consumer database when measuring performance on these outcomes.

ANALYSIS

The ordinance includes a set of six questions that must be responded to in the annual evaluation of recovery outcome performance. These questions and the evaluation of performance for 2001 follow.

There are two separate analyses in this section. This first will address outcomes achieved from outpatient benefits, and the second will address long-term residential (LTR) outcomes. Consumers served with an outpatient benefit might live in a range of housing options, while consumers served with the LTR benefit must reside in licensed long-term rehabilitation facilities. Typically, these consumers are quite ill, and many were hospitalized immediately prior to living in an LTR.

It is not possible to provide an analysis that integrates both types of benefits because of contrasts between them. The most significant is that an outpatient benefit is limited to one year (which may be renewed), while the LTR benefit is open-ended - many consumers live in an LTR for several years. Without a defined length of stay, it is difficult to achieve reliable outcome measurements that are based on comparisons between start and end dates.

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[3] There are no appropriate measures available for measuring "infrequent maintenance services"

Outpatient

The definitions and perimeters described in the ordinance were used to develop a database that includes information on 7,831 adults who completed a tier benefit[4] during calendar year 2001. The table and charts that follow respond to each of the questions found in ordinance language.

Table 1 responds to questions 1-4

Table 1. Change in Recovery Status for Tier Benefits

Recovery status at beginning of benefit period		Recovery status at end of benefit period		
Status	Number	Dependent	Less Dependent	Recovered
Dependent	5879	5284	593	2
Less Dependent	1952	285	1665	2
Total	7831	5569	2258	4

Question 1 asks: How many consumers at the beginning of their benefit period[5] were categorized as dependent, or less dependent? Of the 7,831 consumers:

- 5,879 (75%) began their benefit as "dependent"
- 1,952 (25%) began their benefit as "less dependent"

Question 2 asks: How many consumers at the end of their benefit period were categorized as: dependent, less dependent, recovered and receiving maintenance level of services, recovered and discharged, or left services for another reason? Of the 7,831 consumers:

- 5,569 (71%) ended their benefit as "dependent"
- 2,258 (29%) ended their benefit as "less dependent"
- 4 (>1%) ended their benefit as "recovered"

2,022 consumers did not receive a subsequent benefit.[6] Of these:

- 1,250 (62%) ended their benefit as "dependent"
- 768 (38%) ended their benefit as "less dependent"
- 4 (>1%) ended their benefit as "recovered"[7]

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[4] A "tier benefit" is a defined service package based on service intensity and expected outcomes that includes an array of services tailored to meet the consumers' needs identified in the treatment plan. There were five levels of tier benefits available during 2001.

[5] A "benefit period" is the span of time a consumer is authorized for a mental health program. During 2001, all tier benefits were authorized for one year.

[6] For the purpose of this report, a "subsequent benefit" is defined as a benefit that begins within 30 days from the end of the previous benefit.

[7] Note that none of the four consumers who ended their benefit as "recovered" received a subsequent benefit.

Question 3 asks: By "recovery category", how many consumers progressed, regressed, or remained unchanged?

5,879 consumers began their benefit period as "dependent". Of these:

- 5,284 (90%) remained dependent at the end of their benefit
- 593 (10%) improved to "less dependent"
- 2 (<1%) were "recovered"

1,952 consumers began their benefit period as "less dependent". Of these:

- 285 (15%) regressed to "dependent" at the end of their benefit
- 1,665 (85%) remained "less dependent"
- 2 (<1%) improved to "recovered"

Overall, of the 7,831 consumers:

- 285 (4%) regressed and
- 6,949 (88.7% of total) remained in the same recovery category
- 597 (8%) consumers improved

Question 4 asks: For those consumers who changed, what was the extent of progression or regression (by recovery category)?[8]

Of the 5,879 consumers who began their benefit as "dependent":

- 593 (10%) improved by one recovery category
- 2 (>1%) improved by two recovery categories

Of the 1,952 consumers who began their benefit as "less dependent":

- 2 (>1% improved) by one category ("recovered")

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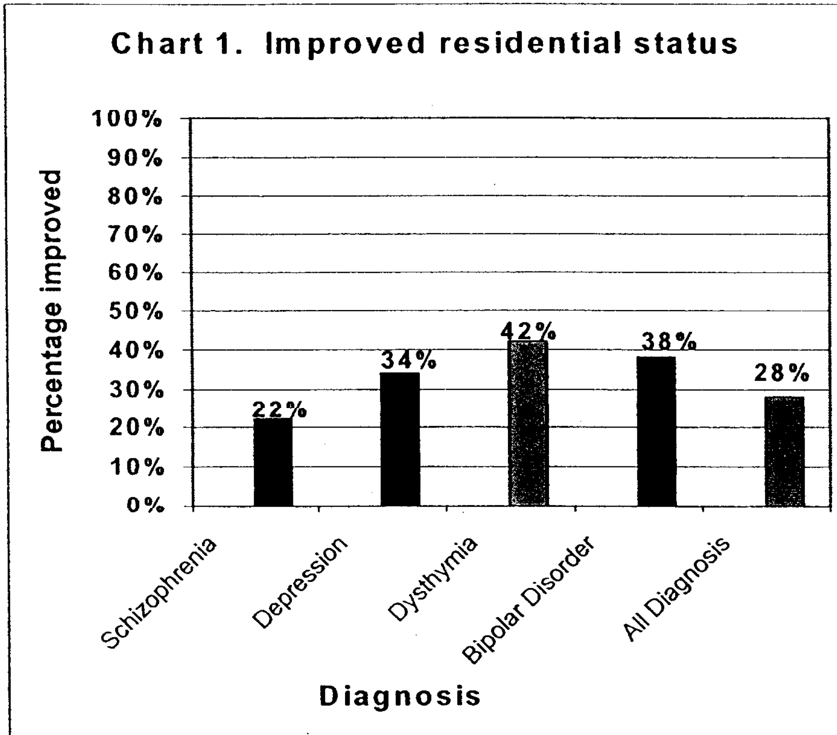
[8] It is not possible for a person to begin a benefit as "recovered" because a GAF score of 81 does not meet minimum eligibility criteria.

Question 5 asks: What percent of consumers have improved housing compared to the beginning of their benefit period? *Note: The category labeled "All Diagnosis" is inclusive of all consumers.*[9]



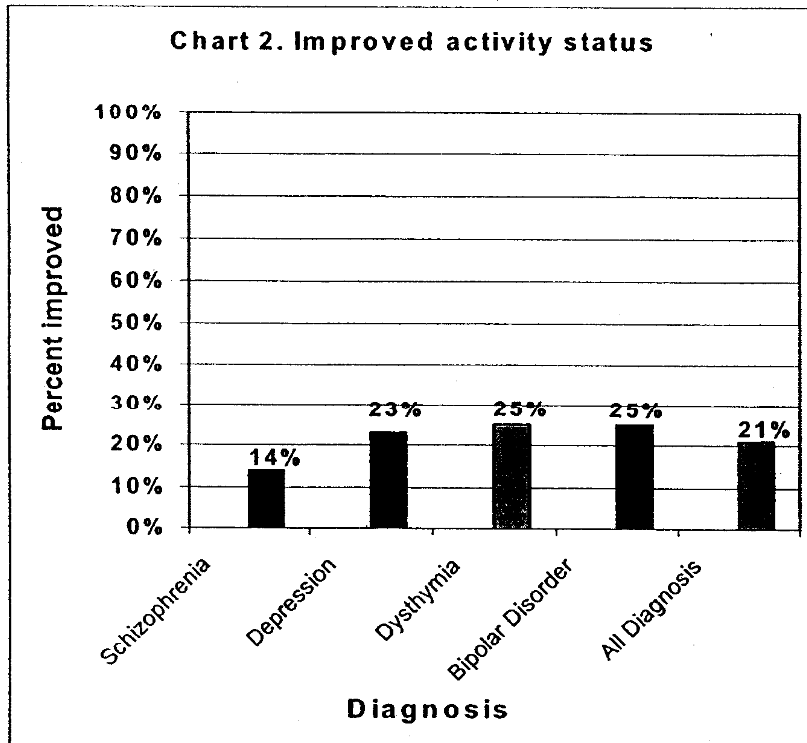
1,501 consumers had the potential to improve (i.e., did not begin their benefit with the residential status of "independent" housing – the highest housing "level"). Of these:

- 22% (n = 71) of the consumers with a diagnosis of schizophrenia improved their housing status during the course of their benefit
- 34% (n = 101) of those diagnosed with depression improved
- 42% (n = 15) of those diagnosed with dysthymia improved
- 38% (n = 94) of those diagnosed with bipolar disorder improved

As an overview, 28% (n = 421) of all individuals with potential to enhance their residential status (1,501) showed improvement by the end of their benefit, regardless of diagnosis.

[9] This means that consumers "counted" under a specific diagnostic category were also counted in the "All Diagnosis" category.

Question 6 asks: What percent of consumers have improved daily activities compared to the beginning of their benefit period?



4,863 consumers had the potential to improve (i.e., did not start their benefit with highest level of activity status):

- 14% (n = 147) of the consumers of those diagnosed with schizophrenia had improved activity status
- 23% (n = 254) of those diagnosed with depression improved
- 25% (n = 50) of those diagnosed with dysthymia improved
- 25% (n = 214) of those diagnosed with bipolar disorder improved

As an overview, 21% (n = 1,010) of all consumers with potential to improve their activity status (4,863) showed improvement by the end of their benefit, regardless of diagnosis.

While few consumers reached the status of "recovered"[10], many more did demonstrate progress toward recovery. Of the 7,831 consumers:

- 28% improved their residential status
- 21% improved their activity status
- 1,897 (24%) had improvement in one or more of these areas: GAF score,[11] residential status, activity status. Each of these elements is used to provide the composite definition of "recovered" in the ordinance.

Long-Term Rehabilitation (LTR) benefit

Using the data we have available, we were able to provide a limited analysis of recovery outcomes. Table 2 describes the change in "recovery category" for those consumers who received an LTR benefit during 2001, and for whom a GAF score was available.

Table 2. Change in Recovery status for Long Term Rehabilitation

Recovery status at beginning of) benefit period (LTR benefit only		**Recovery status at end of benefit period (LTR benefit only)**		
Status	**Number**	**Dependent**	**Less Dependent**	**No ending GAF score reported**
Dependent	181	59	2	122
Less Dependent	2	---		---
No starting GAF score reported	13	6	---	7
Total	196	65	2	129

Of the 196 consumers with an LTR benefit, 67 had both beginning and ending GAF scores reported.[12] Two improved to less dependent.

[10] The status "recovered" is a composite score of four components: GAF score, housing status, activity status, and no subsequent benefit.

[11] For the purpose of this report, and improved GAF score means a score improved by at least ten points (on a 100-point scale).

[12] Reporting requirements for the LTR benefit differ from those for the outpatient benefits, in part due to contrasts in the duration of the benefit.

DISCUSSION

The publicly funded mental health system serves a challenging and very ill population. The majority of those served are severely and persistently mentally ill, and receive disability entitlements because of the chronicity of their illness.[13] As a result, progress in recovery oriented outcomes may be slow, difficult to measure, and not always predictable.

Ordinance #13974 required outcome reporting on consumers with specified diagnosis (schizophrenia, depression, dysthymia, and bipolar disorder). In 2001, approximately 2/3 of consumers who completed a benefit were classified with these diagnoses.[14]

This report provides recovery status information about 25 percent of the consumers who received publicly-funded mental health services in King County. Overall, 31,946 individuals[15] were served by the King County mental health system during 2001. Ordinance # 13974 specifically required information about individuals who completed an outpatient or residential benefit during calendar year 2001. Report criteria specifically excludes certain individuals from the analysis of outpatient benefits. These are:

- consumers younger than 21 and older than 59 years of age
- consumers who received "carve out" services[16] only
- consumers who did not complete a benefit
- consumers for whom either a beginning or ending GAF score was missing
- consumers for whom incomplete or invalid data was submitted regarding their housing and/or activity status
- recipients of Tier 1A benefits because contrasts in reporting requirements preclude comparison with other tier benefit recipients.
- recipients of Long Term Rehabilitation (LTR) benefits because contrasts in benefit design and reporting requirements preclude comparison with other benefit recipients.

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[13] As a Regional Support Network, King County is mandated to comply with 71.24 Revised Codes of Washington (RCW) Chapter 388-865 of the Washington Administrative Code (WAC). Included in these regulations are consumer eligibility criteria that require us to serve persons who are acutely or chronically mentally ill. Coupled with medical necessity criteria that bases eligibility on a combined profile of diagnosis, symptoms, level of functioning, and financial need, the qualifying criteria for publicly-funded mental health services results in a consumer population that has significant impairment.

[14] Details about diagnostic classifications used for this report are available upon request.

[15] Attachment 2 is a selection from the King County Regional Support Network (KCRSN) 2001 Year End Report Card, which describes outcomes and system performance for the population served by the publicly funded mental health system in King County.

[16] A "carve out" service is a program funded to provide a specialized service not available through a tier benefit, or a special project that may be grant funded (e.g. demonstration project).

MHCADSD expected to make significant inroads on implementing a model of services with recovery as the guiding principle during 2001. These plans were delayed because the Department of Social and Health Services revised the funding allocation formula for Regional Support Networks,[17] such that King County's allocation was significantly reduced during 2001. Consequently, much of 2001 was spent making adjustments to the system so that quality care could be provided to those who were most in need. The system-wide trainings to introduce implementation of the recovery model were postponed, and the anticipated reforms were not executed (see the "Next steps" section of this report).

NEXT STEPS

MHCADSD expects that declining revenues will continue to be an issue that affects system performance over the next several years. In spite of this, MHCADSD intends to continue to work with service providers to promote the recovery model and to provide practical steps towards accomplishing it.

- A Recovery Steering Committee has been formed and is planning for a one day Recovery Conference to be held during Summer 2002. This conference, which will include nationally known recovery "experts", will establish the vision of a recovery-centered system of care and will introduce "best practice" models.
- Planning for a vocational initiative is underway, and identification of "best practice" models is among expected outcomes.
- A residential planning process is being conducted and is seeking to identify alternative therapeutic housing models that assist consumers in their recovery process.
- MHCADSD plans to establish a "Recovery Page" at its current website that will provide information on a range of resources related to the Recovery Model.

CONCLUSIONS

MHCADSD supports the publishing of this report as a means of establishing baselines against which future achievements can be measured. For 2001, we were able to demonstrate that progress did happen for a large number of consumers in GAF scores, in residential status, and in activities they participate in. We believe the initiatives we are implementing should facilitate further improvements, although we cannot predict what effect budget cuts may have on recovery-based outcomes. As we make the necessary decisions to address the ongoing budget reductions, inevitably the system we report on in 2003 will be different from the 2001 system. Our challenge, in partnership with our provider network and other stakeholders, will be to work toward a recovery oriented system with fewer resources.

[17] A "Regional Support Network" is a population and geographically based entity responsible for administrating publicly funded mental health services. MHCADSD is an RSN.

Global Assessment of Functioning (GAF) Scale

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health - illness. Do not include impairment in functioning due to physical or environmental limitations.

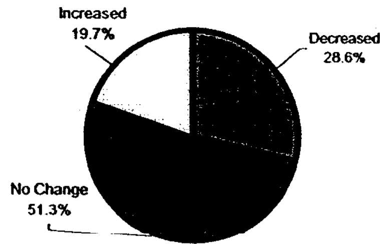
CODE	(**NOTE:** *Use intermediate codes when appropriate, e.g., 45, 68, 72.*)
100 | 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 | 81	**Absent or minimal symptoms** *(e.g., mild anxiety before an exam),* **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** *(e.g., an occasional argument with family members).*
80 | 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** *(e.g., difficulty concentrating after family argument);* **no more than slight impairment in social, occupational, or school functioning** *(e.g., temporarily falling behind in schoolwork).*
70 | 61	**Some mild symptoms** *(e.g., depressed mood and mild insomnia)* **OR some difficulty in social, occupational or school functioning** *(e.g., occasional truancy or theft within the household),* **but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 | 51	**Moderate symptoms** *(e.g., flat affect and circumstantial speech, occasional panic attacks)* **OR moderate difficulty in social, occupational or school functioning** *(e.g., few friends, conflicts with peers or co-workers).*
50 | 41	**Serious symptoms** *(e.g., suicide ideation, severe obsessional rituals, frequent shoplifting)* **OR any serious impairment in social, occupational or school functioning** *(e.g., no friends, unable to keep a job).*
40 | 31	**Some impairment in reality testing or communication** *(e.g., speech is at times illogical, obscure, or irrelevant)* **OR major impairment in several areas such as work or school, family relations, judgment, thinking or mood** *(e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).*
30 | 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** *(e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation)* **OR inability to function in almost all areas** *(e.g., stays in bed all day; no job, home, or friends).*
20 | 11	**Some danger of hurting self or others** *(e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement)* **OR occasionally fails to maintain minimal personal hygiene** *(e.g., smears feces)* **OR gross impairment in communication** *(e.g., largely incoherent or mute).*
10 | 1	**Persistent danger of severely hurting self or others** *(e.g., recurrent violence)* **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
0	Inadequate information.

King County Regional Support Network **Attachment II**
2001 Prepaid Health Plan Year End Report Card
Level 2.6: System Accountability Measures

Q1: Are we able to stabilize or decrease psychiatric symptoms for adults and older adults by benefit end?

A: Yes

Through 4Q01, 80.3% of adult/older adult clients had decreased or stable psychiatric symptoms compared to 78.6% in 2000 and 75% in 1999.

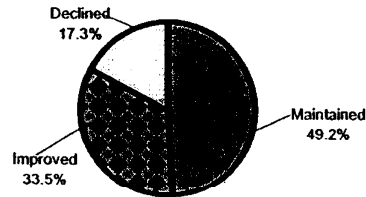


Note: Percent based on valid data (14.3% missing data)

Q2: Are we able to maintain or improve the functioning of clients by the time of their benefit ends?

A: Yes

Through 4Q01, 82.7% of clients maintained or improved their level of functioning by the time their benefit ended, compared to 81.5% in 2000.



Note: Percent based on valid data (17.6% missing data)

Q3: Are we able to reduce the number of homeless clients?

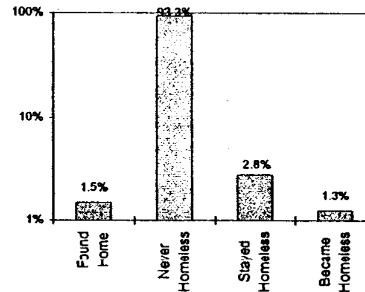
A: No

Through 4Q01, 2.8% of clients stayed homeless compared to 2.1% in 2000 and 2.5% in 1999.

Of the 676 clients who were homeless at the start of their benefit, 34.9% found housing by the end of their benefit. This is a decrease from 38.6% in 2000 but a slight increase from 34% in 1999.

4.1% of clients became or stayed homeless, compared to 3.2% in 2000 and 3.3% in 1999.

The ratio of homeless clients who found housing to clients who became homeless was 1.2:1, the same as in 2000 but less than the 1.6:1 in 1999.

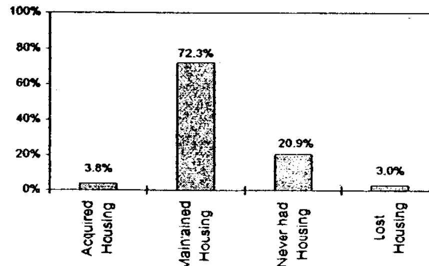


Q4: Are we able to help clients maintain or acquire independent housing by the time their benefit ends?

A: Mixed.

Through 4Q01, 76.1% of clients acquired or maintained independent housing, compared to 76.3% in 2000 and 77.7% in 1999.

The ratio of clients who acquired housing to those who lost housing was 1.3:1 compared to 1.2:1 in 2000 and 1999.



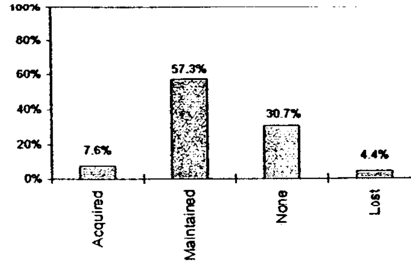
Q5: Are we able to help clients maintain or acquire age appropriate activities by the time their benefits ends?

A: Yes

Through 4Q01, 64.9% of clients maintained or acquired age appropriate activity compared to 61.8% in 2000 and 61.2% in 1999.

The percent of clients who had no age appropriate activity (30.7%) was lower than in 2000 (32.7%) and in 1999 (33.3%).

The ratio of clients who acquired age appropriate activity to those who lost activity was 1.7:1 compared to 1.6:1 in 2000 and 1.4:1 in 1999.



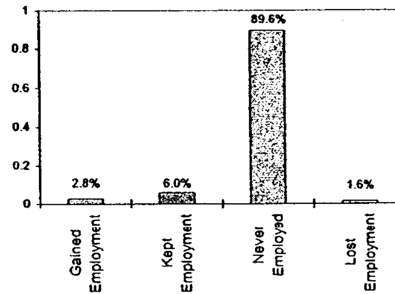
Q6: Are we able to help adults maintain or acquire paid employment by the time their benefit ends?

A: No

Through 4Q01, 8.8% of adult clients maintained or acquired employment compared to 14.5% in 2000 and 11.2% in 1999.

2.8% gained employment compared to 5.9% in 2000 and 4.1% in 1999.

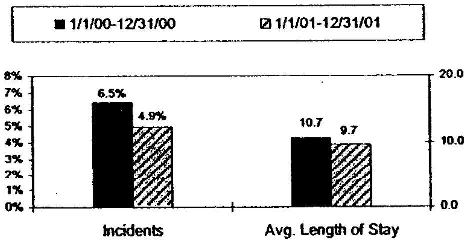
The ratio of clients who gained employment to those who lost employment was 1.8:1 compared to 2.1:1 in 2000 and 1.8:1 in 1999.



Q7: Are we decreasing the incidents and length of stay of voluntary hospitalizations?

A: Yes

Hospitalization incidents were 4.9% of unduplicated tier clients through 4Q01 compared to 6.5% for the same period in 2000. Average length of stay was 9.7 days compared to 10.7 days in 2000.

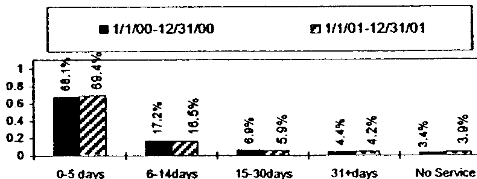


Q8: Are we decreasing the number of days it takes from discharge from a voluntary hospitalization until a face-to-face mental health service is provided?

A: Yes

Through 4Q01, 69.4% of clients received services within 5 days of discharge compared to 68.1% in 2000 and 65.6% in 1999. 85.9% received services within 14 days compared to 85.3% in 2000 and 82.1% in 1999.

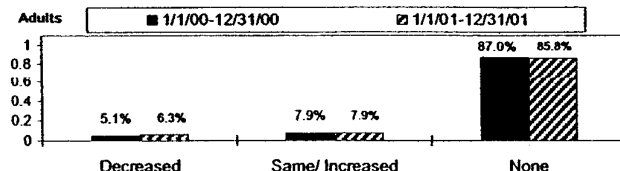
3.9% received no service compared to 3.4% in 2000 and 5.3% in 1999.



Q9: Are we decreasing the number of times clients are incarcerated?

A: **Mixed (adults and older adults). Juvenile detention data for 2001 are not available at this time**

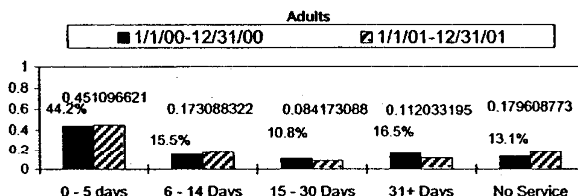
Through 4Q01, 6.3% of adult/older adult clients had decreased incarcerations compared to 5.1% in 2000 and 6.0% in 1999. 7.9% had the same or increased incarcerations, the same as in 2000 but more than the 6.0% in 1999. 85.8% of clients had no incarcerations compared to 87.0% in 2000 and 88.0% in 1999. When only those clients who had incarcerations (n = 1580) were examined, 44.4% had decreased incarcerations compared to 39.5% in 2000 and 50.2% in 1999.



Q10: Are we decreasing the number of days it takes from release from jail until a face-to-face mental health service is provided?

A: Yes

Through 4Q01, 45.1%of adult/older adult clients received a face-to-face service within 5 days of release, compared to 44.2% in 2000 and 36.1% in 1999. 62.4% received services within 14 days of release, compared to 59.7% in 2000 and 54.3% in 1999. 18.0% received no service compared to 13.1% in 2000 and 17.9% in 1999.

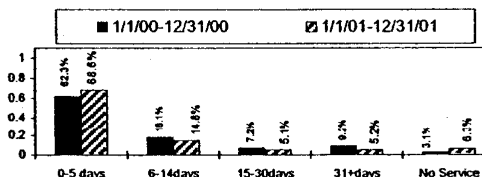


Q11: Are we decreasing the number of days it takes from discharge from an involuntary hospitalization until a face-to-face mental health service is provided?

A: Yes

Through 4Q01, 68.6% of persons received services within 5 days of discharge compared to 62.3% in 2000 and 56.8% in 1999. 83.4% received services within 14 days compared to 80.4% in 2000 and 76.9% in 1999.

6.3% received no service, compared to 3.1% in 2000 and 5.5% in 1999.



Report of Missing Data

Report 1 = Psychiatric Symptoms
Report 2 = Level of Function
Report 3 = Homeless
Report 4 = Independent housing
Report 5 = Activity
Report 6 = employment

OUTCOME DATA

The following lists the client outcome report summaries found in Level 2.6 of the Report Card. This list includes information on the composition of the data.

Question	Description
Q1: Are we able to stabilize or decrease psychiatric symptoms for adults and older adults by the time their benefit ends?	Comparison of Problem Severity Summary (PSS) symptom indicator scores for adults and older adults at the beginning of a benefit for benefits expired year-to-date.
Q2: Are we able to maintain or improve the functioning of clients by the time of their benefit ends?	Comparison of Tier 2 and 3 CGAS and GAF scores at the beginning of the benefit with scores at the end of the benefit for benefits expired year-to-date.
Q3: Are we able to reduce the number of homeless clients?	Comparison of homeless status for children, adults, older adults from the beginning of the benefit to the status at the end of the benefit for benefits expired year-to-date.
Q4: Are we able to help clients maintain or acquire independent housing by the time their benefit ends?	Comparison of residential arrangement status (excluding adult family housing, foster care, long-term adoptive services, congregate care facilities, group homes, long-term rehabilitative services, correctional or inpatient facilities, crisis respite or homeless) for children, adults and older adults at the beginning of the benefit to the status at the end of the benefit for benefits expired year-to-date.
Q5: Are we able to help clients maintain or acquire age appropriate activities by the time their benefits ends?	Comparison of age appropriate activity status (full or part time employment, full or part time school, vendor operated employment, formal preparation for employment or other structured non-clinic activity) for Tier 2 and 3 children, adults and older adults at the beginning of the benefit to the status at the end of the benefit for benefits expired year-to-date.
Q6: Are we able to help adults maintain or acquire paid employment by the time their benefit ends?	Comparison of employment status for adults at the beginning of the benefit to the status at the end of the benefit for expired year-to-date.
Q7: Are we decreasing the incidents and length of stay of voluntary hospitalizations?	Actual bed days and hospital visits for children, adults and older adults, year-to-date.
Q8: Are we decreasing the number of days it takes from discharge from a voluntary hospitalization until a face to face mental health service is provided?	Actual time elapsed to first mental health outpatient service for authorized children, adults, older adults following discharge from voluntary hospitalization, year-to-date.
Q9: Are we decreasing the number of times clients are incarcerated?	Comparison of King County Correctional Facility (KCCF) incarceration episodes in the previous calendar year with episodes in the current calendar year for adults and older adults with benefits expired year-to-date. Comparison of King County Department of Adult and Juvenile Detention (DAJD) juvenile detention episodes in the previous calendar year with episodes in the current calendar year for children with benefits expired year-to-date.
Q10: Are we decreasing the number of days it takes from release from jail until a face to face mental health service is provided?	Actual time elapsed to first mental health outpatient service for authorized adults, and older adults following release from King County Correctional Facility (KCCF), year-to-date. Actual time elapse of first mental health outpatient service for authorized children following release from DAJD, year-to-date.
Q11: Are we decreasing the number of days it takes from discharge from a involuntary hospitalization until a face to face mental health service is provided?	Actual time elapsed to first mental health outpatient service for authorized children, adults, older adults following discharge from involuntary hospitalization, year-to-date.