Attachment A

King County

Mental Illness and Drug Dependency Comprehensive Retrospective Report

As Required by Ordinance 17998

June 2016

Contents

I. Executive Summary

Key Findings: MIDD's Effectiveness in Meeting Policy Goals

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

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

The MIDD Plan was intended to be a comprehensive approach to creating improvements across the continuum of the behavioral health[1] system and making progress toward five key public policy goals. Ordinance 15949 established five policy goals for King County's MIDD sales tax. These goals have guided and informed all aspects of the MIDD policy and services work since 2007.

MIDD Adopted Policy Goals

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

Policy Goal 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

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 County Recovery Plan.

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

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

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

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

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

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

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

Approach and Organization of This Report

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

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

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

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

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

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

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

Background

MIDD I : Acting in response to new authority from the state legislature for counties to impose taxes to support new and expanded[2] mental health, substance abuse, and therapeutic court services, the King County Council passed the Mental Illness and Drug Dependency (MIDD) sales tax in 2007. King County's tax was given a sunset date of January 1, 2017 designed to promote evaluation of programming and success in meeting policy goals. The Council further provided guidance for MIDD's formation through adopted oversight, implementation and evaluation plans that promoted accountability and transparency.

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

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

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

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

Performance Targets and Associated Changes

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

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

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

Policy Goals

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

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

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

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

Evaluation Revisions

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

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

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

Conclusion

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

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

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

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

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

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

King County's Mental Illness and Drug Dependency (MIDD) is a countywide sales tax generating approximately $53 million per year for mental health and substance abuse services and programs. As required by state legislation (Revised Code of Washington 82.14.460), revenue raised under the MIDD is to be used for certain mental health and substance use disorder services, including King County's therapeutic courts. King County's MIDD was passed by the King County Council in 2007, and MIDD-funded services began in October 2008. Unless renewed by the Council, the MIDD will expire on December 31, 2016. King County is one of 23 counties in Washington state that has authorized the tax revenue.

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

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

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

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

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

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

Ordinance 17998 Requirements

1. An assessment of the effectiveness of the current MIDD funded strategies, programs and services in meeting the five policy goals outlined in Ordinance 15949 and an explanation of the methodology used to make the determination of effectiveness.

2. An **enumeration of all performance measurements and performance measurement targets** used over the life of all MIDD funded strategies, programs and services and a summary of performance outcome findings by type by year.

3. **Identification of all MIDD funded strategies, programs and services that did not provide performance measurements** on an annual basis or did not meet established performance measurement targets, including for all an explanation of the basis for not providing performance measurements or not meeting the targets, including strategies, programs and services that received moneys that were supplanted by MIDD revenue or that experienced cuts in funding due to MIDD Oversight Committee prioritization review, steps taken to address underperforming MIDD funded strategies, programs and services and the outcome of the steps taken.

4. Identification of all **MIDD funded strategies, programs and services that amended or adjusted performance measurement targets during the 2008-2015 MIDD funding period** and an explanation of why changes were made and the results of the changed performance targets.

5. Identification of **how performance measurement data was used in MIDD strategy, program and service revisions** and a description of all revisions made to strategies, programs or services over the life of the MIDD.

6. **Proposed recommendations on improvements to MIDD** performance measures, evaluation data gathering, including a review of the evaluation processes, timeframes and data gathering.

7. **Proposed modifications to the MIDD policy goals** outlined in Ordinance 15949 and the basis of the proposed modifications.

8. The executive shall ensure that recommendations in the comprehensive, historical review and assessment report of the MIDD-funded strategies, services and programs are **developed with input from the MIDD oversight committee**.

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

Methodology for Addressing the Requirements of Ordinance 17998

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

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

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

MIDD Oversight Committee Values & Guiding Principles **Revised August 6, 2015**
• 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[4] reviewed and provided feedback on the recommendations contained within this report. Some members of the Oversight Committee were interviewed by PSB for its assessment report. Additionally, the Oversight Committee

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

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

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

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

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

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

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

III. Background: MIDD I and Key Environmental Changes

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

> *(1)(a) A county legislative authority may authorize, fix, and impose a sales and use tax in accordance with the terms of this chapter.*
>
> *(b) If a county with a population over eight hundred thousand has not imposed the tax authorized under this subsection by January 1, 2011, any city with a population over thirty thousand located in that county may authorize, fix, and impose the sales and use tax in accordance with the terms of this chapter. The county must provide a credit against its tax for the full amount of tax imposed under this subsection (1)(b) by any city located in that county if the county imposes the tax after January 1, 2011.*
>
> *(2) The tax authorized in this section is in addition to any other taxes authorized by law and must be collected from those persons who are taxable by the state under chapters 82.08 and 82.12 RCW upon the occurrence of any taxable event within the county for a county's tax and within a city for a city's tax. The rate of tax equals one-tenth of one percent of the selling price in the case of a sales tax, or value of the article used, in the case of a use tax.*
>
> *(3) Moneys collected under this section must be used solely for the purpose of providing for the operation or delivery of chemical dependency or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services. For the purposes of this section, "programs and services" includes, but is not limited to, treatment services, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service.*
>
> *(4) All moneys collected under this section must be used solely for the purpose of providing new or expanded programs and services as provided in this section, except as follows:*
> *(a) For a county with a population larger than twenty-five thousand or a city with a population over thirty thousand, which initially imposed the tax authorized under this section prior to January 1, 2012, a portion of moneys collected under this section may be used to supplant existing funding for these purposes as follows: Up to fifty percent may be used to supplant existing funding in calendar years 2011-2012; up to forty percent may be used to supplant existing funding in calendar year 2013; up to thirty percent may be used to supplant existing funding in calendar year 2014; up to twenty percent may be used to supplant existing funding in calendar year 2015; and up to ten percent may be used to supplant existing funding in calendar year 2016;*

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

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

The state statute has been amended several times since its origination in 2005. The first change (2008) allowed for housing that is a component of a coordinated chemical dependency or mental health treatment program or service. Most notably, the 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.* [5]

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

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

MIDD Adopted Policy Goals

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

Policy Goal 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

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 County Recovery Plan.

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

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

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

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

The MIDD Oversight Plan, adopted by Ordinance 16077, established the MIDD Oversight Committee. It set the role and duties of the Oversight Committee, and established the composition of the Oversight

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

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

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

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

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

MIDD I Service Areas and Programming

MIDD I Service Area	MIDD Programs and Strategies
Community-Based Care	• 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 contained information on each individual program (strategy) including the following:

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

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

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

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

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

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

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

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

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

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

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

Replacement of lost federal funds is permitted.

MIDD Today: MIDD serves thousands of people annually[9], 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 MIDD funds. Three youth strategies: Services for Parents in Substance Abuse Outpatient Treatment (4a); Prevention Services to Children of Substance Abusing Parents (4b); and, Reception Centers for Youth in Crisis (7a), remain on hold. A substantially modified version of Strategy 7a known as FIRS (Family Intervention and Restorative Services) was awarded one time supplemental funding during 2015.

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

- Twenty strategies or sub-strategies were expected to reduce jail bookings and days for individuals served. It was more common for clients to reduce bookings than to reduce days.

- Fourteen strategies or sub-strategies were expected to reduce admissions to Harborview Medical Center's emergency department. Ten of these achieved reductions of 20 percent or greater in the second year after the start of MIDD services, which was a favorable outcome.

- Ten strategies were expected to reduce psychiatric hospitalizations for clients served. At least nine strategies achieved targeted reductions during at least one outcomes analysis period.

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

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

Balance Review subcommittee to conduct analysis and have a menu of recommendations at the ready for future opportunities to utilize undesignated fund balance.

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

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

Key Changed Conditions Impacting MIDD

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

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

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

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

disorder systems, reflecting the joining of systems through behavioral health integration.

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

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

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

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

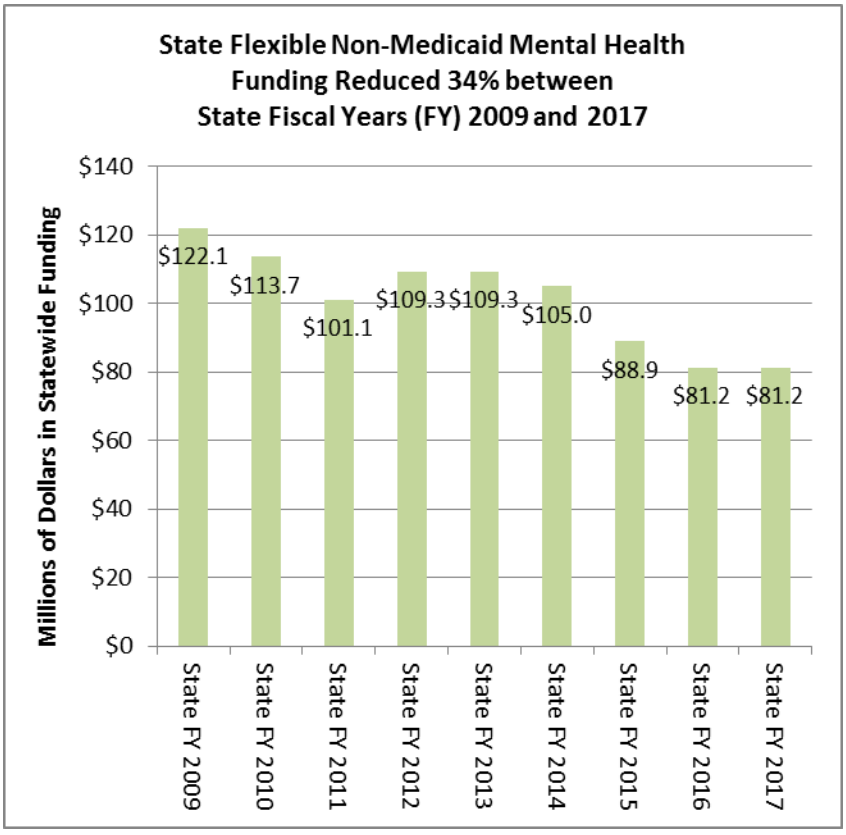
Prior to implementation of the ACA, most people served in the substance use disorder system were not eligible for Medicaid, as Medicaid eligibility was determined by a combination of income and disability and having solely a substance use disorder was not considered a qualifying condition for federal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

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

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

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

Table 1



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

mental illnesses or substance use disorders.

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

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

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

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

Court Rulings

Psychiatric Boarding: On August 7, 2014, the Washington State Supreme Court ruled that hospital

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

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

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

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

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

boarding of individuals in mental health crisis, absent medical need, is unconstitutional. Psychiatric boarding or "boarding" became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as hospital EDs until a psychiatric bed became available.

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

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

State and local partners, including King County's Community Alternatives to Boarding Task Force, are developing system innovations and deploying new resources strategically to improve access to care. Local flexible resources like MIDD also play a key part in expanding treatment capacity in King County and reducing emergency department and psychiatric hospital usage for service participants.

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 services to individuals in jails within seven days of such services being ordered by a court. 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

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

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

negatively impact the publicly funded behavioral health care system when trained, licensed, and qualified staff are difficult to find and/or retain in community provider organizations.

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

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

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

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

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

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

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

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

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

Providing services under a trauma-informed framework can result in better outcomes than "treatment as usual." A variety of studies have revealed that programs utilizing a trauma-informed model are

[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.

associated with a decrease in psychiatric symptoms and substance use. Some programs have shown an improvement in daily functioning and a decrease in trauma symptoms, substance use and mental health symptoms. [22, 23] Trauma-informed care may lead to decreased utilization of crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed services.[24]

King County's Equity and Social Justice Agenda: The County's Equity and Social Justice Agenda recognizes that race, place and income impact quality of life for residents of King County and people of color, 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, 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 and to build an inclusive community that values the needs, priorities, and contributions of a broad range of cultural groups, including but not limited to immigrants, refugees[25], and Lesbian, Gay, Bisexual, Transgender, Questioning/Queer (LGBTQ) residents.

While King County government has made progress, especially with regard to pro-equity policies, there is still a long way to go. Though the County's ability to create greater levels of institutional and regional equity may be limited by the scope of its services and influence, by working collaboratively with providers, consumers, and other stakeholders, further improvements will be made.

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

[22] Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.B., Reed, B.G., & Fallot, R. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. Journal of Substance Abuse Treatment, 28(2), 109-119.
[23] Morrissey, J.P., and Ellis, A.R. (2005). Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. Journal of Substance Abuse Treatment, 28(2), 121-133.
[24] Community Connections. (2002). Trauma and Abuse in the Lives of Homeless Men and Women. Online PowerPoint presentation. Washington, DC: Authors. Retrieved September 3, 2007, from http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt
[25] http://kingcounty.gov/elected/executive/equity-social-justice.aspx.

IV. MIDD Evaluation Overview

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

MIDD Evaluation Plan

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

Requirements of the MIDD Evaluation Plan

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

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

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

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

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

supported by MIDD funds. MIDD policy goals and strategies were linked to the results via the matrices, which in turn provided a structure for identifying performance indicators, targets and data sources, and for collecting and reporting results[26].

The MIDD Evaluation Plan that was adopted contained preliminary performance measurement targets for five broad MIDD policy goals. Due to timing issues, it was not possible for the county to identify individual performance measurement targets for each of the 37 individual strategies before the due date of the plan. During Council's deliberation on the Evaluation Plan, it was determined that the targets contained in the MIDD Evaluation Plan would be revised over time as programs developed and changed. Ordinance 16262 adopting the Evaluation Plan stated[27],

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

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

Please note that programs that used MIDD funds as supplantation for lost other funds, including treatment courts, were not required to participate in on-going MIDD evaluations.[28]

MIDD Evaluation Overview

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

[26] 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.
[27] Ordinance 16262 Lines 66-71
[28] With the exception of a one-time, ad hoc evaluation conducted in 2012 when MIDD revenue shortfalls were expected. The evaluation had significant methodological limitations and was not utilized.

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

Once the data are clean, they are loaded into the MIDD database and queried for analysis. Depending on the MIDD strategy, the data are then matched with data from other systems that King County BHRD accesses via business associate and data sharing agreements. These include data from municipal jails, the King County Department of Adult and Juvenile Detention (DAJD), Harborview Medical Center, Western State Hospital, Pre-Manage (a new data source accessed for the first time in 2015 for hospital emergency department data beyond Harborview), and the Homeless Management Information System (HMIS).[29] Initial matching is automated, and then manually reviewed. This time-intensive process involves working with many thousands of records associated with the MIDD, but remains necessary to ensure that evaluation results associated with the MIDD are reliable.

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

In accordance with the MIDD Evaluation Plan, MIDD strategy data are examined in light of relevant outcome types, eligible sample sizes, either total or average number of system use admissions or days in each time period, and the percent change over time. Analysts look for patterns in the data that suggest relationships between measured variables without implying causation. MIDD evaluators are cognizant of the fact that for all strategies, other factors not being measured, such as law enforcement practices and state or federal policy changes, could also be contributing to any observed results.[30]

Definitions of Key MIDD Evaluation Terms	
MIDD Strategy	A program or series of programs that provide specific services
Output	The quantifiable amount of something being measured, such as how many people served or how many services provided
Outcomes	Measurable or observable end results or effects; something that happens as a result of an activity or process
Target	Quantifiable outputs expected of an entity implementing a strategy such as how

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

	many people will be served and/or how many services will be provided
Revised Target	Changed expected output goals, usually permanent, due to new or better information
Adjusted Target	Changed expected output goals, usually temporary, due to changes in funding, staffing, policy or approach
FTE	Full-time equivalent staffing. This is used to contextualize several MIDD targets
Performance Measurement	The actual number of clients seen or services delivered; also represented as a percentage the original, revised or adjusted target
Targeted Reductions	The amount of change expected in system use (jail, emergency department, psychiatric reductions hospital) over time by individuals being served by particular strategies

Evaluating Outcomes

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

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

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

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

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

This transition from process to outcome evaluation was made possible as outcome measures for some strategies became available in the first quarter of calendar year 2010. Outcomes measurement varied depending upon the primary and/or secondary policy goals associated with each strategy. In some cases, outcomes involved matching information about MIDD service recipients against multiple outside

data sources such as jail bookings, psychiatric hospitalizations and emergency room utilization. In other situations, outcomes were assessed by comparing measures of mental health or substance use disorder symptoms at two different points in time.

As has been stated in the MIDD Annual Reports and in other arenas throughout the life of MIDD, direct causation of outcomes cannot be attributed to MIDD I. Causation cannot be established within the evaluation framework of MIDD, particularly given the lack of a control group. Creation of a MIDD control group was considered and dismissed for a number of reasons, including the ethics of withholding services from one group of individuals in order to compare them with another group. Statistical analysis of system use and symptom reduction indicates that the strength of associations between predictors and outcomes are sufficient to demonstrate the MIDD's value.[31]

It is important to note that MIDD is comprised of multiple and often interrelated interventions that are designed to achieve the same or similar policy goals. For example, reducing caseloads, enhancing workforce development activities and service capacity are expected to *collectively* reduce incarceration and use of emergency services. MIDD is not a single intervention: it is a very complex set of interventions serving a wide variety of individuals, in an array of settings, by multiple providers. Therefore, evaluating the impact of the MIDD is a multifaceted endeavor. MIDD evaluation involves multiple target populations, goals, strategies,[32] programs, interventions, providers, administrators, partners, locations, timelines and expected results. Additionally, the MIDD evaluation was never intended to be a series of independent program evaluations although many programs included within MIDD strategies do undergo their own separate, in-depth evaluations, often conducted by third parties[33].

The overall evaluation approach of MIDD is designed to assess whether the expected results are being achieved and whether benefits are derived from MIDD investments.[34]

[31] MIDD Second Annual Report
[32] The word "strategies" was used in MIDD I to indicate a category of programming with discrete goals, target populations, and similar intervention approaches, that distinguished them from other "strategies" within MIDD I. A single "strategy" sometimes encompassed multiple related interventions, and often included multiple contracted providers. In MIDD II (if renewed), these categories will be called "programs," but throughout this report, the word "strategies" is used for consistency with language used in other MIDD documents from 2008 through 2016.
[33] Screening, Brief Intervention and Referral to Treatment (SBIRT), Supported Employment, for example.
[34] MIDD Action Plan, Part 3: Evaluation Plan

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

Measuring Success and Determining Effectiveness

The MIDD Plan was intended to be a comprehensive approach to creating improvements across the continuum of the behavioral health[35] system and making progress toward five key public policy goals. Ordinance 15949 established five policy goals for King County's MIDD sales tax. These goals have guided and informed all aspects of the MIDD policy and services work since 2007.

MIDD Adopted Policy Goals

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

Policy Goal 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

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 County Recovery Plan.

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

Assessment of Effectiveness of MIDD in meeting Policy Goals
• **Overall, MIDD achieved significant reductions in jail, emergency department and psychiatric hospital utilization.**
• **Symptom reduction data was limited, but symptom reductions were shown for most individuals in smaller samples where change was evident.**
• **MIDD did not quantitatively measure furtherance of other initiatives.**

[35] Behavioral Health is a term that refers to both mental health and chemical dependency.

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

Fourteen MIDD strategies have a primary or secondary policy goal of reducing emergency department (ED) use by individuals with behavioral health disorder(s).[36] Data were provided by Harborview Medical Center[37] in Seattle in order to monitor changes in use of their ED over time. King County was not able to secure data agreements with other hospitals.

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

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

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

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

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

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

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

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

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

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

A total of 25 MIDD strategies seek to reduce jail use, reduce the degree to which individuals cycle through the jail and/or to divert individuals with behavioral health conditions away from justice system involvement. Of the strategies with jail reduction goals, two were never implemented[38], two secured non-MIDD funding[39], and four began late[40], therefore long-term impacts on jail and detention use (over a five-year period)[41] are currently available for 17 MIDD strategies. See Appendix H for detailed jail use outcomes.

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

In Strategy 12d Behavior Modification Classes, where clients receive Moral Reconation Therapy (MRT), this evidence-based cognitive-behavioral treatment showed impactful jail reduction results with a demonstrated long-term reduction in jail bookings of 74 percent. Jail use reductions were not limited to the MIDD criminal justice strategies, however, as strategies involving housing, behavioral health treatment, and the therapeutic courts showed jail use reductions as well. MIDD evaluation data found[42]:

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

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

[38] 4b Substance Use Disorder Prevention for Children; 7a Youth Reception Centers
[39] 17a Crisis Intervention/Mental Health Partnership; 17b Safe Housing – Child Prostitution
[40] 4c School-Based Services; 7b Expand Youth Crisis Services; 10b Adult Crisis Diversion; 12b Hospital Re-Entry Respite Beds
[41] Long-term impacts are analyzed because it takes time to identify trends
[42] Please see MIDD Eighth Annual Report, Appendix V Aggregate System Use by Relevant Strategies, pgs. 59-69. http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/Reports/160413_MIDD_8th_Annual_Report.ashx?la=en,

Juvenile Drug Court. Juvenile Drug Court data indicated a 48 percent reduction in detention was achieved, with behavioral health treatment for youth (Strategies 1a-1 and 1a-2) showing the best short term jail reductions for youth (23 percent and 28 percent in the second post period). Use of detention as a sanction for youth in 9a over the short term increased detention days, with long-term data showing overall reductions in detention bookings as high as 48 percent[43].

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

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

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

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

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

[43] Ibid.

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

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

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

Alignment with other initiatives was not quantitatively tracked by MIDD evaluation. Anecdotally, DCHS staff tasked with these efforts collaborated on issues such as outreach and data gathering.

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

A core purpose of King County's justice operational master plans is to work collaboratively across King County criminal justice partners to ensure that the criminal justice system is fair, effective, efficient and integrated.[44] The MIDD strategies included improvements to coordination between behavioral treatment and services and the criminal and juvenile justice systems, including diversion programs; alternative sentencing methods such as therapeutic courts; and improvements in screening, assessment and discharge planning that connect directly to community service engagement and placement.[45]The following strategies advance the Adult & Juvenile Justice Operational Master Plans.

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

Ten-Year Plan to End Homelessness[46] - The plan's goals of "…promot(ing) long-term and sustainable

[44] http://www.kingcounty.gov/exec/PSB/AJOMP.aspx
[45] The MIDD Action Plan
[46] No link available to the original plan. See http://allhomekc.org/wp-content/uploads/2015/09/All-Home-Strategic-Plan.pdf for the current strategic plan.

solutions to homelessness including alignment of funding, programs and services among the public, private and non-profit sectors align with MIDD policy goals."[47] The MIDD strategies are designed to prevent and reduce chronic homelessness in alignment with the Plan to End Homelessness. Specific MIDD strategies directly linked to the plan are described below.

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

Veterans and Human Services Levy - The Veterans and Human Services Levy aims to generate funding to help veterans, military personnel and their families, and other individuals and families in need across the county through a variety of housing and supportive services.[48] Veterans comprise a large percentage of the population of individuals who are homeless and who enter the criminal justice system and receive services from MIDD strategies. The following strategies promote the Veterans and Human Services Levy.

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

Mental Health Recovery Plan -This plan seeks to align and integrate recovery and resiliency initiatives for behavioral health services, shaping services to be trauma-informed and to attend to whole-person health.[49] Many MIDD strategies support individuals working to "improve their own health and well-being" while meeting "life's challenges with a sense of self-determination, mastery and hope." The following MIDD strategies support the Mental Health Recovery Plan.

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

[47] https://en.wikipedia.org/wiki/Homelessness_in_Seattle
[48] http://www.kingcounty.gov/operations/DCHS/Services/Levy.aspx
[49] http://www.kingcounty.gov/~/media/health/mentalHealth/Recovery/Documents/130524_FINAL_Plan-R_and_R_Oriented_Behavioral_Health_Services_Rev_6.ashx?la=en

Overall Conclusions about MIDD's Effectiveness in Meeting Policy Goals

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

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

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

Strategy	Evaluation Component Example
1e Chemical Dependency Professional Education and Training	• Data collected from individuals attending "Motivational Interviewing" workshops were analyzed to demonstrate training effectiveness. • Comparison of survey responses prior to trainings and at 30-day follow-ups showed statistically significant gains in knowledge or skill level across a variety of topics addressed in the trainings. • Courses continue to be evaluated for quality, relevance and effectiveness, with satisfaction ratings above 95 percent. • The majority of trainees feel they are better able to serve clients after participating in MIDD-funded workforce development activities.

<table>
<tr><td>1f Peer Support and Parent Partner Family Assistance</td><td>
Key outcomes for Strategy 1f involve increasing protective factors for families and youth served, decreasing risk factors by expanding knowledge of service systems and connections to natural supports.
<table>
<tr><th>Services Provided</th><th>N</th><th>Percent</th></tr>
<tr><td>Assisted in obtaining services*</td><td>568</td><td>80%</td></tr>
<tr><td>Systems navigation</td><td>487</td><td>69%</td></tr>
<tr><td>Life skills</td><td>466</td><td>66%</td></tr>
<tr><td>Gaining advocacy skills</td><td>359</td><td>51%</td></tr>
<tr><td>Self care</td><td>349</td><td>49%</td></tr>
<tr><td>Strengths assessment</td><td>331</td><td>47%</td></tr>
<tr><td>Basic needs assistance</td><td>197</td><td>28%</td></tr>
<tr><td>Identifying natural supports</td><td>171</td><td>24%</td></tr>
</table>
</td></tr>
<tr><td>2a Caseload Reduction for Mental Health</td><td>
A study was conducted in 2012 to assess the impact of MIDD-funded staff increases on staff-to-client ratios.
Data from five agencies showed that each staff member served 17 to 57 clients (depending on the agency), with the average being 40 clients per staff member.
Highs and lows over a four-year period balanced out such that overall caseload size was reduced from 42, on average, to 35 clients per direct services staff member; this represents a 17 percent reduction[50].
</td></tr>
<tr><td>2b Employment Services for Individuals with Mental Illness and Chemical Dependency</td><td>
As reported in the Seventh Annual Report (February 2015), job placement outcomes were tracked for 885 people who had at least one supported employment service during the previous MIDD year, regardless of when they initially enrolled in the program.
A total of 271 people (31%) had one or more job placements prior to October 2014; a job placement rate consistent with 2013 findings and up from 20 percent or less in prior MIDD years.
Jobs were retained more than 90 days for 177 employed clients (65%), and one in four people retained their job for nine months or longer.
</td></tr>
<tr><td>4d School Based Suicide Prevention</td><td>
Retrospective pre/post self-assessments given to a sample of 2,503 youth who attended suicide prevention training presentations in 2009 showed statistically significant increases in knowledge and/or awareness in the following content areas:
· Teen Link (a teen crisis help line)
· Coping mechanisms
</td></tr>
</table>

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

	· Warning signs for people who may be suicidal · How to help if someone seems suicidal. • For adults, 179 evaluations were analyzed and demonstrated the effectiveness of trainings in increasing knowledge about: · Rates and incidence of youth suicide · Signs of depression · Suicide warning signs · Resources and ways to help.
10a Crisis Intervention Training	• Since the first MIDD-funded Crisis Intervention Team (CIT) training was offered in October 2010, all CIT attendees have had the opportunity to evaluate their learning experiences through online surveys conducted upon course completion. • Two courses in the 40-hour training have been rated "excellent" by more than 75 percent of respondents since data collection began: Excited Delirium and Communicating with Persons with Mental Illness/De-Escalation Techniques.

As described above, evidence indicates that most of the strategies of MIDD I have played a role in advancing the five policy goals for MIDD as outlined by the King County Council. Because the aims of the policy goals are wide-ranging, the breadth and/or depth of impact varies by strategy depending on the particular strategy or service being considered. As noted previously in this report, statistical analysis of system use and symptom reduction indicates that the strength of associations between predictors and outcomes are sufficient to demonstrate the MIDD's value.[51]

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

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

[51] MIDD Second Annual Report

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

Performance Measurements and Summary of Performance Outcomes

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

MIDD targets are considered met if 85 percent or more of the established target was achieved after adjustment.[52] In addition, some strategies use blended funding from multiple sources which prevents the separation of people served by MIDD funds from those served by other funds. This, in turn, led to these strategies significantly exceeding the performance target (such as for 7b Expand Youth Crisis Services).

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

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

Table 2

MIDD Strategies: Performance Target Rating	Year 1 2008-09	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15	All Years
Met or Exceeded Target	19	27	31	38	39	36	33	**223**
85% or greater of target	(70%)	(77%)	(79%)	(86%)	(89%)	(80%)	(73%)	**(80%)**

[52] See Section Four for more information about adjustments.

Did Not Meet Target *65-84% of target*	5 (19%)	4 (11%)	4 (10%)	3 (7%)	4 (9%)	7 (16%)	6 (13%)	**33 (12%)**
Considerably Below Target *Less than 65% of target*	3 (11%)	4 (11%)	4 (10%)	3 (7%)	1 (2%)	2 (4%)	6 (13%)	**23 (8%)**
Total Performance Targets[53]	**27**	**35**	**39**	**44**	**44**	**45**	**45**	**279**

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

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

Unmet Performance Measurement Targets

The previous section of this report provided an overview of the performance measurement targets and outcomes findings. As indicated, some MIDD-funded strategies, programs and services did not provide performance measurements on an annual basis or did not meet established performance measurement targets. Of the 33 implemented MIDD strategies, 6 (18 percent) had annual performance measurement targets that were unmet at least three times between 2008 and 2015. See Appendix L for details on unmet performance targets.

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

[53] The number of performance targets increased over time as more MIDD strategies were implemented.

needed to match individuals with other data sets for MIDD policy goal analysis.

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

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

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

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

Strategy 1a-2 Substance Use Disorder (SUD) Treatment did not meet its adult outpatient treatment unit goal except in Year Two. For SUD treatment, federal and state funds are expended before MIDD funds, as MIDD funding is to be used only when other funds are not available (MIDD is "funder of last resort" for this strategy). The SUD treatment system has limited capacity which was maximized and did not allow for further use of MIDD-funded treatment services. State funds are not stable enough to allow the treatment system to expand capacity. In one year underspent funds were redirected to the MIDD fund balance, and in subsequent years underspent funds were used to enhance treatment success with treatment support activities such as outreach and transportation.

In April 2015, Recovery Centers of King County (RCKC) unexpectedly ended its contract with King County and closed its operations. RCKC was the sole provider of County-funded detoxification services, and other options were rapidly developed to address the major loss of service. The County quickly contracted with Fairfax Hospital and Cascade Behavioral Health for temporary detoxification services. From April 2015 – November 2015 state and MIDD 1a-2 Substance Use Disorder (SUD) Treatment funds were used to provide the necessary detoxification services while a long-term solution was implemented.

MIDD provided $1.75 million in funding for detoxification services, which in turn impacted availability funds for other levels of service in Strategy 1a-2 Substance Use Disorder (SUD) Treatment. As a result, none of the 1a-2 Substance Use Disorder (SUD) Treatment performance targets were met during Year Seven. Detoxification targets were not developed due to the temporary nature of these services.

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

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

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

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

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

Amended or Adjusted Performance Measurement Targets

Revisions to Targets: Performance targets were revised as strategy implementation plans were altered,

budgets changed and/or certain data elements were determined not to be feasible or relevant for the populations served by the strategies. As noted above, some targets were based on untested assumptions about program and staff capacity.

Revisions of the original performance measures for 23 strategies were completed in 2010. The revisions were included in the MIDD Year Two Progress Report which was electronically transmitted to the MIDD Oversight Committee and reviewed and approved at the August 26, 2010 MIDD Oversight Committee meeting.[54] See Table 3 for summary of the performance target changes made in 2010.

Table 3

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

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

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

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

In other cases, performance targets were amended when programs were enhanced or redesigned.

[54] See Section Five for more information on MIDD OC Review of Strategy Revisions

Strategies 1e Chemical Dependency Trainings, 1f Parent Partners Family Assistance, 5a Juvenile Justice Assessments, 9a Juvenile Drug Court, 11b Mental Health Courts and 15a Adult Drug Court expanded their program in some manner or had changes to the implementation plan.

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

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

Table 4

Strategy		Date	Old Annual Target(s)	New Annual Target(s)	Reason	Result of Change
1a-2	Substance Use Disorder (SUD) Treatment	4/29/2010	400 outpatient (OP) clients 461 opiate (OTP) clients	50,000 adult OP units 4,000 youth OP units 70,000 OTP units	Units purchased more accurate measure than clients served	Adult OP targets not met as other funds were used
1c	Emergency Room Intervention	7/1/2011	7,680 clients	6,400 screens and 4,340 brief interventions with 8 FTE	Service type was better measure	Screening targets never met
1e	Chemical Dependency Trainings	5/25/2012	125 reimbursed trainees	125 reimbursed trainees 250 workforce development trainees	Expanded in Year 4	Targets always met
1f	Parent Partners Family Assistance	5/1/2013	4,000 clients	400 families (individual data) 1,000 clients in groups (summary data)	New program design	Too soon to assess (Began Year 6)
3a	Supportive Housing	2/14/2012	N/A	Targets adjust to new capacity each year	Beds increase annually	Targets always met
4d	Suicide Prevention Training	5/3/2010	12 presentations for 200 adults	40 presentations for 1,500 adults	New targets based on Year 1 results	Target met in 2 of 6 years
5a	Juvenile Justice Assessments	7/1/2011	1,230 youth	500 assessment coordinations 200 psychological services 140 mental health & 165 full SUD assessments	Service type was better measure	Only one target (psychological services) not met in 2 of 5 years
5a	Juvenile Justice Assessments	4/29/2014	500 coordinations	1,200 coordinations	Added short screener assessments	Too soon to assess (New target Year 6)
6a	Wraparound	5/25/2012	920 youth (including siblings)	450 enrolled youth only	Unable to track siblings	Target always met
8a	Family Treatment Court	8/1/2011	45 additional children	No more than 90 children	Cap imposed per FTC proviso	Cap not exceeded in calendar year
9a	Juvenile Drug Court	5/1/2013	36 new youth with 5.5 FTE	36 new youth including pre opt-ins	Program redesign	Target met with increased counts

10a	Crisis Intervention Team Training	7/12/2010	40-hour: 480 trainees One-day: 1,200 trainees	40-hour: 375 trainees One-day: 1,000 trainees	Old target too high	New targets still high for capacity
10a	Crisis Intervention Team Training	2/14/2012	40-hour:375 trainees One-day:1,000 trainees	40-hour: 180 trainees One-day: 300 trainees Other: 150 trainees	Matched targets to actual capacity	Targets always met
10b	Adult Crisis Diversion	7/9/2010	3,600 clients	3,000 clients	Old target too high	Target met in 1 of 3 years
11a	Increase Jail Liaison Capacity	5/5/2010	360 additional clients	200 additional clients	Old target too high	Target met for 3 consecutive years
11b	Mental Health Courts	7/12/2010	250 Regional clients over current 300	115 Regional clients over current 200 (Note: Actually two-year period)	Old target too high	Target met in 1 of 4 years
11b	Mental Health Courts	6/10/2013	Seattle Muni Court 50 clients (not competent for trial)	Seattle Muni Court 300 clients (competent or not)	Expanded competency status inclusion	Targets always met
11b	Mental Health Courts	3/11/2014	Regional Court 57 clients	Regional Court 28 expansion opt-ins & 83 non-expansion cases	Probation staff position not filled	Targets met in Year 6
12a	Jail Re-Entry & Education Classes	7/21/2010	1,440 additional clients 480 for re-entry 960 for education	300 re-entry clients with 3 FTE 600 education clients (Duplicated OK)	Old target too high	Targets not always met
13a	Domestic Violence Services	2/14/2012	700-800 clients	560-640 clients	Funding cut (19%)	Target always met
14a	Sexual Assault Services	7/1/2011	400 clients	170 clients	Funding cut (20%)	Target always met with blended funds
15a	Adult Drug Court	7/9/2010	450 clients, then 300	250 clients	Old target too high	Target always met
16a	New Housing & Rental Subsidies	5/1/2013	25 tenants; 50, then 40 rental subsidies	25 tenants 25 rental subsidies	Fewer available subsidies	Targets always met

Excluding the first year, when targets for all implemented strategies were adjusted to account for the number of months each strategy was able to provide data, other strategies were adjusted for a variety of reasons in subsequent years. Of the 45 performance targets measured consistently between program implementation and 2015, 19 (42%) were adjusted at least once. The table below provides the primary reasons for adjusting targets and the MIDD years in which each strategy was impacted by the adjustment. Note that some MIDD strategies have more than one performance measurement target.

Table 5

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

In one instance, Strategy 1f Parent Partners was completely redesigned from its initial plan in order to fulfill its intended goals of providing support to families in the behavioral health system. Family, youth and system partner roundtables were held to gather information and input regarding the opportunities and challenges to the successful support of families. Inputs from the meetings and best practices research were used in the redesign. It was determined that a Family Support Organization[55] could most effectively meet community and family needs. The redesign created a centralized hub for family support technical assistance, groups and other activities, which in turn led to a considerable revision of the performance target for this strategy. Along with measuring the number of individual people, targets were set around numbers of families and group attendees.

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

Distinct performance targets are used for some strategies based on implementation or program design. The target for Strategy 3a Supportive Housing climbed each year as five-year grants were awarded to pay for supportive services at new or existing housing that was developed or set aside for those with special needs. As more grants were awarded, the target rose accordingly. Capacity did not grow in Year Seven as funding was ending for some existing programs they received funding in the next set of awards. Fifteen rental subsidies ended in November 2012 for Strategy 16a New Housing and Rental Subsidies when a facility closed. As a result of the facility closing, the performance target for 16a was

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

decreased. A 2011 budget proviso[56] for Strategy 8a Family Treatment Court led to its performance targets having a maximum by serving no more than 90 children per year and 60 children at one time. In Year Seven, this performance target was 120 children per year due to changes in funding of staff positions.

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

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

Many strategies' performance targets are based on the premise that programs had certain levels of staffing. Staffing levels were described as Full-Time Equivalents (FTE)[57] in the Implementation Plan. As noted in the Section III, there is a significant workforce issue, as nationally[58] and locally, the behavioral health system has a shortage of skilled workers, an aging workforce, and inadequate compensation, which together make it difficult for community agencies to hire and retain qualified staff.[59] When positions in MIDD programs are unfilled, temporary adjustments were made to prorate targets based on which positions were unfilled and the amount of time in the reporting period the position remained open. Meanwhile, BHRD staff work with provider agencies to support recruitment and explore options for backfilling positions to maintain continuity of MIDD services, although this is not always possible.

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

The practice of adjusting and amending targets were one way that the evaluation team modified the

[56] Ordinance 16984, Section 69, Proviso PI
[57] An FTE is the hours worked by one employee on a full-time basis. http://www.accountingtools.com/questions-and-answers/how-to-calculate-ftes.html
[58] Source: http://store.samhsa.gov/; Search on: PEP13-RTC-BHWORK
[59] MIDD Seventh Annual Report
http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/Reports/150616_MIDD_Seventh_Annual_Report.ashx?la=en

evaluation plan to be linked with the program developments in the MIDD strategies. Another means to ensure the evaluation stayed connected with long-term program changes was through inclusion of strategy revisions as described in the next section.

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

Strategy Revisions

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

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

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

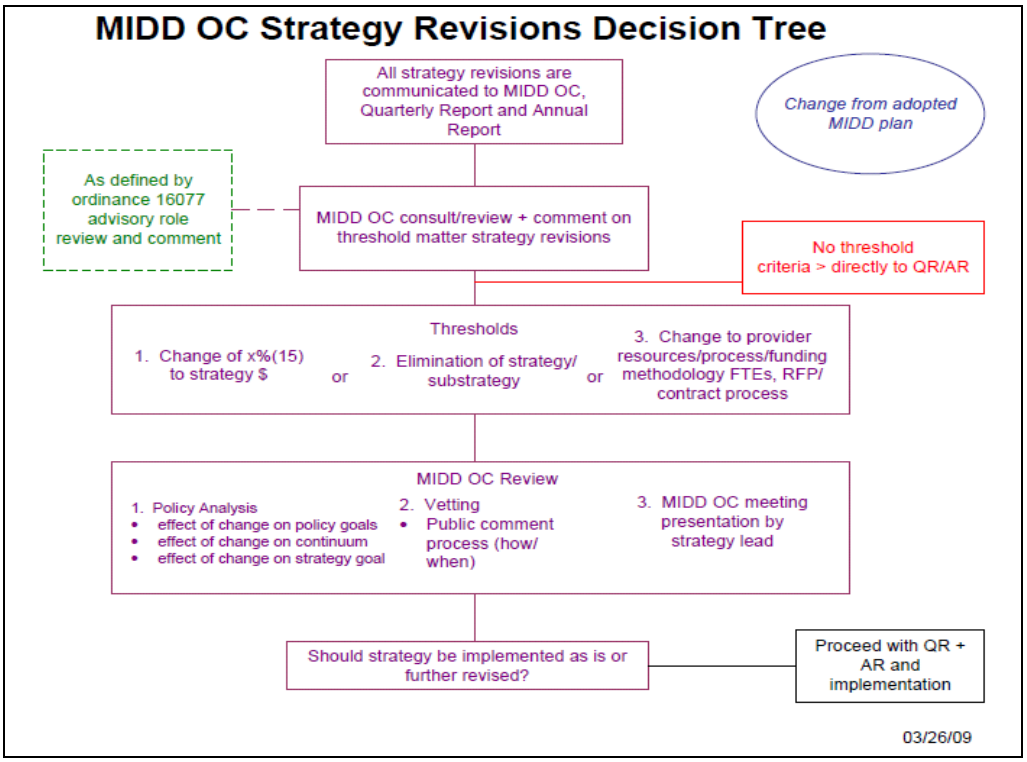
- 1a1 Mental Health Treatment
- 1a2 Substance Use Disorder (SUD) Treatment
- 1c Emergency Room Intervention
- 1e Chemical Dependency Trainings
- 1f Parent Partners Family Assistance
- 1g Older Adults Prevention
- 2b Employment Services
- 8a Family Treatment Court (FTC)
- 9a Juvenile Drug Court
- 10a Crisis Intervention Team Training
- 10b Adult Crisis Diversion
- 11a Increase Jail Liaison Capacity
- 12d Behavior Modification Classes
- 15a Adult Drug Court
- 16a New Housing and Rental Subsidies.

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

Due to a number of factors, such as the design of the evaluation, infrequent reports, and combined reporting of programs in a single strategy[60], evaluation data was difficult to use for quality assurance processes. Consequently, there were no strategy revisions based on performance measurement data, though technical assistance was provided and program adjustments were made using this information. For example, intensified education and outreach with first responders was conducted to increase referrals to 10b Adult Crisis Diversion.

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

Table 6



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

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

VI. Recommended Revisions to Policy Goals

The King County Council established the MIDD policy goals via Ordinance 15949, creating a policy framework whereby the public and policymakers could see the return on the investment of MIDD. As stated in the Ordinance, "It is the policy of the county that citizens and policy makers be able to measure the effectiveness of the investment of these public funds."[61] The Council further stated its intent that the MIDD programs were to be designed to achieve the five policy goals. Consequently, the five policy goals have shaped not only the programs and services, but also provide the foundation for the evaluation and reporting of MIDD, including assessment of strategy effectiveness. Maintaining policy goals as overarching guidance to the work of MIDD is necessary, as is refining them for the current environment.

Proposed Policy Goal Modifications

Ordinance 17998 requires this report to include "proposed modifications to the MIDD policy goals outlined in Ordinance 15949 and the basis of the proposed modifications."[62] In response to this requirement, the county staff and the MIDD Oversight Committee's Renewal Strategy Team worked to refine the policy goals in order to:

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

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

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

[61] Ordinance 15949 lines 80-82
[62] Ordinance 17998 lines 103-104

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

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

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

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

MIDD Framework Highlights
***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.*

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

MIDD Strategy Area Name	Purpose
Prevention and Early Intervention	*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 II strategy areas and programming. Indicators reflected in the framework are expected to change over time based on final MIDD II programming decisions and community and stakeholder feedback.

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

RECOMMENDED REVISIONS TO MIDD POLICY GOALS	
2007 Policy Goal	**Recommended Revised Policy Goal**
1. A reduction of the number of mentally ill and chemically dependent using costly interventions like 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 of 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 County Recovery Plan.	5. Explicit linkage with, and furthering the work of, other King County and community initiatives.

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

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

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

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

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

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

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

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

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

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

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

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

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

> When reading this report, it is important to keep in mind that the assessment compares MIDD evaluations conducted between 2008 and 2015 to (1) the MIDD Evaluation Plan adopted by the King County Council in 2008; (2) current expectations of stakeholders, which may not have been the same in 2008; and (3) to current practices in behavioral health care evaluation, which is a continually evolving field. Therefore, in some cases the findings reflect gaps between the original evaluation plan and its implementation, but other times they reflect how expectations and practices have changed over time. All findings are important learnings that roll into actionable recommendations that can inform the design of the evaluation of a potential MIDD renewal. (pg. 2)[63]

Recommendations

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

I. Update and Revise the Evaluation Framework

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

[63] See Appendix A for the full MIDD Evaluation Assessment Report.

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.[64]
b. Replace semi-annual progress reports with digitally-available dashboard data.
c. Increase the frequency of performance evaluation availability.
d. Establish guidelines for report creators and editors on the scope of their decision making.
e. Continue to avoid presenting non-causal results in ways that imply causality.
f. Continue to produce one annual report that includes both performance measurement and outcome evaluation.
g. Enhance the quality and frequency of communication regarding evaluation data and reporting, updating the MIDD Oversight Committee and others on substantive findings.
h. Develop and deploy a continuous quality improvement process for MIDD programs and services based in part in evaluation.
i. To the extent possible, align MIDD evaluation approach with Best Starts for Kids initiative evaluation approach to ensure consistency.

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

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

VIII. Conclusion

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

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

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

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

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

In keeping with the county's transparency in MIDD, DCHS is committed to involving its provider partners in the retooling of MIDD's Evaluation Plan. All revisions, however, require time to thoughtfully implement and avoid unintended consequences. Should the King County Council call for an Evaluation Plan for MIDD II as it did for MIDD I, the Evaluation Plan deliverable timelines must take into consideration the need to involve stakeholders and providers in the development of the Evaluation Plan,

as recommended.

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

IX. Appendices

MENTAL ILLNESS AND DRUG DEPENDENCY EVALUATION ASSESSMENT

Final Report

April 2016

Completed by:
King County Office of Performance, Strategy, and Budget

Completed for:
King County Department of Community and Human Services

MIDD Evaluation Assessment
Final Report

Table of Contents

EXECUTIVE SUMMARY

Purpose and Approach

King County levies a one tenth of one percent sales tax known as the Mental Illness and Drug Dependency (MIDD) sales tax to support mental health and chemical dependency treatment and therapeutic programs and services. As required by Ordinance 15949, to measure the effectiveness of the programs funded by MIDD, the King County Department of Community and Human Services (DCHS) conducts evaluations that describe how MIDD funding is spent and report on a set of required output and outcome measures for each MIDD strategy.

This report, as required by King County Metropolitan Council Ordinance 17998, presents the results of a comprehensive assessment of the MIDD evaluations conducted from 2008-2015. The assessment was conducted by the King County Office of Performance, Strategy and Budget (PSB). The report identifies strengths and weaknesses of the MIDD evaluations and offers recommendations for future evaluations of MIDD.

The assessment is based on the results of 30 stakeholder interviews, a review and comparison of evaluation documents, a review of current practices in behavioral health evaluations and evaluation best practices.

Overview

MIDD adoption and implementation

Ordinance 15949, adopted by the Council in 2007, authorized the collection of the MIDD sales tax, established five policy goals to guide the development of MIDD implementation and called for the development of three separate plans:

- An **Oversight Plan** guiding the establishment of a group responsible for oversight of the MIDD action plan.
- An **Implementation Plan** describing the implementation of the programs and services outlined in the Mental Illness and Drug Dependency Action Plan, including a schedule for implementation; a discussion of needed resources; a spending and financial plan; and milestones for implementation of the programs.
- An **Evaluation Plan** describing an evaluation and reporting plan, including a process and outcome evaluation component; a proposed schedule for evaluations; output and outcome measures and measure targets; and data elements that would be used for reporting and evaluations.

What is evaluation?

Evaluation has been standard practice in health and human services for many years. Evaluation is a mechanism for learning what is and is not working, for providing information to be used in quality improvement efforts, and for demonstrating value of spending. Decision makers may use evaluation results to determine whether a program should be adjusted, expanded or defunded based on its effectiveness in achieving outcomes.

The basis of any evaluation is the evaluation framework, which defines how programs being evaluated connect to desired outcomes. In an evaluation framework, measures are selected that demonstrate the connection between programs and outcomes, which allows tracking progress towards established targets and adjustments to programs not meeting targets.

How MIDD works today

The 2008 MIDD Implementation Plan is organized around five service areas subdivided into 37 different strategies. Each strategy is implemented through one or more programs that provide services for clients. Services are delivered either through County-based programs or through community-based programs contracted by the County.

The MIDD Evaluation Plan outlines the intent to monitor and evaluate the MIDD strategies. It consists of three evaluation components:

1. **System Process Evaluation** to describe *how* the implementation of MIDD is progressing.
2. **Strategy Process Evaluation** to assess *what* was done based on the performance goals specified in the Evaluation Plan's evaluation matrix (Appendix IV).
3. **Outcome Evaluation** to assess the *effect* of MIDD strategies on MIDD policy goals (Appendix III) and other expected results.

The results of the MIDD evaluation work are published twice a year in a MIDD Annual Report that summarizes the findings of the most recent October-September time period and a mid-year Progress Report that summarizes the findings of the most recent October-March time period. The reporting periods for MIDD were established in 2008 in Ordinance 16262.

MIDD Evaluation Assessment Findings and Recommendations

This section summarizes the key findings and recommendations of this report. These findings and recommendations are based on opinions and expertise of interviewees, document reviews, best practices research, and staff conducting this assessment. The table on the following page contains a summary of the key strengths identified in this assessment as well as identified challenges and associated recommendations to address these challenges. More context, explanation, and examples of how these strengths and challenges were identified and the details of each recommendation are included in the body of the report

Note: Key evaluation terms in the summary table below are defined in the glossary on page 72.

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

EVALUATION PLAN AND FRAMEWORK	**Strengths** • The Plan provides flexibility to adjust measures as learning takes place over time, especially with respect to output measures and their targets. • The Plan accommodates the diversity of strategies supported by MIDD funding.	
	Challenges • The framework lacks detail and intermediate linkages that describe how MIDD strategies and programs bring about changes to reach MIDD policy goals. • Interviewees have different expectations for the MIDD evaluation than what the MIDD Evaluation Plan articulates. • Interviewees do not agree on the outputs and outcomes they would like to see included in MIDD evaluations. • Interviewees expressed interest in understanding the level of community need that each MIDD strategy would meet.	**Recommendations** **R1. Clarify the purpose of the evaluation and logic of the evaluation framework.** • Create and include a defined and stated purpose and identify limitations on conclusions that can be drawn from the evaluation. • Include a logic model that identifies proximal outcomes for each program or strategy and describes how impacting these outcomes affect distal outcomes. **R2. Involve stakeholders in developing the evaluation framework.**
OUTPUT AND OUTCOME MEASURES	**Strengths** • The MIDD evaluation plan includes an evaluation matrix that lists, for each MIDD strategy, output and outcome measures.	
	Challenges • No or too few proximal outcomes are measured for many MIDD strategies; evaluation best practice notes that both distal and proximal outcomes are important to understanding the impact of each MIDD strategy. • Interviewees stated that measures should be clinically relevant, including behavioral health symptoms, daily function and quality of life. • The detail and specificity of output measures in the	**Recommendations** **R3. Establish relevant output and outcome measures.** • Establish output and outcome measures across the entire logic chain – from services provided to goals. Measures should be relevant to participants and providers and be useful to monitor implementation and improvements. **R4. When available, select valid, reliable and sensitive proximal outcome measures in collaboration with service providers.**

	Evaluation Matrix vary by strategy.	• The MIDD evaluation should select measures that have been demonstrated to be reliable, sensitive, and valid. In addition, providers should be involved when proximal outcome measures are selected for the services they provide. **R5. Focus on clinically and practically meaningful changes in outcomes.** • Future MIDD evaluations may include a focus on clinically or practically meaningful changes.
EVALUATION PROCESS	**Strengths** • The data acquisition process supports providers who have different levels of data collection and sharing capabilities.	• MIDD includes dedicated resources for data cleaning, merging and analysis.
	Challenges • Data are provided in varying formats, which means King County staff spend significant time preparing data for analysis. • Feared loss of funding creates a disincentive for reporting on, understanding, and learning from lower than anticipated performance on output and outcome measures.	**Recommendations** **R6. Invest in data collection infrastructure.** • Offer technical assistance to providers; involve evaluation staff and provider staff in contract negotiations to set expectations; review data quality on an on-going basis and provide timely feed-back to providers; and continue to provide dedicated resources for data collection and sharing.
OUTCOME EVALUATION	**Strengths** • MIDD progress and annual reports provide detailed information on the vast majority of outcome measures listed in the MIDD Evaluation Matrix.	
	Challenges • The evaluation methodology used is not suitable to assess the causal impact of MIDD strategies on outcomes, including MIDD policy goals.	**Recommendations** **R7. Modify evaluation design if the next MIDD evaluation is to show causality.** • Random assignment is the gold standard for determining whether an intervention is the reason for observed changes, but requires significant resources and may not be feasible

due to ethical considerations or implementation challenges.
- The evaluation designers should determine if the investment in conducting such assessments is necessary, and know the limitations of any selected approach in understanding cause and effect.

EVALUATION REPORTING

Strengths

- MIDD reports clearly describe to what extent strategies reached their output targets.
- Changes in the MIDD evaluation process are captured well in the evaluation reports.
- The reports are accessible and readable for multiple audiences and include an effective mix of quantitative analysis with qualitative anecdotes and information.
- MIDD reports describe how MIDD funding is spent.

Challenges

- Results are not available at a frequency and time to inform funding decisions and continuous improvement efforts.
- It is not clear why MIDD strategy process evaluation changes are made.
- Evaluation report drafts are reviewed and edited by multiple stakeholders, which at times has introduced bias into reports.
- In some instances, the reports could be clearer in avoiding implications of a causal relationship between MIDD strategies and outcomes.

Recommendations

R8. Increase frequency of performance evaluation availability.

- Future evaluations should make results available more than twice per year, potentially through a dashboard that provides results for key output and outcome measures in real time.
- The scope and frequency of formal reports could be reduced due to this increased availability and transparency of results.

R9. Establish guidelines for report creators and editors on the scope of their decision making.

- Reviewers and editors of the report should clearly understand the scope of their editing role, and all edits should be reviewed by the person responsible for finalizing content before publishing information.
- Decisions about which results to publish should be made before results are known.
- Significant results should be reported, favorable or not.

R10. Avoid presenting non-causal results in ways that imply causality.

INTRODUCTION

In 2005, the Washington State Legislature authorized counties to implement a one-tenth of one percent sales tax for mental health and chemical dependency treatment and therapeutic court programs and services. In King County, this tax is known as the Mental Illness and Drug Dependency (MIDD) sales tax. In 2015, MIDD sales tax revenues totaled nearly $60 million and served more than 23,000 individuals.

MIDD-funded programs are intended "*to prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services."*[1]

Ordinance 15949 defines five policy goals (see Appendix III) and requires that the King County Department of Community and Human Services (DCHS) conduct evaluations that describe how MIDD funding is spent and report on a set of required output[2] and outcome[3] measures. To fulfill these requirements, the System Performance Evaluation Group in the King County Department of Community and Human Services, Mental Health, Chemical Abuse and Dependency Services Division[4] conducts evaluations according to the MIDD Evaluation Plan. The MIDD Evaluation Plan was adopted by the Metropolitan King County Council (the Council) via Ordinance 16262 in 2008.

The intent of the MIDD evaluation efforts was to *"examine the impact of all strategies to demonstrate effectiveness of MIDD funds and to assess whether the MIDD goals are being achieved, on both individual and system levels"*[5]and to provide transparency to decision makers, stakeholders and the public on how MIDD dollars were being spent.

Purpose of this MIDD Evaluation Assessment

The 2007 MIDD sales tax legislation includes a sunset date of December 31, 2016, ending the authority of King County to collect the tax. King County and community partners are in the process of identifying future MIDD activities, if the tax is renewed by the Council.

In planning for the potential renewal of MIDD, the Council adopted Ordinance 17998 in March 2015 requiring a comprehensive review and assessment of the MIDD sales tax that was collected from 2008-2016, including *"… proposed recommendations on improvements to MIDD performance measures, evaluation data gathering, including a review of the evaluation processes, timeframes, and data gathering."*

This report is an assessment of the MIDD evaluations conducted from 2008 to 2015. It is designed to address certain requirements of Ordinance 17998, specifically:

[1] Ordinance 15949, lines 25-31
[2] Output measure: A measure of the product or service produced through a program.
[3] Outcome measure: "A measure of the effects of what is done." (Mental Illness and Drug Dependency 2008 Annual Report, p.17). The MIDD Evaluation Plan refers to output and outcome measures as performance measures.
[4] The division has since been renamed the Behavioral Health and Recovery Division (BHRD).
[5] Metropolitan King County Ordinance 16262, Attachment A, p.11

- The extent to which the 2008 MIDD Evaluation Plan was used to guide evaluation activities
- Strengths and challenges of the 2008-2015 MIDD evaluation activities that were conducted, according to those interviewed and evaluation best practices, including data collection processes, measures, analysis methodology, and reporting
- Opportunities to strengthen future MIDD evaluations.

MIDD Evaluation Assessment Methodology

The King County Department of Community and Human Services engaged the King County Office of Performance, Strategy and Budget (PSB) to conduct the independent evaluation assessment. The results of this work comprise the body of this report.

The methodology used for the assessment, which was conducted from November 2015 through February 2016, included three approaches:

- **Review of Evaluation Documents**. PSB staff gathered and reviewed historical MIDD evaluation information, including the MIDD Evaluation Plan and the 2008 – 2015 MIDD progress and annual reports. PSB staff compared the Evaluation Plan with the MIDD progress and annual reports to determine to what extent the Plan was implemented. PSB staff also assessed the evaluation methodology, drawing on evaluation literature, key informant interviews, and expertise in evaluation methodology and performance measurement.
- **Current Practice Review**. PSB staff reviewed practices used by counties similar in size to King County for the evaluation of behavioral health care programs and reviewed innovative approaches to the evaluation of behavioral health care.
- **Stakeholder Interviews**. PSB staff interviewed 30 people, including MIDD Oversight Committee members and designees, MIDD service providers, staff from the King County Executive Office, King County Council, King County Department of Community and Human Services, King County Information Technology and external subject matter experts. The list of interviewees is provided in Appendix I, and the list of interview questions is provided in Appendix II. Due to the qualitative nature of the interviews and the purposive selection of stakeholders interviewed, this document does not quantify interview results. For instance, reporting the percent of interviewees who mentioned a particular topic during the conversation would convey specificity that is not warranted based on the methodology used.

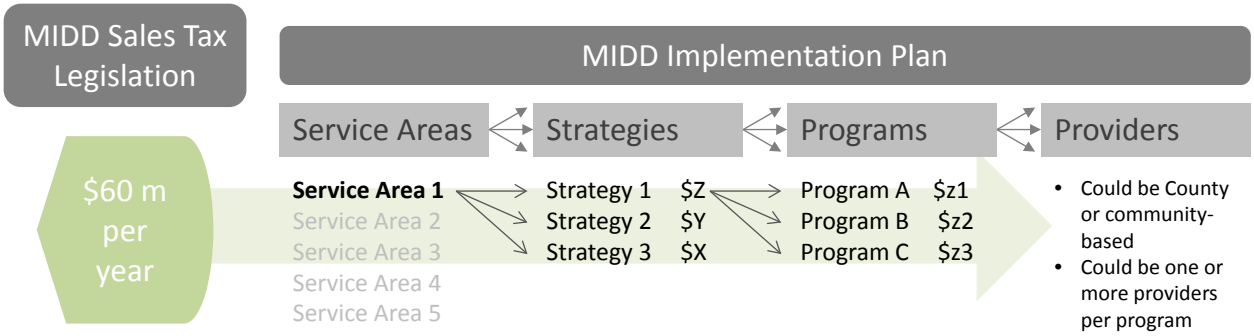
BACKGROUND FOR MIDD EVALUATION ASSESSMENT

The purpose of this section is to provide background and context for the themes and recommendations of this MIDD evaluation assessment. The section addresses the purpose and key concepts used in health and human service evaluations. It also provides a summary of current practices in behavioral health care evaluations, after briefly describing MIDD implementation and programming.

MIDD Implementation Structure

In 2007, the Council voted to enact a MIDD sales tax to support new or expanded mental illness and chemical dependency and therapeutic court programs and services. This vote adopted Ordinance 15949, in which the Council authorized the collection of the sales tax and established major policy goals to guide the development of the MIDD implementation. MIDD implementation is organized around five

service areas which are subdivided into 37 different strategies. Each strategy is implemented through one or more programs that provide services for clients. Services are delivered either through County-based programs or through community-based programs contracted by the County. The following graphic illustrates the multi-layered structure of the MIDD as implemented.



This report of the MIDD evaluation assessment focuses on the MIDD Evaluation Plan, adopted by Council via Ordinance 16262 in October 2008, which describes the evaluation and reporting plans for the strategies funded with the MIDD sales tax.

Purpose of Evaluations

Program[6] evaluation has become standard practice in health and human services over the past 40 years[7] to help managers and policymakers determine whether to continue, improve, expand or curtail a program; to increase the effectiveness of program management and administration; to assess the utility of new programs; and to address the accountability requirements of program sponsors.[8]

Program evaluation is *"defined as a social science activity directed at collection, analyzing, interpreting, and communicating information about the workings and effectiveness of social programs."* [9] Typically, program evaluation involves assessing one or more of the following: *"(1) the need for the program, (2) the design of the program, (3) program implementation and service delivery, (4) program impact or outcomes, and (5) program efficiency."* [10]

Ordinance 15949 required the development of a MIDD evaluation plan with a focus on two of these five evaluation domains: (3) program implementation and service delivery and (4) program impact. The key

[6] In this section, the term *program* refer to any set of health and human services being evaluated, which may not be the same definition used in MIDD documents.
[7] Centers for Disease Control and Prevention (1999). Framework for Program Evaluation in Public Health. MMWR; 48 (No.RR-11)
[8] Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications
[9] Ibid, p. 1
[10] Ibid, p. 28

evaluation concepts described in the next section describe concepts that are relevant for these two domains of program evaluation and represent best practices in program evaluation.[11]

Key Program Evaluation Concepts

The ultimate goal of health and human service programs is to bring about change by affecting a problem in beneficial ways. The changed or improved conditions are the intended outcomes or products of the programs. A program's intended outcomes are identified in the program evaluation framework. The framework articulates the "*outcomes of social programs as part of a logic model that connects the program's activities to proximal (immediate) outcomes that, in turn, are expected to lead to other, more distal outcomes. If correctly described, this series of linked relationships among outcomes represents the program's assumptions about the critical steps between program services and the ultimate social benefits the program is intended to produce.*"[12] Program evaluation terms used throughout this report are defined in the Evaluation Term Glossary below.

Evaluation Term Glossary

Causal Relationship: A causal relationship between two events exists if the occurrence of the first causes the other.

Proximal Outcome: An outcome a program can impact directly, for example, the severity of mental health symptoms among participants of programs that provide mental health services.

Distal Outcome: An outcome that is distant from program activities but the ultimate outcome of interest, such as the MIDD policy goals articulated in Ordinance 15949. Because distal outcomes are more removed from program activities than proximal outcomes, the former tend to be impacted by many factors outside of a program's control. A program, therefore, has less direct influence on distal than proximal outcomes.

Effectiveness: Effectiveness addresses how well a program achieves its stated goals and objectives.

Measure: A measure is a value, characteristic, or metric used to track the performance of a program.

Outcome Measure: A measure that describes the state of the population or social condition a program is expected to have changed.

Output Measure: A measure of the product or service produced through a program.

Target: A desired number or level for an output or outcome measure. Targets are the objectives an organization is striving to reach.

The definitions are based on:
Kinney AS, Mucha MJ, eds. (2010). State and Local Government Performance Management: Sourcebook. Chicago, IL: Government Finance Officers Association
Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications
U.S. Department of Health and Human Services (2011). Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. Introduction to Program Evaluation for Public Health Programs: A Self-study Guide. Atlanta, GA: Centers for Disease Control and Prevention

[11] Best practices as described in: Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications and Hatry HP, Wholey JS (2006). Performance Measurement: Getting Results, 2nd Edition. Washington DC: Urban Institute

[12] Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications, pp. 208-209

Best practices indicate that the strongest evaluation frameworks are developed during, and help inform, program design. Considering the relationships between a desired outcome and the multiple pathways to achieve the outcome provides the opportunity to consider individual, organizational and system factors that contribute to improving the outcome.

Approaches used for developing an evaluation framework based on best practices include:

- Identifying program activities performed and then linking activities with desired outcomes.[13]
- Identifying a desired outcome and then designing program activities that are assumed to best achieve the outcome based on existing research and emerging and innovative program design.[14]
- Describing the relationship between inputs (resources and staff), program activities, outputs (how much of an activity was delivered) and desired outcomes in a logic model.[15]

Describing causal relationships between program activities and desired distal outcomes can be challenging for any evaluation framework in health and human services, due to the numerous and complex factors that contribute to individuals' mental and physical health, substance use and other behaviors. Because *"a given set of outcomes can be produced by factors other than program processes"*[16], for health and human services evaluations interested in demonstrating impact, it is therefore particularly important to be grounded in a detailed evaluation framework that links program activities to proximal and distal outcomes.

Current Practice Review of Behavioral Health Care Evaluations

The purpose of this section is to describe current practices being used to evaluate behavioral health care.

Behavioral health care quality measurement is an evolving practice

To support access to safe, effective and affordable behavioral health care for all Americans, the U.S. Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) started to develop the National Behavioral Health Quality Framework (NBHQF) in 2011, that is, after the 2008 adoption of the MIDD Evaluation Plan.[17] The NBHQF framework is intended to guide the *"identification and implementation of key behavioral health care quality measures for use in agency or system funding decisions, monitoring behavioral health of the nation, and the delivery of behavioral health care."*

[13] Hatry HP, Wholey JS (2006). Performance Measurement: Getting Results, 2nd Edition. Washington DC: Urban Institute

[14] Friedman M (2005). Trying Hard is not Good Enough: How to Produce Measurable Improvements for Customers and Communities. Victoria, BC: Trafford

[15] *"A logic model is a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve." (W.K. Kellogg Foundation 2004)* http://toolkit.pellinstitute.org/evaluation-guide/plan-budget/using-a-logic-model/ - accessed 01/29/2016

[16] Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications, p.203

[17] http://www.samhsa.gov/data/national-behavioral-health-quality-framework

In designing the framework, SAMHSA recognized that in the field of behavioral health care quality measurement, at this time, *"relatively few acceptable outcome measures exist that are endorsed by NQF*[18] *or other relevant national entities."* SAMHSA noted that behavioral health care quality measurement is a relatively young field and that many measures have yet to be defined and validated, but that significant growth in outcome measures can be expected in the next few years.

SAMHSA, nevertheless, recently proposed a set of core measures for use in a variety of settings and programs, including evaluation efforts. In addition, SAMHSA encouraged utilizing these measures, as appropriate, to have a consistent set of indicators of quality in behavioral health prevention, promotion, treatment, and recovery support efforts across the U.S.

National call for measurement-based care in the delivery of behavioral health services

To advance the quality of behavioral health care in the United States, the Kennedy Forum[19] recently endorsed the use of measurement-based care. *"All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected."*

The Washington State Mental Health Integration Program (MHIP)[20] is one example of a measurement-based mental health care approach that has been implemented locally. The program, which started in January 2008, now includes almost 200 community health and mental health centers across Washington, with funding from Washington state, King County and Community Health Plan of Washington. MHIP uses a patient registry to track and measure patient goals and clinical outcomes. The approach combines the provision of mental health care with concurrent evaluation of patient response to inform providers, who may adjust care if a patient is not improving as expected. In addition, provider payment is tied to quality of care indicators.

As indicated, such an approach is not commonly applied. This is due in part to the fact that measurement-based behavioral health care is not common practice in the U.S., despite having been proposed as long as twenty years ago.[21] Organizations with integrated physical and behavioral health care may be more open to a measurement-based focus than community mental health and chemical dependency providers for whom measurement-based care has not been widely applied. That said, MHIP does provide a measurement-based care approach for consideration.

[18] National Quality Forum, http://www.qualityforum.org/Home.aspx
[19] Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Issue Brief, The Kennedy Forum, 2015, https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf - accessed 01/06/2016
[20] https://aims.uw.edu/washington-states-mental-health-integration-program-mhip - accessed 01/19/2016
[21] Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Issue Brief, The Kennedy Forum, 2015

Evaluation practices used by other counties focus on output measures

While MIDD includes a focus on justice system diversion efforts[22], several counties implemented behavioral health care programs to improve the mental health of the overall population in their jurisdiction. A sampling of jurisdictions comparable to King County in population size (see Figure 1) indicates that behavioral health care evaluations typically report on output measures, such as the number of patient visits or patients in care.

In Dallas County, the North Texas Behavioral Health Authority publishes a Collaborative Report that includes output measures such as patients served, complaints and appeals, utilization, and provider network activity.[24] The report also publishes financial data, such as cost per person and acute costs relative to overall costs. Additional reports provide customer satisfaction results and a needs assessment. The San Francisco County approach, similar to the North Texas Behavioral Health Authority, is to document customer satisfaction in addition to other output and outcome measures, including reduction in individuals' drug use.[25]

Figure 1: Jurisdictions included in comparative analysis

Jurisdiction	Population	Evaluation Report
Dallas County, TX	2.4 M[23]	North Texas Behavioral Health Authority Collaborative Report from 2015
San Bernardino County, CA	2.0 M	Mental Health Services Act Annual Update
Santa Clara County, CA	1.8 M	Med-Cal Specialty Mental Health External Quality Review MHP Final Report
Cuyahoga County, OH	1.3 M	Alcohol, Drug Addiction & Mental Health Services CountyStat
Allegheny County, CA	1.2 M	Annual Report
Hennepin County, MN	1.2 M	SHAPE Survey and accompanying analyses
San Francisco County, CA	0.8 M	Satisfaction Reports and Frequency of Use Outcomes Reports

San Bernardino and Santa Clara Counties in California report by programs focusing on budgets and capacity, claim payments, access to care and timeliness of care.[26] Cuyahoga County and Allegheny County also provide finance data, though Cuyahoga County's CountyStat, in addition, includes output measures such as the number of available beds in treatment facilities and the number of individuals receiving treatment.[27]

Hennepin County in Minnesota reports results from the Survey of the Health of All the Population and the Environment (SHAPE), which periodically inquires about the health of county residents. When last

[22] The MIDD policy goals adopted by Ordinance 15949 are listed in Appendix III: Additional Information on MIDD and its Evaluation Plan.
[23] The regional authority also covers Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.
[24] North Texas Behavioral Health Authority, http://www.ntbha.org/reports.aspx
[25] San Francisco Department of Health, https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/default.asp
[26] San Bernardino County Department of Behavioral Health, http://www.sbcounty.gov/dbh/index.asp and County of Santa Clara Mental Health Department, https://www.sccgov.org/sites/mhd/Pages/default.aspx
[27] Alcohol, Drug Addiction & Mental Health Services, Board of Cuyahoga County, http://adamhscc.org/en-US/CountyStat.aspx and http://adamhscc.org/en-US/publications.aspx and Allegheny County Department of Human Services, http://www.alleghenycounty.us/Human-Services/Resources/Publications.aspx

released in 2010, SHAPE provided information on the county's overall health, including mental health concerning depression and anxiety.[28]

MIDD EVALUATION ASSESSMENT FINDINGS AND RECOMMENDATIONS

This MIDD evaluation assessment report focuses on the MIDD Evaluation Plan adopted by Council via Ordinance 16262 in October 2008. The adopted plan outlines the evaluation and reporting plan for the strategies funded with the MIDD sales tax, including a proposed schedule for evaluations; output and outcome measures and measure targets (the "evaluation matrix"); and data elements to be used for reporting and evaluations. The Plan consists of three components:

1. **System Process Evaluation** to describe *how* the implementation of MIDD is progressing.
2. **Strategy Process Evaluation** to assess *what* was done.
3. **Outcome Evaluation** to assess the *effect* of MIDD strategies on MIDD policy goals and other expected results.

The results of the evaluation work are published twice a year in an Annual Report that summarizes the findings of the most recent October-September time period and a mid-year Progress Report that summarizes the findings of the most recent October-March time period. The reporting periods for MIDD were established in 2008 in Ordinance 16262.[29]

This section describes strengths and challenges of the MIDD Evaluation Plan as implemented. These findings and recommendations are based on the opinions of the interviewees, document reviews, and best practices review conducted for this assessment. The chapter is organized into five topical parts. Each part presents analytic findings, followed by recommendations to address identified challenges.

MIDD Evaluation Plan and Evaluation Framework

The 2008 MIDD Evaluation Plan describes an approach to evaluate (1) strategy implementation and (2) strategy impact. For these two domains of evaluation, the Plan is comprehensive, oriented toward learning and improvement and focused on accountability to achieve desired outputs and outcomes. Multiple strengths of the Plan were evident during this assessment:

- **The Plan provides flexibility to adjust measures as learning takes place over time**, especially with respect to output measures and their targets. As strategies are implemented and better understood, evaluation may require new or updated measures and targets.[30] For instance, if a strategy can serve more clients than originally anticipated, the target for its output measure may be increased. In contrast, if a data source does not materialize as anticipated, data may not be available to collect and analyze planned output and outcome measures.

[28] Hennepin County, http://www.hennepin.us/your-government/research-data/shape-surveys
[29] For additional information on the history and structure of the MIDD and its Evaluation Plan, please see Appendix III: Additional Information on MIDD and its Evaluation Plan.
[30] Kinney AS, Mucha MJ, eds. (2010). State and Local Government Performance Management: Sourcebook. Chicago, IL: Government Finance Officers Association

The MIDD Evaluation Plan includes a process to make amendments, which benefits the evaluation by keeping it relevant to decision makers and stakeholders over time.

- **The Plan accommodates the diversity of strategies supported by MIDD funding**. MIDD funds dozens of strategies, ranging from increasing the number of trainings and licensed behavioral health care providers, to improving school-based suicide prevention, to providing direct services to people in crisis.

  The MIDD Evaluation Plan accommodates this variety by identifying strategy-specific output and outcome measures, which sets up an evaluation that can provide meaningful, relevant measures for each strategy.

This assessment also identified challenges associated with how the Evaluation Plan was implemented and communicated. Challenges include:

- **The MIDD logic model lacks detail in describing how MIDD strategies are expected to bring about changes to reach MIDD policy goals.** Evaluation best practice recommends that logic models describe in detail how MIDD strategies are expected to influence both proximal and distal outcomes based on evidence.[31] Interviewees and a review of evaluation reports found that while the current MIDD evaluation framework has logic chains between measures for some strategies, it does not have enough proximal outcomes and clear logical linkages to the distal outcomes (or policy goals) to support audience understanding of how MIDD strategies are influencing MIDD policy goals.[32] In addition, interviewees noted that, in their opinion, it is not possible for MIDD-funded providers to influence the MIDD policy goals directly.
- **Interviewees have different expectations for the MIDD evaluation than what the MIDD Evaluation Plan articulates**. The Evaluation Plan fulfills the requirements of legislation as described in Ordinances 15949 and 16262. However, interviewees have different opinions on the usefulness of the MIDD evaluation, as executed, because it does not meet all of their expected purposes. Expectations for how the evaluation could be used include: monitoring program implementation, supporting continuous improvement, informing MIDD funding decisions, and demonstrating impact at the participant, provider, program, strategy, or community level. Interviewees also identified multiple potential audiences for the evaluation, such as: the community, MIDD providers, King County staff managing MIDD funding, King County Council and the King County Executive Office.

  When evaluation intent and stakeholder expectations do not match, the usefulness of an evaluation is limited because some users of the results will not be able to meet their desired purpose.
- **Interviewees do not agree on the outputs and outcomes they would like to see included in MIDD evaluations.** This assessment included interviews with MIDD Oversight Committee members/designees, MIDD service providers, King County Executive Office staff, Department of Community and Human Services staff and behavioral health and program evaluation subject matter experts. Among interviewees, there was no consistent response about which of the current measures are useful and what new measures would be desirable. Similar to the finding above, this

[31] Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications

[32] In cases in which a strategy is supported by multiple distinct programs, the logic model may want to reflect each distinct program.

inconsistency in expectations results in dissatisfaction with the evaluation, as currently implemented, among some users of the results.

- **Interviewees expressed interest in understanding the level of community need that each MIDD strategy would meet.** This observation is not a challenge of the current MIDD evaluation, but provides information for future evaluation design discussions. It highlights a disconnect between what the current evaluation was designed to do and how stakeholders desire to use the evaluation results.

  Interviewees expressed that they would like to better understand how much need there is in the community for each type of service, how different MIDD strategies contribute to meeting that need, and the unmet need that remains. If decision makers want to address these questions in the design of the new MIDD evaluation, conducting a needs assessment is a common practice in health and human service program design.[33] A "needs assessment" is an analysis to determine the number of individuals who would benefit from services and ways in which their needs can be met. A needs assessment grounds a program in an understanding of the current state; provides baseline data for quantifying the impact of a program on meeting community needs; and, when used in evaluation, provides context for output and outcome measures and demonstrates the potential of the program in relation to the community as a whole.

  There are multiple challenges inherent in conducting a needs assessment that should be considered as well, including the cost of conducting an assessment, availability of information to support a rigorous assessment, developing agreed-upon definitions of "need" and "unmet need" across multiple areas, and an agreed upon framework for how to use assessment results in decision making.

Recommendations

To address the challenges related to the Evaluation Plan and framework identified above, the MIDD II evaluation design should:

R1. Clarify the purpose of the evaluation and logic of the evaluation framework.

The evaluation plan for MIDD II, and its accompanying evaluation framework, should have a clearly defined and stated purpose. This purpose should describe what the evaluation is intended to inform, who will be informed by the results, and how the results can and should be used by the intended audience. It should also clarify any caveats or limitations about conclusions that should not be drawn from the evaluation, based on its design.

The evaluation framework should describe how MIDD-funded activities are expected to influence MIDD participant outcomes and how participant outcomes link to system- and community-based outcomes and policy goals. The framework should include a logic model that identifies proximal outcomes for each strategy[34] and describes how impacting these outcomes affects distal outcomes. In addition, factors that influence policy goals aside from MIDD-funded activities should

[33] Watkins R, West Meiers M, Visser Y (2012). A Guide to Assessing Needs: Tools for Collecting Information, Making Decisions, and Achieving Development Results. Washington, DC: World Bank

[34] As noted above, when a strategy is supported by multiple distinct programs, each program may need to be reflected in the logic model.

be described. Once these logical linkages are made, a strategy can be evaluated on its ability to generate the proximal and distal outcomes.

R2. Involve stakeholders in developing the evaluation framework.

Any future evaluation framework would benefit from more involvement of community stakeholders, King County MIDD staff, program providers and the evaluation team in developing its purpose, the logic chain that connects MIDD strategies to policy goals, and identifying measures for outputs and proximal and distal outcomes.[35]

Involving community stakeholders, King County MIDD staff and program providers in developing the evaluation framework with the evaluation team will help build agreement regarding desired results and values and beliefs about change processes and their underlying assumptions. Working in partnership may help address resistance to data collection and reporting by selecting measures that are relevant to stakeholders and program providers and thus enhance the use of evaluation results to further policy goals. Evaluation best practice suggests this approach to make the evaluation more relevant to those implementing programs and to help avoid future issues around conflicting expectations.

MIDD Evaluation Output and Outcome Measures

The MIDD evaluation plan includes an evaluation matrix that lists, for each MIDD strategy, output and outcome measures. The goal of the output measurement was to assess *what* was done with MIDD money. The goal of the outcome measurement was to assess the *effect* of MIDD strategies on MIDD policy goals and other expected results. MIDD document reviews and interviews identified the following challenges related to the output and outcome measures selected for the MIDD evaluation:

- **No or too few proximal outcomes are measured for many MIDD strategies**. As described on page 9, evaluation best practice notes that both distal and proximal outcomes are important for understanding the impact of a MIDD strategy. The evaluation matrix in the Evaluation Plan lists output and outcome measures by MIDD strategies. In this matrix and in subsequent updates to the matrix published in MIDD progress and annual reports, MIDD strategies are linked with output measures, proximal outcome measures and measures of policy goals (the distal outcomes) for some strategies. For the remaining strategies, however, either no or too few proximal outcomes are included to be able to assess whether MIDD strategies influence the MIDD policy goals or to support MIDD continuous improvement efforts.

  For example, to gauge whether spending money for Strategy 1a-1 (Increase access to mental health outpatient services) reduces the number of jail bookings, the MIDD evaluation matrix links:

  - people who received services (measured output) to:
    - changes in symptom severity (measured proximal outcome), which is assumed to:
      - improve daily functioning (not measured) and reduce behaviors (not measured) that result in:
        - a jail booking (measured distal outcome) or emergency room visit (measured distal outcome).

[35] Friedman M (2005). Trying Hard is not Good Enough: How to Produce Measurable Improvements for Customers and Communities. Victoria, BC: Trafford

In this case, some links between MIDD strategies, output and proximal outcome measures and policy goals are assumed instead of measured, which is not sufficient to be able to attribute attaining MIDD policy goals to Strategy 1a-1.

In addition, the evaluation does not measure proximal outcomes for strategies that use evidence-based approaches, such as Strategy 1c: Emergency Room Substance Abuse and Early Intervention Program. For such strategies, the evaluation instead measures the number of clients served (output) and jail and ER use (distal outcomes). The Evaluation Plan notes that for MIDD strategies based on evidence-based practices there is no need to demonstrate a causal relationship between MIDD funding and MIDD policy goals. While this approach sounds efficient, it does not support continuous improvement efforts, which interviewees noted as one desired purpose of the evaluation. Continuous improvement efforts require information on whether MIDD activities have the intended immediate impact on program participants so that adjustments can be made, if necessary. Moreover, evidence-based practices can only be expected to support MIDD policy goals if the practices have been shown to impact the type of goals specified for MIDD. The MIDD evaluation plan and the MIDD progress and annual reports do not note which evidence-based practices supported by MIDD have been proven to impact such policy goals as the ones adopted for MIDD.

- **Interviewees stated that, for providers of behavioral health treatment, measures should be clinically relevant, including measures of behavioral health symptoms, daily function and quality of life.** Behavioral health symptoms are measured for some MIDD strategies in the current evaluation. However, interviewees perceived that, in an effort to avoid additional data collection burden, some measures were chosen because providers collected the data already, not because the measures are necessarily well-suited for behavioral health screening and treatment monitoring. Therefore, the selected measures may not be useful in determining the effectiveness of strategies funded by MIDD.

  In particular, the symptom and function measures that are used for the MIDD evaluation include the PHQ-9 (for depression), the GAD7 (for anxiety), the Problem Severity Summary (PSS), and the Children's Functional Assessment Rating Scale (CFARS). The first two measures (PHQ-9 and GAD-7) have been thoroughly validated[36] and recommended by the Center for Integrated Health Solutions (CIHS) [37] and the Agency for Healthcare Research and Quality (AHRQ)[38]. However, there is limited (PSS) or no validation (CFARS) in the behavioral health research literature for the other two measures and neither is included in the list of measures kept by CIHS and AHRQ. CFARS was selected based on a 2009 review of mental health measures for children and adolescents conducted by staff from the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). The

[36] Both measures have been validated with diverse groups of patients in different settings, languages and countries. The two original validation studies are as follows:
Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13
Kroenke K, Spitzer RL, Williams JB et al. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-97

[37] Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS); http://www.integration.samhsa.gov/clinical-practice/screening-tools - accessed on 2016/03/07

[38] Agency for Healthcare Research and Quality (AHRQ) resources to advance the integration of behavioral health and primary care https://integrationacademy.ahrq.gov/evaluationtools - accessed on 2016/03/07

measure selection process considered data collection burden for clients, providers and MHCADSD staff, cost and measure properties such as validity, reliability and sensitivity. The PSS was selected after a 2009 survey of King County mental health providers revealed that no outcome measure was employed by a majority of survey respondents. About half of the respondents reported using the PSS, which had been utilized countywide in the past. The PSS was developed locally for an adult community and mental health population, is available free of charge and relatively brief, which reduces data collection burden. When the decision was made to include the PSS in the MIDD outcome measures, it was noted that the measure does not have a strong recovery orientation and that it is reported by clinicians, not the individuals who receive services.

- **The detail and specificity of output measures in the Evaluation Matrix vary by strategy**. While most output measures in the evaluation focus on ongoing service provision, some strategies include output measures only for program start-up activities. For example, Strategy 1f includes a measure of "Employ a 1.0 FTE parent partner specialist." In contrast, Strategy 16a includes the ongoing measures "Number of residential units created" and "Number of rental subsidies dispersed." Further, it is not clear why measure types and details vary across strategies, nor why some measures are categorized as output instead of outcome measures. Having consistency across strategies in selecting measures for start-up versus ongoing activities and in categorizing output versus outcome measures improves the clarity and purpose of the evaluation and enhances transparency and accountability.

Recommendations

To address the challenges related to output and outcome measures identified above, the MIDD II evaluation design should:

R3. Establish relevant output and outcome measures.

To have an evaluation that supports learning and continuous improvement, output and outcome measures must be relevant to participants and program providers and be useful to monitor implementation and improvements.

In addition, future MIDD evaluations may benefit from measures that communicate and monitor program quality and benefits from the clients' perspective. The Institute of Medicine Committee on Crossing the Quality Chasm strongly recommends a focus on behavioral health care that is safe, effective, patient-centered, timely, efficient and equitable.[39] The current practice review shows that measures of the quality of service – such as client complaints and client satisfaction – are used by other jurisdictions. For instance, the North Texas Behavioral Health Authority employs the following client satisfaction measures as one way to monitor and improve the quality of its services:

- How satisfied are you with being treated with respect by staff at this clinic?
- How satisfied are you about your ability to improve your own life?
- Overall, how satisfied are you with the mental health services of your clinic?

[39] Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington (DC): National Academies Press (US); 2006. Summary. Available from: http://www.ncbi.nlm.nih.gov/books/NBK19817/

These and other questions may ensure that clients are receiving care that is respectful and meets their needs. In some cases, particularly where MIDD is only a portion of the total funding of a program that might be evaluated by other funders, these types of measures may already be tracked and the evaluation design should take care to not duplicate efforts.

R4. When available, select valid, reliable and sensitive proximal outcome measures in collaboration with service providers.

Applying best practices, the MIDD evaluation should select measures that have been demonstrated to be reliable, sensitive and valid.[40] In addition, providers should be involved when proximal outcome measures are selected for the services they provide. Providers are more likely to support evaluation efforts when they see value in the data they have to collect for the evaluation. For example, validated symptom rating scales could be administered to MIDD participants during MIDD-funded contacts with behavioral health care providers.

"Symptom rating scales (also known as patient-reported outcome measures) are brief structured instruments that patients use to report their perceptions about the frequency and/or severity of the psychiatric symptoms they are experiencing (…) These symptom rating scales (e.g., PHQ-9 for depression) are practical to administer, interpretable, reliable and sensitive to changes in the frequency/severity of psychiatric symptoms and functional impairment over time. (….) With clinical judgement alone, behavioral health providers frequently fail to detect a lack of improvement or a worsening of symptoms in their patients, and this can lead to clinical inertia (i.e., not changing the treatment plan even though the patient is not benefiting from the current treatment).

Without the systematic monitoring of symptoms, providers miss opportunities to improve their treatments over time and clinical practices miss opportunities to evaluate quality improvement activities. In addition, when aggregated across all patients in a clinical practice or healthcare system, symptom rating scales data can be used to demonstrate the value of behavioral health services to payers." [41]

Currently, MIDD funds often pay only for a subset of individuals who receive services that are included in the MIDD strategies. It would be challenging to introduce new outcome measures only for this subset of individuals. Thus, future MIDD evaluation designs need to weigh the cost to providers and the County of introducing new outcome measures versus the benefit of having valid, reliable and sensitive measures.

R5. Focus on clinically and practically meaningful changes in outcomes.

A statistically significant difference from zero does not necessarily imply that there was a meaningful change in an outcome, or that patients noticed a difference in their daily lives. Thus, instead of assessing whether there was any change, future MIDD evaluations may want to

[40] **Reliability**: The extent to which a measure produces the same results when used repeatedly to measure the same thing. **Sensitivity**: The extent to which the values on a measure change when there is a change or difference in what is measured. **Validity**: The extent to which a measure actually measures what it intends to measure. Source: Babbie ER (2015). The Practice of Social Research, 14th Edition. Belmont, CA: Wadsworth Publishing Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications

[41] Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Issue Brief, The Kennedy Forum, 2015. https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf - accessed 01/06/2016

measure the extent of clinically or practically meaningful changes. For instance, the PHQ-9 distinguishes depression levels ranging from no to severe depression. Knowing that depression symptoms changed from severe to mild after a person participated in MIDD would be more meaningful than knowing that there was any change in their symptoms, because any change may not be enough to make a difference in the person's life. An example of this suggestion can be found in the Mental Illness and Drug Dependency Fifth Annual Report, which notes that *"of the 613* [people] *with severe or extremely severe anxiety symptoms during their pre period, 161 (26%) showed only slight or no impairment in at least one follow-up measure"* (p. 60).

MIDD Evaluation Process

The MIDD evaluation is conducted by the System Performance Evaluation (SPE) section within the Behavioral Health and Recovery Division of DCHS. The SPE team is responsible for reviewing output and outcome data collected and submitted to the county by MIDD-funded providers; cleaning and consolidating the data; and conducting data analyses that are the foundation for the evaluation reports. SPE staff also write the MIDD evaluation progress and annual reports and provide data and analysis results in response to ad-hoc inquiries. The team works closely with providers and BHRD MIDD program staff throughout the year to review output targets and needs for adjustment.

Strengths of the current evaluation process include:

- **The data acquisition process supports providers who have different levels of data collection and sharing capabilities**. The evaluation team uses data submitted to King County by providers, generally on a monthly basis. The data track providers' status toward meeting output goals specified in their contracts with the County. Interviewees highlighted that the decision to accept data in multiple formats, even formats that are inconsistent with King County data standards, allows providers who have limited expertise and/or infrastructure for collecting and sharing data to participate in MIDD. This flexibility increases the pool of providers who may participate in MIDD, which supports King County equity and social justice goals.
- **MIDD includes dedicated resources for data cleaning, merging and analysis**. Interviewees noted that, due to the flexibility of submitting data in varying formats, MIDD's dedicated resources for data cleaning, merging and analysis are necessary to meeting evaluation timelines because the resources make it possible to manage multiple data formats in a timely way.

This assessment also identified challenges with the evaluation process, including:

- **Data are provided in varying formats, which means King County staff spend significant time preparing data for analysis**. Because providers submit data in multiple formats, including formats that are prone to formatting errors (e.g., Microsoft Excel), the evaluation team performs considerable data cleaning and merging activities before they can analyze the data. As long as providers continue to submit data in spreadsheets, manual cleaning by King County staff will be necessary, despite the evaluation team's use of computer programs to check for data errors electronically after they obtain data from providers.
- **Feared loss of funding creates a disincentive for reporting on, understanding and learning from lower than anticipated performance on output and outcome measures**. Interviewees reported that the MIDD evaluation does not foster a continuous learning environment where strategies and/or programs are adjusted or modified based on data and outcomes. Some interviewees suggested that this may be due to concerns about losing funding in case of unfavorable evaluation results. However, in our assessment of MIDD evaluation and reporting, we did not find any instances of

strategies or programs losing funding due to performance issues. Funding declined due to the decline in sales tax revenue caused by the Great Recession, which began shortly after MIDD implementation started. Less tax revenue resulted in MIDD cuts, which some believed were influenced by evaluation results.

Recommendation

To address the challenges related to the evaluation process identified above, the MIDD II evaluation should:

R6. Invest in data collection infrastructure.

As noted, data collection, sharing, and cleaning consume considerable time, both for providers and the King County evaluation team. Future evaluations will benefit from efforts to reduce manual data collection and sharing, including offering resources for technical assistance with data reporting and/or development of data reporting systems to providers who have limited capacity for data collection and sharing; involving evaluation staff and provider staff responsible for data collection and sharing in contract negotiations to set realistic expectations before MIDD funds are distributed; reviewing data quality on an on-going basis and providing timely feed-back to providers; leveraging data requirements for the County's Behavioral Health Integration IT project, in particular the electronic medical records requirement; and continuing to provide dedicated resources for data collection and sharing.

Implementing this recommendation may increase administrative and infrastructure costs for MIDD II, but investing in data infrastructure may increase the capacity to use data for learning and improvement and reduce the use of staff time for data management.

MIDD Outcome Evaluation

As stated earlier in this report, the MIDD outcome evaluation is focused on whether MIDD-funded strategies achieve expected outcomes as outlined in the Evaluation Plan. Strengths of the MIDD outcome evaluation, as highlighted by this assessment, include:

- **MIDD progress and annual reports provide detailed information on the vast majority of outcome measures listed in the MIDD Evaluation Matrix.**[42] PSB's review of the Evaluation Plan and all subsequent annual and progress reports showed that the Evaluation Plan was closely followed during implementation and that information on most outcome measures is available in the evaluation reports.

  Where possible, the information presented in MIDD reports is based on data collected from individuals before and after they started MIDD-funded services and, thus, captures changes that occurred while MIDD was in place. This approach answers to what extent there were changes in outcomes and outputs for individuals served by MIDD.

[42] Due to lack of data, no results were reported for (a) *case manager job satisfaction* (Strategy 2a); (b) *truancy petitions filed* (Strategy 4c); (c) *depression symptoms* (Strategy 13a); and (d) *job placement* (Strategy 11b). Because treatment participants were promised anonymity, results were not reported for *completion of mental health treatment* (Strategy 13b). An explanation for the lack of results was not found for (a) *utilization of natural supports* (Strategy 6a) and (b) *severity of mental health symptoms* (Strategy 11b).

However, as readers of the MIDD progress and annual reports are reminded, observed changes in outcomes are not necessarily due to MIDD funding alone, as modifications in policing or sentencing practices, psychiatric hospital capacity, housing supply, or other factors in a person's life also can make a difference.

Additional observations about the outcome evaluation include:

- **The evaluation methodology used is not suitable to assess the causal impact of MIDD strategies on outcomes, including MIDD policy goals**. There are usually many factors that influence desired outcomes, many of which are outside the control of the MIDD strategies. As noted, it is, therefore, not appropriate to attribute observed changes in outcome measures only to MIDD strategies.

  Randomized field experiments are the strongest research design for assessing the impact of an intervention because they provide unbiased estimates of intervention effects.[43] Appendix VI lists examples of social service projects administered in non-research settings that use randomized comparison groups to measure impact. When a randomized field experiment is not feasible due to ethical concerns, cost considerations, or other challenges, nonrandomized quasi-experimental designs[44] are often used instead. Nonrandomized quasi-experimental designs include constructed control groups, equating groups using statistical techniques, regression-discontinuity designs and the comparison of participants with themselves.[45]

  The MIDD outcome evaluation relies mostly on what is called a simple pre-post reflexive design, which involves comparing outcomes measured for the same individuals before and after receiving services through MIDD (e.g., jail utilization in the year prior to starting MIDD compared to jail utilization during the year after participating in MIDD). This design was approved by the King County Council and the MIDD Oversight Committee. While all quasi-experimental designs may provide biased estimates *"simple pre-post reflexive designs provide biased estimates of program effects that have little value for purposes of impact assessment"*.[46] Therefore, the results of the MIDD evaluations cannot be used to claim or imply causality.

  King County considered other types of comparisons during the MIDD, including:

  - Ordinance 16262 directed the MIDD Oversight Committee to review and study the concept of establishing a historical comparison group and make a recommendation. The Historical Control Group workgroup recognized that a historical comparison group would not be appropriate to determine to what extent MIDD caused changes in the outcomes of interest. Accordingly, the MIDD Oversight Committee did not recommend using such a comparison group for the MIDD evaluation.
  - The MIDD evaluation team attempted to use a concurrent comparison group design to assess whether changes in the criminal justice system, rather than MIDD strategies alone, contributed

[43] List JA. Why economists should conduct field experiments and 14 tips for pulling one off. Journal of Economic Perspectives. 2011;25(3):3-16

[44] Quasi-experimental design: A research design in which intervention and control groups are formed by a procedure other than random assignment.

[45] DiNardo J, Lee DS (2010). Program Evaluation and Research Designs. Cambridge, MA: National Bureau of Economic Research, Working Paper 16016

[46] Rossi PH, Freeman HE, Lipsey MW (2004). Evaluation: A Systematic Approach, 7th Edition. Thousand Oaks, CA: Sage Publications, p.290

to the reduction in jail days reported for MIDD participants.[47] It is unclear from the MIDD report whether the comparison group meets the requirements for a valid concurrent comparison group. The information in the report suggests, however, that the MIDD group was not typical of other jail users and that the comparison group, thus, is not likely to be valid. The difficulty (or impossibility) of identifying a suitable concurrent comparison group for MIDD participants may have led to the decision to forego additional analyses based on a concurrent comparison group design.

Recommendation

To address the challenges related to the outcome evaluation identified above, the MIDD II evaluation design should:

R7. Modify evaluation design if the next MIDD evaluation is to show causality.

If future evaluations are expected to establish whether MIDD-funded activities caused changes in outcomes, an evaluation design needs to be employed that can achieve this goal.

Random assignment is the gold standard for determining whether an intervention is the reason for observed changes. As noted earlier, random assignment may not be feasible when an intervention is implemented outside of a research setting due to ethical concerns, cost considerations, or implementation challenges.[48]

An alternative approach to random assignment is a concurrent comparison group design. An example of a recent evaluation that used this approach is the New York City ABLE Project of Incarcerated Youth.[49] The design requires determining: (a) characteristics that influence the outcome of interest (e.g., severity of crime: individuals who commit more serious crimes spend more days in jail); and (b) characteristics that influence whether a person participates in a program (e.g., readiness to change: individuals motivated to reduce their criminal behavior are more likely to participate in MIDD-funded programs). Next, one needs to identify non-program participants who have the same characteristics as participants (e.g., individuals with the same motivation to reduce criminal behavior and who committed the same types of crimes as MIDD participants). It can be challenging to find the necessary data and individuals who meet these conditions.

Given the challenges of implementing evaluation designs that are suitable to establish causality and the significant resources such designs may require, future MIDD evaluations may want to weigh the advantages and disadvantages of conducting assessments that demonstrate an impact on MIDD policy goals versus proximal outcomes. Because proximal outcomes are more directly linked to activities than are policy goals, factors outside a program's control may be less likely to influence proximal outcomes, increasing the opportunity for establishing causality between MIDD activities and outcome measures.

[47] Mental Illness and Drug Dependency Year Three Progress Report, p.24

[48] If a MIDD strategy uses more than one distinct program, it may be necessary to evaluate each program separately to assess causal impacts with a comparison group design, which would add considerable time and expense to the evaluation.

[49] http://www.vera.org/sites/default/files/resources/downloads/adolescent-behavioral-learning-experience-evaluation-rikers-island-summary.pdf

Policymakers and county leaders should determine whether the investment in conducting causal evaluations is necessary and know the limitations of any selected evaluation design in understanding cause and effect.

MIDD Evaluation Reporting

The evaluation team prepares the evaluation reports, which are reviewed by MIDD strategy leads, DCHS leadership and County executive leadership before publication. Strengths of the evaluation reports include:

- **MIDD reports clearly describe to what extent strategies reached their output targets.** As noted previously, the objective of the Strategy Process Evaluation is to measure progress towards meeting the output targets described in the MIDD evaluation matrix. The MIDD reports fulfill this objective by clearly reporting on output measures by strategy, which allows the reader to understand how much progress is being made toward output targets.
- **MIDD reports describe how MIDD funding is spent**. Interviewees stated that MIDD reports include useful information on how MIDD funding is being spent, such as the amount of money spent on individual MIDD strategies, and the outputs that each strategy is generating, such as the number of people served or the number of visits. Interviewees found the reports useful for demonstrating the level and impact of MIDD strategies to their respective organizations and to other potential funders.
- **The reports are accessible and readable for multiple audiences and include an effective mix of quantitative analysis with qualitative anecdotes and information.** These qualities were praised by interviewees, although interviewees also mentioned that the reports assume more background knowledge than readers may have. Interviewees also mentioned that they like the anecdotal success stories included in the report because it brings meaning to numbers.
- **Changes in the MIDD evaluation process are captured well in the evaluation reports**. A review of MIDD progress and annual evaluation reports by PSB found that the reports describe when there are changes in the evaluation matrix and changes in output measure targets. It is important to document these changes to understand how the current evaluation process relates to the original Evaluation Plan.

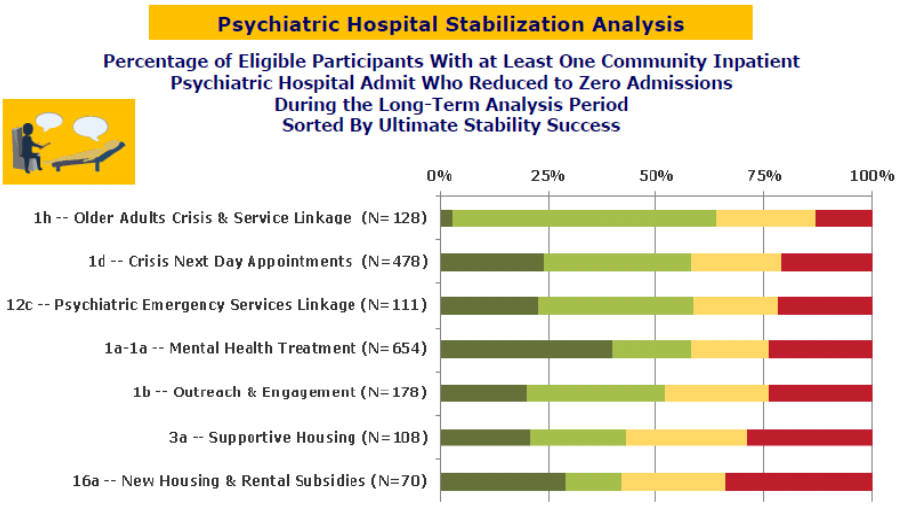
In addition, the assessment team identified challenges related to the evaluation reports, including:

- **Results are not available at a frequency and time to inform funding decisions and continuous improvement efforts**. Interviewees would like to use evaluation reports to inform funding decisions or continuous improvement activities. Although data are submitted at least monthly to the MIDD evaluation team and then analyzed and reported semi-annually, outcome results are not available for a year or longer, which is partially due to outcome data being collected infrequently (e.g., at baseline and 6 and 12 months post baseline). More frequent collection of outcome measures and more frequent and timely reporting would provide actionable information to MIDD decision makers and program managers.
- **It is not clear why MIDD strategy process evaluation changes are made**. Each MIDD strategy has output targets. These targets are sometimes adjusted by the MIDD evaluation team and reported in the MIDD annual and progress reports. While changes are noted, the rationale for the change is not consistently provided. Interviewees explained that strategy and data improvement activities are generally managed between County contract monitors and providers, and that this level of detail is not usually included in the MIDD annual and progress reports. This practice decreases the transparency of the evaluation and makes it difficult to learn from the experience of the strategy

implementation. If the reason for changing the target represents learning and improvement, publishing the rationale and method for the adjustment would enhance future target setting.

- **Evaluation report drafts are reviewed and edited by multiple stakeholders, which at times has introduced bias into reports**. There was a perception among interviewees that County leadership, the MIDD Oversight Committee and strategy owners may focus only on positive results in the MIDD reports. At times, this resulted in edits to the reports that included changed wording to imply a stronger link between MIDD funding and results than is supported by the analyses used to derive outcomes. These types of edits create the same issues as noted in the finding below, in that they can potentially mislead readers about the results of the evaluation.
- **In some instances, the reports could be clearer in avoiding implications of a causal relationship between MIDD strategies and outcomes**. MIDD reports include reminders that the evaluation design used for the outcome evaluation is not sufficient to determine whether MIDD was the reason for an observed change. However, in some cases, the reader may infer causation due to the way results are presented. For example, listing results in order of greatest change in outcome (see Figure 2) can be interpreted to mean that some MIDD strategies are more effective than others. Since this conclusion would be inappropriate, ranking and sorting of MIDD results by strategy can be misleading, unless the reader is reminded at this point that the evaluation design cannot establish causality.

Figure 2: Example of Sorted Results from MIDD Annual Report, 2015, Page 64



Recommendations

To address the challenges related to the evaluation reporting identified above, the MIDD II design should:

R8. Increase frequency of performance evaluation availability.

Evaluation results become available twice per year in the current MIDD evaluation process. To increase the evaluation's ability to support timely decision-making and continuous improvement and understanding of what is and is not working, future evaluations should consider making

output and outcome results available through a real-time or frequently-updated dashboard.[50] This recommendation requires that outcome data are collected more frequently, which is consistent with a measurement-based approach to behavioral health care. If evaluation staff capacity is a constraint, the scope and frequency of formal reports could be reduced due to this increased availability and transparency of results.

The dashboard content and format should be designed with the intended purpose of the evaluation and the intended audience clearly in mind, to best support decision-making and strategy and/or program improvement.

The value of an evaluation increases when its information is used to improve the services provided to improve desired outcomes.[51] Increasing the shared expectations about how evaluation results will be used and aligning evaluation processes and the availability of evaluation results can increase accountability for using data to improve strategies and/or programs in a transparent way.

R9. Establish guidelines for report creators and editors on the scope of their decision making.

Roles and responsibilities for developing and deciding upon the final content of the evaluation reports should be established. Reviewers and editors of the reports should clearly understand the scope of their editing role, and all edits should be reviewed by the person responsible for finalizing content before publishing information.

In addition, decisions about which evaluation results to publish should be made before results are known, and significant results should be reported on, whether favorable or unfavorable. These changes will help maintain the objectivity of future MIDD evaluation reporting.

R10. Avoid presenting non-causal results in ways that imply causality.

If an evaluation design suitable for causal inference is not feasible for future MIDD evaluations, the description of evaluation results needs to avoid the impression that MIDD is causally related to changes in outcomes. When results are presented in a way that may imply causality, at a minimum, the reader should be reminded that the evaluation design cannot establish causality.

CONCLUSION

This assessment of the MIDD evaluations conducted from 2008-2015 found that there are many strengths to build upon. These evaluations provided information for stakeholders and the community to understand how MIDD funding was spent and the progress made toward the targets and goals identified in the MIDD Evaluation Plan. Additionally, this assessment identified some challenges and an evolution in behavioral health care evaluation that will need to be considered as the new evaluation plan is developed for potential MIDD renewal. It may be beneficial for the development of the next MIDD evaluation to build upon these learnings and consider the recommendations in this report.

[50] A dashboard provides the current status of an organization's key indicators in an easy-to-read format using a real-time computer user interface.

[51] Kinney AS, Mucha MH, eds. (2010). State and Local Government Performance Management: Sourcebook. Chicago, IL: Government Finance Officers Association

APPENDICES

Appendix I: List of Interviewees

King County Department of Community and Human Services Staff

1. Jesse Benet, MIDD Strategy Lead
2. Kimberly Cisson, MIDD Research Analyst
3. Nancy Creighton, Data Analyst
4. Marla Hoffman, Statistician
5. Lisa Kimmerly, Lead MIDD Evaluator
6. Andrea LaFazia-Geraghty, MIDD Project Manager
7. Susan McLaughlin, Health and Human Services Integration Manager
8. Adrienne Quinn, Director
9. Genevieve Rowe, Program Evaluator
10. Deb Srebnik, Program Evaluator
11. Laurie Sylla, Evaluation Section Supervisor
12. Jim Vollendroff, Behavioral Health and Recovery Division Director
13. Josephine Wong, Deputy Director

King County Information Technology Staff

14. Michael Csendes, IT Service Delivery Manager
15. Diep Nguyen, IT Service Delivery Manager

MIDD Oversight Committee Members and/or Designees

16. Merril Cousin, Executive Director, King County Coalition Ending Gender-Based Violence, MIDD Oversight Committee Co-Chair
17. Shirley Havenga, CEO, Community Psychiatric Clinic
18. Mike Heinisch, Executive Director, Kent Youth and Family Services
19. Leesa Manion, Deputy Chief of Staff, King County Prosecuting Attorney's Office *(designee)*
20. Ann McGettigan, Executive Director, Seattle Counseling Center
21. Barb Miner, Director, King County Department of Judicial Administration
22. Dan Satterberg, Prosecuting Attorney, King County Prosecuting Attorney's Office
23. Wendy Soo Hoo, Senior Legislative Analyst, Metropolitan King County Council

MIDD Service Providers

24. Graydon Andrus, Director of Clinical Programs, Downtown Emergency Services Center
25. Calista Welbaum, Program Manager, Regional Mental Health Court/Veterans Court

Other Stakeholders and Subject Matter Experts

26. Carrie Cihak, Chief of Policy, King County Executive's Office
27. Katie Hong, Director, Youth Homelessness, Raikes Foundation

28. Keith Humphreys, Professor of Psychiatry and Behavioral Sciences, Stanford University
29. Betsy Jones, Health and Human Potential Policy Advisor, King County Executive's Office
30. Amnon Shoenfeld, Previous Director of MHCADSD, King County DCHS

Appendix II: Interview Protocols

Interview Protocol for King County Staff

1. Please describe your role in the MIDD evaluation process (or MIDD in general) during the current MIDD (2008-2015).
2. Are you an end user of the reports?
    a. If so, how do you use them?
    b. At a high level, what do you see as the main strengths and weaknesses of the MIDD Annual and Progress Reports?
3. When thinking about data collection and preparing data for analysis, what are the current strengths of this process?
    a. What are the most important components to keep in place for the renewed MIDD?
4. When thinking about data collection and preparing data for analysis, what are some of the key challenges you experience?
    b. How could these processes be improved in the future?
5. Are there limitations, such as data availability, that have made it challenging to complete the requested MIDD progress reports and annual reports?
    a. Do you have recommendations on how to mitigate these challenges in the future?
6. Are there measures that you would like to see included in future MIDD evaluation reports?
    a. What barriers are there to reporting these measures, and how could those be removed?
7. Are there data analysis or evaluation approaches you recommend using for future MIDD evaluations?
    a. Are there barriers to using these approaches, and how could those be removed?
8. Is there anything else you'd like us to know for our assessment?
9. Is there anyone else you think we should talk with?

Interview Protocol for Service Providers

1. Please describe your organization's service area and role in MIDD or a specific MIDD strategy.
2. Please describe, at a high level, the process for sharing your data with King County DCHS for the purpose of creating MIDD reports.
    a. What about this process works well for you/your organization?
    b. What are some of the key challenges in this process for you/your organization?

3. Are there data elements/measures that King County has asked you to report that are not available in your organization?
    a. What are the barriers to reporting this information?
4. Thinking about future MIDD evaluations, what recommendations do you have on how to improve the data collection process to make it work better for providers?
5. Thinking about future MIDD evaluations, what recommendations do you have on measures that should be tracked to better evaluate the success of MIDD strategies?
    a. What measures do you already report on internally or for other funders?
6. What barriers exist to accomplishing your above recommendations? What can be done to remove them?
7. Are data or information collected now that you think are not important to track?
    a. If yes, why are they unimportant?
8. Is there anything else you'd like us to know for our assessment of the MIDD evaluation?

Interview Protocol for Other Stakeholders

1. Please describe your role in the MIDD or in the provision of behavioral health services in King County.
    a. Are there specific MIDD strategies you are involved in or are most familiar with?
2. At a high level, what do you see as the main strengths of the MIDD Annual and Progress Reports?
3. What information in the MIDD Annual and Progress Reports is most helpful to you for understanding the impact of the MIDD Programs? *Feel free to comment on specific strategies or the MIDD overall.*
    b. What data/information, if any, do you use to inform your decisions or recommendations?
4. What changes would you make to the current MIDD Annual and Progress Reports?
    c. Do you have evaluation or performance questions that are not answered by these reports?
    d. What data would you like to see included in future reports?
5. Is there anything else you'd like us to know for our assessment of the MIDD evaluation?
6. Is there anyone else you think we should talk with?

Appendix III: Additional Information on MIDD and its Evaluation Plan

In 2007, the Council voted to enact a MIDD sales tax to support new or expanded mental illness and chemical dependency and therapeutic court programs and services. This vote adopted Ordinance 15949, in which the Council authorized the collection of the sales tax and established five policy goals to guide the development of the MIDD implementation:

Adopted MIDD Policy Goals
Ordinance 15949

1. A reduction of the number of mentally ill and chemically dependent using costly interventions like 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;
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; 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 King County Mental Health Recovery Plan.

Ordinance 15949 also called for the development of three separate plans to be completed prior to the release of MIDD funds:

- **Oversight Plan**. The oversight plan was required to propose a group responsible for ongoing oversight of the MIDD action plan, the role of the group, and how the group would coordinate with other county groups. Ordinance 15949 also outlines the types of representation that should comprise the oversight group, including state, county, and community agencies and entities involved in the mental health, substance abuse, domestic violence and sexual assault, homeless, justice, public health, and hospital systems.
- **Implementation Plan**. The implementation plan was required to describe the implementation of the programs and services outlined in the Mental Illness and Drug Dependency Action Plan, including a schedule for implementation; a discussion of needed resources; and milestones for program implementation. The implementation plan would also include a spending and financial plan developed in collaboration with the oversight group.
- **Evaluation Plan**. The Evaluation Plan was required to describe an evaluation and reporting plan for the programs funded with the MIDD sales tax, including a process and outcome evaluation component; a proposed schedule for evaluations; output and outcome measures and measure targets; and data elements that would be used for reporting and evaluations.

Throughout 2007 and 2008, the County worked with community partners to develop the plans required by the original MIDD ordinance.

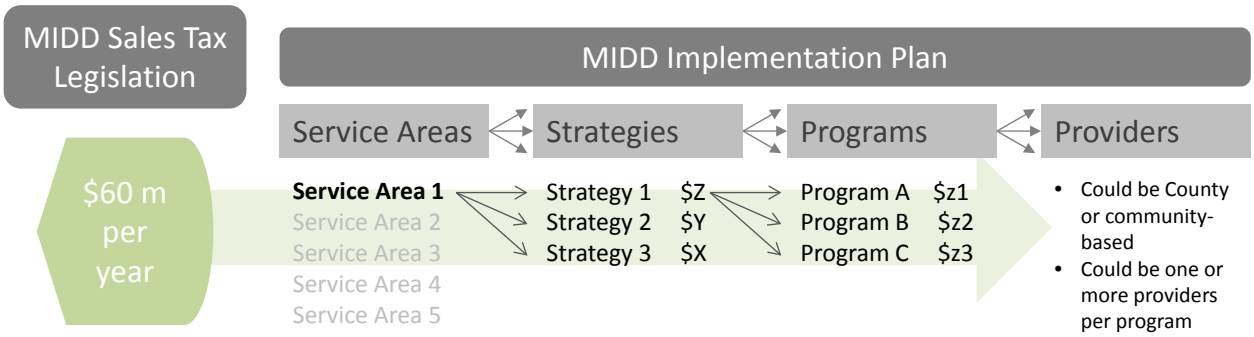
The first plan to be adopted was the **Oversight Plan**, via Ordinance 16077, in April 2008. This plan established the MIDD Oversight Committee as an advisory body to the King County Executive and the Council. Its purpose is to ensure that the implementation and evaluation of the strategies and programs

funded by the MIDD sales tax revenue are transparent, accountable, collaborative, and effective. The Oversight Committee first convened in June 2008 and has met approximately monthly ever since.

The **Implementation Plan** was adopted via Ordinance 16261 in October 2008. It outlines the programs and services that would be funded by MIDD and the budget and spending plan for each. The Implementation Plan established that MIDD would support an integrated system of:

- Prevention and early intervention services
- Community-based treatment
- Expanded therapeutic court programs
- Jail and hospital diversion programs
- Housing and housing supportive services.

The Implementation Plan was organized around five service areas that were subdivided into 37 different strategies. Each strategy is implemented through one or more programs that provide services for clients. Services are delivered either through County-based programs or through community-based programs contracted by the County. The following graphic illustrates the multi-layered structure of the MIDD Implementation Plan.



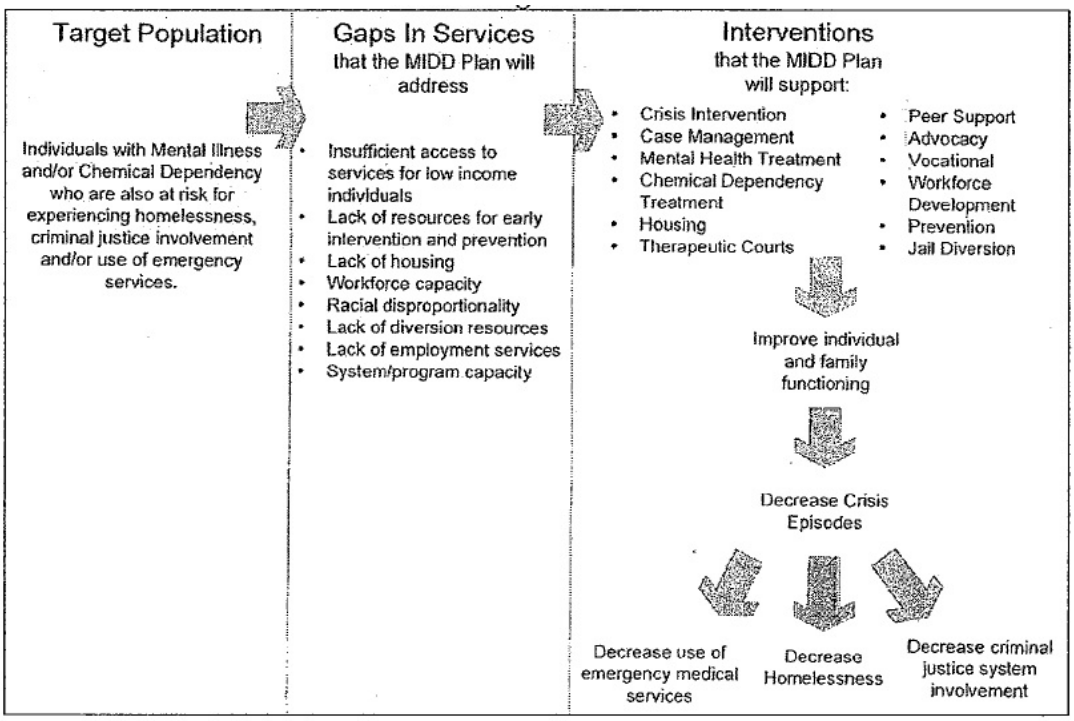
The **Evaluation Plan** was also adopted by Council via Ordinance 16262 in October 2008. The next section describes the main components of this plan.

Components of MIDD Evaluation Plan

Ordinance 15949 specified that the evaluation plan was to *"… describe an evaluation and reporting plan for the programs funded with the sales tax revenue* (and) *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. Part three shall be developed in collaboration with the oversight group."* (pp. 7-8)

The MIDD Evaluation Plan outlines the rationale and intent to monitor and evaluate the strategies funded by MIDD. It includes an evaluation framework that is guided by a high-level logic model (Figure 3) and shows how MIDD strategies are expected to further the MIDD policy goals.

Figure 3: MIDD Logic Model as printed in Appendix A of Ordinance 16262



The MIDD Evaluation Plan has three main components:

4. **System Process Evaluation** to describe *how* the implementation of MIDD is progressing.
5. **Strategy Process Evaluation** to assess *what* was done.
6. **Outcome Evaluation** to assess the *effect* of MIDD strategies on MIDD policy goals.

The plan also includes an evaluation matrix that lists, for each MIDD strategy, the activities to be performed, output measures, output targets, outcome measures and data sources. In addition, the Evaluation Targets Addendum of the Evaluation Plan specifies targets for four of the five MIDD policy goals the King County Council sought to achieve with MIDD funding. The targets were based on the length of time until a program would be fully implemented and information from programs serving similar populations across the country.

The following sections provide more detail about the three main components of the Evaluation Plan.

1. System Process Evaluation

The objectives of the System Process Evaluation are to describe how the implementation of MIDD is progressing, to identify unintended consequences of MIDD activities, and to establish a quality improvement feed-back loop to inform revisions to MIDD processes and strategies. In particular, the process evaluation component of the plan focuses on:

- Initial MIDD start-up activities
- Development and management of requests for proposal and service contracts
- Strategies to leverage and blend funding streams
- Efforts to coordinate the work of partners, stakeholders, and providers
- Implementation of working agreements and Memoranda of Understanding

- Service-level changes resulting from efforts to promote integration of housing, treatment, and supportive services
- System-level changes resulting from MIDD funds or the management of MIDD-related resources
- An evaluation the MIDD Action Plan's integration with and support of system level goals and objectives as articulated in 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

Much of the work on the system process evaluation was part of ongoing activities of the MIDD Oversight Committee. Aspects of the system process evaluation that were discussed by interviewees and were included in MIDD evaluation reporting are incorporated into this assessment, but the system process evaluation was not the primary focus of this assessment.

2. Strategy Process Evaluation

The objective of the Strategy Process Evaluation is to measure progress towards meeting the output goals specified in the MIDD evaluation matrix of the MIDD Evaluation Plan (see Appendix IV). The Strategy Process Evaluation focuses on program reporting to provide transparency to constituents that funds are being used as intended. The Strategy Process Evaluation is available upon request.

Output measures were adjusted over time based on input from evaluation staff, providers and the MIDD Oversight Committee to reflect changes in MIDD strategies, strategy implementation or data availability. Any changes to the measures are published in MIDD progress reports and must be adopted by the Council to become official.

3. Outcome Evaluation

The objective of the Outcome Evaluation is to measure whether MIDD-funded strategies achieve expected results. For each MIDD strategy, this entails selecting outcome measures that reflect the expected results, collecting data for each measure at multiple points in time for individuals served by MIDD, analyzing data to determine whether there were changes over time and publishing results in the MIDD annual and progress reports.

Proximal measures selected for the MIDD Outcome Evaluation address behaviors, skills, knowledge, attitudes, and external circumstances relevant for individuals served by MIDD. Examples include screening for mental health and chemical dependency symptoms, symptom severity, enrolling in mental health treatment, skills and knowledge obtained in crisis intervention training, attitudes about stigma associated with mental health illness and risk factors impacting families and youth served by MIDD. The selected distal outcome measures reflect behavior and address jail utilization, emergency room visits and hospital use, that is, MIDD policy goals (1) through (4).

MIDD Evaluation Reporting

Ordinance 15949 also specified what type of evaluation reporting would occur and when.

"In addition to reviewing and approving the parts one, two and three of the oversight, implementation and evaluation plan outlined in subsection C. of this section, in coordination with the oversight group, the executive shall submit four quarterly progress reports and an one annual summary report for the programs supported with the sales tax revenue to the council. The quarterly reports 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.

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. 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; and

(c) recommendations on program and/or process changes to the funded programs based on the measurement and evaluation data." (pp. 8-9)

Currently, the results of the evaluation work are published twice per year in two reports. The MIDD Annual Report, published in February of each year and transmitted to the Council with a motion to accept the report, summarizes the findings of the evaluation work for the most recent October-September time period. Each report includes:

- A summary of the MIDD strategies that operated during the time period being evaluated
- A reminder of MIDD background, policy goals, and Oversight Committee membership
- The number of individuals served by type of service, as well as demographic information such as age, gender, race, and geography
- A summary of how each strategy progressed toward its output measurement targets during the period being evaluated
- A summary of outcome progress achieved by MIDD programs during the period being evaluated
- Recommendations for revisions to the Evaluation Plan for future evaluations to respond to changing services and information over time
- A financial report comparing budget to actual spending for the period being evaluated

The **MIDD Progress Report**, published in August of each year, contains much of the same information as the annual report for the most recent October-March time period, as a way to check in on progress between annual reports. This report is transmitted to the Council as well.

Appendix IV: Evaluation Matrices

Strategy 1

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
1a(1) – Increase Access to Mental Health Outpatient Services for People Not On Medicaid Target Pop: Individuals who have received MH services but have lost Medicaid eligibility or those who meet clinical and financial criteria for MH services but are not Medicaid eligible.	1. Provide expanded access to outpatient MH services to persons not eligible for or who lose Medicaid coverage, yet meet income standards for public MH services (goal is 2400 additional non-Medicaid eligible clients per year).	Short-term measures: 1. Increase # non-Medicaid eligible clients served by 2400 per year 2. Reduce severity of MH symptoms of clients served Long-term measures: 3. Reduce # of jail bookings and days for those served 4. Reduce # of inpatient admissions and days for those served 5. Reduce # of emergency room (ER) admissions for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	MHCADSD Management Information System (MIS) Jail data Hospital data ER data
1a(2) – Increase Access to Substance Abuse (SA) Outpatient Services for People Not On Medicaid Target Pop: Low-income individuals who are not Medicaid, ADATSA, or GAU eligible who need CD services	1. Provide expanded access to substance abuse treatment to individuals not eligible or covered by Medicaid, ADATSA, or GAU benefits but who are low-income (have 80% of state median income or less, adjusted for family size). Services include opiate substitution treatment (OST) and outpatient treatment.	Short-term measures: 1. Increase # non-Medicaid eligible clients admitted to substance abuse treatment and OST. (Goal is additional 461 individuals in OST and 400 in outpatient substance abuse disorder treatment per year) 2. Reduce severity of SA symptoms of clients served Long-term measures: 3. Reduce # of jail bookings and days for those served 4. Reduce # of inpatient admissions and days for those served 5. Reduce # of emergency room admissions for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	MIS TBD (e.g., survey) Jail data Hospital data ER data
1b – Outreach and Engagement to Individuals leaving hospitals, jails, or crisis facilities Target Pop: Homeless adults	1. Intervention to be defined. Intent is to fill gaps identified in the high utilizer service system, once other programs dedicated to this population are implemented.	Short-term measures: 1. Link individuals to needed community treatment and housing 2. Increase # of individuals in shelters being placed in services and permanent housing	1. Output 2. Outcome	TBD when specifics of intervention are defined

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
being discharged from jails, hospital ERs, crisis facilities and in-patient psychiatric and chemical dependency facilities		Long-term measures: 3. Reduce # of jail bookings and days for those served 4. Reduce # of inpatient admissions and days for those served 5. Reduce # of emergency room admissions for those served	 3. Outcome 4. Outcome 5. Outcome	 Jail data Hospital data ER data
1c - Emergency Room Substance Abuse and Early Intervention Program Target Pop: At risk substance abusers, including high utilizers of hospital ERs	1. Continue lapsed funding for program at Harborview (5 current FTE SA professionals) 2. Create 1 new program in South King County (hire 4 new FTE CD professionals) 3. Serve a total of 7,680 cts/yr	Short-term measures: 1. Hire 4 new FTE SA professionals 2. SA services to 7,680 cts/yr 3. Expansion of existing program 4. Create 1 new program in South King County Long-term measures: 5. Reduce # of jail bookings and days for those served 6. Reduce # of ER admissions for those served 7. Reduce # of inpatient admissions and days for those served 8. Reduce # of detox admissions for those served 9. Reduce ER costs for those served	1. Output 2. Output 3. Output 4. Output 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	Agency report MIS MHCADSD MHCADSD Jail data ER data Hospital data MIS ER/Hospital data
1d - Mental health crisis next day appointments (NDAs) Target Pop: adults in crisis and at risk for inpatient psychiatric admission	1. Increase access for NDAs to provide them for 750 clients 2. Provide expanded crisis stabilization services	Short-term measures: 1. Provide expanded NDA services to 750 clients Long-term measures: 2. Reduce # of jail bookings and days for those served 3. Reduce # of ER admissions for those served 4. Reduce # of inpatient admissions and days for those served	1. Output 2. Outcome 3. Outcome 4. Outcome	MIS Jail data ER data Hospital data
1e – Chemical Dependency Professional Education and Workforce Development Target Pop: Staff (CDPTs) at	1. Provide tuition and book stipends to agency staff in training to become certified chemical dependency professionals.	Short-term measures: 1. Increase # of certified CD treatment professionals (CDPs) by 125 annually 2. Test 45 CDPTs at each test cycle 3. # certification programs	1. Output 2. Output	Agency data DASA data

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
KC contracted treatment agencies training to become CDPs.		4. # trainings provided Long-term measures: 5. Increase # clients receiving CD services	3. Output 4. Output 5. Outcome	DASA data Agency data MIS
1f - Peer support and parent partners family assistance Target Pop: 1) Families whose children and/or youth receive services from the public mental health or substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports for their children/youth. 2) Youth who receive services from the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports	1. Hire 1 FTE MHCADSD Parent Partner Specialist 2. Provide up to 40 part-time parent partners/youth peer counselors to provide outreach and engagement and assist families to navigate the complex child-serving systems, including juvenile justice, child welfare, and mental health and substance abuse treatment. 3. Provide education, training and advocacy to parents and youth involved in the different child serving systems	Short-term measures: 1. 1 FTE Parent Partner Specialist hired 2. A sufficient # of contracts are secured with network parent/youth organizations to provide up to 40 parent partners and/or youth peer mentors 3. Increase in # of families and youth receiving parent partner/peer counseling services 4. Increase in # of parent partner/peer counseling service hours provided 5. # of parent/youth engaged in the Networks of Support 6. # of education and training events held annually Long-term measures: 7. Reduce # of inpatient admissions and days for those families served 8. Reduce # of detention admits for those families served 9. Reduce # of out of home placements and/or placement disruptions for families and youth served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome 9. Outcome	MHCADSD MHCADSD MIS MIS Agency data Agency data MIS Juvenile Justice (JJ) data (TBD) DCFS data
1g - Prevention and early intervention mental health and substance abuse services for older adults Target Pop: Adults age 55 years and older who are low-income, have limited or no	1. Hire 10 FTEs behavioral health specialists/staff to provide prevention and early intervention services by integrating staff into safety net primary care clinics. This includes screening for depression and/or alcohol/drug abuse, identifying treatment needs, and connecting adults to appropriate interventions.	Short-term measures: 1. 10 FTEs hired 2. Improved access to screening and services 3. Prevention and early intervention services to 2,500 to 4,000 cts/yr Long-term measures:	1. Output 2. Output 3. Output	Agency data Agency data MIS

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
medical insurance, and are at risk of mental health problems and/or alcohol or drug abuse.		4. Reduce # of psych ER admissions for those served 5. Reduce # of psych inpatient admissions and days for those served 6. Reduce self-report of depression for those served 7. Reduce self-report of substance abuse for those served 8. Reduce self-report of suicidal ideation for those served 9. Reduce psych ER and hospital costs for those served	4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	ER data Hospital data TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) ER/Hospital data
1h - Expand the availability of crisis intervention and linkage to on-going services for older adults Target Pop: Adults age 55 and older experiencing a crisis in which MH or substance abuse is a contributing factor	1. Expand the GRAT by providing 1 FTE geriatric MH outreach specialist, 1 FTE geriatric CD outreach specialist, 1 geriatric CD trainee, and 1 .6 FTE nurse (serve 340 cts/yr) 2. In response to requests from police and other first responders, provide crisis intervention, functional assessments, referral, and linkages to services	Short-term measures: 1. Hire 1 FTE geriatric MH specialist, 1 FTE geriatric CD specialist, 1 geriatric CD trainee, and 1 .6 FTE nurse 2. Crisis intervention and linkages to services for an additional new 340 cts/yr 3. # of crisis interventions 4. # of functional assessments 5. # of referrals 6. # of linkages made to services Long-term measures: 7. Reduce # of jail bookings and days for those served 8. Reduce # of psych ER admissions for those served 9. Reduce # of psych inpatient admissions and days for those served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome 9. Outcome	Agency data MIS Agency data Agency data Agency data Agency data Jail data ER data Hospital data

Strategy 2

Strategy 2 - Improve Quality of Care				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
2a – Caseload Reduction for Mental Health Target Pop: 1) Contracted MH agencies and MH Case Managers 2) Consumers receiving outpatient services through KCRSN	1. Develop strategy for addressing definition of case manager, calculation of caseload size and severity of case mix. 2. Increase payment rates for MH providers in order to increase number of case managers/supervisors and reduce caseloads. Specific goals for # of additions by type of staff will be set in above strategy.	Short-term measures: 1. Develop and implement strategy that addresses variability of caseload size and severity of case mix within and among agencies. 2. Increase # MH case managers and supervisors as specified in above strategy. 3. Decrease caseload size for MH case managers by percent determined in above strategy. 4. Increase # of service hours for those served 5. Increase # of services provided within 7 days of hospitalization/jail discharge Long-term measures: 6. Reduce # of jail bookings and days for adults served 7. Reduce JJ involvement for youth served 8. Reduce # of inpatient admissions and days for those served 9. Reduce # of emergency room admissions for those served 10. Reduce # of out of home placements for children 11. Increase case manager job satisfaction 12. Decrease case manager turnover rates	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome	MHCADSD Agency data Agency data MIS MIS Jail data JJ data Hospital data ER data DCFS data Survey Agency data
2b - Employment services for individuals with mental illness and chemical dependency Target Pop: Individuals receiving public mental health	1. Provide 23 vocational specialists (each provider serves ~40 cts/yr) to provider fidelity-based supported employment (trial work experience, job placement, on-the-job retention services) 2. Also public assistance benefits	Short-term measures: 1. Provide employment services to 920 cts/yr 2. Change in number of enrolled MH clients who become employed 3. Number/rate of individuals who become	1. Output 2. Outcome 3. Outcome	MIS MIS MIS

Strategy 2 - Improve Quality of Care				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
and/or chemical dependency services who need supported employment to obtain competitive employment	counseling 3. Provide training in vocational services to MH providers first, then CD providers	employed who are retained in employment for 90 days 4. Decreased reliance on public assistance Long-term measures: 5. Increase housing stability (retention)	4. Outcome 5. Outcome	DSHS MIS

Strategy 3

Strategy 3 – Increase Access to Housing				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
3a – Supportive Services for Housing Projects Target Pop: Persons in the public MH & CD treatment system who are homeless; have not been able to attain housing stability; are exiting jails and hospitals; or have been seen at a crisis diversion facility.	1. Expand on-site supportive housing services by adding housing support specialists to serve an estimated 400 individuals in addition to current capacity.	Short-term measures: 1. Increase # individuals served by about 400 2. Increase # housing providers accepting this target population Long-term measures: 3. Increase housing stability of those served 4. Increase treatment participation of those served 5. Reduce # of jail bookings and days for those served 6. Reduce # of inpatient admissions and days for those served 7. Reduce # of emergency room admissions for those served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Agency data Agency data MIS MIS Jail data Hospital data ER data

Strategy 4

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
4a –Services to parents participating in substance abuse outpatient treatment programs Target Pop: Custodial parents participating in outpatient substance abuse treatment	1. Implement two evidence based programs to help parents in recovery become more effective parents and reduce the risk that their children will abuse drugs or alcohol. (Serve 400 parents per year)	Short-term measures: 1. Serve 400 parents per year 2. Increase parent services at outpatient SA treatment programs 3. Improve parenting skills of those served 4. Increased family communication 5. Increased positive family structure Long-term measures: 6. Reduce substance abuse by children of parents served	 1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome	 Agency data Agency data TBD from contract with service provider “ “ TBD
4b – Prevention Services to Children of Substance Abusers Target Pop: Children of substance abusers and their parents/guardians/kinship caregivers.	1. Implement evidence-based educational/support programming for children of substance abusers to reduce risk of future substance abuse and increase protective factors. (Serve 400 per year)	Short-term measures: 1. Contract with service provider for evidence-based programs 2. # children served (goal 400 per year) 3. # activities provided by King County region 4. Improve individual and family functioning of those served 5. Improve school attendance of children served 6. Improve school performance of children served 7. Improve health outcomes of children served Long-term measures: 8. Reduce JJ involvement of children served 9. Reduce substance abuse of children served	 1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	 Agency data Agency data Agency data TBD from contract with service provider TBD (e.g., School data) TBD (e.g., School data) TBD JJ data TBD
4c - School district based mental health and substance abuse services Target Pop: Children and youth enrolled in King County	1. Fund 19 competitive grant awards to school based health programs in partnership with mental health, chemical dependency and youth service providers to provide a continuum of mental health and substance abuse services in schools	Short-term measures: 1. 19 grants are funded in school districts across King County 2. Increase # of youth receiving MH and/or CD services through school-based programs	1. Output 2. Outcome	MHCADSD Agency/School data

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
schools who are at risk for future school drop out		3. Improved school performance for youth served 4. Improved school attendance for youth served 5. Decrease in truancy petitions filed for youth served Long-term measures: 6. Decrease in JJ involvement for youth served 7. Decrease use of emergency medical system and psychiatric hospitalization for youth served	3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	School data School data School/JJ data JJ data ER/Hospital data
4d - School based suicide prevention Target Pop: King County school students, including alternative schools students, age 12-19 years, school staff and administrators, and the students' parents and guardians	1. Fund staff to provide suicide awareness and prevention training to children, administrators, teachers and parents to include: • Suicide Awareness Presentations for Students • Teacher Training • Parent Education • Developing school policies and procedures	Short-term measures: 1. 3 FTE are hired to provide suicide awareness and prevention training to children, administrators, teachers, and parents 2. # of suicide awareness trainings for students 3. # of teacher trainings 4. # of parent education trainings 5. # of school policies and procedures addressing appropriate steps for intervening with students who are at-risk for suicide 6. Increased awareness of the warning signs and symptoms of suicide for students, teachers, and parents 7. # of at-risk youth referred and linked to treatment	1. Output 2. Output 3. Output 4. Output 5. Output 6. Outcome 7. Outcome	Agency data Agency data Agency data Agency data Agency data TBD (e.g., pre/post survey) Agency data

Strategy 4 – Invest in Prevention and Early Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
		Long-term measures: 8. Decrease # of suicides and suicide attempts of youth served	8. Outcome	TBD

Strategy 5

Strategy 5 - Expand Assessments for Youth in the Juvenile Justice System				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
5a - Increase capacity for social and psychological assessments for juvenile justice youth (including youth involved with the Becca truancy process) Target Pop: Youth age 12 years or older who have become involved with the juvenile justice system.	1. Hire administrative and clinical staff to expand the capacity for social and psychological assessments, substance abuse assessment and other specialty evaluations (i.e., psychiatric, forensic, neurological, etc.) for juvenile justice involved youth	Short-term measures: 1. 1 FTE CDP hired to provide an additional 280 GAIN assessments per year 2. 1 FTE MH Liaison hired to provide an additional 200 MH assessments per year 3. Increase # of youth involved in JJ completing a GAIN assessment 4. # of youth involved in JJ completing a MH assessment 5. # of JJ involved youth linked to CD treatment 6. # of JJ involved youth linked to MH treatment 7. # of JJ involved youth receiving a psychiatric evaluation Long-term measures: 8. Reduction in recidivism rates for youth linked to CD and/or MH treatment	1. Output 2. Output 3. Output 4. Output 5. Outcome 6. Outcome 7. Output 8. Outcome	MHCADSD MHCADSD MHCADSD Agency data Agency data/TARGET data Agency data/MIS TBD – JJ or Agency data JJ data

Strategy 6

Strategy 6 - Expand Wraparound Services for Youth				
Sub-Strategy	**Intervention(s)/Objectives - including target**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
6a - Wraparound family, professional and natural support services for emotionally disturbed youth Target Pop: Emotionally and/or behaviorally disturbed children and/or youth (up to the age of 21) and their families who receive services from two or more of the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, developmental disabilities and/or special education programs, and who would benefit from high fidelity wraparound	1. 40 additional wraparound facilitators and 5 wraparound supervisors/coaches 2. Provide wraparound orientation to community on a quarterly basis 3. Flexible funding available to individual child and family teams	Short-term measures: 1. Provide wraparound to an additional 920 youth and families per year 2. # of trainings provided annually 3. Improved school performance for youth served 4. Reduced drug and alcohol use for youth served 5. Improvement in functioning at home, school and community for youth served 6. Increased community connections and utilization of natural supports by youth and families 7. Maintain stability of current placement for youth served Long-term measures: 8. Reduced juvenile justice involvement for youth served 9. Improved high school graduation rates for youth served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	MIS MHCADSD School data/survey TBD – survey TBD – survey TBD - survey Agency/DCFS data JJ data TBD

Strategy 7

Strategy 7 - Expand Services for Youth in Crisis				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
7a - Reception centers for youth in crisis Target Pop: Youth who have been arrested, are ineligible for detention, and do not have a readily available parent or guardian.	1. Conduct a comprehensive needs assessment to determine most appropriate interventions to provide police officers with more options when interacting with runaways and minor youth who may be experiencing mental health and/or substance abuse problems. 2. Create a coordinated response/entry system for the target population that allows law enforcement and other first responders to link youth to the appropriate services in a timely manner. 3. Develop an enhanced array of services for the target population as deemed appropriate by the needs assessment.	Short-term measures: 1. Complete a needs assessment in conjunction with Strategy 7b to determine appropriate strategies to meet goals 2. Implementation of strategies identified through needs assessment Long-term measures: 3. Reduction in admissions to juvenile detention for youth served 4. Reduction in admissions to hospital emergency rooms and inpatient units for youth served 5. Decrease homelessness for youth served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome	MHCADSD MHCADSD JJ data ER/Hospital data TBD
7b - Expanded crisis outreach and stabilization for children, youth, and families Target Pop: 1) Children and youth age 3-17 who are currently in King County and who are experiencing a mental health crisis. This includes children, youth, and families where the functioning of the child and/or 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. 2) Children and youth being	1. Expand current CCORS program to provide crisis outreach and stabilization to youth involved in the JJ system and/or at risk for placement in juvenile detention due to emotional and behavioral problems.	Short-term measures: 1. Conduct needs assessment, in conjunction with strategy 7a to determine additional capacity and resource needed to develop the full continuum of crisis options within the CCORS program 2. Increased # of youth in King County receiving crisis stabilization within the home environment 3. Maintain current living placement for youth served Long-term measures: 4. Reduced admissions to hospital emergency rooms and inpatient psychiatric units 5. Reduced admissions and detention days	1. Output 2. Output 3. Outcome 4. Outcome	MHCADSD MIS Agency data Hospital data/MIS

Strategy 7 - Expand Services for Youth in Crisis				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement		in juvenile detention facilities for youth served 6. Reduced requests for placement in child welfare system for youth served	5. Outcome 6. Outcome	JJ data Agency data/DCFS data

Strategy 8

Strategy 8 - Expand Family Treatment Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
8a - Expand family treatment court services and supports to parents Target Pop: Parents in the child welfare system who are identified as being chemically dependent and who have had their child(ren) removed due to their substance use	1. Sustain and expand capacity of the Family Treatment Court model	Short-term measures: 1. Expand family treatment court capacity to serve a total of 90 youth and families per year	1. Output	Superior Court
		2. Eligibility/enrollment completed quickly	2. Output	TBD
		3. Parents are enrolled with appropriate CD services	3. Output	TARGET data
		4. Parents served are compliant with and complete treatment	4. Outcome	TARGET data
		5. Parents/children receive needed services	5. Outcome	TBD
		6. Parents compliant with court orders	6. Outcome	Superior Court
		7. Decreased placement disruptions	7. Outcome	Superior Court/DCFS
		8. Earlier determination of alternative placement options	8. Outcome	TBD
		9. Increase in after care plan/connection to services	9. Outcome	TBD
		10. Decreased substance use of parents served	10. Outcome	TBD
		Long-term measures: 11. Increased family reunification rates	11. Outcome	DCFS data
		12. Decrease subsequent out-of-home placements and/or CPS involvement	12. Outcome	DCFS data
		13. Reduction in juvenile justice system involvement for children served through FTC	13. Outcome	JJ data
		14. Reduction in substance abuse for		

Strategy 8 - Expand Family Treatment Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
		children served through FTC	14. Outcome	TARGET data/Survey

Strategy 9

Strategy 9 - Expand Juvenile Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
9a - Expand juvenile drug court treatment Target Pop: Youth involved in the JJ system who are identified as having substance abuse issues or are diagnosed chemically dependent	1. Maintain and expand capacity of the Juvenile Drug Court (JDC) model	Short-term measures: 1. Expand juvenile drug court capacity to serve an additional 36 chemically dependent youth per year for a total of 72 youth served annually 2. Increase # of youth involved in JDC linked to drug/alcohol treatment 3. Increase the # of youth involved in JDC completing drug/alcohol treatment 4. Reduce days spent in detention for youth involved in drug court Long-term measures: 5. Reduce juvenile recidivism rates for youth completing juvenile drug court 6. Reduce substance abuse/dependency for youth involved in drug court	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome	Superior Court Superior Court or TARGET data TARGET data JJ data JJ data TBD

Strategy 10

Strategy 10 - Pre-booking Diversion				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
10a - Crisis intervention training program for King County Sheriff, police, jail staff, and other first responders Target Pop: KC Sheriff, police, firefighters, emergency medical technicians, ambulance drivers, jail staff, other first responders *and* clients	1. Crisis intervention training (CIT) for KC Sheriff, police, firefighters, emergency medical technicians, ambulance drivers, jail staff, and other first responders 2. Provide 40-hr CIT training to 480 police and other first responders per year 3. Provide one-day CIT training to 1,200 other officers and other first responders	Short-term measures: 1. Hire 1 FTE educator/consultant II or III 2. Hire 1 FTE administrative specialist II 3. Provide 40-hr CIT training to 480 police and other first responders per year 4. Provide one-day CIT training to 1,200 other officers and other first responders per year 5. # of KC Sheriff, police, jail staff, and other first responders given training 6. Self-Report of training effectiveness/ skills learned Long-term measures: 7. Increased use of diversion options for those served 8. Reduce # of jail bookings and days for those served 9. Reduce # of ER admissions for those served 10. Reduce # of inpatient admissions and days for those served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome	Agency data Agency data Agency data Agency data Agency data Training evaluations TBD Jail data ER data Hospital data
10b -Adult crisis diversion center, respite beds and mobile behavioral health crisis team Target Pop: 1) Adults in crisis in the community who might otherwise be arrested for minor crimes and taken to jail or to a hospital emergency department. 2) Individuals who have been seen in emergency	1. Increase number of respite beds 2. Create a mobile crisis team of MH and CD specialists to evaluate, refer and link clients to services 3. Create a crisis diversion center for police and crisis responders	1. Serve ~3,600 adults/year (xx # depends on when different components implemented) Short-term measures: 2. Successfully link xx% of those seen by 10b services to MH and/or CD services (benchmark to be determined during contracting) Long-term measures: 3. Reduce # of ER admissions for those served 4. Reduce # of inpatient admissions and	1. Output 2. Outcome 3. Outcome	MIS MIS and TARGET data ER data

Strategy 10 - Pre-booking Diversion				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
departments or at jail booking and who are ready for discharge but still in crisis and in need of services. Target population will be refined during the planning process.		days for those served 5. Reduce # of jail bookings and days for those served	4. Outcome 5. Outcome	MIS Jail data

Strategy 11

Strategy 11 - Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
11a - Increase capacity of jail liaison program Target Pop: King County Work Release (WER) inmates who are residents of King County or likely to be homeless within King County upon release from custody, and who are assessed as needing mental health services, chemical dependency treatment, other human services, or housing upon release.	1. One additional jail liaison to handle increased mental health courts caseload as designed under MIDD. 2. Liaisons linked inmates within 10-45 from release to community-based MH, CD, medical services and housing.	1. Serve 360 additional clients via liaison Short-term measures: 2. Assist target population in applying for DSHS benefits when they are within 45 days of discharge 3. Refer veterans to Veterans Reintegration Services. 4. Successfully link xx% of those seen by liaison to MH and/or CD services (benchmark to be determined through contracting) 5. Improve rates of target population being placed in housing (temporary or permanent) upon discharge Long-term outcomes: 6. Reduce # of jail bookings and days for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome	CJ liaison Excel reports CJ liaison Excel reports TBD MIS and TARGET data TBD MIS or jail data
11b - Increase services available for new or existing mental health court programs Target Pop: Adult misdemeanants with serious mental illness who opt-in to the mental health court and those who are unable to opt-in because of the lack of legal competency. Access to participate will also be developed for individuals in court jurisdictions in all parts of King County.	1. Add court liaison/monitor and peer support specialist to existing mental health court and/or develop new municipal mental health courts 2. Other components may include increases in dedicated service capacity for mental health and co-occurring disorder treatment, housing, and access to community treatment providers	1. Serve 250 additional clients/year (over 300/yr current capacity) Short-term measures: 2. Successfully engage 90% of those seen to MH and/or CD services Long-term outcomes: 3. Reduced # of jail bookings and days for those served	1. Output 2. Outcome 3. Outcome	Data from courts - TBD MIS and TARGET data combined with data from courts - TBD MIS or jail data

Strategy 12

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
12a - Increase jail re-entry program capacity	1. Add four re-entry case managers	Short-term measures: 1. Serve 1,440 additional clients served (over current capacity of 900/yr) 2. Successfully link xx% of those seen by liaison to MH and/or CD services Long-term measures: 3. Decrease jail bookings and days for those served by liaison 4. House xx% of homeless individuals served	1. Output 2. Outcome 3. Outcome 4. Outcome	CCAP Excel reports MIS and/or TARGET data MIS or jail data CCAP Excel reports
12b - Hospital re-entry respite beds Target Pop: Homeless persons with mental illness and/or chemical dependency who require short-term medical care upon discharge from hospitals	1. Create Hospital re-entry respite beds 2. Serve 350-500 cts/yr	Short-term measures: 1. xx beds created for 350-500 cts/yr 2. Reduce # of ER admissions for those served 3. Reduce # of inpatient admissions and days for those served 4. Reduce hospitalization costs for those served Long-term measures: 5. Reduce # of jail bookings and days for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	MHCADSD ER data Hospital data Hospital data Jail data
12c - Increase capacity for Harborview's Psychiatric Emergency Services (PES) to link individuals to community-based services upon discharge from the emergency room Target pop: Adults who are frequent users of the Harborview Medical Center's PES	1. Hire 2 MH/CD staff and 1 program assistant 2. Build Harborview's capacity to link individuals to community-based services upon discharge from the ER	Short-term measures: 1. Hire 2 MH/CD staff and 1 program assistant 2. # of referrals 3. # of linkages made to services Long-term measures: 4. Reduce # of ER admissions for those served 5. Reduce # of inpatient admissions and days for those served 6. Reduce # of jail bookings and days for those served	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome	Agency data Agency data Agency data ER data Hospital data Jail data
12d - Urinalysis supervision for	1. Hire urinalysis technician(s) to provide	Short-term measures:		

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
CCAP clients Target Pop: CCAP clients who are mandated by Superior Court or District Court to report to CCAP and participate in treatment	on-site analyses for both male and female clients of CCAP. Urinalyses will be done for those who are ordered by the court to have one or more urine samples taken and analyzed each month.	1. New tech provide 2,700 UAs/yr – no change in current capacity 2. Increase "efficiency" in CCAP operations - decreased CCAP staff time dedicated to this service 3. Assure gender-specific staff is available for the collection of urine samples.	1. Output 2. Output 3. Output	TBD (e.g., CCAP reports) TBD (e.g., CCAP reports) TBD (e.g., CCAP reports)

Strategy 13

Strategy 13 – Domestic Violence Prevention/Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
13a – Domestic Violence (DV)/Mental Health Services and System Coordination Target Pop: (1) DV survivors who are experiencing mental health and substance abuse concerns but have been unable to access mental health or substance abuse services due to barriers (2) Providers at sexual assault, mental health, substance abuse, and DV agencies who work with DV survivors and participate in the coordination and cross training of programs	1. 3 mental health professionals (MHPs) will be added to community-based DV agencies 2. A .5 MHP will be housed at an agency serving immigrant and refugee survivors of DV. 3. A .5 Systems Coordinator/Trainer will coordinate ongoing cross training, policy development, and consultation on DV issues between MH, CD, and DV county agencies 4. MHPs will provide assessment and MH treatment to DV survivors. Treatment includes brief therapy and MH support through group and/or individual sessions. 5. MHPs will provide assessment and referrals to community MH and CD agencies for those DV survivors who need more intensive services. 6. MHPs will offer consultation to DV advocacy staff and staff of community MH or CD agencies.	Short-term measures: 1. 3 MHPs added to community-based DV agencies 2. .5 FTE MHP housed at culturally-specific provider of sexual assault advocacy services 3. .5 Systems Coordinator/Trainer hired 4. Interpreters hired 5. 175-200 clients served per year 6. 200 counselors/advocates trained per year 7. Access to MH/CD treatment services for DV survivors 8. Culturally relevant MH services provided to DV survivors from immigrant and refugee communities in their own language 9. Consistent screening for DV among participating MH and CD agencies 10. Consistent screening for MH and CD needs 11. Increased referrals to DV providers 12. Development of new policies in DV agencies that are responsive to survivors' MH concerns 13. Increased coordination and collaboration between MH, substance abuse, DV, and sexual assault service providers Long-term measures: 14. Decreased trauma symptoms and depression among DV survivors served 15. Increased resiliency and coping skills among DV survivors served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output 8. Output 9. Output 10. Output 11. Output 12. Output 13. Output 14. Outcome 15. Outcome	Agency data Agency data Agency data Agency data MIS MHCADSD MIS Agency data Agency data Agency data Agency data TBD TBD TBD (e.g., survey) TBD (e.g., survey)
13b – Provide early intervention for children experiencing DV and for their	1. A DV response team will provide MH and advocacy services to children ages 0-12 who have experienced DV.	Short-term measures: 1. 1 lead clinician will be added at Sound Mental Health	1. Output	Agency data

Strategy 13 – Domestic Violence Prevention/Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
supportive parent Target Pop: Children who have experienced DV and their supportive parents	2. A DV response team will provide support, advocacy, and parent education to the non-violent parent. 3. Children's therapy will include trauma focused cognitive behavioral-therapy as well as Kids Club, a group therapy intervention for children experiencing DV. 4. Families will be referred through the DV Protection Order Advocacy program as well as through partner agencies (goal is to serve approx 85 families with 150 children)	2. 2 FTE DV Advocates will be added at the subcontractor 3. DV services to approx 85 families with 150 children. Long-term measures: 4. Decrease children's trauma symptoms. 5. Reduce children's externalizing behaviors. 6. Reduce children's internalizing behaviors. 7. Increase protective/resiliency factors available to children and their supportive parents. 8. Reduce children's negative beliefs related to DV, including that the violence is their fault, and/or that violence is an appropriate way to solve problems. 9. Improve social and relationship skills so that children may access needed social supports in the future. 10. Support and strengthen the relationship between children and their supportive parents. 11. Increase supportive parents' understanding of the impact of DV on their children and ways to help.	2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome	Agency data Agency data TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey)

Strategy 14

Strategy 14 – Expand Access to Mental Health Services for Survivors of Sexual Assault				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
14a – Sexual Assault Services Target Pop: (1) Adult, youth, and child survivors of sexual assault who are experiencing mental health and substance abuse concerns (2) Providers at sexual assault, mental health, substance abuse, and DV agencies who work with sexual assault survivors and participate in the coordination and cross training of programs	1. Expand the capacity of Community Sexual Assault programs (CSAPs) and culturally specific providers of sexual assault advocacy services to provide evidenced-based MH services. 2. Provide services to women and children from immigrant and refugee communities by housing a MH provider specializing in evidenced-based trauma-focused therapy at an agency serving these communities.	Short-term measures: 1. Hire 4 FTEs to work at CSAP provider agencies. 2. Hire .5 FTE as a MH provider to be housed at a culturally-specific provider of sexual assault services. 3. Hire .5 FTE Systems Coordinator/Trainer 4. Interpreters hired 5. Provide therapy and case management services to 400 adult, youth, and child survivors. 6. Increased access to services for adult, youth, and child survivors. 7. Increased coordination between CSAPs, culturally specific providers of sexual assault advocacy services, public MH, substance abuse, and DV service providers. 8. Culturally relevant MH services provided to sexual assault survivors from immigrant and refugee communities in their own language Long-term measures: 9. Reduction in trauma symptoms for those adult, youth, and child survivors receiving services. 10. Increased resiliency and coping skills among sexual assault survivors served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output 8. Output 9. Outcome 10. Outcome	Agency data Agency data Agency data Agency data MIS Service records TBD (e.g., qualitative data) Agency data TBD (e.g., survey) TBD (e.g., survey)

Strategy 15

Strategy 15 - Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
15a - Increase services available to drug court clients Target pop: King County Adult Drug Court participants	Provide to Drug Court clients: 1. Employment services per strategy 2b 2. Access to CHOICES program for individuals with learning or attention disabilities 3. Expanded evidence-based treatment (e.g., Wraparound, MST) for ages 18-24 (1.0 FTE) 4. Expanded services for women with COD and/or trauma (1.0 FTE) and funding for suboxone for this population 5. Housing case management (1.5 FTE)	Short-term measures: 1. Serve 450 clients 2. Reduced substance use for those served Long-term measures 3. Decrease jail bookings and days for those served	1. Output 2. Outcome 3. Outcome	Drug court TARGET data Jail data

Strategy 16

Strategy 16 – Increase Housing Available for Individuals with Mental Illness and/or Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
16a – Housing Development Target Pop: Individuals with mental illness and/or chemical dependency who are homeless or being discharged from hospitals, jails, prisons, crisis diversion facilities, or residential chemical dependency treatment	1. Provide additional funds to supplement existing fund sources, which will allow new housing projects to complete their capital budgets and begin construction sooner than would otherwise be possible.	Short-term measures: 1. # of residential units created 2. # of rental subsidies disbursed Long-term measures: 3. Reduce # of jail bookings and days for those served 4. Reduce # of emergency room admissions for those served 5. Reduce # of inpatient admissions and days for those served	 1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome	 MHCADSD MHCADSD Jail data ER data Hospital data

Appendix V: Additional Information on Logic Models

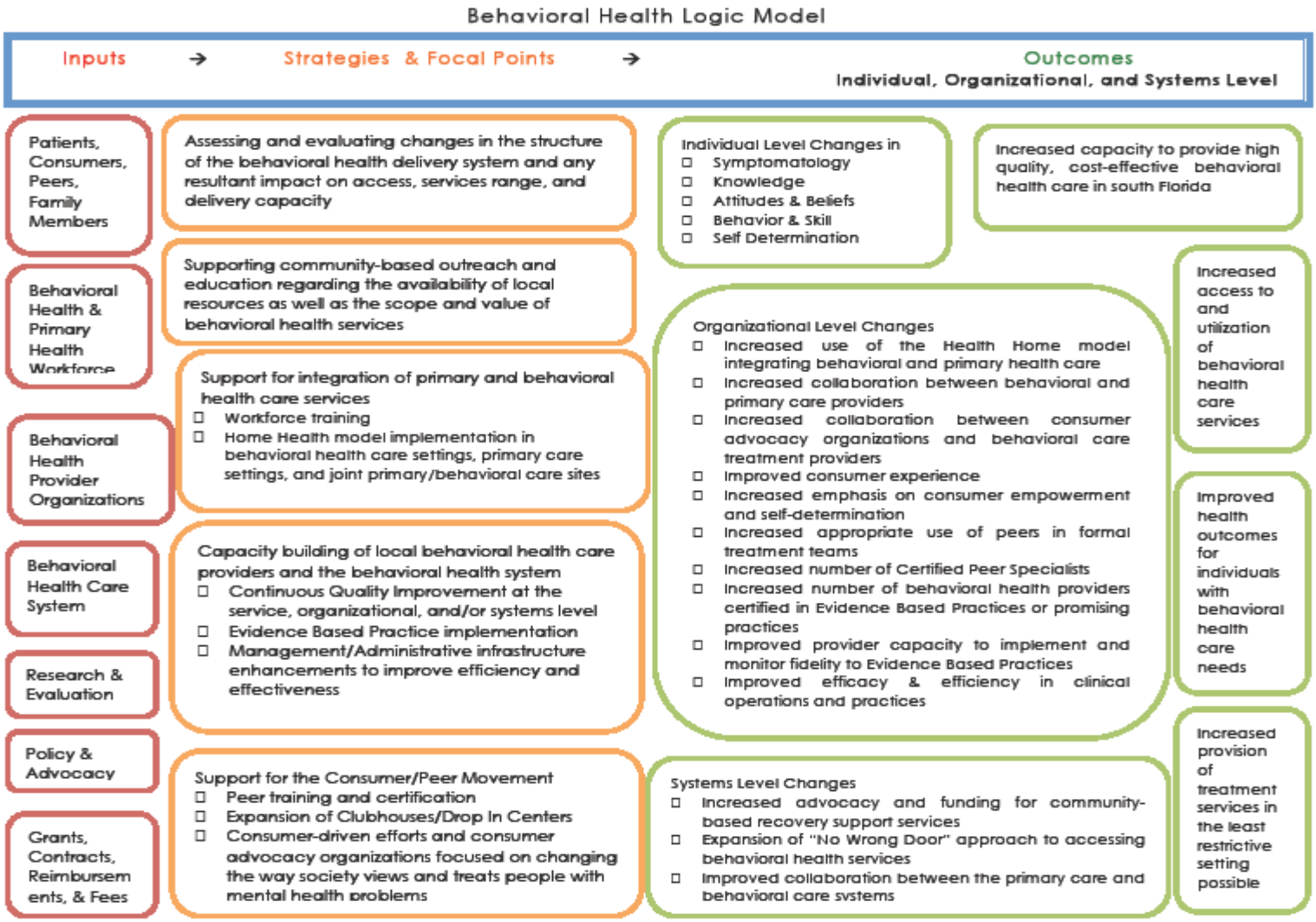
A logic model, which is commonly used as an evaluation framework, shows inputs (resources needed and people involved), program activities, outputs (how much of an activity was delivered) and outcomes (what changed). While many good logic models exist that show a flow from inputs to outcomes (see Figure 4 on next page), the best logic models ensure that each element is measurable and that there is evidence to believe there is a relationship between the elements.

A logic model is the foundation for an actionable plan that includes strategies with clearly defined outcomes and explicit steps for addressing the problems that were identified. Logic models describe the sequence of activities that is expected to bring about change and how the activities are linked to the desired results. The process of thinking through change includes:

1) Identifying the problem(s): What is the community need?
2) Naming the desired results: What is the vision for the future?
3) Developing the strategies for achieving desired results: How can the vision be achieved?

Having an actionable plan is essential for successful program implementation, continuous improvement activities, a useful evaluation, and, ultimately for accomplishing the desired results.

Figure 4: Centers for Disease Control Behavioral Health Logic Model



Appendix VI: Social Service Projects with Random Assignment Evaluations

Randomized field experiments are the strongest research design for measuring the causal impact of an intervention.[52] Conducting an evaluation with random assignment in a non-research setting can be challenging for a number of reasons, including ethical concerns (e.g., do services need to be withheld for some participants?), cost considerations (e.g., is money available to conduct such an evaluation?), or implementation challenges (e.g., will randomized groups 'contaminate' each other?).

However, tight budgets and the desire to allocate public resources equitably have increased the need to know whether public-sector programs have their intended impact. As a result, random assignment is being used more often in evaluations of public-sector projects. Below are examples of projects that incorporated random assignment into their evaluation design. The examples are from the Pay for Success model, which leverages private funding up-front to ensure jurisdictions only pay for services when specified outcomes are met. Project details are available from the Nonprofit Finance Fund.[53]

- Connecticut Family Stability Pay for Success Project

  Led by the Connecticut Department of Children and Families and its partners, this project aims to promote family stability and reduce parental substance use for 500 families. The University of Connecticut Health Center leads the evaluation using a randomized controlled trial approach, which is described in the program documentation as "the gold standard for a rigorous evaluation."[54]

- South Carolina Nurse-Family Partnership Pay for Success Project

  Focused on improving health outcomes for mothers and children living in poverty, this project extends the Nurse-Family Partnership services to 3,200 low-income mothers in the state. The Massachusetts Institute of Technology J-PAL North America leads the evaluation using a randomized controlled trial to determine whether the project meets its identified goals.[55]

- New York State Recidivism and Workforce Development Project

  This project focuses on reducing recidivism and increasing employment for 2,000 formerly incarcerated individuals in New York City and Rochester, New York. The evaluation for this project also uses a randomized controlled trial.[56]

- The Denver Social Impact Bond Program

  This project will provide housing and supportive case management services to at least 250 homeless individuals who are frequent users of the city's emergency services, such as police, jail, the courts, and emergency rooms. Eligible individuals will be randomly assigned to one of two groups – one group receives supportive housing as part of the initiative and another group "usual care" services.[57]

---

[52] List JA. Why economists should conduct field experiments and 14 tips for pulling one off. Journal of Economic Perspectives.2011;25(3):3-16

[53] Nonprofit Finance Fund, http://www.payforsuccess.org/provider-toolkit/pfs-projects

[54] Connecticut Family Stability Pay for Success Project Fact Sheet, http://socialfinance.org/content/uploads/2016/03/CT-Family-Stability-PFS_Fact-Sheet_vFINAL.pdf

[55] Fact Sheet: South Carolina Nurse-Family Partnership Pay for Success Project, http://socialfinance.org/content/uploads/2016/02/021616-SC-NFP-PFS-Fact-Sheet_vFINAL.pdf

[56] Investing in What Works: "Pay for Success" in New York State, http://www.payforsuccess.org/sites/default/files/pfsfactsheet_0314.pdf

[57] http://www.payforsuccess.org/sites/default/files/Denver%20PFS%20Contract_201523939_20160205_172505.pdf

Appendix B

DRAFT MIDD II FRAMEWORK Revised *4.7.16* DRAFT		
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.		
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 II Strategy Areas	**SAMPLE[i] MIDD II 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	**How much? Service capacity measures** • Expanded workforce including increased provider retention • Decreased provider caseloads • Increased culturally diverse workforce	

Strengthen the behavioral health system to become more accessible and deliver on outcomes	• Increased capacity for outreach and engagement • Increased workforce cross-trained in both mental health and substance abuse treatment methods. **<u>How well?</u> 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. **<u>Is anyone better off?</u> Individual outcome measures** • Improved client experience of care

Please note that the contents of this document are subject to change and modification.

<u>Adopted MIDD I Policy Goals:</u>

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.

Adult Jail Diversion Sequential Intercept Model

Current Interventions

Intercept 1
1. Jail high utilizer program

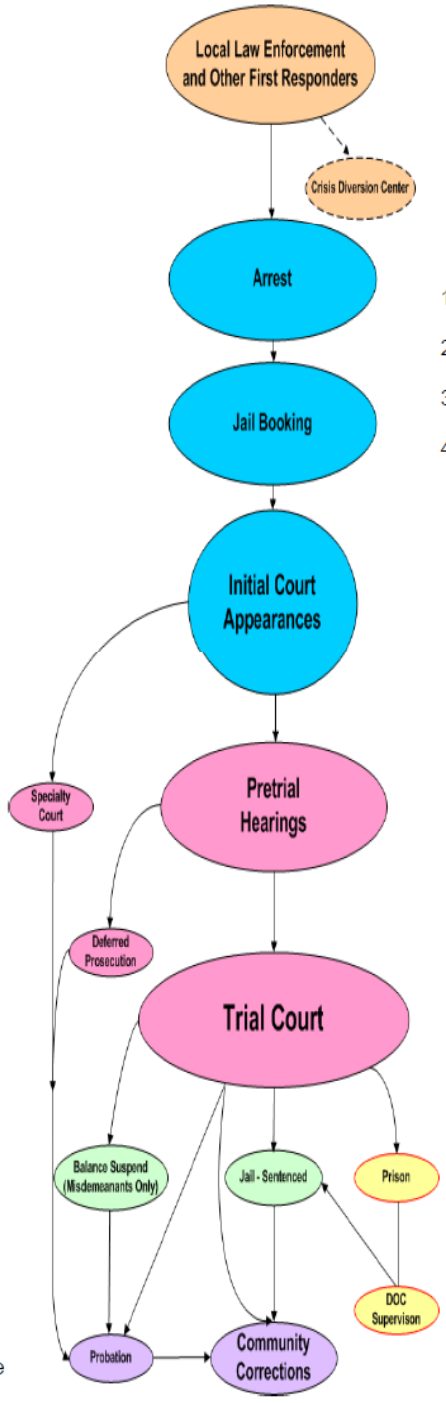
Intercept 2
1. Incoming Referrals to CJ Liaisons from:
   - ✓ Family members
   - ✓ DOC community corrections officers
   - ✓ Jail Health psychiatric evaluation specialists
   - ✓ Inmate requests
   - ✓ Public defenders and public defense social workers
   - ✓ Probation officers
2. Assessments requested by Intake Services

Intercept 3
1. Initial Referrals from CJ Liaisons:
   - ✓ Reconnect with existing mental health case manager
   - ✓ Link to COD treatment
   - ✓ Link to DSHS
   - ✓ Refer to VA
   - ✓ Link to ADATSA for CD treatment
2. Refer to Mental Health Court
   - ✓ Link to Housing Voucher and Case Mgmt Program
   - ✓ Link to COD treatment

Intercept 4
1. Ongoing Referrals from CJ Liaisons:
   - ✓ Link to Reentry Case Management Program
   - ✓ Rental assistance

Intercept 5
1. Forensic Programming at Community Corrections:
   - ✓ Screen and assess CCAP participants for appropriate services
   - ✓ On-site CD treatment
   - ✓ On-site COD treatment
   - ✓ On-site educational classes

Ultimate Intercept
New and enhanced prevention and community treatment programs will prevent many adults from entering the criminal justice system



New/Enhanced Interventions

Intercept 1
1. Crisis intervention training
2. Establish Crisis Diversion Center
3. Respite beds
4. Mobile crisis team

Intercept 2
1. Release prior to filing when community treatment available
2. Increase deferred prosecution cases
3. Increase referrals from Intake Services
4. Stay competency process to allow for community treatment

Intercept 3
1. Increase CJ Liaison staff in the jail in order to:
   - ✓ Reconnect more inmates to community services
   - ✓ Refer more veterans and their dependents to VA for treatment and housing
   - ✓ Increase felony drop down referrals to MH Court
2. Increase program services for existing and new MH courts

Intercept 4
1. Increase Reentry Case Management Program staff in order to assist more offender-clients in connecting to treatment and housing
2. Reduce MH caseloads

Intercept 5
1. Urinalysis testing supervision at Community Corrections
2. Increased access to community services for non-Medicaid clients
3. Housing supportive services
4. Employment services

Acronyms:
ADATSA = Alcoholism and Drug Addiction Treatment and Support Act
CCAP = Community Center for Alternative Programs (day reporting center)
CD = **Chemical Dependency**
CJ = Criminal Justice
COD = Co-occurring Disorders
DOC = State Dept. of Corrections
DSHS = State Dept. of Social and Health Services
MH = **Mental Health**
VA = U.S. or State Dept. of Veterans Affairs

Prepared by King County Department of Community and Human Services

Youth Detention Diversion Model

Current Interventions

New/Enhanced Interventions

Ultimate Intercept

More youth are connected to community resources and services that are outside of the justice center and youth do not have to enter the juvenile justice system to get those services

Prevention/Early Intervention
1. SA prevention programs
2. Skill building for children, youth & families

EBP MH/SA Treatment
1. Limited wraparound for seriously emotionally disturbed youth
2. Parent networks

BECCA
1. Project TEAM
2. Functional Family Therapy

Initial Contact
1. CCORS

Processing
1. WSRAT Prescreen
2. Global Assessment of Individual Needs
3. Diversion/Community Boards
4. Drug Court
5. Treatment Court
6. MH/CD liaison evaluation and linkage
7. Advocacy teams

Probation
1. Full risk assessment
2. MH liaison evaluation and linkage
3. Multi-Systemic Therapy
4. Functional Family Therapy
5. Aggression Replacement Therapy
6. Project TEAM

Prevention/Early Intervention
1. School based MH
2. Suicide prevention
3. Fully implement and expand Family Treatment Court
4. Comprehensive SA treatment for parents
5. SA prevention programs

EBP MH/SA Treatment
1. Increased access to community MH and SA treatment for non-Medicaid youth
2. Case load reductions for MH providers
3. Increased capacity for wraparound for serious emotionally disturbed youth
4. Expanded parent/youth peer support

BECCA
1. MH/SA screening & assessment
2. Increased capacity for wraparound
3. Increased access to parent/youth partners
4. Increased access to EBPs

Initial Contact
1. Youth Reception Center
2. Expansion of CCORS program
3. Crisis Intervention Training for first responders
4. Increased access to wraparound
5. Increased access to parent/youth partners

Processing
1. Increased assessments of juvenile justice clients
2. Expand Juvenile Drug Court
3. Increased access to wraparound
4. Increased access to parent/youth partners
5. Fully implement and expand Family Treatment Court

Probation
1. Increased access to MH & SA services for non-Medicaid clients
2. Increased capacity for wraparound
3. Increased access to parent/youth partners

Acronyms

CCORS: Children Crisis Outreach Response System
MH: Mental Health
EBP: Evidence Based Practice
WSRAT: WA State Risk Assessment Tool
SA: Substance Abuse

Prepared by King County Department of Community and Human Services

14712

Oversight Committee Membership

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

Merril Cousin, Executive Director, King County Coalition Against Domestic Violence (Co-Chair)
Representing: Domestic violence prevention services

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

Rhonda Berry, Chief of Operations
Representing: King County Executive

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mark Putnam, Director, Committee to End Homelessness in King County
Representing: Committee to End Homelessness

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

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

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

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

Dave Upthegrove, Councilmember, Metropolitan King County Council
Representing: King County Council

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

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

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

Oversight Committee Staff:
Bryan Baird , Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)
Kelli Carroll, Strategic Advisor, MHCADSD
Andrea LaFazia-Geraghty, MHCADSD

As of 9/30/2015

14712

King County

Mental Health, Chemical Abuse and Dependency Services

Mental Illness and Drug Dependency Action Plan

Part 3: Evaluation Plan

VERSION 2

REVISED September 2, 2008

14712

King County

Mental Illness and Drug Dependency Action Plan

Evaluation Targets Addendum
September 2, 2008

King County

Mental Illness and Drug Dependency Action Plan

Proposed Targets for Key MIDD Policy Goals

At the request of the Operating Budget, Fiscal Management, and Select Issues Committee and the Regional Policy Committee, King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) has established targets for key Mental Illness and Drug Dependency Action Plan (MIDD) policy goals established in King County Council Ordinance 15949.

The target areas addressed here include: (a) a reduction in the number of jail bookings/detentions for individuals served in MIDD programs, (b) a reduction in the jail detention population with serious mental illness (SMI) or severe emotional disturbance (SED), (c) a reduction in homelessness as measured by formerly homeless adults served by MIDD housing programs who remain in stable housing after one year, (d) a reduction in emergency room visits among individuals served by MIDD programs, and (e) a reduction in inpatient psychiatric hospital admissions among individuals served by MIDD programs. As identified in County Ordinance 15949, the outcomes presented here are explicitly linked to the following MIDD policy goals:

- A reduction in the number of mentally ill and chemically dependent people using costly interventions like jail, emergency rooms, and hospitals
- A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency
- Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement

Targets for the broad MIDD policy goals were established based on the assumption that a set of programs has been up and running for one full year and has enrolled enough participants to detect significant changes. The programs within the MIDD strategies will build on each other and also improve over time and as such, targets will change over time. Some of the programs that we expect to have the largest impact (e.g., housing and crisis diversion) will be fully implemented anywhere from one to four years after other programs have been in operation. We have therefore developed targets that change over time, as programs develop and increase effectiveness and as more programs come on line.

We have based the development of our outcome targets on information we have from programs serving populations similar to those served by MIDD, and on program results from similar programs across the country. There are, however, a number of factors that cannot be predicted but may directly influence whether the anticipated targets are achieved. Factors such as changes in law enforcement policies and funding, significant changes in the economy, changes in Federal entitlement and housing funding and policies, state funding for mental health and substance abuse treatment, and population

growth may affect the number of jail admissions regardless of MIDD strategy implementation. Furthermore, there are a number of local and state initiatives that directly influence outcomes associated with the MIDD. For example, the MacArthur Models for Change Initiative is focusing on juvenile justice reform; the King County Systems Integration Initiative is addressing issues of coordination, collaboration, and blending resources for multi-system youth; and the Ten-year Plan to End Homelessness and the Veterans and Human Services Levy are working to increase the availability of housing and services for homeless individuals. Consistent with the fifth policy goal, the MIDD Evaluation will track coordination and linkage with these other Council directed efforts through a process evaluation.

Baseline Data

In some cases, sufficient baseline data for some of the subsets of the five policy goals across all of King County does not exist. Such baseline data will be established during the first year of full strategy implementation. Data sharing agreements will be executed with many municipalities and entities in order to create a comprehensive baseline to ensure accurate baseline estimates and to continue to collect such data on an ongoing basis to monitor targeted outcomes. For example, baseline data on particular populations will include youth with mental health disorders in King County Juvenile Detention and adults with SMI in jails across King County.

Monitoring and Evaluation

Monitoring and evaluation results will be used to support quality improvements and revisions to MIDD strategies, to highlight successes, and to demonstrate cost effectiveness to the taxpayer.

These targets may be adjusted to account for changes in program implementation. Monitoring outcomes at short-term, intermediate, and long-term phases will allow us to make changes in program implementation based on the targeted outcomes.

As programs in the MIDD Implementation Plan are implemented and evolve over time, the Evaluation Plan will be updated accordingly to accurately measure the effectiveness and impact of each individual strategy.

Tests for statistical significance will be used to address the question: What is the probability that the relationship between variables (e.g., MIDD program and an outcome) is due to chance? The influence of certain known factors that may bias the results, such as attrition and population growth, will be examined.

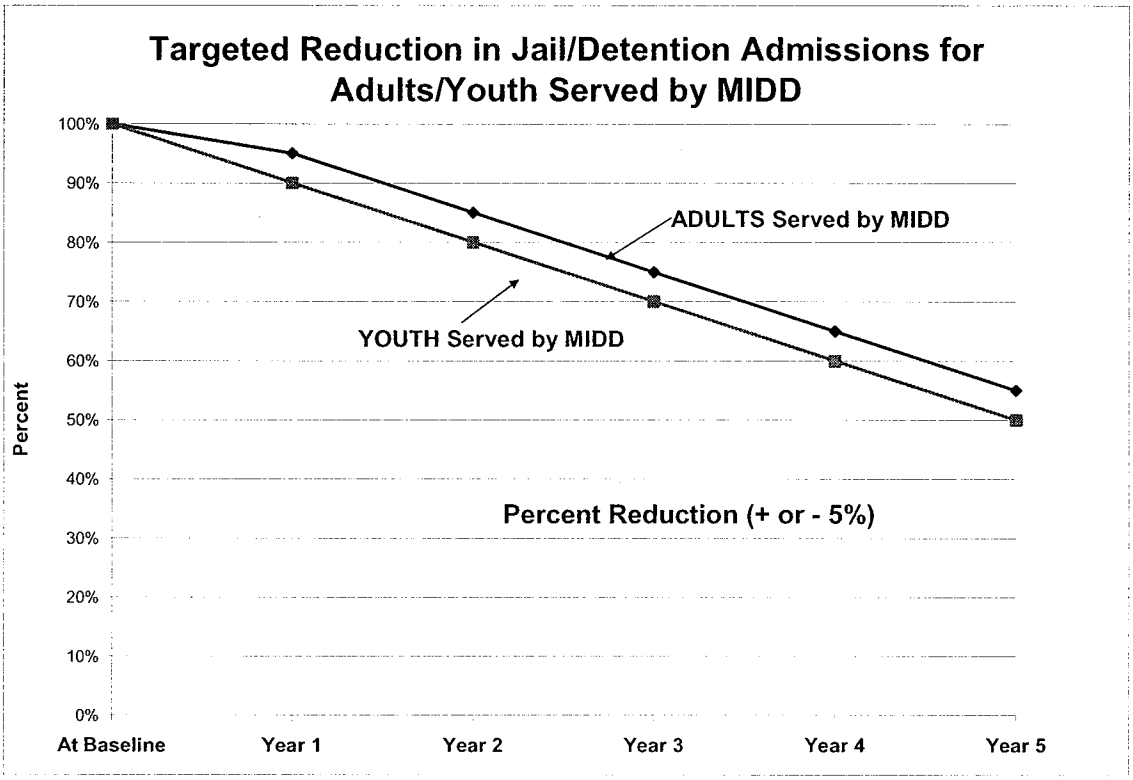
Figures

In each of the figures below, the percent reduction (or increase) in the policy goal is shown by year. The baseline year is the year prior to when a set of programs have been up and running for one full year.

King County

Mental Illness and Drug Dependency Action Plan

Figure 1: Targeted Reduction in the Number of Jail/Detention Admissions Among Mentally Ill and Chemically Dependent Individuals Served by MIDD Programs



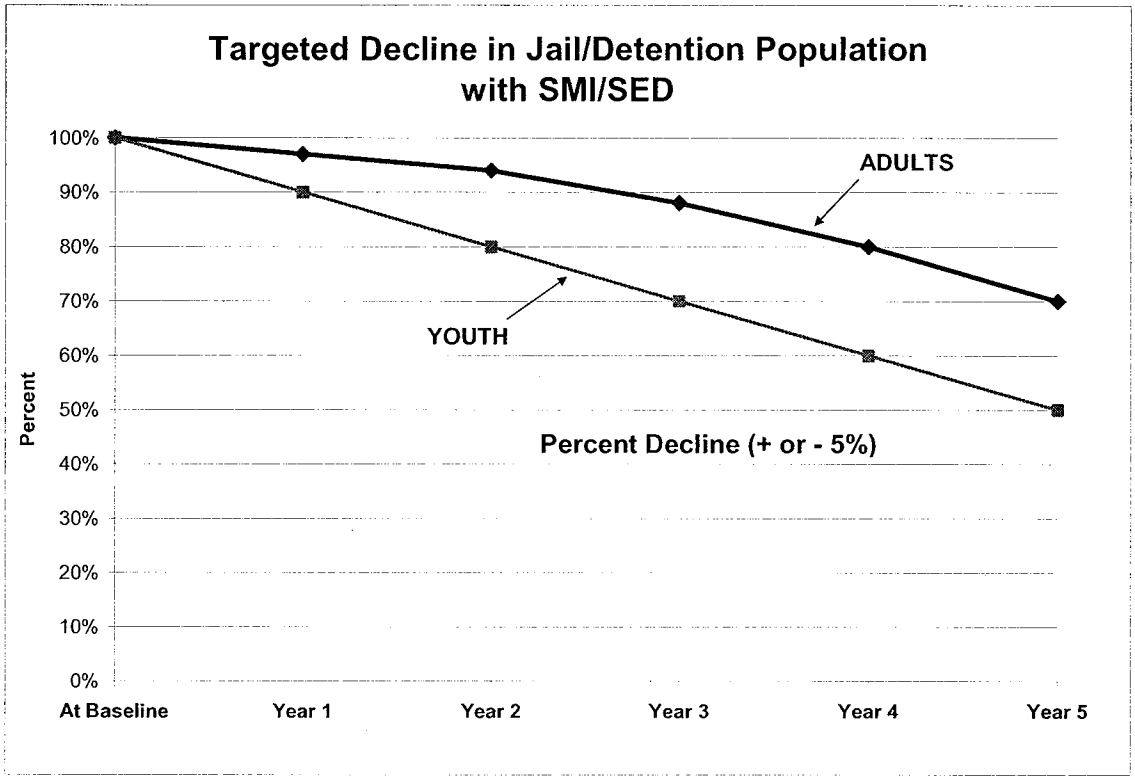
Proportion of Jail/Detention Admissions among Individuals served by MIDD Programs

- For adults, we have set a target of a 5% reduction in the number of jail bookings among individuals served by MIDD programs, one year after the MIDD programs are up and running. In subsequent years, the additional target reductions are 10% for subsequent years two through five for a total reduction of 45%. It should be noted that the total reduction of 45% only refers to those individuals who receive MIDD services, which is a smaller proportion of those individuals in jail (e.g., the MIDD will not reduce the jail population by 45%).
- For youth, we have set a target of a 10% reduction in the proportion of juvenile detentions among youth served by MIDD programs one year after the MIDD programs are up and running. For the next four subsequent years, additional reductions of 10% each year are anticipated for a total reduction of 50%. While baseline estimates were not available, the outcomes are based on results reported in Skowyra & Cocozza (2007) (see References).

King County

Mental Illness and Drug Dependency Action Plan

Figure 2: Targeted Decline in the Percent of Jail/Detention Population with Severe Mental Illness (adults) /Severe Emotional Disorder (youth)

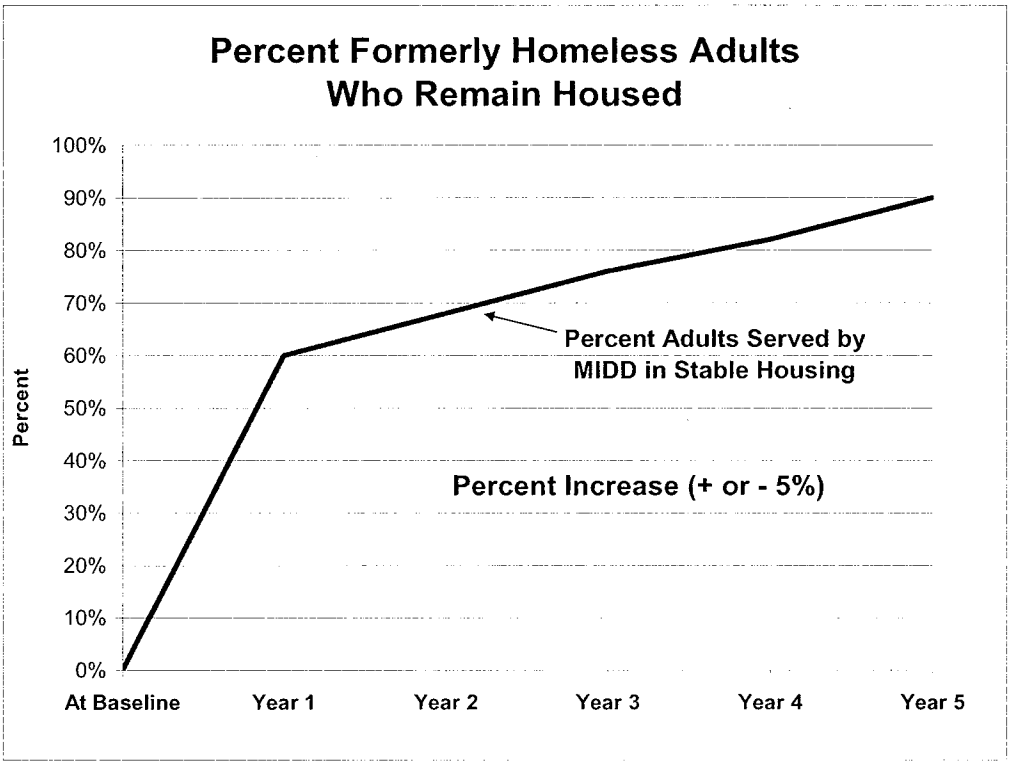


In 2007, there were approximately 17.5 Individuals with SMI per thousand in the adult detention population.

Jail/Detention Population with SMI/SED

- For adults, we have set a target of a 3% reduction in the percentage of the jail population with SMI/SED, one year after the MIDD programs are up and running. In subsequent years, the additional target reductions are 3%, 6%, 8%, and 10% for subsequent years two through five for a total reduction of 30%. It should be emphasized that the total reduction of 30% only refers to those individuals with SMI/SED, which is a small proportion of those individuals in jail (e.g., the MIDD will not reduce the jail population by 30%).
- For youth, we have set a target of a 10% reduction in the juvenile detention population with severe emotional disturbance, one year after the MIDD programs are up and running. In subsequent years, the additional target reductions are 10% for years two through five for a total reduction of 50%.
- An important caveat is that there is no consistently adopted standard definition for SMI or SED (this is particularly true for youth) across jail/detention facilities. Variations in the definitions of these diagnoses make it difficult to extrapolate from various studies and programs findings. The MIDD Evaluation Team will work to ensure consistency of definitions within the MIDD evaluation.

Figure 3: Increase in Percentage of Formerly Homeless Adults with Mental Illness or Chemical Dependency Receiving MIDD Housing Services Who Remain Housed for One Year



The 2006 One Night Homelessness Count in King County indicated that almost half of the 5,963 homeless individuals counted in shelters or transitional housing had problems with mental illness or substance abuse.

Housing Stability among the Formerly Homeless Receiving MIDD Housing Services

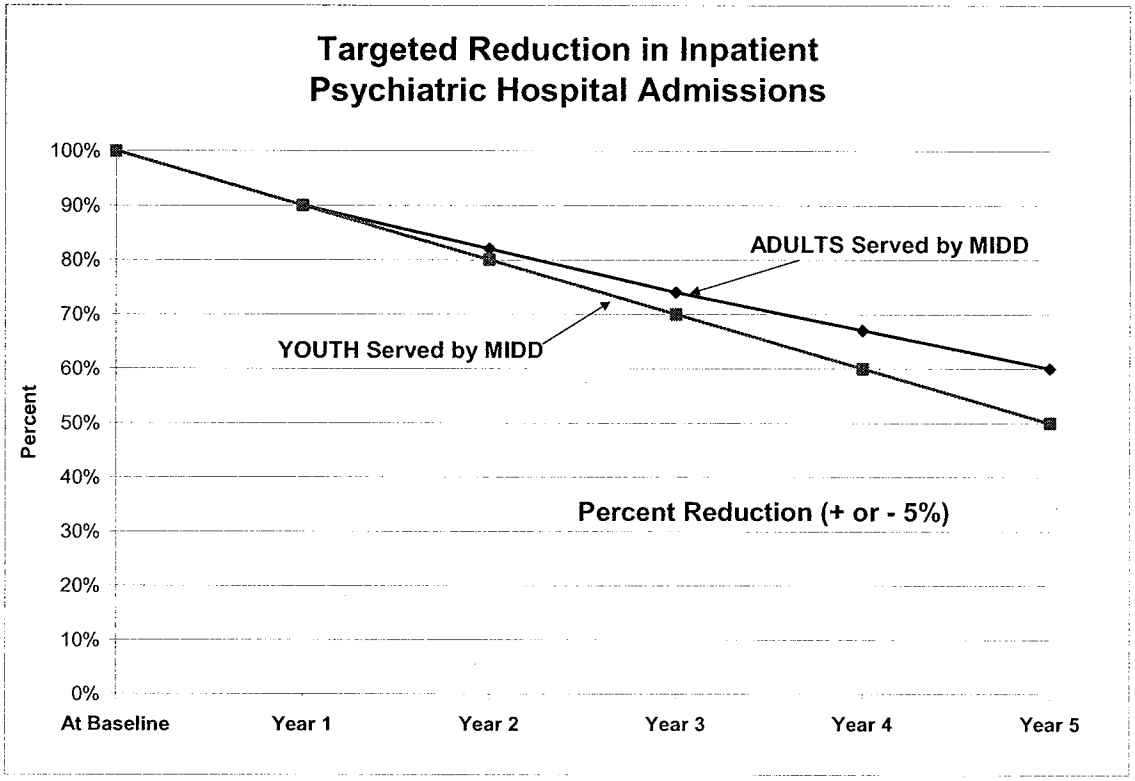
- For homeless adults, we have set a target after one full year of implementation of the MIDD housing strategy, 60% of formerly homeless adults will be able to maintain housing stability for 12 consecutive months. In subsequent years, the additional target reductions are that 80% will achieve housing stability in year two with a total of 90% of individuals attaining housing stability five years after the implementation of the housing strategy.
- The NY, NY Agreement Cost Study found that 70% of formerly homeless individuals with diagnoses of severe and persistent mental illness remained in housing after one year (Culhane, 2002).[1]
- The *Closer to Home Initiative* evaluation focused on six programs in Chicago, New York, San Francisco, and Los Angeles. Evaluation results from these programs indicated that among formerly homeless adults with the most severe psychiatric disorders, 79% remained in housing after one year.

[1] A research team from the Center for Mental Health Policy and Services Research, University of Pennsylvania, has published the most comprehensive study to date on the effects of homelessness and service-enriched housing on mentally ill individuals' use of publicly funded services.

King County

Mental Illness and Drug Dependency Action Plan

Figure 4: Targeted Reduction in Inpatient Psychiatric Hospital Admissions Among Mentally Ill and Chemically Dependent Youth and Adults served by MIDD Programs



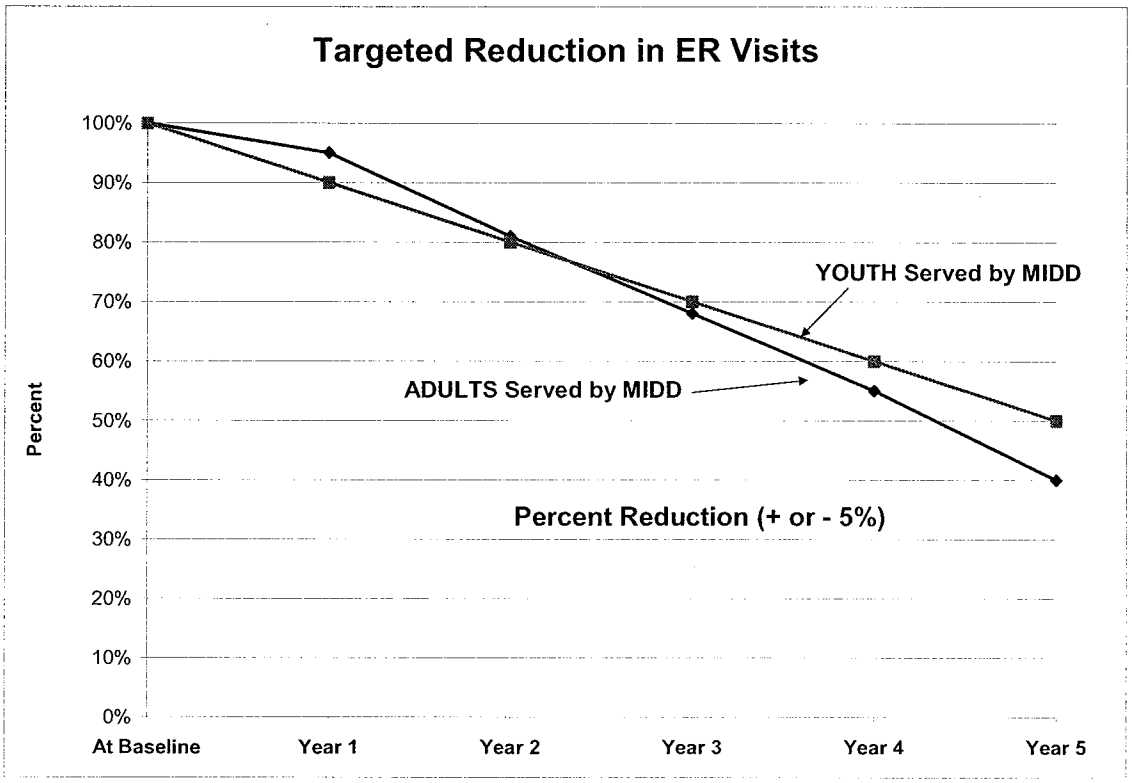
Inpatient Psychiatric Admissions Individuals served by MIDD Programs

- For adults, we have set a target of a 10% reduction in Inpatient Psychiatric Hospitalizations among those adults served by MIDD programs one year after the MIDD programs are up and running. In subsequent years, the additional target reductions are 8%, 8%, 7%, and 7% for years two, three, four, and five respectively for a total reduction of 40%.
- For youth, we have set a target of a 10% reduction in Inpatient Psychiatric Hospitalizations among those youth served by MIDD programs one year after the MIDD programs are up and running. For the next four subsequent years, additional target reductions are 10% each year are anticipated for a total reduction of 50%.

King County

Mental Illness and Drug Dependency Action Plan

Figure 5: Targeted Reduction in Emergency Room (ER) Visits among Mentally Ill and Chemically Dependent Youth and Adults served by MIDD Program



ER Utilization among Individuals served by MIDD Programs

- For adults served by MIDD programs, we have set a target of a 5% reduction in ER visits one year after the MIDD programs are up and running. In subsequent years, the additional target reductions are 14%, 13%, 13%, and 15% for years two, three, four, and five respectively for a total reduction of 60%.
- For youth served by MIDD programs, we have set a target of a 10% reduction in ER visits one year after the MIDD programs are up and running. For the next four subsequent years, additional target reductions of 10% each year are anticipated for a total reduction of 50%.
- A comprehensive program for the chronically homeless called the HHISN (i.e., the Lyric and Canon Kip Community House in San Francisco) found that after 12 months of moving into supportive housing, there was a 56% decline in emergency room use among adults. [i]

King County

Mental Illness and Drug Dependency Action Plan

References

Garrison, Richardson, Christakis et al. (August 2004). Mental Illness Hospitalizations of Youth in Washington State. *Archives of Pediatric Adolescent Medicine, 158*, 781-785.

Owens, P., Myers, M., Elixhauser, A. et al. (2007). Care of Adults with Mental Health and Substance Abuse Disorders in US Community Hospitals, 2004. Agency for Healthcare Research and Quality 2007. HCUP Fact Book No. 10. AHRQ Publication No. 07-0008. ISBN 1-58763-229-2. Retrieved from: http://www.ahrq.gov/data/hcup/factbk10/

President's New Freedom Commission on Mental Health, Final Report to the President (2003). Retrieved from http://www.mentalhealthcommission.gov/reports/reports.htm

Skowyra, K. R., & Cocozza, J. J. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. National Center for Mental Health and Juvenile Justice Policy Research Associates, Inc. Delmar, NY.

Solomon, P., Draine, J., & Marcus, S. (2002). Predicting incarceration of clients of a psychiatric probation and parole service. *Psychiatric Services, 53*(1), 50-56.

King County

Mental Illness and Drug Dependency Action Plan

INTRODUCTION

The Mental Illness and Drug Dependency (MIDD) Action Plan and the Metropolitan King County Council Ordinance 15949 define the expectations for the MIDD evaluation. The Ordinance calls for the plan to describe how the MIDD will be evaluated in terms of its impact and benefits and whether the MIDD achieves its goals. It requires that:

> *"...the evaluation plan shall describe an evaluation and reporting plan for the programs funded with the sales tax revenue. Part three [the Evaluation Plan] 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."*

The primary goal of the MIDD is to:

> *Prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing, and case management services.*

The Ordinance identified five policy goals:

1. A reduction in the number of mentally ill and chemically dependent people using costly interventions like jail, emergency rooms, and hospitals

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

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

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

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

In the MIDD Action Plan, the MIDD Oversight Committee, the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and its stakeholders identified

sixteen core strategies and corresponding sub-strategies (see Appendix for a list and description of strategies) for service improvement, enhancement and expansion to address these goals. The Evaluation Plan will examine the impact of all strategies to demonstrate effective use of MIDD funds and to assess whether the MIDD goals are being achieved, on both individual program and system levels. Results from the ongoing evaluation will be regularly reported on though quarterly and annual reports that will be reviewed by the MIDD Oversight Committee and transmitted to the King County Executive and Metropolitan King County Council. It also should be noted that the Evaluation Plan will evolve and change as the strategies evolve and change. Changes to the Evaluation Plan will be included in the regular reports as described above.

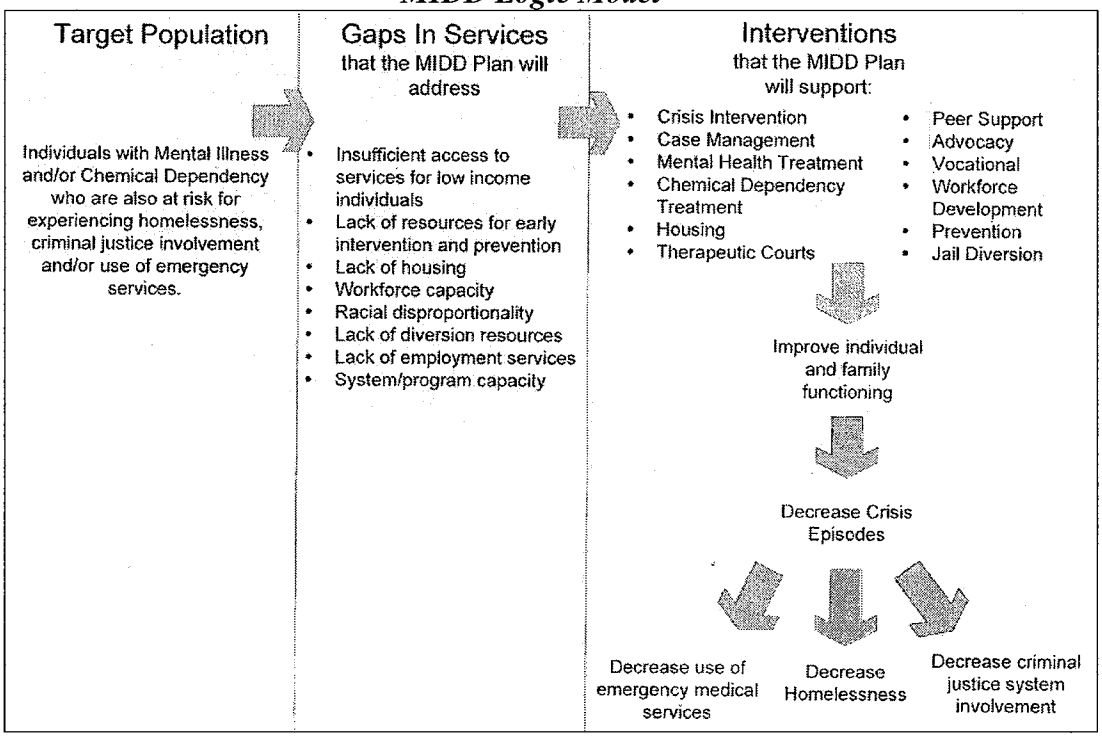
OVERVIEW OF THE EVALUATION PLAN

MIDD Framework

The MIDD Evaluation Plan establishes a framework for evaluating each of the 16 core strategies and sub-strategies in the MIDD Implementation Plan, by measuring what is done (output), how it is done (process), and the effects of what is done (outcome). Measuring *what* is done entails determining if the service has occurred. Measuring *how* an intervention is done is more complex and may involve a combination of contract monitoring, as well as process and outcome evaluation to determine if a program is being implemented as intended. Measuring the *effects* of what is done is also complex, and will require the use of both basic quantitative and qualitative methods as appropriate

The evaluation framework ties the MIDD goals and strategies to the MIDD results. It lays out the links between what is funded, what is expected to happen as a result of those funds, and how those results will contribute to realizing the MIDD goals and objectives. The schematic diagram below shows the high level relationships between the components of the framework.

MIDD Logic Model



The MIDD Plan is designed to be a comprehensive approach to create improvements across the continuum of services. Multiple and oftentimes interrelated interventions are designed to achieve the policy goals (e.g., reducing caseloads, increasing funding, enhancing workforce development activities and service capacity are expected to collectively reduce incarceration and use of emergency services). Many of the outcomes expected from the MIDD interventions are highly correlated to each other. For example, a decrease in mental health symptoms can lead to a decrease in crisis episodes, which can lead to a decrease in incarcerations, which can lead to an increase in housing stability, which can lead to a further decrease in mental health symptoms, and so on. Interventions that have an impact on any one of these outcomes can therefore be expected to have some impact on the other outcomes. The specifics of each intervention and the population it is targeting will determine which outcome(s) will be impacted in the short-term and how much additional time will be necessary before other longer-term outcomes will be seen. (Examples of longer term outcomes include reduction in jail recidivism and/or re-hospitalizations, or prevention of substance abuse in children of substance abusing parents.)

1. Process Evaluation

King County

Mental Illness and Drug Dependency Action Plan

The first component of the MIDD evaluation is a process evaluation that will assess how the MIDD is being implemented at both the system and strategy levels.

A. System Process Evaluation

The system process evaluation will provide a general assessment of how implementation is progressing. Sometimes referred to as an 'implementation status report', this type of evaluation may also answer specific programmatic questions (e. g., "How can we improve the quality of training for chemical dependency specialists?").

The system process evaluation will examine:

- Initial startup activities (e.g., acquiring space, hiring and training staff, developing policies and procedures)
- Development and management of Requests for Proposals (RFPs) and contracts for services
- Strategies to leverage and blend multiple funding streams
- Efforts to coordinate the work of partners, stakeholders, and providers
- Implementation of working agreements and Memoranda of Understanding
- Service-level changes that occur as the result of efforts to promote integration of housing, treatment, and supportive services
- Systems-level changes that occur as a result of the use of MIDD funds or the management of MIDD related resources
- An evaluation of the MIDD Action Plan's integration with and support of system level goals and objectives, as articulated in 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.

The goal of the system process evaluation is not only to capture what actually happens as the MIDD is implemented, but also to identify the unintended consequences of MIDD activities (e.g., circumstances that were not anticipated or were unusual in ways that helped or hindered MIDD-related work).

The system process evaluation establishes a quality improvement feedback loop as implementation progresses. Areas needing additional effort will be identified in order to make any needed mid-course adjustments. Evaluation activities will increase opportunities to learn about and practice service and system integration strategies.

B. Strategy Process Evaluation

In addition to the system process evaluation, evaluation at the strategy level will measure performance and assess progress toward meeting specified performance goals. These performance measures and goals are specified as *outputs* in the evaluation matrices at the end of the document (See Appendix).

2. Outcome Evaluation

The outcome evaluation will assess the impact of the funded services and programs on the MIDD goals. This approach consists of evaluating the full range of program outcomes in the context of a logical framework. The evaluation matrix designed for this part of the evaluation links the MIDD goals and strategies to the MIDD results and provides a structure for identifying performance indicators, targets and data sources, and for collecting and reporting results.

The MIDD outcome evaluation is broader than a program evaluation or a series of program evaluations. The framework defines the expected outcomes for each program and helps demonstrate how these outcomes individually and collectively contribute to the achievement of the overall goals of the MIDD.

A. Strategies

Evaluating the impact of the MIDD Action Plan is a multifaceted endeavor. There are multiple target populations, goals, strategies, programs, interventions, providers, administrators, partners, locations, timelines, and expected results. The comprehensive evaluation strategy is designed to demonstrate whether the expected results are being achieved and whether value is returned on MIDD investments.

Underlying principles for the outcome evaluation include:

- The evaluation will build upon existing evaluation activities and coordinate with current and/or developing information systems (e.g., Strategy 7b, expanded Children's Crisis Outreach Response System).

- When the implementation of a strategy will take multiple years, making it impossible to immediately demonstrate any long-term outcomes, the evaluation will establish intermediate outcomes to show that the strategy is on course to achieve results (e.g., Strategy 4b, Prevention Services to Children of Substance Abusers).

- The evaluation will coordinate its activities with MIDD administrative activities, including RFPs, contract management, etc. Process and outcome data collection will be incorporated into ongoing monitoring functions and will support regional coordination of data collection.

The MIDD Action Plan specifies that the MIDD dollars be used to fund effective practices and strategies. Evaluation approaches can range from purely verifying that something happened to comparing intervention results with a statistically valid control group to ascertain causality. The MIDD evaluation will utilize the strongest and also the most feasible evaluation design for each strategy.

- An evaluation that requires a control group to prove that a program is the cause of any effects can be expensive and time consuming. In general, it will not be possible for an evaluation of most MIDD programs to include a control or comparison group to show a causal relationship. Establishing a control or comparison group would require that some individuals *not* receive services so that they can be compared with those who receive services. However, there may be situations when a 'natural' comparison group may be used if feasible.

- A proven program, such as an evidence-based practice, has already had an evaluation utilizing a control or comparison group. When the MIDD strategies fund practices and services that are currently working or have been proven to work elsewhere, there is no need to again prove a causal relationship. Instead, the evaluation will focus on measuring the quantity and results of MIDD funded services, in addition to their adherence to fidelity measures.

- For many strategies a proven program and/or best practice will be substantially modified in order to be useful to the specific populations targeted by the MIDD. Evaluation of these programs will stress on-going monitoring and early feedback so that any necessary changes can take place in a timely manner. Short-term results will be identified as a marker of which longer-term desired outcomes are likely to be detected. This formative type of evaluation will help ensure that the program is functioning as intended.

B. Evaluation Matrix

Organizing an evaluation as complex as this requires a systematic approach. An evaluation matrix has been designed for compiling the needed information for each sub-strategy. Completed evaluation matrices for each sub-strategy specify what data are needed from which sources and what program level evaluations are needed.

The evaluation framework also describes how data will be collected. Baseline information about the target population and their use of services will be obtained. To provide results related to racial disproportionality and cultural competency, data about race, ethnicity, and language will also be collected. Some of the data can be obtained immediately from existing sources such as the King County Regional Support Network database, Safe Harbors, and TARGET (the state Division of Alcohol and Substance Abuse database). Accessing other data may require an investment of resources and time (e.g., developing data sharing agreements to obtain information regarding emergency room use in outlying hospitals). Any changes to a particular strategy that occur as implementation progresses may signal a needed modification to the evaluation matrix. A template for the evaluation matrix follows; completed matrices can be found in the Appendix.

Evaluation Matrix

Strategy xx – Strategy Name				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
xx – Sub-Strategy name Target Population:	1.	Short-term measures: 1. 2. Longer-term measures: 3. 4.	1. 2. 3. 4.	

3. Timeline

The lifespan of the MIDD Action Plan extends through December 31, 2016. The evaluation must demonstrate value to the taxpayer throughout the life of the MIDD Plan.

An evaluation timeline is attached (See Attachment A). It shows proposed evaluation activities in relation to the MIDD implementation timeline(s). As individual strategies are finalized, evaluation dates may be adjusted. These dates will balance the need for ongoing reporting to meet MIDD oversight requirements with the lifecycles of individual strategy evaluations. It must be stressed that results for both short and long term outcomes may not be available for months or even years, depending upon the strategy.

MIDD programs will begin at different times and reach their respective conclusions on different schedules. Data may be readily available or may require system upgrades

and/or data sharing agreements before the information is accessible. For each program the evaluation timeline addresses:

- When the program will start (or when the MIDD funding will be initiated)
- At what point a sufficient number of clients will have reached the outcome to generate a statistically reliable result
- When baseline and indicator data may be reported
- The requirements for reporting on process and outcome data

4. Reporting

In accordance with the Ordinance, MHCADSD will report on the status and progress of the programs supported with MIDD funds. During the first two years of the MIDD implementation, quarterly reports will be submitted to the Executive and Council for review. Thereafter reports will be submitted every six months and annually. At a minimum these reports will include:

- Performance measure statistics
- Program utilization statistics
- Request for proposal and expenditure status updates
- Progress reports on the implementation of the evaluation.

In addition, the annual report will also include "a summary of quarterly report data, updated performance measure targets for the upcoming year, and recommendations for program/process improvements based on the measurement and evaluation data".

The existing service system is constantly evolving in response to funding, changing needs, and other environmental influences. Reports will show how the administration of the MIDD Plan both responds to these influences and has an impact on the system at large.

5. Evaluation Matrices

The Appendix includes the evaluation matrix for each sub-strategy. More specific information may be added for each individual activity as the program is implemented and evolves. For strategies that are still being developed, outcomes may be marked "TBD" (To Be Determined). When strategies are further developed or modified following initial implementation, new or revised outcomes will be developed, and included in the quarterly reports.

King County

Mental Illness and Drug Dependency Action Plan

ADDENDUM: EVALUATION APPROACH

The MIDD Evaluation Plan was developed in the context of existing quality management approaches currently utilized by the Department of Community and Human Services (DCHS) and the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). MHCADSD is responsible for the publicly funded mental health and substance abuse treatment systems, and as such is obligated to assure the quality, appropriateness, availability and cost effectiveness of treatment services. MHCADSD must demonstrate to federal, state, and county government the capacity to operate and monitor a complex network of service providers. This is accomplished through well-established quality assurance and improvement strategies, including contract development and monitoring, setting expectations for performance, conducting periodic review of performance, and offering continuous feedback to providers regarding successes and needed improvements. In that context, all MIDD contracts will specify what the provider is expected to do, including service provision, data submission, and reporting of key deliverables. The MIDD evaluation will extend beyond the contract monitoring process to assess whether services were performed effectively, and whether they resulted in improved outcomes for the individuals involved in those services.

The MIDD Evaluation Plan was developed by MHCADSD program evaluation staff whose collective experience with program evaluation, performance measurement, research, and quality improvement is summarized in Attachment B. The MHCADSD System Performance Evaluation team will continue to provide leadership and staffing to assure that the evaluation proceeds in a timely and transparent manner. The ongoing evaluation of the MIDD will involve coordination with MIDD Oversight Committee, stakeholders, providers, and other agencies responsible for evaluating the effectiveness of related or overlapping programs (Veteran's and Human Services Levy Service Improvement Plan, Committee to End Homelessness, Public Health of Seattle/King County, United Way Blueprint to End Chronic Homelessness, City of Seattle, University of Washington, etc.).

The Evaluation Plan and the evaluation matrices for each individual strategy were developed directly from the individual implementation strategies. Some strategies are still in the process of being developed; therefore the evaluation matrices for those strategies will need to be revised as plans are finalized. Updates to the Evaluation Plan will be included in the quarterly, bi-annual, and annual reports reviewed by the MIDD Oversight Committee and transmitted to the King County Executive and Metropolitan King County Council. The Plan utilizes a basic approach to evaluation: measure what is done (output), how it is done (process), and the effects of what is done (outcome).

- Measuring *what* is done is usually straightforward, as it entails determining if the service has occurred. For example, Strategy 1d aims to increase access to "next day" appointments for individuals experiencing a mental health crisis. The

evaluation will determine whether the program met its target of increasing availability of next day appointments for an additional 750 people.

- Measuring *how* an intervention is done is more complex and may involve a combination of contract monitoring (MHCADSD contract staff review agency policies and procedures, client charts, staff credentials, billing, etc.), and process and outcome evaluation to determine if a program is being implemented as intended.

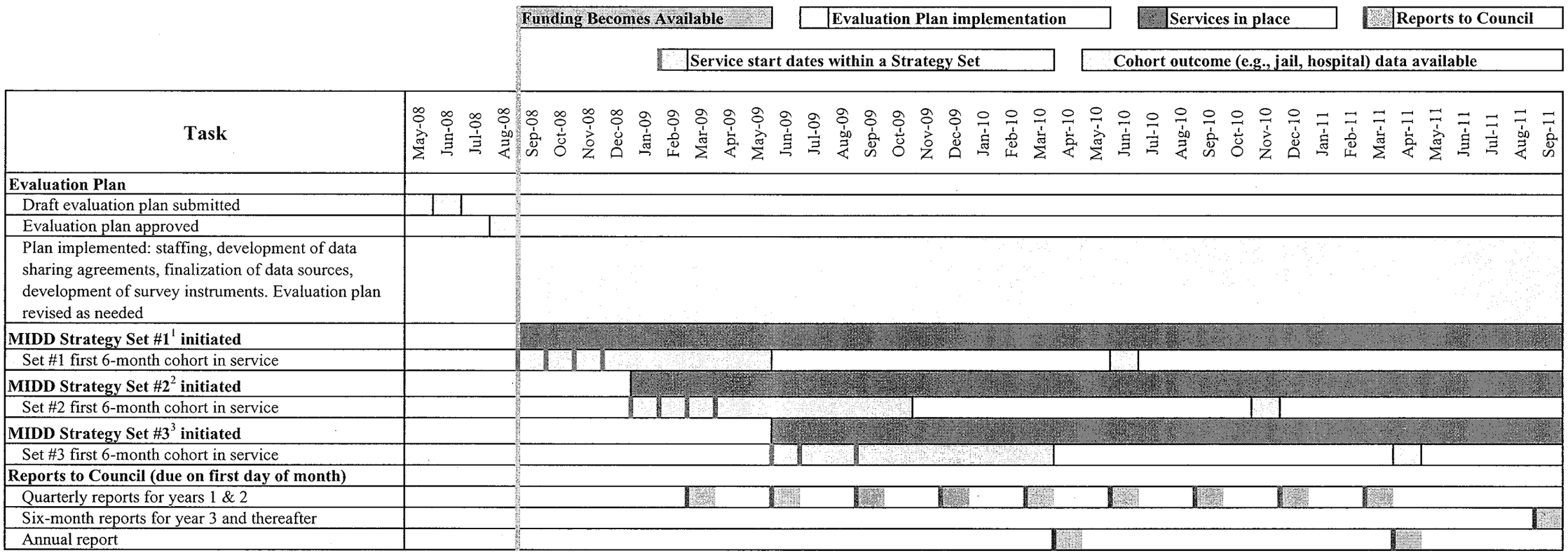
- Measuring *the effects* of what is done can vary in complexity. The outcome evaluation of MIDD activities will utilize basic quantitative and qualitative methods as appropriate. Many outcome indicators are a measurement of change. The Evaluation Plan uses terms such as 'increase', 'decrease', 'expand' or 'improve'-- all of which imply a difference from what was happening before the intervention occurred. Baseline data will be needed in order to measure whether there has been any change. Targets for improvement will vary, depending on what is currently happening (e.g., percentage of individuals receiving mental health services who are employed) and how long it will take to see results, taking into account the combined impact of all the MIDD strategies.

Data collected on performance will offer a rich opportunity to analyze how the MIDD strategies are impacting people throughout the county, in parts of the county, and at specific providers. Every effort will be made to utilize existing data and reports to avoid unnecessary administrative burden. Through both ongoing contract monitoring and evaluation activities providers will receive feedback about the effectiveness of their strategies and will be held accountable to make any needed changes to ensure the expected results are achieved over time. Monitoring and evaluation results will be used to support quality improvements and revisions to MIDD strategies, to highlight successes, and to demonstrate cost effectiveness to the taxpayer.

---

[i] Harder and Company, February 2004, pp.6-9

Mental Illness and Drug Dependency Action Plan
Attachment A: Evaluation Timeline



Task
Evaluation Plan
Draft evaluation plan submitted
Evaluation plan approved
Plan implemented: staffing, development of data sharing agreements, finalization of data sources, development of survey instruments. Evaluation plan revised as needed
MIDD Strategy Set #1[1] initiated
Set #1 first 6-month cohort in service
MIDD Strategy Set #2[2] initiated
Set #2 first 6-month cohort in service
MIDD Strategy Set #3[3] initiated
Set #3 first 6-month cohort in service
Reports to Council (due on first day of month)
Quarterly reports for years 1 & 2
Six-month reports for year 3 and thereafter
Annual report

[1]Strategy set #1 includes:
1a, 1ci, 1d,1e, 1g, 1h, 2a, 2b, 3a, 4d, 5ai, 8a, 9a, 11a, 14a, and 15a

[2]Strategy set #2 includes:
1cii, 4b, 5aii, 10a, 12aii, 12d, 13a, and 13b

[3]Strategy set #3 includes:
1f, 4a, 6a, 7b, 11b, and 12b

Timelines for implementing the following strategies are TBD:
1b, 1c, 4c, 5a, 7a, 10b, 12ai, 12c, and 16a

**NOTE: MIDD evaluation will likely need to wait at least 1-year to complete a cohort for strategies 1f, 5ai, 5aii, 8a, and 9a due to smaller numbers served

King County

Mental Illness and Drug Dependency Action Plan

Attachment B
Evaluation Team

Kathleen Crane, MS: Coordinator, System Performance Evaluation and Clinical Services Section.

Lyscha Marcynyszyn, PhD: BA, Whitman College; PhD in Developmental Psychology, Cornell University. Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Privacy Officer and Research Committee Chair. Lyscha has published articles in *Journal of Applied Developmental Psychology* (in-press), *Psychological Science*, the *American Journal of Public Health*, and *Development and Psychopathology*. In 2006, she received the American Psychological Association Division 7 Outstanding Dissertation Award given yearly for the best dissertation in Developmental Psychology. Evaluation work has focused on three national, randomized-controlled demonstration trials: the Next Generation Welfare-to-Work transition studies, Building Strong Families, and the Evaluation of the Social and Character Development interventions. Research has been funded by the National Institute of Mental Health and the Science Directorate of the American Psychological Association.

Susan McLaughlin, PhD: BA, San Diego State University; PhD, University of California San Diego/San Diego State University Joint Doctoral Program. Child clinical internship, University of Washington; Post-Doctoral Fellowship in Juvenile Forensic Psychology, University of Washington and Child Study and Treatment Center. MHCADSD Children's Mental Health Planner. Project Evaluator for MHCADSD Children and Families in Common grant from 1999-2005. Conducted a longitudinal outcome study of services to at-risk youth involved in the juvenile justice system aimed at improving overall functioning of youth at home, school, and in communities and reducing juvenile justice involvement. Involved in program evaluations and quality improvement projects for MHCADSD youth programs, including the Interagency Staffing Teams, Wraparound, and the Children's Crisis Outreach Response Program. Conducted studies examining the social and emotional development of maltreated children, the long term impacts of childhood abuse, and the appropriateness of IQ measures for ethnic minority populations in a gifted program.

Genevieve Rowe, MS: BS, University of Saskatchewan; MS in Biostatistics, University of Washington. Currently the evaluator of the MHCADSD Forensic Assertive Community Treatment program. From 1993 to 2007 part of Public Health's Epidemiology, Planning and Evaluation Unit participating in a variety of evaluation projects including:

- A framework for the evaluation of the King County Veterans and Human Services Levy - 2007.
- Seattle's School-based Health Clinics funded by the Families and Education Levy - 2003.
- Mental Health service improvement program in Seattle's School-based Health Clinics – 2003-2005.
- Seattle Early Reading First (SERF) program - 2006.
- Highway 99 Traffic Safety Coalition - 2004.

- WorkFirst Children with Special Health Care Needs program – 2004

Represented Public Health on King County's interagency Juvenile Justice Evaluation Workgroup (1999 – 2005)

Debra Srebnik, PhD: BS, University of Washington; PhD in clinical psychology, University of Vermont. Program evaluator for the MHCADSD Criminal Justice Initiative since 2003 (Includes five treatment and/or housing programs and process improvement components aimed at reducing use of secure detention and improving rehabilitative outcomes for individuals being released from King County jails). Conducted evaluations of public mental health and chemical dependency treatment programs including:

- Three Housing First programs, including Begin at Home-current
- Program Assertive Community Treatment-current
- Coalition for Children, Families and Schools-2000-2001
- Parent Party Patrol - substance use prevention program-1999-2000
- SSB6547- design an outcomes system for use in public mental health-1994-1998
- "Becca Bill"-1996-1997
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-1994-1996
- Design of Mental Health Levels of Care-1993-1994

Research faculty, University of Washington Department of Psychiatry and Behavioral Sciences since 1992. Led or been an investigator on several federally or locally-funded clinical trial and services research grants.

King County

Mental Illness and Drug Dependency Action Plan
Evaluation Plan Matrix

Appendix

Strategy 1

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
1a(1) – Increase Access to Mental Health (MH) Outpatient Services for People Not On Medicaid Target Pop: Individuals who have received MH services but have lost Medicaid eligibility or those who meet clinical and financial criteria for MH services but are not Medicaid eligible.	1. Provide expanded access to outpatient MH services to persons not eligible for or who lose Medicaid coverage, yet meet income standards for public MH services (goal is 2,400 additional non-Medicaid eligible clients per year).	Short-term measures: 1. Increase # of non-Medicaid eligible clients served by 2,400 per year 2. Reduce severity of MH symptoms of clients served Long-term measures: 3. Reduce # of jail bookings for those served 4. Reduce # of days in jail for those served 5. Reduce # of psychiatric hospital admissions for those served 6. Reduce # of psychiatric hospital days for those served 7. Reduce # of emergency room (ER) admissions for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Management Information System (MIS) Jail data Jail data Hospital data Hospital data ER data
1a(2) – Increase Access to Substance Abuse (SA) Outpatient Services for People Not On Medicaid Target Pop: Low-income individuals who are not Medicaid, Alcohol and Drug Assessment and Treatment Service Agency (ADATSA), or Government Assistance – Unemployable (GAU) eligible who need chemical dependency (CD) services	1. Provide expanded access to substance abuse treatment to individuals not eligible or covered by Medicaid, ADATSA, or GAU benefits but who are low-income (have 80% of state median income or less, adjusted for family size). Services include opiate substitution treatment (OST) and outpatient treatment.	Short-term measures: 1. Increase # of non-Medicaid eligible clients admitted to substance abuse treatment and OST. (Goal is an additional 461 individuals in Opiate Substitution Treatment (OST) and 400 individuals in outpatient substance abuse disorder treatment per year) 2. Reduce severity of SA symptoms of clients served Long-term measures: 3. Reduce # of jail bookings for those served 4. Reduce # of days in jail for those served 5. Reduce # of psychiatric hospital	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	MIS TBD (e.g., survey) Jail data Jail data Hospital data

14712

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
		admissions for those served 6. Reduce # of psychiatric hospital days for those served 7. Reduce # of ER admissions for those served	6. Outcome 7. Outcome	Hospital data ER data
1b – Outreach and Engagement to Individuals leaving hospitals, jails, or crisis facilities Target Pop: Homeless adults being discharged from jails, hospital ERs, crisis facilities and in-patient psychiatric and chemical dependency facilities	1. Intervention to be defined. Intent is to fill gaps identified in the high utilizer service system, once other programs dedicated to this population are implemented.	Short-term measures: 1. Link individuals to needed community treatment and housing 2. Increase # of individuals in shelters being placed in: a) services and b) permanent housing Long-term measures: 3. Reduce # of jail bookings for those served 4. Reduce # of days in jail for those served 5. Reduce # of psychiatric hospital admissions for those served 6. Reduce # of psychiatric hospital days for those served 7. Reduce # of ER admissions for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	TBD when specifics of intervention are defined Jail data Jail data Hospital data Hospital data ER data
1c – Emergency Room Substance Abuse and Early Intervention Program Target Pop: At risk substance abusers, including high utilizers of hospital ERs	1. Continue lapsed federal grant funding for program at Harborview (5 current FTE SA professionals) 2. Create 1 new program in South King County (hire 4 new FTE CD professionals) 3. Serve a total of 7,680 clients/yr	Short-term measures: 1. Hire 4 new FTE SA professionals 2. SA services to 7,680 cts/yr 3. Expansion of existing program 4. Create 1 new program in South King County Long-term measures: 5. Reduce # of jail bookings for those served 6. Reduce # of days in jail for those served 7. Reduce # of ER admissions for those served 8. Reduce # of psychiatric hospital admissions for those served	1. Output 2. Output 3. Output 4. Output 5. Outcome 6. Outcome 7. Outcome 8. Outcome	Agency report MIS MHCADSD MHCADSD Jail data Jail data ER data Hospital data

14712

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
		9. Reduce # of psychiatric hospital days for those served	9. Outcome	Hospital data
		10. Reduce # of detox admissions for those served	10. Outcome	MIS
		11. Reduce ER costs for those served	11. Outcome	ER/Hospital data
1d – Mental health crisis next day appointments (NDAs) Target Pop: adults in crisis and at risk for inpatient psychiatric admission	1. Increase access for NDAs to provide them for 750 clients 2. Provide expanded crisis stabilization services	Short-term measures: 1. Provide expanded NDA services to 750 clients	1. Output	MIS
		Long-term measures: 2. Reduce # of ER admissions for those served	2. Outcome	ER data
		3. Reduce # of psychiatric hospital admissions for those served	3. Outcome	Hospital data
		4. Reduce # of psychiatric hospital days for those served	4. Outcome	Hospital data
1e – Chemical Dependency Professional (CDP) Education and Workforce Development Target Pop: Staff (Chemical Dependency Professional Trainees CDPTs) at KC contracted treatment agencies training to become CDPs.	1. Provide tuition and book stipends to agency staff in training to become certified chemical dependency professionals.	Short-term measures: 1. Increase # of certified CD treatment professionals (CDPs) by 125 annually	1. Output	Agency data
		2. Test 45 CDPTs at each test cycle	2. Output	WA State Divisions of Alcohol & Substance Abuse (DASA) data
		3. Increase # of certification programs	3. Output	DASA data
		4. Increase # of trainings provided	4. Output	Agency data
		Long-term measures: 5. Increase # of clients receiving CD services	5. Outcome	MIS
1f – Peer support and parent partners family assistance Target Pop: 1) Families whose children and/or youth receive services from the public mental health or substance abuse treatment systems, the child welfare system,	1. Hire 1 FTE MHCADSD Parent Partner Specialist 2. Provide up to 40 part-time parent partners/youth peer counselors to provide outreach and engagement and assist families to navigate the complex child-serving systems, including juvenile justice, child welfare, and mental health and substance abuse treatment.	Short-term measures: 1. 1 FTE Parent Partner Specialist hired	1. Output	MHCADSD
		2. A sufficient # of contracts are secured with network parent/youth organizations to provide up to 40 parent partners and/or youth peer mentors	2. Output	MHCADSD
		3. Increase in # of families and youth receiving parent partner/peer counseling services	3. Output	MIS
		4. Increase in # of parent partner/peer	4. Output	MIS

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
the juvenile justice system, and/or special education programs, and who need assistance to successfully access services and supports for their children/youth. 2) Youth who receive services from the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, and/or special education programs, and who need assistance to successfully access services & supports	3. Provide education, training and advocacy to parents and youth involved in the different child serving systems	counseling service hours provided 5. Increase # of parent/youth engaged in the Networks of Support 6. Increase # of education and training events held annually Long-term measures: 7. Reduce # of psychiatric hospital admissions for those served 8. Reduce # of psychiatric hospital days for those served 9. Reduce # of detention admits for youth within those families served 10. Reduce # of out of home placements 11. Reduce # of placement disruptions for families and youth served	5. Output 6. Output 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome	Agency data Agency data Hospital data Hospital data Juvenile Justice (JJ) data (TBD) DCFS data (TBD) DCFS data
1g - Prevention and early intervention mental health and substance abuse services for older adults Target Pop: Adults age 55 years and older who are low-income, have limited or no medical insurance, and are at risk of mental health problems and/or alcohol or drug abuse.	1. Hire 10 FTEs behavioral health specialists/staff to provide prevention and early intervention services by integrating staff into safety net primary care clinics. This includes screening for depression and/or alcohol/drug abuse, identifying treatment needs, and connecting adults to appropriate interventions.	Short-term measures: 1. 10 FTEs hired 2. Improved access to screening and services 3. Prevention and early intervention services provided to 2,500 to 4,000 clients/yr Long-term measures: 4. Reduce # of ER admissions for those served 5. Reduce # of psychiatric hospital admissions for those served 6. Reduce # of psychiatric hospital days for those served 7. Reduce self-report of depression for those served 8. Reduce self-report of substance abuse for those served 9. Reduce self-report of suicidal ideation for those served	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	Agency data Agency data MIS ER data Hospital data Hospital data TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey)

14712

Strategy 1 – Increase Access to Community Mental Health and Substance Abuse Treatment				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
1h - Expand the availability of crisis intervention and linkage to on-going services for older adults Target Pop: Adults age 55 and older experiencing a crisis in which MH or substance abuse is a contributing factor	1. Expand the Geriatric Regional Assessment Team (GRAT) by providing 1 FTE geriatric MH outreach specialist, 1 FTE geriatric CD outreach specialist, 1 FTE geriatric trainee, and 1.6 FTE nurse (serve 340 clients/yr) 2. In response to requests from police and other first responders, provide crisis intervention, functional assessments, referral, and linkages to services	10. Reduce ER costs for those served 11. Reduce hospital costs for those served Short-term measures: 1. Hire 1 FTE geriatric MH specialist, 1 FTE geriatric CD specialist, 1 geriatric CD trainee, and 1.6 FTE nurse 2. Crisis intervention and linkages to services for an additional new 340 clients/yr 3. Increase # of crisis interventions 4. Increase # of functional assessments 5. Increase # of referrals 6. Increase # of linkages made to services Long-term measures: 7. Reduce # of jail bookings for those served 8. Reduce # of days in jail for those served 9. Reduce # of ER admissions for those served 10. Reduce # of psychiatric hospital admissions for those served 11. Reduce # of psychiatric hospital days for those served	10. Outcome 11. Outcome 1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome	ER data Hospital data Agency data MIS Agency data Agency data Agency data Agency data Jail data Jail data ER data Hospital data Hospital data

Strategy 2

Strategy 2 - Improve Quality of Care Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
2a – Caseload Reduction for Mental Health Target Pop: 1) Contracted MH agencies and MH Case Managers 2) Consumers receiving outpatient services through King County Regional Support Network (KCRSN)	1. Develop strategy for addressing definition of case manager, calculation of caseload size and severity of case mix. 2. Increase payment rates for MH providers in order to increase number of case managers/supervisors and reduce caseloads. Specific goals for # of additions by type of staff will be set in above strategy.	Short-term measures: 1. Develop and implement strategy that addresses variability of caseload size and severity of case mix within and among agencies. 2. Increase # of MH case managers and supervisors as specified in above strategy. 3. Decrease caseload size for MH case managers by percent determined in above strategy. 4. Increase # of case management (CM) service hours for those served 5. Increase # of CM services provided within 7 days of hospitalization/jail discharge Long-term measures: 6. Reduce # of jail bookings for adults served 7. Reduce # of days in jail for adults served 8. Reduce juvenile justice (JJ) involvement for youth served 9. Reduce # of psychiatric hospital admissions for those served 10. Reduce # of psychiatric hospital days for those served 11. Reduce # of ER admissions for those served 12. Reduce # of out of home placements for children 13. Increase case manager job satisfaction as a result of reduced caseload 14. Decrease case manager turnover rates	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome 12. Outcome 13. Outcome 14. Outcome	MHCADSD Agency data Agency data MIS MIS Jail data Jail data JJ data Hospital data Hospital data ER data Division of Children and Family Services (DCFS) data Survey Agency data
2b - Employment services for	1. Provide 23 vocational specialists (each	Short-term measures:		

14712

Strategy 2 - Improve Quality of Care				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
individuals with mental illness and chemical dependency Target Pop: Individuals receiving public mental health and/or chemical dependency services who need supported employment to obtain competitive employment	provider serves ~40 clients/yr) to provider fidelity-based supported employment (trial work experience, job placement, on-the-job retention services) 2. Provide public assistance benefits counseling 3. Provide training in vocational services to MH providers first, then CD providers	1. Provide employment services to 920 clients/yr 2. Change in number of enrolled MH & CD clients who become employed 3. Number/rate of individuals who become employed who are retained in employment for 90 days 4. Decreased reliance on public assistance Long-term measures: 5. Increase housing stability (retention)	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	MIS MIS MIS Department of Social and Health Services (DSHS) MIS

14712

Strategy 3

Strategy 3 – Increase Access to Housing				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
3a – Supportive Services for Housing Projects Target Pop: Persons in the public MH and CD treatment system who are homeless; have not been able to attain housing stability; are exiting jails and hospitals; or have been seen at a crisis diversion facility.	1. Expand on-site supportive housing services by adding housing support specialists to serve an estimated 400 individuals in addition to current capacity.	Short-term measures: 1. Increase # of individuals served by about 400 2. Increase # of housing providers accepting this target population Long-term measures: 3. Increase housing stability of those served 4. Increase treatment participation of those served 5. Reduce # of jail bookings for those served 6. Reduce # of days in jail for those served 7. Reduce # of psychiatric hospital admissions for those served 8. Reduce # of psychiatric hospital days for those served 9. Reduce # of ER admissions for those served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	Agency data Agency data MIS MIS Jail data Jail data Hospital data Hospital data ER data

14712

Strategy 4

Strategy 4 – Invest in Prevention and Early Intervention Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
4a –Services to parents participating in substance abuse outpatient treatment programs Target Pop: Custodial parents participating in outpatient substance abuse treatment	1. Implement two evidence based programs to help parents in recovery become more effective parents and reduce the risk that their children will abuse drugs or alcohol. (Serve 400 parents per year)	Short-term measures: 1. Serve 400 parents per year 2. Increase parent services at outpatient SA treatment programs 3. Improve parenting skills of those served 4. Increased family communication 5. Increased positive family structure Long-term measures: 6. Reduce substance abuse by children of parents served 7. Reduce risk factors for substance abuse & other problem behaviors by children of parents served 8. Increase protective factors for prosocial behavior by children of parents served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	Agency data Agency data TBD from contract with service provider TBD TBD TBD TBD TBD
4b – Prevention Services to Children of Substance Abusers Target Pop: Children of substance abusers and their parents/guardians/kinship caregivers.	1. Implement evidence-based educational/support programming for children of substance abusers to reduce risk of future substance abuse and increase protective factors. (Serve 400 per year)	Short-term measures: 1. Contract with service provider for evidence-based programs 2. Increase # of children served (goal 400/year) 3. Increase # of activities provided by King County region 4. Improve individual and family functioning of those served 5. Improve school attendance of children served 6. Improve school performance of children served 7. Improve health outcomes of children served Long-term measures:	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome	Agency data Agency data Agency data TBD from contract with service provider TBD (e.g., School data) TBD (e.g., School data) TBD

14712

Strategy 4 – Invest in Prevention and Early Intervention Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
		8. Reduction of JJ involvement of children served 9. Reduction in substance abuse of children served 10. Reduction of risk factors for substance abuse and other problem behaviors of children served 11. Increased protective factors for prosocial behavior of children served	8. Outcome 9. Outcome 10. Outcome 11. Outcome	JJ data TBD TBD TBD
4c - School district based mental health and substance abuse services Target Pop: Children and youth enrolled in King County schools who are at risk for future school drop out	1. Fund 19 competitive grant awards to school based health programs in partnership with mental health, chemical dependency and youth service providers to provide a continuum of mental health and substance abuse services in schools	Short-term measures: 1. 19 grants are funded in school districts across King County 2. Increase # of youth receiving MH and/or CD services through school-based programs 3. Improved school performance for youth served 4. Improved school attendance for youth served 5. Decrease in truancy petitions filed for youth served Long-term measures: 6. Decrease in JJ involvement for youth served 7. Decrease use of emergency medical system for youth served 8. Decrease use of psychiatric hospitalization for youth served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	MHCADSD Agency/School data School data School data School/JJ data JJ data ER data Hospital data
4d - School based suicide prevention Target Pop: King County school students, including alternative schools students, age 12-19 years, school staff and administrators, and the students' parents and	1. Fund staff to provide suicide awareness and prevention training to children, administrators, teachers and parents to include: • Suicide Awareness Presentations for Students • Teacher Training • Parent Education • Developing school policies and	Short-term measures: 1. Hire three FTEs to provide suicide awareness and prevention training to children, administrators, teachers, and parents 2. Increase # of suicide awareness trainings for students 3. Increase # of teacher trainings 4. Increase # of parent education trainings	1. Output 2. Output 3. Output 4. Output	Agency data Agency data Agency data Agency data

Strategy 4 – Invest in Prevention and Early Intervention Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
guardians	procedures	5. Increase # of school policies and procedures addressing appropriate steps for intervening with students who are at-risk for suicide	5. Output	Agency data
		6. Increased awareness of the warning signs and symptoms of suicide for students, teachers, and parents	6. Outcome	TBD (e.g., pre/post survey)
		7. Increase # of at-risk youth referred and linked to treatment	7. Output	Agency data
		Long-term measures: 8. Decrease # of suicides and suicide attempts of youth served	8. Outcome	TBD
		9. Decreased suicidal ideation among youth served	9. Outcome	TBD
		10. Decreased depression and/or depressive symptoms among youth served	10. Outcome	TBD
		11. Increased help seeking behavior among target population	11. Outcome	TBD
		12. Decreased risk factors for suicide among target population	12. Outcomes	TBD
		13. Increased protective factors for suicide prevention among target population	13. Outcomes	TBD

14712

Strategy 5

Strategy 5 - Expand Assessments for Youth in the Juvenile Justice System				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
5a - Increase capacity for social and psychological assessments for juvenile justice youth (including youth involved with the Becca truancy process) Target Pop: Youth age 12 years or older who have become involved with the juvenile justice system.	1. Hire administrative and clinical staff to expand the capacity for social and psychological assessments, substance abuse assessment and other specialty evaluations (i.e., psychiatric, forensic, neurological, etc.) for juvenile justice involved youth	Short-term measures: 1. 1 FTE CDP hired to provide an additional 280 Global Appraisal of Individual Needs (GAIN) assessments per year 2. 1 FTE MH Liaison hired to provide an additional 200 MH assessments per year 3. Increase # of youth involved in JJ completing a GAIN assessment 4. Increase # of youth involved in JJ completing a MH assessment 5. Increase # of JJ involved youth linked to CD treatment 6. Increase # of JJ involved youth linked to MH treatment 7. Increase # of JJ involved youth receiving a psychiatric evaluation Long-term measures: 8. Reduction in recidivism rates for youth linked to CD and/or MH treatment 9. Reduction in substance use for youth served 10. Increased retention in CD and MH treatment for youth referred	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output 8. Outcome 9. Outcome 10. Outcome	MHCADSD MHCADSD MHCADSD Agency data Agency data/TARGET data Agency data/MIS TBD – JJ or Agency data JJ data TBD TBD

14712

Strategy 6

Strategy 6 - Expand Wraparound Services for Youth				
Sub-Strategy	**Intervention(s)/Objectives - including target**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
6a - Wraparound family, professional and natural support services for emotionally disturbed youth Target Pop: Emotionally and/or behaviorally disturbed children and/or youth (up to the age of 21) and their families who receive services from two or more of the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, developmental disabilities and/or special education programs, and who would benefit from high fidelity wraparound	1. 40 additional wraparound facilitators and 5 wraparound supervisors/coaches 2. Provide wraparound orientation to community on a quarterly basis 3. Flexible funding available to individual child and family teams	Short-term measures: 1. Provide wraparound to an additional 920 youth and families per year 2. Increase # of trainings provided annually 3. Improved school performance for youth served 4. Reduced drug and alcohol use for youth served 5. Improvement in functioning at home, school and community for youth served 6. Increased community connections and utilization of natural supports by youth and families 7. Maintained stability of current placement for youth served Long-term measures: 8. Reduced juvenile justice involvement for youth served 9. Improved high school graduation rates for youth served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome	MIS MHCADSD School data/survey TBD – survey TBD – survey TBD - survey Agency/DCFS data JJ data TBD

14712

Strategy 7

Strategy 7 - Expand Services for Youth in Crisis				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
7a - Reception centers for youth in crisis Target Pop: Youth who have been arrested, are ineligible for detention, and do not have a readily available parent or guardian.	1. Conduct a comprehensive needs assessment to determine most appropriate interventions to provide police officers with more options when interacting with runaways and minor youth who may be experiencing mental health and/or substance abuse problems. 2. Create a coordinated response/entry system for the target population that allows law enforcement and other first responders to link youth to the appropriate services in a timely manner. 3. Develop an enhanced array of services for the target population as deemed appropriate by the needs assessment.	Short-term measures: 1. Complete a needs assessment in conjunction with Strategy 7b to determine appropriate strategies to meet goals 2. Implementation of strategies identified through needs assessment Long-term measures: 3. Reduce # of admissions in juvenile detention facilities for youth served 4. Reduce # of ER admissions for youth served 5. Reduce # of psychiatric hospital admissions for youth served 6. Decreased homelessness for youth served 7. Reduction in risk factors for delinquency for youth served 8. Increased protective factors for prosocial behavior for youth served	1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	MHCADSD MHCADSD JJ data ER/Hospital data TBD TBD TBD TBD
7b - Expanded crisis outreach and stabilization for children, youth, and families Target Pop: 1) Children and youth age three-17 who are currently in King County and who are experiencing a mental health crisis. This includes children, youth, and families where the functioning of the child and/or	1. Expand current Children's Crisis Outreach Response System (CCORS) program to provide crisis outreach and stabilization to youth involved in the JJ system and/or at risk for placement in juvenile detention due to emotional and behavioral problems.	Short-term measures: 1. Conduct needs assessment, in conjunction with strategy 7a to determine additional capacity and resource needed to develop the full continuum of crisis options within the CCORS program 2. Increased # of youth in King County receiving crisis stabilization within the home environment 3. Maintain current living placement for	1. Output 2. Output 3. Outcome	MHCADSD MIS Agency data

14712

Strategy 7 - Expand Services for Youth in Crisis				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
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. 2) Children and youth being discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement		youth served Long-term measures: 4. Reduce # of ER admissions to for youth served 5. Reduce # of psychiatric hospital admissions for youth served 6. Reduce # of admissions in juvenile detention facilities for youth served 7. Reduce # of detention days in juvenile detention for youth served 8. Reduce # of requests for placement in child welfare system for youth served	 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	 ER data Hospital data JJ data JJ data Agency data/DCFS data

14712

Strategy 8

Strategy 8 - Expand Family Treatment Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
8a - Expand family treatment court services and supports to parents Target Pop: Parents in the child welfare system who are identified as being chemically dependent and who have had their child(ren) removed due to their substance use	1. Sustain and expand capacity of the Family Treatment Court (FTC) model	Short-term measures: 1. Expand family treatment court capacity to serve a total of 90 youth and families per year	1. Output	Superior Court
		2. Eligibility/enrollment completed quickly (timeframe TBD)	2. Output	TBD
		3. Parents are enrolled with appropriate CD services	3. Output	TARGET data
		4. Parents served are compliant with and complete treatment	4. Outcome	TARGET data
		5. Parents/children receive needed services	5. Outcome	TBD
		6. Parents are compliant with court orders	6. Outcome	Superior Court
		7. Decreased placement disruptions	7. Outcome	Superior Court/DCFS
		8. Earlier determination of alternative placement options	8. Outcome	TBD
		9. Increase in after care plan/connection to services	9. Outcome	TBD
		10. Decrease in substance use of parents served	10. Outcome	TBD
		Long-term measures: 11. Increased family reunification rates	11. Outcome	DCFS data
		12. Decrease subsequent out-of-home placements and/or Child Protection Services (CPS) involvement	12. Outcome	DCFS data

14712

Strategy 8 - Expand Family Treatment Court Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
		13. Reduction in juvenile justice system involvement for children served through FTC	13. Outcome	JJ data
		14. Reduction in substance abuse for children served through FTC	14. Outcome	TARGET data/Survey
		15. Reduction of risk factors for substance abuse & other problem behaviors of children served	15. Outcome	TBD
		16. Increased protective factors for prosocial behavior of children served	16. Outcome	TBD

Strategy 9

Strategy 9 - Expand Juvenile Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
9a - Expand juvenile drug court treatment Target Pop: Youth involved in the JJ system who are identified as having substance abuse issues or are diagnosed chemically dependent	1. Maintain and expand capacity of the Juvenile Drug Court (JDC) model	Short-term measures: 1. Expand juvenile drug court capacity to serve an additional 36 chemically dependent youth per year for a total of 72 youth served annually 2. Increase # of youth involved in JDC linked to drug/alcohol treatment 3. Increase # of youth involved in JDC completing drug/alcohol treatment 4. Reduce # of days spent in detention for youth involved in juvenile drug court Long-term measures: 5. Reduce juvenile recidivism rates for youth completing juvenile drug court 6. Reduce substance abuse/dependency for youth involved in juvenile drug court 7. Reduce risk factors for substance abuse and other problem behaviors of youth served 8. Increase protective factors for prosocial behavior of youth served	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	Superior Court Superior Court or TARGET data TARGET data JJ data JJ data TBD TBD TBD

14712

Strategy 10

Strategy 10 - Pre-booking Diversion				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
10a - Crisis intervention training program for King County Sheriff, police, jail staff, and other first responders Target Pop: KC Sheriff, police, firefighters, emergency medical technicians, ambulance drivers, jail staff, and other first responders *and* clients	1. Crisis intervention training (CIT) for KC Sheriff, police, firefighters, emergency medical technicians, ambulance drivers, jail staff, and other first responders 2. Provide 40-hr CIT training to 480 police and other first responders per year 3. Provide one-day CIT training to 1,200 other officers and other first responders	Short-term measures: 1. Hire 1 FTE educator/consultant II or III 2. Hire 1 FTE administrative specialist II 3. Provide 40-hr CIT training to 480 police and other first responders per year 4. Provide one-day CIT training to 1,200 other officers and other first responders per year 5. Increase # of KC Sheriff, police, jail staff, and other first responders given training 6. Self-Report of training effectiveness/ skills learned 7. Increase support for treatment services for individuals with MH and/CD needs among CIT trainees 8. Increase CIT trainees knowledge of individuals with MH and/or CD illnesses. 9. Reduce CIT trainees' stigma toward individuals with MH and/or CD illnesses. Long-term measures: 10. Increased use of diversion options for those served 11. Reduce # of jail bookings for those served 12. Reduce # of days in jail for those served 13. Reduce # of ER admissions for those served 14. Reduce # of psychiatric hospital admissions for those served 15. Reduce # of psychiatric hospital days	1. Output 2. Output 3. Output 4. Output 5. Output 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome 12. Outcome 13. Outcome 14. Outcome 15. Outcome	Agency data Agency data Agency data Agency data Agency data Training evaluations CIT pre/post survey CIT pre/post survey CIT pre/post survey TBD Jail data Jail data ER data Hospital data Hospital data

Strategy 10 - Pre-booking Diversion				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
		for those served		
10b -Adult crisis diversion center, respite beds and mobile behavioral health crisis team Target Pop: 1) Adults in crisis in the community who might otherwise be arrested for minor crimes and taken to jail or to a hospital emergency department. 2) Individuals who have been seen in emergency departments or at jail booking and who are ready for discharge but still in crisis and in need of services. Target population will be refined during the planning process.	1. Increase number of respite beds 2. Create a mobile crisis team of MH and CD specialists to evaluate, refer and link clients to services 3. Create a crisis diversion center for police and crisis responders	1. Serve ~3,600 adults/year (xx # depends on when different components implemented) Short-term measures: 2. Successfully link xx% of those seen by 10b services to MH and/or CD services (benchmark to be determined during contracting) 3. Increase # of respite beds 4. Mobile crisis team of MH & CD specialists is created 5. Crisis diversion center for police and crisis responders is created Long-term measures: 6. Reduce # of ER admissions for those served 7. Reduce # of psychiatric hospital admissions for those served 8. Reduce # of psychiatric hospital days for those served 9. Reduce # of jail bookings for those served 10. Reduce # of days in jail for those served	1. Output 2. Outcome 3. Output 4. Output 5. Output 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome	MIS MIS and TARGET data MHCADSD MHCADSD MHCADSD ER data Hospital data Hospital data Jail data Jail data

14712

Strategy 11

Strategy 11 - Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
11a - Increase capacity of jail liaison program Target Pop: King County Work Release (WER) inmates who are residents of King County or likely to be homeless within King County upon release from custody, and who are assessed as needing mental health services, chemical dependency treatment, other human services, or housing upon release.	1. One additional jail liaison to handle increased mental health courts caseload as designed under MIDD. 2. Liaisons linked inmates within 10-45 days from release to community-based MH, CD, medical services and housing.	1. Serve 360 additional clients via liaison Short-term measures: 2. Assist target population in applying for DSHS benefits when they are within 45 days of discharge 3. Refer veterans to Veterans Reintegration Services. 4. Successfully link xx% of those seen by liaison to MH and/or CD services (benchmark to be determined through contracting) 5. Improve rates of target population being placed in housing (temporary or permanent) upon discharge Long-term outcomes*: 6. Reduce # of jail bookings for those served 7. Reduce # of days in jail for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	CJ liaison Excel reports CJ liaison Excel reports TBD MIS and TARGET data TBD Jail data Jail data
11b - Increase services available for new or existing mental health court programs Target Pop: Adult misdemeanants with serious mental illness who opt-in to the mental health court and those who are unable to opt-in because of the lack of legal competency. Access to participate will also be developed for individuals in	1. Add court liaison/monitor and peer support specialist to existing mental health court and/or develop new municipal mental health courts 2. Other components may include increases in dedicated service capacity for mental health and co-occurring disorder treatment, housing, and access to community treatment providers	1. Serve 250 additional clients/year (over 300/yr current capacity) Short-term measures: 2. Successfully engage 90% of those seen to MH and/or CD services Long-term outcomes*: 3. Reduce # of jail bookings for those served 4. Reduce # of days in jail for those served	1. Output 2. Outcome 3. Outcome 4. Outcome	Data from courts - TBD MIS and TARGET data combined with data from courts - TBD Jail data Jail data

14712

Strategy 11 - Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency

Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
court jurisdictions in all parts of King County. *Because drug and mental health courts employ incarceration as a programmatic sanction, we expect reductions jail utilization to be modest during the first year (prior to participants' court "graduation"), with more pronounced reductions occurring in the second year.				

Strategy 12

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
12a - Increase jail re-entry program capacity	1. Add four re-entry case managers	Short-term measures: 1. Serve 1,440 additional clients served (over current capacity of 900/yr) 2. Successfully link xx% of those seen by liaison to MH and/or CD services Long-term measures: 3. Reduce # of jail bookings for those served 4. Reduce # of days in jail for those served by liaison 5. House xx% of homeless individuals served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome	CCAP Excel reports MIS and/or TARGET data Jail data Jail data CCAP Excel reports
12b - Hospital re-entry respite beds Target Pop: Homeless persons with mental illness and/or chemical dependency who require short-term medical care upon discharge from hospitals	1. Create Hospital re-entry respite beds 2. Serve 350-500 clients/year	Short-term measures: 1. Increase # of re-entry respite beds created for 350-500 clients/yr 2. Reduce # of ER admissions for those served 3. Reduce # of psychiatric hospital admissions for those served 4. Reduce # of psychiatric hospital days for those served 5. Reduce hospitalization costs for those served Long-term measures: 6. Reduce # of jail bookings for those served 7. Reduce # of days in jail for those served	1. Output 2. Outcome 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	MHCADSD ER data Hospital data Hospital data Hospital data Jail data Jail data
12c - Increase capacity for Harborview's Psychiatric Emergency Services (PES) to link individuals to community-based	1. Hire 2 MH/CD staff and 1 program assistant 2. Build Harborview's capacity to link individuals to community-based services upon discharge from the ER	Short-term measures: 1. Hire 2 MH/CD staff and 1 program assistant 2. Increase # of referrals 3. Increase # of linkages made to services	1. Output 2. Output 3. Output	Agency data Agency data Agency data

14712

Strategy 12 - Expand Re-entry Programs				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
services upon discharge from the emergency room Target pop: Adults who are frequent users of the Harborview Medical Center's PES		Long-term measures: 4. Reduce # of ER admissions for those served 5. Reduce # of psychiatric hospital admissions for those served 6. Reduce # of psychiatric hospital days for those served 7. Reduce # of jail bookings for those served 8. Reduce # of days in jail for those served	4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome	ER data Hospital data Hospital data Jail data Jail data
12d - Urinalysis supervision for Community Center for Alternative Programs (CCAP) clients Target Pop: CCAP clients who are mandated by Superior Court or District Court to report to CCAP and participate in treatment	1. Hire urinalysis technician(s) to provide on-site analyses for both male and female clients of CCAP. Urinalyses will be done for those who are ordered by the court to have one or more urine samples taken and analyzed each month.	Short-term measures: 1. New urinalysis technician(s) provide 2,700 UAs/yr – no change in current capacity 2. Increase "efficiency" in CCAP operations 3. Decreased CCAP staff time dedicated to this service 4. Assure gender-specific staff is available for the collection of urine samples.	1. Output 2. Output 3. Output 4. Output	TBD (e.g., CCAP reports) TBD (e.g., CCAP reports) TBD (e.g., CCAP reports) TBD (e.g., CCAP reports)

14712

Strategy 13

Strategy 13 – Domestic Violence Prevention/Intervention Sub-Strategy	Intervention(s)/Objectives - including target numbers	Performance Measures	Type of Measure	Data source(s) - Note any existing evaluation activity
13a – Domestic Violence (DV)/Mental Health Services and System Coordination Target Pop: (1) DV survivors who are experiencing mental health and substance abuse concerns but have been unable to access mental health or substance abuse services due to barriers (2) Providers at sexual assault, mental health, substance abuse, and DV agencies who work with DV survivors and participate in the coordination and cross training of programs	1. 3 mental health professionals (MHPs) will be added to community-based DV agencies 2. A .5 MHP will be housed at an agency serving immigrant and refugee survivors of DV. 3. A .5 Systems Coordinator/Trainer will coordinate ongoing cross training, policy development, and consultation on DV issues between MH, CD, and DV county agencies 4. MHPs will provide assessment and MH treatment to DV survivors. Treatment includes brief therapy and MH support through group and/or individual sessions. 5. MHPs will provide assessment and referrals to community MH and CD agencies for those DV survivors who need more intensive services. 6. MHPs will offer consultation to DV advocacy staff and staff of community MH or CD agencies.	Short-term measures: 1. Hire three MHPs within community-based DV agencies 2. Hire a .5 FTE MHP housed at culturally-specific provider of sexual assault advocacy services 3. Hire a .5 Systems Coordinator/Trainer hired 4. Interpreters hired 5. 175-200 clients served per year 6. 200 counselors/advocates trained per year 7. Increase access to MH/CD treatment services for DV survivors 8. Culturally relevant MH services provided to DV survivors from immigrant and refugee communities in their own language 9. Consistent screening for DV among participating MH and CD agencies 10. Consistent screening for MH and CD needs 11. Increased referrals to DV providers 12. Development of new policies in DV agencies that are responsive to survivors' MH & CD concerns 13. Increased coordination and collaboration between MH, substance abuse, DV, and sexual assault service providers Long-term measures: 14. Decreased trauma symptoms and depression among DV survivors served 15. Increased resiliency and coping skills	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output 8. Output 9. Output 10. Output 11. Output 12. Output 13. Output 14. Outcome	Agency data Agency data Agency data Agency data MIS MHCADSD MIS Agency data Agency data Agency data Agency data TBD TBD TBD (e.g., survey)

14712

Strategy 13 – Domestic Violence Prevention/Intervention				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
		among DV survivors served	15. Outcome	TBD (e.g., survey)
13b – Provide early intervention for children experiencing DV and for their supportive parent Target Pop: Children who have experienced DV and their supportive parents	1. A DV response team will provide MH and advocacy services to children ages 0-12 who have experienced DV. 2. A DV response team will provide support, advocacy, and parent education to the non-violent parent. 3. Children's therapy will include trauma focused cognitive behavioral-therapy as well as Kids Club, a group therapy intervention for children experiencing DV. 4. Families will be referred through the DV Protection Order Advocacy program as well as through partner agencies (goal is to serve approximately 85 families with 150 children)	Short-term measures: 1. One lead clinician will be added at Sound Mental Health 2. Two FTE DV Advocates will be added at the subcontractor 3. DV services to approx 85 families with 150 children. Long-term measures: 4. Decrease children's trauma symptoms. 5. Reduce children's externalizing behaviors. 6. Reduce children's internalizing behaviors. 7. Increase protective/resiliency factors available to children and their supportive parents. 8. Reduce children's negative beliefs related to DV, including that the violence is their fault, and/or that violence is an appropriate way to solve problems. 9. Improve social and relationship skills so that children may access needed social supports in the future. 10. Support and strengthen the relationship between children and their supportive parents. 11. Increase supportive parents' understanding of the impact of DV on their children and ways to help.	1. Output 2. Output 3. Output 4. Outcome 5. Outcome 6. Outcome 7. Outcome 8. Outcome 9. Outcome 10. Outcome 11. Outcome	Agency data Agency data Agency data TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey) TBD (e.g., survey)

Strategy 14

Strategy 14 – Expand Access to Mental Health Services for Survivors of Sexual Assault				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
14a – Sexual Assault Services Target Pop: (1) Adult, youth, and child survivors of sexual assault who are experiencing mental health and substance abuse concerns (2) Providers at sexual assault, mental health, substance abuse, and DV agencies who work with sexual assault survivors and participate in the coordination and cross training of programs	1. Expand the capacity of Community Sexual Assault programs (CSAPs) and culturally specific providers of sexual assault advocacy services to provide evidenced-based MH & CD services. 2. Provide services to women and children from immigrant and refugee communities by housing a MH provider specializing in evidenced-based trauma-focused therapy at an agency serving these communities.	Short-term measures: 1. Hire four FTEs to work at CSAP provider agencies. 2. Hire .5 FTE as a MH provider to be housed at a culturally-specific provider of sexual assault services. 3. Hire .5 FTE Systems Coordinator/Trainer 4. Interpreters hired 5. Provide therapy and case management services to 400 adult, youth, and child survivors. 6. Increased access to services for adult, youth, and child survivors. 7. Increased coordination between CSAPs, culturally specific providers of sexual assault advocacy services, public MH, substance abuse, and DV service providers. 8. Culturally relevant MH services provided to sexual assault survivors from immigrant and refugee communities in their own language Long-term measures: 9. Reduction in trauma symptoms for those adult, youth, and child survivors receiving services. 10. Increased resiliency and coping skills among sexual assault survivors served	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Output 8. Output 9. Outcome 10. Outcome	Agency data Agency data Agency data Agency data MIS Service records TBD (e.g., qualitative data) Agency data TBD (e.g., survey) TBD (e.g., survey)

14712

Strategy 15

Strategy 15 - Drug Court				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
15a - Increase services available to drug court clients Target pop: King County Adult Drug Court participants	Provide to Drug Court clients: 1. Employment services per strategy 2b 2. Access to CHOICES program for individuals with learning or attention disabilities 3. Expanded evidence-based treatment (e.g., Wraparound, Multi-Systemic Therapy (MST)) for ages 18-24 (1.0 FTE) 4. Expanded services for women with Co-occurring disorder (COD) and/or trauma (1.0 FTE) and funding for suboxone for this population 5. Housing case management (1.5 FTE)	Short-term measures: 1. Increase # of clients served to 450 2. Hire 1.5 FTE Housing case management positions 3. Increase # of evidence-based treatment services available for ages 18-24. 4. Increase # of services available for women with COD and/or trauma. 5. Increase # of women receiving suboxone 6. Increase # of drug clients accessing the CHOICES program (of those eligible) 7. Reduce substance use for those served Long-term measures* 8. Reduce # of jail bookings for those served 9. Reduce # of days in jail for those served 10. Increase the rates of program completion/attrition	1. Output 2. Output 3. Output 4. Output 5. Output 6. Output 7. Outcome 8. Outcome 9. Outcome 10. Outcome	Drug court databases MHCADSD MHCADSD MHCADSD MHCADSD MHCADSD TARGET and drug court (Monitor) databse Jail data Jail data court (Monitor) database

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

14712

Strategy 16

Strategy 16 – Increase Housing Available for Individuals with Mental Illness and/or Chemical Dependency				
Sub-Strategy	**Intervention(s)/Objectives - including target numbers**	**Performance Measures**	**Type of Measure**	**Data source(s) - Note any existing evaluation activity**
16a – Housing Development Target Pop: Individuals with mental illness and/or chemical dependency who are homeless or being discharged from hospitals, jails, prisons, crisis diversion facilities, or residential chemical dependency treatment	1. Provide additional funds to supplement existing fund sources, which will allow new housing projects to complete their capital budgets and begin construction sooner than would otherwise be possible.	Short-term measures: 1. Increase # of residential units created 2. Increase # of rental subsidies disbursed Long-term measures: 3. Reduce # of jail bookings for those served 4. Reduce # of days in jail for those served 5. Reduce # of ER admissions for those served 6. Reduce # of psychiatric hospital admissions for those served 7. Reduce # of psychiatric hospital days for those served	 1. Output 2. Output 3. Outcome 4. Outcome 5. Outcome 6. Outcome 7. Outcome	 MHCADSD MHCADSD Jail data Jail data ER data Hospital data Hospital data

14712

14712

Effectiveness of MIDD Strategies in Reducing Emergency Department Use

Fourteen MIDD strategies had a primary or secondary policy goal of reducing emergency room use by mentally ill or drug dependent clients, as shown below. Data were provided by Harborview Medical Center in Seattle, WA in order to monitor changes in use of their emergency department over time. Substance use disorder treatment was analyzed separately for those in outpatient treatment versus opiate treatment. Strategy 17a was excluded from the analysis, as other non-MIDD funding was secured to run this program.

			MIDD Policy Goal
Strategy Number	Strategy Name	Strategy Description	Reduce Emergency Department Use
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+
1a-2	Substance Use Disorder Treatment	Increase Access to Community Substance Use Disorder (SUD) Treatment	+
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	✪
1c	Emergency Room Intervention	Emergency Room Substance Abuse Early Intervention Program	✪
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪
1g	Older Adults Prevention	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	+
1h	Older Adults Crisis & Service Linkage	Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults	✪
3a	Supportive Housing	Supportive Services for Housing Projects	✪
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	✪
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	✪
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	✪
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪
17a	Crisis Intervention/MH Partnership	Crisis Intervention Team/Mental Health Partnership Pilot	+

Key: ✪ = Primary Goal + = Secondary Goal

Emergency Department Reduction Goals

Incremental and cumulative goals for reduction of emergency room use by MIDD participants were established in an Evaluation Targets Addendum dated September 2, 2008, as shown in the grid below. The incremental reduction goals for each post period represent an additional reduction from the pre period (the year prior to an individual's MIDD start date), rather than a reduction from the previous post period. The green highlighting indicates adequate data availability for most strategies (as of February 2015) for preliminary assessment of long-term effectiveness.

Harborview ED Admissions				
Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-10%
Post 2	-14%	-19%	-10%	-20%
Post 3	-13%	-32%	-10%	-30%
Post 4	-13%	-45%	-10%	-40%
Post 5	-15%	-60%	-10%	-50%

Factors Impacting Assessment of Effectiveness

Late Strategy Start Date

Strategies that began after October 1, 2010, do not have enough data to assess effectiveness yet.

- Strategy 7b—Expand Youth Crisis Services
- Strategy 10b—Adult Crisis Diversion
- Strategy 12b—Hospital Re-Entry Respite Beds

Low Use of Harborview ED

Strategies with use rates lower than 25 percent of all who are eligible may take longer to achieve their reduction goals.*

- Strategy 1a-1—Mental Health Treatment
- Strategy 1a-2a—Outpatient SUD Treatment
- Strategy 1g—Older Adults Prevention
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services.

* Note: If strategies have very small sample sizes, they are less likely to show changes over time that reach statistical significance.

Factors Impacting Effectiveness Results

Lower Admissions to ED Prior to the MIDD

Strategies with fewer average admissions in the pre period have less room for improvement.

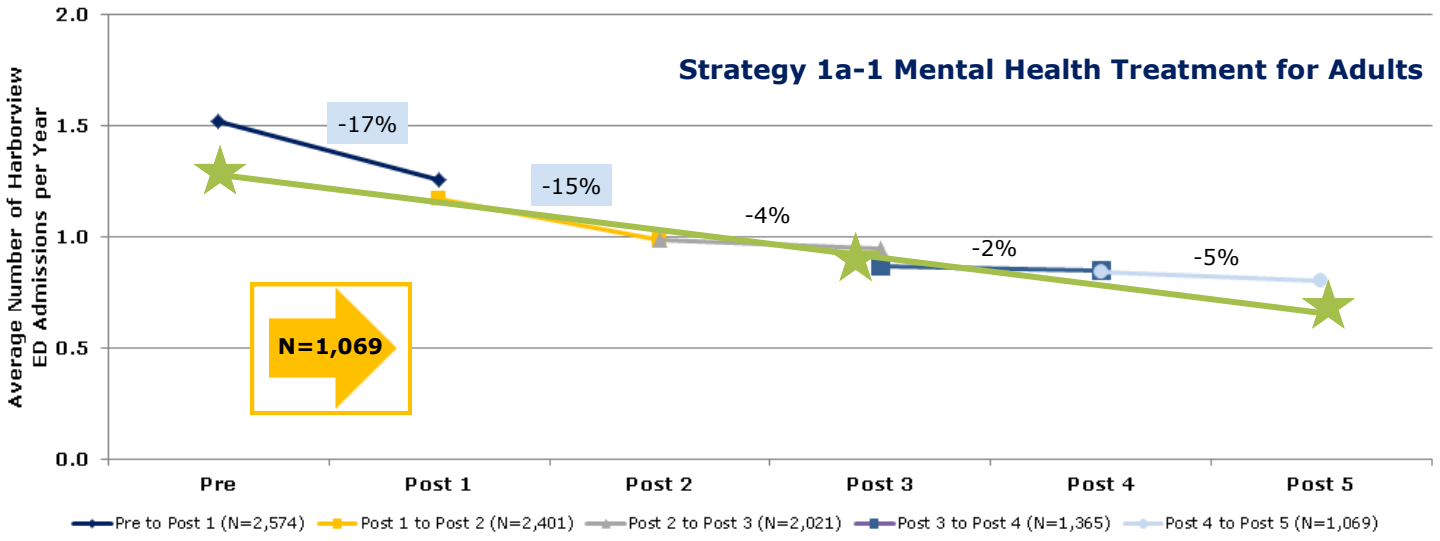
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services

Increases in ED Use Associated with Start of MIDD Services

Outreach and crisis intervention strategies may show initial increases in system use due to discovery of individuals not previously linked with needed/ necessary emergency medical care. Strategies with initial increases are expected to decrease over time, but may need more time to achieve reduction goals.

- Strategy 1b—Outreach & Engagement
- Strategy 1c—Emergency Room Intervention
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 10b—Adult Crisis Diversion
- Strategy 12b—Hospital Re-Entry Respite Beds.

Incremental Change Over Time for Individuals with Emergency Department Use Who Were Served in MIDD Mental Health, Support, and Certain Outreach Strategies



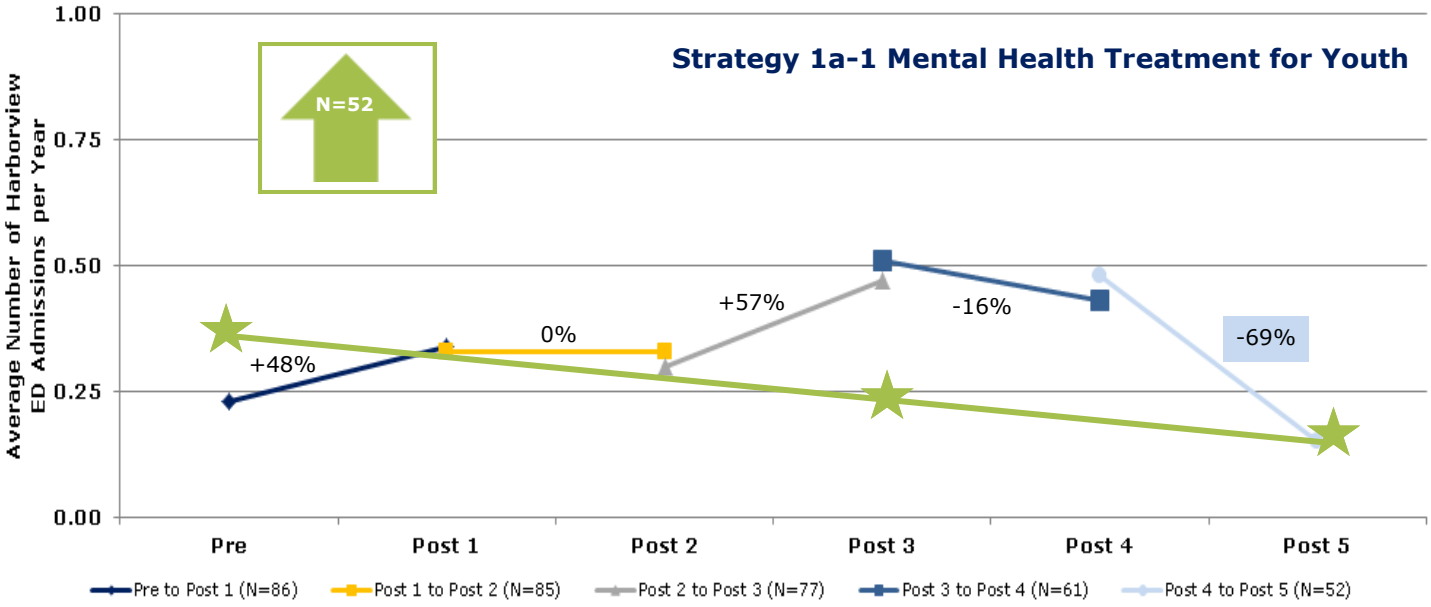
Key:

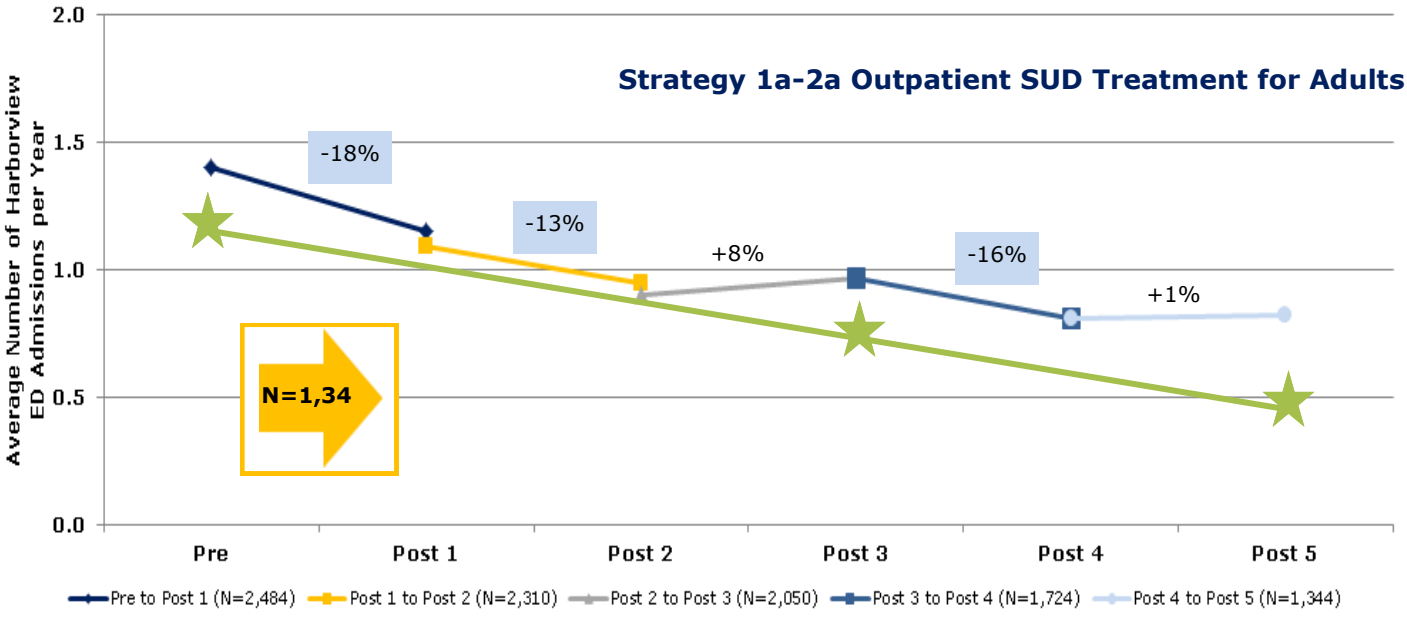
Ultimate targeted reduction goal was met by sample of strategy participants eligible for longest post period who had jail use in any period.

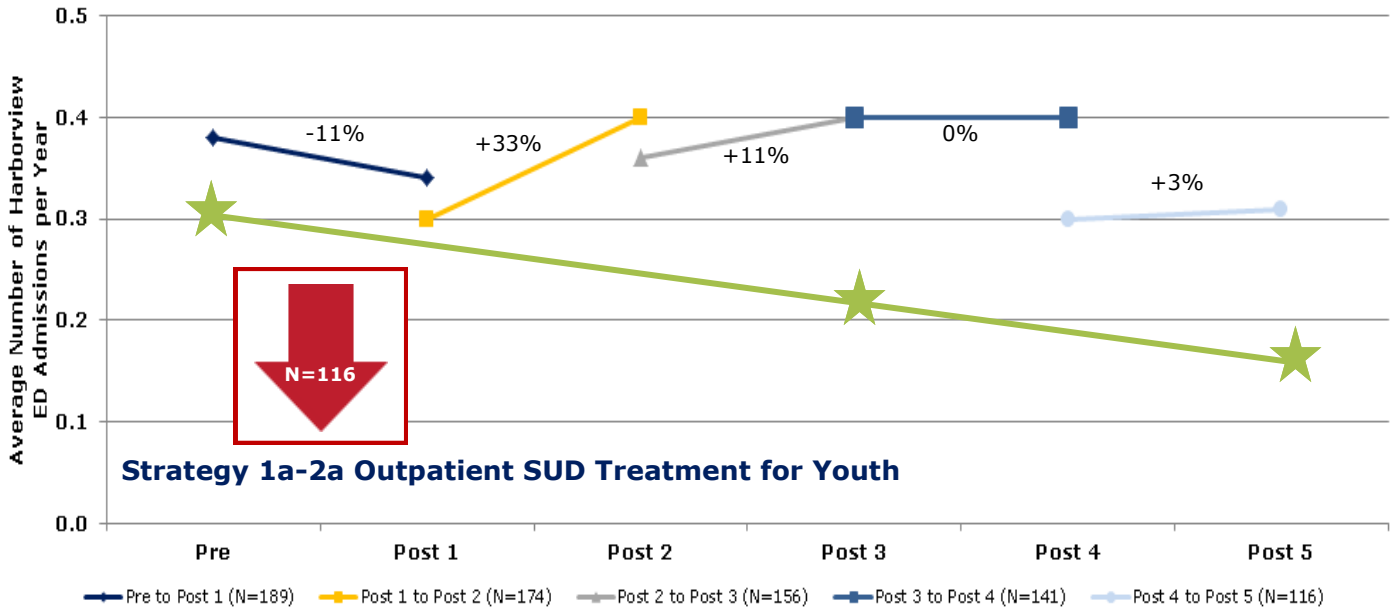
Strategy was on pace to meet ultimate targeted reduction goal, but an unexpected shift in the data pattern prevented goal attainment.

Ultimate targeted reduction goal is not expected to be met based on trends noted in currently available data.

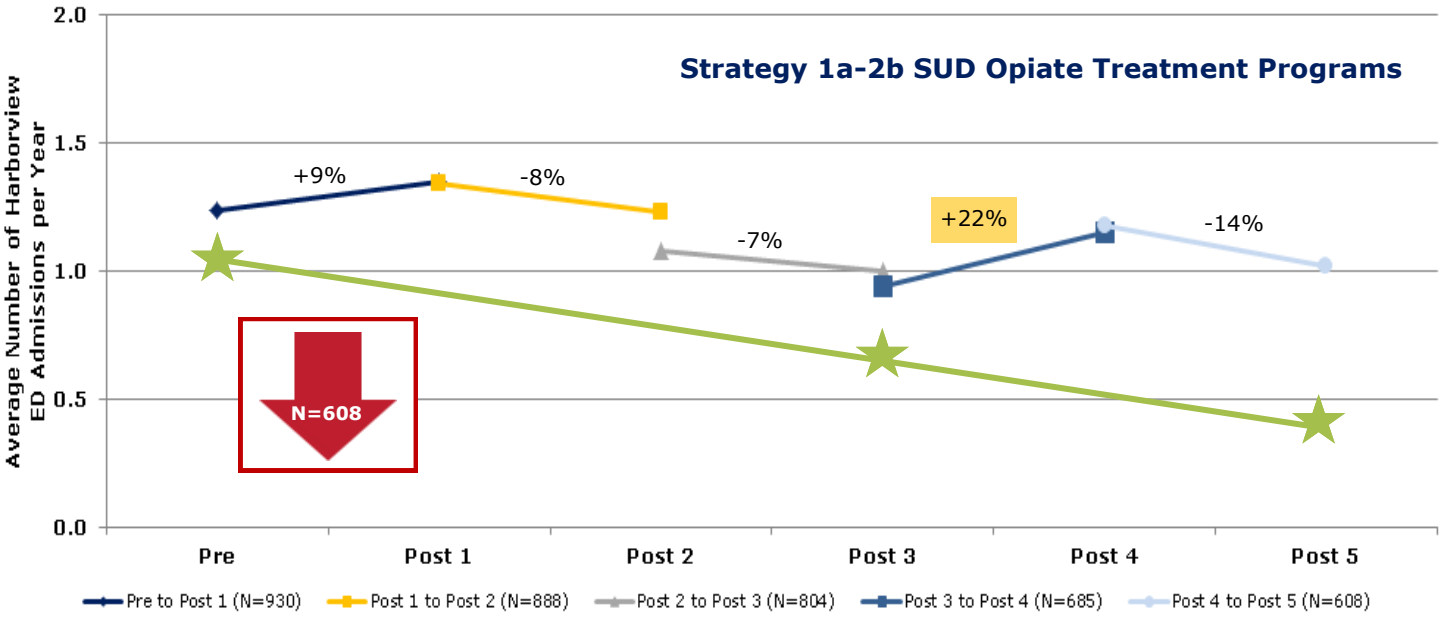
Statistically significant reductions are highlighted in blue. Statistically significant increases are highlighted in yellow.

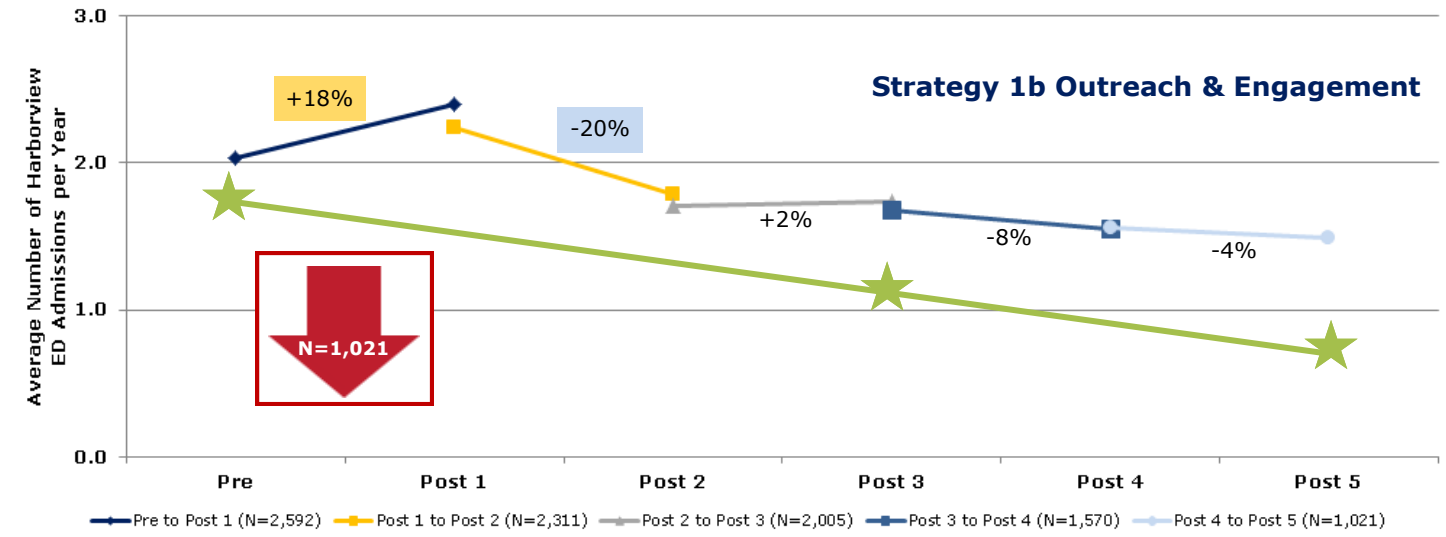

Strategy 1a-1 Mental Health Treatment for Youth
N=52
Average Number of Harborview ED Admissions per Year
1.00
0.75
0.50
0.25
0.00
+48%
0%
+57%
-16%
-69%
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=86)
Post 1 to Post 2 (N=85)
Post 2 to Post 3 (N=77)
Post 3 to Post 4 (N=61)
Post 4 to Post 5 (N=52)

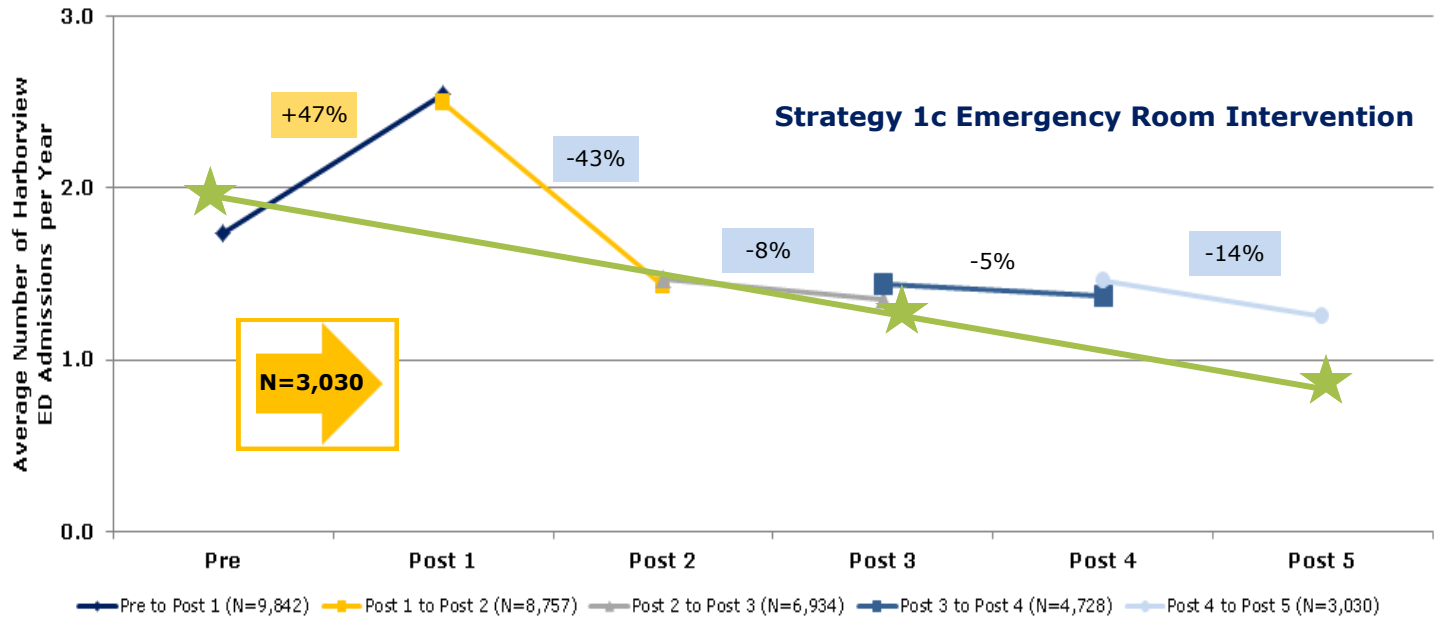

Strategy 1a-2a Outpatient SUD Treatment for Adults
N=1,34
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
-18%
-13%
+8%
-16%
+1%
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=2,484)
Post 1 to Post 2 (N=2,310)
Post 2 to Post 3 (N=2,050)
Post 3 to Post 4 (N=1,724)
Post 4 to Post 5 (N=1,344)


N=116
Average Number of Harborview ED Admissions per Year
0.5
0.4
0.3
0.2
0.1
0.0
-11%
+33%
+11%
0%
+3%
Strategy 1a-2a Outpatient SUD Treatment for Youth
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=189)
Post 1 to Post 2 (N=174)
Post 2 to Post 3 (N=156)
Post 3 to Post 4 (N=141)
Post 4 to Post 5 (N=116)

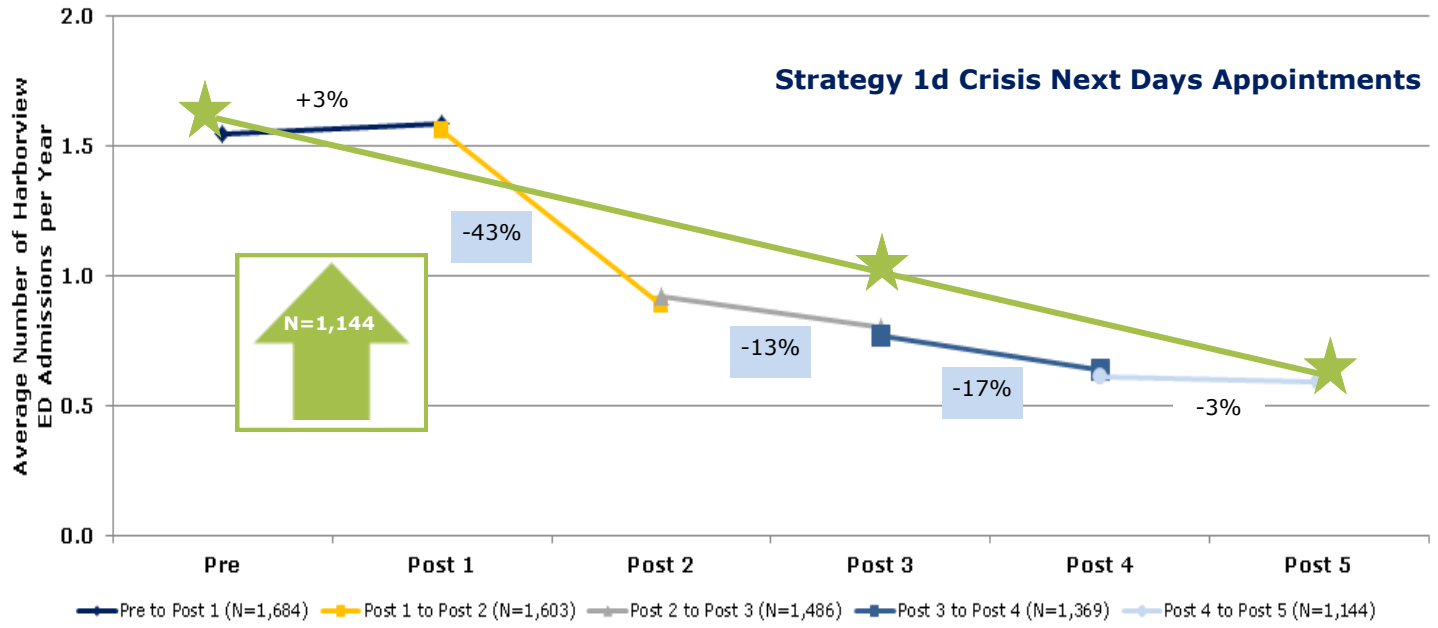
14712

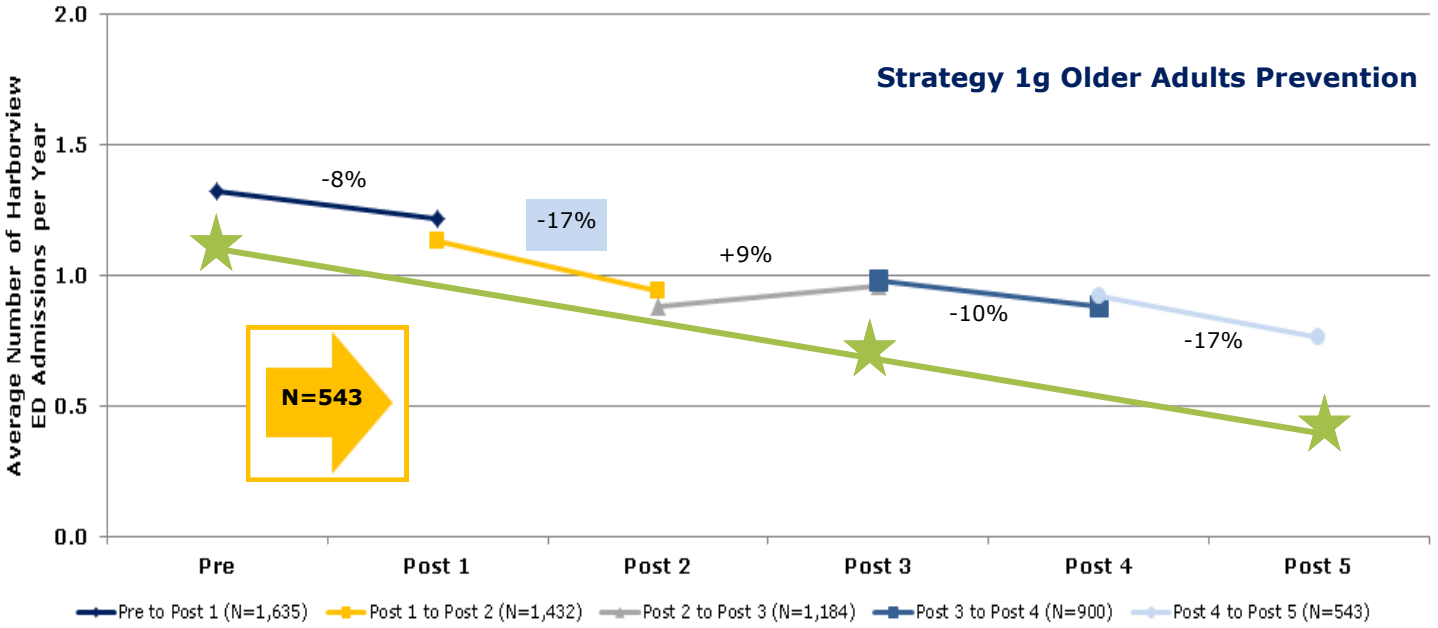

Strategy 1a-2b SUD Opiate Treatment Programs
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
+9%
-8%
-7%
+22%
-14%
N=608
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=930)
Post 1 to Post 2 (N=888)
Post 2 to Post 3 (N=804)
Post 3 to Post 4 (N=685)
Post 4 to Post 5 (N=608)

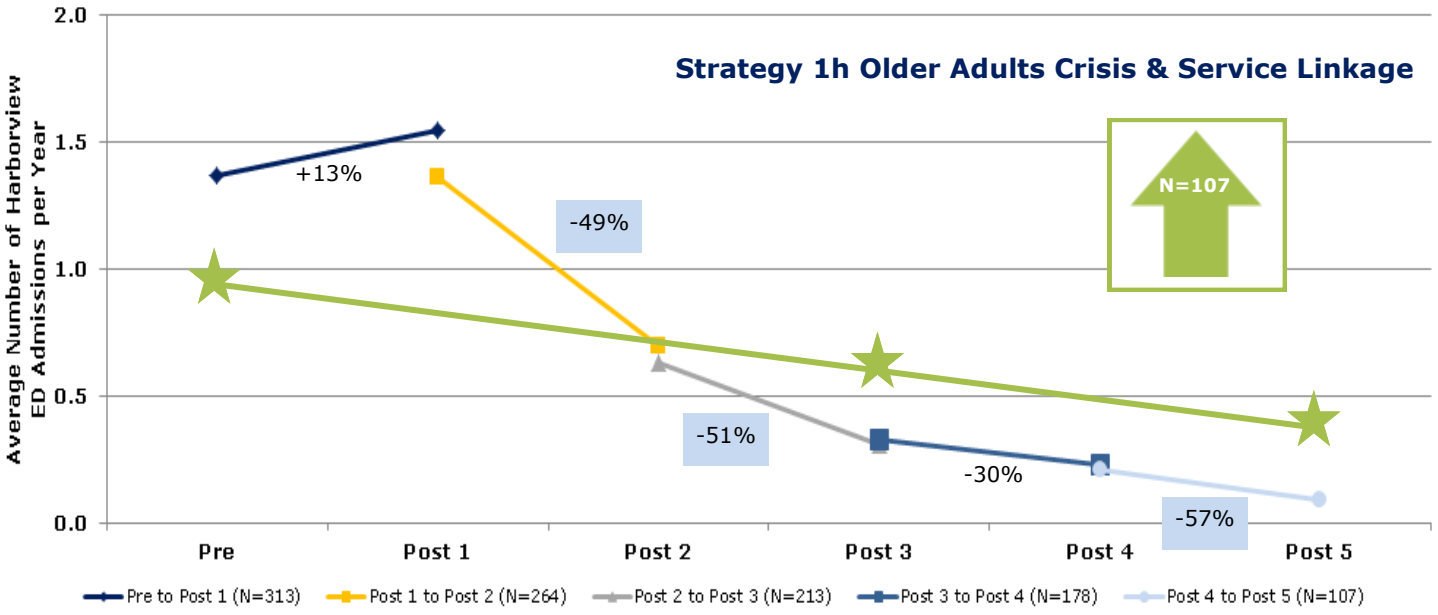

Strategy 1b Outreach & Engagement
Average Number of Harborview ED Admissions per Year
3.0
2.0
1.0
0.0
+18%
-20%
+2%
-8%
-4%
N=1,021
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=2,592)
Post 1 to Post 2 (N=2,311)
Post 2 to Post 3 (N=2,005)
Post 3 to Post 4 (N=1,570)
Post 4 to Post 5 (N=1,021)


Strategy 1c Emergency Room Intervention
Average Number of Harborview ED Admissions per Year
3.0
2.0
1.0
0.0
+47%
-43%
-8%
-5%
-14%
N=3,030
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=9,842)
Post 1 to Post 2 (N=8,757)
Post 2 to Post 3 (N=6,934)
Post 3 to Post 4 (N=4,728)
Post 4 to Post 5 (N=3,030)

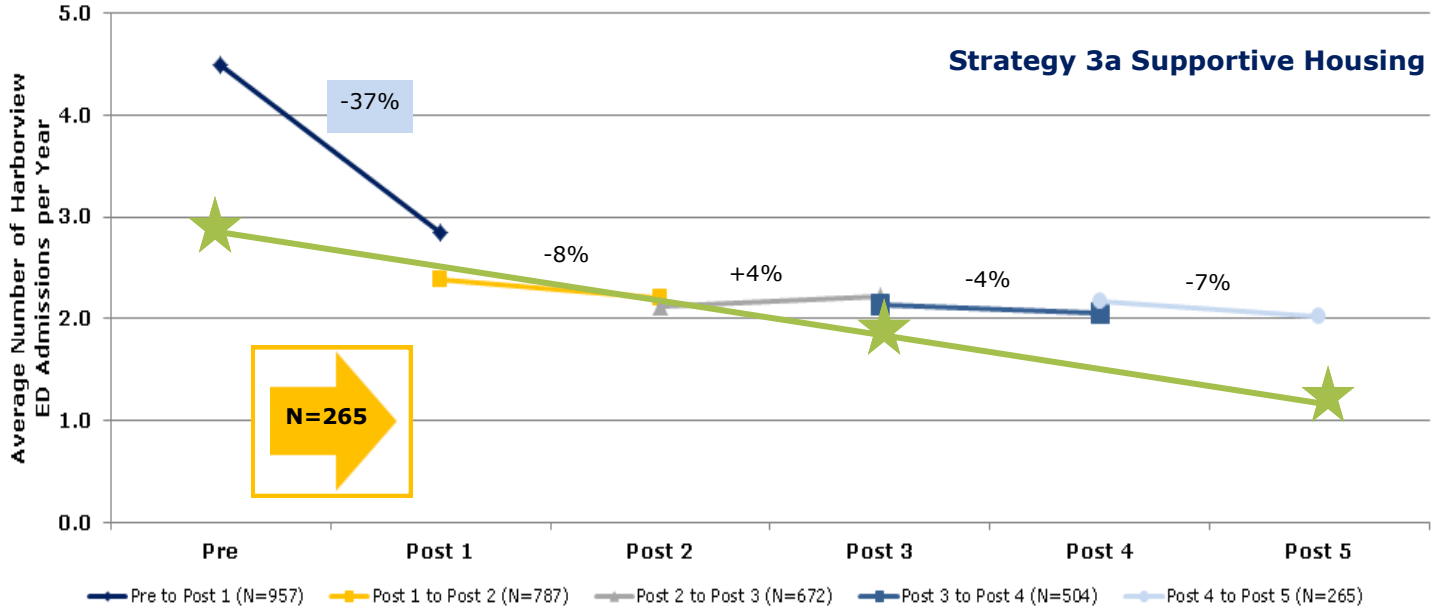
14712

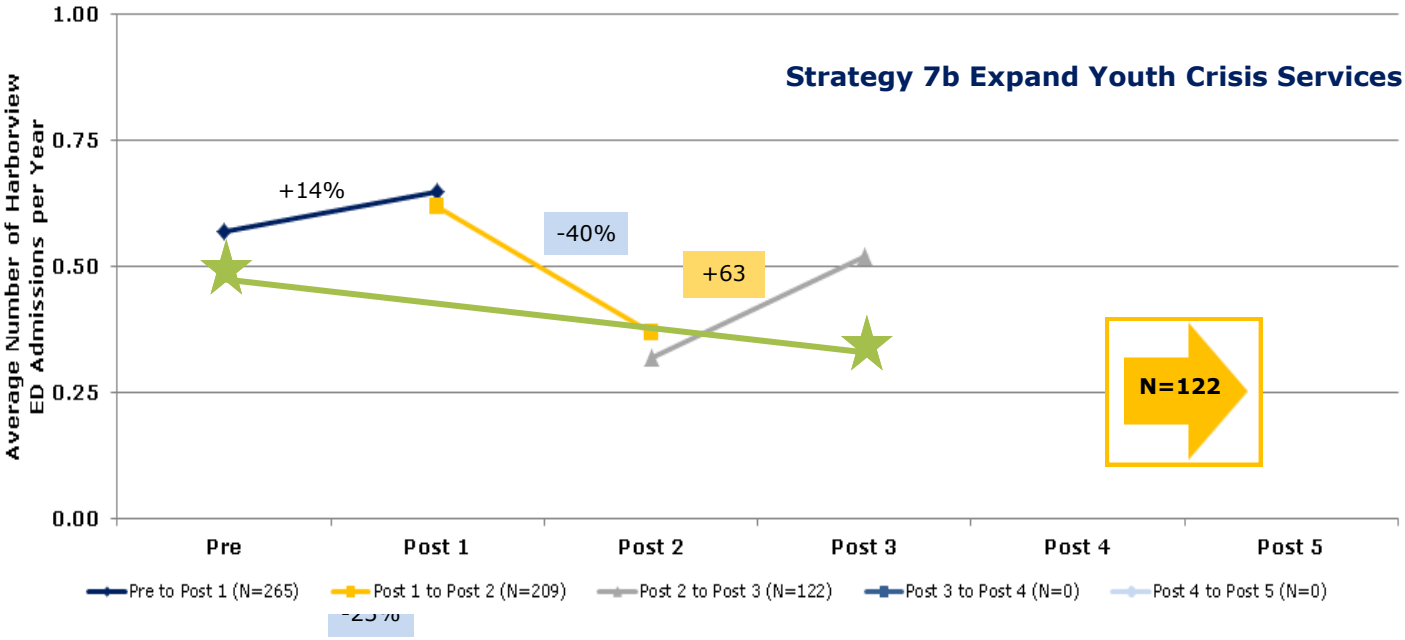

Strategy 1d Crisis Next Days Appointments
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
+3%
-43%
-13%
-17%
-3%
N=1,144
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,684)
Post 1 to Post 2 (N=1,603)
Post 2 to Post 3 (N=1,486)
Post 3 to Post 4 (N=1,369)
Post 4 to Post 5 (N=1,144)

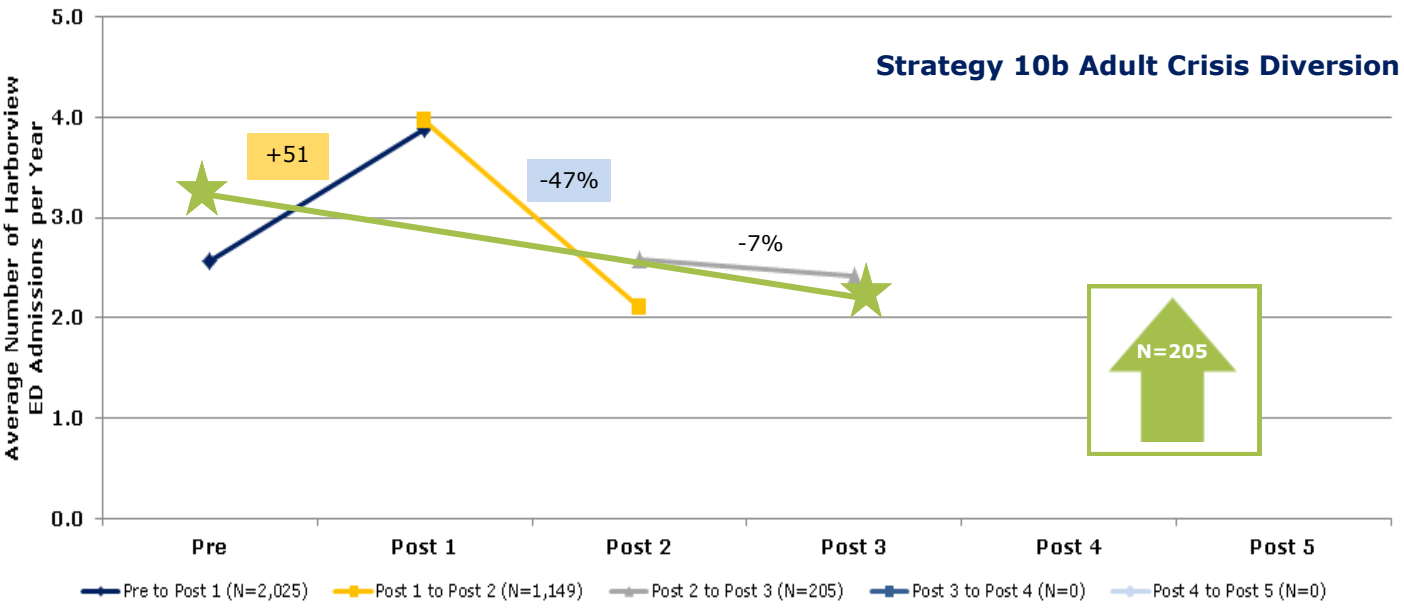

Strategy 1g Older Adults Prevention
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
-8%
-17%
+9%
-10%
-17%
N=543
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,635)
Post 1 to Post 2 (N=1,432)
Post 2 to Post 3 (N=1,184)
Post 3 to Post 4 (N=900)
Post 4 to Post 5 (N=543)


Strategy 1h Older Adults Crisis & Service Linkage
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
+13%
-49%
-51%
-30%
-57%
N=107
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=313)
Post 1 to Post 2 (N=264)
Post 2 to Post 3 (N=213)
Post 3 to Post 4 (N=178)
Post 4 to Post 5 (N=107)

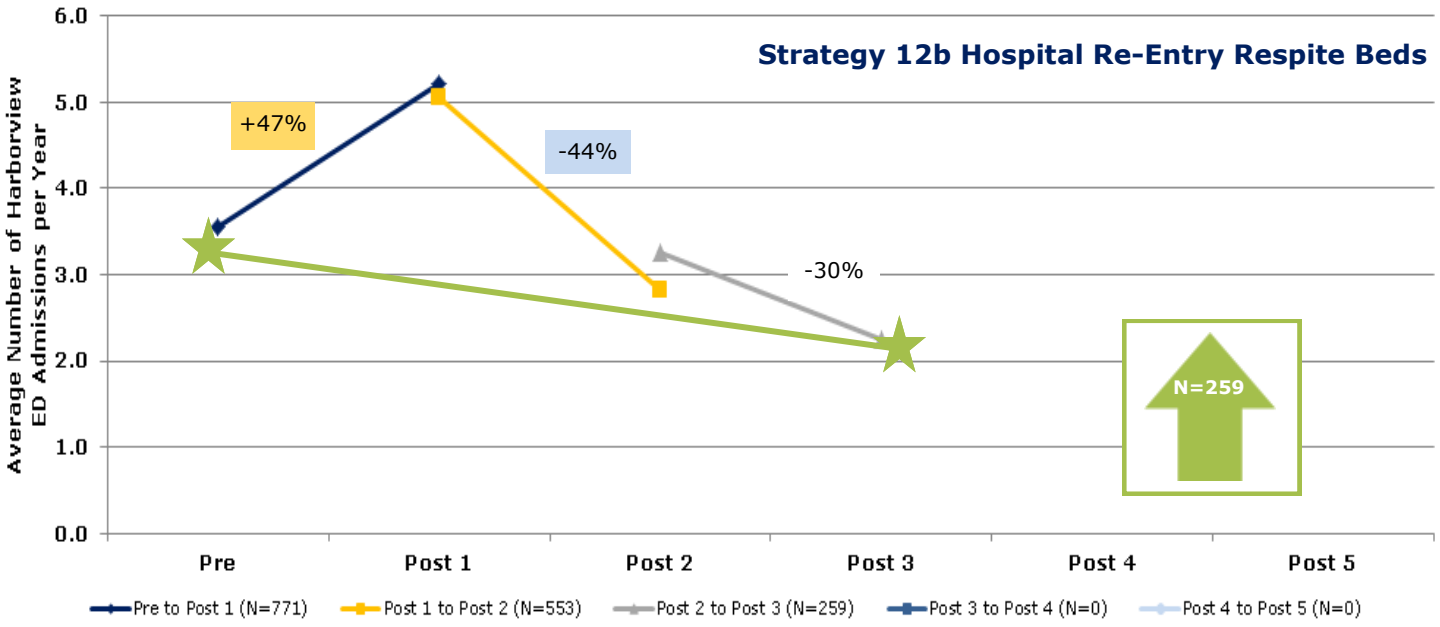
14712

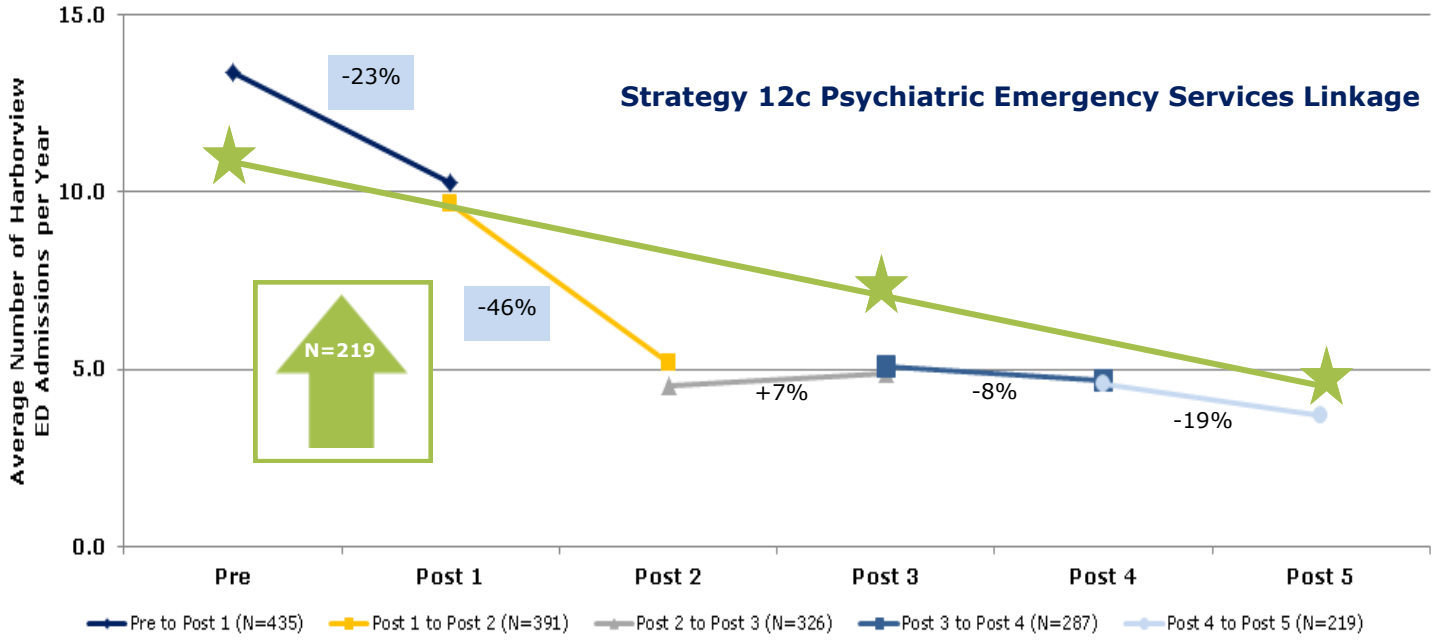

Strategy 3a Supportive Housing
Average Number of Harborview ED Admissions per Year
5.0
4.0
3.0
2.0
1.0
0.0
-37%
-8%
+4%
-4%
-7%
N=265
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=957)
Post 1 to Post 2 (N=787)
Post 2 to Post 3 (N=672)
Post 3 to Post 4 (N=504)
Post 4 to Post 5 (N=265)

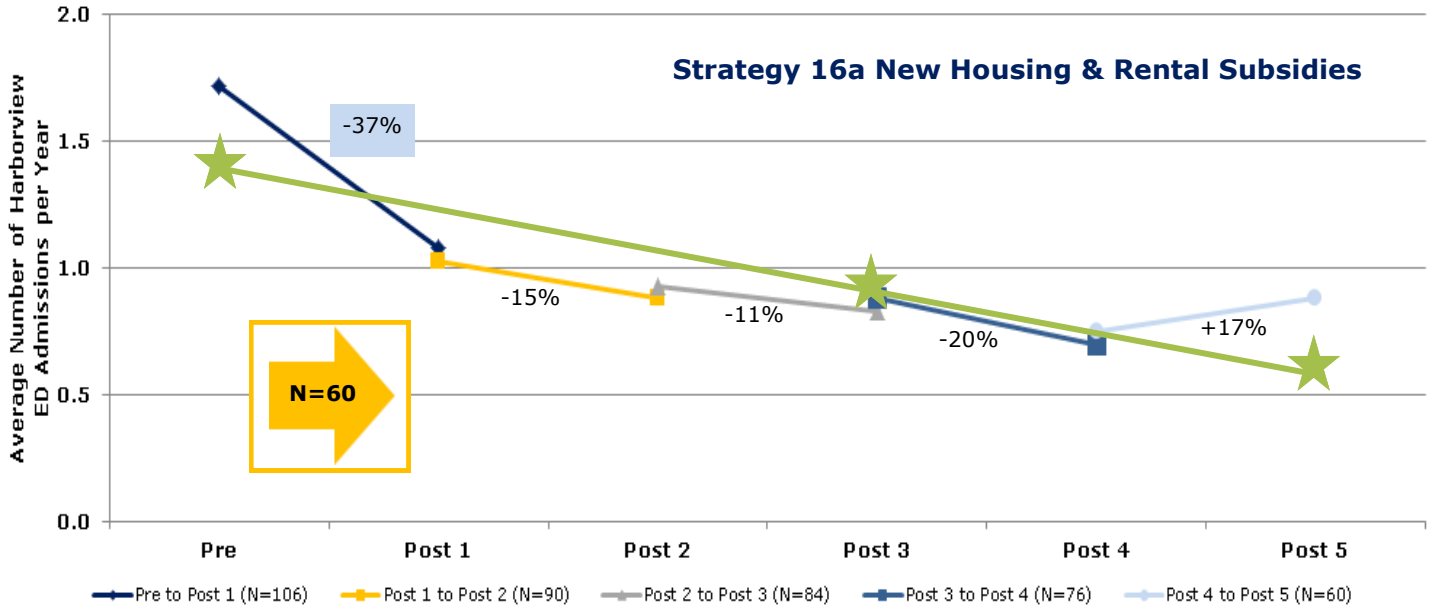

Strategy 7b Expand Youth Crisis Services
Average Number of Harborview ED Admissions per Year
1.00
0.75
0.50
0.25
0.00
+14%
-40%
+63
N=122
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=265)
Post 1 to Post 2 (N=209)
Post 2 to Post 3 (N=122)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)


Strategy 10b Adult Crisis Diversion
Average Number of Harborview ED Admissions per Year
5.0
4.0
3.0
2.0
1.0
0.0
+51
-47%
-7%
N=205
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=2,025)
Post 1 to Post 2 (N=1,149)
Post 2 to Post 3 (N=205)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

14712


Strategy 12b Hospital Re-Entry Respite Beds
Average Number of Harborview ED Admissions per Year
6.0
5.0
4.0
3.0
2.0
1.0
0.0
+47%
-44%
-30%
N=259
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=771)
Post 1 to Post 2 (N=553)
Post 2 to Post 3 (N=259)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)


Strategy 12c Psychiatric Emergency Services Linkage
Average Number of Harborview ED Admissions per Year
15.0
10.0
5.0
0.0
-23%
-46%
+7%
-8%
-19%
N=219
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=435)
Post 1 to Post 2 (N=391)
Post 2 to Post 3 (N=326)
Post 3 to Post 4 (N=287)
Post 4 to Post 5 (N=219)


Strategy 16a New Housing & Rental Subsidies
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
-37%
-15%
-11%
-20%
+17%
N=60
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=106)
Post 1 to Post 2 (N=90)
Post 2 to Post 3 (N=84)
Post 3 to Post 4 (N=76)
Post 4 to Post 5 (N=60)

Effectiveness of MIDD Strategies in Reducing Community Inpatient Psychiatric and Western State Hospital Use

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

			MIDD Policy Goal
Strategy Number	Strategy Name	Strategy Description	Reduce Psychiatric Hospital Use
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	✪
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪
1h	Older Adults Crisis & Service Linkage	Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults	✪
3a	Supportive Housing	Supportive Services for Housing Projects	✪
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	✪
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	✪
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	✪
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪

Key: ✪ = Primary Goal + = Secondary Goal

Psychiatric Hospitalization Reduction Goals

Incremental and cumulative goals for reduction of psychiatric hospital use by MIDD participants were established in an Evaluation Targets Addendum dated September 2, 2008, as shown in the grid below. Although the original targeted reductions were based on admissions, the average number of days per year more fully captures utilization of psychiatric hospitals. While psychiatric admissions and days are closely correlated, days hospitalized can vary widely between individuals. The incremental reduction goals for each post period represent an additional reduction from the pre period (the year prior to an individual's MIDD start date), rather than a reduction from the previous post period. The green highlighting indicates adequate data availability for most strategies (as of February 2016) for preliminary assessment of long-term effectiveness.

The green line shown on graphs over the next several pages indicates the ultimate expected reduction from Pre to Post 5 for strategy participants eligible for the longest time period who had psychiatric hospitalizations in any time period, unless stated otherwise.

Psychiatric Hospital Admissions or Days				
Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-10%	-10%	-10%	-10%
Post 2	-8%	-18%	-10%	-20%
Post 3	-8%	-26%	-10%	-30%
Post 4	-7%	-33%	-10%	-40%
Post 5	-7%	-40%	-10%	-50%

Factors Impacting Assessment of Effectiveness

Late Strategy Start Date

Strategies that began after October 1, 2010, do not have enough data to assess effectiveness yet.

- Strategy 7b—Expand Youth Crisis Services
- Strategy 10b—Adult Crisis Diversion
- Strategy 12b—Hospital Re-Entry Respite Beds

Low Use of Inpatient Psychiatric Facilities

Six of 10 strategies had use rates lower than 25 percent of all who were eligible for outcomes analysis. These programs may take longer to achieve their reduction goals.*

- Strategy 1a-1—Mental Health Treatment
- Strategy 1b—Outreach & Engagement
- Strategy 1d—Crisis Next Day Appointments
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services
- Strategy 12b—Hospital Re-Entry Respite Beds

* Note: If strategies also have small sample sizes, they are less likely to show changes over time that reach statistical significance.

Factors Impacting Effectiveness Results

Shorter Hospitalizations Prior to the MIDD

Strategies with fewer average hospital days in the pre period have less room for improvement.

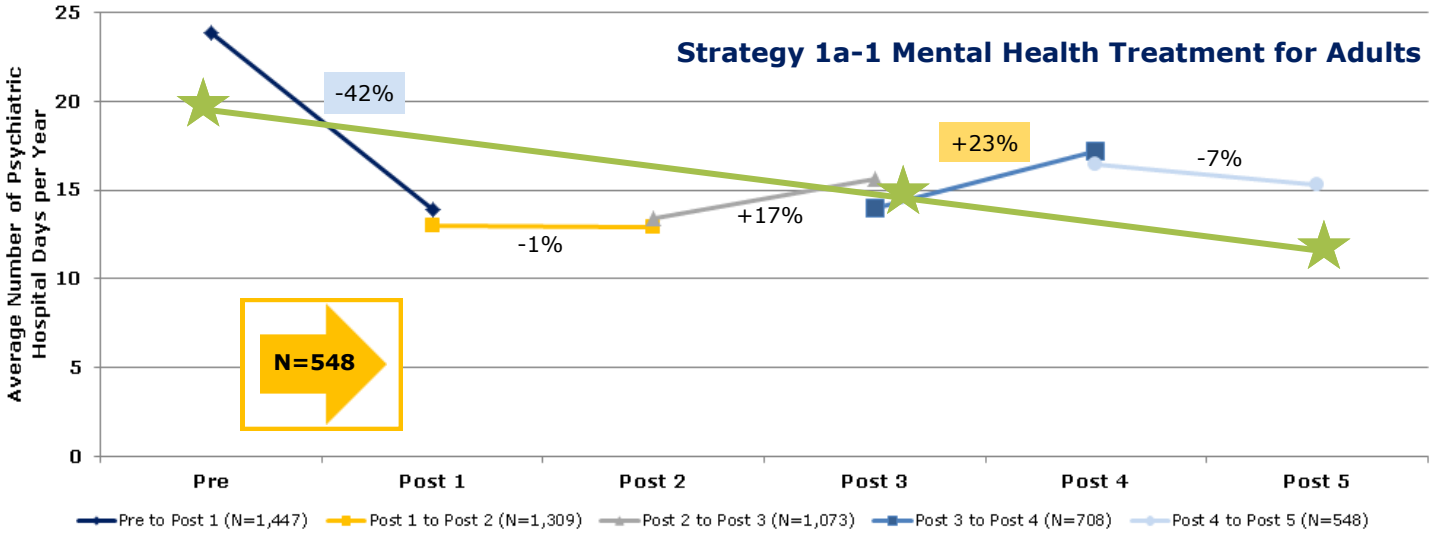
- Strategy 1b—Outreach & Engagement
- Strategy 1d—Crisis Next Day Appointments

Increases in Psychiatric Hospitalizations Associated with Start of MIDD Services

As with emergency department use, outreach and crisis intervention strategies may show initial increases in system use due to discovery of individuals not previously linked with needed/ necessary psychiatric care. Strategies with initial increases are expected to decrease over time, but may need more time to achieve reduction goals.

- Strategy 1b—Outreach & Engagement
- Strategy 1d—Crisis Next Day Appointments
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services
- Strategy 10b—Adult Crisis Diversion
- Strategy 12c—Psychiatric Emergency Services Linkage.

Incremental Change Over Time for Individuals with Psychiatric Hospital Use Who Were Served in MIDD Mental Health, Support, and Certain Outreach Strategies



Key:

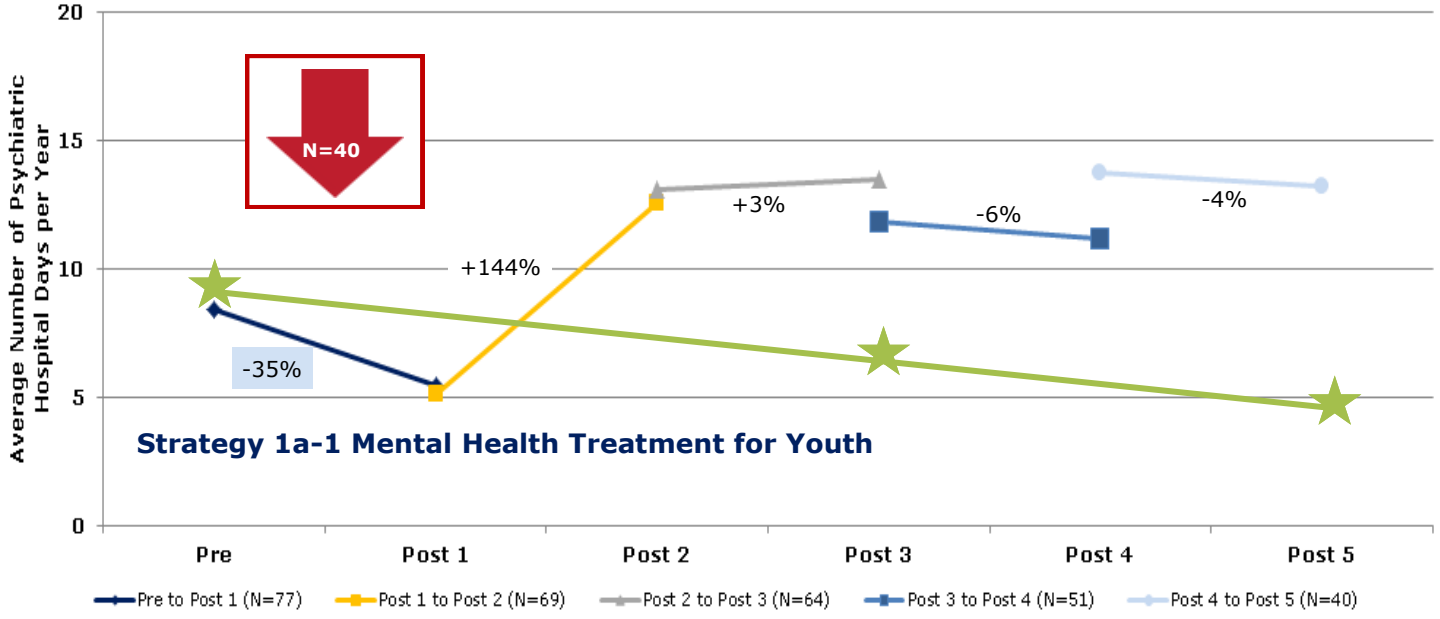
Ultimate targeted reduction goal was met by sample of strategy participants eligible for longest post period who had jail use in any period.

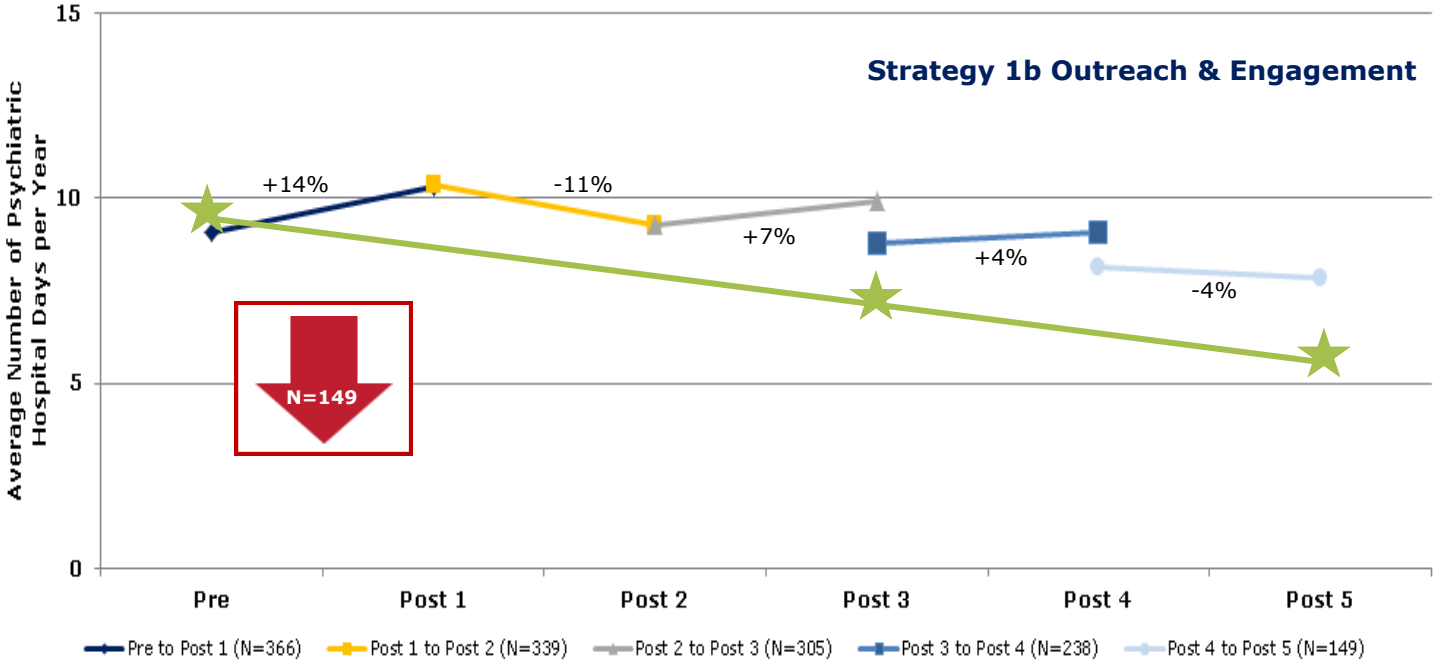
Strategy was on pace to meet ultimate targeted reduction goal, but an unexpected shift in the data pattern prevented goal attainment.

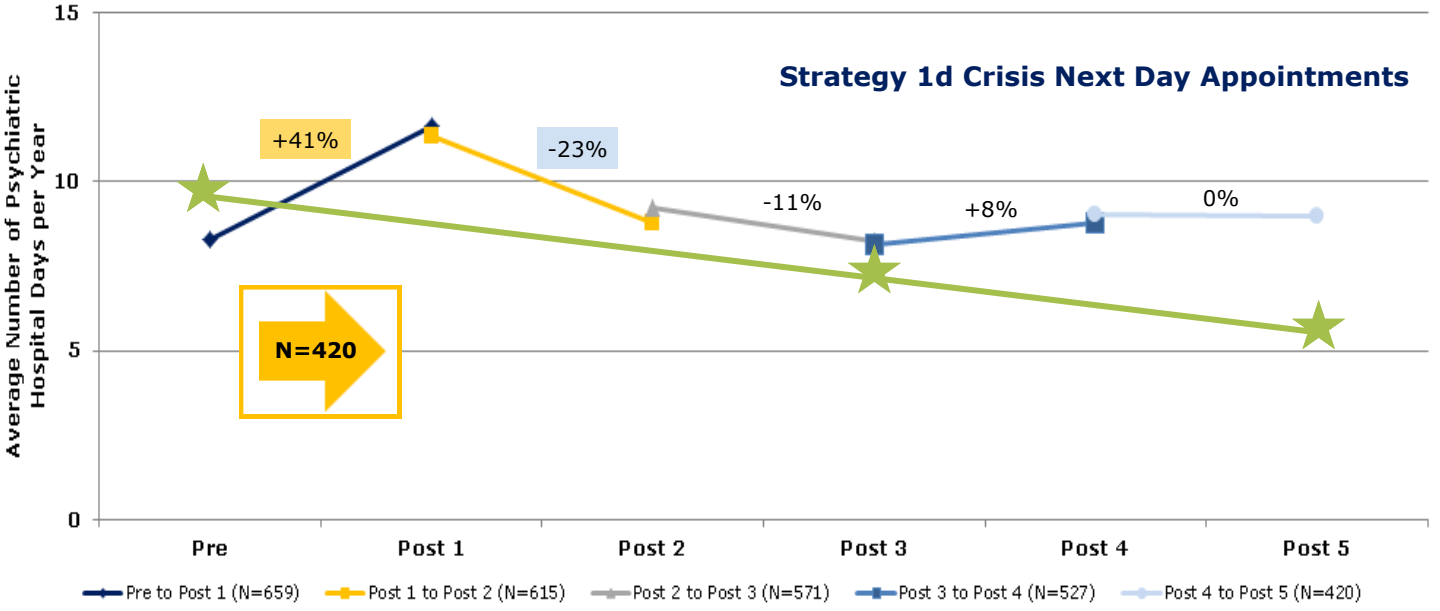
Ultimate targeted reduction goal is not expected to be met based on trends noted in currently available data.

Statistically significant reductions are highlighted in blue. Statistically significant increases are highlighted in yellow.

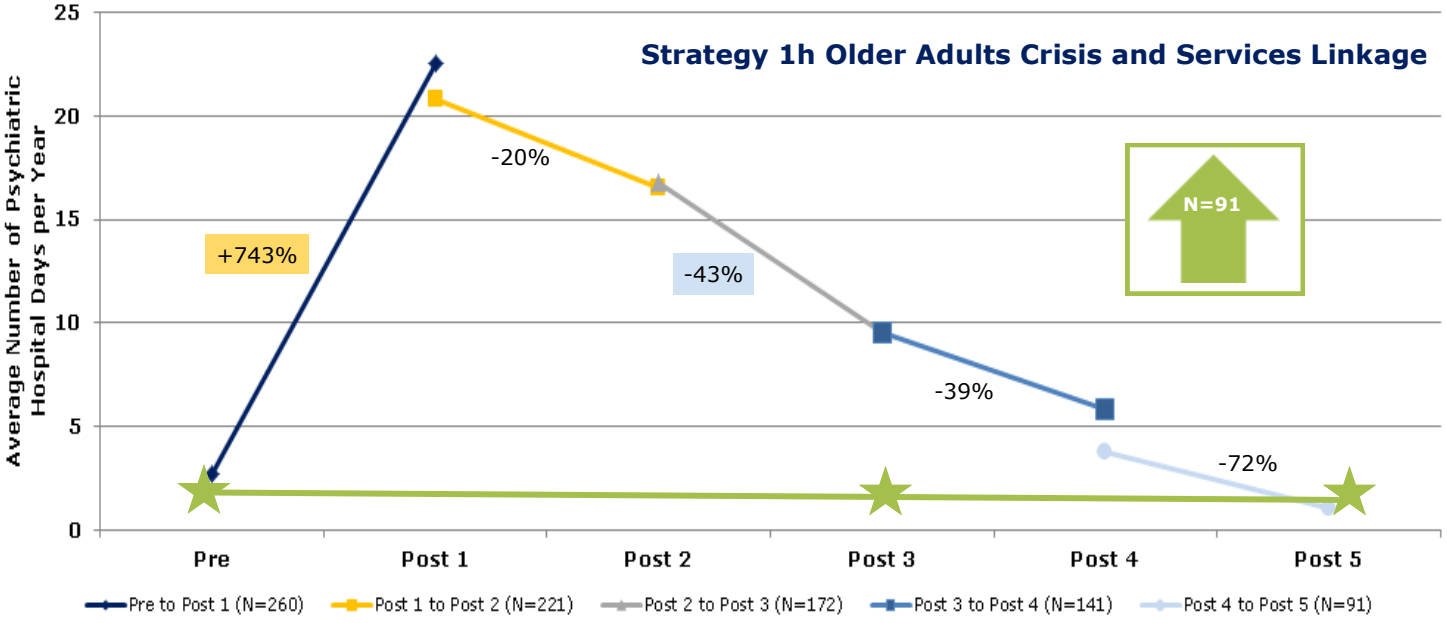
14712

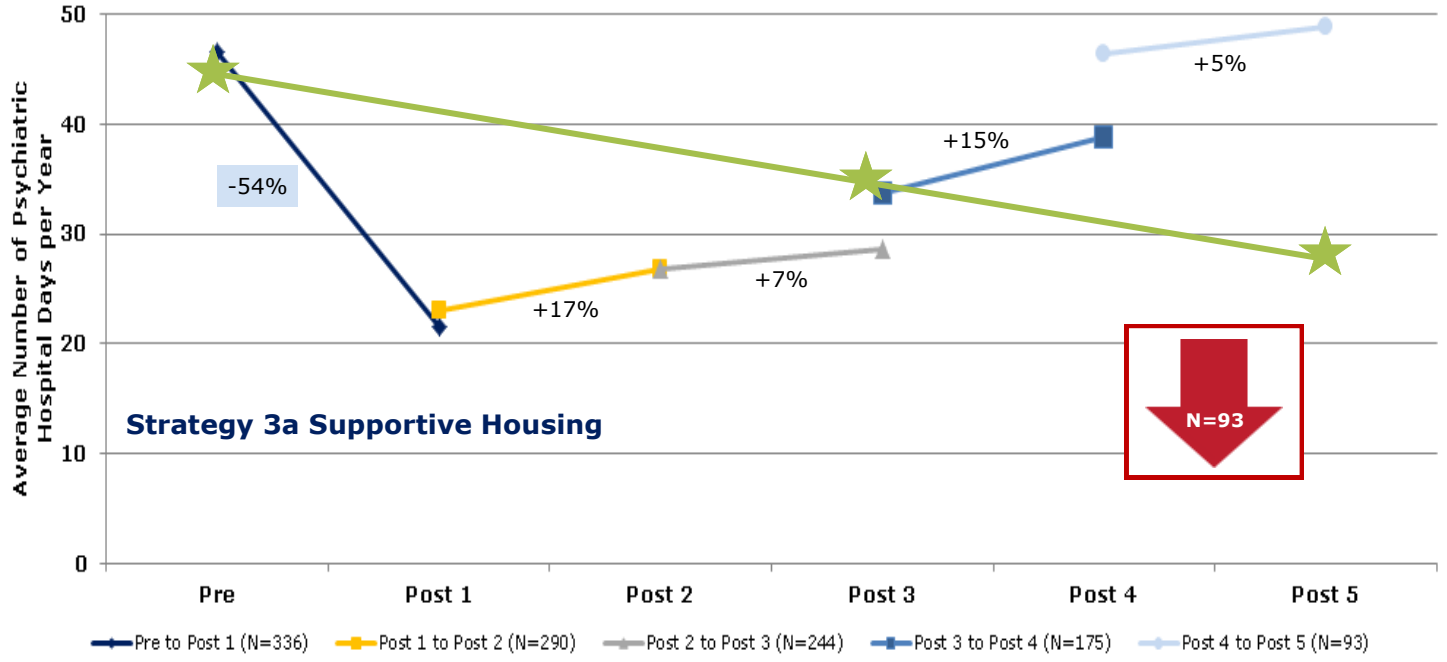

Average Number of Psychiatric Hospital Days per Year
20
15
10
5
0
N=40
+144%
+3%
-6%
-4%
-35%
Strategy 1a-1 Mental Health Treatment for Youth
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=77)
Post 1 to Post 2 (N=69)
Post 2 to Post 3 (N=64)
Post 3 to Post 4 (N=51)
Post 4 to Post 5 (N=40)

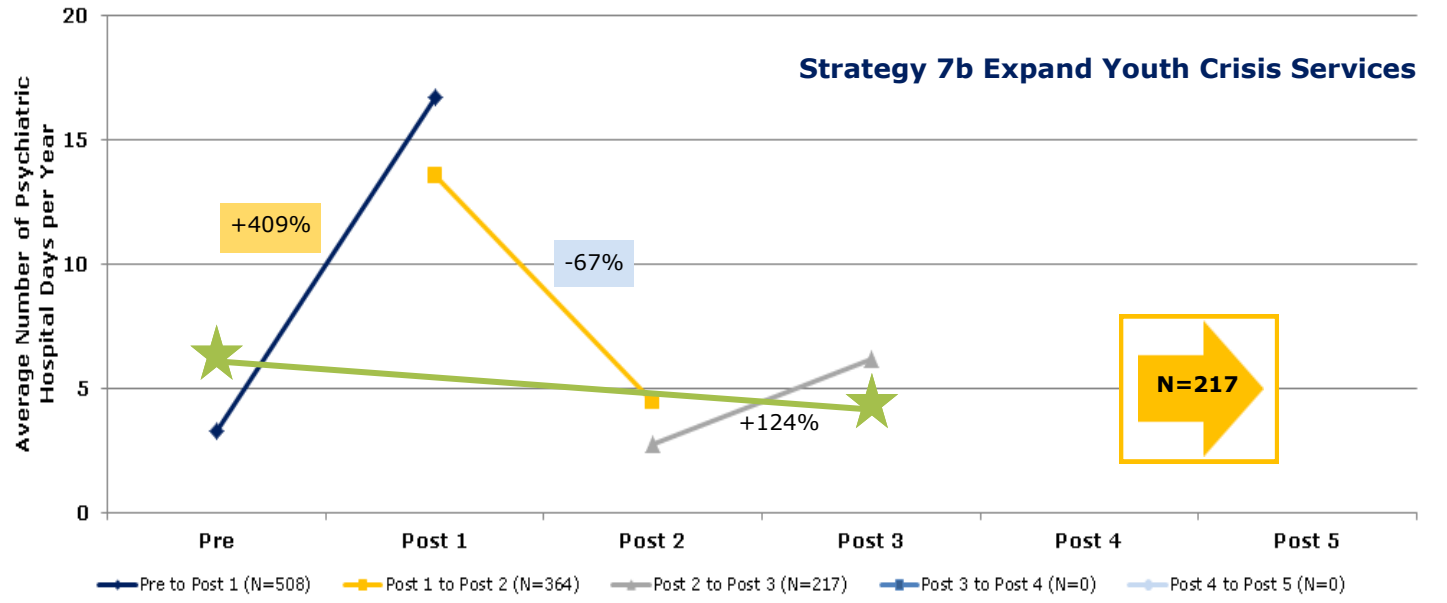

Average Number of Psychiatric Hospital Days per Year
15
10
5
0
Strategy 1b Outreach & Engagement
+14%
-11%
+7%
+4%
-4%
N=149
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=366)
Post 1 to Post 2 (N=339)
Post 2 to Post 3 (N=305)
Post 3 to Post 4 (N=238)
Post 4 to Post 5 (N=149)


Average Number of Psychiatric Hospital Days per Year
15
10
5
0
Strategy 1d Crisis Next Day Appointments
+41%
-23%
-11%
+8%
0%
N=420
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=659)
Post 1 to Post 2 (N=615)
Post 2 to Post 3 (N=571)
Post 3 to Post 4 (N=527)
Post 4 to Post 5 (N=420)

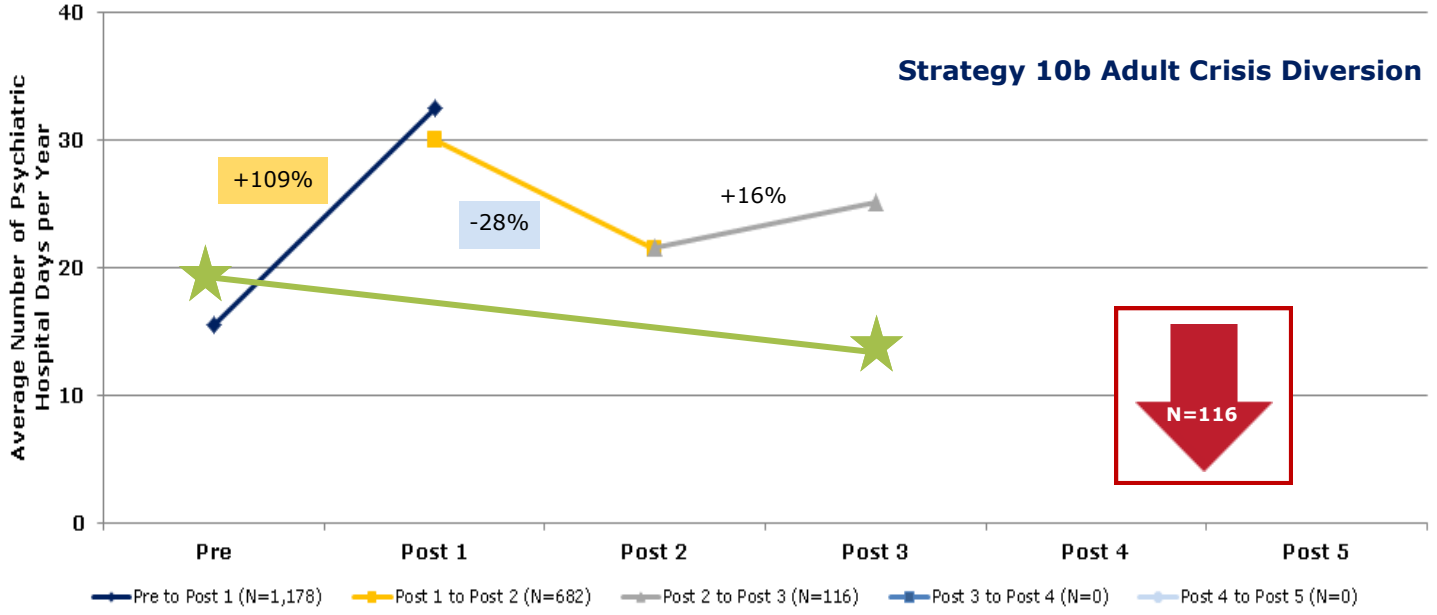
14712

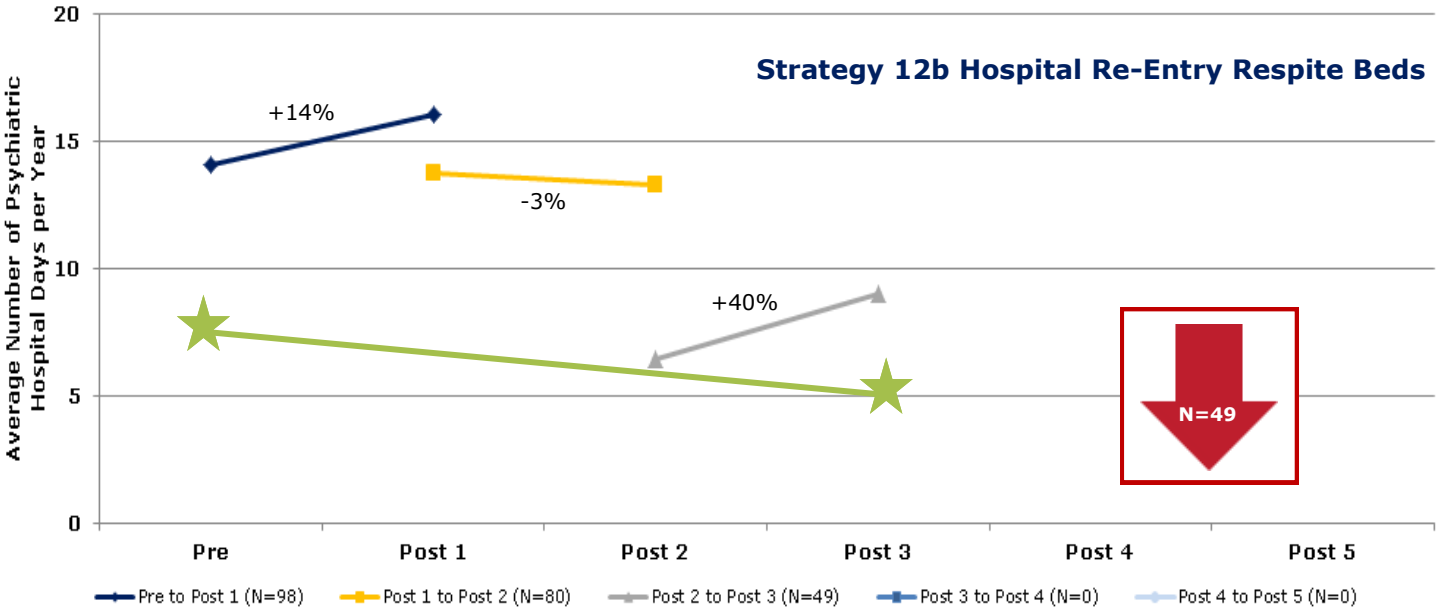

Strategy 1h Older Adults Crisis and Services Linkage
Average Number of Psychiatric Hospital Days per Year
25
20
15
10
5
0
+743%
-20%
-43%
-39%
-72%
N=91
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=260)
Post 1 to Post 2 (N=221)
Post 2 to Post 3 (N=172)
Post 3 to Post 4 (N=141)
Post 4 to Post 5 (N=91)

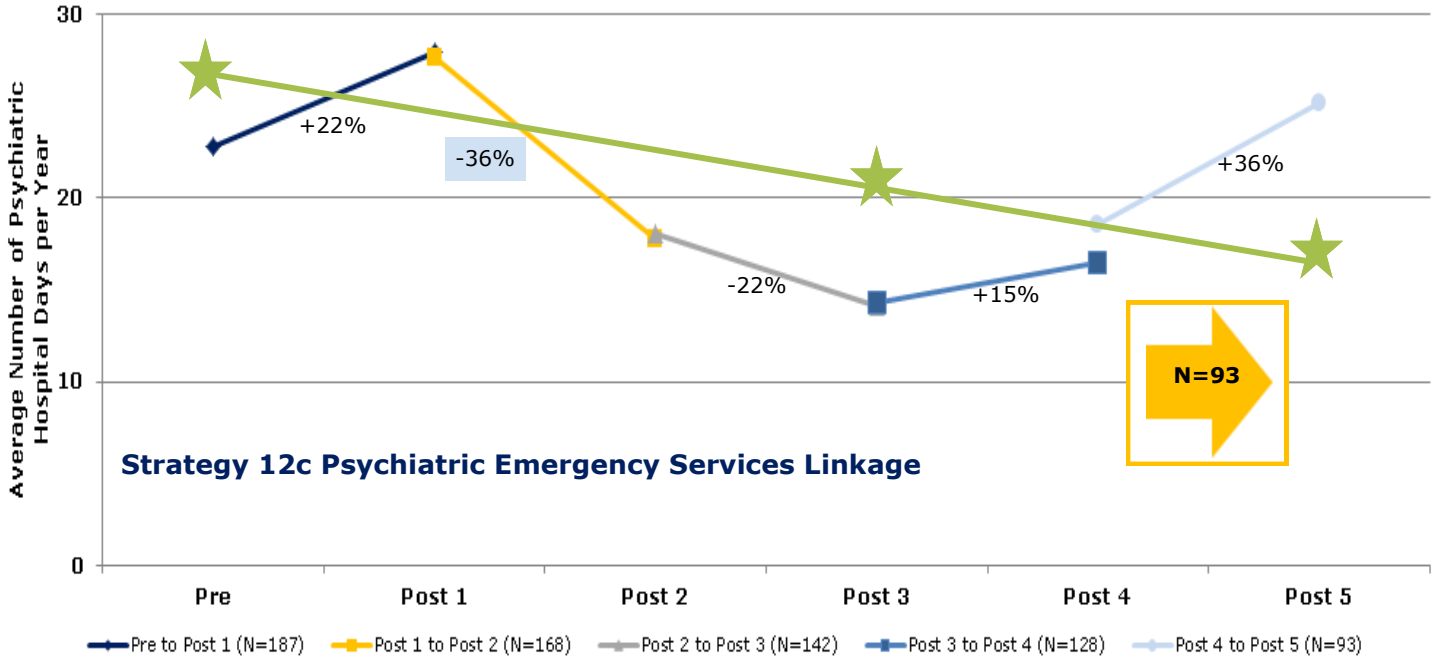

Strategy 3a Supportive Housing
Average Number of Psychiatric Hospital Days per Year
50
40
30
20
10
0
-54%
+17%
+7%
+15%
+5%
N=93
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=336)
Post 1 to Post 2 (N=290)
Post 2 to Post 3 (N=244)
Post 3 to Post 4 (N=175)
Post 4 to Post 5 (N=93)


Strategy 7b Expand Youth Crisis Services
Average Number of Psychiatric Hospital Days per Year
20
15
10
5
0
+409%
-67%
+124%
N=217
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=508)
Post 1 to Post 2 (N=364)
Post 2 to Post 3 (N=217)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

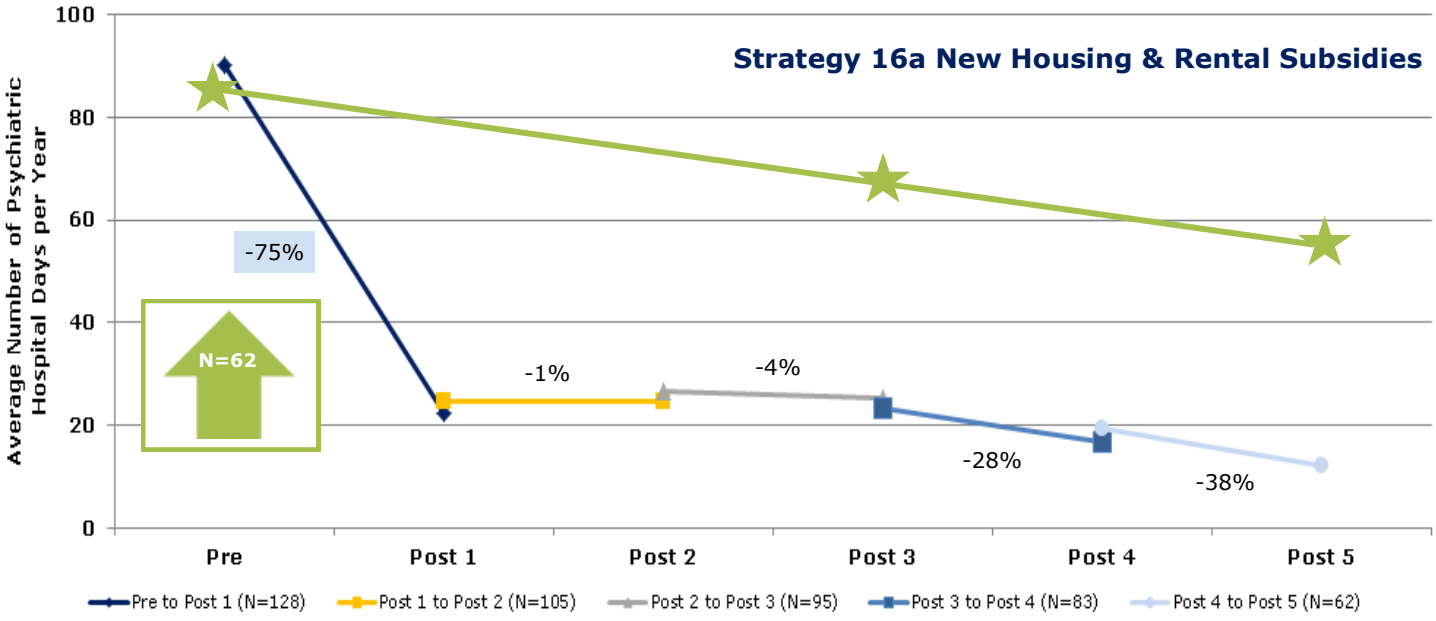
14712


Strategy 10b Adult Crisis Diversion
Average Number of Psychiatric Hospital Days per Year
40
30
20
10
0
+109%
-28%
+16%
N=116
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,178)
Post 1 to Post 2 (N=682)
Post 2 to Post 3 (N=116)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)


Strategy 12b Hospital Re-Entry Respite Beds
Average Number of Psychiatric Hospital Days per Year
20
15
10
5
0
+14%
-3%
+40%
N=49
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=98)
Post 1 to Post 2 (N=80)
Post 2 to Post 3 (N=49)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)


Strategy 12c Psychiatric Emergency Services Linkage
Average Number of Psychiatric Hospital Days per Year
30
20
10
0
+22%
-36%
-22%
+15%
+36%
N=93
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=187)
Post 1 to Post 2 (N=168)
Post 2 to Post 3 (N=142)
Post 3 to Post 4 (N=128)
Post 4 to Post 5 (N=93)

14712


Strategy 16a New Housing & Rental Subsidies
Average Number of Psychiatric Hospital Days per Year
100
80
60
40
20
0
-75%
N=62
-1%
-4%
-28%
-38%
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=128)
Post 1 to Post 2 (N=105)
Post 2 to Post 3 (N=95)
Post 3 to Post 4 (N=83)
Post 4 to Post 5 (N=62)

Effectiveness of MIDD Strategies in Reducing Jail Use

Eleven MIDD strategies had a primary policy goal of reducing jail use by individuals with mental illness or drug dependency. Another three strategies listed this policy goal as secondary. Reducing jail recycling for MIDD clients was a primary objective for five other strategies, and diversion from initial or further justice system involvement was indicated as either a primary or secondary goal for 11 strategies, as shown in the grid below. Strategies grayed out in the table above were never implemented or were piloted without adequate data for change over time analysis.

			MIDD Policy Goals Relevant to Jail Use		
Strategy Number	Strategy Name	Strategy Description	Reduce Jail Use	Reduce Jail Recycling	Divert from Justice System
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+		
1a-2	Substance Use Disorder Treatment	Increase Access to Community Substance Use Disorder (SUD) Treatment	+		
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	✪		
1c	Emergency Room Intervention	Emergency Room Substance Abuse Early Intervention Program	✪		
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪		
3a	Supportive Housing	Supportive Services for Housing Projects	✪		
4b	SUD Prevention for Children	Prevention Services to Children of Substance Abusing Parents			+
4c	School-Based Services	Collaborative School-Based Mental Health and Substance Abuse Services			+
5a	Juvenile Justice Assessments	Expand Assessments for Youth in the Juvenile Justice System		✪	✪
6a	Wraparound	Wraparound Services for Emotionally Disturbed Youth	✪		✪
7a	Youth Reception Centers	Reception Centers for Youth in Crisis	✪		✪
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	✪		+
8a	Family Treatment Court	Family Treatment Court Expansion		✪	
9a	Juvenile Drug Court	Juvenile Drug Court Expansion			✪
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	✪		✪
11a	Increase Jail Liaison Capacity	Increase Jail Liaison Capacity		✪	
11b	Mental Health Courts	Increase Services for New or Existing Mental Health Court Programs			✪
12a	Jail Re-Entry& Education Classes	Jail Re-Entry Program Capacity Increase & Education Classes at Community Center for Alternative Programs (CCAP)		✪	
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	✪		
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪		
12d	Behavior Modification Classes	Behavior Modification Classes for CCAP Clients		✪	
15a	Adult Drug Court	Adult Drug Court Expansion of Recovery Support Services			✪
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪		
17a	Crisis Intervention/MH Partnership	Crisis Intervention Team/Mental Health Partnership Pilot	+		
17b	Safe Housing - Child Prostitution	Safe Housing and Treatment for Children in Prostitution Pilot			+

Key: ✪ = Primary Goal + = Secondary Goal

Jail Use Reduction Goals

Separate goals for adults and youth (below right) were established in an Evaluation Targets Addendum dated September 2, 2008. For adults, an extra five percent reduction per year was recently added to account for overall declines in general population jail use between 2008 and 2013. Incremental reductions are those that occur from one measurement period to the next, starting from the pre period (or the year prior to the start of MIDD services). Cumulative reductions refer to the ultimate changes from the pre period to each post period. The green line shown on graphs over the next several pages indicates the ultimate expected reduction from Pre to Post 5 for strategy participants eligible for the longest time period who had jail use in <u>any</u> time period, unless stated otherwise.

	Adult			Youth	
Period	Incremental	Additional	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-10%	-10%
Post 2	-10%	-5%	-25%	-10%	-20%
Post 3	-10%	-5%	-40%	-10%	-30%
Post 4	-10%	-5%	-55%	-10%	-40%
Post 5	-10%	-5%	-70%	-10%	-50%

Factors Impacting Assessment of Effectiveness

Low Incidence of Incarceration

Strategies with jail use rates lower than 40 percent of all who are eligible may take longer to achieve their reduction goals.

- Strategy 1a-1—Mental Health Treatment
- Strategy 1a-2b—Opiate SUD Treatment
- Strategy 1c—Emergency Room Intervention
- Strategy 1d—Crisis Next Day Appointments
- Strategy 6a—Wraparound
- Strategy 16a—New Housing & Rental Subsidies

Small Sample Size

It is more difficult for strategies serving fewer clients to show significant change over time.

- Strategy 8a—Family Treatment Court
- Strategy 9a—Juvenile Drug Court
- Strategy 12c—Psychiatric Emergency Svcs Link
- Strategy 12d– Behavior Modification Classes
- Strategy 16a—New Housing & Rental Subsidies

Factors Impacting Effectiveness Results

Fewer Jail Days Prior to the MIDD

Strategies with fewer average jail days in the pre period have less room for improvement.

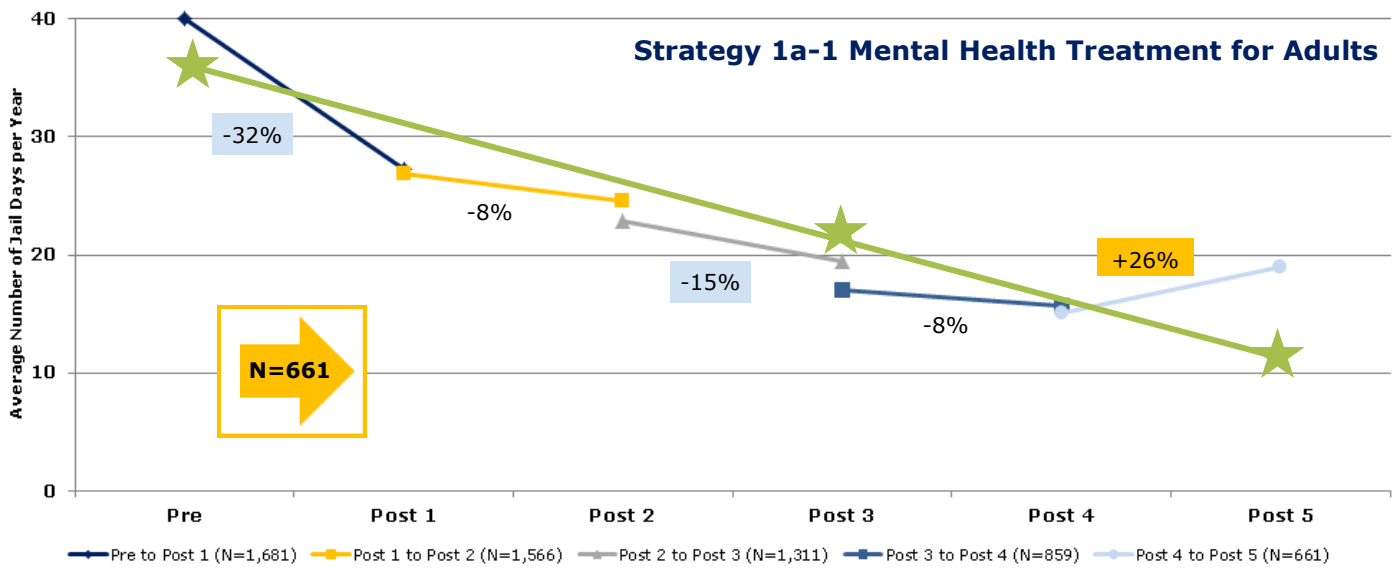
- Strategy 5a—Juvenile Justice Assessments
- Strategy 8a—Family Treatment Court

Increases in Jail Use Associated with Start of MIDD Services

Several strategies showed significant increases in average jail days during the first year of MIDD services. For therapeutic courts, jail sanctions are often used to increase program compliance. For criminal justice programs, adjudication of additional charges may factor in. Strategies with first year increases may need extra time to reach their goals.

- Strategy 1c—Emergency Room Intervention
- Strategy 5a—Juvenile Justice Assessments
- Strategy 9a—Juvenile Drug Court
- Strategy 12a2b—CCAP DV Education Classes
- Strategy 12d—Behavior Modification Classes
- Strategy 15a—Adult Drug Court

Incremental Change Over Time for Individuals with Jail Use Who Were Served in Mental Health and Support Strategies



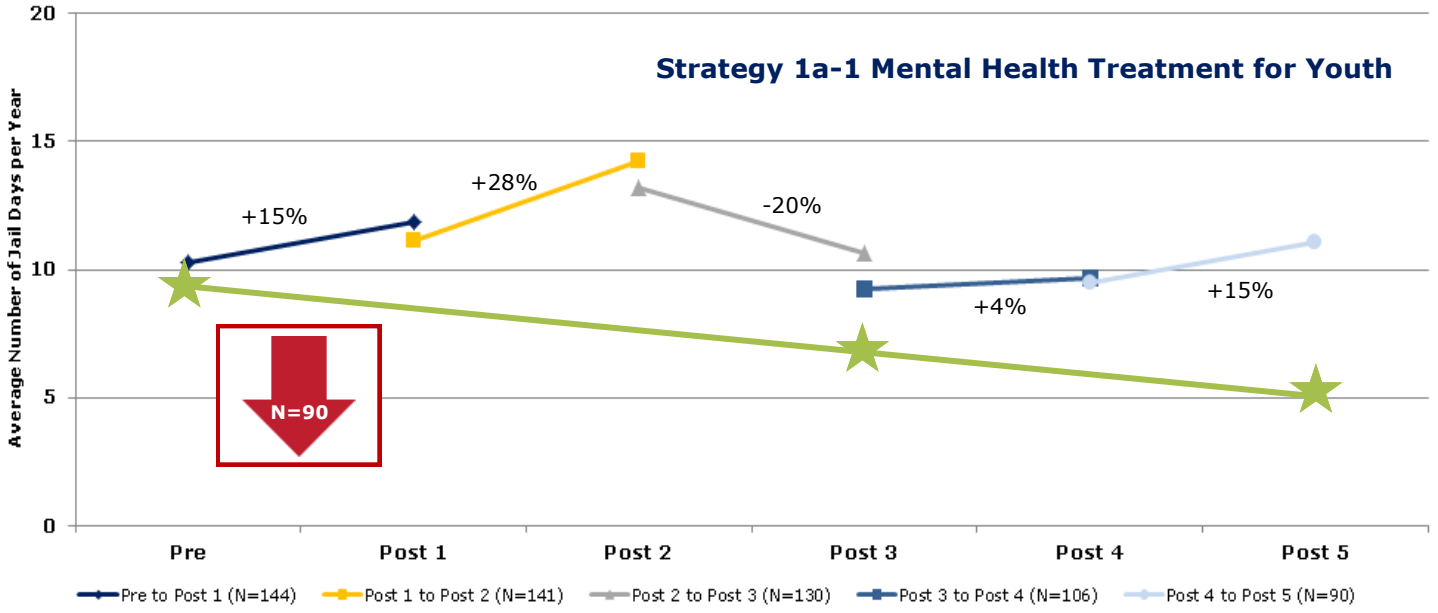
Key:

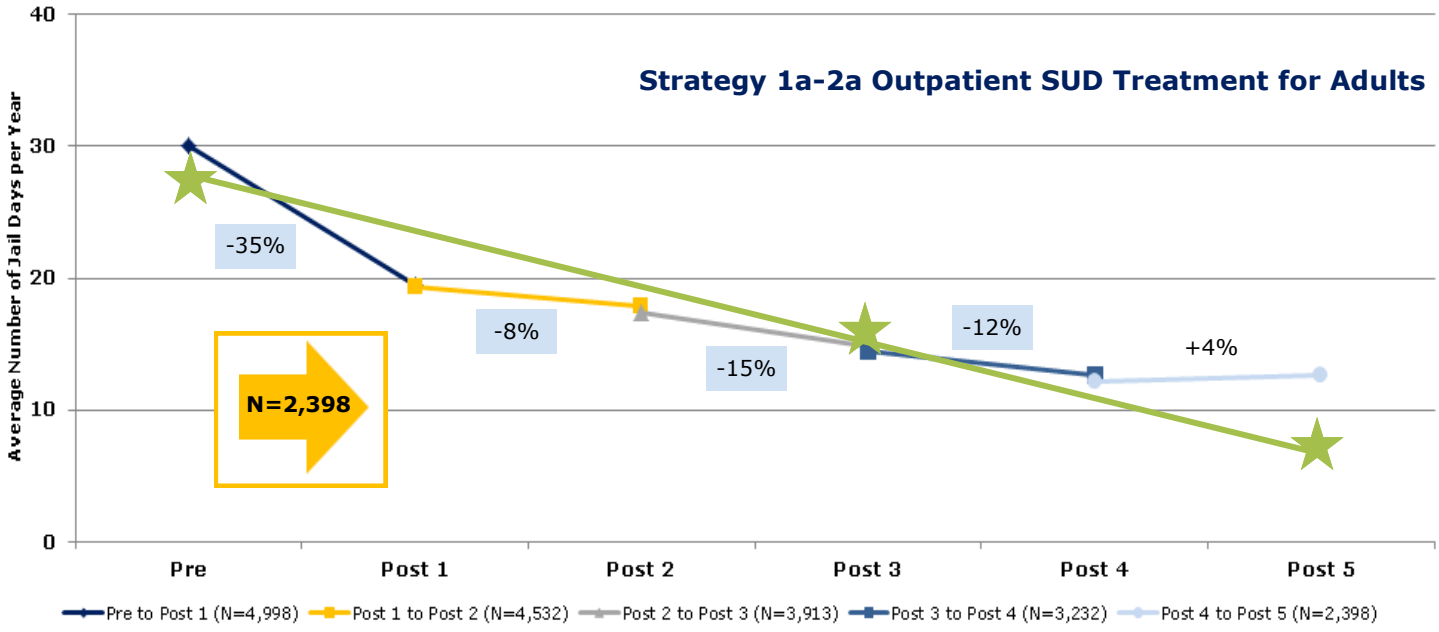
Ultimate targeted reduction goal was met by sample of strategy participants eligible for longest post period who had jail use in any period.

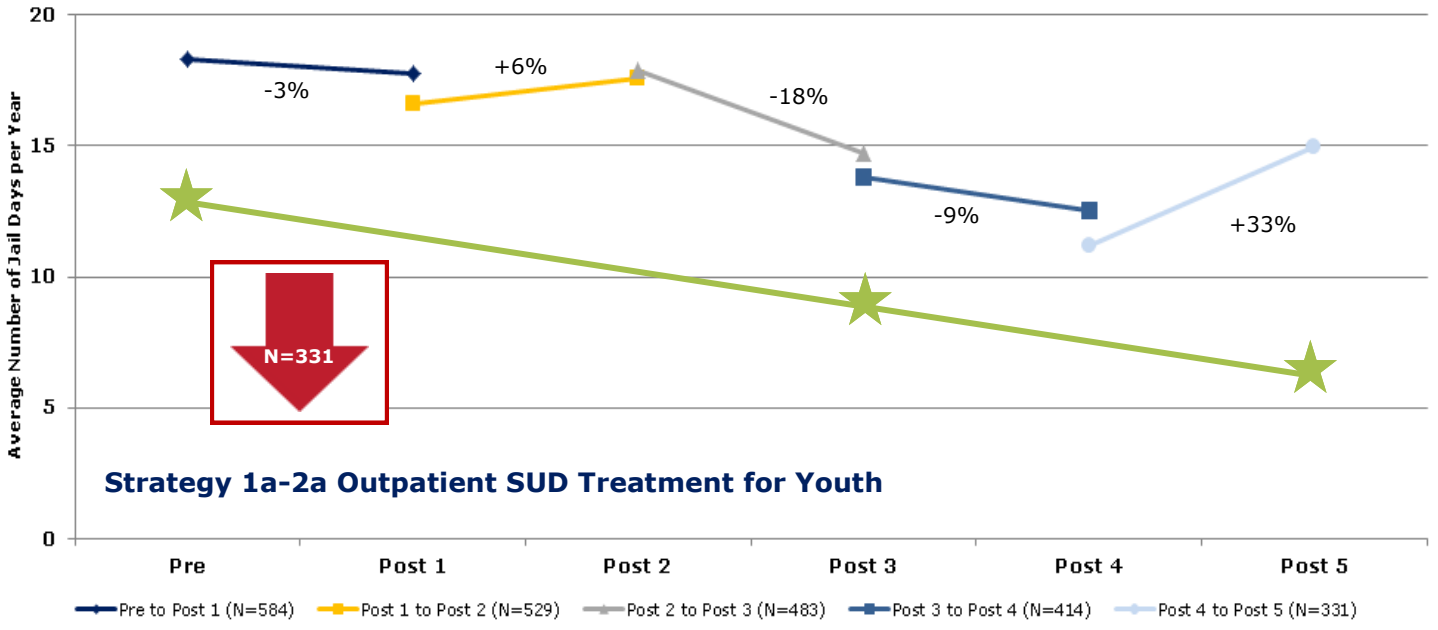
Strategy was on pace to meet ultimate targeted reduction goal, but an unexpected shift in the data pattern prevented goal attainment.

Ultimate targeted reduction goal is not expected to be met based on trends noted in currently available data.

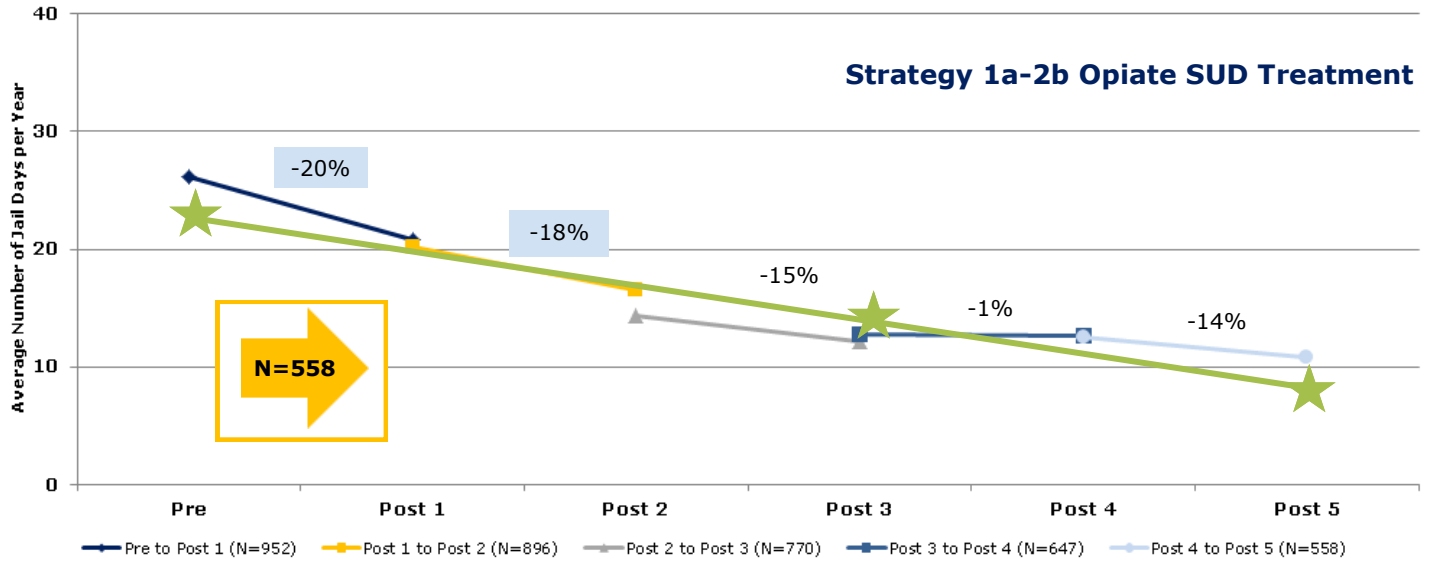
Statistically significant reductions are highlighted in blue. Statistically significant increases are highlighted in yellow.

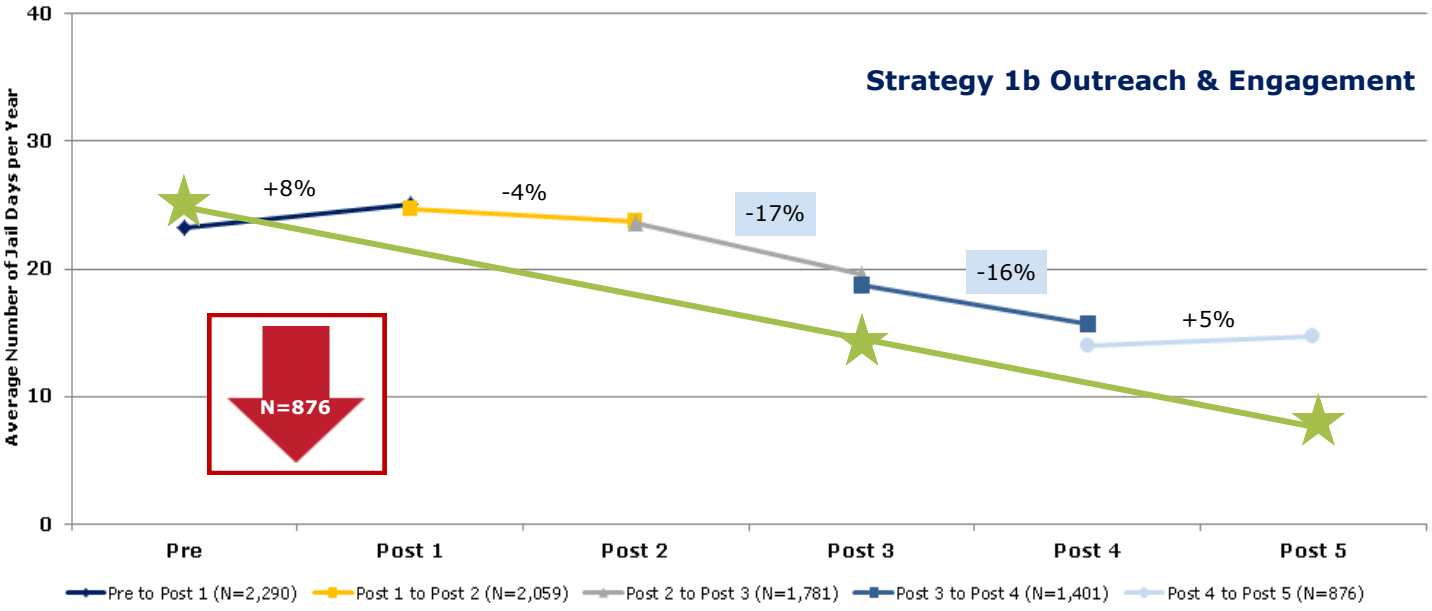

Strategy 1a-1 Mental Health Treatment for Youth
Average Number of Jail Days per Year
20
15
10
5
0
+15%
+28%
-20%
+4%
+15%
N=90
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=144)
Post 1 to Post 2 (N=141)
Post 2 to Post 3 (N=130)
Post 3 to Post 4 (N=106)
Post 4 to Post 5 (N=90)

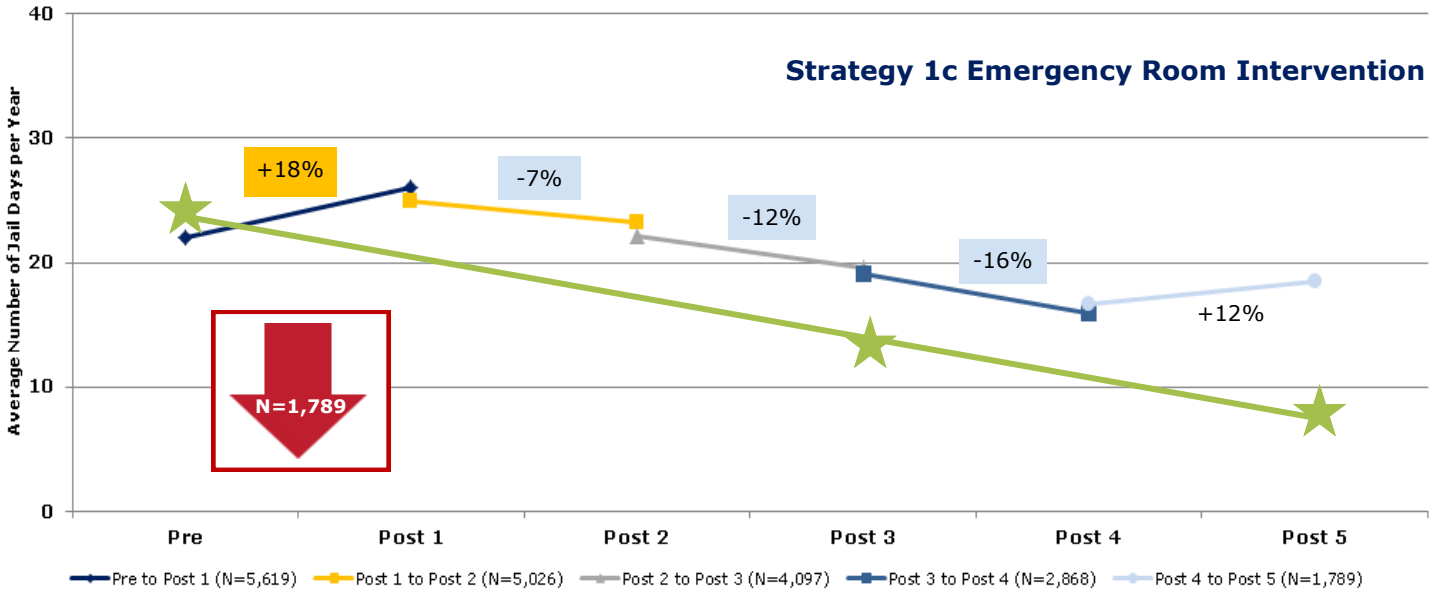

Strategy 1a-2a Outpatient SUD Treatment for Adults
Average Number of Jail Days per Year
40
30
20
10
0
-35%
-8%
-15%
-12%
+4%
N=2,398
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=4,998)
Post 1 to Post 2 (N=4,532)
Post 2 to Post 3 (N=3,913)
Post 3 to Post 4 (N=3,232)
Post 4 to Post 5 (N=2,398)

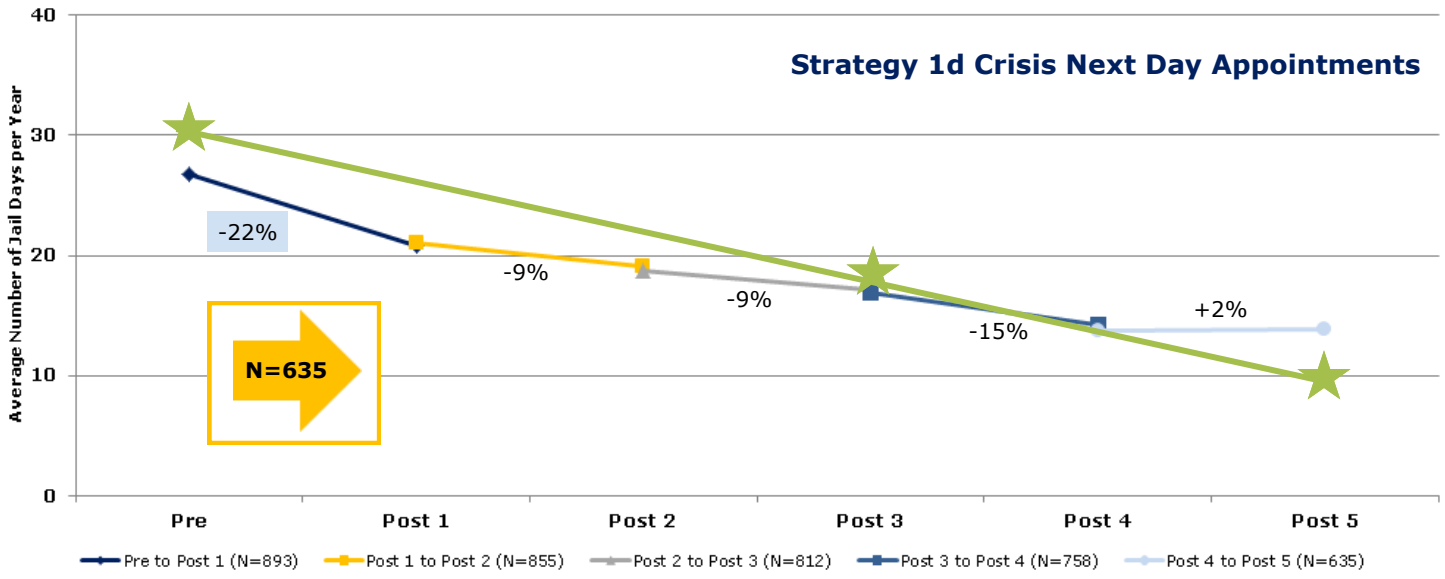

Average Number of Jail Days per Year
20
15
10
5
0
-3%
+6%
-18%
-9%
+33%
N=331
Strategy 1a-2a Outpatient SUD Treatment for Youth
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=584)
Post 1 to Post 2 (N=529)
Post 2 to Post 3 (N=483)
Post 3 to Post 4 (N=414)
Post 4 to Post 5 (N=331)

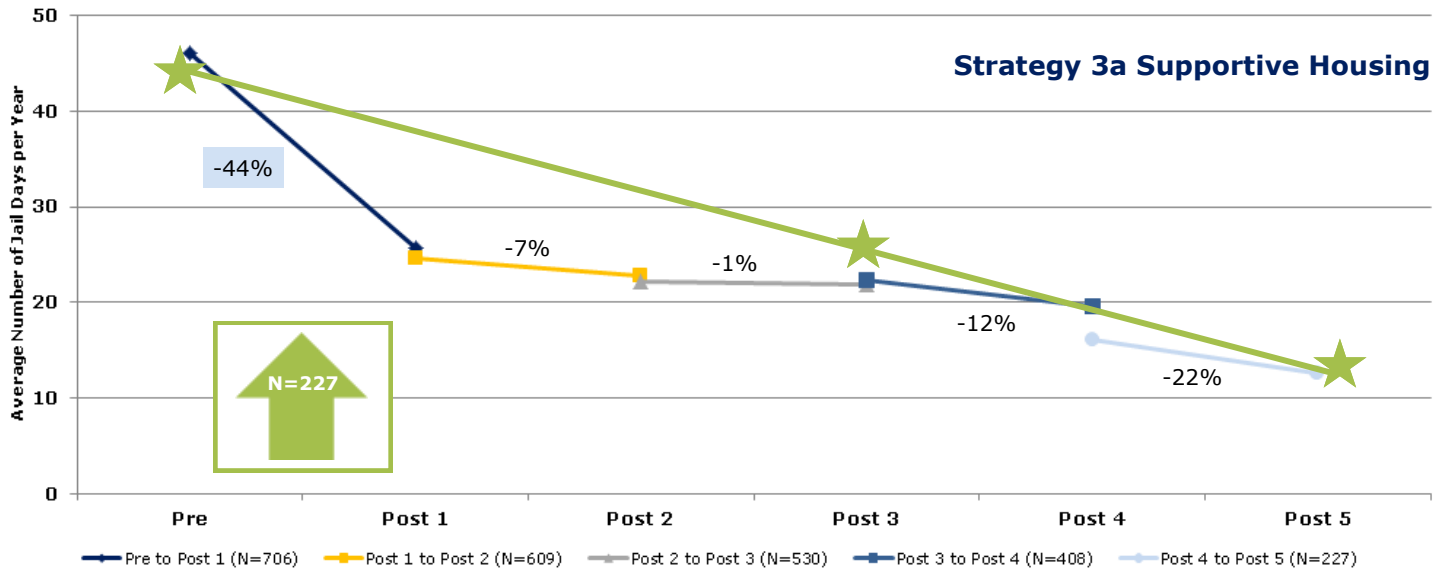
14712

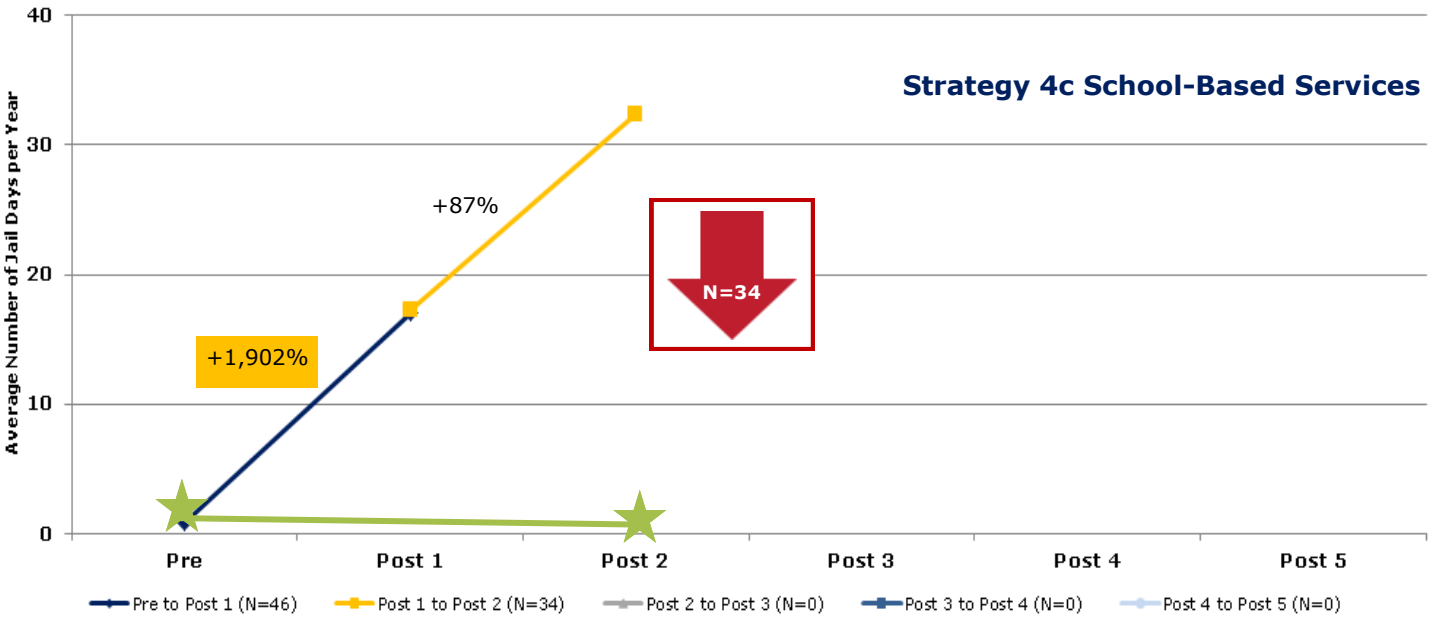

Strategy 1a-2b Opiate SUD Treatment
Average Number of Jail Days per Year
40
30
20
10
0
-20%
-18%
-15%
-1%
-14%
N=558
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=952)
Post 1 to Post 2 (N=896)
Post 2 to Post 3 (N=770)
Post 3 to Post 4 (N=647)
Post 4 to Post 5 (N=558)


Strategy 1b Outreach & Engagement
Average Number of Jail Days per Year
40
30
20
10
0
+8%
-4%
-17%
-16%
+5%
N=876
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=2,290)
Post 1 to Post 2 (N=2,059)
Post 2 to Post 3 (N=1,781)
Post 3 to Post 4 (N=1,401)
Post 4 to Post 5 (N=876)

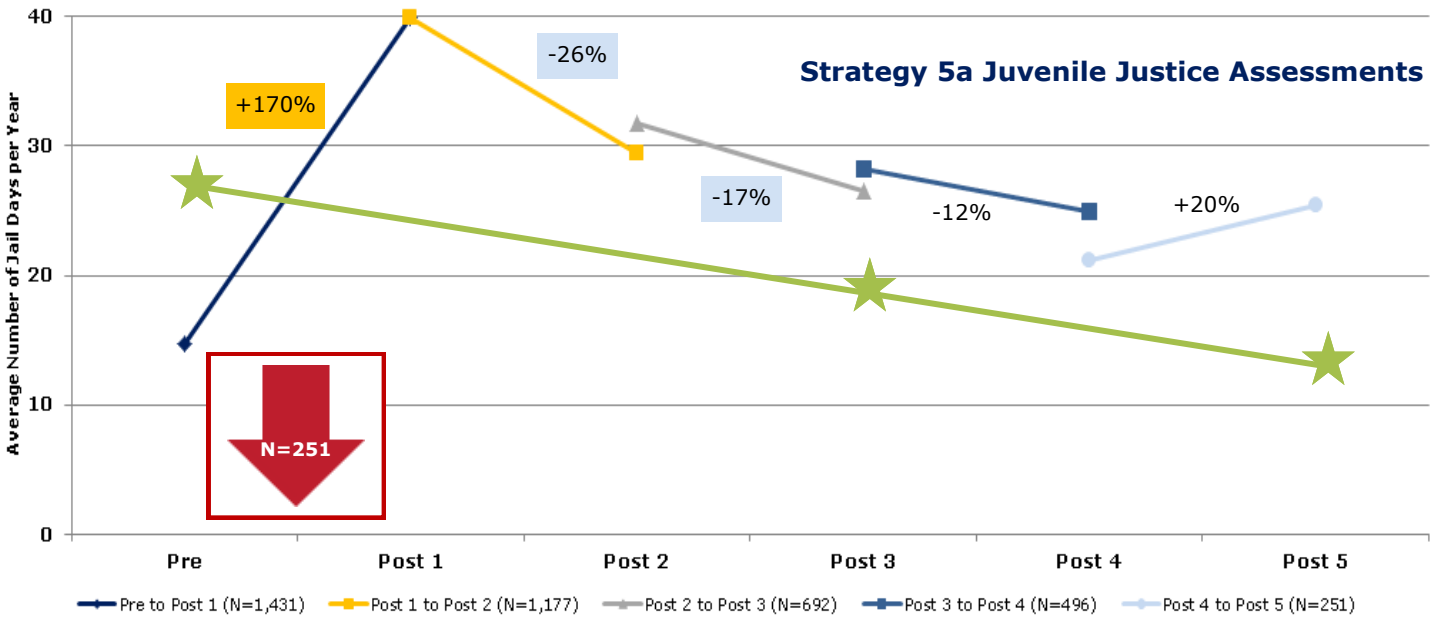

Strategy 1c Emergency Room Intervention
Average Number of Jail Days per Year
40
30
20
10
0
+18%
-7%
-12%
-16%
+12%
N=1,789
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=5,619)
Post 1 to Post 2 (N=5,026)
Post 2 to Post 3 (N=4,097)
Post 3 to Post 4 (N=2,868)
Post 4 to Post 5 (N=1,789)

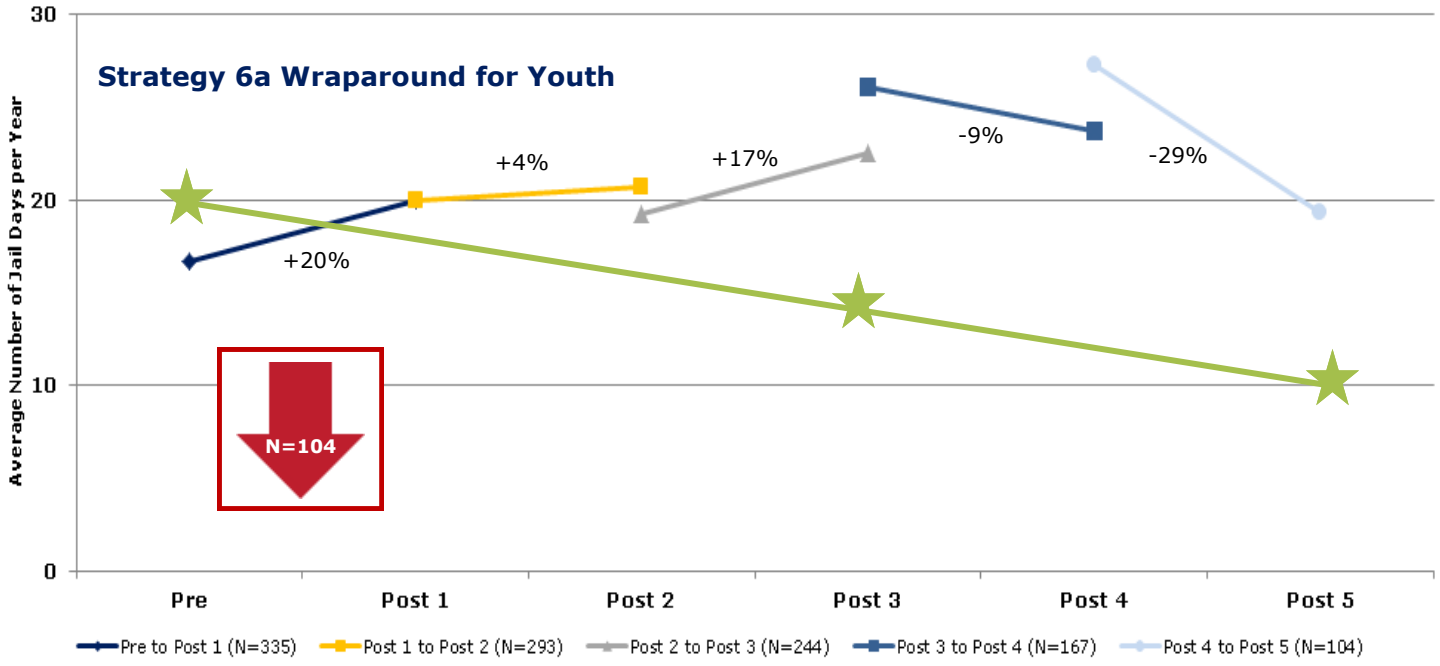

Strategy 1d Crisis Next Day Appointments
Average Number of Jail Days per Year
40
30
20
10
0
-22%
-9%
-9%
-15%
+2%
N=635
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=893)
Post 1 to Post 2 (N=855)
Post 2 to Post 3 (N=812)
Post 3 to Post 4 (N=758)
Post 4 to Post 5 (N=635)

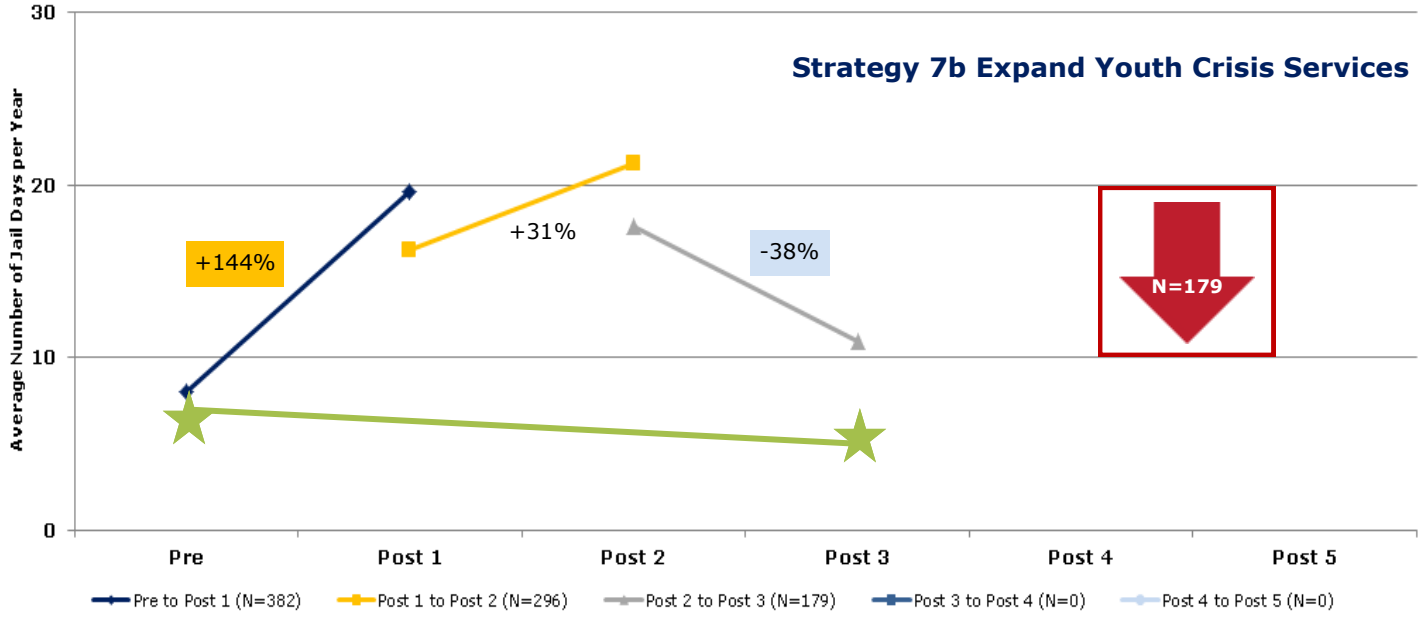

Strategy 3a Supportive Housing
Average Number of Jail Days per Year
50
40
30
20
10
0
-44%
-7%
-1%
-12%
-22%
N=227
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=706)
Post 1 to Post 2 (N=609)
Post 2 to Post 3 (N=530)
Post 3 to Post 4 (N=408)
Post 4 to Post 5 (N=227)


Strategy 4c School-Based Services
Average Number of Jail Days per Year
40
30
20
10
0
+87%
+1,902%
N=34
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=46)
Post 1 to Post 2 (N=34)
Post 2 to Post 3 (N=0)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

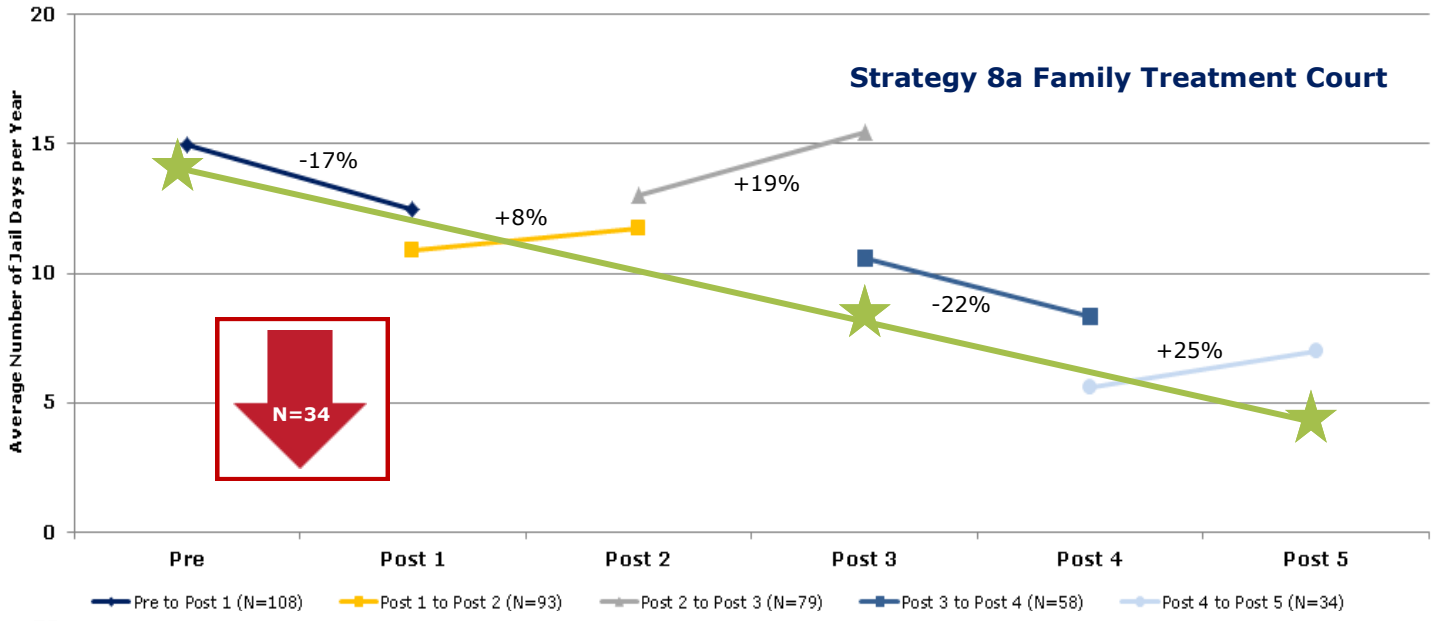
14712

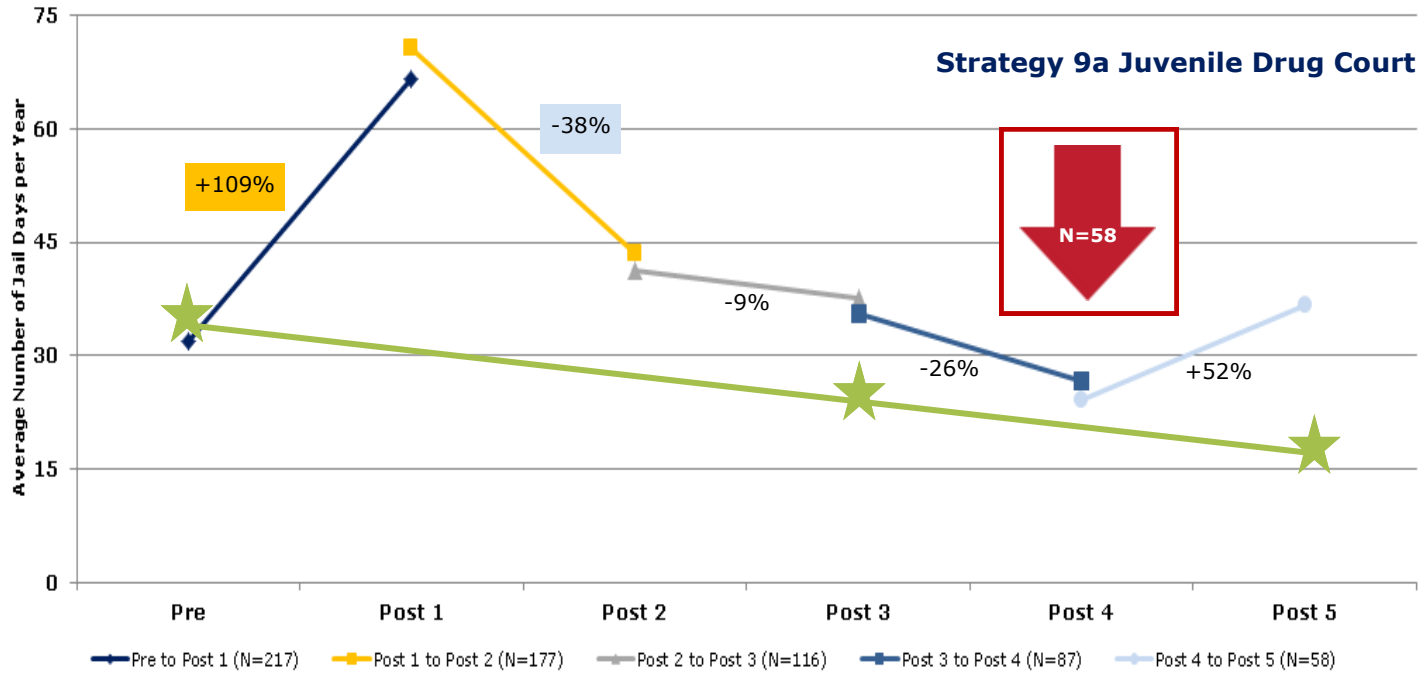

Strategy 5a Juvenile Justice Assessments
Average Number of Jail Days per Year
40
30
20
10
0
+170%
-26%
-17%
-12%
+20%
N=251
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,431)
Post 1 to Post 2 (N=1,177)
Post 2 to Post 3 (N=692)
Post 3 to Post 4 (N=496)
Post 4 to Post 5 (N=251)

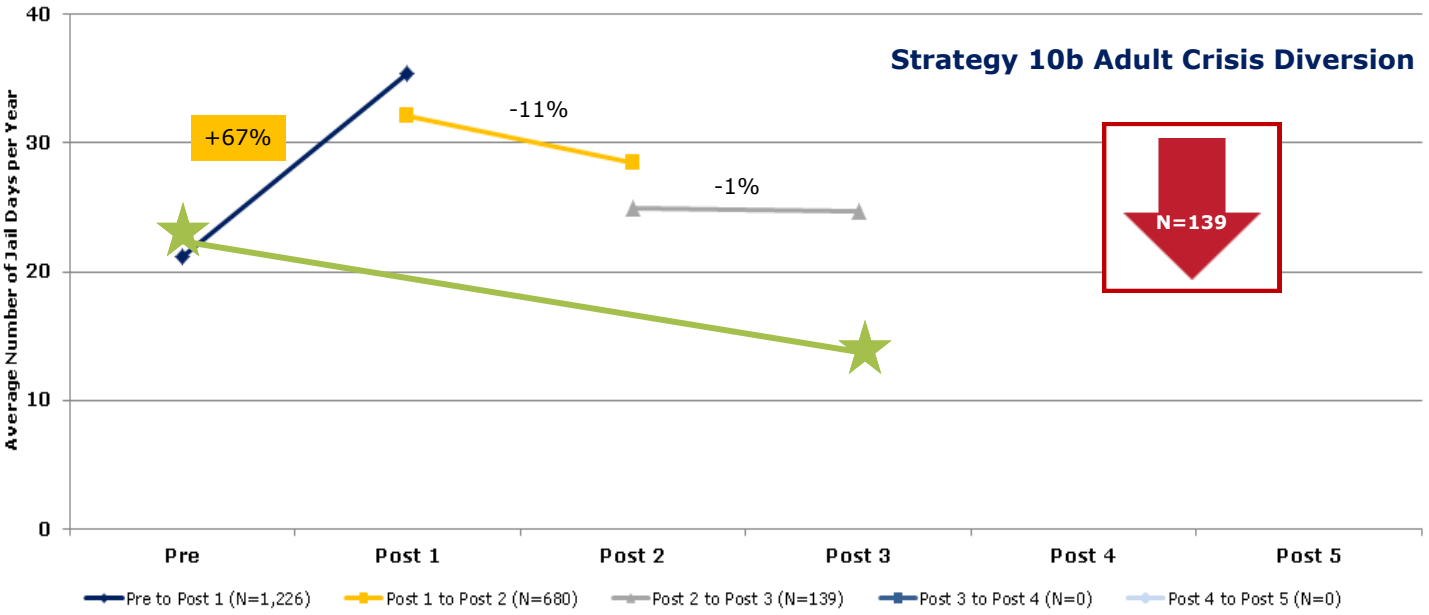

Strategy 6a Wraparound for Youth
Average Number of Jail Days per Year
30
20
10
0
+20%
+4%
+17%
-9%
-29%
N=104
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=335)
Post 1 to Post 2 (N=293)
Post 2 to Post 3 (N=244)
Post 3 to Post 4 (N=167)
Post 4 to Post 5 (N=104)


Strategy 7b Expand Youth Crisis Services
Average Number of Jail Days per Year
30
20
10
0
+144%
+31%
-38%
N=179
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=382)
Post 1 to Post 2 (N=296)
Post 2 to Post 3 (N=179)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

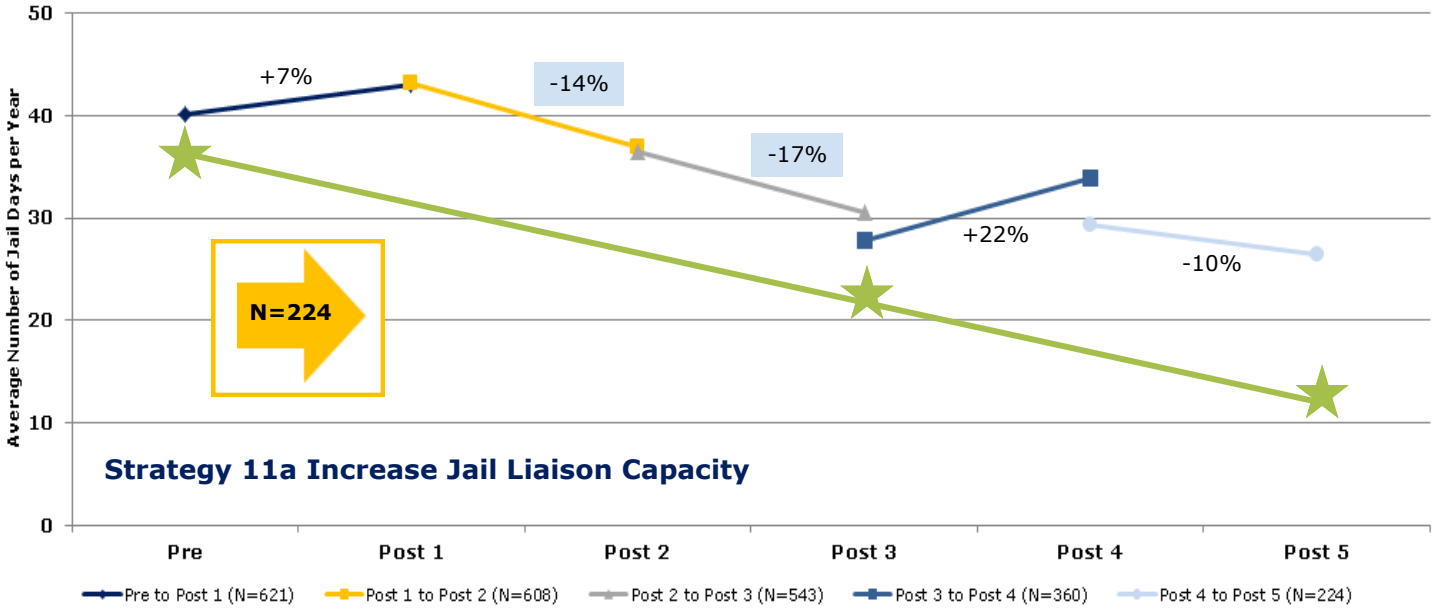
14712

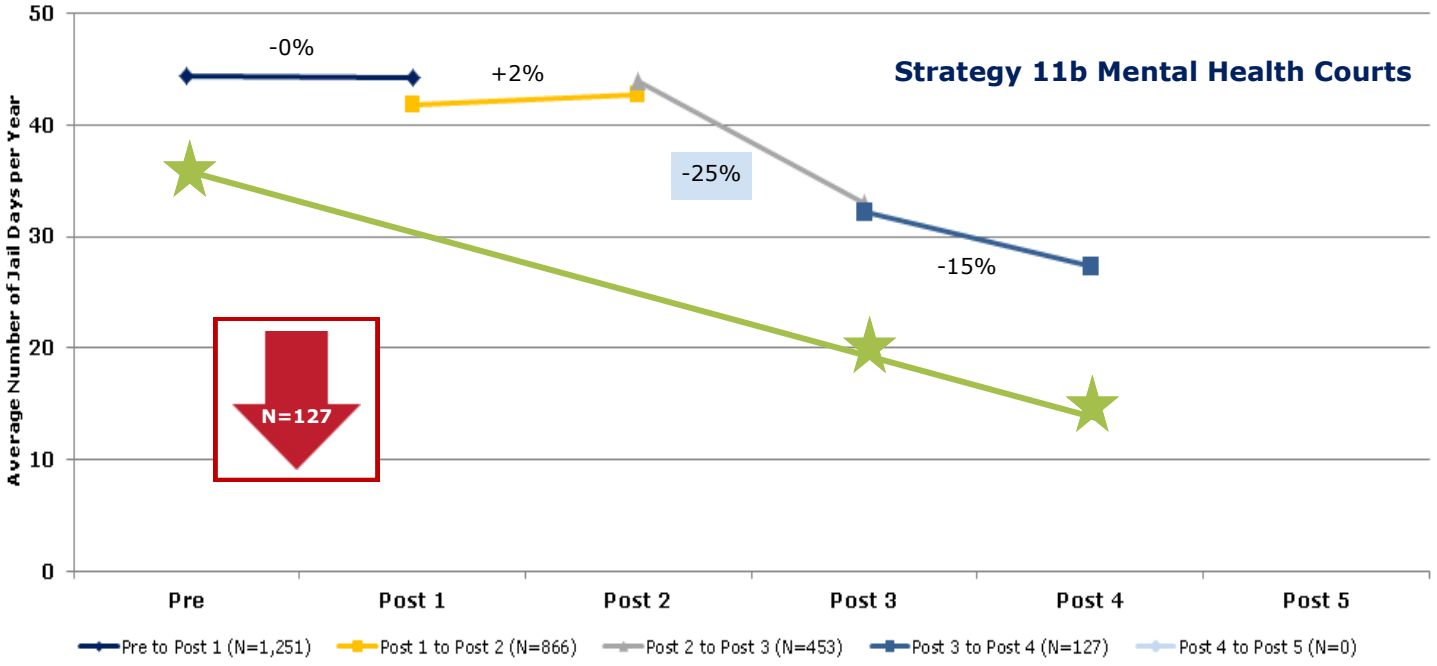

Strategy 8a Family Treatment Court
Average Number of Jail Days per Year
20
15
10
5
0
-17%
+8%
+19%
-22%
+25%
N=34
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=108)
Post 1 to Post 2 (N=93)
Post 2 to Post 3 (N=79)
Post 3 to Post 4 (N=58)
Post 4 to Post 5 (N=34)

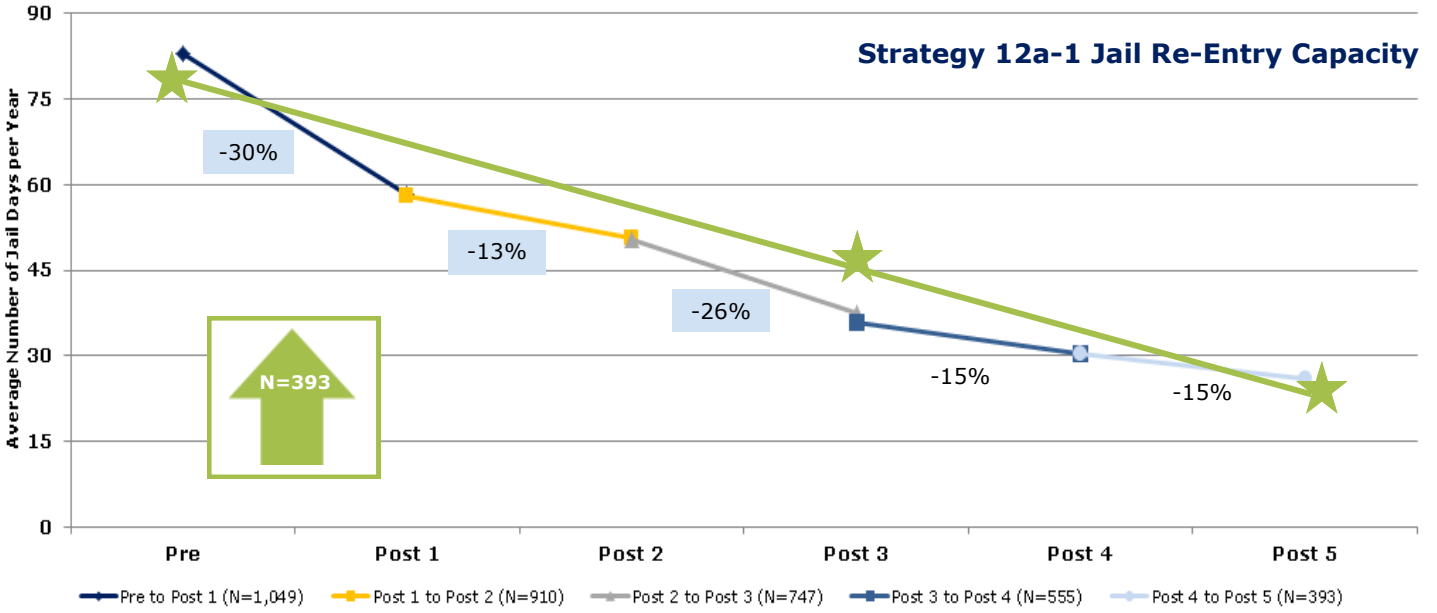

Strategy 9a Juvenile Drug Court
Average Number of Jail Days per Year
75
60
45
30
15
0
+109%
-38%
-9%
-26%
+52%
N=58
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=217)
Post 1 to Post 2 (N=177)
Post 2 to Post 3 (N=116)
Post 3 to Post 4 (N=87)
Post 4 to Post 5 (N=58)


Strategy 10b Adult Crisis Diversion
Average Number of Jail Days per Year
40
30
20
10
0
+67%
-11%
-1%
N=139
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,226)
Post 1 to Post 2 (N=680)
Post 2 to Post 3 (N=139)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

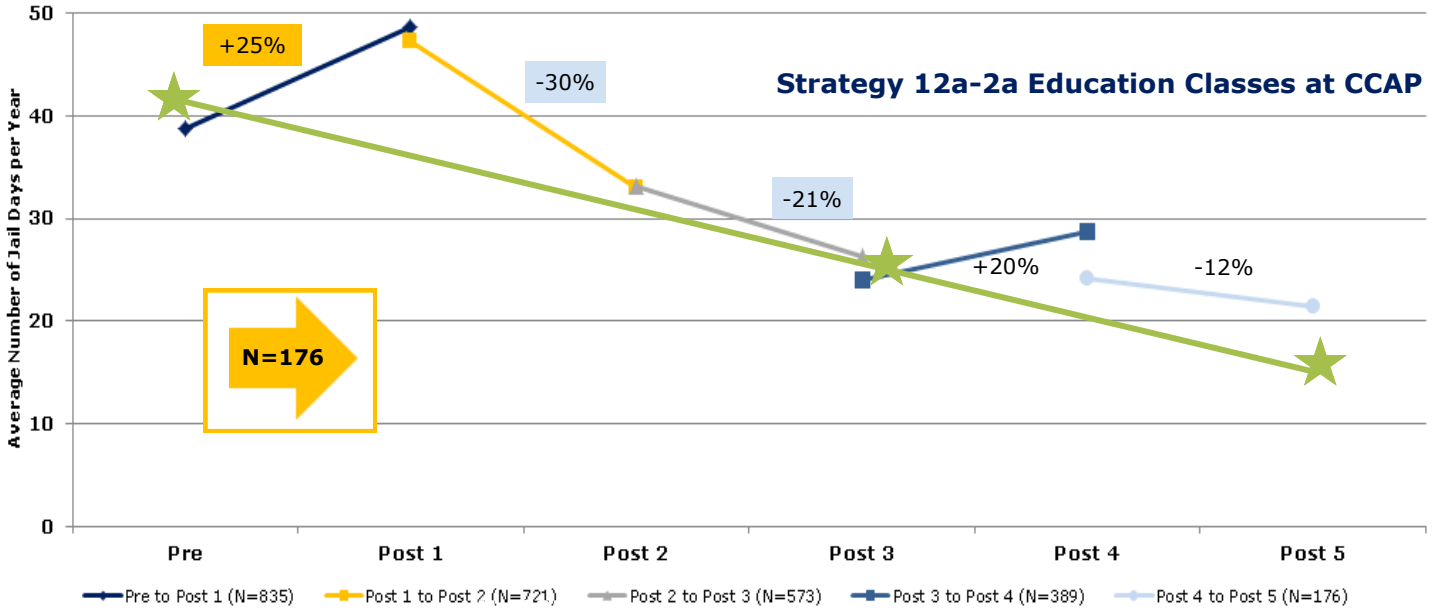
14712

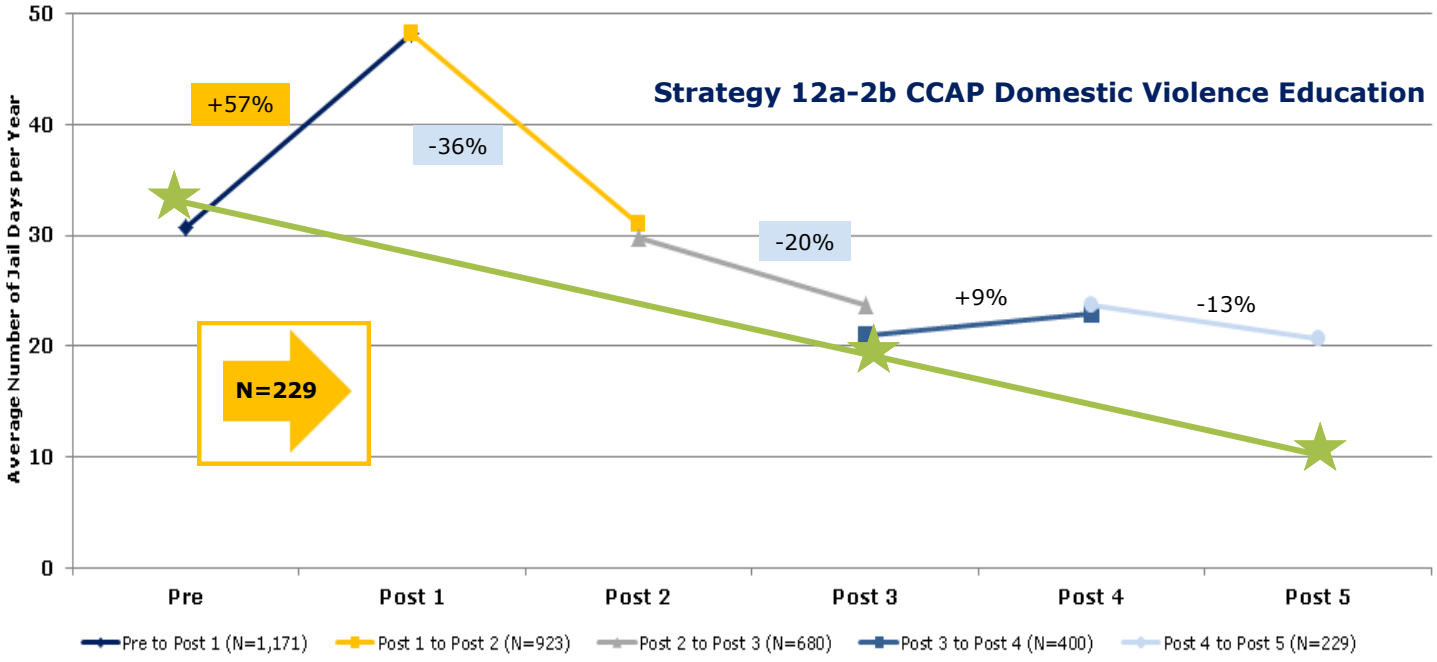

Average Number of Jail Days per Year
50
40
30
20
10
0
+7%
-14%
-17%
+22%
-10%
N=224
Strategy 11a Increase Jail Liaison Capacity
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=621)
Post 1 to Post 2 (N=608)
Post 2 to Post 3 (N=543)
Post 3 to Post 4 (N=360)
Post 4 to Post 5 (N=224)

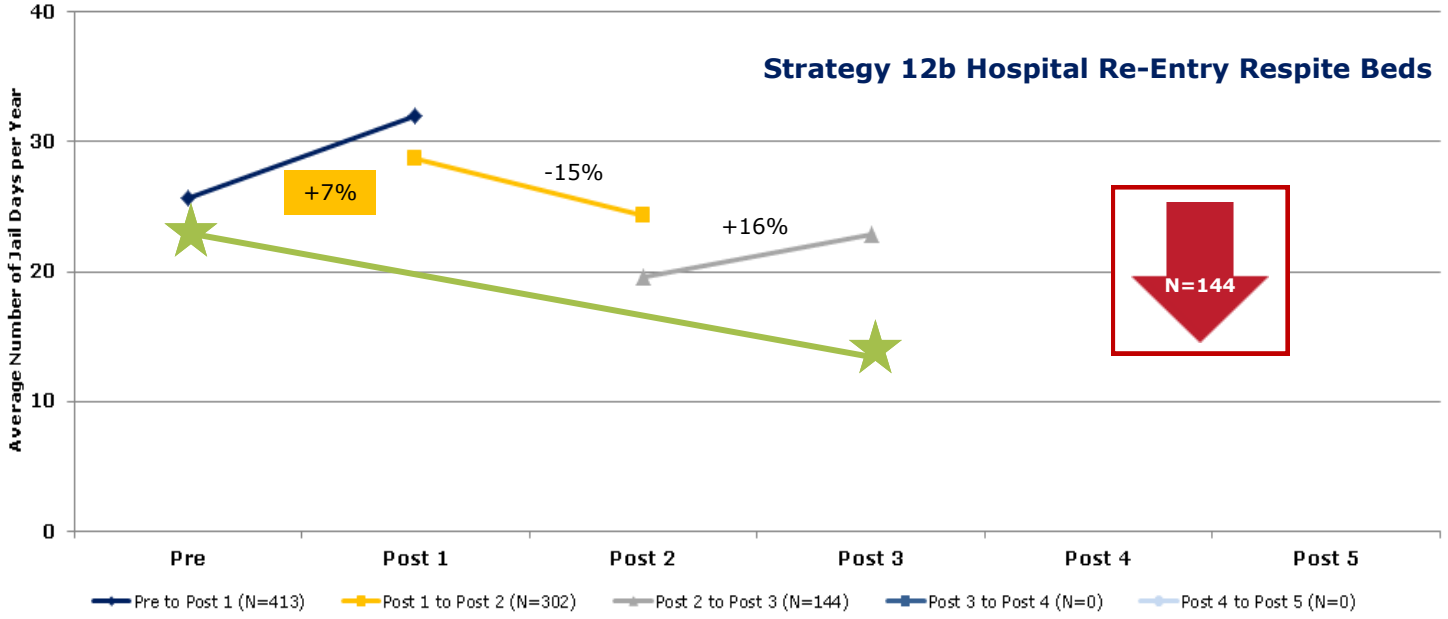

Average Number of Jail Days per Year
50
40
30
20
10
0
-0%
+2%
-25%
-15%
N=127
Strategy 11b Mental Health Courts
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,251)
Post 1 to Post 2 (N=866)
Post 2 to Post 3 (N=453)
Post 3 to Post 4 (N=127)
Post 4 to Post 5 (N=0)


Average Number of Jail Days per Year
90
75
60
45
30
15
0
-30%
-13%
-26%
-15%
-15%
N=393
Strategy 12a-1 Jail Re-Entry Capacity
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,049)
Post 1 to Post 2 (N=910)
Post 2 to Post 3 (N=747)
Post 3 to Post 4 (N=555)
Post 4 to Post 5 (N=393)

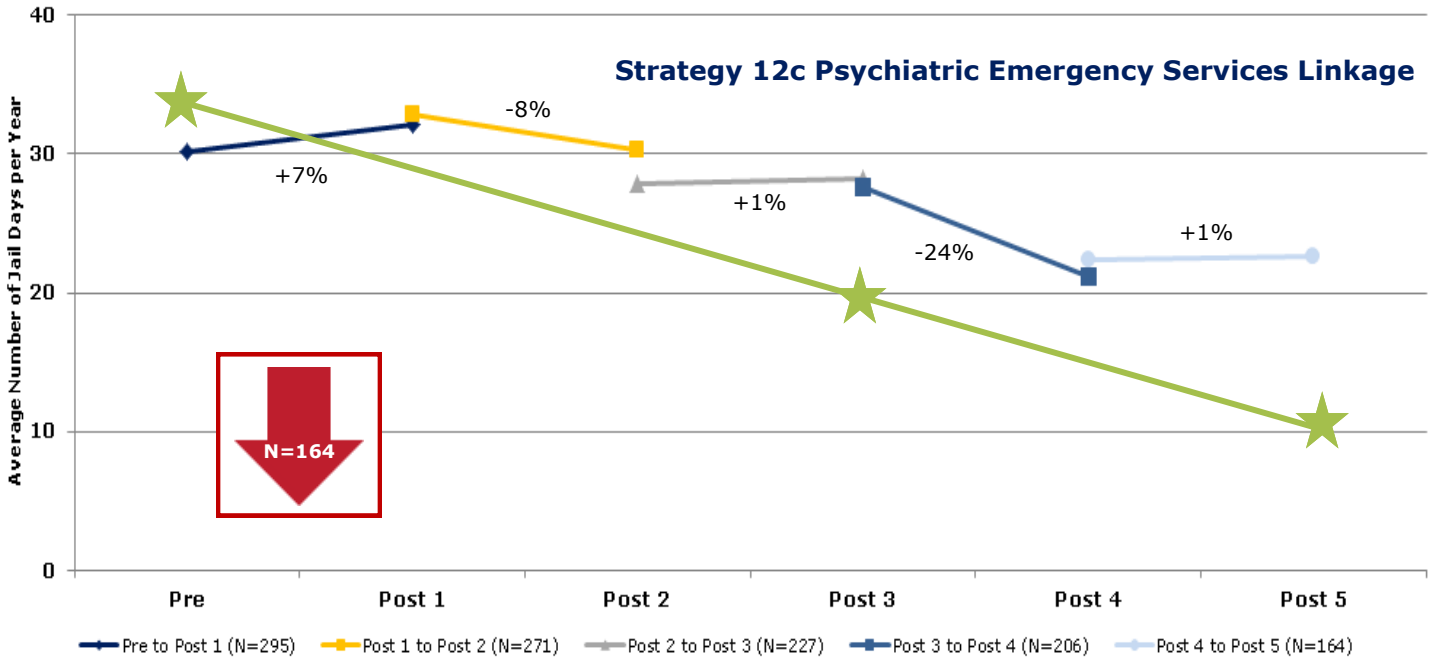
14712

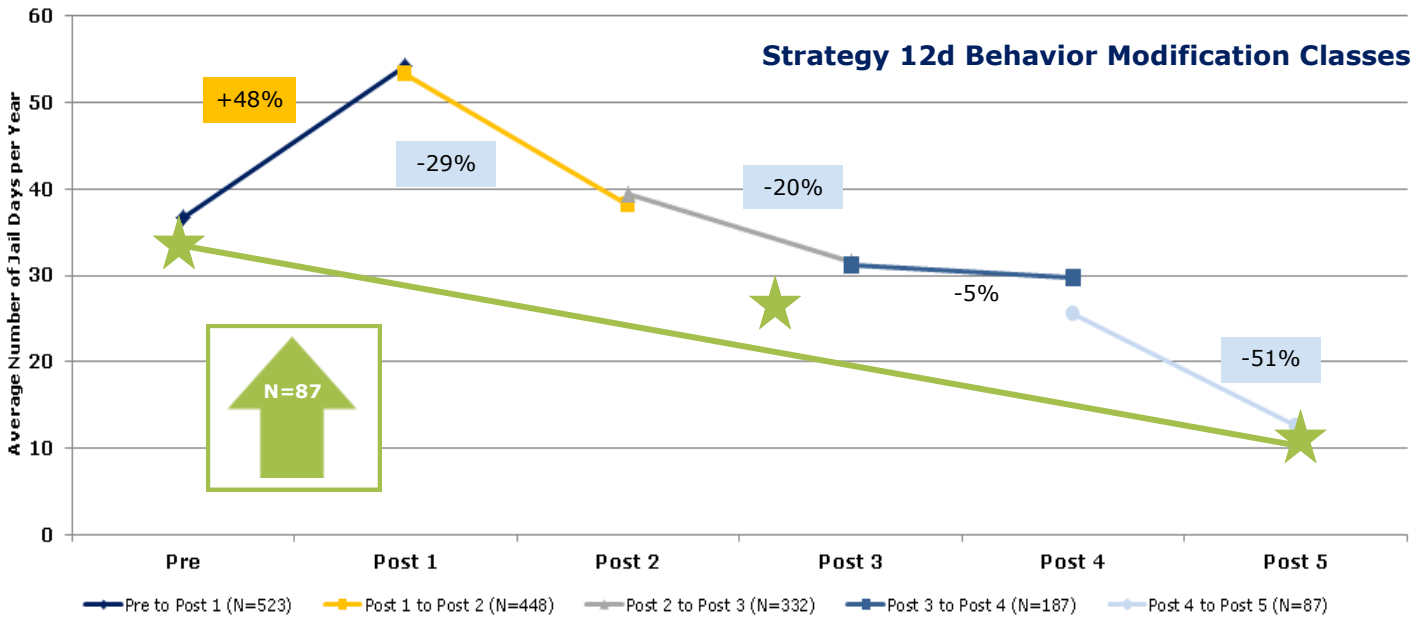

Strategy 12a-2a Education Classes at CCAP
Average Number of Jail Days per Year
50
40
30
20
10
0
+25%
-30%
-21%
+20%
-12%
N=176
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=835)
Post 1 to Post 2 (N=721)
Post 2 to Post 3 (N=573)
Post 3 to Post 4 (N=389)
Post 4 to Post 5 (N=176)

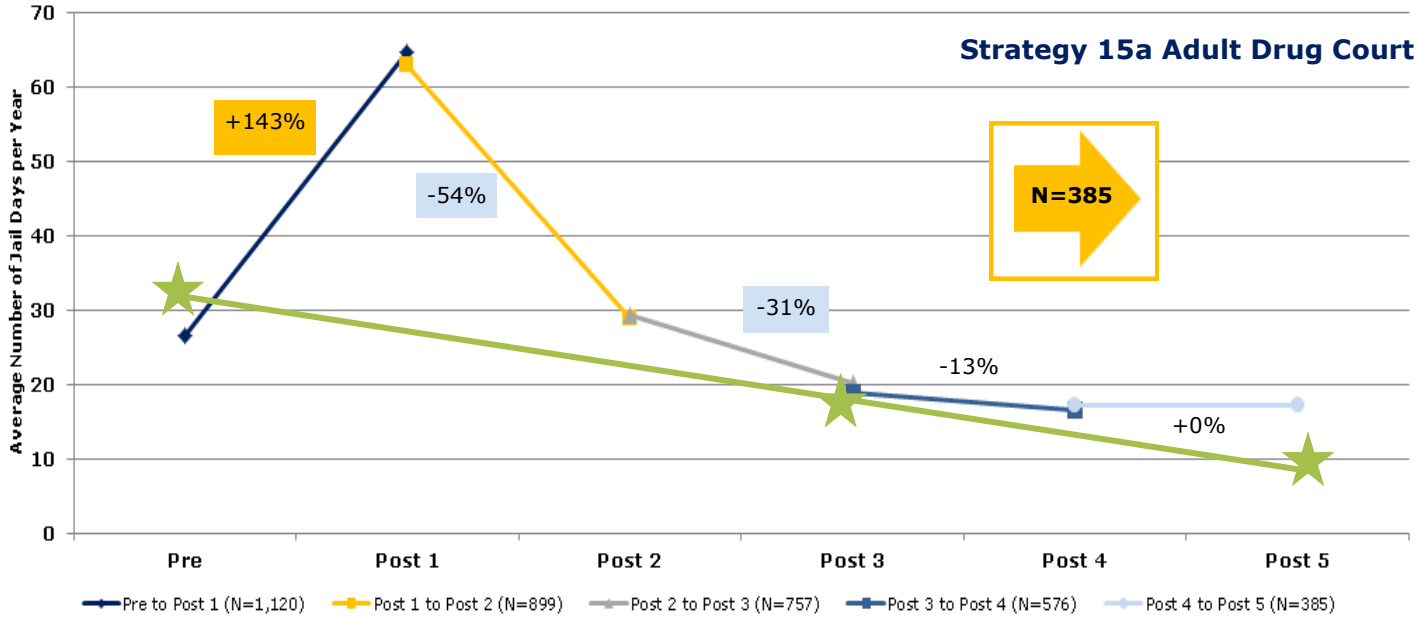

Strategy 12a-2b CCAP Domestic Violence Education
Average Number of Jail Days per Year
50
40
30
20
10
0
+57%
-36%
-20%
+9%
-13%
N=229
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,171)
Post 1 to Post 2 (N=923)
Post 2 to Post 3 (N=680)
Post 3 to Post 4 (N=400)
Post 4 to Post 5 (N=229)


Strategy 12b Hospital Re-Entry Respite Beds
Average Number of Jail Days per Year
40
30
20
10
0
+7%
-15%
+16%
N=144
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=413)
Post 1 to Post 2 (N=302)
Post 2 to Post 3 (N=144)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

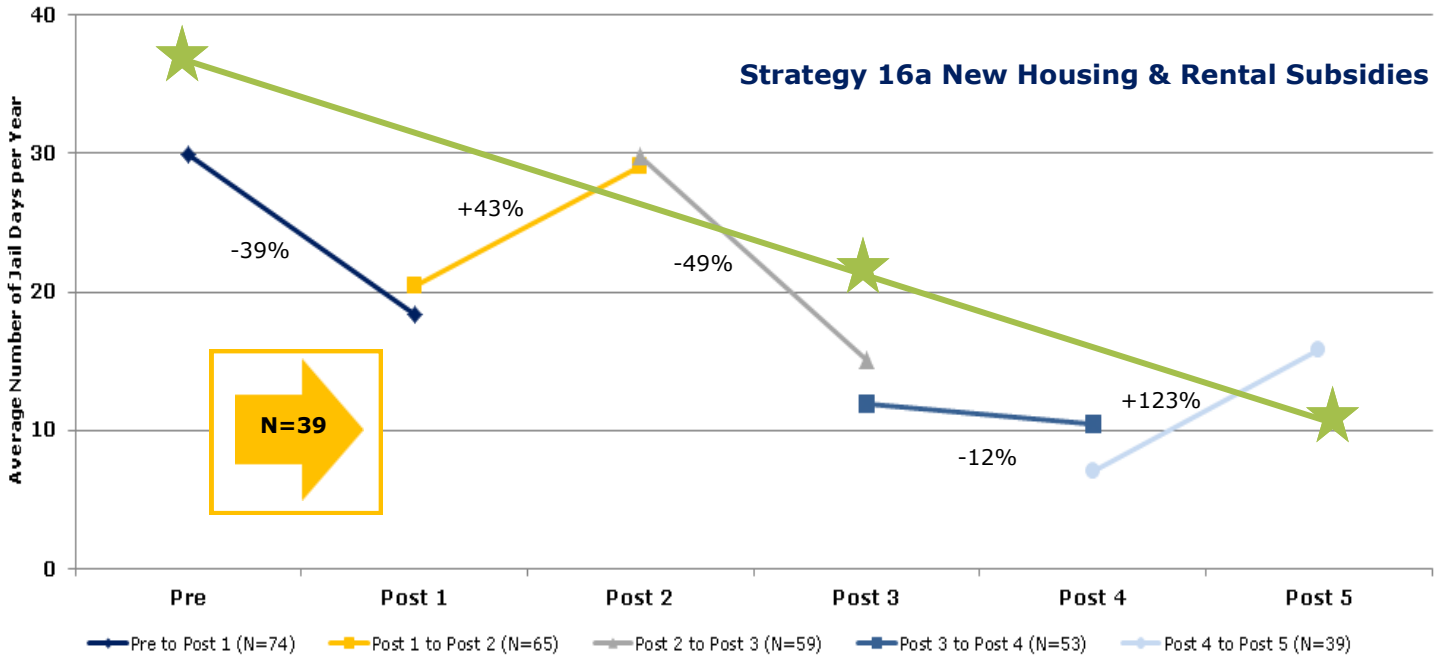
14712


Strategy 12c Psychiatric Emergency Services Linkage
Average Number of Jail Days per Year
40
30
20
10
0
+7%
-8%
+1%
-24%
+1%
N=164
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=295)
Post 1 to Post 2 (N=271)
Post 2 to Post 3 (N=227)
Post 3 to Post 4 (N=206)
Post 4 to Post 5 (N=164)


Strategy 12d Behavior Modification Classes
Average Number of Jail Days per Year
60
50
40
30
20
10
0
+48%
-29%
-20%
-5%
-51%
N=87
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=523)
Post 1 to Post 2 (N=448)
Post 2 to Post 3 (N=332)
Post 3 to Post 4 (N=187)
Post 4 to Post 5 (N=87)


Strategy 15a Adult Drug Court
Average Number of Jail Days per Year
70
60
50
40
30
20
10
0
+143%
-54%
-31%
-13%
+0%
N=385
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,120)
Post 1 to Post 2 (N=899)
Post 2 to Post 3 (N=757)
Post 3 to Post 4 (N=576)
Post 4 to Post 5 (N=385)

14712


Strategy 16a New Housing & Rental Subsidies
Average Number of Jail Days per Year
40
30
20
10
0
-39%
+43%
-49%
-12%
+123%
N=39
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=74)
Post 1 to Post 2 (N=65)
Post 2 to Post 3 (N=59)
Post 3 to Post 4 (N=53)
Post 4 to Post 5 (N=39)

Appendix I

Tools used in Measuring Symptom Reduction

Symptom Reduction Tool	Summary
Problem Severity Summary (PSS)	The PSS was adopted to measure mental illness symptom changes over time in adults. The PSS is an inventory used to assess the functioning level for adults in a number of life domains. Scores on the clinician-rated instrument are assigned to each dimension from *0 – Above Average: Area of strength relative to average* to *5 – Extreme impairment: Out of control, unacceptable.* The PSS assesses 14 dimensions, including symptoms of depression, anxiety, psychosis (thought disorders), and dissociation (unreality). The PSS also notes cognitive impairment.
Children's Functional Assessment Rating Scale (CFARS)	CFARS is a clinician-rated tool used for standardizing impressions from assessment of cognitive, social, and role functioning in children/youth. It includes measures for 16 domains, including depression and anxiety. Ratings are assigned using a 9-point scale where 1 is "no problem" and 9 is a "severe problem."
Addiction Severity Index (**ASI**)	The ASI is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client's life that may contribute to their substance-abuse problems.
PHQ-9 (part of the Patient Health Questionnaire)	The PHQ-9 has cut points of 5, 10, and 15 to indicate mild, moderate, and severe levels. Symptom reduction is analyzed by comparing changes in instrument scores within individuals over time. Questions from the PHQ-9 assess patient mood, sleeping patterns, energy, appetite, concentration, and thoughts of suicide, among others.
Generalized Anxiety Disorder (GAD-7)	The GAD-7 provides an index to gauge patient anxiety levels. It has cut points of 5, 10, and 15 to indicate mild, moderate, and severe levels. Symptom reduction is analyzed by comparing changes in instrument scores within individuals over time. The GAD-7 includes questions about feeling worried, nervous, restless, annoyed or afraid.
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)	The GAIN-SS, while not designed as a symptom reduction measure, is used to screen clients for behavioral health issues. It serves as a periodic measure of behavioral health change over time.
Global Appraisal of Individual Needs Initial (GAIN-I)	The GAIN-I has sections covering background, substance use, physical health, risk behaviors and disease prevention, mental and emotional health, environment and living situation, legal, and vocational. Within these sections are questions that address problems, services, client attitudes and beliefs, and the client's desire for services. The GAIN-I also collects information on recency of problems, breadth of symptoms, recent prevalence lifetime service utilization, recent utilization and the frequency of recent utilization.
Pediatric Symptom Checklist (PSC-17)	This instrument rates levels of internalizing, externalizing and attentional behaviors with a maximum score of 34. Total scale scores above 14 are considered above the clinical threshold.

14712

Symptom Reduction Effectiveness Results

Reducing symptoms associated with mental illness and/or substance use disorder was a primary or secondary goal for 13 implemented MIDD strategies. Analysis results demonstrating symptom reduction effectiveness are summarized by strategy below, along with the source and date of the original publication if more detail is needed.

Summary of Findings or Update	Original Publication	Date
1a-1 Mental Health Treatment		
Mental health treatment providers began submitting symptom measures for adults in January 2010 and for children in April 2010. The first set of analysis data is expected in February 2011.	Third Annual Report Page 34	February 2011
The Problem Severity Summary (PSS) was used to assess changes in depression and anxiety for 1,019 adults with measures at two time points. Of those with severe or extreme anxiety (N=251) or depression (N=325) at baseline, 42 percent improved over time. The vast majority of individuals remained stable. The Children's Functional Assessment Rating Scale (CFARS) provided symptom change measures for 79 individuals aged five to 22. Of those with baseline scores above the clinical threshold for concern, 67 percent reduced depression symptoms, 61 percent reduced anxiety, and half reduced traumatic stress.	Year 3 Progress Report Page 22 and Fourth Annual Report Page 36	August 2011 and February 2012
Baseline PSS data for 2,719 people showed that many MIDD participants are severely impaired by depression (27%) or anxiety (21%). Of the 1,044 whose anxiety symptoms changed over time, 884 (85%) showed some improvement. Of the 767 people with the most severe depression during their pre period, 179 (23%) had only slight or no impairment during at least one subsequent measure. The average time associated with symptom reduction was about 15 months between measures.	Fifth Annual Report Page 60	February 2013
Analysis of baseline PSS scores for 5,364 clients showed response to stress, depression, anxiety, and social withdrawal to have the highest incidence of severe to extreme impairment. Of the 3,026 people who had PSS data at baseline and each of the next three years, the percentage who reduced their symptoms in these four categories grew over time. All incremental and long-term improvements were statistically significant. Among the 629 youth and children with CFARS ratings, depression and anxiety were again the most problematic from a symptoms standpoint. Improvements in severity over time were noted, although youth with extreme issues were very rare (less than one percent in any functional domain).	Seventh Annual Report Page 59	February 2015
1a-2a Substance Use Disorder (SUD) Outpatient Treatment		
In July 2011, SUD treatment providers were required to submit "periodic milestone" data for the purpose of measuring symptom reduction in adults over time. Over 2,500 of these Addiction Severity Index (ASI) records had been entered, but were unavailable for download from the State of Washington.	Year 4 Progress Report Page 23	August 2012
For 2,699 adults in outpatient SUD treatment, the top three drugs were: alcohol (55%), marijuana (25%), and cocaine (6%). For those with primary alcohol use, 128 of 499 (26%) reduced their use to abstinence by the second measure (usually one year later). The abstinence rate for marijuana was 24 percent and for cocaine it was 20 percent.	Fifth Annual Report Page 11	February 2013
Substance use symptom reduction was studied for 195 youth enrolled in MIDD-funded SUD treatment using Global Appraisal of Individual Needs (GAIN) data. Marijuana was the drug of choice for the majority of these youth. Combined with youth from other MIDD strategies, marijuana use "in the past 90 days" fell significantly from 40 days (pre) to 33 days (post). Average days without substance use rose significantly over time and the average days spent drunk or high declined by 22 percent. The total number of youth reporting abstinence from substances rose from 22 to 60, a 173 percent increase.	Sixth Annual Report Page 55	February 2014
Continued on Next Page		

Summary of Findings or Update	Original Publication	Date
1a-2a SUD Outpatient Treatment (Continued)		
Outcomes were sought for 7,587 adults in outpatient SUD treatment with MIDD service starts between October 2008 and 2013. Usable data was found for 4,658 people (a 61% match rate). Males accounted for 73 percent of all treatment episodes and females 27 percent. Treatment was evenly divided between people of color and those who identified as Caucasian/White. Compared to 2013, marijuana as the primary drug of choice declined from 25 percent to 14 percent. Cocaine, heroin and methamphetamine each accounted for seven percent of all treatment admissions. Alcohol remained the top primary substance (56%) for individuals entering treatment. Over half of all people treated reported no primary substance abuse in the 30 days before treatment. Data quality may be a factor. Successful completions of treatment were recorded for 43 percent of cases. Excluding those who reported no substance use prior to starting treatment, 72 percent of cases with six-month milestone data experienced decreased substance use; 27 percent show decreased use when comparing admission use to discharge use. Note that at discharge, data matched the intake precisely for 65 percent of cases. This reflects the default data entry setting if no discharge data are entered. The percentage of active users who reduced their use to zero was 26 percent and the percentage of all treatment cases who reduced their use to zero or stayed use free was 66 percent.	Year 7 Progress Report Page 14	August 2015
1a-2b SUD Opiate Treatment Programs (OTP)		
The analysis sample was 1,961 treatment episodes for 1,421 individuals matched to 1,917 outcomes-eligible people served. Males had 59 percent of OTP episodes, compared to 73 percent in outpatient care. Caucasian/Whites had 77 percent of these episodes (vs. 50% for outpatient). Heroin was the primary drug used in 82 percent of all OTP treatment admissions. Daily use of heroin and opiates in the 30 days leading to treatment was found in 64 percent of all cases. From admission to first periodic milestone (collected at six-month intervals), 457 of 515 people with active drug use leading up to treatment (89%) reduced use of their primary substance. Of 901 people without milestone data, 465 decreased use by discharge (52%). Very few people in treatment experienced increased substance use over time. The proportion of treatment participants who reduced their use to zero or who stayed use-free over time was 40 percent.	Year 7 Progress Report Page 14	August 2015
1g Older Adults Prevention		
Of the 106 people with initial and later depression ratings, 59% showed a reduction in depressive symptoms.	Second Annual Report Page 12	February 2010
The Patient Health Questionnaire (PHQ-9) is used to measure depression and the Generalized Anxiety Disorder (GAD-7) gauges client anxiety levels. Of the 1,096 people with two or more PHQ-9 scores, 740 (68%) showed reduced depression. Of the 742 with two GAD-7 scores, 483 (65%) showed improvement. The more severe the symptoms, the greater opportunity for improvement over time. Successful outcomes (noted above) were realized, on average, in as few as ten visits or within approximately seven service hours.	Year 3 Progress Report Page 23 and Fourth Annual Report Page 10	August 2011 and February 2012
Public Health—Seattle & King County reported that in cases where symptoms were not improving, 74 percent of patients received a psychiatric consultation. In general, more contacts and more service minutes were associated with symptom reduction or stabilization.	Year 5 Progress Report Page 15	August 2013

Continued on Next Page

Summary of Findings or Update	Original Publication	Date
1g Older Adults Prevention (Continued)		
Data were analyzed from 1,985 older adults engaged in treatment beyond their initial screening. For the 1,229 with improved depression scores or stabilizing below the clinical threshold for concern (62%), the average treatment minutes was 479. By contrast, the 756 adults with symptoms above moderate or worsening over time (38%) averaged only 383 treatment minutes. Eight months was the average time between first and last measure. For anxiety, only 10 percent of the 1,435 with two or more scores were initially below clinical threshold, but by the last measure, 27 percent were considered clinically stabilized.	Sixth Annual Report Page 16	February 2014
4c School-Based Services		
In November 2012, GAIN short screener (GAIN-SS) results for 39 students at one school showed that 46 percent had high scores on internalizing disorders, such as depression and anxiety. Thirty-two percent had high externalizing scores, suggesting a need for help with attention deficits or conduct problems. Only three percent of the sample scored high for substance use disorders (SUD).	Year 5 Progress Report Page 23	August 2013
Healthy Youth Survey data indicated that 90 percent of 8th graders did not drink alcohol. Of those who used alcohol, binge drinking was higher on average in 4c schools than in King County, but less than statewide. The statewide incidence for depression was about 25 percent both statewide and in 4c schools. Suicidal thoughts were slightly lower in 4c schools than in King County as a whole. In 4c schools, 69 percent of 8th graders were aware of adults available to help them vs. only 46 percent of the 8th graders in King County. Of 1,043 youth eligible for outcomes, 109 (10%) had initial GAIN-SS data. Sixty percent scored high on depression or anxiety, while only 13 percent had high SUD screens. No data were available for change analysis.	Seventh Annual Report Page 35	February 2015
6a Wraparound		
An independent analysis by King County's Children's Mental Health Planner showed improved behavior, rule compliance and school performance for 159 youth with scores at two different points in time.	Year 5 Progress Report Page 26	August 2013
Behavioral data were available for 638 youth with service starts before April 2014. Property damage and harm to others were both reduced significantly over time, while compliance with household rules increased significantly. At one year after initial assessment, 42 percent of caregivers felt youth behavior had improved, compare to only 28 percent surveyed at the six-month mark. Caregivers reported reductions in perceived problem severity across 21 items measured, including worry, sadness and caregiver strain.	Seventh Annual Report Page 30	February 2015
8a Family Treatment Court (FTC)		
Of the 17 parents exited from the program, five (29%) were clean and sober for a consecutive six month period, were consistently attending sober support programs, and were engaged in relapse prevention.	Third Annual Report Page 22	February 2011
External academic evaluations suggest that participants experienced significant positive gains in both their attitudes (trust and understanding) and their behaviors (engagement, compliance, and visitation). Of the 28 parents with end dates between October 2011 and September 2012, 10 graduated (36%) and two had their cases dismissed. Children were returned home in all but one of these cases. Of the 47 parents for whom SUD data was available, 12 (28%) listed methamphetamine as their drug of choice, followed by cocaine and alcohol at 19 percent apiece. More data are needed to examine change over time.	Fifth Annual Report Page 32	February 2013

Continued on Next Page

Summary of Findings or Update	Original Publication	Date
8a Family Treatment Court (Continued)		
The total number of FTC clients eligible for symptom reduction measurement was 139. Information on 148 treatment admissions matched to 86 of these people (61%). Treatment was successfully completed by 33 percent of admissions (49 people). The majority of FTC clients in treatment were women (82%) and their most common drug of choice was methamphetamine (27%), followed by cocaine and alcohol at 20 percent each. Of 49 treatment admissions with milestone outcomes data, 30 said they had no drug use in the 30 days before treatment or six months after. Of the remaining 19 with some use, 17 (79%) decreased their substance use over time. By contrast, where milestone data were unavailable, 16 of 36 people (44%) with active substance use prior to treatment had experienced a decline in use by the discharge time point. Altogether, 78 percent of FTC clients in treatment reduced their substance use to zero or stayed use free.	Year 7 Progress Report Page 15	August 2015
9a Juvenile Drug Court		
Substance use symptom reduction was studied for six male youth enrolled in Juvenile Drug Court. When combined with youth from other MIDD strategies, including 139 who participated in 5a Juvenile Justice Youth Assessments, it was found that marijuana was the drug used most often. For youth who used alcohol, 57 percent reduced their frequency use over time. (See 1a-2a on Page 3.)	Sixth Annual Report Page 55	February 2014
11b Mental Health Courts (MHC)		
For a sample of 472 MHC clients with anxiety and depression scores at two time points, 74 percent remained stable over time. Where change was evident, up to 84 percent of clients improved their symptoms at some point during treatment.	Eighth Annual Report	February 2016
12d Behavior Modification Classes		
For 235 clients with anxiety and depression scores at two different time points, about half of all clients remained stable over time. When the scores changed, the majority (up to 86%) showed improvements rather than declines.	Eighth Annual Report	February 2016
13a Domestic Violence Services		
Clients become eligible for symptom reduction outcomes after being seen in three separate months. Of the 243 people eligible, 202 (83%) agreed or strongly agreed that they are better able to manage stress in their lives.	Year 3 Progress Report Page 23	August 2011
In surveys received throughout the year, not a single client disagreed with statements about the positive role of their MIDD-funded therapist in helping them with stress management, decision-making and self-care.	Fourth Annual Report Page 12	February 2012
A total of 85 client or clinician-rated surveys were submitted. Most respondents (73%) felt they could manage their stress better as a result of therapy.	Fifth Annual Report Page 22	February 2013
13b Domestic Violence Prevention		
Nearly 400 children were screened using the Pediatric Symptom Checklist (PSC-17). This instrument rates levels of internalizing, externalizing and attentional behaviors with a maximum score of 34. Total scale scores above 14 are considered above the clinic threshold. Scores were not available to assess change over time.	Fourth Annual Report Page 20	February 2012
An analysis of symptom reduction was completed using 97 cases with PSC-17 measures taken at least two months apart. Scores dropped below the threshold of concern for 43 children (44%) at some point during their treatment. Those reducing symptoms were in treatment on average for 17 months vs. only 14 months for those remaining at elevated symptom levels.	Fifth Annual Report Page 34	February 2013
14a Sexual Assault Services		
Clients needed to attend at least two therapy sessions in order to be considered outcomes-eligible. For 54 children and 26 adults, more than 88 percent had positive overall outcomes. Negative symptoms were reduced for 17 adults (65%).	Year 3 Progress Report Page 23	August 2011
For 53 adults with outcomes data, 49 (92%) had achieved successful outcomes by meeting two or more of these measured items: understanding their experience, coping skills, symptom reduction, and treatment goals.	Fifth Annual Report Page 34	February 2013

Continued on Next Page

Summary of Findings or Update	Original Publication	Date
14a Sexual Assault Services (Continued)		
In 2012, one sexual assault agency receiving MIDD funding reported that nine of every 10 clients increased their coping skills, reduced negative symptoms, and/or met treatment goals.	Year 5 Progress Report Page 21	August 2013
For youth, 29 of 32 (90%) had achieved positive outcomes related to emotional stability and behavior change. Positive outcomes, including symptom reduction, were achieved by 71 of 80 adults (89%).	Sixth Annual Report Page 22	February 2014
15a Adult Drug Court (ADC)		
Addiction Severity Index data were available for 629 ADC clients of the 937 eligible for outcomes (67% match rate). The average number of treatment episodes was 1.9 per person. Marijuana was the most common substance used (22% primary). The rate of successful treatment completions was 45 percent. Substance use reductions to zero occurred in 46 percent of cases with active use before treatment. Overall, 78 percent of clients reduced their use to zero or stayed use free over time.	Year 7 Progress Report Page 15	August 2015

Enumeration of All Performance Measurements and Summary of Performance Outcomes

On the following three pages, performance measurements used over the life of all MIDD-funded strategies, programs and services are shown in the rows labeled "Target." Performance outcomes are show in the rows labeled "Actual" (raw numbers) and "% of Target" (percentages). Results are provided by the following MIDD strategy groupings: Strategies with Programs to Help Youth, Community-Based Care Strategies, and Jail and Hospital Diversion Strategies. Where targets differed in any given year from those posted in the "Original or Revised Target" column, an explanatory notation has been provided in the far right column under "Target Adjustments and Notes". Where actual achievement was lower than 65 percent of the annual or adjusted target, the percentage is highlighted in red. Where achievement ranged from 65 to 85 percent of target, the percentage is highlighted in yellow. Achievements in excess of 85 percent of the posted targets are unmarked. In all tables, FTE refers to full-time equivalent staffing.

		Annual or Adjusted Targets and Performance Outcomes								
Measure	**Original or Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**	**Target Adjustments and Notes**
1a-1 Mental Health (MH) Treatment										
Number of Clients	2,400	Target	2,300	2,400	2,400	2,400	2,400	2,400	2,400	Year 1 (11.5 months)
		Actual	2,047	3,481	3,090	4,345	4,612	3,117	2,730	
		% of Target	89%	145%	129%	181%	192%	130%	114%	
1a-2 Substance Use Disorder (SUD) Treatment										
Adult Outpatient Units	50,000	Target	47,917	50,000	50,000	50,000	50,000	50,000	50,000	Year 1 (11.5 months) ~ Other funds available ~ Federal and state funds expended first Note: In Year 7, this strategy funded over $1.75 million in detoxification services
		Actual	36,181	43,751	26,978	30,053	31,409	30,366	20,362	
		% of Target	**76%**	88%	**54%**	**60%**	**63%**	**61%**	**41%**	
Youth Outpatient Units	4,000	Target	3,833	4,000	4,000	4,000	4,000	4,000	4,000	
		Actual	10,370	6,617	5,749	6,564	4,254	3,829	2,833	
		% of Target	271%	165%	144%	164%	106%	96%	**71%**	
Opiate Treatment Program Units	70,000	Target	67,083	70,000	70,000	70,000	70,000	70,000	70,000	
		Actual	66,957	82,560	72,677	79,017	88,189	53,791	21,231	
		% of Target	100%	118%	104%	113%	126%	**77%**	**30%**	
1b Outreach & Engagement										
Number of Clients	675 with 5.6 FTE	Target	239	675	675	675	675	675	675	Year 1 (3 to 3.5 months) Year 1 (5 FTE) ~ Blended funds ~
		Actual	435	1,857	1,693	1,530	1,346	1,096	1,074	
		% of Target	182%	275%	251%	227%	199%	162%	159%	
1c Emergency Room Intervention										
Screenings	6,400 with 8 FTE	Target	3,333	4,800	6,000	5,600	5,600	4,000	4,560	Year 1 (5 to 9 months) Year 1 and Year 2 (6 FTE) Year 3 (7.5 FTE) Year 4 and Year 5 (7 FTE) Year 6 (5 FTE) Year 7 (5.7 FTE)
		Actual	2,558	3,344	4,649	3,695	4,422	2,584	2,177	
		% of Target	**77%**	**70%**	**77%**	**66%**	**79%**	**65%**	**48%**	
Brief Interventions	4,340 with 8 FTE	Target	2,260	3,255	4,069	3,798	3,798	2,688	3,092	
		Actual	2,250	4,050	5,475	4,763	3,488	2,869	2,585	
		% of Target	100%	124%	135%	125%	92%	107%	**84%**	
1d Crisis Next Day Appts										
Number of Clients with Enhanced Services	750	Target	688	750	413	285	285	285	634	Year 1 (11 months) Year 3 (9 months at 60% less) Year 4 to Year 6 (62% less) Year 7 (state funds restored 1/2015)
		Actual	868	960	475	231	291	259	339	
		% of Target	126%	128%	115%	**81%**	102%	91%	**53%**	
1e Chemical Dependency Trainings										
Number of Reimbursed Trainees	125	Target	120	125	125	125	125	125	125	Year 1 (11.5 months)
		Actual	165	194	344	349	374	341	345	
		% of Target	138%	155%	275%	279%	299%	273%	276%	
Number of Workforce Development Trainees	250	Target	0	0	0	250	250	250	250	Workforce development trainees target was added in Year 4
		Actual	0	0	0	253	400	369	482	
		% of Target	N/A	N/A	N/A	101%	160%	148%	193%	
1f Parent Partners Family Assistance										
Number of Individually-Identified Clients	400	Target	0	0	0	0	0	200	300	Year 6 (Startup) Year 7 (Fully staffed 1/1/2015)
		Actual	0	0	0	0	0	137	182	
		% of Target	N/A	N/A	N/A	N/A	N/A	**69%**	**61%**	

Measure	Original or Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15	Target Adjustments and Notes
			Annual or Adjusted Targets and Performance Outcomes							
1g Older Adults Prevention										
Number of Clients	2,500	Target	1,875	2,500	2,500	2,500	2,500	2,500	2,500	Year 1 (9 months)
		Actual	1,805	2,495	2,993	3,635	4,231	4,892	8,933	
		% of Target	96%	100%	120%	145%	169%	196%	357%	
1h Older Adults Crisis & Service Linkage										
Number of Clients	340	Target	312	340	340	340	340	340	340	Year 1 (11 months)
		Actual	327	444	424	326	435	443	294	
		% of Target	105%	131%	125%	96%	128%	130%	86%	
2a Workload Reduction										
Number of Agencies Participating	16	Target	16	16	16	16	16	16	16	
		Actual	16	16	16	17	17	16	16	
		% of Target	100%	100%	100%	106%	106%	100%	100%	
2b Employment Services										
Number of Clients	920 for both MH/SUD	Target	671	700	700	700	700	700	700	Year 1 (11.5 months) Year 1 to Year 7 (MH only)
		Actual	734	820	793	834	884	935	871	
		% of Target	109%	117%	113%	119%	126%	134%	124%	
3a Supportive Housing										
Number of Clients	Capacity grew until 2014	Target	70	251	445	553	614	690	690	Year 1 (6 months)
		Actual	114	244	506	624	787	869	772	
		% of Target	163%	97%	114%	113%	128%	126%	112%	
4c School-Based Services										
Number of Youth	2,268 with 19 programs	Target	0	0	1,550	1,550	1,550	1,550	1,550	Year 3 to Year 7 (13 programs)
		Actual	0	0	1,896	1,410	1,510	1,213	1,031	
		% of Target	N/A	N/A	122%	91%	97%	**78%**	**67%**	
4d Suicide Prevention Training										
Number of Adults	1,500	Target	192	1,500	1,500	1,500	1,500	1,500	1,500	Year 1 (11.5 months) Target was 200 in Year 1
		Actual	1,486	688	1,065	633	1,746	1,005	1,072	
		% of Target	774%	**46%**	**71%**	**42%**	116%	**67%**	**72%**	
Number of Youth	3,250	Target	3,115	3,250	3,250	3,250	3,250	3,250	3,250	Year 1 (11.5 months) ~ Blended funds ~
		Actual	4,764	7,600	7,873	8,129	8,634	9,721	8,530	
		% of Target	153%	234%	242%	250%	266%	299%	262%	
5a Juvenile Justice Assessments										
Number of Assessments Coordinated	1,200	Target	0	250	500	500	500	750	833	Year 2 (Operated at 50% capacity) Year 6 & 7 (Staff vacancies) Year 2 to 5 Target = 500
		Actual	0	407	580	856	1,467	790	841	
		% of Target	N/A	163%	116%	171%	293%	105%	101%	
Number of Psychological Services	200	Target	0	100	200	200	200	117	200	Year 2 (Operated at 50% capacity) Year 6 (Staff vacancies)
		Actual	0	32	98	209	186	101	311	
		% of Target	N/A	**32%**	**49%**	105%	93%	86%	156%	
Number of Mental Health Assessments	140	Target	0	70	105	140	140	117	140	Year 2 (Operated at 50% capacity) Year 3 and Year 6 (Staff vacancies)
		Actual	0	124	143	128	123	116	139	
		% of Target	N/A	177%	136%	91%	88%	99%	99%	
Number of Full Substance Use Disorder Assessments	165	Target	0	82	145	165	165	165	165	Year 2 (Operated at 50% capacity) Year 3 (Staff vacancies)
		Actual	0	251	234	420	291	225	190	
		% of Target	N/A	306%	161%	255%	176%	136%	115%	
6a Wraparound										
Number of Enrolled Youth	450	Target	0	920	374	450	450	450	450	Year 2 Target = 920 youth/siblings Year 3 (Staff vacancies)
		Actual	0	282	414	520	635	593	558	
		% of Target	N/A	**31%**	111%	116%	141%	132%	124%	
7b Expand Youth Crisis Services										
Number of Enrolled Youth	300	Target	0	0	0	300	300	300	300	~ Blended funds ~
		Actual	0	0	0	951	959	1,030	1,043	
		% of Target	N/A	N/A	N/A	317%	320%	343%	348%	
8a Family Treatment Court										
Number of Children in Families Served	90	Target	34	45	90	90	90	90	120	Year 1 (9 months) Year 1 & 2 Target = 45 Note: Cap lifted in Year 7 to 120 per year, not to exceed 60 at any time
		Actual	27	48	83	103	90	93	103	
		% of Target	**79%**	107%	92%	114%	100%	103%	86%	
9a Juvenile Drug Court										
Number of New Youth	36 with 5.5 FTE	Target	27	33	36	36	36	36	36	Year 1 (9 months) Year 2 (5 FTE) Year 1 to 3 Target = opt-ins only
		Actual	29	41	26	50	84	76	89	
		% of Target	107%	124%	**72%**	139%	233%	211%	247%	
10a Crisis Intervention Team Training										
Number of 40-Hour Trainees	180	Target	0	0	375	180	180	180	180	Year 3 Target = 375
		Actual	0	0	275	256	251	200	199	
		% of Target	N/A	N/A	**73%**	142%	139%	111%	111%	
Number of One-Day Trainees	300	Target	0	0	1,000	300	300	300	300	Year 3 Target = 1,000 Year 6 Actual = Special project to train Seattle Police Department
		Actual	0	0	626	266	268	657	553	
		% of Target	N/A	N/A	**63%**	89%	89%	219%	184%	
Number of Other Trainees	150	Target	0	0	0	150	150	150	150	
		Actual	0	0	0	185	163	159	312	
		% of Target	N/A	N/A	N/A	123%	109%	106%	208%	

Measure	Original or Revised Target		Annual or Adjusted Targets and Performance Outcomes: Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15	Target Adjustments and Notes
10b Adult Crisis Diversion										
Number of Clients	3,000	Target	0	0	0	500	3,000	3,000	3,000	Year 1 (2 months)
		Actual	0	0	0	359	2,353	2,905	3,352	~ Not unduplicated across three
		% of Target	N/A	N/A	N/A	**72%**	**78%**	97%	112%	program components ~
11a Increase Jail Liaison Capacity										
Number of Clients	200	Target	270	200	200	200	100	50	100	Year 1 (9 months)
		Actual	116	279	195	192	69	13	35	Year 5 & 6 (Staff vacancies)
		% of Target	**43%**	140%	98%	96%	**69%**	**26%**	**35%**	Year 7 (Reduced capacity) Year 1 Target = 360
11b Mental Health (MH) Courts										
Number of Regional MH Court Opt-In Clients	28 expansion 83 non-expansion[1]	Target	0	44	57	38	57	28	28	Year 2 (Startup)
		Actual	0	26	31	22	53	44	28	Year 4 (Staff vacancies)
		% of Target	N/A	**59%**	**54%**	**58%**	93%	157%	100%	Year 2 to 5 Target = 57 expansion opt-ins
Number of Seattle Municipal MH Court Clients Screened	300	Target	0	0	0	50	300	300	300	Year 4 Target = 50 clients not
		Actual	0	0	0	268	318	**303**	287	competent to stand trial
		% of Target	N/A	N/A	N/A	536%	106%	101%	96%	
12a-1 Jail Re-Entry										
Number of Clients	300 with 3 FTE	Target	480	200	250	300	300	300	300	Year 1 (Split with 12a-2)
		Actual	297	258	260	258	213	213	214	Year 2 & 3 (2 FTE, then 2.5 FTE)
		% of Target	**62%**	129%	104%	86%	**71%**	**71%**	**71%**	Year 1 Target = 1,440 for all 12a
12a-2 Education Classes at Community Center for Alternative Programs										
Number of Clients	600	Target	960	600	600	600	600	600	600	Year 1 (Split with 12a-1)
		Actual	114	449	545	579	520	590	532	Year 1 Target = 1,440 for all 12a
		% of Target	**12%**	**75%**	91%	97%	87%	98%	87%	~ Not unduplicated across various program components ~
12b Hospital Re-Entry Respite Beds										
Number of Clients	350-500	Target	0	0	29	350	350	350	350	Year 3 (1 month)
		Actual	0	0	26	342	395	334	366	
		% of Target	N/A	N/A	90%	98%	113%	95%	105%	
12c Psychiatric Emergency Services Linkage										
Number of Clients	75-100	Target	69	75	75	75	75	75	75	Year 1 (11 months)
		Actual	87	175	111	77	104	86	81	
		% of Target	126%	233%	148%	103%	139%	115%	108%	
12d Behavior Modification Classes										
Number of Clients	100	Target	25	100	100	100	100	100	40	Year 1 (3 months)
		Actual	42	79	131	189	162	129	43	Year 7 Target = 40
		% of Target	168%	**79%**	131%	189%	162%	129%	108%	
13a Domestic Violence Services										
Number of Clients	560-640	Target	240	700	560	560	560	560	560	Year 1 (3 to 7 months)
		Actual	197	489	517	514	583	558	595	Year 1 & 2 Target = 700-800
		% of Target	**82%**	**70%**	92%	92%	104%	100%	106%	
13b Domestic Violence Prevention										
Number of Unique Families	85	Target	78	85	85	85	85	85	85	Year 1 (11 months)
		Actual	102	144	134	147	135	144	155	
		% of Target	131%	169%	158%	173%	159%	169%	182%	
14a Sexual Assault Services										
Number of Clients	170	Target	260	400	170	170	170	170	170	Year 1 (5 to 9 months)
		Actual	179	364	301	387	413	348	358	Year 1 & 2 Target = 400
		% of Target	**69%**	91%	177%	228%	243%	205%	211%	~ Blended funds ~
15a Adult Drug Court										
Number of Clients	250	Target	113	300	250	250	250	250	250	Year 1 (3 months)
		Actual	125	337	313	294	268	261	388	Year 1 Target = 450
		% of Target	111%	112%	125%	118%	107%	104%	155%	Year 2 Target = 300
16a New Housing & Rental Subsidies										
Number of Tenants	25	Target	0	25	25	25	25	25	25	
		Actual	0	25	31	29	28	26	23	
		% of Target	N/A	100%	124%	116%	112%	104%	92%	
Number of Rental Subsidies	25	Target	38	50	40	40	25	25	25	Year 1 (9 months)
		Actual	27	52	52	41	31	25	19	Year 1 & 2 Target = 50
		% of Target	**71%**	104%	130%	103%	124%	100%	**76%**	Year 3 & 4 Target = 40

[1] Tracking of 83 non-expansion cases began in Year 6. Results are not shown here.

Appendix L

Unmet Annual Performance Measurement Targets and Supplantation Programs Receiving MIDD Funding Prior to 2016

Of the 37 original MIDD strategies, 19 (51%) had annual performance measurement targets that were unmet at least one time between 2008 and 2015. Targets were considered unmet if less than 85 percent of the established goal was achieved after adjustment. Adjustments were typically made when fewer programs or staff positions were funded than planned, when start-up allowances were made, and when programs were unable to fill staff vacancies. The table below shows which strategies underperformed, when they fell short of expectations and by how much, most likely reasons for not meeting their goals, and the actions taken to correct identified issues.

Strategy		Year(s) and Target(s)	Reason(s)	Action(s) Taken
1a-2	Substance Use Disorder (SUD) Treatment	Years 1 to 6 (2008-2014), except Year 2 26,978 to 36,181 adult outpatient units each year 54% to 76% of 50,000 annual goal	Other fund sources were available to pay for these services	No corrective action was taken as individuals were able to access treatment through other sources and underspent funds were redirected to the MIDD fund balance, which was addressed in Year 7 (2014-2015)
1a-2	Substance Use Disorder (SUD) Treatment	Year 6 (2013-2014) 53,791 opiate treatment program units 77% of 70,000 goal	Treatment access through Medicaid expansion contributed to a 13% decline over the prior year in the total number of people served in Strategy 1a-2	Excess funds were redirected to other SUD treatment priorities such as copays, outreach, and urinalysis testing (2014)
1c	Emergency Room Intervention	Year 1 to 6 (2008-2014) 2,558 to 4,649 screens per year 65% to 79% of adjusted annual goals	1) Delivery of more intensive services (beyond initial screening) reduced time available for screening only 2) Referral to these services varied by hospital: targeted screening vs. universal 3) Individuals who are approached but decline screening do not count toward performance targets, but take provider time	1) Met with providers to set daily targets in order to meet annual goals, with caveat that clients at higher risk take more time to serve (2010) 2) Assuming 20 working days per month, a daily target was set for each funded staff to average 4 screens per day to meet the annual target (2011) 3) Discussed throughput vs. encounter quality with consensus to not sacrifice quality to meet screening goals (2012)
1d	Crisis Next Day Appointments	Year 4 (2011-2012) 231 clients with "enhanced services" 81% of 285 adjusted goal	Medical services are used as a proxy to count the number of clients who receive "enhanced services"; this may under-represent the number of enhanced services provided	Additional queries and data analyses were done to affirm the reported results; no corrective actions were taken (2013)
1f	Parent Partners Family Assistance	Year 6 (2013-2014) 137 individually-identified clients 69% of 200 adjusted goal	While the strategy served many clients in large group events, fewer than expected engaged in one-on-one services	The addition of a youth peer coordinator position will provide greater opportunities to engage clients individually (2015)
4c	School-Based Services	Year 6 (2013-2014) 1,213 youth 78% of 1,550 goal	Greater emphasis was placed on delivery of large group presentations and assemblies	While fewer individuals were tracked, the number of youth reached in larger groups doubled over prior years, so no action was taken (2014)
4d	Suicide Prevention Training	Years 2 to 4 (2009-2012) Year 6 (2013-2014)	1) Outreach needed (2010) 2) Under-reporting of trainings	1) Outreach ideas to engage more men in trainings (2010) 2) Contract monitor/provider

Appendix L

Strategy		Year(s) and Target(s)	Reason(s)	Action(s) Taken
		633 to 1,065 adults trained each year 42% to 71% of 1,500 annual goal	delivered (2011) 3) Provider management and staff turnover (2012) 4) Low adult attendance at contracted number of trainings delivered (2014)	collaboration to improve reporting accuracy (2011) 3) Corrective action plan with payment withholding contingency developed (2012) 4) Additional outreach brainstorming and reporting corrections (2014)
5a	Juvenile Justice Assessments	Years 2 to 3 (2009-2011) 32 psychological services 32% of 100 goal in Yr 2 98 psychological services 49% of 200 goal in Yr 3	Screening, triage, and consultation process (program efficiencies) reduced the need to complete full psychological evaluations	The psychological services definition was expanded to count all consultations with the team psychologist, not just psychological evaluations (2011)
6a	Wraparound	Year 2 (2009-2010) 282 youth 31% of 920 enrolled youth/siblings goal	Only enrolled youth could be counted utilizing existing reporting mechanisms	Annual targets were revised to count 450 enrolled youth only and not their siblings (2010)
8a	Family Treatment Court	Year 1 (2008-2009) 27 children 79% of 34 children over 9 months goal	Start-up of expanded capacity	Enrollment was slightly lower than expected in the first year; no corrective action was needed as the program soon reached capacity (2009)
9a	Juvenile Drug Court	Year 3 (2010-2011) 26 new youth 72% of 36 goal	Declining referrals in 2011, when only new opt-in cases counted toward the goal	Reorganized structure to offer "engagement" phase where new pre opt-in cases counted toward meeting goal (2011)
10a	Crisis Intervention Team Training	Year 3 (2010-2011) 275 40-hour trainees 626 one-day trainees 63% to 73% of unamended goals	In the first year of operation, initial targets were set too high	Amended targets (2011)
10b	Adult Crisis Diversion	Year 4 and 5 (2011-2013) 359 to 2,353 clients 72% to 78% of adjusted goals	In the first two years of operation, referrals were lower than expected	The MIDD Crisis Diversion Program Manager was hired and began substantial outreach efforts to educate all referral sources about the new Crisis Solutions Center (2011)
11a	Increase Jail Liaison Capacity	Year 1 (2008-2009) Year 5 and 6 (2012-2014) 13 to 116 clients 26% to 69% of adjusted goals	1) In the first year of operation, initial target was set too high 2) Unable to fill staff vacancies and obtain clearance to secure facility	1) Amended target (2010) 2) After the position was filled following a long vacancy, jail clearance issues had to be resolved (2013) 3) King County Work Education Release was downsized from 160 to 79 beds so targets must be amended (2014)
11b	Mental Health Courts (MHC)	Year 2 to 4 (2009-2012) 22 to 31 opt-in clients to the Regional MHC 54% to 59% of adjusted goals	Expansion to include cases referred to the court by area municipalities ramped-up slowly over time	Targets were amended and the strategy was revised to realign funding with current court needs (2012-2014)
12a-1	Jail Re-Entry & Education Classes	Year 1 & Year 5 to 6 (2008-2009, 2012-2014) 213 to 297 re-entry clients 62% to 71% of goals	1) In the first year of operation, initial target was set too high 2) Provider staffing and reporting issues contributed to lower numbers served and/or counted	1) Amended target (2009) 2) Contract monitor/provider collaboration to improve reporting accuracy (2012) 3) Continuous quality improvement feedback given to provider (2013) 4) Communications with provider regarding

Appendix L

Strategy		Year(s) and Target(s)	Reason(s)	Action(s) Taken
				performance target expectations (2014)
12a-2	Jail Re-Entry & Education Classes	Year 1 and 2 (2008-2010) 114 to 449 education clients 12% to 75% of goals	Class capacity limited the number of clients who could be served initially	Additional classes were added and filled to new capacity slowly over time (2009-2011)
12d	Behavior Modification Classes	Year 2 (2009-2010) 79 clients 79% of 100 goal	In the first two years of operation, referrals were lower than expected	Program referrals increased without intervention (2010)
13a	Domestic Violence Services	Year 1 and 2 (2008-2010) 197 to 489 clients 70 to 82% of adjusted goals	Funding cuts due to the recession made it difficult for the providers to serve the projected number of clients	1) Targets were aligned with actual funding (2010) 2) Evaluation/provider collaboration to improve outcomes reporting for clients served (2010) 3) Continuous quality improvement feedback given to providers (2010)
14a	Sexual Assault Services	Year 1 (2008-2009) 179 clients 69% of adjusted goal	Funding cuts due to the recession made it difficult for the providers to serve the projected number of clients	1) Outreach ideas to increase referrals at one agency (2009) 2) Clarification of reporting requirements (2010) 3) Continuous quality improvement feedback given to providers (2010)
16a	New Housing & Rental Subsidies	Year 1 (2008-2009) 27 rental subsidies 71% of 38 goal	Time was needed for this program to reach its full capacity	Rental subsidy distribution increased without intervention (2009)

Appendix M

Strategy Revisions

Strategy		Date of Revision	Revision
1a1	Mental Health Treatment	07/01/2010	Clubhouse Services added.[1]
1a2	Substance Use Disorder (SUD) Treatment	01/01/2009	Buprenorphine[2] at Detoxification program added.
1a2	Substance Use Disorder (SUD) Treatment	01/01/2010 - Youth Transportation 07/01/2014 - Outreach	Treatment support activities added: • Youth Transportation • Outreach.
1a2	Substance Use Disorder (SUD) Treatment	10/01/2014	Detoxification beds added.
1a2	Substance Use Disorder (SUD) Treatment	01/01/2011	1811 Case Management added.
1a2	Substance Use Disorder (SUD) Treatment	5/01/2015	Peer services added.
1a2	Substance Use Disorder (SUD) Treatment	10/01/2013	Sobering services added.
1b	Outreach & Engagement	03/01/2009	At the time the MIDD plan was initially adopted, a final service design was not proposed for this strategy because other initiatives related to people experiencing homelessness were in the process of being implemented. In winter 2008-09, two assessments occurred to help inform the programming of these funds: Health Care for the Homeless conducted a needs assessment. Public Health conducted an analysis of the numbers and characteristics of homeless people seen in the King County Jail. The revised design included: (1) Increase homeless program-based mental health/chemical dependency outreach and engagement services at selected homeless program sites in East King County, South King County, and Seattle. Services will be prioritized for those sites with the highest

[1] 1. A Clubhouse is a community intentionally organized to support individuals living with the effects of mental illness and certified by the International Center for Clubhouse Development (ICCD). Through participation in a Clubhouse, members are given opportunities to rejoin the worlds of friendships, family, important work, employment, education, and to access the services and supports they may individually need. A Clubhouse is a restorative environment for people who have had their lives drastically disrupted, and need the support of others who believe that recovery from mental illness is possible for all.

[2] Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates. http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

Strategy		Date of Revision	Revision
			numbers of people with histories of jail and/or hospital involvement. (2) Increase chemical dependency outreach and engagement for homeless Native Americans
1c	Emergency Room Intervention	09/15/2011	Four new FTE Chemical Dependency Professionals (CDP) in south King County were planned. Three FTEs were filled in 2011. One FTE resigned in 2011 and was not refilled. Two new FTEs were maintained.
1d	Crisis Next Day Appointments	11/1/2008	The original plan did not identify specific additional treatment and stabilization services. A stakeholder process was planned to develop the specific components. Enhanced stabilization services added to plan: Additional brief, intensive, short-term treatment to resolve the crisis, benefits counseling and psychiatric medication access.
1e	Chemical Dependency Trainings	03/01/2009	Reimbursement was expanded beyond books and tuition to include the costs of testing to become a CDP and annual recertification. A Science to Service/Workforce Development Coordinator was hired. This position was responsible for providing technical assistance/training to the provider community about the selection and implementation of evidence-based treatment activities and assured that the selected programs were implemented and delivered with fidelity to the model. The position also monitored the utilization of the tuition reimbursement program.
1e	Chemical Dependency Trainings	09/23/2010	BHRD had a pilot project with the University of Washington (UW), School of Social Work, to develop a program within the School of Social Work to allow MSW students to jointly receive their CDP certificate.
1f	Parent Partners Family Assistance	11/01/2012	Originally Strategy 1f's design involved funding parent and youth partners throughout the behavioral health system to support families seeking assistance. After some consideration it

Strategy		Date of Revision	Revision
			was decided that a different plan was needed to fulfill the goals. Family, youth and system partner roundtables were held to gather information regarding the opportunities and challenges to the successful support of families. Input from the meetings and best practices research was used in the redesign. It was determined that a Family Support Organization (FSO)[3] could most effectively meet community and family needs and the implementation plan was revised to fund a FSO. Start-up activities began in mid-October 2011. Contracting with Guided Pathways – Support for Youth and Families (GPS) started on 11/01/2012.
1g	Older Adults Prevention	01/01/2010	Decreased FTEs and funding.
1g	Older Adults Prevention	01/01/2011	Decreased FTEs.
2b	Employment Services	01/01/2009	Added incentive payments for job retention outcomes. Added the SUD population in a modified employment services in 2015/2016 pilot.
4c	School-Based Services	07/01/2010	At the time of the MIDD Implementation Plan adoption, MIDD Strategy 4c was still under development and beginning the stakeholder planning phase. Originally, the strategy was written as if every school district in the county would receive funding. The allocation amount did not allow for adequate distribution to every school district, so it was changed to be open and available to every school district. The process was designed to ensure the four geographical regions of the county had equal distribution of funding if there were applications received and awards available to those areas. The services included prevention, early intervention, brief treatment and referral to treatment.
4c	School-Based Services	10/23/2014	The MIDD 4c strategy was awarded by a competitive request for proposals (RFP) in 2010. The RFP was for five

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

Strategy		Date of Revision	Revision
			years (expiring in June 2015). The County originally notified its 13 projects (with 10 providers) that the contracts were ending due to the RFP timeline ending. The County decided, due to the MIDD expiring January 1, 2017, that the projects were to be extended to the end of MIDD I.
8a	Family Treatment Court (FTC)	10/01/2010	FTC was funded with a blend of funding sources from the Veterans and Human Services Levy, MIDD funding, and general fund support that became unavailable. There were extra costs not budgeted in 2010 assigned to the Veterans and Human Services Levy. The 2011 Adopted Budget, Ordinance 16984, Section 69, Proviso 1 directed the King County Department of Community and Human Services (DCHS) Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), now BHRD, to develop a report regarding the FTC. A workgroup developed the FTC report. The resulting strategy revision was a cap of no more than 60 children at any given time and no more than 90 children per calendar year for the performance target retroactive to 10/01/2010.
8a	Family Treatment Court (FTC)	10/01/2014	This strategy was revised to expand the number of target children served from 90 to 120. Due to the Department of Public Defense work coming within King County and cases moving to an FTE model for FTC, the target for the number of children to be served could be increased.
9a	Juvenile Drug Court	07/01/2012	Co-occurring (mental health and chemical dependency) track added. Expanded participants to include youth receiving engagement service prior to opting in.
10a	Crisis Intervention Team Training	04/01/2010	Contracted with Washington State Criminal Justice Training Commission (WSCJTC) to implement the Crisis Intervention Team Training (CIT) program.
10b	Adult Crisis Diversion	4/01/2010	1.0 FTE BHRD Program Manager was added to coordinate the Crisis Diversion Services (CDS) strategy, staff the MIDD OC CDS strategy sub-

Strategy		Date of Revision	Revision
			committee and provide general support to the implementation of the MIDD plan.
10b	Adult Crisis Diversion	08/12/2012	The original plan included interim "respite" housing for homeless individuals ready to leave the Crisis Diversion Facility (CDF) in need of temporary housing while permanent supported housing was being arranged. This was revised to include people that were not homeless but in need of stabilization beyond the CDF three day limit.
11a	Increase Jail Liaison Capacity	11/01/2015	The location of services was revised from the King County Work and Education Release (WER) site to serve the population in a community-based setting.
11b	Mental Health Courts (MHC)	2/19/2009	At the time of the MIDD Implementation Plan adoption, MIDD Strategy 11b was still under development. This strategy enhanced services and capacities at existing mental health courts to increase access to programs for eligible adult misdemeanants throughout King County. Service enhancements were to include expanded mental health court treatment services programming within the City of Seattle Municipal Mental Health Court and the City of Auburn Municipal Mental Health Court. King County Regional Mental Health Court was made available to any misdemeanor offender in King County who was mentally ill, regardless of where the offense was committed.
11b	Mental Health Courts (MHC)	08/08/2011	Removed City of Auburn Mental Health Court, added Veteran's Court pilot.
11b	Mental Health Courts (MHC)	06/05/2014	Strategy funds were used to expand residential treatment beds and housing units for therapeutic court participants.
12c	Psychiatric Emergency Services Linkage	11/1/2008	At the time of the MIDD Implementation Plan adoption, MIDD Strategy 12c was still under development. Two case managers were added to Psychiatric Emergency Services.
12d	Behavior Modification Classes	03/20/2009	The original goal of this strategy was to increase efficiency in the treatment and programming operations at

Appendix M

Strategy		Date of Revision	Revision
			Community Center for Alternative Programs (CCAP). As originally constructed this would be done through freeing up CCAP staff to do more programming by contracting out urinalysis (UA) supervision, by the Community Corrections Division (CCD) case workers. Due to several administrative barriers, it was determined that the best way to accomplish greater efficiency was to offer behavior modification programming instead. The revised strategy increased the scope and effectiveness of the services offered at CCAP and appropriately addressed the changing service needs of court-ordered participants. Moral Reconation Therapy (MRT), an evidence-based practice, was implemented at CCAP in April 2009.
15a	Adult Drug Court	01/01/2010	Services for women with co-occurring disorders ended due to declining MIDD revenue.
15a	Adult Drug Court	06/01/2012	Changed the 1.0 FTE subcontracted Wraparound position targeted to young adults, to transitional housing for young adults.
16a	New Housing & Rental Subsidies	11/01/2012	Facility closed. Funds transferred to remaining program to extend duration of subsidies.