2008-0490

ATTACHMENT A.

16262

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

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.

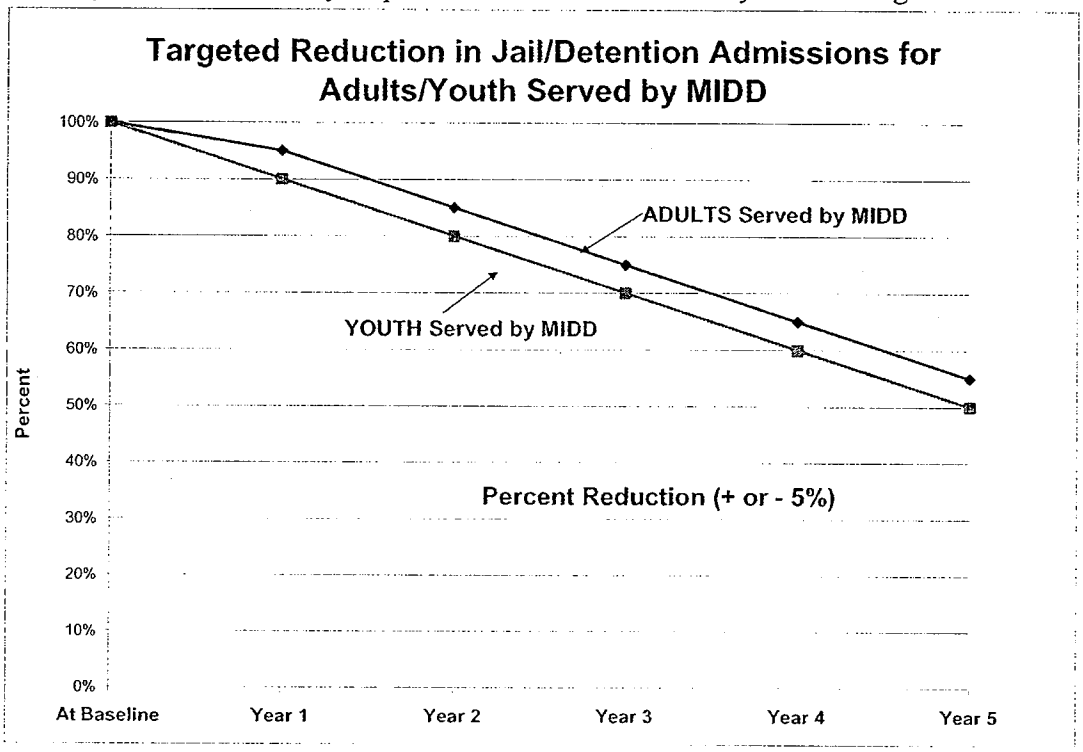
As programs in the MIDD Implementation Plan are implemented and evolve over time, the Evaluation Plan will be updated accordingly to accurately measure the effectiveness and impact of each individual strategy.

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.

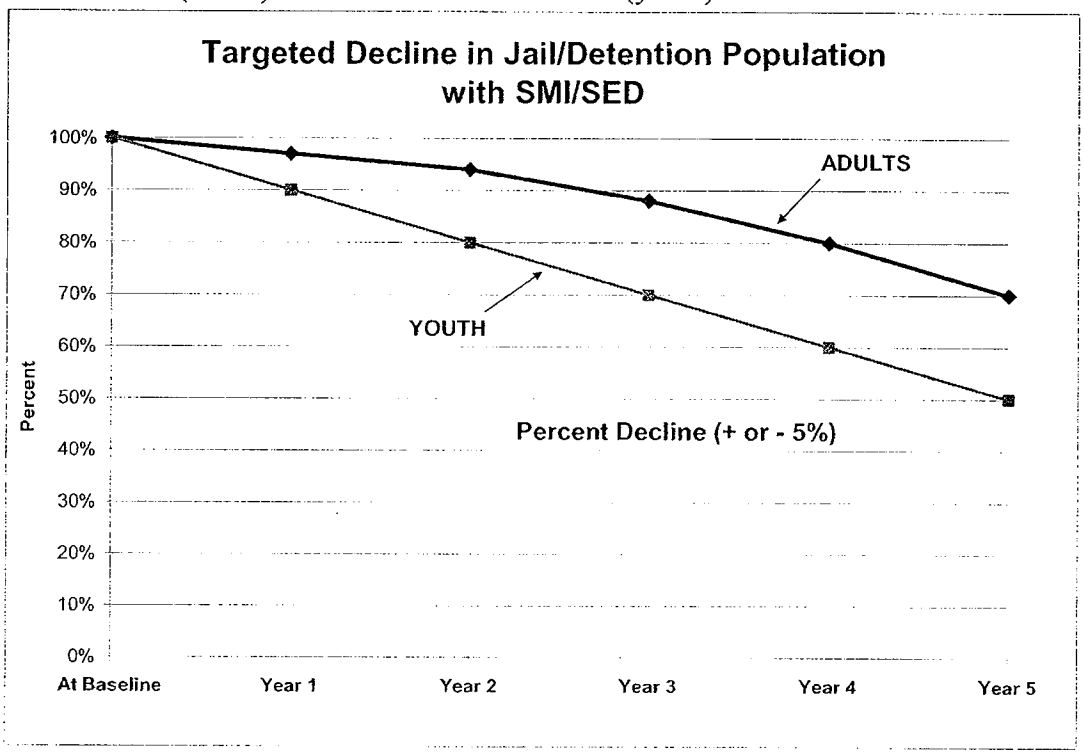
Figure 1: Targeted Reduction in the Number of Jail/Detention Admissions Among Mentally Ill and Chemically Dependent Individuals Served by MIDD Programs



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).

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

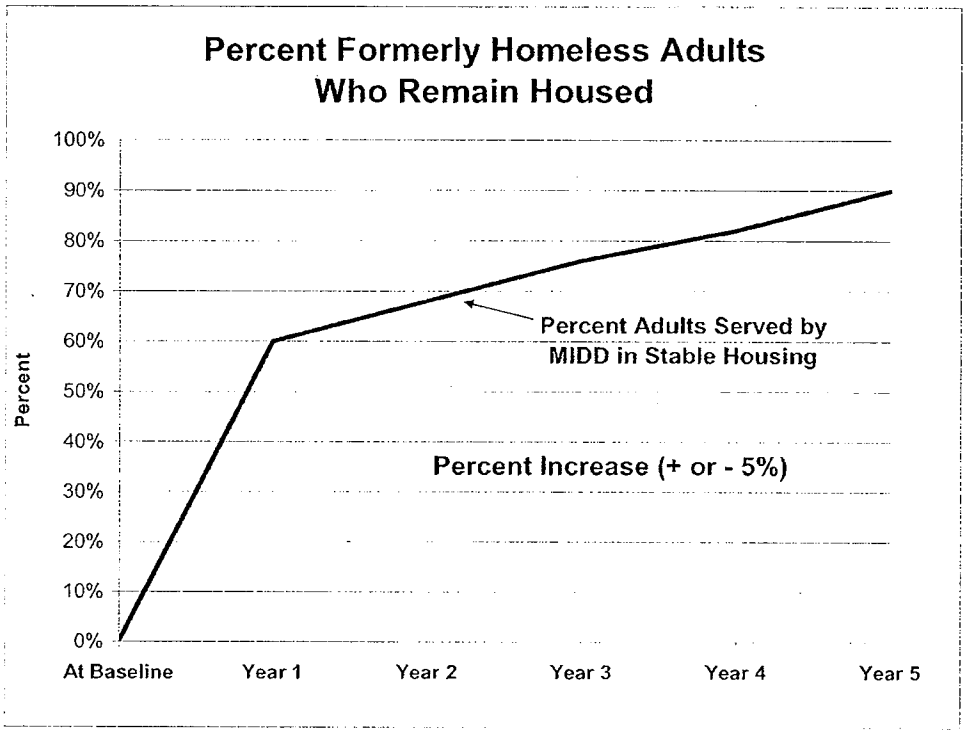


In 2007, there were approximately 17.5 Individuals with SMI per thousand in the adult detention population.

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



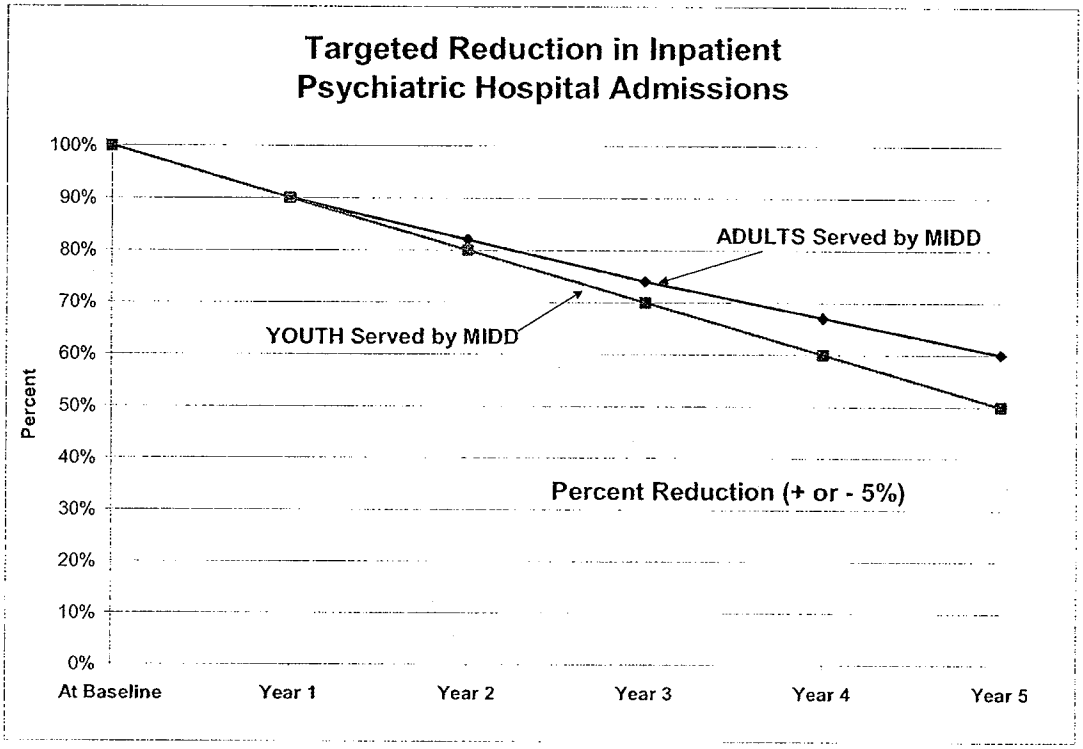
The 2006 One Night Homelessness Count in King County indicated that almost half of the 5,963 homeless individuals counted in shelters or transitional housing had problems with mental illness or substance abuse.

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.

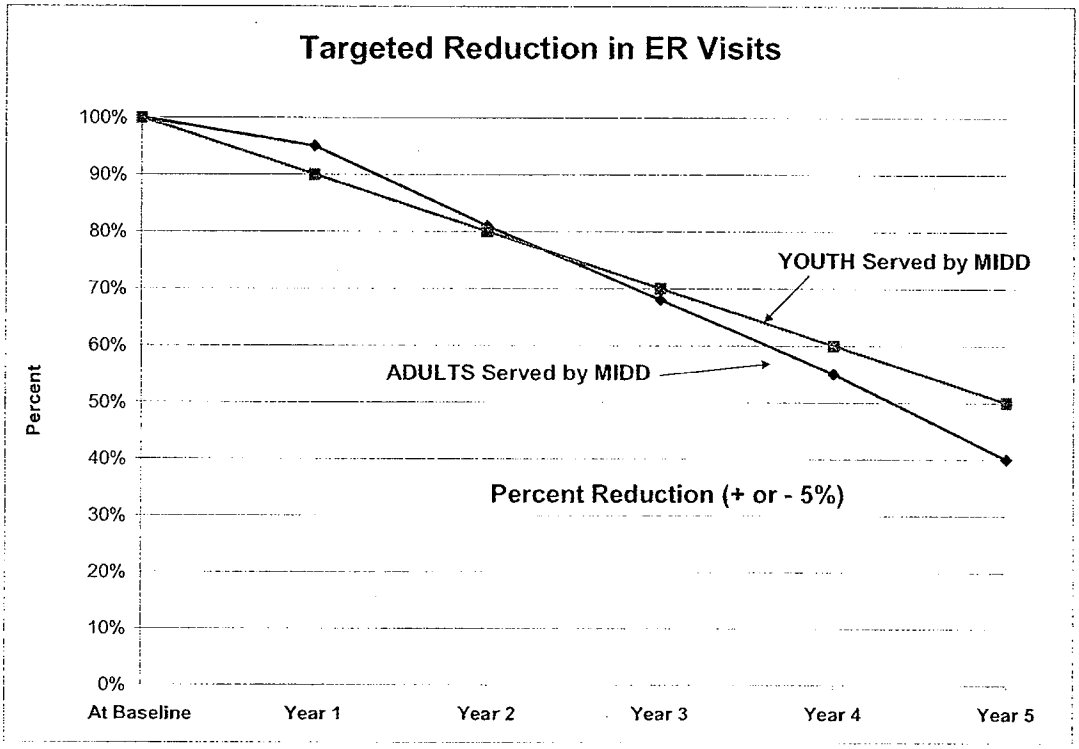
Figure 4: Targeted Reduction in Inpatient Psychiatric Hospital Admissions Among Mentally Ill and Chemically Dependent Youth and Adults served by MIDD Programs



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%.

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]

References

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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.

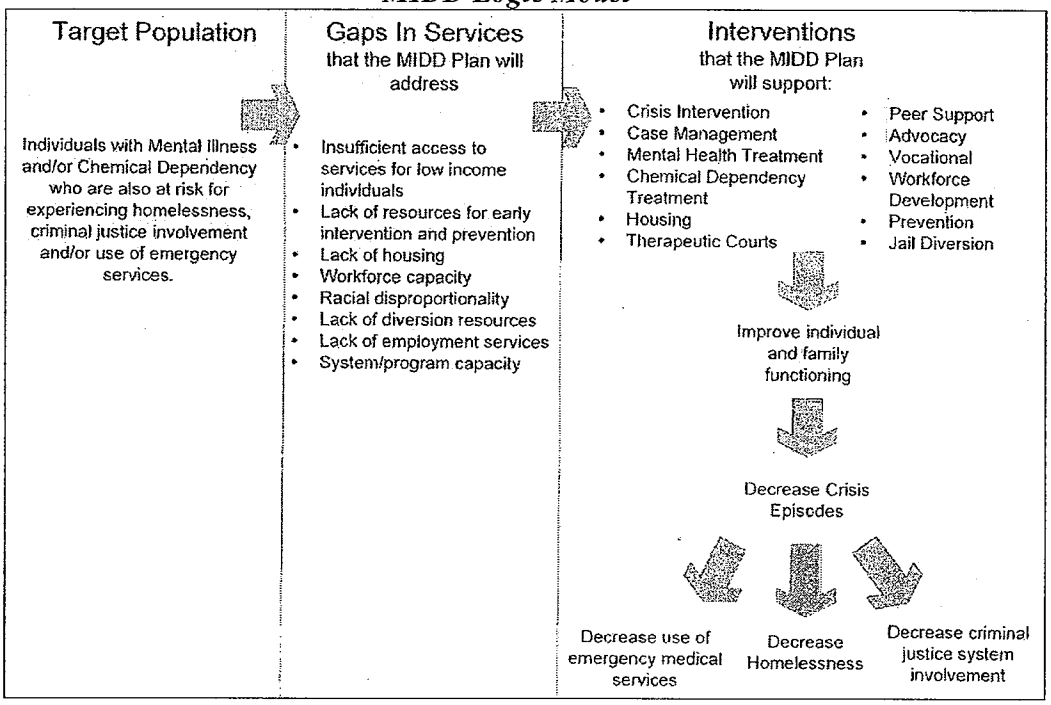
OVERVIEW OF THE EVALUATION PLAN

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

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.

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.

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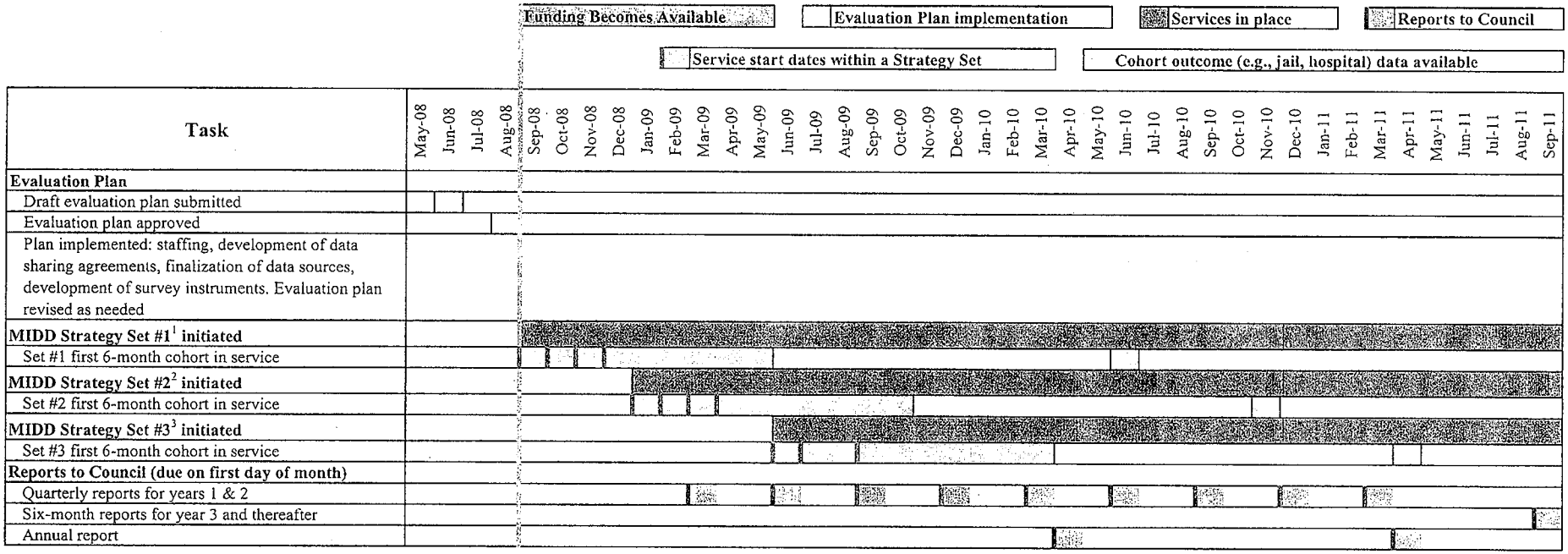
[i] Harder and Company, February 2004, pp.6-9

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



[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

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

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

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)

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 geriatric CD 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:		

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

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

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

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	8. Outcome	JJ data
		9. Reduction in substance abuse of children served	9. Outcome	TBD
		10. Reduction of risk factors for substance abuse and other problem behaviors of children served	10. Outcome	TBD
		11. Increased protective factors for prosocial behavior of children served	11. Outcome	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	1. Output	MHCADSD
		2. Increase # of youth receiving MH and/or CD services through school-based programs	2. Outcome	Agency/School data
		3. Improved school performance for youth served	3. Outcome	School data
		4. Improved school attendance for youth served	4. Outcome	School data
		5. Decrease in truancy petitions filed for youth served	5. Outcome	School/JJ data
		Long-term measures: 6. Decrease in JJ involvement for youth served	6. Outcome	JJ data
		7. Decrease use of emergency medical system for youth served	7. Outcome	ER data
		8. Decrease use of psychiatric hospitalization for youth served	8. Outcome	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	1. Output	Agency data
		2. Increase # of suicide awareness trainings for students	2. Output	Agency data
		3. Increase # of teacher trainings	3. Output	Agency data
		4. Increase # of parent education trainings	4. Output	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

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

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

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

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

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

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

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. 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

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

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

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)

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)

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)

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.

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