Appendix A

MENTAL ILLNESS AND DRUG DEPENDENCY EVALUATION ASSESSMENT

Final Report

April 2016

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

Completed for:
King County Department of Community and Human Services

MIDD Evaluation Assessment
Final Report

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EXECUTIVE SUMMARY

Purpose and Approach

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

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

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

Overview

MIDD adoption and implementation

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

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

What is evaluation?

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

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

How MIDD works today

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

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

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

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

MIDD Evaluation Assessment Findings and Recommendations

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

Note: Key evaluation terms in the summary table below are defined in the glossary on page 9.

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

EVALUATION PLAN AND FRAMEWORK

Strengths

- The Plan provides flexibility to adjust measures as learning takes place over time, especially with respect to output measures and their targets.
- The Plan accommodates the diversity of strategies supported by MIDD funding.

Challenges

- The framework lacks detail and intermediate linkages that describe how MIDD strategies and programs bring about changes to reach MIDD policy goals.
- Interviewees have different expectations for the MIDD evaluation than what the MIDD Evaluation Plan articulates.
- Interviewees do not agree on the outputs and outcomes they would like to see included in MIDD evaluations.
- Interviewees expressed interest in understanding the level of community need that each MIDD strategy would meet.

Recommendations

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

- Create and include a defined and stated purpose and identify limitations on conclusions that can be drawn from the evaluation.
- Include a logic model that identifies proximal outcomes for each program or strategy and describes how impacting these outcomes affect distal outcomes.

R2. Involve stakeholders in developing the evaluation framework.

OUTPUT AND OUTCOME MEASURES

Strengths

- The MIDD evaluation plan includes an evaluation matrix that lists, for each MIDD strategy, output and outcome measures.

Challenges

- No or too few proximal outcomes are measured for many MIDD strategies; evaluation best practice notes that both distal and proximal outcomes are important to understanding the impact of each MIDD strategy.
- Interviewees stated that measures should be clinically relevant, including behavioral health symptoms, daily function, and quality of life.
- The detail and specificity of output measures in the

Recommendations

R3. Establish relevant output and outcome measures.

- Establish output and outcome measures across the entire logic chain – from services provided to goals. Measures should be relevant to participants and providers and be useful to monitor implementation and improvements.

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

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

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

EVALUATION REPORTING

Strengths

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

Challenges

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

Recommendations

R8. Increase frequency of performance evaluation availability.

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

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

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

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

INTRODUCTION

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

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

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

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

Purpose of this MIDD Evaluation Assessment

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

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

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

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

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

MIDD Evaluation Assessment Methodology

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

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

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

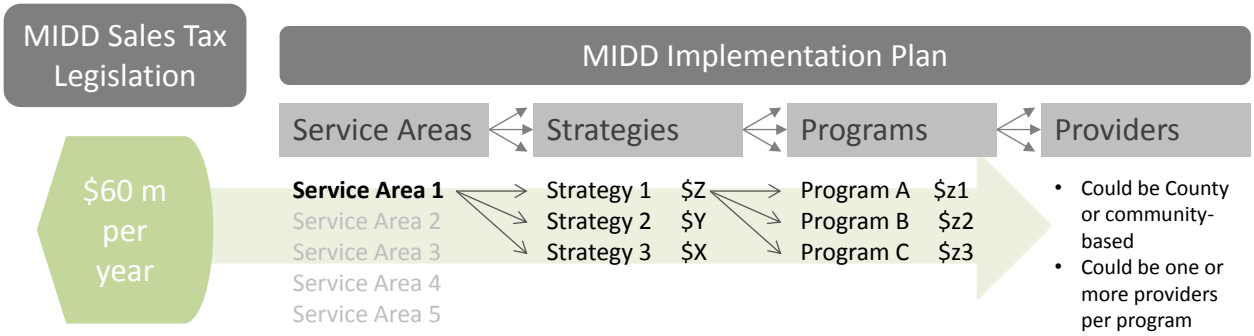
BACKGROUND FOR MIDD EVALUATION ASSESSMENT

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

MIDD Implementation Structure

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

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



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

Purpose of Evaluations

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

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

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

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

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

Key Program Evaluation Concepts

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

Evaluation Term Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Practice Review of Behavioral Health Care Evaluations

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

Behavioral health care quality measurement is an evolving practice

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

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

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

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

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

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

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

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

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

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

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

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

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

Evaluation practices used by other counties focus on output measures

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

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

Figure 1: Jurisdictions included in comparative analysis

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

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

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

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

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

MIDD EVALUATION ASSESSMENT FINDINGS AND RECOMMENDATIONS

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

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

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

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

MIDD Evaluation Plan and Evaluation Framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

R2. Involve stakeholders in developing the evaluation framework.

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

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

MIDD Evaluation Output and Outcome Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

R3. Establish relevant output and outcome measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MIDD Evaluation Process

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

Strengths of the current evaluation process include:

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

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

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

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

Recommendation

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

R6. Invest in data collection infrastructure.

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

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

MIDD Outcome Evaluation

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

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

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

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

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

Additional observations about the outcome evaluation include:

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

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

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

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

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

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

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

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

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

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

Recommendation

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

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

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

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

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

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

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

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

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

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

MIDD Evaluation Reporting

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

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

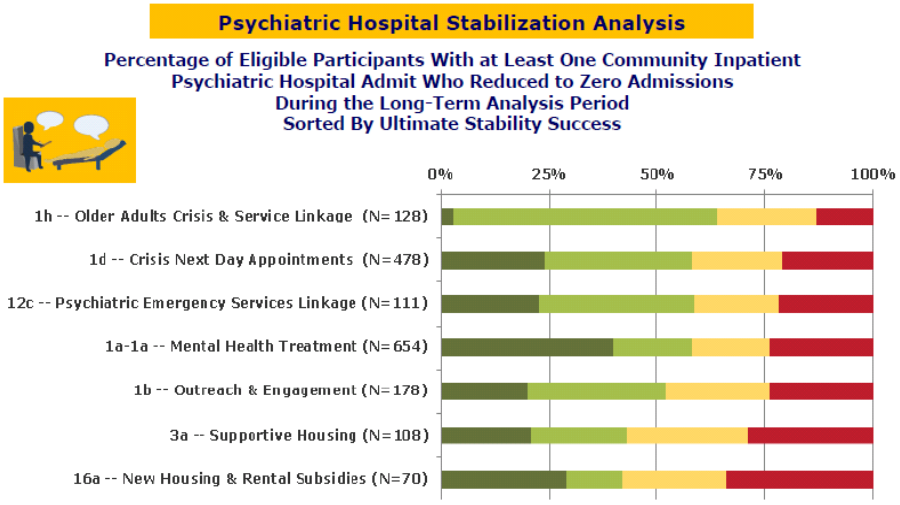
In addition, the assessment team identified challenges related to the evaluation reports, including:

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

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

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

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



Recommendations

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

R8. Increase frequency of performance evaluation availability.

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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

APPENDICES

Appendix A: List of Interviewees

King County Department of Community and Human Services Staff

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

King County Information Technology Staff

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

MIDD Oversight Committee Members and/or Designees

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

MIDD Service Providers

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

Other Stakeholders and Subject Matter Experts

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

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

Appendix B: Interview Protocols

Interview Protocol for King County Staff

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

Interview Protocol for Service Providers

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

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

Interview Protocol for Other Stakeholders

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

Appendix C: Additional Information on MIDD and its Evaluation Plan

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

Adopted MIDD Policy Goals
Ordinance 15949

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

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

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

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

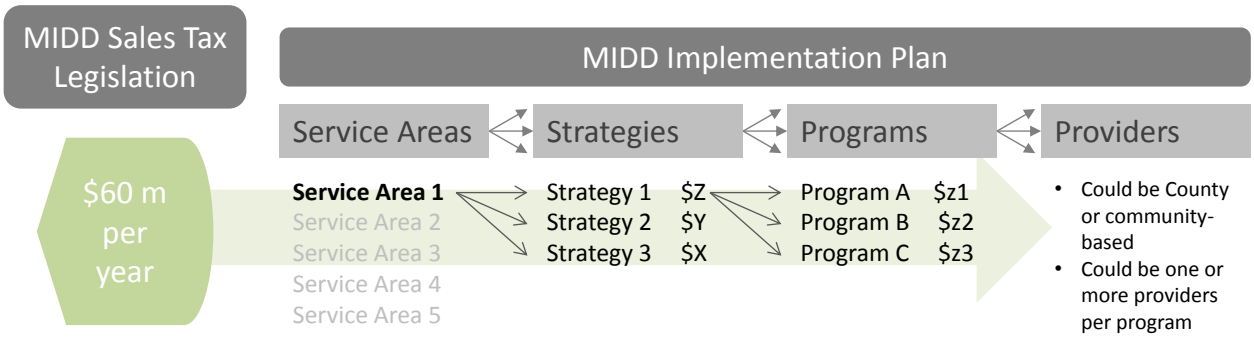
The first plan to be adopted was the **Oversight Plan**, via Ordinance 16077, in April 2008. This plan established the MIDD Oversight Committee as an advisory body to the King County Executive and the Council. Its purpose is to ensure that the implementation and evaluation of the strategies and programs

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

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

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

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



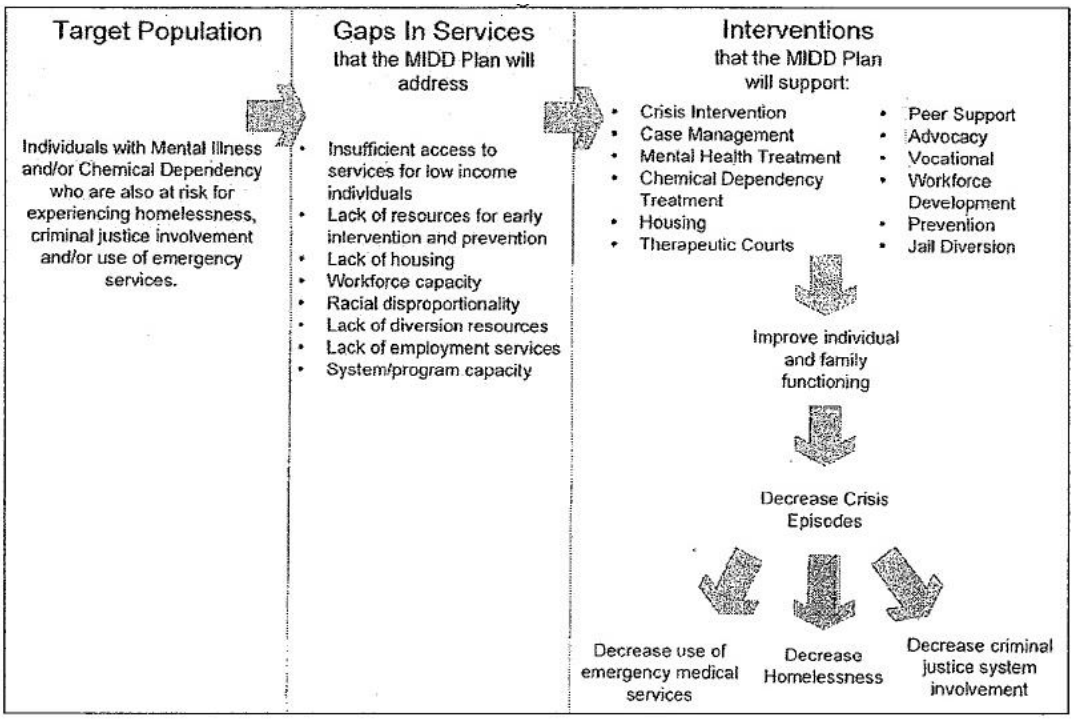
The **Evaluation Plan** was also adopted by Council via Ordinance 16262 in October 2008. The next section describes the main components of this plan.

Components of MIDD Evaluation Plan

Ordinance 15949 specified that the evaluation plan was to *"… describe an evaluation and reporting plan for the programs funded with the sales tax revenue* (and) *specify: process and outcome evaluation components; a proposed schedule for evaluations; performance measurements and performance measurement targets; and data elements that will be used for reporting and evaluations. Performance measures shall include, but not be limited to: the amount of funding contracted to date, the number and status of request for proposals to date, individual program status and statistics such as individuals served, data on utilization of the justice and emergency medical systems and resources needed to support the evaluation requirements identified in this subsection C.3. Part three shall be developed in collaboration with the oversight group."* (pp. 7-8)

The MIDD Evaluation Plan outlines the rationale and intent to monitor and evaluate the strategies funded by MIDD. It includes an evaluation framework that is guided by a high-level logic model (**Error! eference source not found.**) and shows how MIDD strategies are expected to further the MIDD policy goals.

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



The MIDD Evaluation Plan has three main components:

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

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

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

1. System Process Evaluation

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

- Initial MIDD start-up activities
- Development and management of requests for proposal and service contracts
- Strategies to leverage and blend funding streams

- Efforts to coordinate the work of partners, stakeholders, and providers
- Implementation of working agreements and Memoranda of Understanding
- Service-level changes resulting from efforts to promote integration of housing, treatment, and supportive services
- System-level changes resulting from MIDD funds or the management of MIDD-related resources
- An evaluation the MIDD Action Plan's integration with and support of system level goals and objectives as articulated in the Adult and Juvenile Justice Operational Master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan, and the King County Mental Health Recovery Plan

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

2. Strategy Process Evaluation

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

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

3. Outcome Evaluation

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

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

MIDD Evaluation Reporting

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

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

programs supported with the sales tax revenue to the council. The quarterly reports shall include at a minimum:

a. performance measurement statistics;

b. program utilization statistics;

c. request for proposal and expenditure status updates; and

d. progress reports on evaluation implementation.

2.a. The quarterly reports to the council are due to the council March 1, June 1, September 1 and December 1 for council review for years one and two and thereafter, every six months.

b.(1) The annual report to the council shall be submitted to the council by April 1, for council review. The annual report shall also include:

(a) a summary of quarterly report data;

(b) updated performance measure targets for the following year of the programs; and

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

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

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

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

Appendix D: Evaluation Matrices

Strategy 1

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

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

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

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

Strategy 2

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

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

Strategy 3

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

Strategy 4

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

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

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

Strategy 5

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

Strategy 6

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

Strategy 7

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

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

Strategy 8

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

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

Strategy 9

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

Strategy 10

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

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

Strategy 11

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

Strategy 12

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

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

Strategy 13

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

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

Strategy 14

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

Strategy 15

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

Strategy 16

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

Appendix E: Additional Information on Logic Models

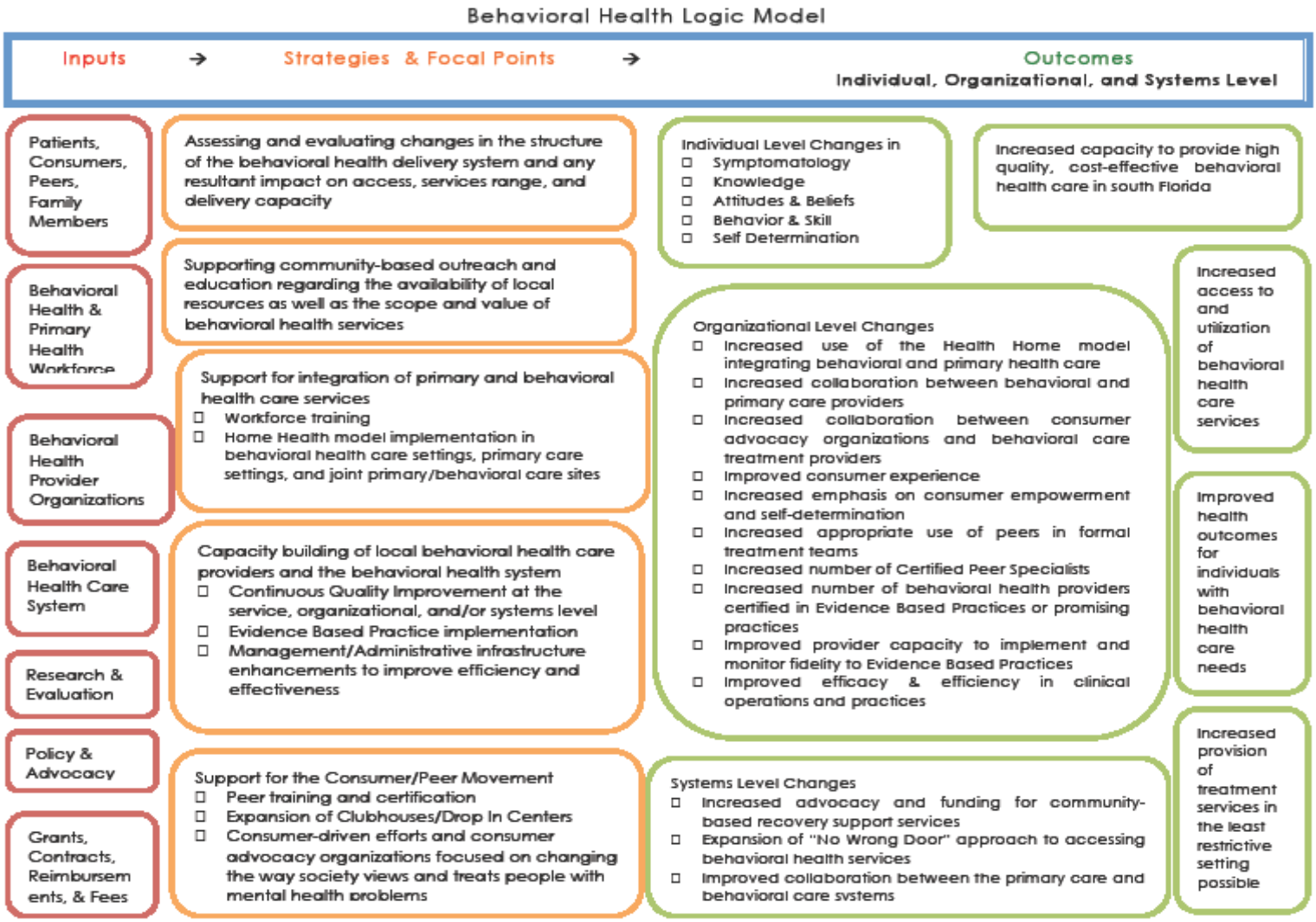
A logic model, which is commonly used as an evaluation framework, shows inputs (resources needed and people involved), program activities, outputs (how much of an activity was delivered) and outcomes (what changed). While many good logic models exist that show a flow from inputs to outcomes (see Figure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

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

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

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

Figure 4: Centers for Disease Control Behavioral Health Logic Model



Appendix F: Social Service Projects with Random Assignment Evaluations

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

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

- Connecticut Family Stability Pay for Success Project

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

- South Carolina Nurse-Family Partnership Pay for Success Project

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

- New York State Recidivism and Workforce Development Project

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

- The Denver Social Impact Bond Program

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

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

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

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

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

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

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

Appendix B

DRAFT MIDD II FRAMEWORK Revised *4.7.16* DRAFT		
MIDD RESULT People living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid criminal justice involvement.		
MIDD THEORY OF CHANGE When people who are living with or who are at risk of behavioral health disorders utilize culturally relevant prevention and early intervention, crisis diversion, community reentry, treatment, and recovery services, and have stable housing and income, they will experience wellness and recovery, improve their quality of life, and reduce involvement with crisis, criminal justice and hospital systems.		
OUTCOMES		
Population Indicators	**MIDD and other King County and community initiatives contribute to the overall health and well-being of King County residents that is demonstrated by positive changes in population**	• Emotional health – rated by level of mental distress • Daily functioning - rated by limitations to due to physical, mental or emotional problems • Reduced or eliminated alcohol and substance use • Health rated as 'very good' or 'excellent' • Housing stability • Representation of people with behavioral health conditions within jail, hospitals and emergency departments
MIDD II Strategy Areas	**SAMPLE[i] MIDD II Performance Measures (to be refined after specific programs/services are selected)**	
Prevention and Early Intervention *People get the help they need to stay healthy and keep problems from escalating*	**How much? Service capacity measures** • Increased number of people receiving substance abuse and suicide prevention services • Increased number of people receiving screening for health and behavioral health conditions within behavioral health and primary care settings **How well? Service quality measures** • Increased treatment and trainings in non-traditional settings (day cares, schools, primary care) • Increased primary care providers serving individuals enrolled in Medicaid **Is anyone better off? Individual outcome measures** • Increased use of preventive (outpatient) services • Reduced use of drugs and alcohol in youth & adults • Increased employment and/or attainment of high school diploma and post-secondary credential • Reduced risk factors for behavioral health problems (e.g., social isolation, stress, etc.)	
Crisis Diversion *People who are in crisis get the help they need to avoid unnecessary hospitalization OR incarceration*	**How much? Service capacity measures** • Increased capacity of community alternatives to hospitalization and incarceration (e.g., crisis triage, respite, LEAD, therapeutic courts, etc.) **How well? Service quality measures** • Increased use of community alternatives to hospitalization and incarceration by first responders **Is anyone better off? Individual outcome measures** • Reduced unnecessary hospitalization, emergency department use and incarceration • Decreased length and frequency of crisis events	
Recovery and Reentry *People become healthy and safely reintegrate to community after crisis*	**How much? Service capacity measures** • Increased in affordable, supported, and safe housing • Increased availability of community reentry services from jail and hospitals • Increased capacity of peer supports **How well? Service quality measures** • Increased linkage to employment, vocational, and educational services • Increased linkage of individuals to community reentry services from jail or hospital • Increased housing stability **Is anyone better off? Individual outcome measures** • Increased employment and attainment of high school diploma and post-secondary credential • Improved wellness self-management • Improved social relationships • Improved perception of health and behavioral health issues and disorders • Decreased use of hospitals and jails	
System Improvements *Strengthen the*	**How much? Service capacity measures** • Expanded workforce including increased provider retention • Decreased provider caseloads • Increased culturally diverse workforce • Increased capacity for outreach and engagement	

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

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

Adopted MIDD I Policy Goals:

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

Adult Jail Diversion Sequential Intercept Model

Current Interventions

Intercept 1
1. Jail high utilizer program

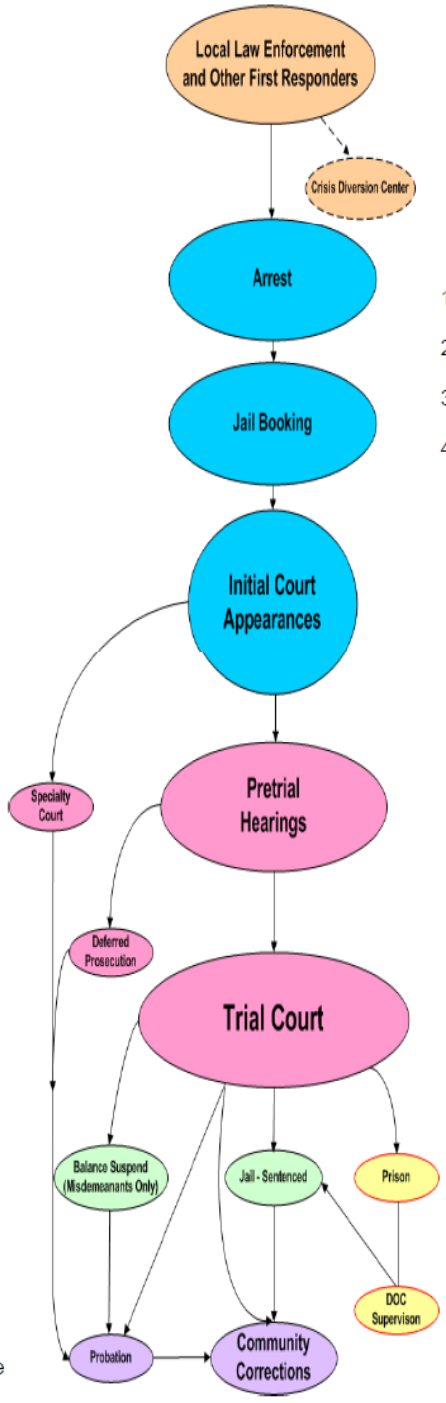
Intercept 2
1. Incoming Referrals to CJ Liaisons from:
   - ✓ Family members
   - ✓ DOC community corrections officers
   - ✓ Jail Health psychiatric evaluation specialists
   - ✓ Inmate requests
   - ✓ Public defenders and public defense social workers
   - ✓ Probation officers
2. Assessments requested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

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

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

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

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



New/Enhanced Interventions

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

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

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

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

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

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

Prepared by King County Department of Community and Human Services

Youth Detention Diversion Model

Ultimate Intercept

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

Current Interventions

Prevention/Early Intervention

1. SA prevention programs
2. Skill building for children, youth & families

EBP MH/SA Treatment

1. Limited wraparound for seriously emotionally disturbed youth
2. Parent networks

BECCA

1. Project TEAM
2. Functional Family Therapy

Initial Contact

1. CCORS

Processing

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

Probation

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

New/Enhanced Interventions

Prevention/Early Intervention

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

EBP MH/SA Treatment

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

BECCA

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

Initial Contact

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

Processing

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

Probation

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

Acronyms

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

Prepared by King County Department of Community and Human Services

Oversight Committee Membership

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

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

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

Rhonda Berry, Chief of Operations
Representing: King County Executive

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Representing: King County DCHS

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

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

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

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

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

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

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

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Kelli Carroll, Strategic Advisor, MHCADSD
Andrea LaFazia-Geraghty, MHCADSD

As of 9/30/2015

Mental Health, Chemical Abuse and Dependency Services

Mental Illness and Drug Dependency Action Plan

Part 3: Evaluation Plan

King County

Mental Illness and Drug Dependency Action Plan

INTRODUCTION

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

> *"…the evaluation plan shall describe an evaluation and reporting plan for the programs funded with the sales tax revenue. Part three [the Evaluation Plan] shall specify: process and outcome evaluation components; a proposed schedule for evaluations; performance measurements and performance measurement targets; and data elements that will be used for reporting and evaluations."*

The primary goal of the MIDD is to:

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

The Ordinance identified five policy goals:

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

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

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

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

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

In the MIDD Action Plan, the MIDD Oversight Committee, the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and its stakeholders identified sixteen core strategies and corresponding sub-strategies (see Appendix for a list and description of strategies) for service improvement, enhancement and expansion to address these goals. The Evaluation Plan will examine the impact of all strategies to

demonstrate effective use of MIDD funds and to assess whether the MIDD goals are being achieved, on both individual program and system levels. Results from the ongoing evaluation will be regularly reported on though quarterly and annual reports that will be reviewed by the MIDD Oversight Committee and transmitted to the King County Executive and Metropolitan King County Council. It also should be noted that the Evaluation Plan will evolve and change as the strategies evolve and change. Changes to the Evaluation Plan will be included in the regular reports as described above.

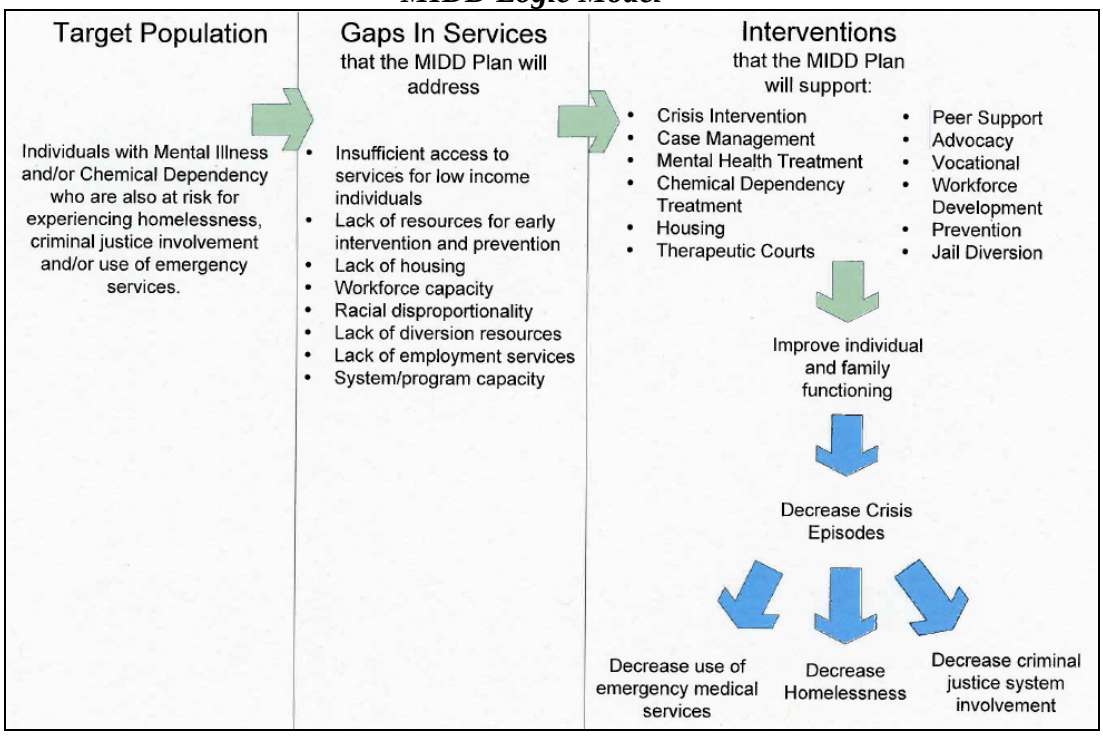
OVERVIEW OF THE EVALUATION PLAN

MIDD Framework

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

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

MIDD Logic Model



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

1. Process Evaluation

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.

Mental Health, Chemical Abuse and Dependency Services

Mental Illness and Drug Dependency Action Plan

Part 3: Evaluation Plan

Evaluation Targets Addendum
September 2, 2008

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.

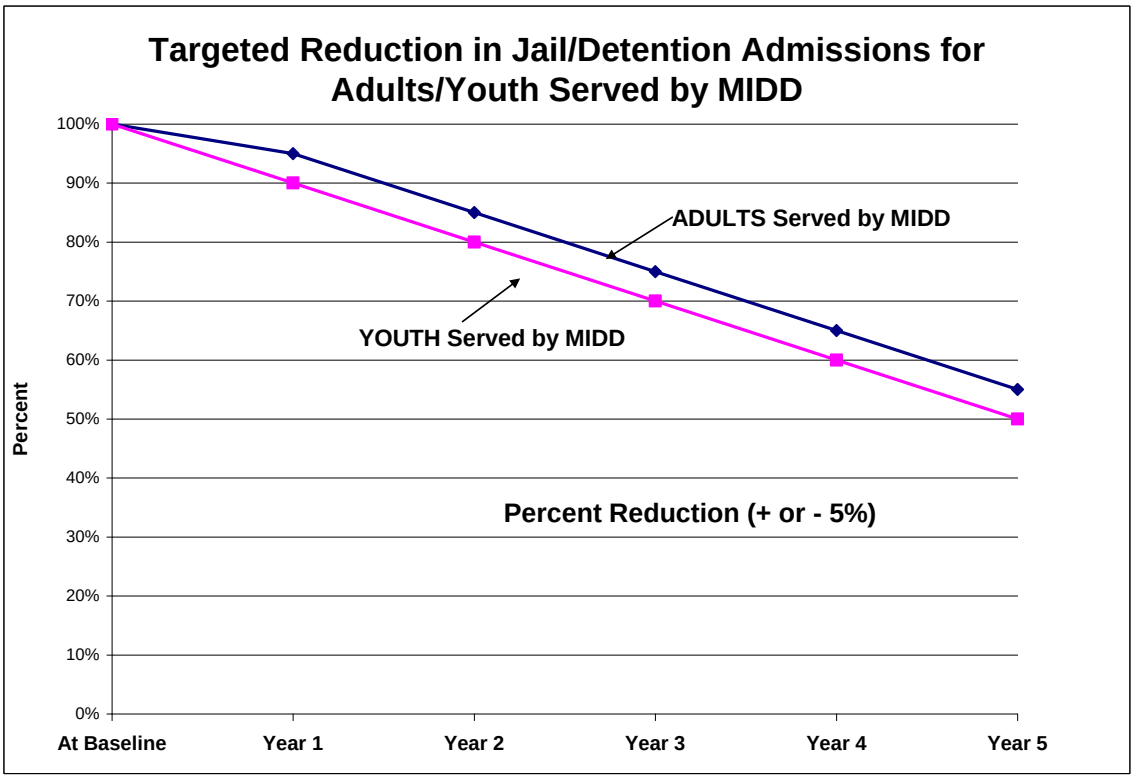
As programs in the MIDD Implementation Plan are implemented and evolve over time, the Evaluation Plan will be updated accordingly to accurately measure the effectiveness and impact of each individual strategy.

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

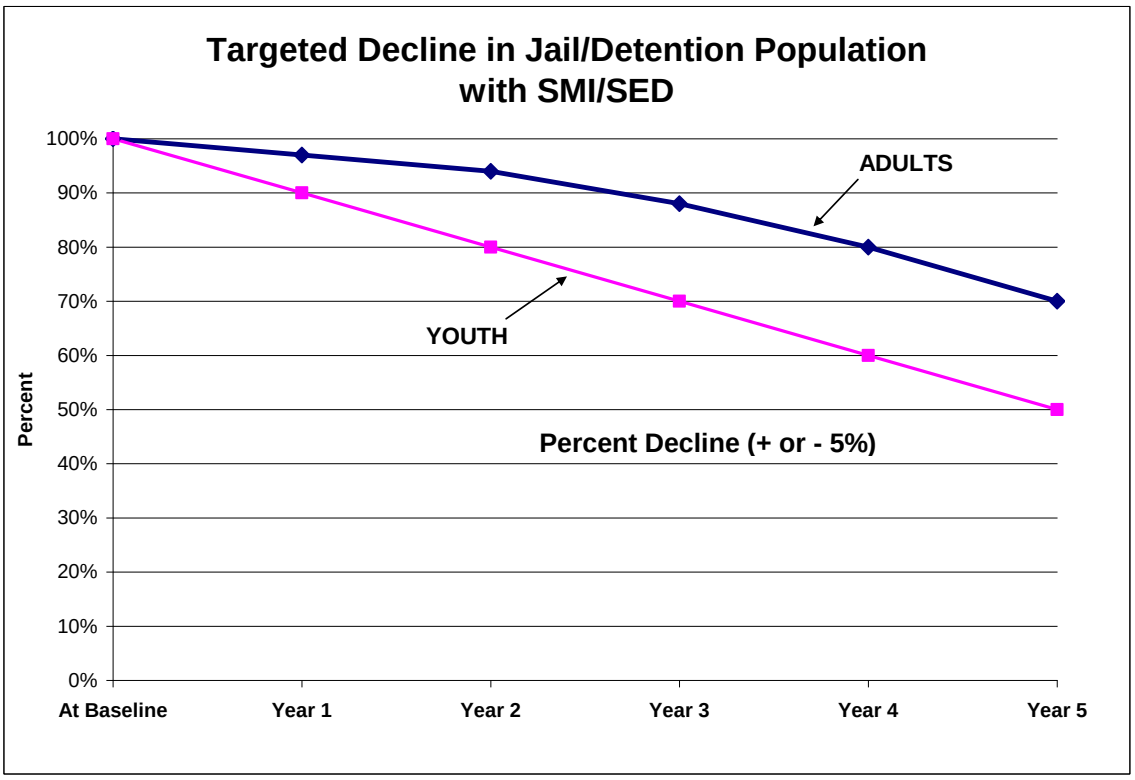


Proportion of Jail/Detention Admissions among Individuals served by MIDD Programs

- 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)



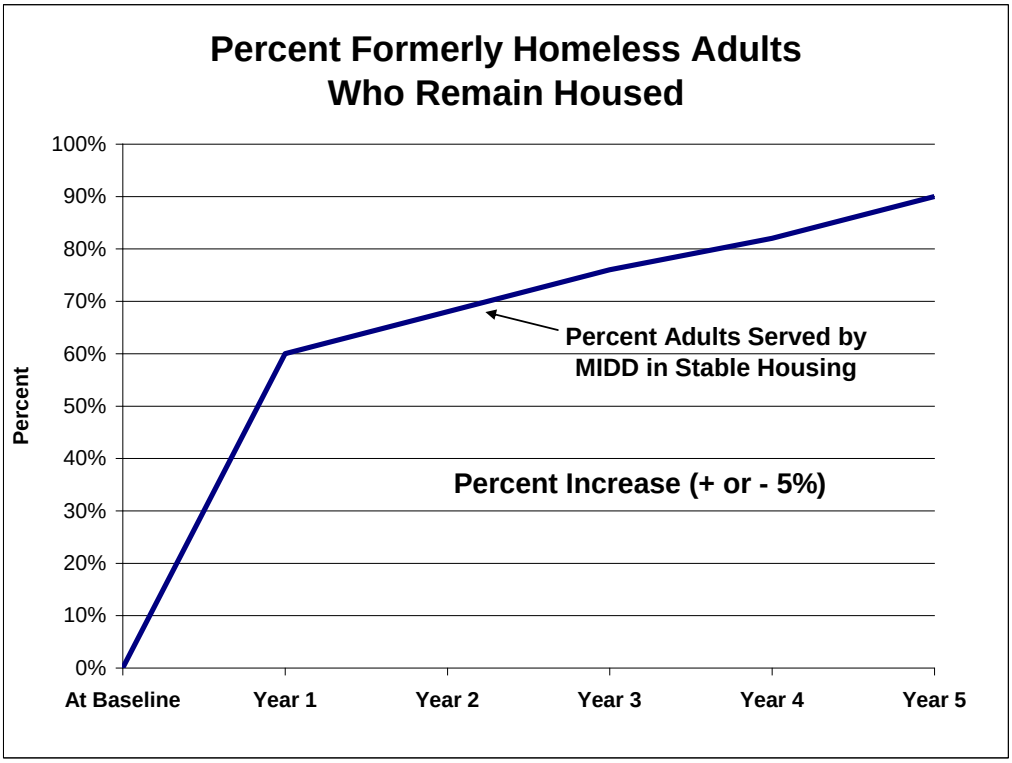
In 2007, there were approximately 17.5 Individuals with SMI per thousand in the adult detention population.

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.

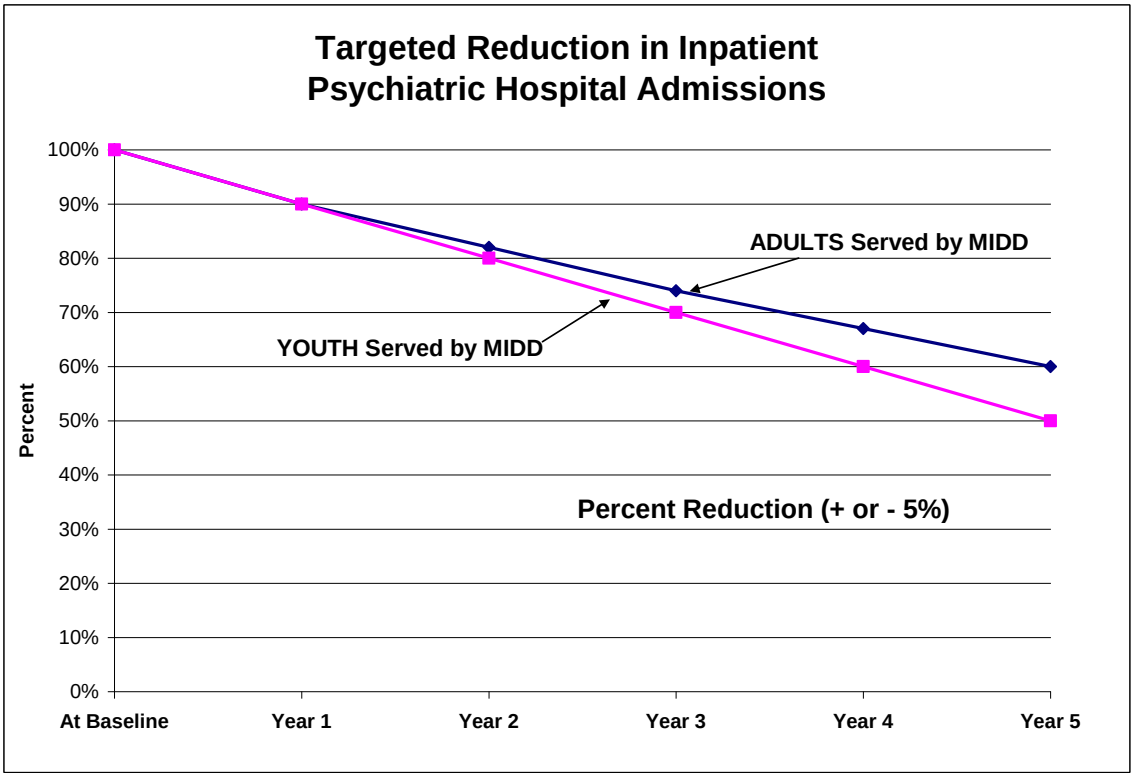
Housing Stability among the Formerly Homeless Receiving MIDD Housing Services

- 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]

[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.

- 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.

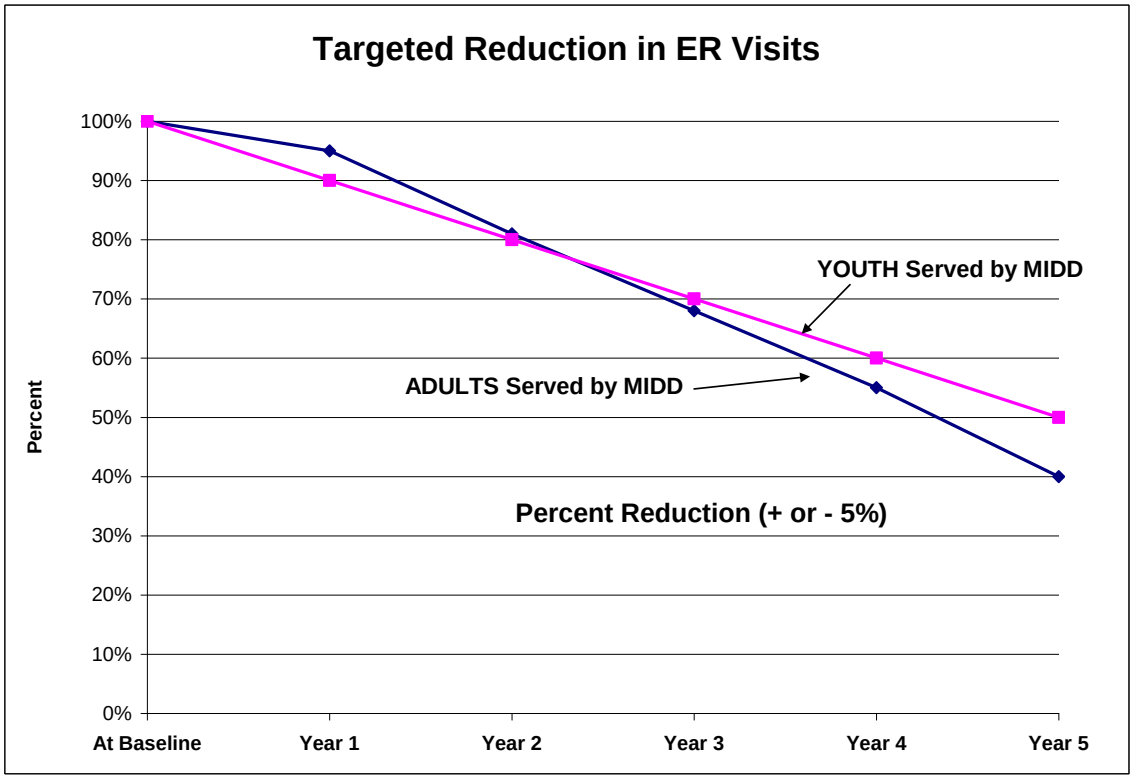
Figure 4: Targeted Reduction in Inpatient Psychiatric Hospital Admissions Among Mentally Ill and Chemically Dependent Youth and Adults served by MIDD Programs



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

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

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

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

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

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

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

Effectiveness of MIDD Strategies in Reducing Emergency Department Use

Fourteen MIDD strategies had a primary or secondary policy goal of reducing emergency room use by mentally ill or drug dependent clients, as shown below. Data were provided by Harborview Medical Center in Seattle, WA in order to monitor changes in use of their emergency department over time. Substance use disorder treatment was analyzed separately for those in outpatient treatment versus opiate treatment. Strategy 17a was excluded from the analysis, as other non-MIDD funding was secured to run this program.

			MIDD Policy Goal
Strategy Number	Strategy Name	Strategy Description	Reduce Emergency Department Use
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+
1a-2	Substance Use Disorder Treatment	Increase Access to Community Substance Use Disorder (SUD) Treatment	+
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	✪
1c	Emergency Room Intervention	Emergency Room Substance Abuse Early Intervention Program	✪
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪
1g	Older Adults Prevention	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	+
1h	Older Adults Crisis & Service Linkage	Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults	✪
3a	Supportive Housing	Supportive Services for Housing Projects	✪
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	✪
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	✪
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	✪
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪
17a	Crisis Intervention/MH Partnership	Crisis Intervention Team/Mental Health Partnership Pilot	+

Key: ✪ = Primary Goal + = Secondary Goal

Emergency Department Reduction Goals

Incremental and cumulative goals for reduction of emergency room use by MIDD participants were established in an Evaluation Targets Addendum dated September 2, 2008, as shown in the grid below. The incremental reduction goals for each post period represent an additional reduction from the pre period (the year prior to an individual's MIDD start date), rather than a reduction from the previous post period. The green highlighting indicates adequate data availability for most strategies (as of February 2015) for preliminary assessment of long-term effectiveness.

Harborview ED Admissions				
Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-10%
Post 2	-14%	-19%	-10%	-20%
Post 3	-13%	-32%	-10%	-30%
Post 4	-13%	-45%	-10%	-40%
Post 5	-15%	-60%	-10%	-50%

Factors Impacting Assessment of Effectiveness

Late Strategy Start Date

Strategies that began after October 1, 2010, do not have enough data to assess effectiveness yet.

- Strategy 7b—Expand Youth Crisis Services
- Strategy 10b—Adult Crisis Diversion
- Strategy 12b—Hospital Re-Entry Respite Beds

Low Use of Harborview ED

Strategies with use rates lower than 25 percent of all who are eligible may take longer to achieve their reduction goals.*

- Strategy 1a-1—Mental Health Treatment
- Strategy 1a-2a—Outpatient SUD Treatment
- Strategy 1g—Older Adults Prevention
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services.

* Note: If strategies have very small sample sizes, they are less likely to show changes over time that reach statistical significance.

Factors Impacting Effectiveness Results

Lower Admissions to ED Prior to the MIDD

Strategies with fewer average admissions in the pre period have less room for improvement.

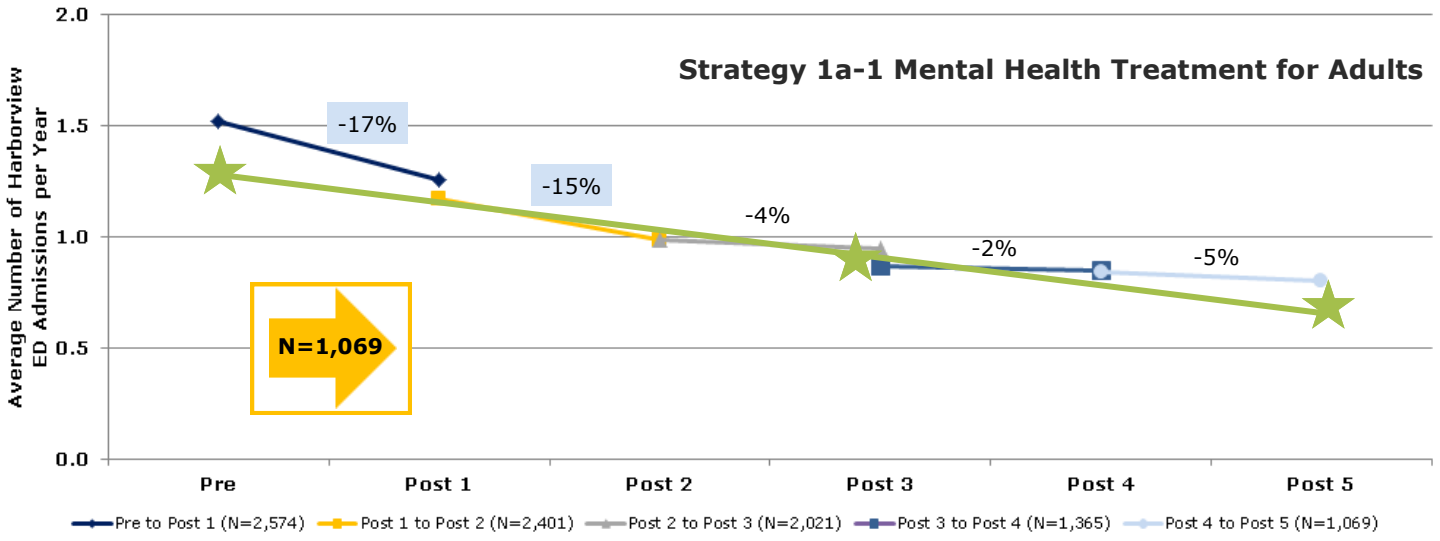
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services

Increases in ED Use Associated with Start of MIDD Services

Outreach and crisis intervention strategies may show initial increases in system use due to discovery of individuals not previously linked with needed/ necessary emergency medical care. Strategies with initial increases are expected to decrease over time, but may need more time to achieve reduction goals.

- Strategy 1b—Outreach & Engagement
- Strategy 1c—Emergency Room Intervention
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 10b—Adult Crisis Diversion
- Strategy 12b—Hospital Re-Entry Respite Beds.

Incremental Change Over Time for Individuals with Emergency Department Use Who Were Served in MIDD Mental Health, Support, and Certain Outreach Strategies



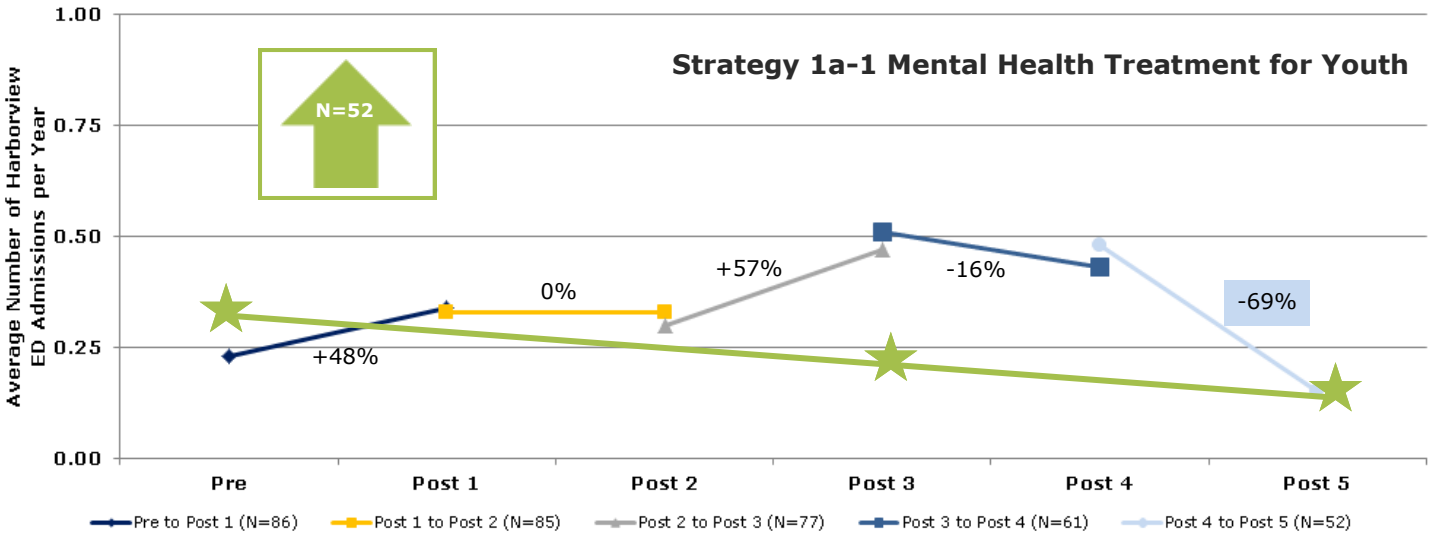
Key:

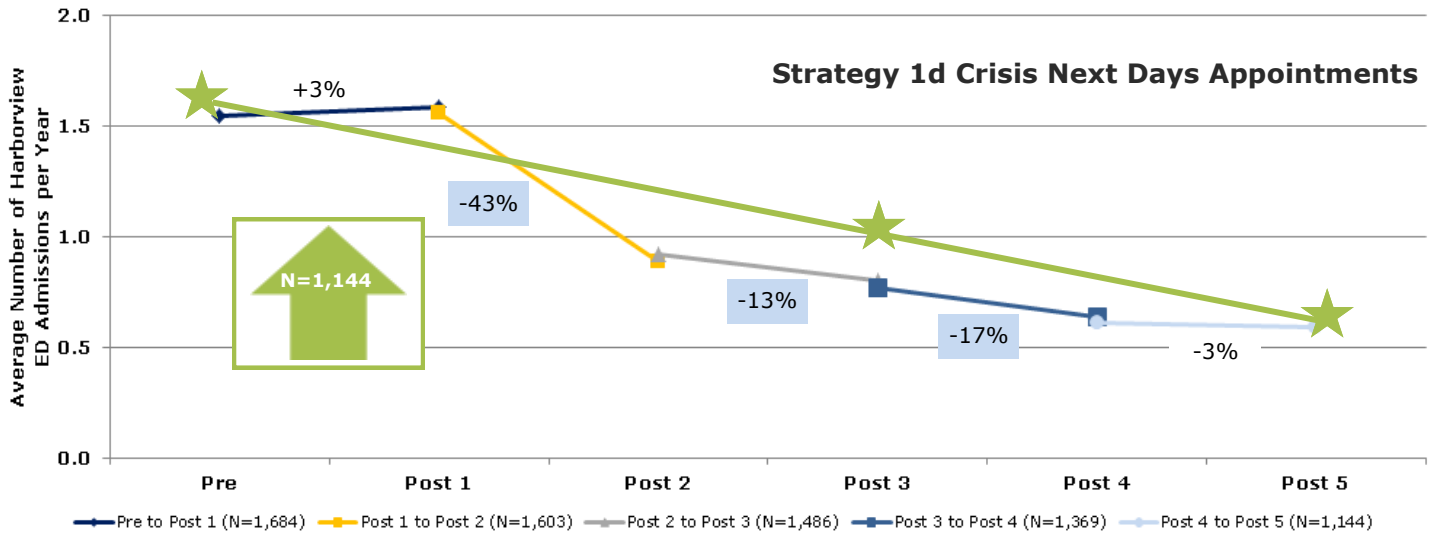
Ultimate targeted reduction goal was met by sample of strategy participants eligible for longest post period who had jail use in any period.

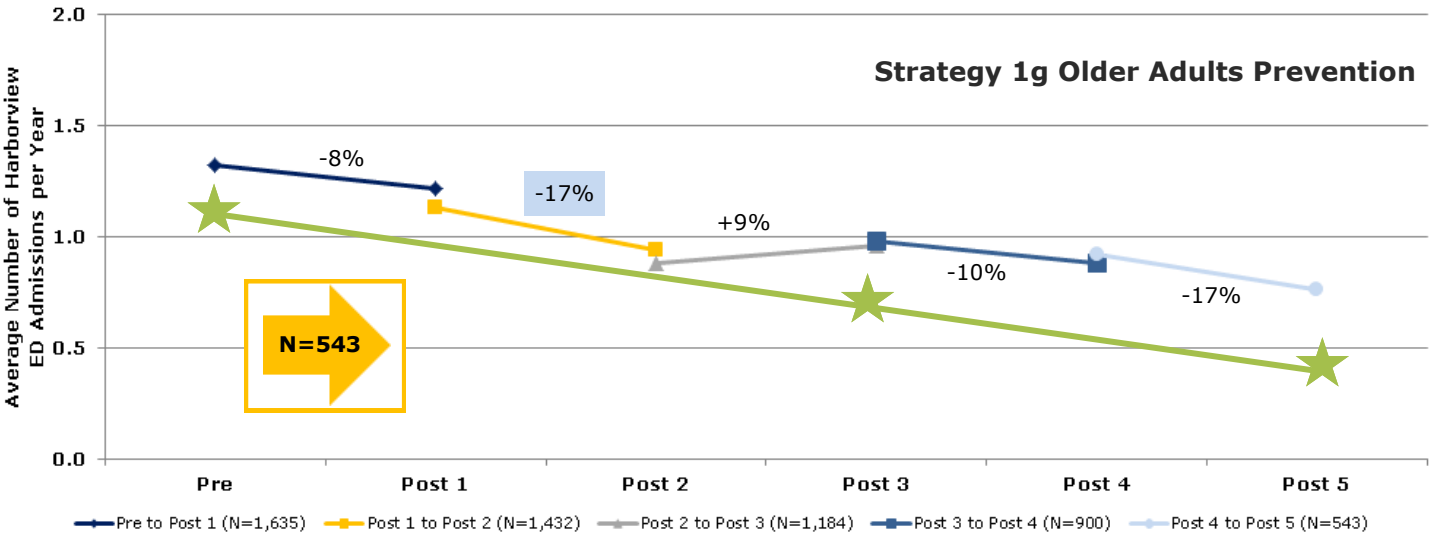
Strategy was on pace to meet ultimate targeted reduction goal, but an unexpected shift in the data pattern prevented goal attainment.

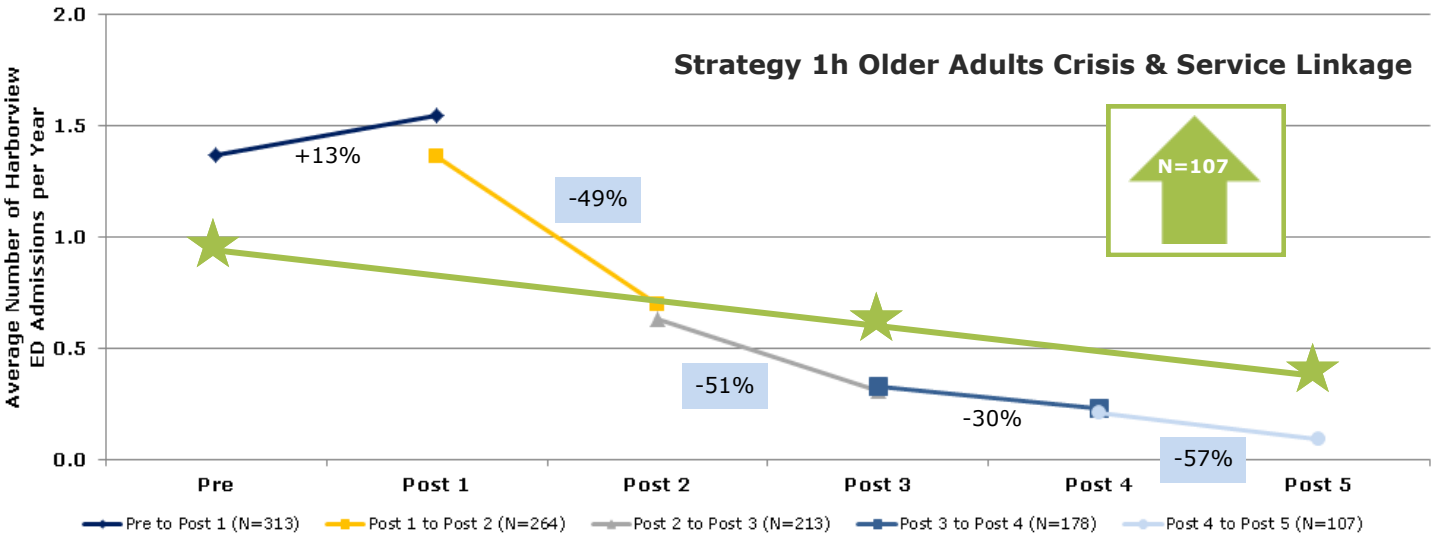
Ultimate targeted reduction goal is not expected to be met based on trends noted in currently available data.

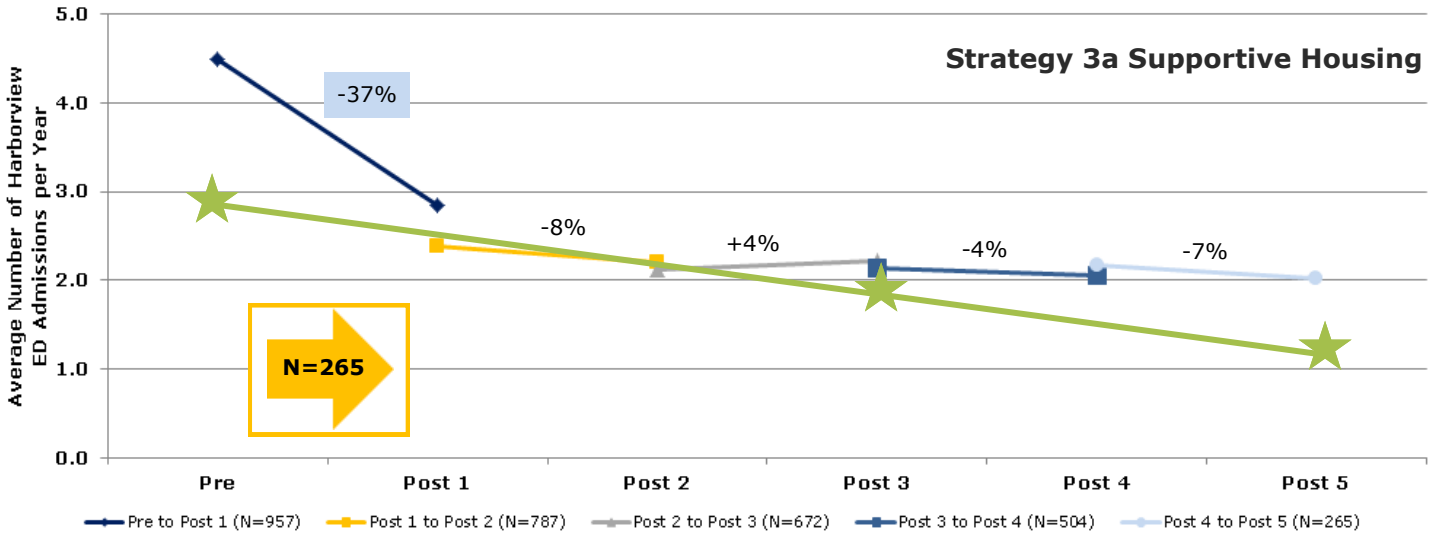
Statistically significant reductions are highlighted in blue. Statistically significant increases are highlighted in yellow.

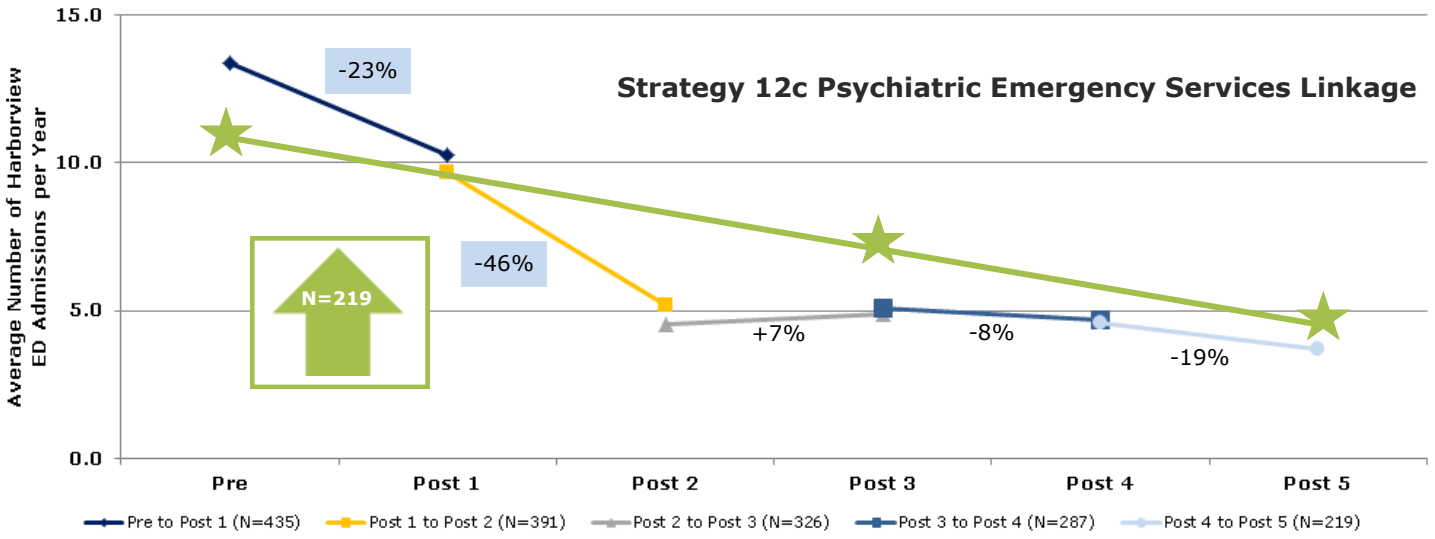

Strategy 1a-1 Mental Health Treatment for Youth
N=52
Average Number of Harborview ED Admissions per Year
1.00
0.75
0.50
0.25
0.00
+48%
0%
+57%
-16%
-69%
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=86)
Post 1 to Post 2 (N=85)
Post 2 to Post 3 (N=77)
Post 3 to Post 4 (N=61)
Post 4 to Post 5 (N=52)

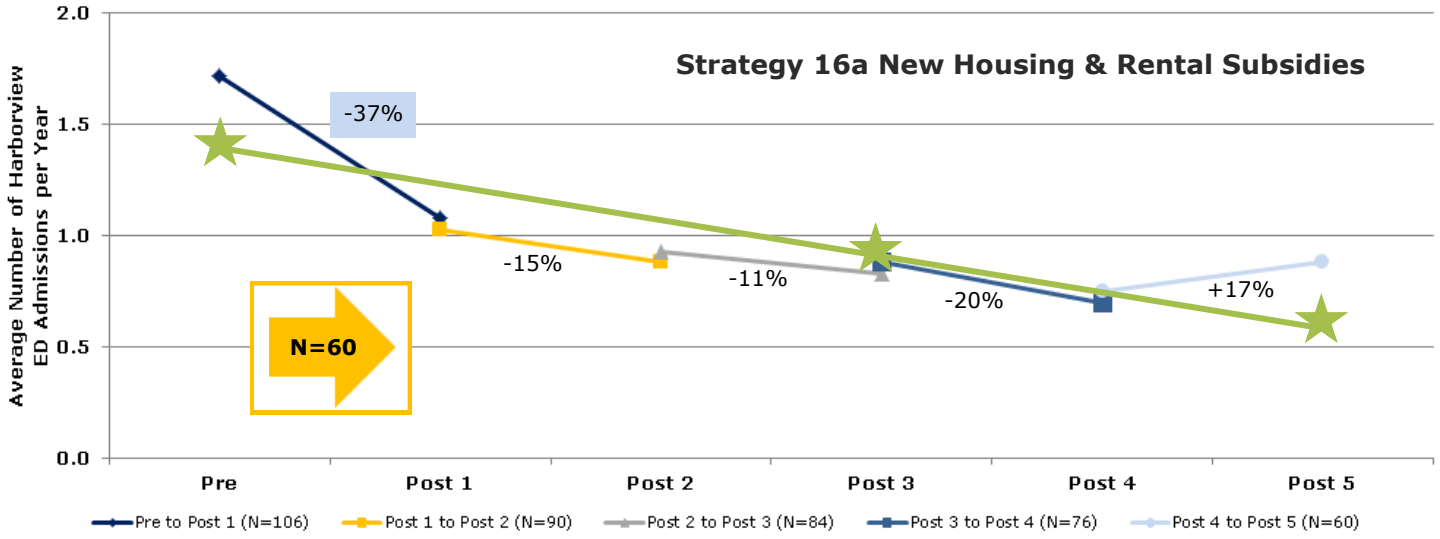

Strategy 1d Crisis Next Days Appointments
N=1,144
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
+3%
-43%
-13%
-17%
-3%
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,684)
Post 1 to Post 2 (N=1,603)
Post 2 to Post 3 (N=1,486)
Post 3 to Post 4 (N=1,369)
Post 4 to Post 5 (N=1,144)


Strategy 1g Older Adults Prevention
N=543
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
-8%
-17%
+9%
-10%
-17%
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,635)
Post 1 to Post 2 (N=1,432)
Post 2 to Post 3 (N=1,184)
Post 3 to Post 4 (N=900)
Post 4 to Post 5 (N=543)

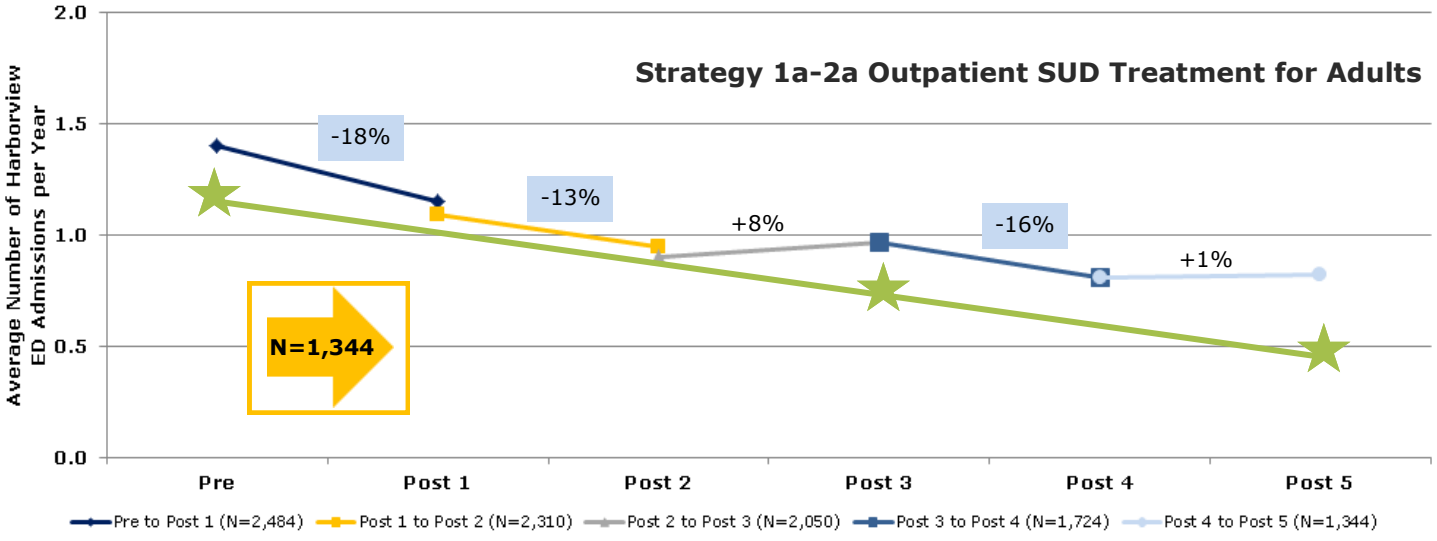

Strategy 1h Older Adults Crisis & Service Linkage
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
+13%
-49%
-51%
-30%
-57%
N=107
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=313)
Post 1 to Post 2 (N=264)
Post 2 to Post 3 (N=213)
Post 3 to Post 4 (N=178)
Post 4 to Post 5 (N=107)

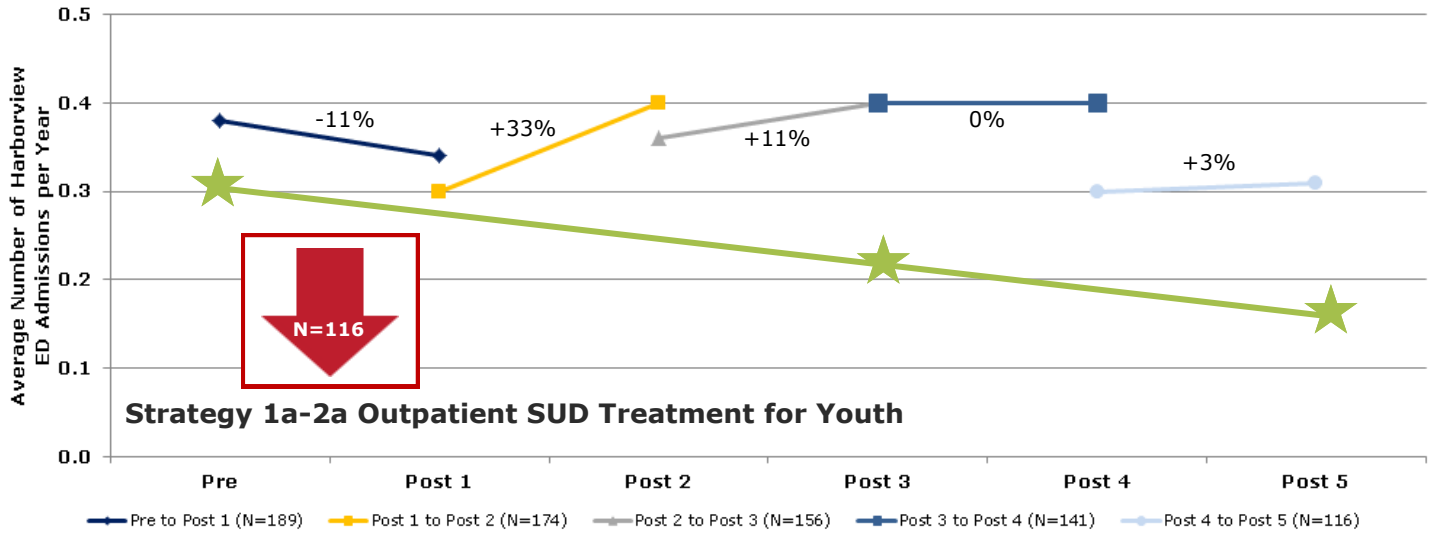

Strategy 3a Supportive Housing
Average Number of Harborview ED Admissions per Year
5.0
4.0
3.0
2.0
1.0
0.0
-37%
-8%
+4%
-4%
-7%
N=265
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=957)
Post 1 to Post 2 (N=787)
Post 2 to Post 3 (N=672)
Post 3 to Post 4 (N=504)
Post 4 to Post 5 (N=265)

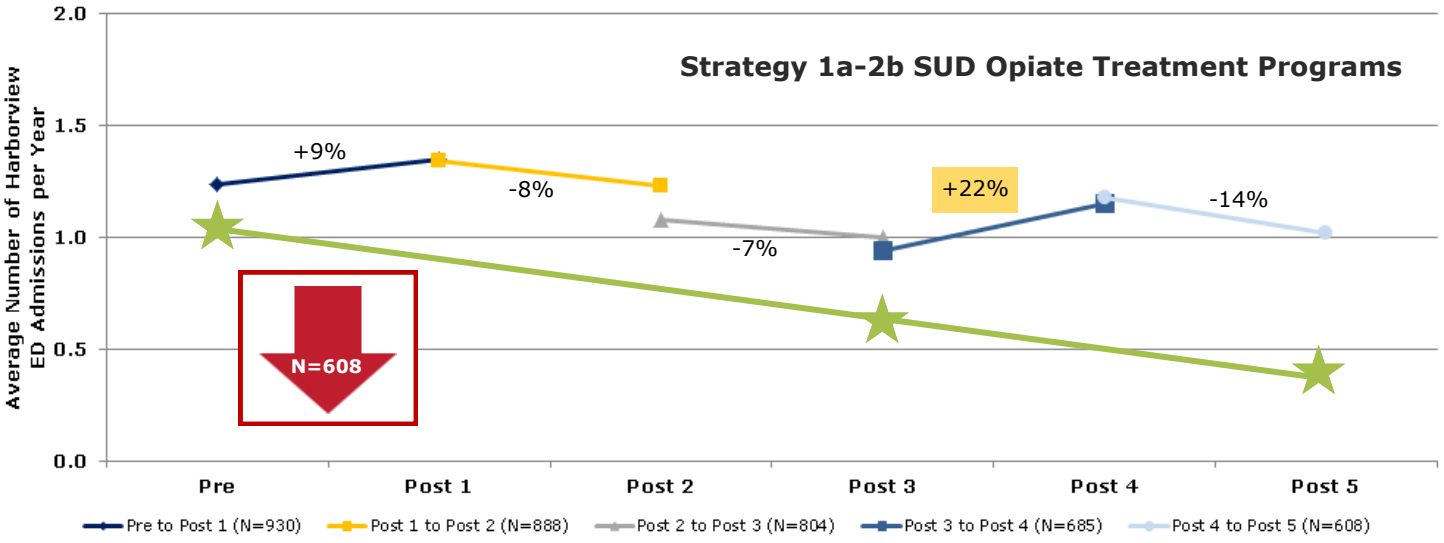

Strategy 12c Psychiatric Emergency Services Linkage
Average Number of Harborview ED Admissions per Year
15.0
10.0
5.0
0.0
-23%
-46%
+7%
-8%
-19%
N=219
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=435)
Post 1 to Post 2 (N=391)
Post 2 to Post 3 (N=326)
Post 3 to Post 4 (N=287)
Post 4 to Post 5 (N=219)

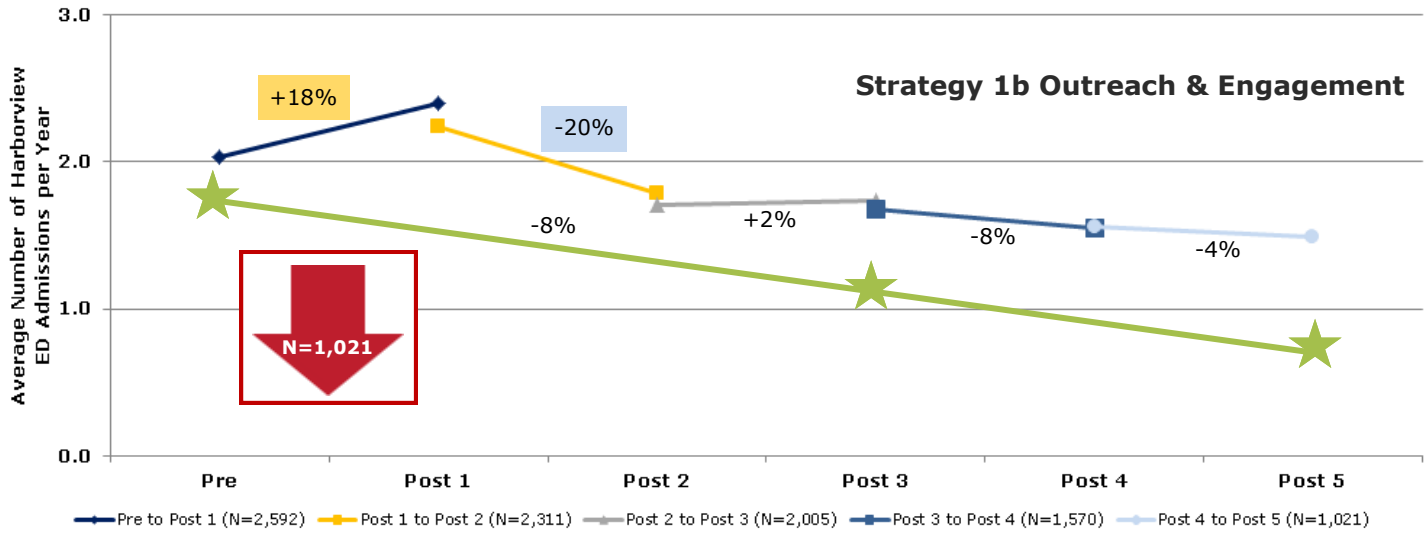


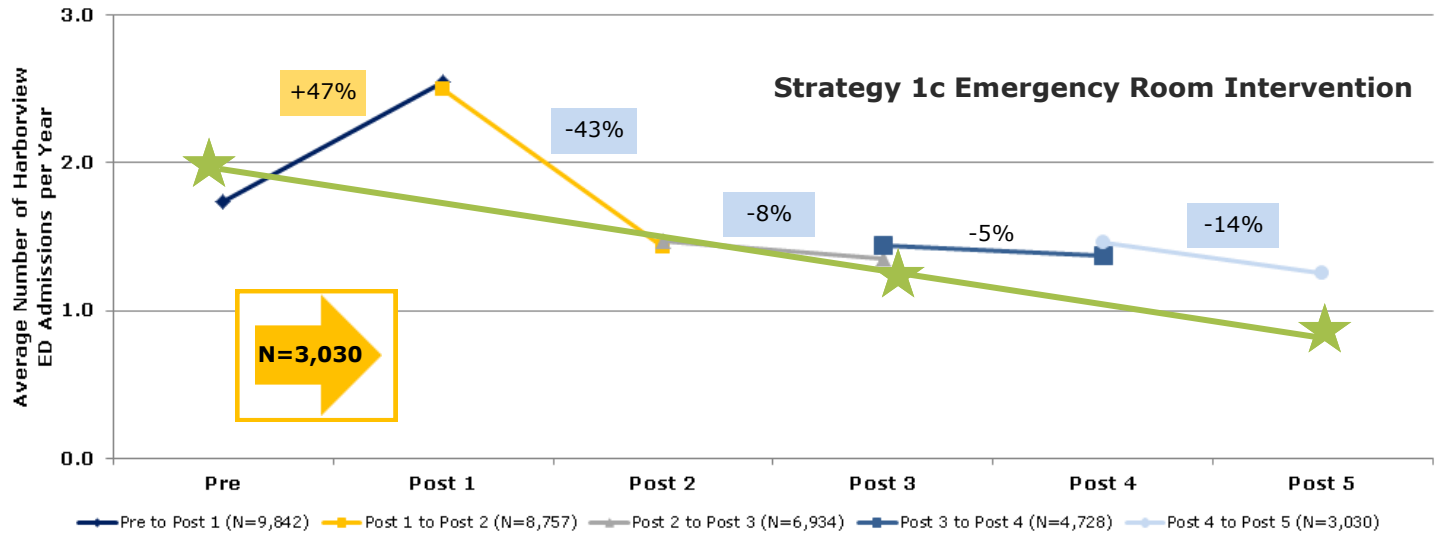
Incremental Change Over Time for Individuals with Emergency Department Use Who Were Served in MIDD Substance Use Disorder (SUD) Treatment and Other Outreach Strategies



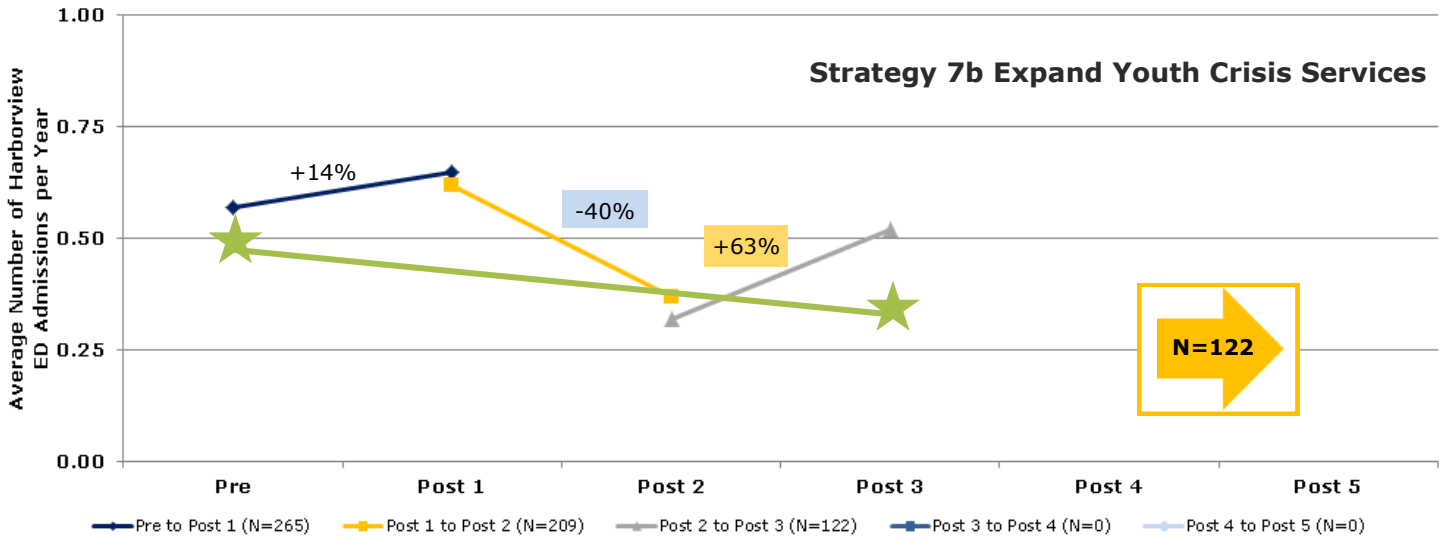


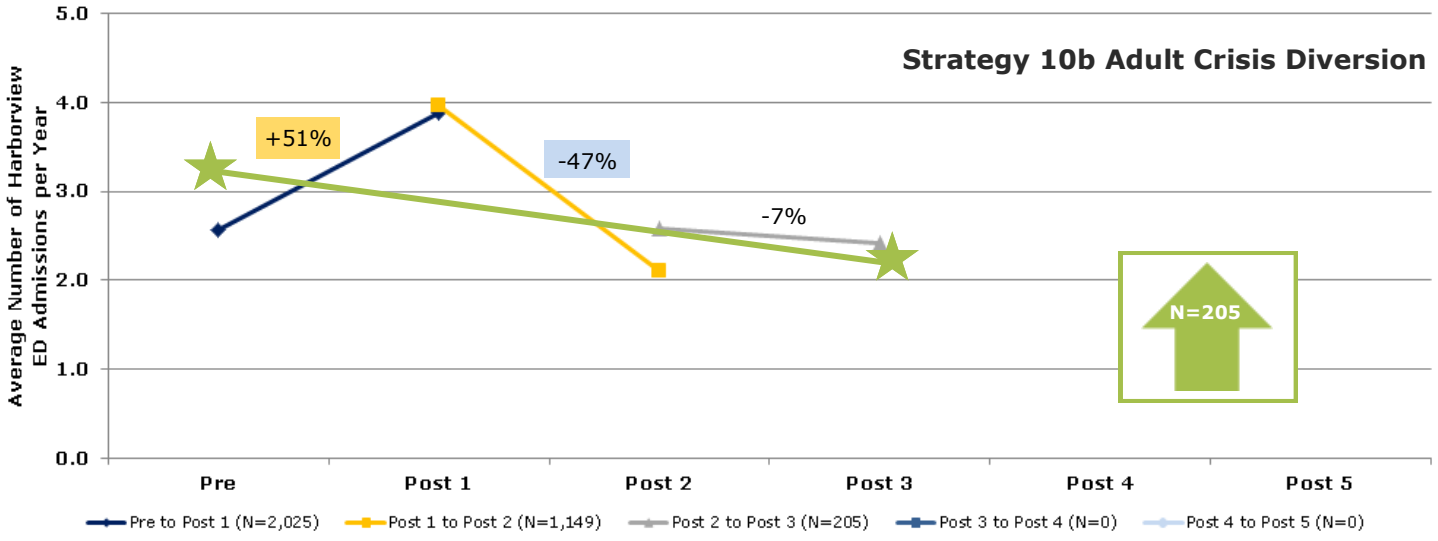

Strategy 1a-2b SUD Opiate Treatment Programs
Average Number of Harborview ED Admissions per Year
2.0
1.5
1.0
0.5
0.0
+9%
-8%
-7%
+22%
-14%
N=608
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=930)
Post 1 to Post 2 (N=888)
Post 2 to Post 3 (N=804)
Post 3 to Post 4 (N=685)
Post 4 to Post 5 (N=608)

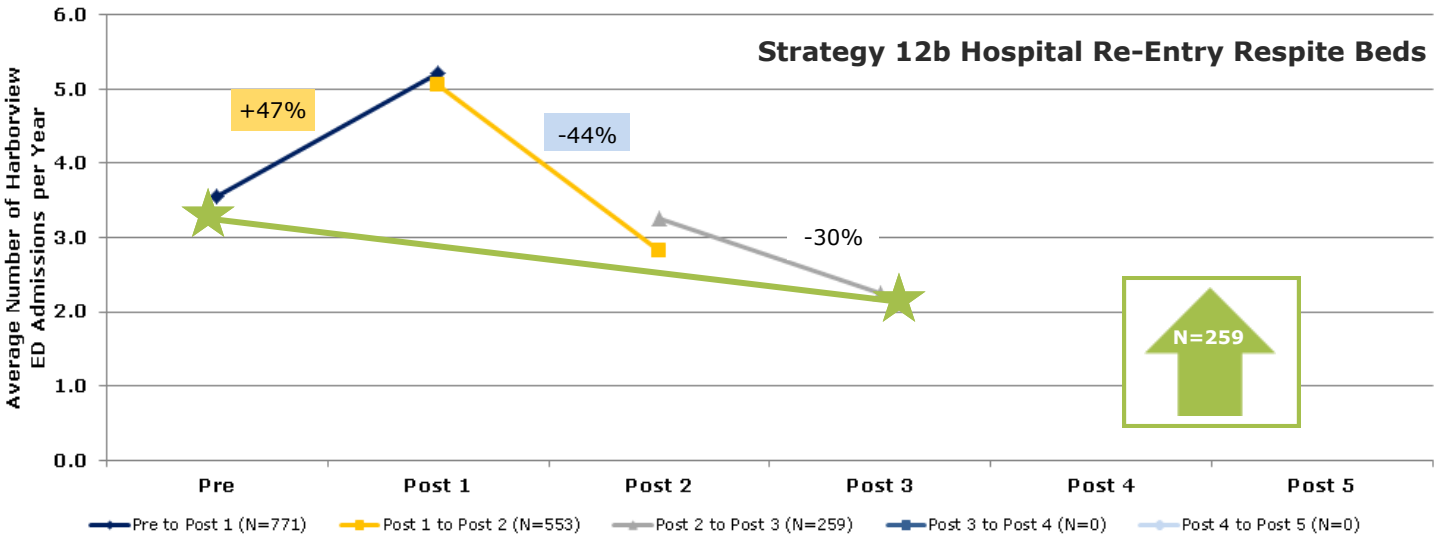

Strategy 1b Outreach & Engagement
Average Number of Harborview ED Admissions per Year
3.0
2.0
1.0
0.0
+18%
-20%
-8%
+2%
-8%
-4%
N=1,021
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=2,592)
Post 1 to Post 2 (N=2,311)
Post 2 to Post 3 (N=2,005)
Post 3 to Post 4 (N=1,570)
Post 4 to Post 5 (N=1,021)


Strategy 1c Emergency Room Intervention
Average Number of Harborview ED Admissions per Year
3.0
2.0
1.0
0.0
+47%
-43%
-8%
-5%
-14%
N=3,030
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=9,842)
Post 1 to Post 2 (N=8,757)
Post 2 to Post 3 (N=6,934)
Post 3 to Post 4 (N=4,728)
Post 4 to Post 5 (N=3,030)

Incremental Change Over Time for Individuals with Emergency Department Use Who Were Served in Crisis Response and Respite Strategies







Effectiveness of MIDD Strategies in Reducing Community

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

			MIDD Policy Goal
Strategy Number	Strategy Name	Strategy Description	Reduce Psychiatric Hospital Use
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	✪
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪
1h	Older Adults Crisis & Service Linkage	Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults	✪
3a	Supportive Housing	Supportive Services for Housing Projects	✪
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	✪
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	✪
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	✪
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪

Key: ✪ = Primary Goal + = Secondary Goal

Psychiatric Hospitalization Reduction Goals

Incremental and cumulative goals for reduction of psychiatric hospital use by MIDD participants were established in an Evaluation Targets Addendum dated September 2, 2008, as shown in the grid below. Although the original targeted reductions were based on admissions, the average number of days per year more fully captures utilization of psychiatric hospitals. While psychiatric admissions and days are closely correlated, days hospitalized can vary widely between individuals. The incremental reduction goals for each post period represent an additional reduction from the pre period (the year prior to an individual's MIDD start date), rather than a reduction from the previous post period. The green highlighting indicates adequate data availability for most strategies (as of February 2016) for preliminary assessment of long-term effectiveness.

The green line shown on graphs over the next several pages indicates the ultimate expected reduction from Pre to Post 5 for strategy participants eligible for the longest time period who had psychiatric hospitalizations in any time period, unless stated otherwise.

Psychiatric Hospital Admissions or Days				
Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-10%	-10%	-10%	-10%
Post 2	-8%	-18%	-10%	-20%
Post 3	-8%	-26%	-10%	-30%
Post 4	-7%	-33%	-10%	-40%
Post 5	-7%	-40%	-10%	-50%

Factors Impacting Assessment of Effectiveness

Late Strategy Start Date

Strategies that began after October 1, 2010, do not have enough data to assess effectiveness yet.

- Strategy 7b—Expand Youth Crisis Services
- Strategy 10b—Adult Crisis Diversion
- Strategy 12b—Hospital Re-Entry Respite Beds

Low Use of Inpatient Psychiatric Facilities

Six of 10 strategies had use rates lower than 25 percent of all who were eligible for outcomes analysis. These programs may take longer to achieve their reduction goals.*

- Strategy 1a-1—Mental Health Treatment
- Strategy 1b—Outreach & Engagement
- Strategy 1d—Crisis Next Day Appointments
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services
- Strategy 12b—Hospital Re-Entry Respite Beds

* Note: If strategies also have small sample sizes, they are less likely to show changes over time that reach statistical significance.

Factors Impacting Effectiveness Results

Shorter Hospitalizations Prior to the MIDD

Strategies with fewer average hospital days in the pre period have less room for improvement.

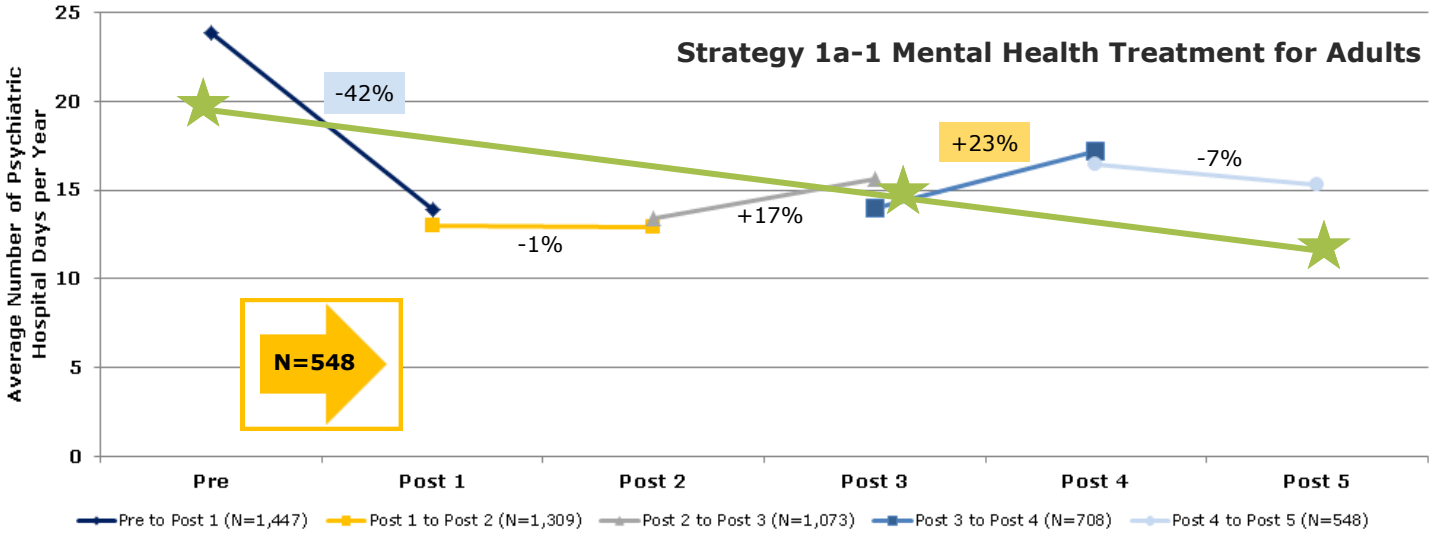
- Strategy 1b—Outreach & Engagement
- Strategy 1d—Crisis Next Day Appointments

Increases in Psychiatric Hospitalizations Associated with Start of MIDD Services

As with emergency department use, outreach and crisis intervention strategies may show initial increases in system use due to discovery of individuals not previously linked with needed/ necessary psychiatric care. Strategies with initial increases are expected to decrease over time, but may need more time to achieve reduction goals.

- Strategy 1b—Outreach & Engagement
- Strategy 1d—Crisis Next Day Appointments
- Strategy 1h—Older Adults Crisis & Service Linkage
- Strategy 7b—Expand Youth Crisis Services
- Strategy 10b—Adult Crisis Diversion
- Strategy 12c—Psychiatric Emergency Services Linkage.

Incremental Change Over Time for Individuals with Psychiatric Hospital Use Who Were Served in MIDD Mental Health, Support, and Certain Outreach Strategies



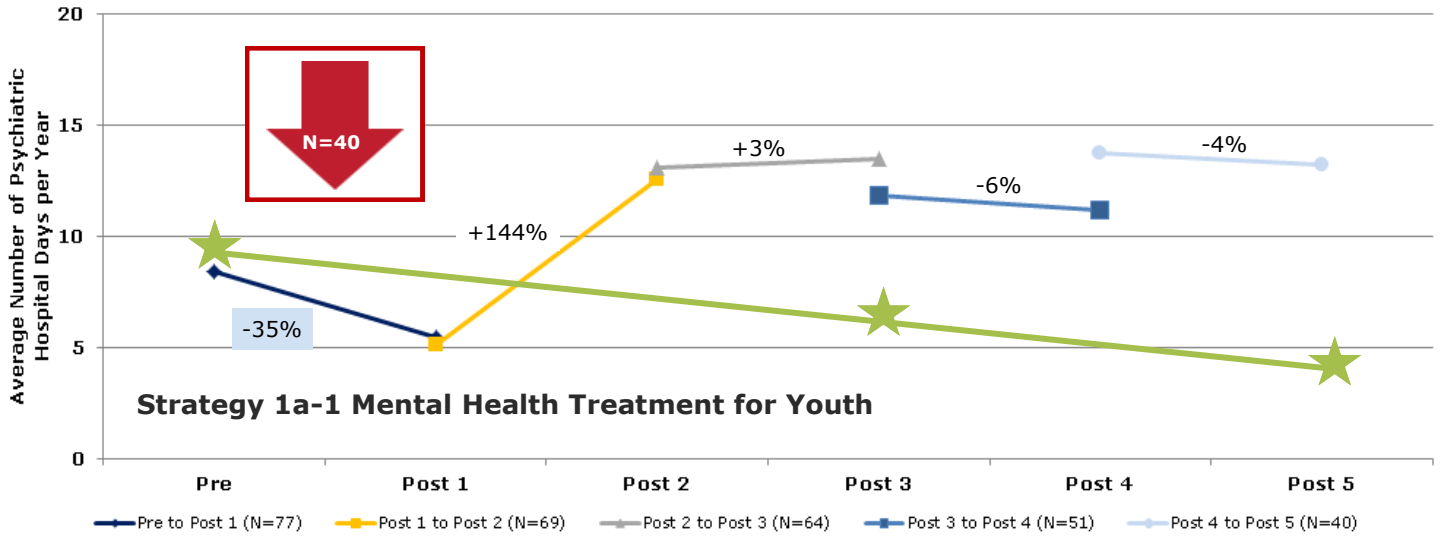
Key:

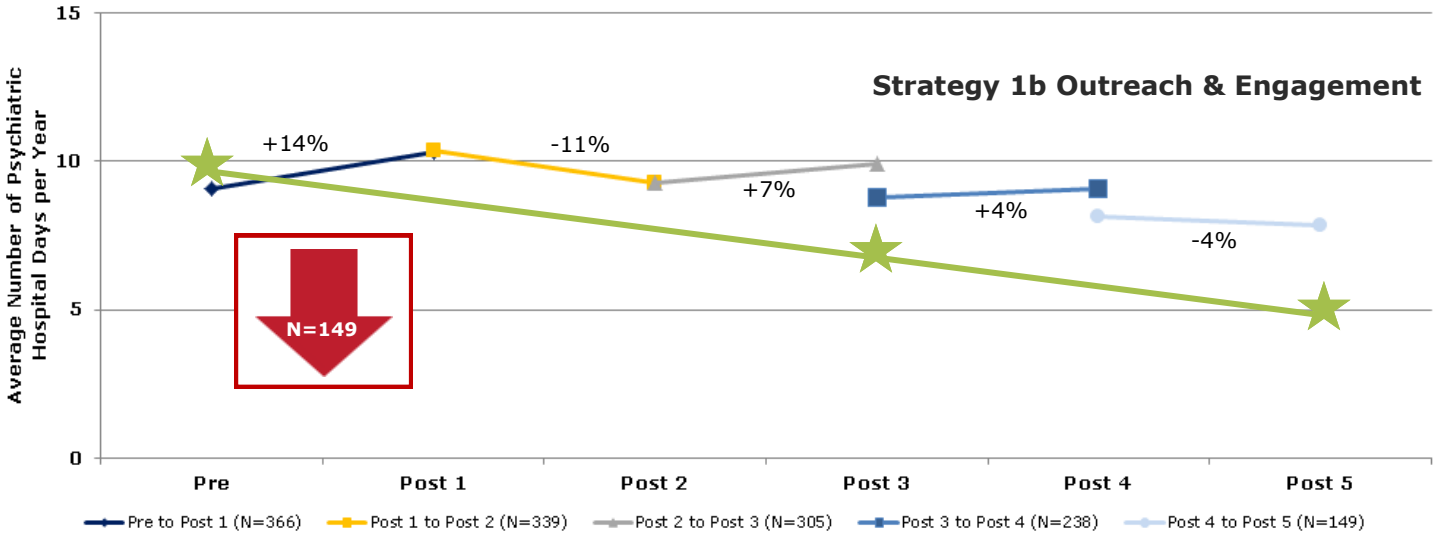
Ultimate targeted reduction goal was met by sample of strategy participants eligible for longest post period who had jail use in any period.

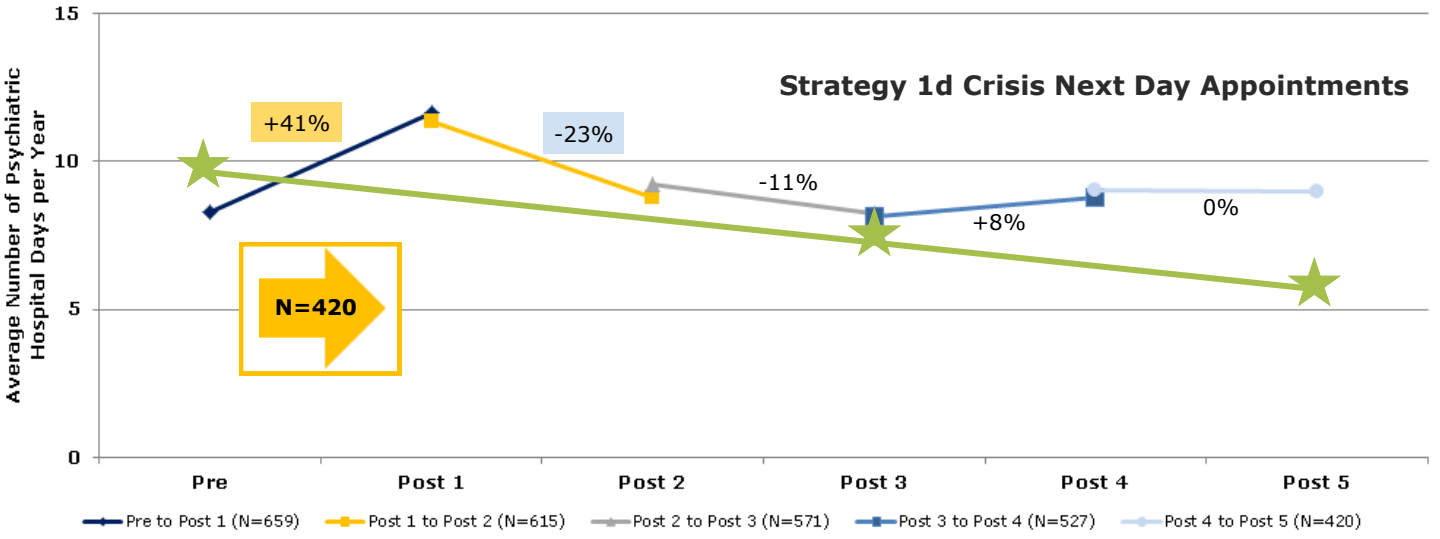
Strategy was on pace to meet ultimate targeted reduction goal, but an unexpected shift in the data pattern prevented goal attainment.

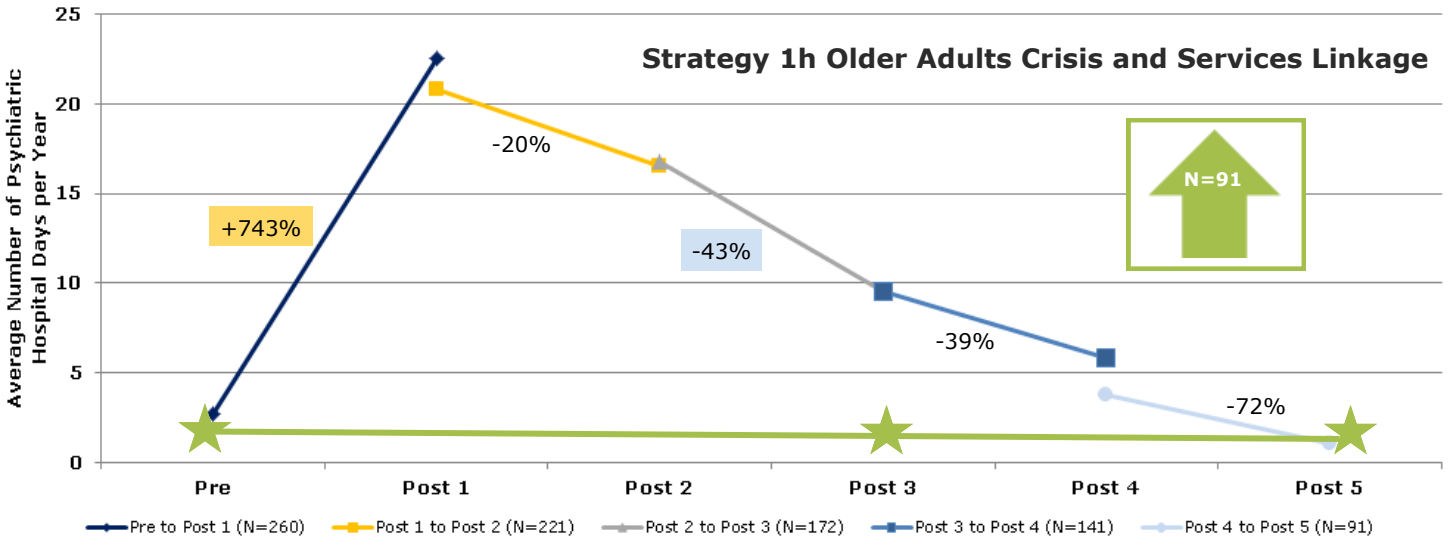
Ultimate targeted reduction goal is not expected to be met based on trends noted in currently available data.

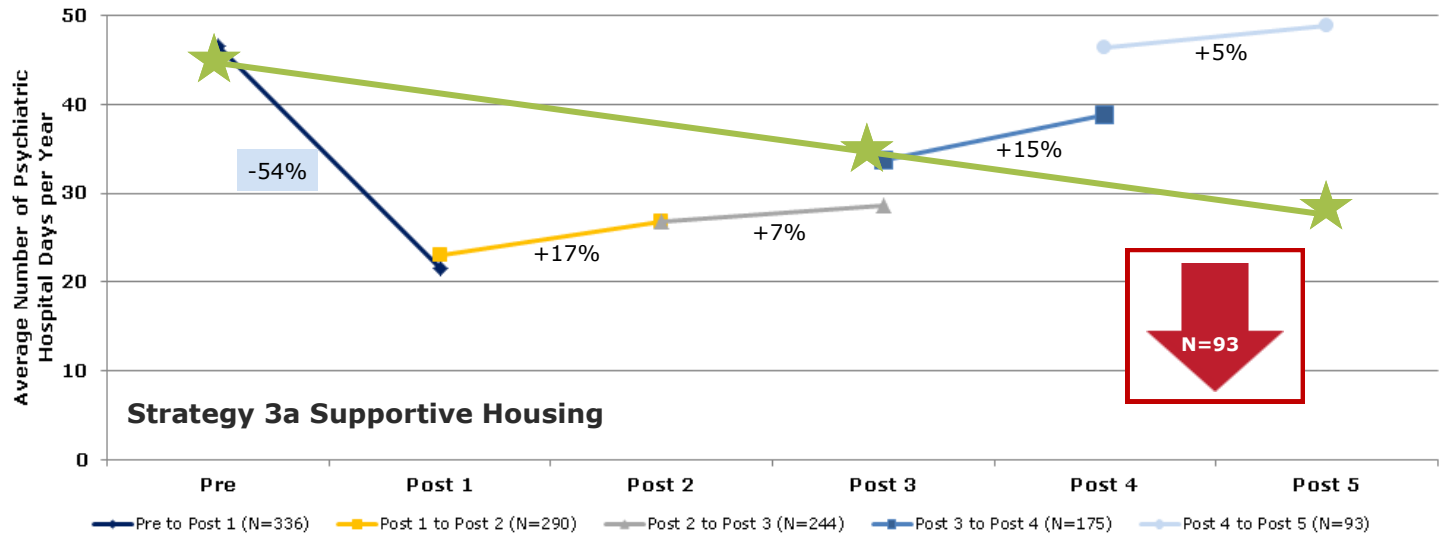
Statistically significant reductions are highlighted in blue. Statistically significant increases are highlighted in yellow.

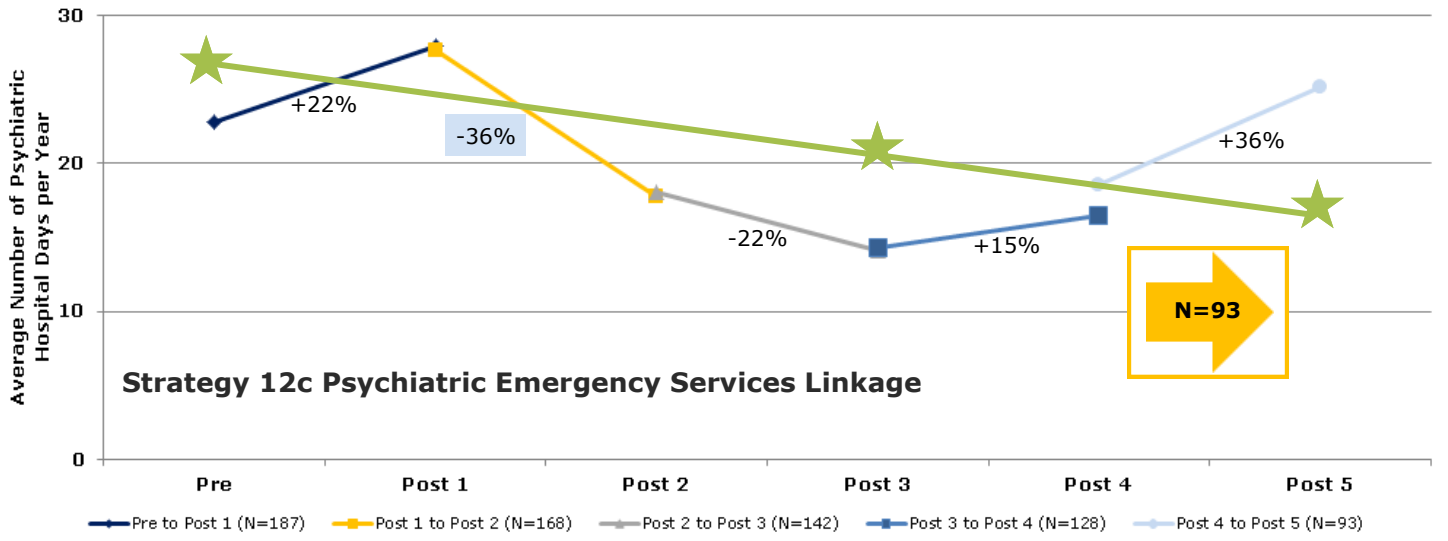

Average Number of Psychiatric Hospital Days per Year
20
15
10
5
0
N=40
+144%
+3%
-6%
-4%
-35%
Strategy 1a-1 Mental Health Treatment for Youth
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=77)
Post 1 to Post 2 (N=69)
Post 2 to Post 3 (N=64)
Post 3 to Post 4 (N=51)
Post 4 to Post 5 (N=40)

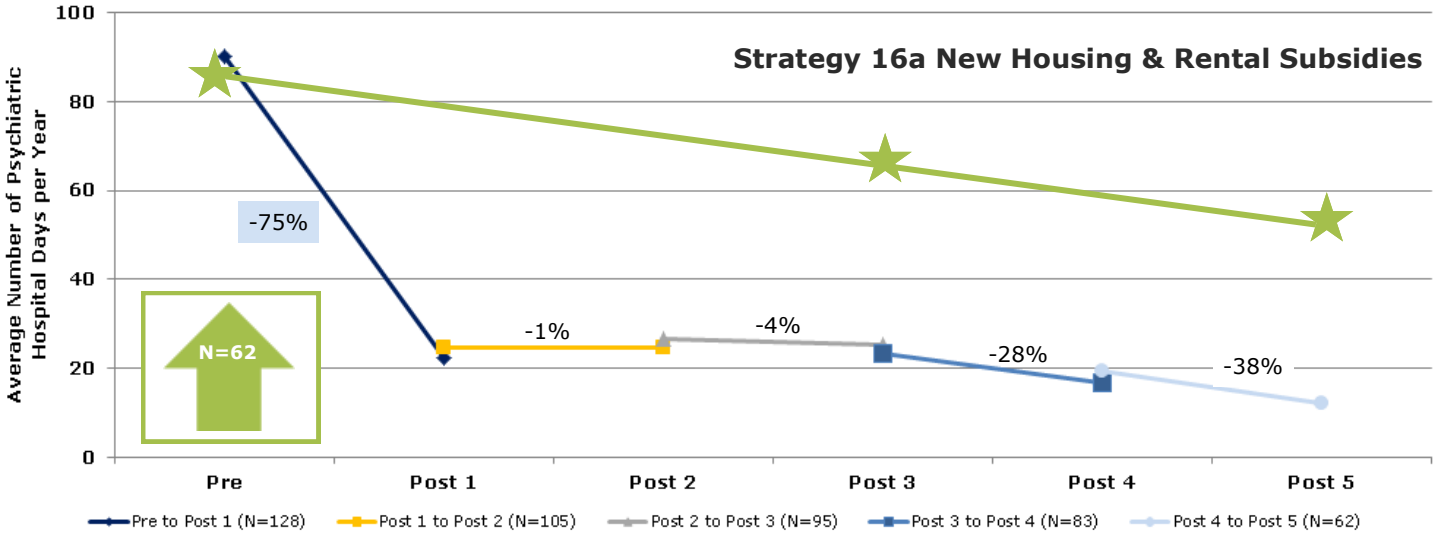

Average Number of Psychiatric Hospital Days per Year
15
10
5
0
Strategy 1b Outreach & Engagement
+14%
-11%
+7%
+4%
-4%
N=149
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=366)
Post 1 to Post 2 (N=339)
Post 2 to Post 3 (N=305)
Post 3 to Post 4 (N=238)
Post 4 to Post 5 (N=149)


Average Number of Psychiatric Hospital Days per Year
15
10
5
0
Strategy 1d Crisis Next Day Appointments
+41%
-23%
-11%
+8%
0%
N=420
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=659)
Post 1 to Post 2 (N=615)
Post 2 to Post 3 (N=571)
Post 3 to Post 4 (N=527)
Post 4 to Post 5 (N=420)

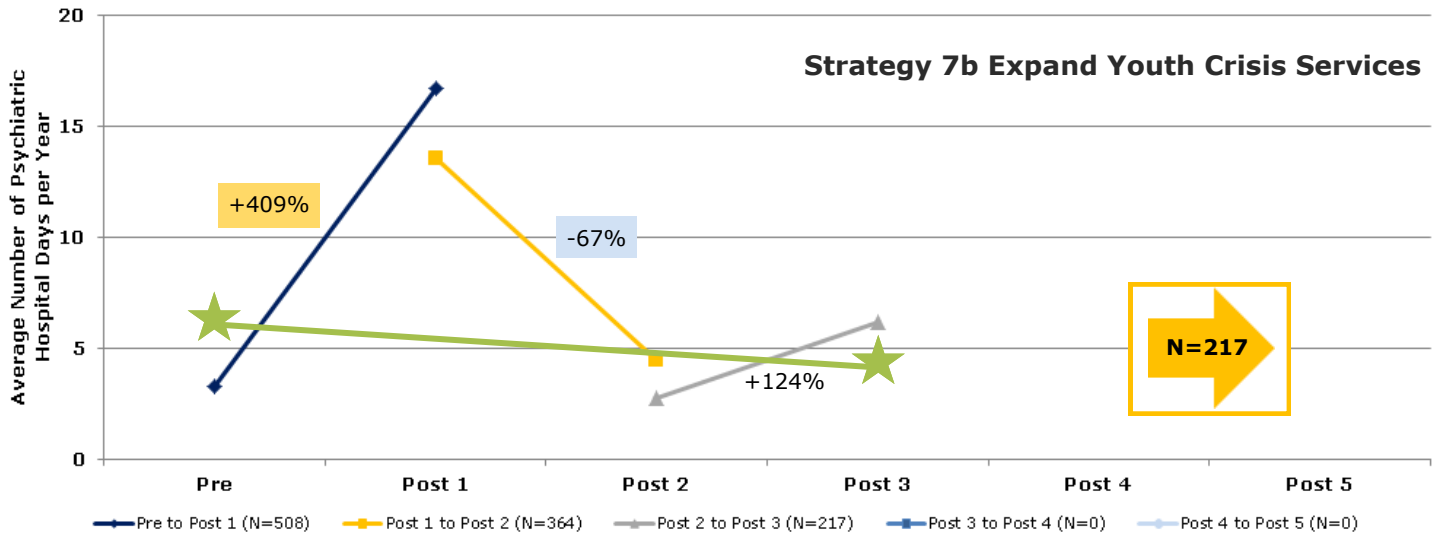

Strategy 1h Older Adults Crisis and Services Linkage
Average Number of Psychiatric Hospital Days per Year
25
20
15
10
5
0
+743%
-20%
-43%
-39%
-72%
N=91
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=260)
Post 1 to Post 2 (N=221)
Post 2 to Post 3 (N=172)
Post 3 to Post 4 (N=141)
Post 4 to Post 5 (N=91)

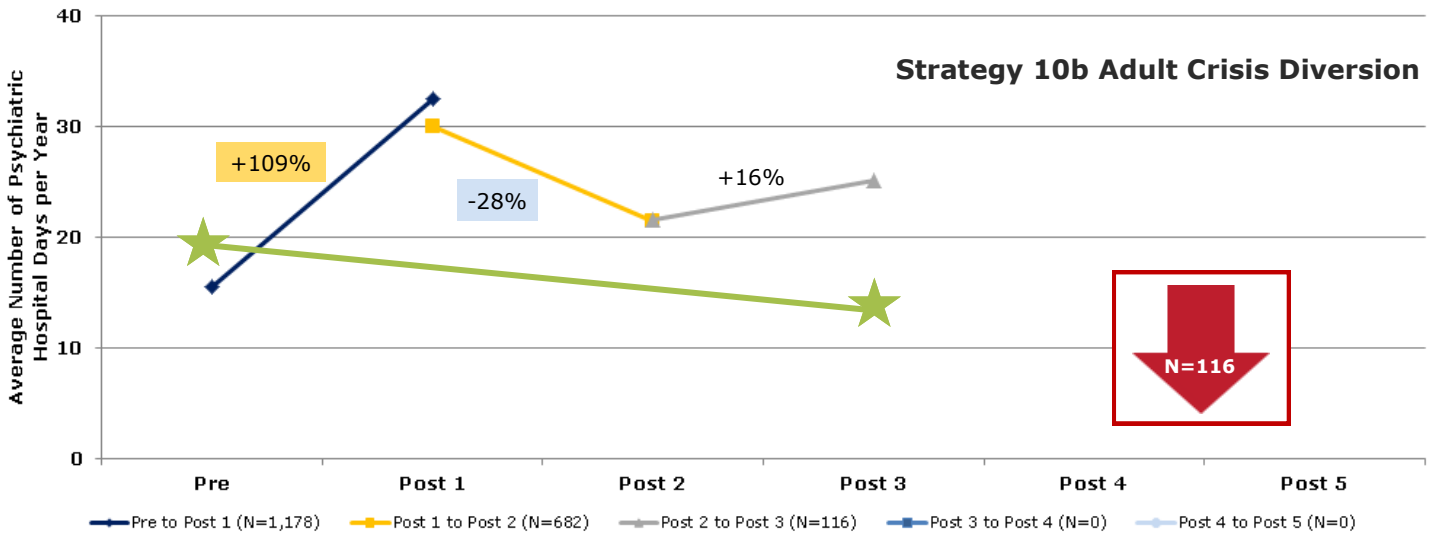

Strategy 3a Supportive Housing
Average Number of Psychiatric Hospital Days per Year
50
40
30
20
10
0
-54%
+17%
+7%
+15%
+5%
N=93
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=336)
Post 1 to Post 2 (N=290)
Post 2 to Post 3 (N=244)
Post 3 to Post 4 (N=175)
Post 4 to Post 5 (N=93)

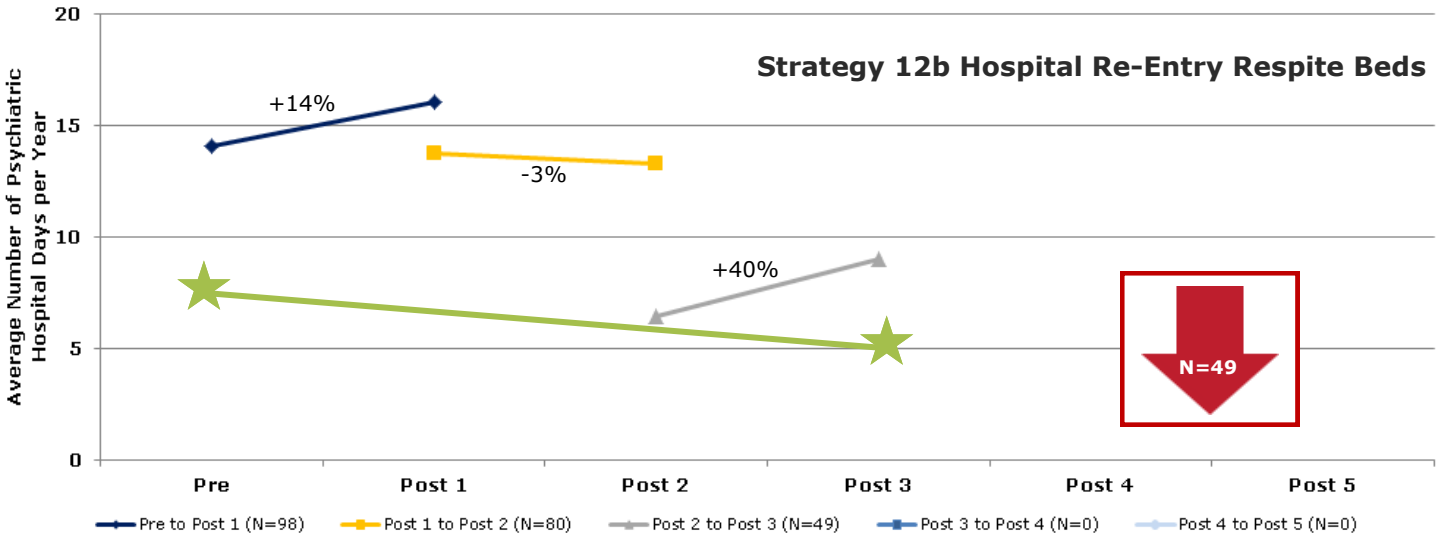

Strategy 12c Psychiatric Emergency Services Linkage
Average Number of Psychiatric Hospital Days per Year
30
20
10
0
+22%
-36%
-22%
+15%
+36%
N=93
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=187)
Post 1 to Post 2 (N=168)
Post 2 to Post 3 (N=142)
Post 3 to Post 4 (N=128)
Post 4 to Post 5 (N=93)



Incremental Change Over Time for Individuals with Emergency Department Use Who Were Served in Crisis Response and Respite Strategies






Strategy 12b Hospital Re-Entry Respite Beds
Average Number of Psychiatric Hospital Days per Year
20
15
10
5
0
+14%
-3%
+40%
N=49
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=98)
Post 1 to Post 2 (N=80)
Post 2 to Post 3 (N=49)
Post 3 to Post 4 (N=0)
Post 4 to Post 5 (N=0)

Effectiveness of MIDD Strategies in Reducing Jail Use

Eleven MIDD strategies had a primary policy goal of reducing jail use by individuals with mental illness or drug dependency. Another three strategies listed this policy goal as secondary. Reducing jail recycling for MIDD clients was a primary objective for five other strategies, and diversion from initial or further justice system involvement was indicated as either a primary or secondary goal for 11 strategies, as shown in the grid below. Strategies grayed out in the table above were never implemented or were piloted without adequate data for change over time analysis.

			MIDD Policy Goals Relevant to Jail Use		
Strategy Number	**Strategy Name**	**Strategy Description**	**Reduce Jail Use**	**Reduce Jail Recycling**	**Divert from Justice System**
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+		
1a-2	Substance Use Disorder Treatment	Increase Access to Community Substance Use Disorder (SUD) Treatment	+		
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities	✪		
1c	Emergency Room Intervention	Emergency Room Substance Abuse Early Intervention Program	✪		
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	✪		
3a	Supportive Housing	Supportive Services for Housing Projects	✪		
4b	SUD Prevention for Children	Prevention Services to Children of Substance Abusing Parents			+
4c	School-Based Services	Collaborative School-Based Mental Health and Substance Abuse Services			+
5a	Juvenile Justice Assessments	Expand Assessments for Youth in the Juvenile Justice System		✪	✪
6a	Wraparound	Wraparound Services for Emotionally Disturbed Youth	✪		✪
7a	Youth Reception Centers	Reception Centers for Youth in Crisis	✪		✪
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	✪		+
8a	Family Treatment Court	Family Treatment Court Expansion		✪	
9a	Juvenile Drug Court	Juvenile Drug Court Expansion			✪
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	✪		✪
11a	Increase Jail Liaison Capacity	Increase Jail Liaison Capacity		✪	
11b	Mental Health Courts	Increase Services for New or Existing Mental Health Court Programs			✪
12a	Jail Re-Entry& Education Classes	Jail Re-Entry Program Capacity Increase & Education Classes at Community Center for Alternative Programs (CCAP)		✪	
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	✪		
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	✪		
12d	Behavior Modification Classes	Behavior Modification Classes for CCAP Clients		✪	
15a	Adult Drug Court	Adult Drug Court Expansion of Recovery Support Services			✪
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	✪		
17a	Crisis Intervention/MH Partnership	Crisis Intervention Team/Mental Health Partnership Pilot	+		
17b	Safe Housing - Child Prostitution	Safe Housing and Treatment for Children in Prostitution Pilot			+

Key: ✪ = **Primary Goal** + = **Secondary Goal**

Jail Use Reduction Goals

Separate goals for adults and youth (below right) were established in an Evaluation Targets Addendum dated September 2, 2008. For adults, an extra five percent reduction per year was recently added to account for overall declines in general population jail use between 2008 and 2013. Incremental reductions are those that occur from one measurement period to the next, starting from the pre period (or the year prior to the start of MIDD services). Cumulative reductions refer to the ultimate changes from the pre period to each post period. The green line shown on graphs over the next several pages indicates the ultimate expected reduction from Pre to Post 5 for strategy participants eligible for the longest time period who had jail use in any time period, unless stated otherwise.

	Adult			Youth	
Period	**Incremental**	**Additional**	**Cumulative**	**Incremental**	**Cumulative**
Post 1	-5%	-5%	-10%	-10%	-10%
Post 2	-10%	-5%	-25%	-10%	-20%
Post 3	-10%	-5%	-40%	-10%	-30%
Post 4	-10%	-5%	-55%	-10%	-40%
Post 5	-10%	-5%	-70%	-10%	-50%

Factors Impacting Assessment of Effectiveness

Low Incidence of Incarceration

Strategies with jail use rates lower than 40 percent of all who are eligible may take longer to achieve their reduction goals.

- Strategy 1a-1—Mental Health Treatment
- Strategy 1a-2b—Opiate SUD Treatment
- Strategy 1c—Emergency Room Intervention
- Strategy 1d—Crisis Next Day Appointments
- Strategy 6a—Wraparound
- Strategy 16a—New Housing & Rental Subsidies

Small Sample Size

It is more difficult for strategies serving fewer clients to show significant change over time.

- Strategy 8a—Family Treatment Court
- Strategy 9a—Juvenile Drug Court
- Strategy 12c—Psychiatric Emergency Svcs Link
- Strategy 12d– Behavior Modification Classes
- Strategy 16a—New Housing & Rental Subsidies

Factors Impacting Effectiveness Results

Fewer Jail Days Prior to the MIDD

Strategies with fewer average jail days in the pre period have less room for improvement.

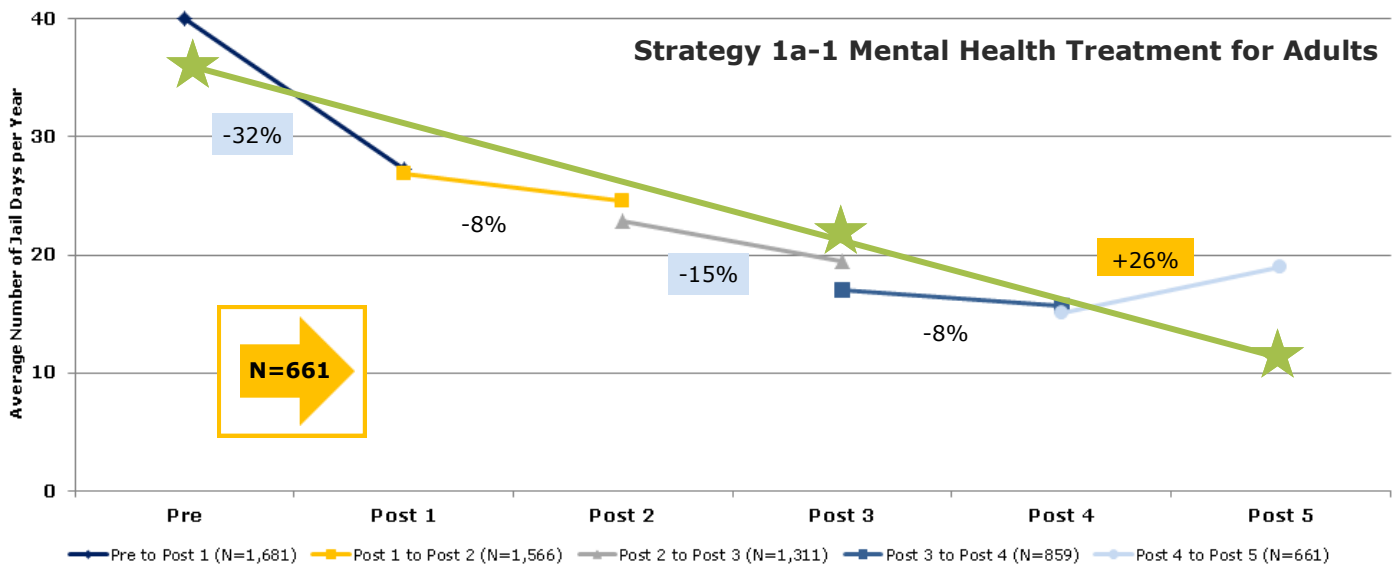
- Strategy 5a—Juvenile Justice Assessments
- Strategy 8a—Family Treatment Court

Increases in Jail Use Associated with Start of MIDD Services

Several strategies showed significant increases in average jail days during the first year of MIDD services. For therapeutic courts, jail sanctions are often used to increase program compliance. For criminal justice programs, adjudication of additional charges may factor in. Strategies with first year increases may need extra time to reach their goals.

- Strategy 1c—Emergency Room Intervention
- Strategy 5a—Juvenile Justice Assessments
- Strategy 9a—Juvenile Drug Court
- Strategy 12a2b—CCAP DV Education Classes
- Strategy 12d—Behavior Modification Classes
- Strategy 15a—Adult Drug Court

Incremental Change Over Time for Individuals with Jail Use Who Were Served in Mental Health and Support Strategies



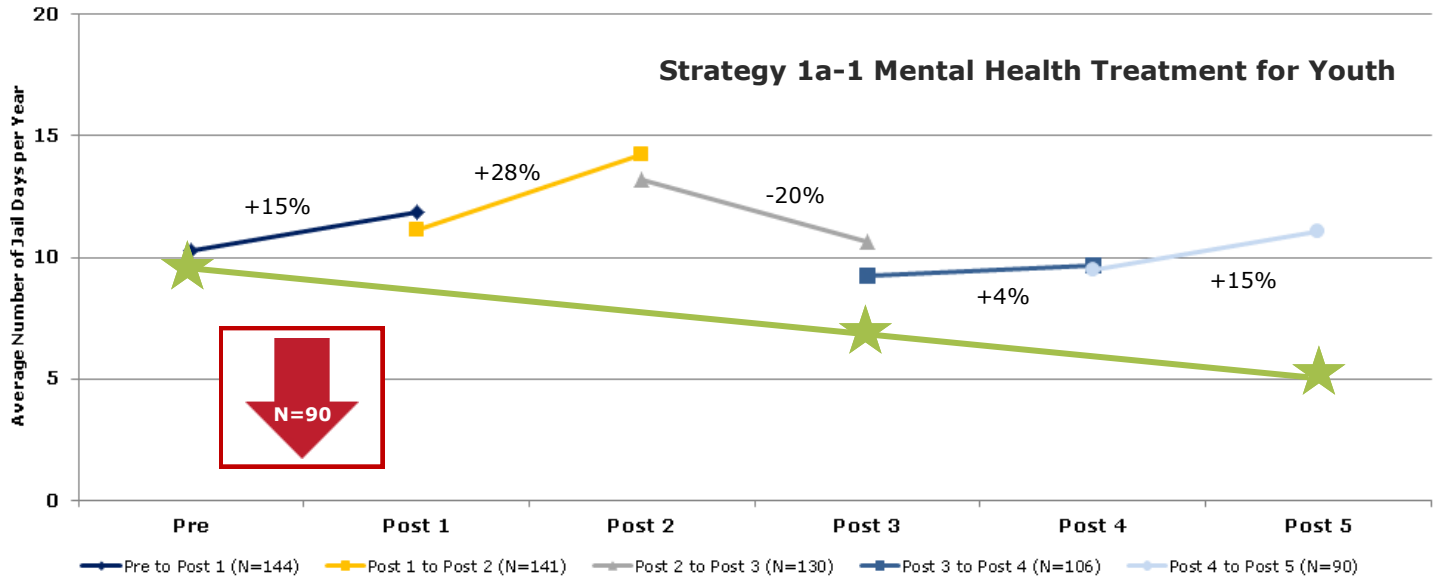
Key:

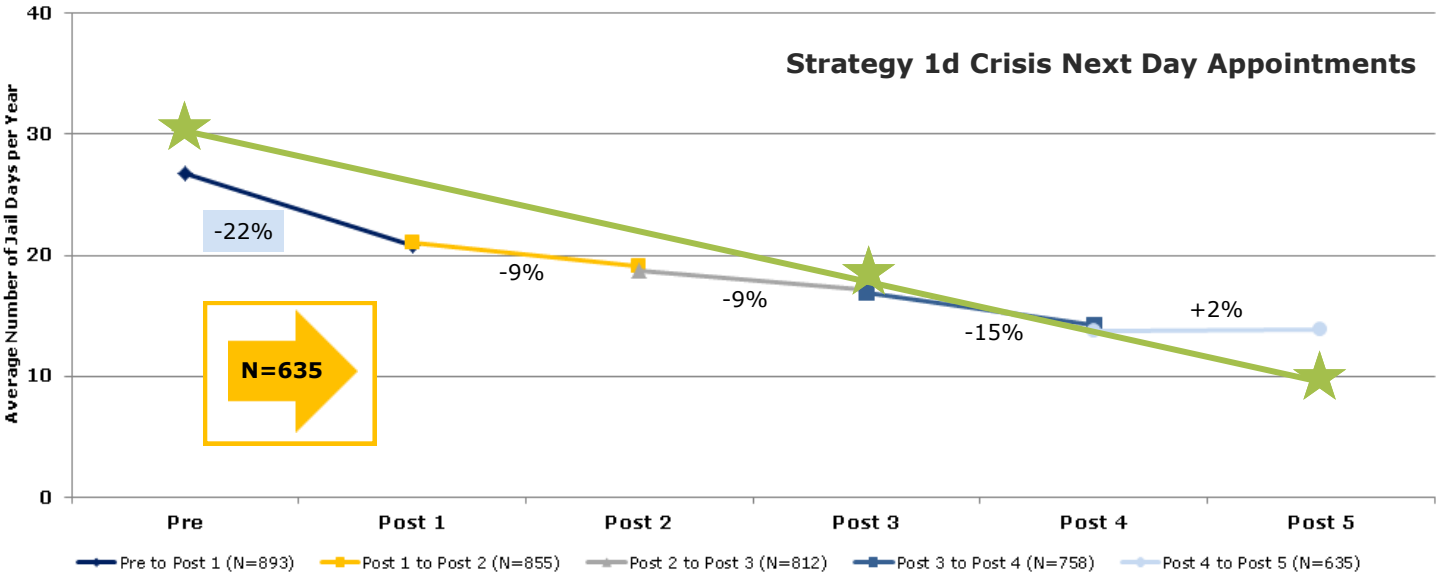
Ultimate targeted reduction goal was met by sample of strategy participants eligible for longest post period who had jail use in any period.

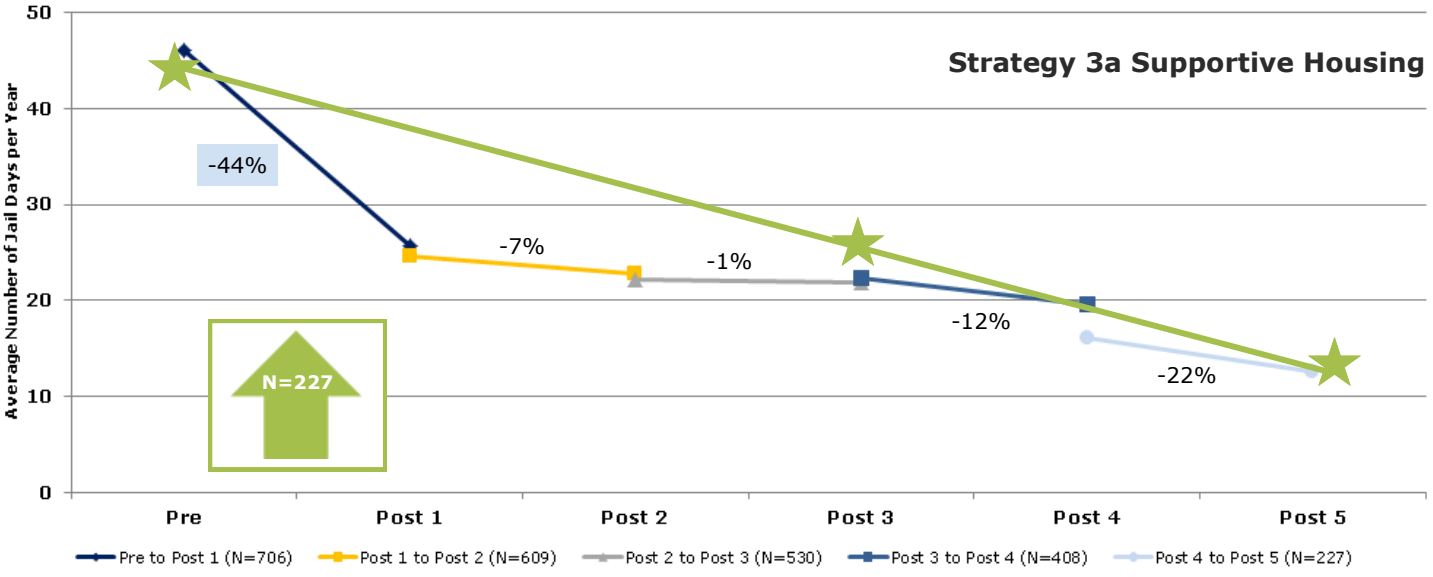
Strategy was on pace to meet ultimate targeted reduction goal, but an unexpected shift in the data pattern prevented goal attainment.

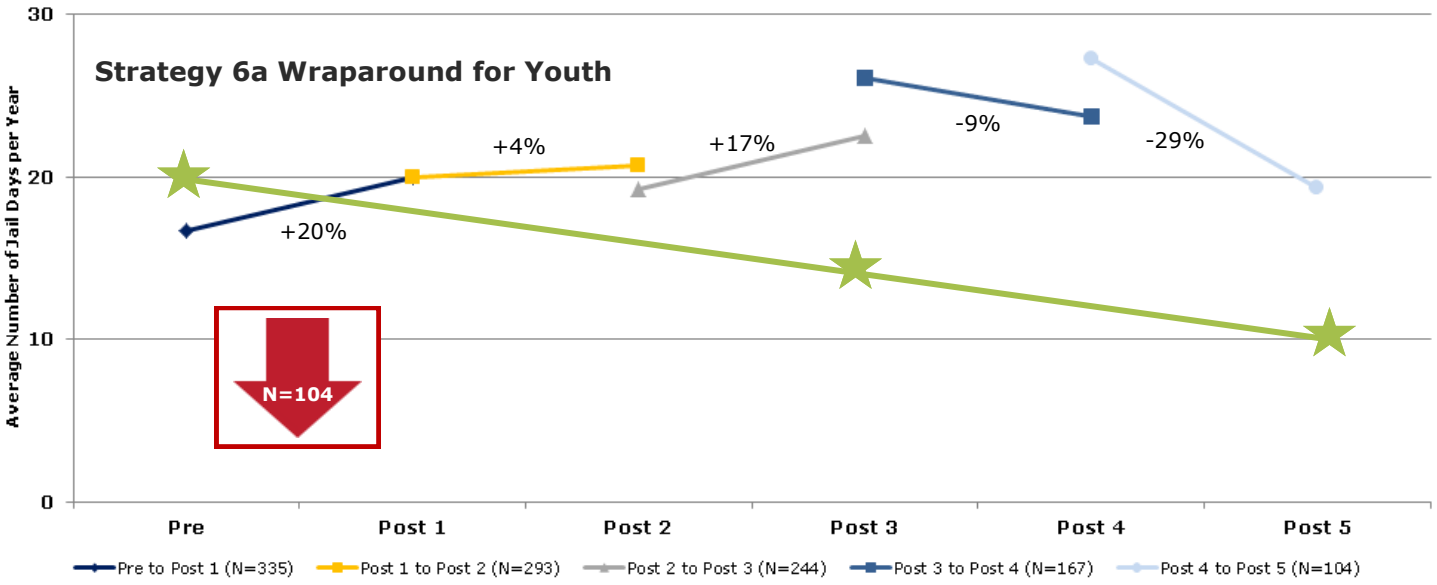
Ultimate targeted reduction goal is not expected to be met based on trends noted in currently available data.

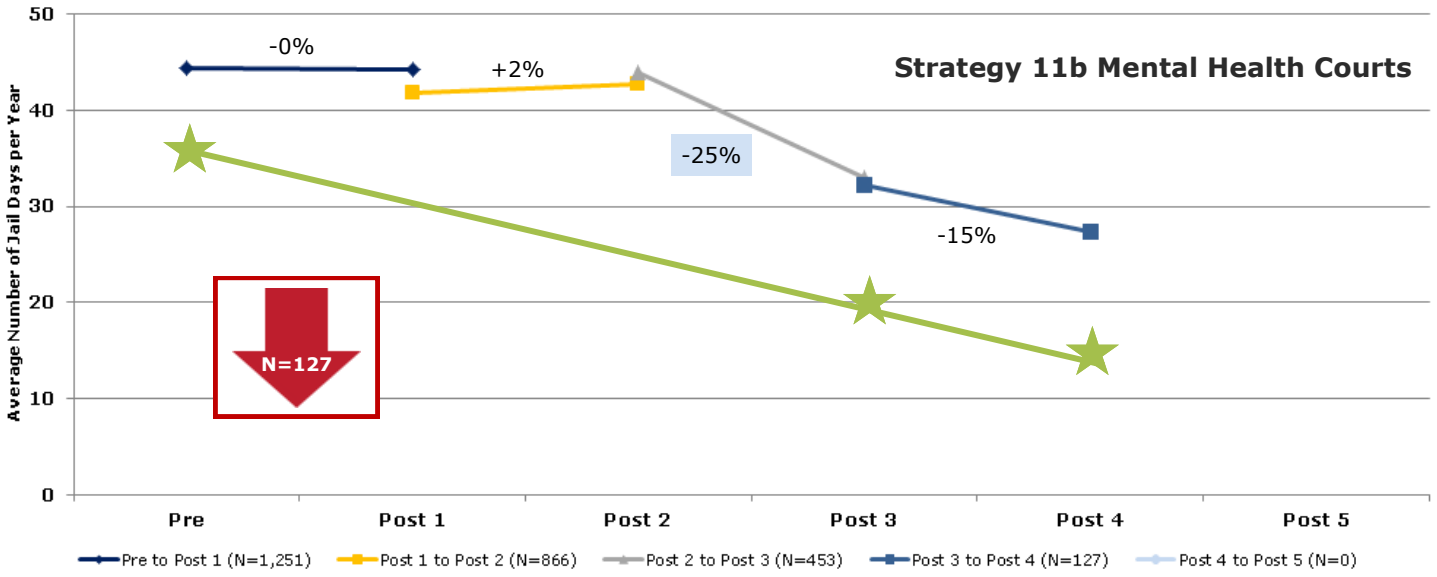
Statistically significant reductions are highlighted in blue. Statistically significant increases are highlighted in yellow.

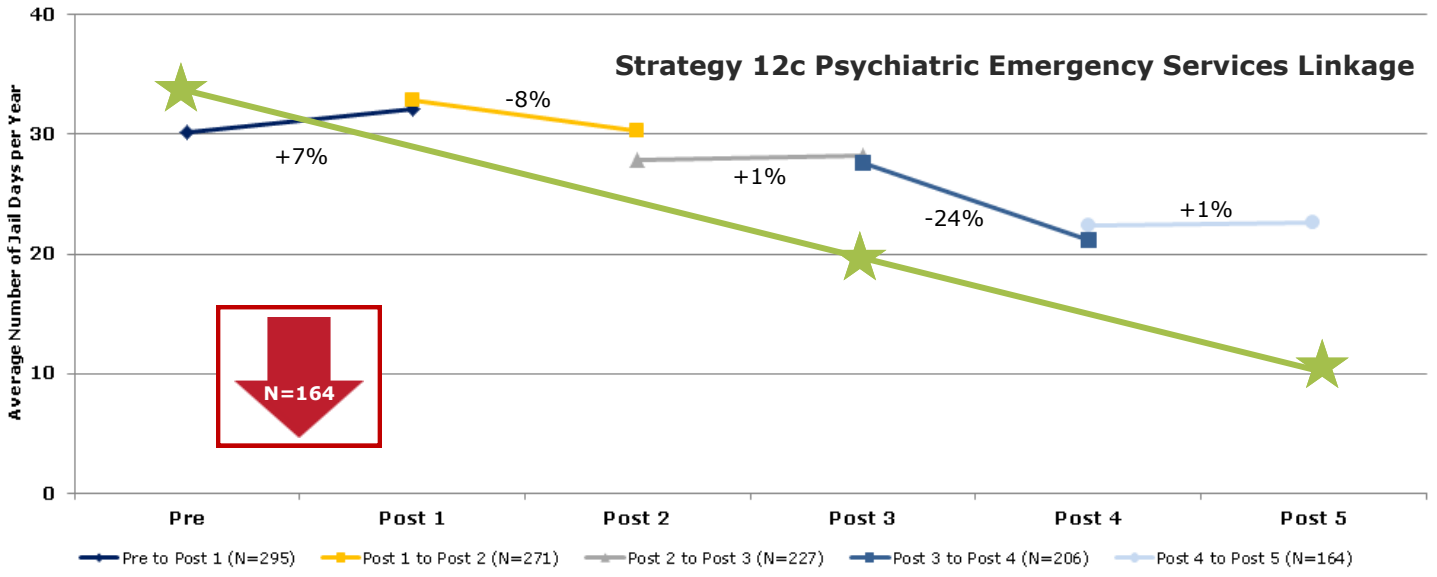

Strategy 1a-1 Mental Health Treatment for Youth
Average Number of Jail Days per Year
20
15
10
5
0
+15%
+28%
-20%
+4%
+15%
N=90
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=144)
Post 1 to Post 2 (N=141)
Post 2 to Post 3 (N=130)
Post 3 to Post 4 (N=106)
Post 4 to Post 5 (N=90)

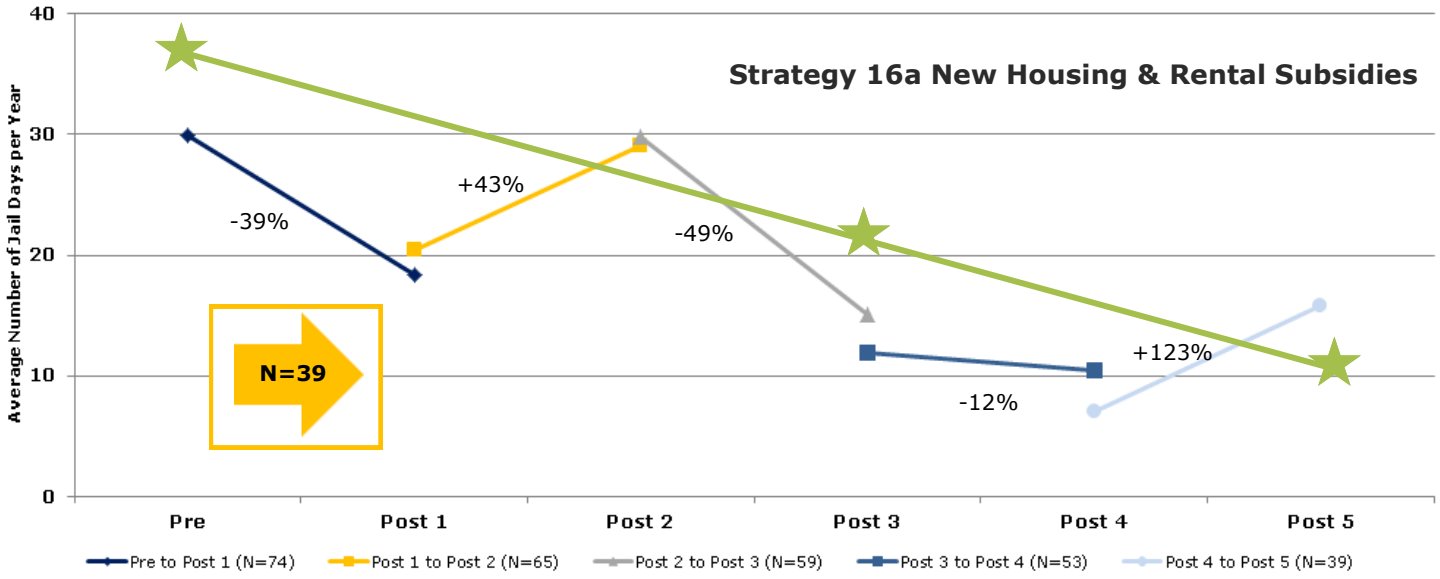

Strategy 1d Crisis Next Day Appointments
Average Number of Jail Days per Year
40
30
20
10
0
-22%
-9%
-9%
-15%
+2%
N=635
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=893)
Post 1 to Post 2 (N=855)
Post 2 to Post 3 (N=812)
Post 3 to Post 4 (N=758)
Post 4 to Post 5 (N=635)


Strategy 3a Supportive Housing
Average Number of Jail Days per Year
50
40
30
20
10
0
-44%
-7%
-1%
-12%
-22%
N=227
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=706)
Post 1 to Post 2 (N=609)
Post 2 to Post 3 (N=530)
Post 3 to Post 4 (N=408)
Post 4 to Post 5 (N=227)

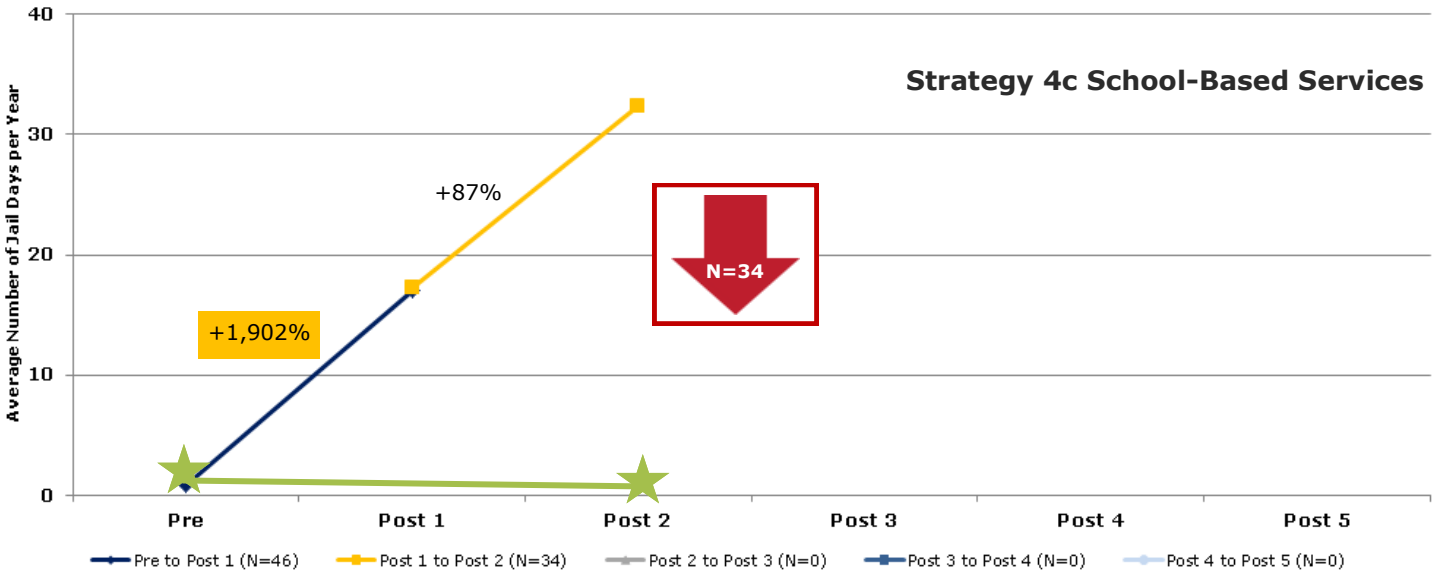

Strategy 6a Wraparound for Youth
Average Number of Jail Days per Year
30
20
10
0
+20%
+4%
+17%
-9%
-29%
N=104
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=335)
Post 1 to Post 2 (N=293)
Post 2 to Post 3 (N=244)
Post 3 to Post 4 (N=167)
Post 4 to Post 5 (N=104)


Strategy 11b Mental Health Courts
Average Number of Jail Days per Year
50
40
30
20
10
0
-0%
+2%
-25%
-15%
N=127
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,251)
Post 1 to Post 2 (N=866)
Post 2 to Post 3 (N=453)
Post 3 to Post 4 (N=127)
Post 4 to Post 5 (N=0)

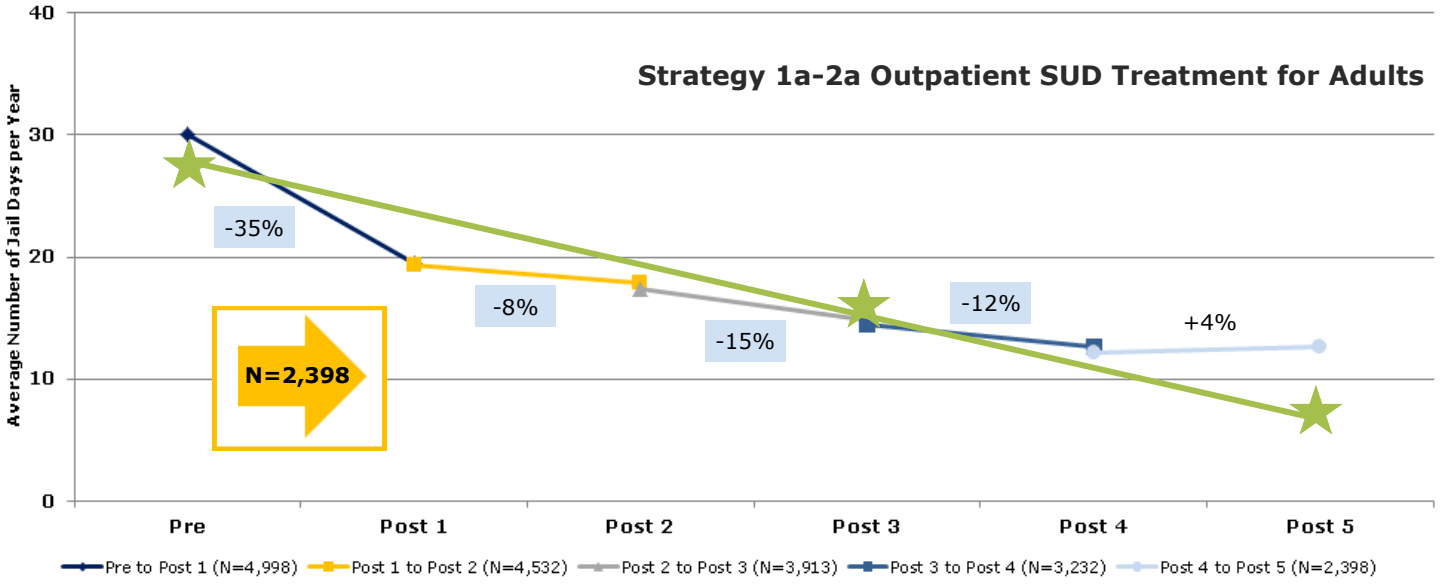

Strategy 12c Psychiatric Emergency Services Linkage
Average Number of Jail Days per Year
40
30
20
10
0
+7%
-8%
+1%
-24%
+1%
N=164
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=295)
Post 1 to Post 2 (N=271)
Post 2 to Post 3 (N=227)
Post 3 to Post 4 (N=206)
Post 4 to Post 5 (N=164)

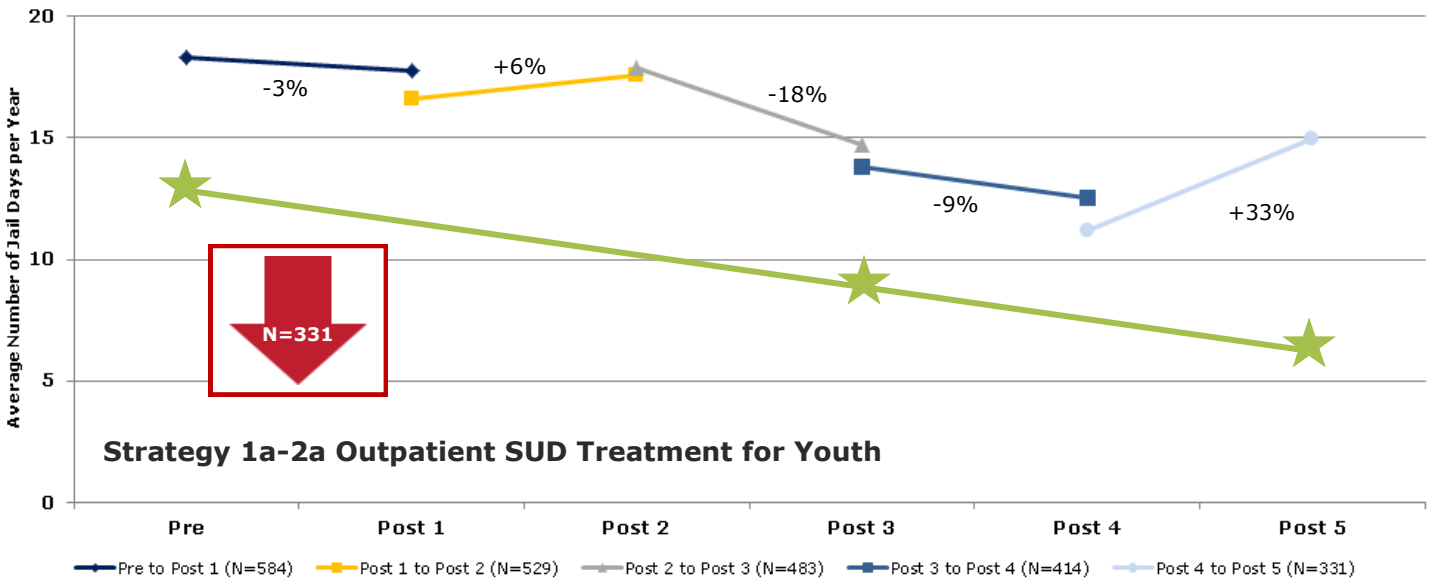


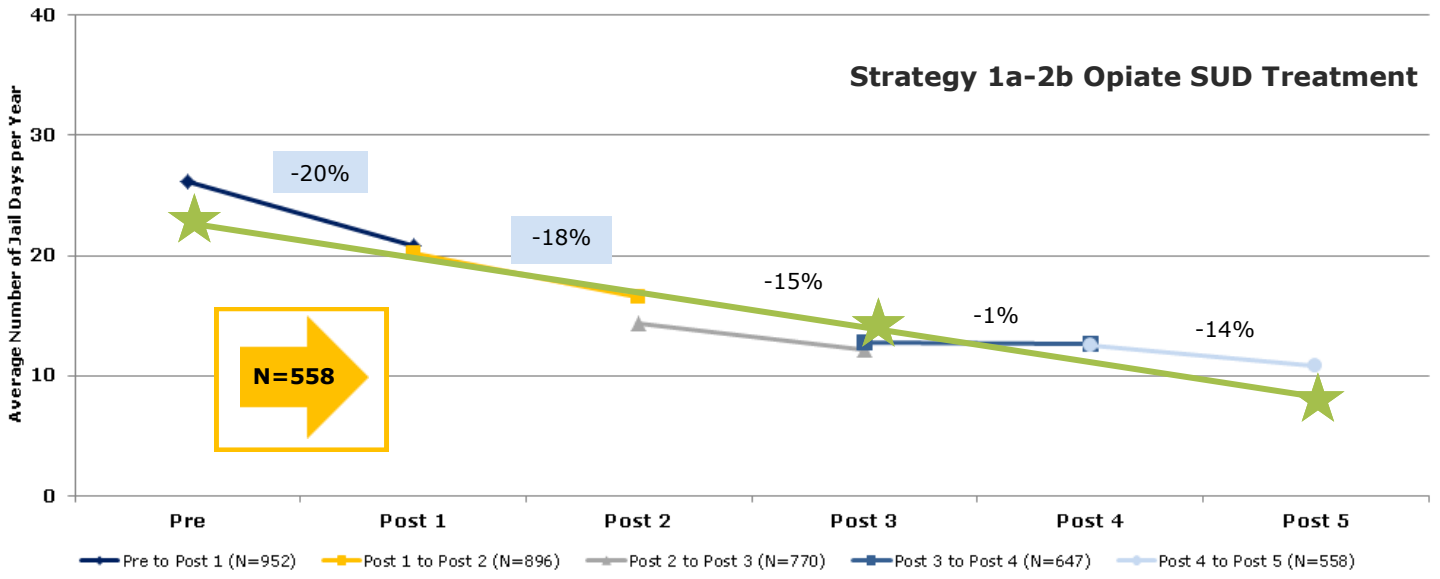
Strategies that began operating with MIDD funds after October 2011, such as Strategy 4c—School-Based Services, have limited data for effectiveness analysis. Of the 46 students eligible for the first post period who had any secure detentions, their average number of days detained increased from 0.85 (Pre) to 17.02 (Post 1). The subset of those students who were eligible for a second post period further increased their average days detained from 17.24 (Post 1) to 32.32 (Post 2). There were no students eligible for the third post period who had any detentions at all, as shown below.

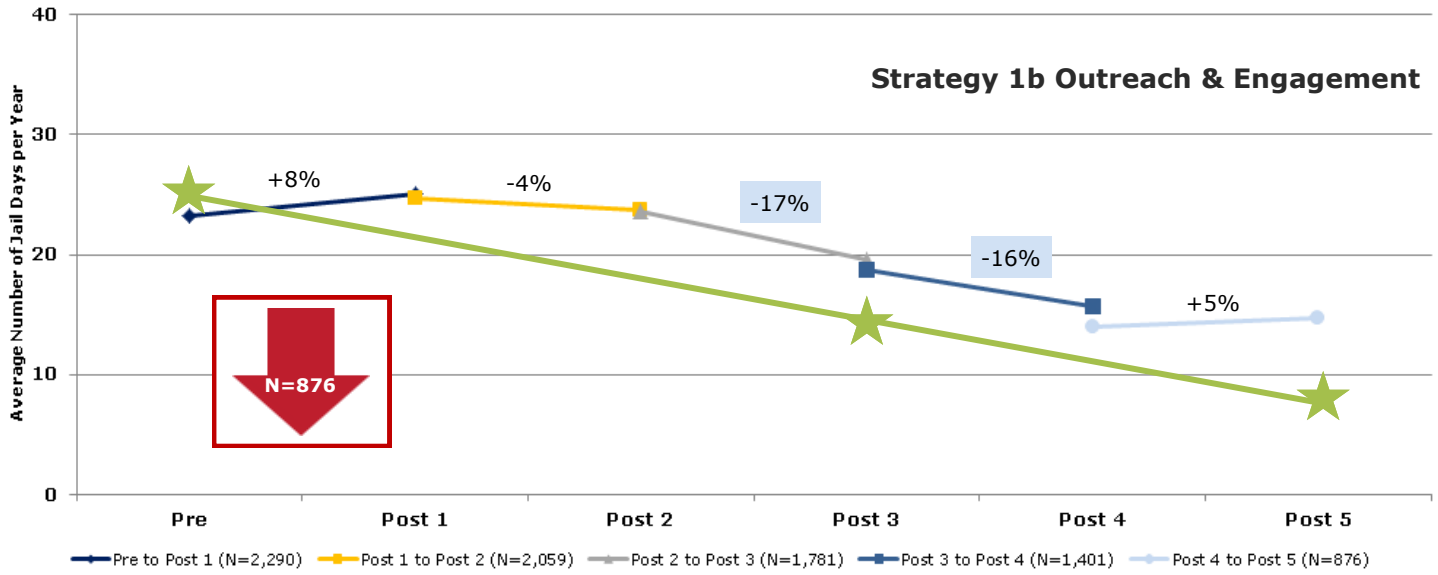


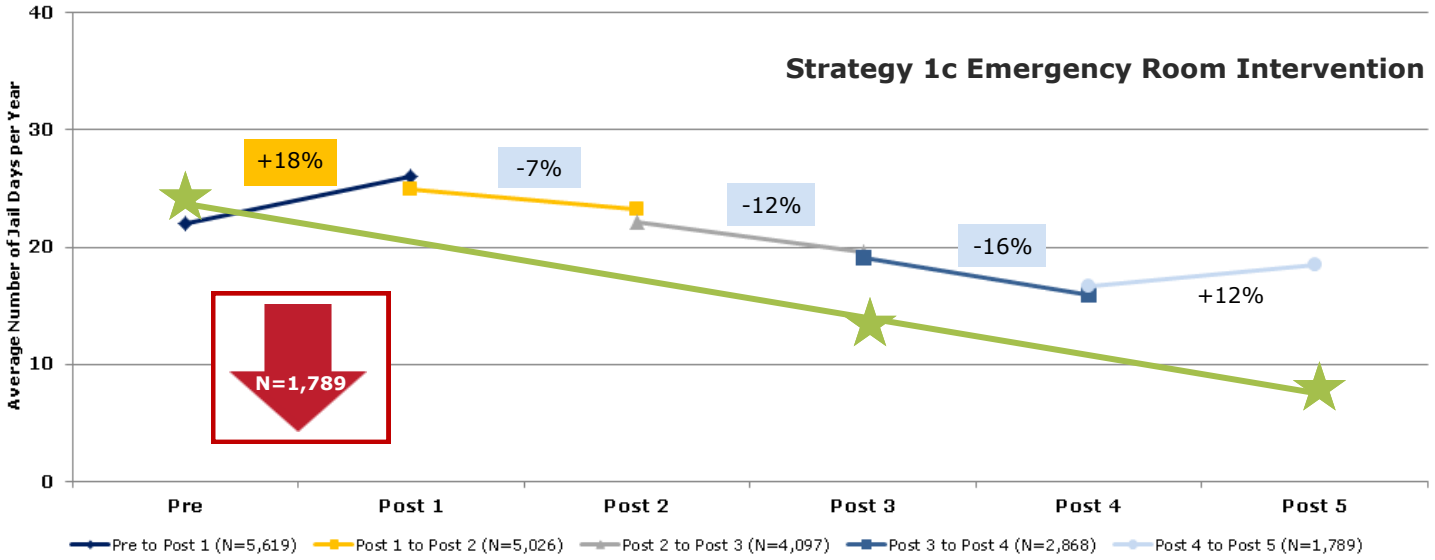
Incremental Change Over Time for Individuals with Jail Use Who Were Served in Substance Use Disorder (SUD) and Related Outreach Strategies

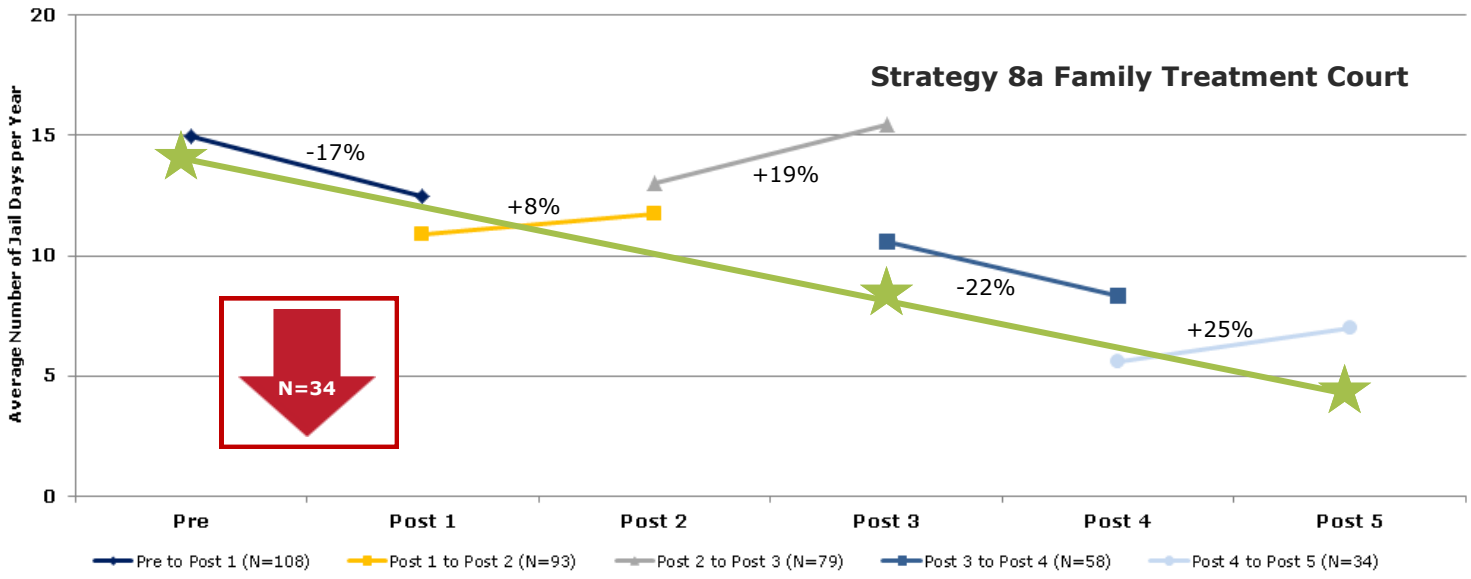


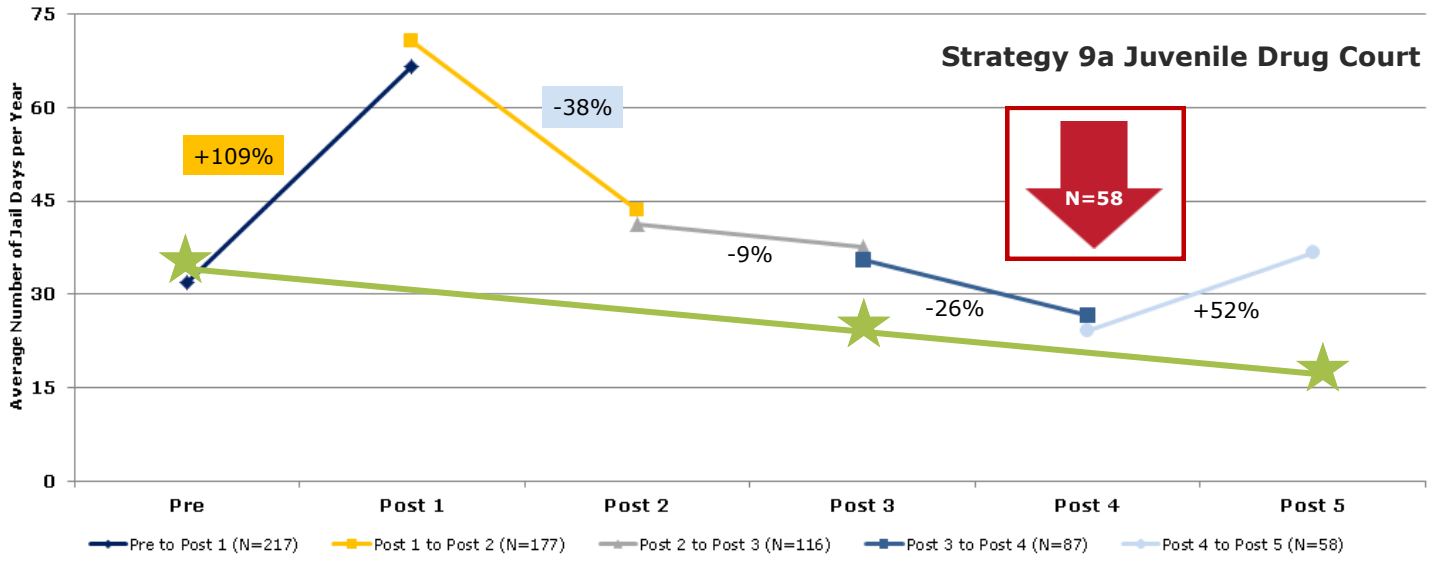


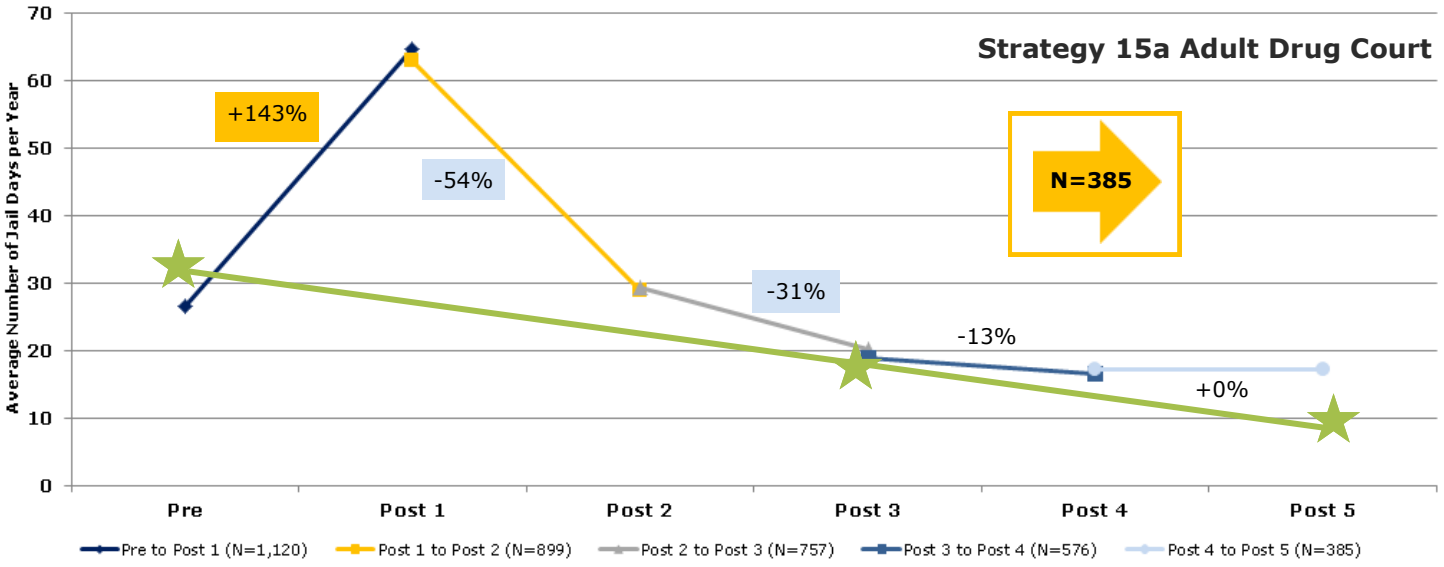



Strategy 1b Outreach & Engagement
Average Number of Jail Days per Year
40
30
20
10
0
+8%
-4%
-17%
-16%
+5%
N=876
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=2,290)
Post 1 to Post 2 (N=2,059)
Post 2 to Post 3 (N=1,781)
Post 3 to Post 4 (N=1,401)
Post 4 to Post 5 (N=876)

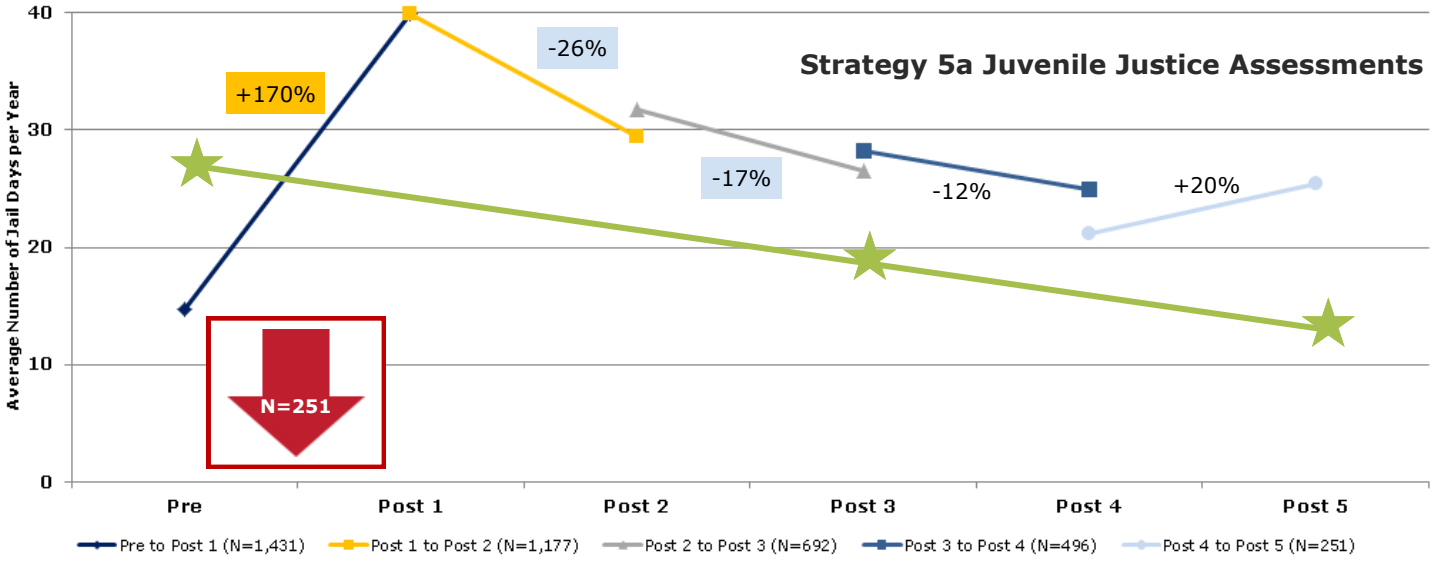

Strategy 1c Emergency Room Intervention
Average Number of Jail Days per Year
40
30
20
10
0
+18%
-7%
-12%
-16%
+12%
N=1,789
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=5,619)
Post 1 to Post 2 (N=5,026)
Post 2 to Post 3 (N=4,097)
Post 3 to Post 4 (N=2,868)
Post 4 to Post 5 (N=1,789)

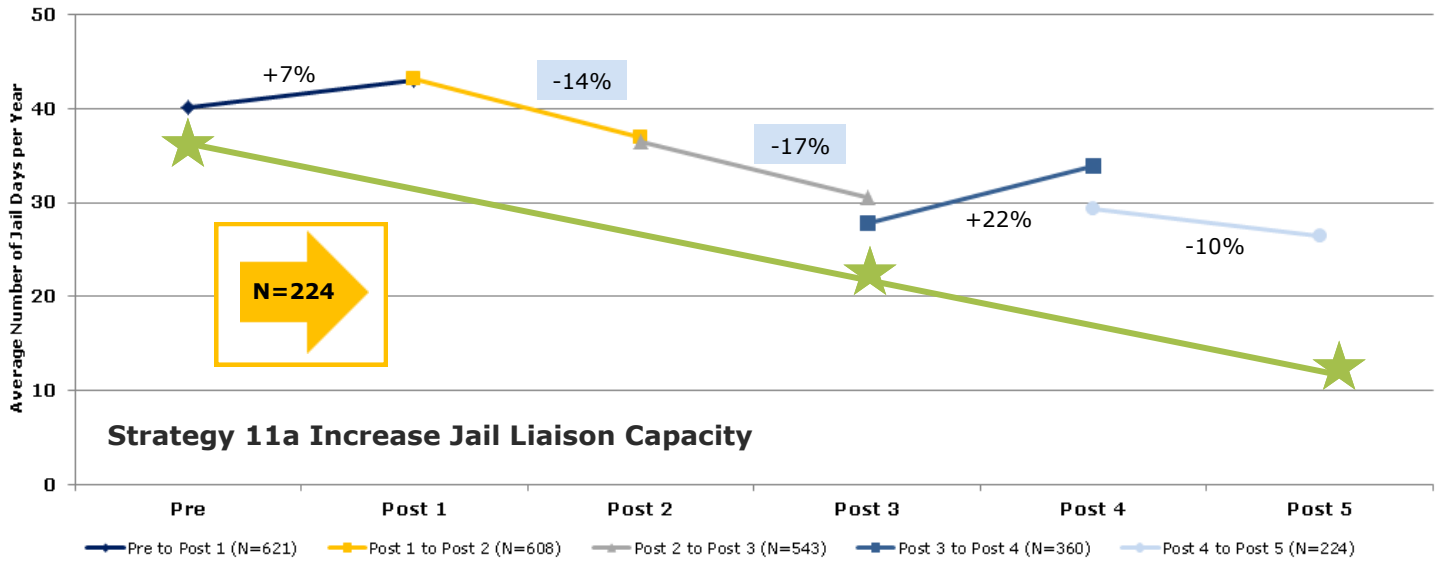

Strategy 8a Family Treatment Court
Average Number of Jail Days per Year
20
15
10
5
0
-17%
+8%
+19%
-22%
+25%
N=34
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=108)
Post 1 to Post 2 (N=93)
Post 2 to Post 3 (N=79)
Post 3 to Post 4 (N=58)
Post 4 to Post 5 (N=34)

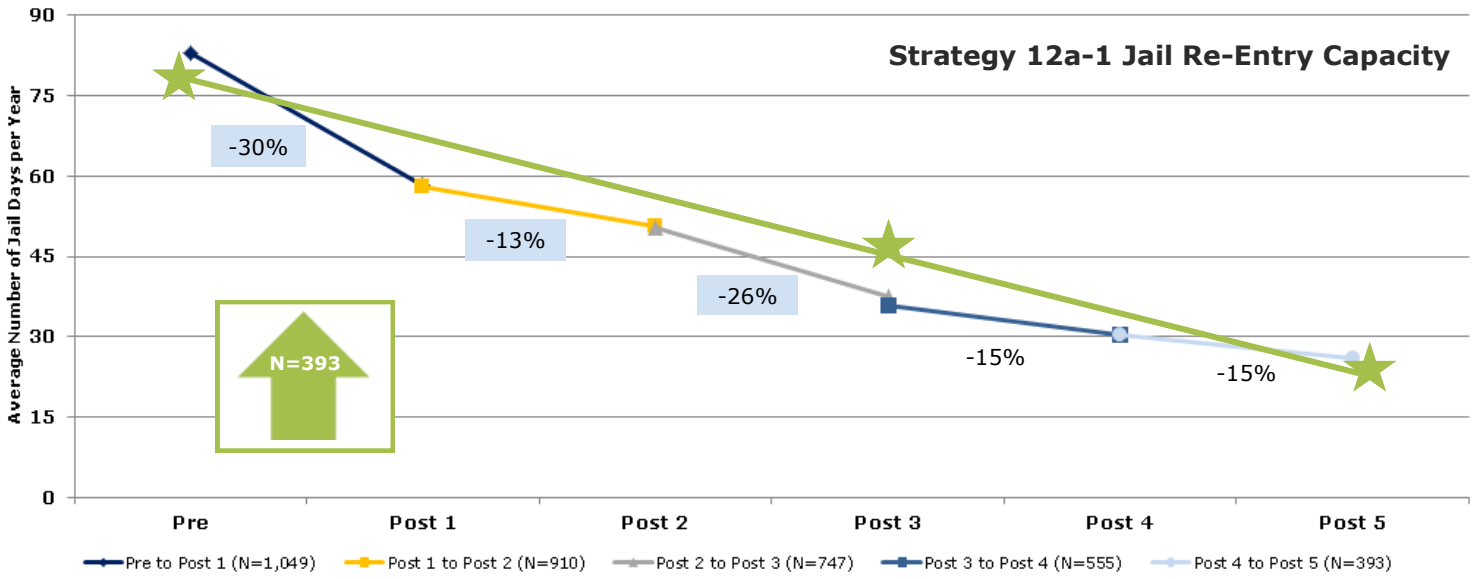

Strategy 9a Juvenile Drug Court
Average Number of Jail Days per Year
75
60
45
30
15
0
+109%
-38%
-9%
-26%
+52%
N=58
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=217)
Post 1 to Post 2 (N=177)
Post 2 to Post 3 (N=116)
Post 3 to Post 4 (N=87)
Post 4 to Post 5 (N=58)

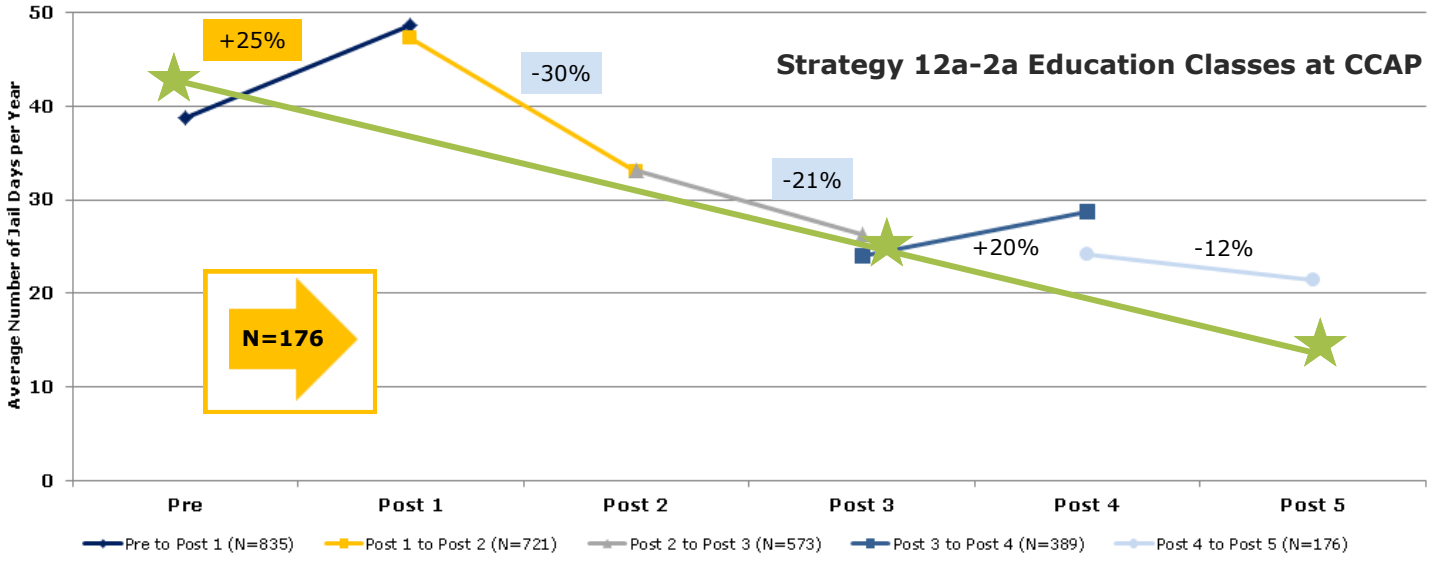

Strategy 15a Adult Drug Court
Average Number of Jail Days per Year
70
60
50
40
30
20
10
0
+143%
-54%
-31%
-13%
+0%
N=385
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,120)
Post 1 to Post 2 (N=899)
Post 2 to Post 3 (N=757)
Post 3 to Post 4 (N=576)
Post 4 to Post 5 (N=385)

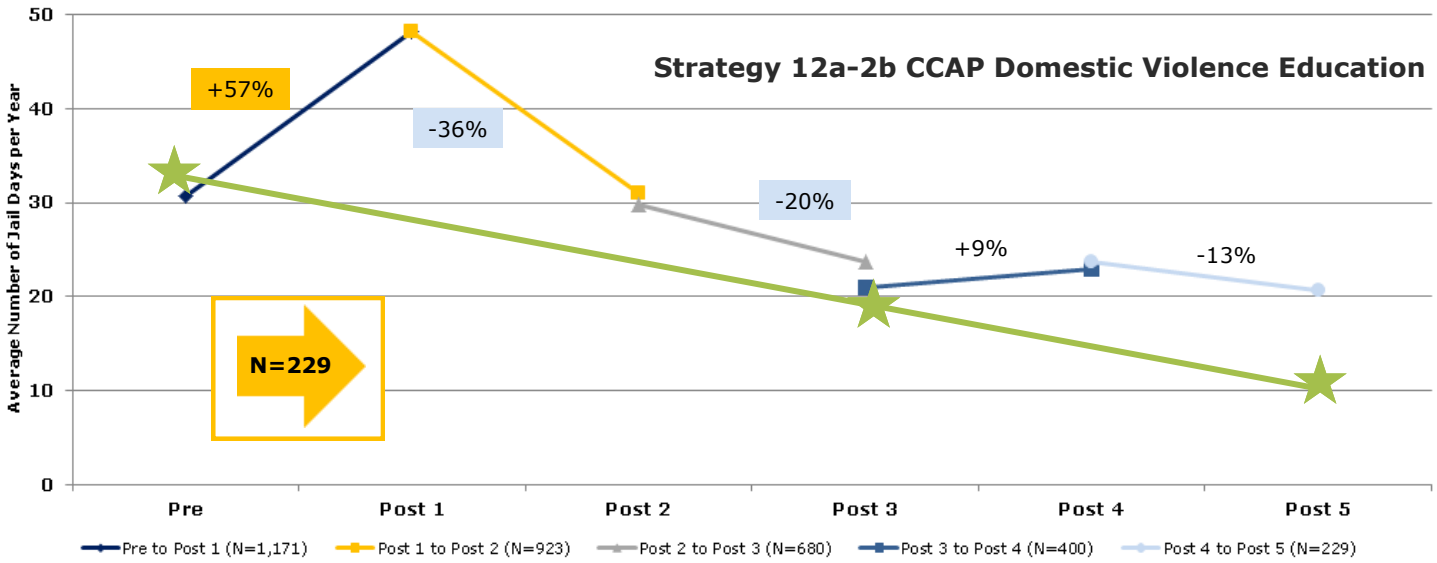
Incremental Change Over Time for Individuals with Jail Use Who Were Served in Criminal Justice Initiative Strategies

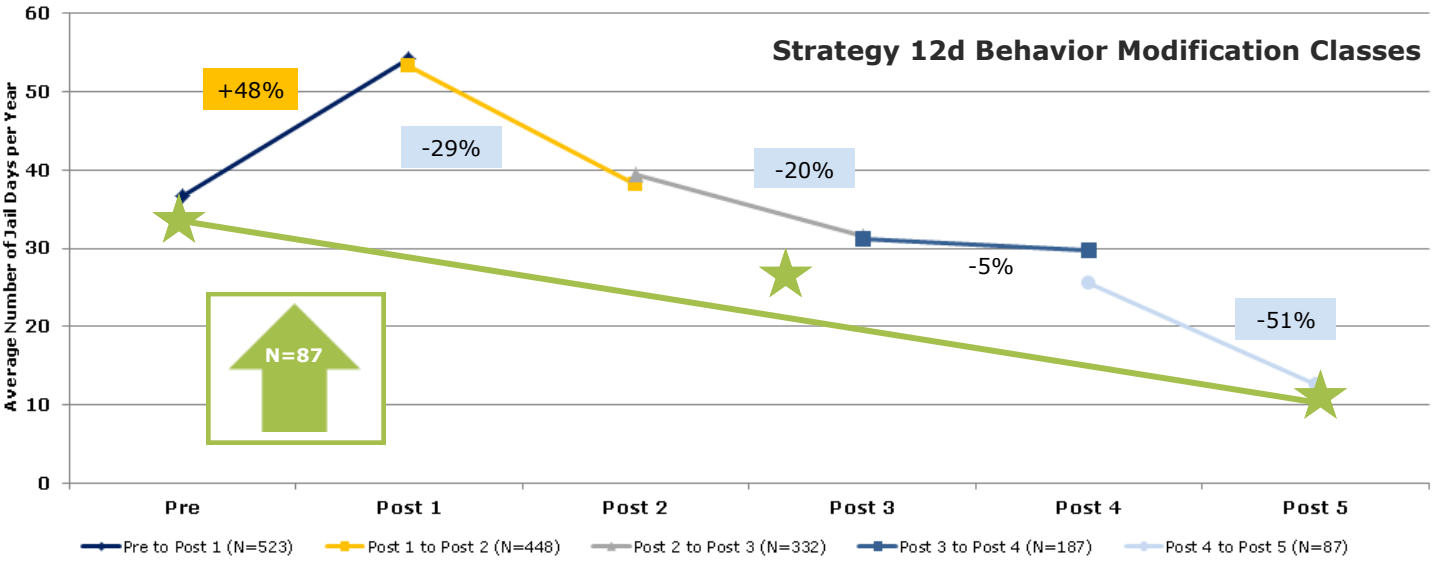






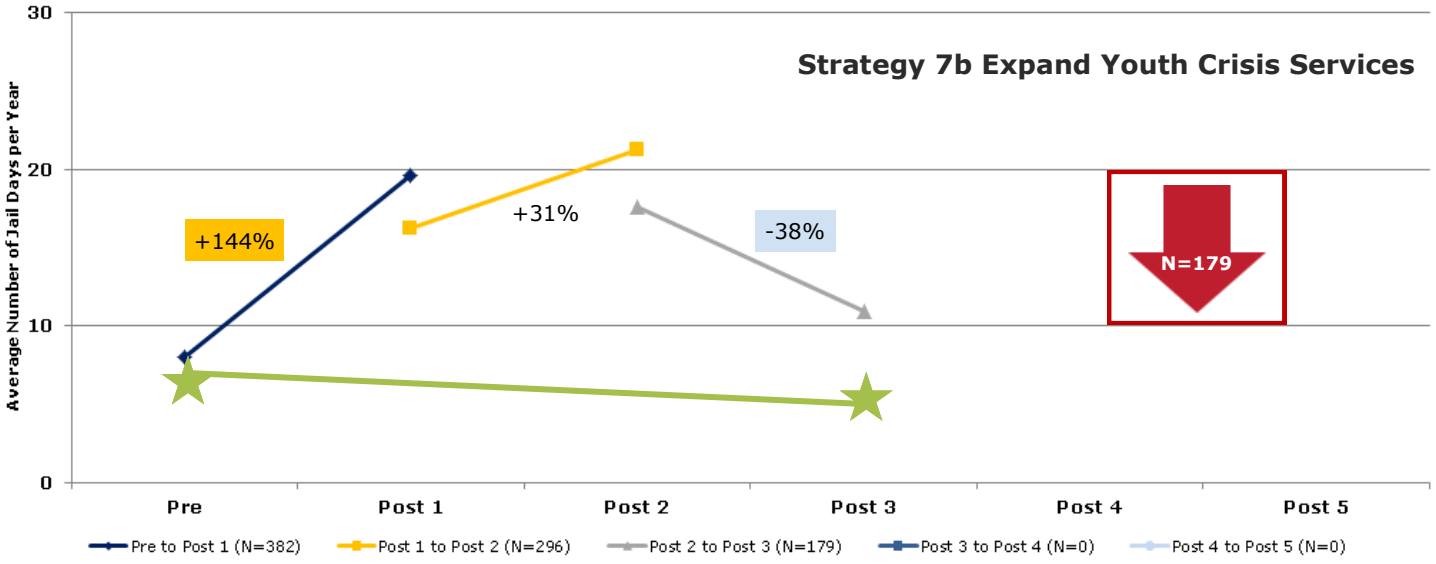

Strategy 12a-2a Education Classes at CCAP
Average Number of Jail Days per Year
50
40
30
20
10
0
+25%
-30%
-21%
+20%
-12%
N=176
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=835)
Post 1 to Post 2 (N=721)
Post 2 to Post 3 (N=573)
Post 3 to Post 4 (N=389)
Post 4 to Post 5 (N=176)

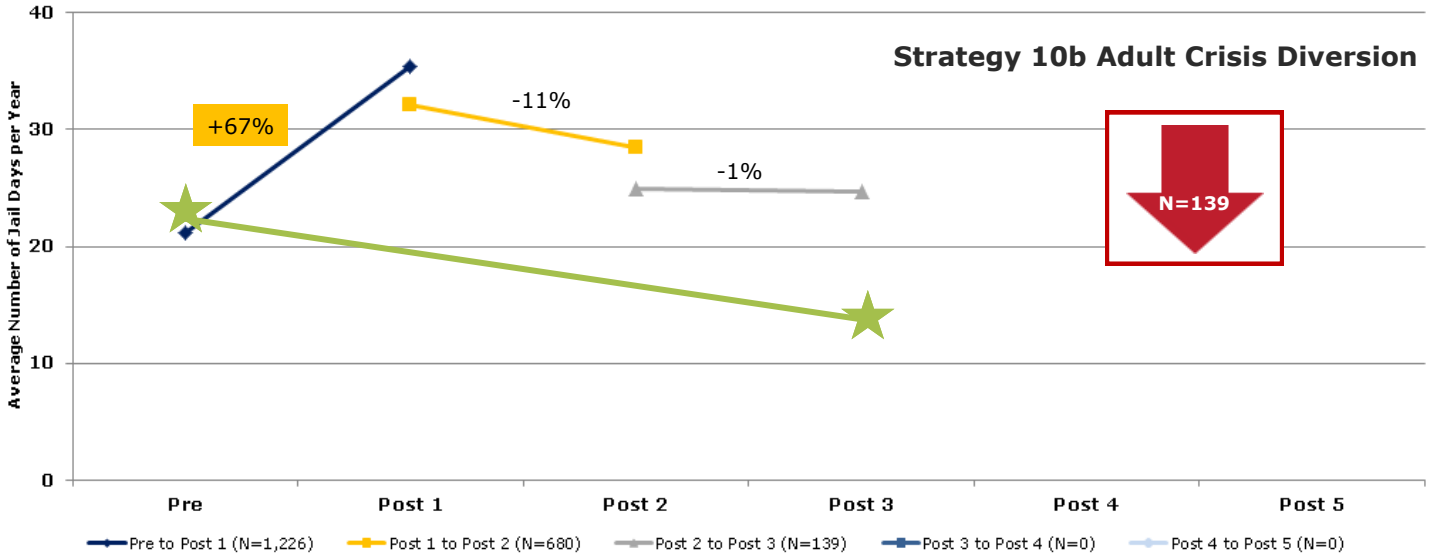

Strategy 12a-2b CCAP Domestic Violence Education
Average Number of Jail Days per Year
50
40
30
20
10
0
+57%
-36%
-20%
+9%
-13%
N=229
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=1,171)
Post 1 to Post 2 (N=923)
Post 2 to Post 3 (N=680)
Post 3 to Post 4 (N=400)
Post 4 to Post 5 (N=229)

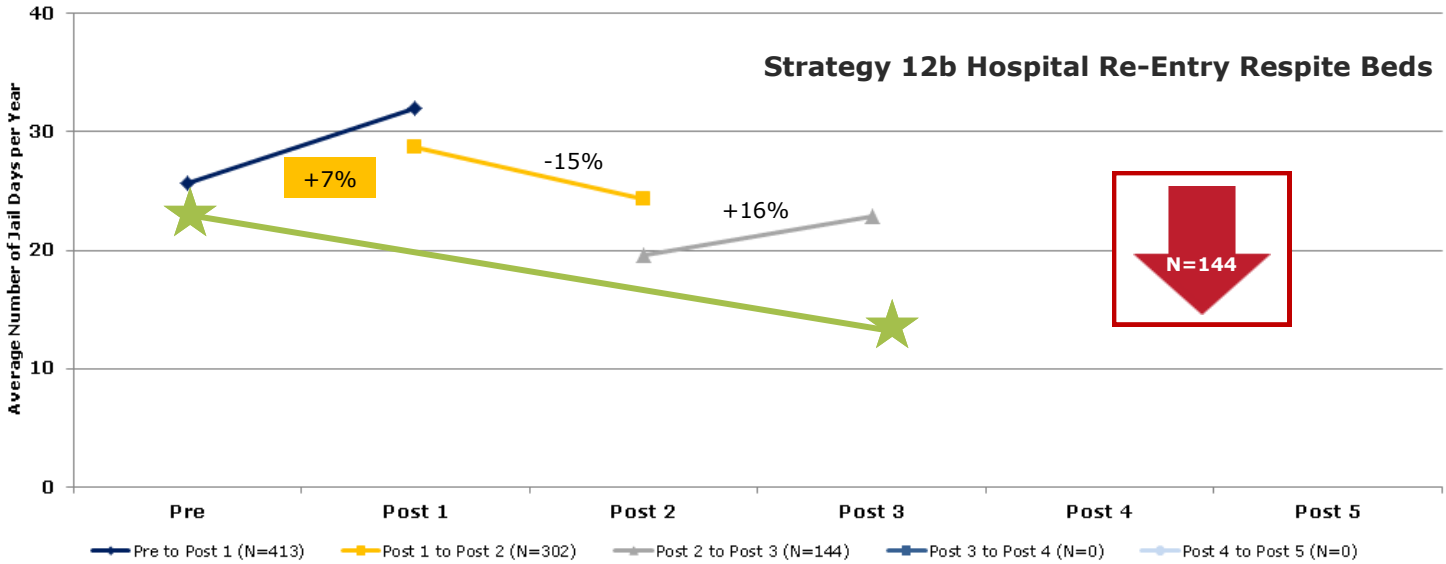

Strategy 12d Behavior Modification Classes
Average Number of Jail Days per Year
60
50
40
30
20
10
0
+48%
-29%
-20%
-5%
-51%
N=87
Pre
Post 1
Post 2
Post 3
Post 4
Post 5
Pre to Post 1 (N=523)
Post 1 to Post 2 (N=448)
Post 2 to Post 3 (N=332)
Post 3 to Post 4 (N=187)
Post 4 to Post 5 (N=87)

Incremental Change Over Time for Individuals with Jail Use Who Were Served in Crisis Response and Respite Strategies

All strategies in this category began after October 2011, so long term outcomes are not yet available.







Appendix I

Tools used in Measuring Symptom Reduction

Symptom Reduction Tool	Summary
Problem Severity Summary (PSS)	The PSS was adopted to measure mental illness symptom changes over time in adults. The PSS is an inventory used to assess the functioning level for adults in a number of life domains. Scores on the clinician-rated instrument are assigned to each dimension from *0 – Above Average: Area of strength relative to average* to *5 – Extreme impairment: Out of control, unacceptable.* The PSS assesses 14 dimensions, including symptoms of depression, anxiety, psychosis (thought disorders), and dissociation (unreality). The PSS also notes cognitive impairment.
Children's Functional Assessment Rating Scale (CFARS)	CFARS is a clinician-rated tool used for standardizing impressions from assessment of cognitive, social, and role functioning in children/youth. It includes measures for 16 domains, including depression and anxiety. Ratings are assigned using a 9-point scale where 1 is "no problem" and 9 is a "severe problem."
Addiction Severity Index (ASI)	The ASI is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client's life that may contribute to their substance-abuse problems.
PHQ-9 (part of the Patient Health Questionnaire)	The PHQ-9 has cut points of 5, 10, and 15 to indicate mild, moderate, and severe levels. Symptom reduction is analyzed by comparing changes in instrument scores within individuals over time. Questions from the PHQ-9 assess patient mood, sleeping patterns, energy, appetite, concentration, and thoughts of suicide, among others.
Generalized Anxiety Disorder (GAD-7)	The GAD-7provides an index to gauge patient anxiety levels. It has cut points of 5, 10, and 15 to indicate mild, moderate, and severe levels. Symptom reduction is analyzed by comparing changes in instrument scores within individuals over time. The GAD-7 includes questions about feeling worried, nervous, restless, annoyed, or afraid.
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)	The GAIN-SS, while not designed as a symptom reduction measure, is used to screen clients for behavioral health issues. It serves as a periodic measure of behavioral health change over time.
Global Appraisal of Individual Needs Initial (GAIN-I)	The GAIN-I has sections covering background, substance use, physical health, risk behaviors and disease prevention, mental and emotional health, environment and living situation, legal, and vocational. Within these sections are questions that address problems, services, client attitudes and beliefs, and the client's desire for services. The GAIN-I also collects information on recency of problems, breadth of symptoms, recent prevalence lifetime service utilization, recent utilization, and the frequency of recent utilization.
Pediatric Symptom Checklist (PSC-17)	This instrument rates levels of internalizing, externalizing, and attentional behaviors with a maximum score of 34. Total scale scores above 14 are considered above the clinical threshold.

Symptom Reduction Effectiveness Results

Reducing symptoms associated with mental illness and/or substance use disorder was a primary or secondary goal for 13 implemented MIDD strategies. Analysis results demonstrating symptom reduction effectiveness are summarized by strategy below, along with the source and date of the original publication if more detail is needed.

Summary of Findings or Update	Original Publication	Date
1a-1 Mental Health Treatment		
Mental health treatment providers began submitting symptom measures for adults in January 2010 and for children in April 2010. The first set of analysis data is expected in February 2011.	Third Annual Report Page 34	February 2011
The Problem Severity Summary (PSS) was used to assess changes in depression and anxiety for 1,019 adults with measures at two time points. Of those with severe or extreme anxiety (N=251) or depression (N=325) at baseline, 42 percent improved over time. The vast majority of individuals remained stable. The Children's Functional Assessment Rating Scale (CFARS) provided symptom change measures for 79 individuals aged five to 22. Of those with baseline scores above the clinical threshold for concern, 67 percent reduced depression symptoms, 61 percent reduced anxiety, and half reduced traumatic stress.	Year 3 Progress Report Page 22 and Fourth Annual Report Page 36	August 2011 and February 2012
Baseline PSS data for 2,719 people showed that many MIDD participants are severely impaired by depression (27%) or anxiety (21%). Of the 1,044 whose anxiety symptoms changed over time, 884 (85%) showed some improvement. Of the 767 people with the most severe depression during their pre period, 179 (23%) had only slight or no impairment during at least one subsequent measure. The average time associated with symptom reduction was about 15 months between measures.	Fifth Annual Report Page 60	February 2013
Analysis of baseline PSS scores for 5,364 clients showed response to stress, depression, anxiety, and social withdrawal to have the highest incidence of severe to extreme impairment. Of the 3,026 people who had PSS data at baseline and each of the next three years, the percentage who reduced their symptoms in these four categories grew over time. All incremental and long-term improvements were statistically significant. Among the 629 youth and children with CFARS ratings, depression and anxiety were again the most problematic from a symptoms standpoint. Improvements in severity over time were noted, although youth with extreme issues were very rare (less than one percent in any functional domain).	Seventh Annual Report Page 59	February 2015
1a-2a Substance Use Disorder (SUD) Outpatient Treatment		
In July 2011, SUD treatment providers were required to submit "periodic milestone" data for the purpose of measuring symptom reduction in adults over time. Over 2,500 of these Addiction Severity Index (ASI) records had been entered, but were unavailable for download from the State of Washington.	Year 4 Progress Report Page 23	August 2012
For 2,699 adults in outpatient SUD treatment, the top three drugs were: alcohol (55%), marijuana (25%), and cocaine (6%). For those with primary alcohol use, 128 of 499 (26%) reduced their use to abstinence by the second measure (usually one year later). The abstinence rate for marijuana was 24 percent and for cocaine it was 20 percent.	Fifth Annual Report Page 11	February 2013
Substance use symptom reduction was studied for 195 youth enrolled in MIDD-funded SUD treatment using Global Appraisal of Individual Needs (GAIN) data. Marijuana was the drug of choice for the majority of these youth. Combined with youth from other MIDD strategies, marijuana use "in the past 90 days" fell significantly from 40 days (pre) to 33 days (post). Average days without substance use rose significantly over time and the average days spent drunk or high declined by 22 percent. The total number of youth reporting abstinence from substances rose from 22 to 60, a 173 percent increase.	Sixth Annual Report Page 55	February 2014

Continued on Next Page

Summary of Findings or Update	Original Publication	Date
1a-2a SUD Outpatient Treatment (Continued)		
Outcomes were sought for 7,587 adults in outpatient SUD treatment with MIDD service starts between October 2008 and 2013. Usable data was found for 4,658 people (a 61% match rate). Males accounted for 73 percent of all treatment episodes and females 27 percent. Treatment was evenly divided between people of color and those who identified as Caucasian/White. Compared to 2013, marijuana as the primary drug of choice declined from 25 percent to 14 percent. Cocaine, heroin and methamphetamine each accounted for seven percent of all treatment admissions. Alcohol remained the top primary substance (56%) for individuals entering treatment. Over half of all people treated reported no primary substance abuse in the 30 days before treatment. Data quality may be a factor. Successful completions of treatment were recorded for 43 percent of cases. Excluding those who reported no substance use prior to starting treatment, 72 percent of cases with six-month milestone data experienced decreased substance use; 27 percent show decreased use when comparing admission use to discharge use. Note that at discharge, data matched the intake precisely for 65 percent of cases. This reflects the default data entry setting if no discharge data are entered. The percentage of active users who reduced their use to zero was 26 percent and the percentage of all treatment cases who reduced their use to zero or stayed use free was 66 percent.	Year 7 Progress Report Page 14	August 2015
1a-2b SUD Opiate Treatment Programs (OTP)		
The analysis sample was 1,961 treatment episodes for 1,421 individuals matched to 1,917 outcomes-eligible people served. Males had 59 percent of OTP episodes, compared to 73 percent in outpatient care. Caucasian/Whites had 77 percent of these episodes (vs. 50% for outpatient). Heroin was the primary drug used in 82 percent of all OTP treatment admissions. Daily use of heroin and opiates in the 30 days leading to treatment was found in 64 percent of all cases. From admission to first periodic milestone (collected at six-month intervals), 457 of 515 people with active drug use leading up to treatment (89%) reduced use of their primary substance. Of 901 people without milestone data, 465 decreased use by discharge (52%). Very few people in treatment experienced increased substance use over time. The proportion of treatment participants who reduced their use to zero or who stayed use free over time was 40 percent.	Year 7 Progress Report Page 14	August 2015
1g Older Adults Prevention		
Of the 106 people with initial and later depression ratings, 59% showed a reduction in depressive symptoms.	Second Annual Report Page 12	February 2010
The Patient Health Questionnaire (PHQ-9) is used to measure depression and the Generalized Anxiety Disorder (GAD-7) gauges client anxiety levels. Of the 1,096 people with two or more PHQ-9 scores, 740 (68%) showed reduced depression. Of the 742 with two GAD-7 scores, 483 (65%) showed improvement. The more severe the symptoms, the greater opportunity for improvement over time. Successful outcomes (noted above) were realized, on average, in as few as ten visits or within approximately seven service hours.	Year 3 Progress Report Page 23 and Fourth Annual Report Page 10	August 2011 and February 2012
Public Health—Seattle & King County reported that in cases where symptoms were not improving, 74 percent of patients received a psychiatric consultation. In general, more contacts and more service minutes were associated with symptom reduction or stabilization.	Year 5 Progress Report Page 15	August 2013

Continued on Next Page

Summary of Findings or Update	Original Publication	Date
1g Older Adults Prevention (Continued)		
Data were analyzed from 1,985 older adults engaged in treatment beyond their initial screening. For the 1,229 with improved depression scores or stabilizing below the clinical threshold for concern (62%), the average treatment minutes was 479. By contrast, the 756 adults with symptoms above moderate or worsening over time (38%) averaged only 383 treatment minutes. Eight months was the average time between first and last measure. For anxiety, only 10 percent of the 1,435 with two or more scores were initially below clinical threshold, but by the last measure, 27 percent were considered clinically stabilized.	Sixth Annual Report Page 16	February 2014
4c School-Based Services		
In November 2012, GAIN short screener (GAIN-SS) results for 39 students at one school showed that 46 percent had high scores on internalizing disorders, such as depression and anxiety. Thirty-two percent had high externalizing scores, suggesting a need for help with attention deficits or conduct problems. Only three percent of the sample scored high for substance use disorders (SUD).	Year 5 Progress Report Page 23	August 2013
Healthy Youth Survey data indicated that 90 percent of 8th graders did not drink alcohol. Of those who used alcohol, binge drinking was higher on average in 4c schools than in King County, but less than statewide. The statewide incidence for depression was about 25 percent both statewide and in 4c schools. Suicidal thoughts were slightly lower in 4c schools than in King County as a whole. In 4c schools, 69 percent of 8th graders were aware of adults available to help them vs. only 46 percent of the 8th graders in King County. Of 1,043 youth eligible for outcomes, 109 (10%) had initial GAIN-SS data. Sixty percent scored high on depression or anxiety, while only 13 percent had high SUD screens. No data were available for change analysis.	Seventh Annual Report Page 35	February 2015
6a Wraparound		
An independent analysis by King County's Children's Mental Health Planner showed improved behavior, rule compliance, and school performance for 159 youth with scores at two different points in time.	Year 5 Progress Report Page 26	August 2013
Behavioral data were available for 638 youth with service starts before April 2014. Property damage and harm to others were both reduced significantly over time, while compliance with household rules increased significantly. At one year after initial assessment, 42 percent of caregivers felt youth behavior had improved, compare to only 28 percent surveyed at the six-month mark. Caregivers reported reductions in perceived problem severity across 21 items measured, including worry, sadness, and caregiver strain.	Seventh Annual Report Page 30	February 2015
8a Family Treatment Court (FTC)		
Of the 17 parents exited from the program, five (29%) were clean and sober for a consecutive six month period, were consistently attending sober support programs, and were engaged in relapse prevention.	Third Annual Report Page 22	February 2011
External academic evaluations suggest that participants experienced significant positive gains in both their attitudes (trust and understanding) and their behaviors (engagement, compliance, and visitation). Of the 28 parents with end dates between October 2011 and September 2012, 10 graduated (36%) and two had their cases dismissed. Children were returned home in all but one of these cases. Of the 47 parents for whom SUD data was available, 12 (28%) listed methamphetamine as their drug of choice, followed by cocaine and alcohol at 19 percent apiece. More data are needed to examine change over time.	Fifth Annual Report Page 32	February 2013

Continued on Next Page

Summary of Findings or Update	Original Publication	Date
8a Family Treatment Court (Continued)		
The total number of FTC clients eligible for symptom reduction measurement was 139. Information on 148 treatment admissions matched to 86 of these people (61%). Treatment was successfully completed by 33 percent of admissions (49 people). The majority of FTC clients in treatment were women (82%) and their most common drug of choice was methamphetamine (27%), followed by cocaine and alcohol at 20 percent each. Of 49 treatment admissions with milestone outcomes data, 30 said they had no drug use in the 30 days before treatment or six months after. Of the remaining 19 with some use, 17 (79%) decreased their substance use over time. By contrast, where milestone data were unavailable, 16 of 36 people (44%) with active substance use prior to treatment had experienced a decline in use by the discharge time point. Altogether, 78 percent of FTC clients in treatment reduced their substance use to zero or stayed use free.	Year 7 Progress Report Page 15	August 2015
9a Juvenile Drug Court		
Substance use symptom reduction was studied for six male youth enrolled in Juvenile Drug Court. When combined with youth from other MIDD strategies, including 139 who participated in 5a Juvenile Justice Youth Assessments, it was found that marijuana was the drug used most often. For youth who used alcohol, 57 percent reduced their frequency use over time. (See 1a-2a on Page 3.)	Sixth Annual Report Page 55	February 2014
11b Mental Health Courts (MHC)		
For a sample of 472 MHC clients with anxiety and depression scores at two time points, 74 percent remained stable over time. Where change was evident, up to 84 percent of clients improved their symptoms at some point during treatment.	Eighth Annual Report	February 2016
12d Behavior Modification Classes		
For 235 clients with anxiety and depression scores at two different time points, about half of all clients remained stable over time. When the scores changed, the majority (up to 86%) showed improvements rather than declines.	Eighth Annual Report	February 2016
13a Domestic Violence Services		
Clients become eligible for symptom reduction outcomes after being seen in three separate months. Of the 243 people eligible, 202 (83%) agreed or strongly agreed that they are better able to manage stress in their lives.	Year 3 Progress Report Page 23	August 2011
In surveys received throughout the year, not a single client disagreed with statements about the positive role of their MIDD-funded therapist in helping them with stress management, decision-making, and self-care.	Fourth Annual Report Page 12	February 2012
A total of 85 client or clinician-rated surveys were submitted. Most respondents (73%) felt they could manage their stress better as a result of therapy.	Fifth Annual Report Page 22	February 2013
13b Domestic Violence Prevention		
Nearly 400 children were screened using the Pediatric Symptom Checklist (PSC-17). This instrument rates levels of internalizing, externalizing, and attentional behaviors with a maximum score of 34. Total scale scores above 14 are considered above the clinic threshold. Scores were not available to assess change over time.	Fourth Annual Report Page 20	February 2012
An analysis of symptom reduction was completed using 97 cases with PSC-17 measures taken at least two months apart. Scores dropped below the threshold of concern for 43 children (44%) at some point during their treatment. Those reducing symptoms were in treatment on average for 17 months vs. only 14 months for those remaining at elevated symptom levels.	Fifth Annual Report Page 34	February 2013
14a Sexual Assault Services		
Clients needed to attend at least two therapy sessions in order to be considered outcomes-eligible. For 54 children and 26 adults, more than 88 percent had positive overall outcomes. Negative symptoms were reduced for 17 adults (65%).	Year 3 Progress Report Page 23	August 2011
For 53 adults with outcomes data, 49 (92%) had achieved successful outcomes by meeting two or more of these measured items: understanding their experience, coping skills, symptom reduction, and treatment goals.	Fifth Annual Report Page 34	February 2013
Continued on Next Page		

Summary of Findings or Update	Original Publication	Date
14a Sexual Assault Services (Continued)		
In 2012, one sexual assault agency receiving MIDD funding reported that nine of every 10 clients increased their coping skills, reduced negative symptoms, and/or met treatment goals.	Year 5 Progress Report Page 21	August 2013
For youth, 29 of 32 (90%) had achieved positive outcomes related to emotional stability and behavior change. Positive outcomes, including symptom reduction, were achieved by 71 of 80 adults (89%).	Sixth Annual Report Page 22	February 2014
15a Adult Drug Court (ADC)		
Addiction Severity Index data were available for 629 ADC clients of the 937 eligible for outcomes (67% match rate). The average number of treatment episodes was 1.9 per person. Marijuana was the most common substance used (22% primary). The rate of successful treatment completions was 45 percent. Substance use reductions to zero occurred in 46 percent of cases with active use before treatment. Overall, 78 percent of clients reduced their use to zero or stayed use free over time.	Year 7 Progress Report Page 15	August 2015

Enumeration of All Performance Measurements and Summary of Performance Outcomes

On the following three pages, performance measurements used over the life of all MIDD-funded strategies, programs, and services are shown in the rows labeled "Target". Performance outcomes are show in the rows labeled "Actual" (raw numbers) and "% of Target" (percentages). Results are provided by the following MIDD strategy groupings: Strategies with Programs to Help Youth, Community-Based Care Strategies, and Jail and Hospital Diversion Strategies. Where targets differed in any given year from those posted in the "Original or Revised Target" column, an explanatory notation has been provided in the far right column under "Target Adjustments and Notes". Where actual achievement was lower than 65 percent of the annual or adjusted target, the percentage is highlighted in red. Where achievement ranged from 65 to 85 percent of target, the percentage is highlighted in yellow. Achievements in excess of 85 percent of the posted targets are unmarked. In all tables, FTE refers to full-time equivalent staffing.

		Annual or Adjusted Targets and Performance Outcomes								
Measure	**Original or Revised Target**		**Year 1 2008-9**	**Year 2 2009-10**	**Year 3 2010-11**	**Year 4 2011-12**	**Year 5 2012-13**	**Year 6 2013-14**	**Year 7 2014-15**	**Target Adjustments and Notes**
1a-1 Mental Health (MH) Treatment										
Number of Clients	2,400	Target	2,300	2,400	2,400	2,400	2,400	2,400	2,400	Year 1 (11.5 months)
		Actual	2,047	3,481	3,090	4,345	4,612	3,117	2,730	
		% of Target	89%	145%	129%	181%	192%	130%	114%	
1a-2 Substance Use Disorder (SUD) Treatment										
Adult Outpatient Units	50,000	Target	47,917	50,000	50,000	50,000	50,000	50,000	50,000	Year 1 (11.5 months) ~ Other funds available ~ Federal and state funds expended first Note: In Year 7, this strategy funded over $1.75 million in detoxification services
		Actual	36,181	43,751	26,978	30,053	31,409	30,366	20,362	
		% of Target	**76%**	88%	**54%**	**60%**	**63%**	**61%**	**41%**	
Youth Outpatient Units	4,000	Target	3,833	4,000	4,000	4,000	4,000	4,000	4,000	
		Actual	10,370	6,617	5,749	6,564	4,254	3,829	2,833	
		% of Target	271%	165%	144%	164%	106%	96%	**71%**	
Opiate Treatment Program Units	70,000	Target	67,083	70,000	70,000	70,000	70,000	70,000	70,000	
		Actual	66,957	82,560	72,677	79,017	88,189	53,791	21,231	
		% of Target	100%	118%	104%	113%	126%	**77%**	**30%**	
1b Outreach & Engagement										
Number of Clients	675 with 5.6 FTE	Target	239	675	675	675	675	675	675	Year 1 (3 to 3.5 months) Year 1 (5 FTE) ~ Blended funds ~
		Actual	435	1,857	1,693	1,530	1,346	1,096	1,074	
		% of Target	182%	275%	251%	227%	199%	162%	159%	
1c Emergency Room Intervention										
Screenings	6,400 with 8 FTE	Target	3,333	4,800	6,000	5,600	5,600	4,000	4,560	Year 1 (5 to 9 months) Year 1 and Year 2 (6 FTE) Year 3 (7.5 FTE) Year 4 and Year 5 (7 FTE) Year 6 (5 FTE) Year 7 (5.7 FTE)
		Actual	2,558	3,344	4,649	3,695	4,422	2,584	2,177	
		% of Target	**77%**	**70%**	**77%**	**66%**	**79%**	**65%**	**48%**	
Brief Interventions	4,340 with 8 FTE	Target	2,260	3,255	4,069	3,798	3,798	2,688	3,092	
		Actual	2,250	4,050	5,475	4,763	3,488	2,869	2,585	
		% of Target	100%	124%	135%	125%	92%	107%	**84%**	
1d Crisis Next Day Appts										
Number of Clients with Enhanced Services	750	Target	688	750	413	285	285	285	634	Year 1 (11 months) Year 3 (9 months at 60% less) Year 4 to Year 6 (62% less) Year 7 (state funds restored 1/2015)
		Actual	868	960	475	231	291	259	339	
		% of Target	126%	128%	115%	**81%**	102%	91%	**53%**	
1e Chemical Dependency Trainings										
Number of Reimbursed Trainees	125	Target	120	125	125	125	125	125	125	Year 1 (11.5 months)
		Actual	165	194	344	349	374	341	345	
		% of Target	138%	155%	275%	279%	299%	273%	276%	
Number of Workforce Development Trainees	250	Target	0	0	0	250	250	250	250	Workforce development trainees target was added in Year 4
		Actual	0	0	0	253	400	369	482	
		% of Target	N/A	N/A	N/A	101%	160%	148%	193%	
1f Parent Partners Family Assistance										
Number of Individually-Identified Clients	400	Target	0	0	0	0	0	200	300	Year 6 (Startup) Year 7 (Fully staffed 1/1/2015)
		Actual	0	0	0	0	0	137	182	
		% of Target	N/A	N/A	N/A	N/A	N/A	**69%**	**61%**	

Measure	Original or Revised Target		Annual or Adjusted Targets and Performance Outcomes: Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15	Target Adjustments and Notes
1g Older Adults Prevention										
Number of Clients	2,500	Target	1,875	2,500	2,500	2,500	2,500	2,500	2,500	Year 1 (9 months)
		Actual	1,805	2,495	2,993	3,635	4,231	4,892	8,933	
		% of Target	96%	100%	120%	145%	169%	196%	357%	
1h Older Adults Crisis & Service Linkage										
Number of Clients	340	Target	312	340	340	340	340	340	340	Year 1 (11 months)
		Actual	327	444	424	326	435	443	294	
		% of Target	105%	131%	125%	96%	128%	130%	86%	
2a Workload Reduction										
Number of Agencies Participating	16	Target	16	16	16	16	16	16	16	
		Actual	16	16	16	17	17	16	16	
		% of Target	100%	100%	100%	106%	106%	100%	100%	
2b Employment Services										
Number of Clients	920 for both MH/SUD	Target	671	700	700	700	700	700	700	Year 1 (11.5 months) Year 1 to Year 7 (MH only)
		Actual	734	820	793	834	884	935	871	
		% of Target	109%	117%	113%	119%	126%	134%	124%	
3a Supportive Housing										
Number of Clients	Capacity grew until 2014	Target	70	251	445	553	614	690	690	Year 1 (6 months)
		Actual	114	244	506	624	787	869	772	
		% of Target	163%	97%	114%	113%	128%	126%	112%	
4c School-Based Services										
Number of Youth	2,268 with 19 programs	Target	0	0	1,550	1,550	1,550	1,550	1,550	Year 3 to Year 7 (13 programs)
		Actual	0	0	1,896	1,410	1,510	1,213	1,031	
		% of Target	N/A	N/A	122%	91%	97%	**78%**	**67%**	
4d Suicide Prevention Training										
Number of Adults	1,500	Target	192	1,500	1,500	1,500	1,500	1,500	1,500	Year 1 (11.5 months) Target was 200 in Year 1
		Actual	1,486	688	1,065	633	1,746	1,005	1,072	
		% of Target	774%	**46%**	**71%**	**42%**	116%	**67%**	**72%**	
Number of Youth	3,250	Target	3,115	3,250	3,250	3,250	3,250	3,250	3,250	Year 1 (11.5 months) ~ Blended funds ~
		Actual	4,764	7,600	7,873	8,129	8,634	9,721	8,530	
		% of Target	153%	234%	242%	250%	266%	299%	262%	
5a Juvenile Justice Assessments										
Number of Assessments Coordinated	1,200	Target	0	250	500	500	500	750	833	Year 2 (Operated at 50% capacity) Year 6 & 7 (Staff vacancies) Year 2 to 5 Target = 500
		Actual	0	407	580	856	1,467	790	841	
		% of Target	N/A	163%	116%	171%	293%	105%	101%	
Number of Psychological Services	200	Target	0	100	200	200	200	117	200	Year 2 (Operated at 50% capacity) Year 6 (Staff vacancies)
		Actual	0	32	98	209	186	101	311	
		% of Target	N/A	**32%**	**49%**	105%	93%	86%	156%	
Number of Mental Health Assessments	140	Target	0	70	105	140	140	117	140	Year 2 (Operated at 50% capacity) Year 3 and Year 6 (Staff vacancies)
		Actual	0	124	143	128	123	116	139	
		% of Target	N/A	177%	136%	91%	88%	99%	99%	
Number of Full Substance Use Disorder Assessments	165	Target	0	82	145	165	165	165	165	Year 2 (Operated at 50% capacity) Year 3 (Staff vacancies)
		Actual	0	251	234	420	291	225	190	
		% of Target	N/A	306%	161%	255%	176%	136%	115%	
6a Wraparound										
Number of Enrolled Youth	450	Target	0	920	374	450	450	450	450	Year 2 Target = 920 youth/siblings Year 3 (Staff vacancies)
		Actual	0	282	414	520	635	593	558	
		% of Target	N/A	**31%**	111%	116%	141%	132%	124%	
7b Expand Youth Crisis Services										
Number of Enrolled Youth	300	Target	0	0	0	300	300	300	300	~ Blended funds ~
		Actual	0	0	0	951	959	1,030	1,043	
		% of Target	N/A	N/A	N/A	317%	320%	343%	348%	
8a Family Treatment Court										
Number of Children in Families Served	90	Target	34	45	90	90	90	90	120	Year 1 (9 months) Year 1 & 2 Target = 45 Note: Cap lifted in Year 7 to 120 per year, not to exceed 60 at any time
		Actual	27	48	83	103	90	93	103	
		% of Target	**79%**	107%	92%	114%	100%	103%	86%	
9a Juvenile Drug Court										
Number of New Youth	36 with 5.5 FTE	Target	27	33	36	36	36	36	36	Year 1 (9 months) Year 2 (5 FTE) Year 1 to 3 Target = opt-ins only
		Actual	29	41	26	50	84	76	89	
		% of Target	107%	124%	**72%**	139%	233%	211%	247%	
10a Crisis Intervention Team Training										
Number of 40-Hour Trainees	180	Target	0	0	375	180	180	180	180	Year 3 Target = 375
		Actual	0	0	275	256	251	200	199	
		% of Target	N/A	N/A	**73%**	142%	139%	111%	111%	
Number of One-Day Trainees	300	Target	0	0	1,000	300	300	300	300	Year 3 Target = 1,000 Year 6 Actual = Special project to train Seattle Police Department
		Actual	0	0	626	266	268	657	553	
		% of Target	N/A	N/A	**63%**	89%	89%	219%	184%	
Number of Other Trainees	150	Target	0	0	0	150	150	150	150	
		Actual	0	0	0	185	163	159	312	
		% of Target	N/A	N/A	N/A	123%	109%	106%	208%	

Measure	Original or Revised Target		Annual or Adjusted Targets and Performance Outcomes: Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15	Target Adjustments and Notes
10b Adult Crisis Diversion										
Number of Clients	3,000	Target	0	0	0	500	3,000	3,000	3,000	Year 1 (2 months) ~ Not unduplicated across three program components ~
		Actual	0	0	0	359	2,353	2,905	3,352	
		% of Target	N/A	N/A	N/A	**72%**	**78%**	97%	112%	
11a Increase Jail Liaison Capacity										
Number of Clients	200	Target	270	200	200	200	100	50	100	Year 1 (9 months) Year 5 & 6 (Staff vacancies) Year 7 (Reduced capacity) Year 1 Target = 360
		Actual	116	279	195	192	69	13	35	
		% of Target	**43%**	140%	98%	96%	**69%**	**26%**	**35%**	
11b Mental Health (MH) Courts										
Number of Regional MH Court Opt-In Clients	28 expansion 83 non-expansion[1]	Target	0	44	57	38	57	28	28	Year 2 (Startup) Year 4 (Staff vacancies) Year 2 to 5 Target = 57 expansion opt-ins
		Actual	0	26	31	22	53	44	28	
		% of Target	N/A	**59%**	**54%**	**58%**	93%	157%	100%	
Number of Seattle Municipal MH Court Clients Screened	300	Target	0	0	0	50	300	300	300	Year 4 Target = 50 clients not competent to stand trial
		Actual	0	0	0	268	318	**303**	287	
		% of Target	N/A	N/A	N/A	536%	106%	101%	96%	
12a-1 Jail Re-Entry										
Number of Clients	300 with 3 FTE	Target	480	200	250	300	300	300	300	Year 1 (Split with 12a-2) Year 2 & 3 (2 FTE, then 2.5 FTE) Year 1 Target = 1,440 for all 12a
		Actual	297	258	260	258	213	213	214	
		% of Target	**62%**	129%	104%	86%	**71%**	**71%**	**71%**	
12a-2 Education Classes at Community Center for Alternative Programs										
Number of Clients	600	Target	960	600	600	600	600	600	600	Year 1 (Split with 12a-1) Year 1 Target = 1,440 for all 12a ~ Not unduplicated across various program components ~
		Actual	114	449	545	579	520	590	532	
		% of Target	**12%**	**75%**	91%	97%	87%	98%	87%	
12b Hospital Re-Entry Respite Beds										
Number of Clients	350-500	Target	0	0	29	350	350	350	350	Year 3 (1 month)
		Actual	0	0	26	342	395	334	366	
		% of Target	N/A	N/A	90%	98%	113%	95%	105%	
12c Psychiatric Emergency Services Linkage										
Number of Clients	75-100	Target	69	75	75	75	75	75	75	Year 1 (11 months)
		Actual	87	175	111	77	104	86	81	
		% of Target	126%	233%	148%	103%	139%	115%	108%	
12d Behavior Modification Classes										
Number of Clients	100	Target	25	100	100	100	100	100	40	Year 1 (3 months) Year 7 Target = 40
		Actual	42	79	131	189	162	129	43	
		% of Target	168%	**79%**	131%	189%	162%	129%	108%	
13a Domestic Violence Services										
Number of Clients	560-640	Target	240	700	560	560	560	560	560	Year 1 (3 to 7 months) Year 1 & 2 Target = 700-800
		Actual	197	489	517	514	583	558	595	
		% of Target	**82%**	**70%**	92%	92%	104%	100%	106%	
13b Domestic Violence Prevention										
Number of Unique Families	85	Target	78	85	85	85	85	85	85	Year 1 (11 months)
		Actual	102	144	134	147	135	144	155	
		% of Target	131%	169%	158%	173%	159%	169%	182%	
14a Sexual Assault Services										
Number of Clients	170	Target	260	400	170	170	170	170	170	Year 1 (5 to 9 months) Year 1 & 2 Target = 400 ~ Blended funds ~
		Actual	179	364	301	387	413	348	358	
		% of Target	**69%**	91%	177%	228%	243%	205%	211%	
15a Adult Drug Court										
Number of Clients	250	Target	113	300	250	250	250	250	250	Year 1 (3 months) Year 1 Target = 450 Year 2 Target = 300
		Actual	125	337	313	294	268	261	388	
		% of Target	111%	112%	125%	118%	107%	104%	155%	
16a New Housing & Rental Subsidies										
Number of Tenants	25	Target	0	25	25	25	25	25	25	
		Actual	0	25	31	29	28	26	23	
		% of Target	N/A	100%	124%	116%	112%	104%	92%	
Number of Rental Subsidies	25	Target	38	50	40	40	25	25	25	Year 1 (9 months) Year 1 & 2 Target = 50 Year 3 & 4 Target = 40
		Actual	27	52	52	41	31	25	19	
		% of Target	**71%**	104%	130%	103%	124%	100%	**76%**	

[1] Tracking of 83 non-expansion cases began in Year 6. Results are not shown here.

Appendix L

Unmet Annual Performance Measurement Targets and Supplantation Programs Receiving MIDD Funding Prior to 2016

Of the 37 original MIDD strategies, 19 (51%) had annual performance measurement targets that were unmet at least one time between 2008 and 2015. Targets were considered unmet if less than 85 percent of the established goal was achieved after adjustment. Adjustments were typically made when fewer programs or staff positions were funded than planned, when start-up allowances were made, and when programs were unable to fill staff vacancies. The table below shows which strategies underperformed, when they fell short of expectations and by how much, most likely reasons for not meeting their goals, and the actions taken to correct identified issues.

Strategy		Year(s) and Target(s)	Reason(s)	Action(s) Taken
1a-2	Substance Use Disorder (SUD) Treatment	Years 1 to 6 (2008-2014), except Year 2 26,978 to 36,181 adult outpatient units each year 54% to 76% of 50,000 annual goal	Other fund sources were available to pay for these services	No corrective action was taken as individuals were able to access treatment through other sources and underspent funds were redirected to the MIDD fund balance, which was addressed in Year 7 (2014-2015)
1a-2	Substance Use Disorder (SUD) Treatment	Year 6 (2013-2014) 53,791 opiate treatment program units 77% of 70,000 goal	Treatment access through Medicaid expansion contributed to a 13% decline over the prior year in the total number of people served in Strategy 1a-2	Excess funds were redirected to other SUD treatment priorities such as copays, outreach, and urinalysis testing (2014)
1c	Emergency Room Intervention	Year 1 to 6 (2008-2014) 2,558 to 4,649 screens per year 65% to 79% of adjusted annual goals	1) Delivery of more intensive services (beyond initial screening) reduced time available for screening only 2) Referral to these services varied by hospital: targeted screening vs. universal 3) Individuals who are approached but decline screening do not count toward performance targets, but take provider time	1) Met with providers to set daily targets in order to meet annual goals, with caveat that clients at higher risk take more time to serve (2010) 2) Assuming 20 working days per month, a daily target was set for each funded staff to average 4 screens per day to meet the annual target (2011) 3) Discussed throughput vs. encounter quality with consensus to not sacrifice quality to meet screening goals (2012)
1d	Crisis Next Day Appointments	Year 4 (2011-2012) 231 clients with "enhanced services" 81% of 285 adjusted goal	Medical services are used as a proxy to count the number of clients who receive "enhanced services"; this may under-represent the number of enhanced services provided	Additional queries and data analyses were done to affirm the reported results; no corrective actions were taken (2013)
1f	Parent Partners Family Assistance	Year 6 (2013-2014) 137 individually-identified clients 69% of 200 adjusted goal	While the strategy served many clients in large group events, fewer than expected engaged in one-on-one services	The addition of a youth peer coordinator position will provide greater opportunities to engage clients individually (2015)
4c	School-Based Services	Year 6 (2013-2014) 1,213 youth 78% of 1,550 goal	Greater emphasis was placed on delivery of large group presentations and assemblies	While fewer individuals were tracked, the number of youth reached in larger groups doubled over prior years, so no action was taken (2014)
4d	Suicide Prevention Training	Years 2 to 4 (2009-2012) Year 6 (2013-2014) 633 to 1,065 adults trained each year	1) Outreach needed (2010) 2) Under-reporting of trainings delivered (2011)	1) Outreach ideas to engage more men in trainings (2010) 2) Contract monitor/provider collaboration to improve reporting accuracy (2011)

Strategy		Year(s) and Target(s)	Reason(s)	Action(s) Taken
		42% to 71% of 1,500 annual goal	3) Provider management and staff turnover (2012) 4) Low adult attendance at contracted number of trainings delivered (2014)	3) Corrective action plan with payment withholding contingency developed (2012) 4) Additional outreach brainstorming and reporting corrections (2014)
5a	Juvenile Justice Assessments	Years 2 to 3 (2009-2011) 32 psychological services 32% of 100 goal in Yr 2 98 psychological services 49% of 200 goal in Yr 3	Screening, triage, and consultation process (program efficiencies) reduced the need to complete full psychological evaluations	The psychological services definition was expanded to count all consultations with the team psychologist, not just psychological evaluations (2011)
6a	Wraparound	Year 2 (2009-2010) 282 youth 31% of 920 enrolled youth/siblings goal	Only enrolled youth could be counted utilizing existing reporting mechanisms	Annual targets were revised to count 450 enrolled youth only and not their siblings (2010)
8a	Family Treatment Court	Year 1 (2008-2009) 27 children 79% of 34 children over 9 months goal	Start-up of expanded capacity	Enrollment was slightly lower than expected in the first year; no corrective action was needed as the program soon reached capacity (2009)
9a	Juvenile Drug Court	Year 3 (2010-2011) 26 new youth 72% of 36 goal	Declining referrals in 2011, when only new opt-in cases counted toward the goal	Reorganized structure to offer "engagement" phase where new pre opt-in cases counted toward meeting goal (2011)
10a	Crisis Intervention Team Training	Year 3 (2010-2011) 275 40-hour trainees 626 one-day trainees 63% to 73% of unamended goals	In the first year of operation, initial targets were set too high	Amended targets (2011)
10b	Adult Crisis Diversion	Year 4 and 5 (2011-2013) 359 to 2,353 clients 72% to 78% of adjusted goals	In the first two years of operation, referrals were lower than expected	The MIDD Crisis Diversion Program Manager was hired and began substantial outreach efforts to educate all referral sources about the new Crisis Solutions Center (2011)
11a	Increase Jail Liaison Capacity	Year 1 (2008-2009) Year 5 and 6 (2012-2014) 13 to 116 clients 26% to 69% of adjusted goals	1) In the first year of operation, initial target was set too high 2) Unable to fill staff vacancies and obtain clearance to secure facility	1) Amended target (2010) 2) After the position was filled following a long vacancy, jail clearance issues had to be resolved (2013) 3) King County Work Education Release was downsized from 160 to 79 beds so targets must be amended (2014)
11b	Mental Health Courts (MHC)	Year 2 to 4 (2009-2012) 22 to 31 opt-in clients to the Regional MHC 54% to 59% of adjusted goals	Expansion to include cases referred to the court by area municipalities ramped-up slowly over time	Targets were amended and the strategy was revised to realign funding with current court needs (2012-2014)
12a-1	Jail Re-Entry & Education Classes	Year 1 & Year 5 to 6 (2008-2009, 2012-2014) 213 to 297 re-entry clients 62% to 71% of goals	1) In the first year of operation, initial target was set too high 2) Provider staffing and reporting issues contributed to lower numbers served and/or counted	1) Amended target (2009) 2) Contract monitor/provider collaboration to improve reporting accuracy (2012) 3) Continuous quality improvement feedback given to provider (2013) 4) Communications with provider regarding performance target expectations (2014)

Strategy		Year(s) and Target(s)	Reason(s)	Action(s) Taken
12a-2	Jail Re-Entry & Education Classes	Year 1 and 2 (2008-2010) 114 to 449 education clients 12% to 75% of goals	Class capacity limited the number of clients who could be served initially	Additional classes were added and filled to new capacity slowly over time (2009-2011)
12d	Behavior Modification Classes	Year 2 (2009-2010) 79 clients 79% of 100 goal	In the first two years of operation, referrals were lower than expected	Program referrals increased without intervention (2010)
13a	Domestic Violence Services	Year 1 and 2 (2008-2010) 197 to 489 clients 70 to 82% of adjusted goals	Funding cuts due to the recession made it difficult for the providers to serve the projected number of clients	1) Targets were aligned with actual funding (2010) 2) Evaluation/provider collaboration to improve outcomes reporting for clients served (2010) 3) Continuous quality improvement feedback given to providers (2010)
14a	Sexual Assault Services	Year 1 (2008-2009) 179 clients 69% of adjusted goal	Funding cuts due to the recession made it difficult for the providers to serve the projected number of clients	1) Outreach ideas to increase referrals at one agency (2009) 2) Clarification of reporting requirements (2010) 3) Continuous quality improvement feedback given to providers (2010)
16a	New Housing & Rental Subsidies	Year 1 (2008-2009) 27 rental subsidies 71% of 38 goal	Time was needed for this program to reach its full capacity	Rental subsidy distribution increased without intervention (2009)

Strategy Revisions

Strategy		Date of Revision	Revision
1a1	Mental Health Treatment	07/01/2010	Clubhouse Services added.[1]
1a2	Substance Use Disorder (SUD) Treatment	01/01/2009	Buprenorphine[2] at Detoxification program added.
1a2	Substance Use Disorder (SUD) Treatment	01/01/2010 - Youth Transportation 07/01/2014 - Outreach	Treatment support activities added: • Youth Transportation • Outreach.
1a2	Substance Use Disorder (SUD) Treatment	10/01/2014	Detoxification beds added.
1a2	Substance Use Disorder (SUD) Treatment	01/01/2011	1811 Case Management added.
1a2	Substance Use Disorder (SUD) Treatment	5/01/2015	Peer services added.
1a2	Substance Use Disorder (SUD) Treatment	10/01/2013	Sobering services added.
1b	Outreach & Engagement	03/01/2009	At the time the MIDD plan was initially adopted, a final service design was not proposed for this strategy because other initiatives related to people experiencing homelessness were in the process of being implemented. In winter 2008-09, two assessments occurred to help inform the programming of these funds: Health Care for the Homeless conducted a needs assessment. Public Health conducted an analysis of the numbers and characteristics of homeless people seen in the King County Jail. The revised design included: (1) Increase homeless program-based mental health/chemical dependency outreach and engagement services at selected homeless program sites in East King County, South King County, and Seattle. Services will be prioritized for those sites with the highest

[1] 1. A Clubhouse is a community intentionally organized to support individuals living with the effects of mental illness and certified by the International Center for Clubhouse Development (ICCD). Through participation in a Clubhouse, members are given opportunities to rejoin the worlds of friendships, family, important work, employment, education, and to access the services and supports they may individually need. A Clubhouse is a restorative environment for people who have had their lives drastically disrupted, and need the support of others who believe that recovery from mental illness is possible for all.

[2] Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates. http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

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			numbers of people with histories of jail and/or hospital involvement. (2) Increase chemical dependency outreach and engagement for homeless Native Americans
1c	Emergency Room Intervention	09/15/2011	Four new FTE Chemical Dependency Professionals (CDP) in south King County were planned. Three FTEs were filled in 2011. One FTE resigned in 2011 and was not refilled. Two new FTEs were maintained.
1d	Crisis Next Day Appointments	11/1/2008	The original plan did not identify specific additional treatment and stabilization services. A stakeholder process was planned to develop the specific components. Enhanced stabilization services added to plan: Additional brief, intensive, short term treatment to resolve the crisis, benefits counseling and psychiatric medication access.
1e	Chemical Dependency Trainings	03/01/2009	Reimbursement was expanded beyond books and tuition to include the costs of testing to become a CDP and annual recertification. A Science to Service/Workforce Development Coordinator was hired. This position was responsible for providing technical assistance/training to the provider community about the selection and implementation of evidence-based treatment activities and assured that the selected programs were implemented and delivered with fidelity to the model. The position also monitored the utilization of the tuition reimbursement program.
1e	Chemical Dependency Trainings	09/23/2010	BHRD had a pilot project with the University of Washington (UW), School of Social Work, to develop a program within the School of Social Work to allow MSW students to jointly receive their CDP certificate.
1f	Parent Partners Family Assistance	11/01/2012	Originally Strategy 1f's design involved funding parent and youth partners throughout the behavioral health system to support families seeking assistance. After some consideration it

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			was decided that a different plan was needed to fulfill the goals. Family, youth and system partner roundtables were held to gather information regarding the opportunities and challenges to the successful support of families. Input from the meetings and best practices research was used in the redesign. It was determined that a Family Support Organization (FSO)[3] could most effectively meet community and family needs and the implementation plan was revised to fund a FSO. Start-up activities began in mid-October 2011. Contracting with Guided Pathways – Support for Youth and Families (GPS) started on 11/01/2012.
1g	Older Adults Prevention	01/01/2010	Decreased FTEs and funding.
1g	Older Adults Prevention	01/01/2011	Decreased FTEs.
2b	Employment Services	01/01/2009	Added incentive payments for job retention outcomes. Added the SUD population in a modified employment services in 2015/2016 pilot.
4c	School-Based Services	07/01/2010	At the time of the MIDD Implementation Plan adoption, MIDD Strategy 4c was still under development and beginning the stakeholder planning phase. Originally, the strategy was written as if every school district in the county would receive funding. The allocation amount did not allow for adequate distribution to every school district, so it was changed to be open and available to every school district. The process was designed to ensure the four geographical regions of the county had equal distribution of funding if there were applications received and awards available to those areas. The services included prevention, early intervention, brief treatment, and referral to treatment.
4c	School-Based Services	10/23/2014	The MIDD 4c strategy was awarded by a competitive request for proposals (RFP) in 2010. The RFP was for five

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

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			years (expiring in June 2015). The County originally notified its 13 projects (with 10 providers) that the contracts were ending due to the RFP timeline ending. The County decided, due to the MIDD expiring January 1, 2017, that the projects were to be extended to the end of MIDD I.
8a	Family Treatment Court (FTC)	10/01/2010	FTC was funded with a blend of funding sources from the Veterans and Human Services Levy, MIDD funding, and general fund support that became unavailable. There were extra costs not budgeted in 2010 assigned to the Veterans and Human Services Levy. The 2011 Adopted Budget, Ordinance 16984, Section 69, Proviso 1 directed the King County Department of Community and Human Services (DCHS) Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), now BHRD, to develop a report regarding the FTC. A workgroup developed the FTC report. The resulting strategy revision was a cap of no more than 60 children at any given time and no more than 90 children per calendar year for the performance target retroactive to 10/01/2010.
8a	Family Treatment Court (FTC)	10/01/2014	This strategy was revised to expand the number of target children served from 90 to 120. Due to the Department of Public Defense work coming within King County and cases moving to an FTE model for FTC, the target for the number of children to be served could be increased.
9a	Juvenile Drug Court	07/01/2012	Co-occurring (mental health and chemical dependency) track added. Expanded participants to include youth receiving engagement service prior to opting in.
10a	Crisis Intervention Team Training	04/01/2010	Contracted with Washington State Criminal Justice Training Commission (WSCJTC) to implement the Crisis Intervention Team Training (CIT) program.
10b	Adult Crisis Diversion	4/01/2010	1.0 FTE BHRD Program Manager was added to coordinate the Crisis Diversion Services (CDS) strategy, staff the MIDD OC CDS strategy sub-

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			committee and provide general support to the implementation of the MIDD plan.
10b	Adult Crisis Diversion	08/12/2012	The original plan included interim "respite" housing for homeless individuals ready to leave the Crisis Diversion Facility (CDF) in need of temporary housing while permanent supported housing was being arranged. This was revised to include people that were not homeless but in need of stabilization beyond the CDF three day limit.
11a	Increase Jail Liaison Capacity	11/01/2015	The location of services was revised from the King County Work and Education Release (WER) site to serve the population in a community-based setting.
11b	Mental Health Courts (MHC)	2/19/2009	At the time of the MIDD Implementation Plan adoption, MIDD Strategy 11b was still under development. This strategy enhanced services and capacities at existing mental health courts to increase access to programs for eligible adult misdemeanants throughout King County. Service enhancements were to include expanded mental health court treatment services programming within the City of Seattle Municipal Mental Health Court and the City of Auburn Municipal Mental Health Court. King County Regional Mental Health Court was made available to any misdemeanor offender in King County who was mentally ill, regardless of where the offense was committed.
11b	Mental Health Courts (MHC)	08/08/2011	Removed City of Auburn Mental Health Court, added Veteran's Court pilot.
11b	Mental Health Courts (MHC)	06/05/2014	Strategy funds were used to expand residential treatment beds and housing units for therapeutic court participants.
12c	Psychiatric Emergency Services Linkage	11/1/2008	At the time of the MIDD Implementation Plan adoption, MIDD Strategy 12c was still under development. Two case managers were added to Psychiatric Emergency Services.
12d	Behavior Modification Classes	03/20/2009	The original goal of this strategy was to increase efficiency in the treatment and programming operations at

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			Community Center for Alternative Programs (CCAP). As originally constructed this would be done through freeing up CCAP staff to do more programming by contracting out urinalysis (UA) supervision, by the Community Corrections Division (CCD) case workers. Due to several administrative barriers, it was determined that the best way to accomplish greater efficiency was to offer behavior modification programming instead. The revised strategy increased the scope and effectiveness of the services offered at CCAP and appropriately addressed the changing service needs of court-ordered participants. Moral Reconation Therapy (MRT), an evidence-based practice, was implemented at CCAP in April 2009.
15a	Adult Drug Court	01/01/2010	Services for women with co-occurring disorders ended due to declining MIDD revenue.
15a	Adult Drug Court	06/01/2012	Changed the 1.0 FTE subcontracted Wraparound position targeted to young adults, to transitional housing for young adults.
16a	New Housing & Rental Subsidies	11/01/2012	Facility closed. Funds transferred to remaining program to extend duration of subsidies.