MIDD Briefing Paper

BP 74, 97, 137, 138 Seattle Sobering Service Enhancement/Replacement, Sobering Center Transportation

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept × (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This concept paper combines four new concept papers involving the range of services available to adults at the Dutch Shisler Service Center (DSSC), specifically sobering services, transportation services and case management services. The center's target populations are adults (people aged 18 and older) experiencing homelessness, chronic substance use disorders (SUD), including alcoholism, and other behavioral health disorders. Individuals in need of service face persistent or chronic factors such as social isolation, poverty, and extreme chronic stressors. Care is complicated and requires multiple providers with multiple funding streams.

Collaborators:

Name	**Department**
Trudi Fajans	**Public Health**
Darby DuComb	**City of Seattle**
Susan Schoeld	**MHCADSD**

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Rob Ewanio	ESP supervisor	BHRD
Ann Allen	Lead Mental Health Practitioner	HMC
Jaimie Moss	CD Manager	DESC
Kim Powers	Jail Release Planner	Public Health
Tyson Curtis	Sobering Program Manager	PHS
Chris Bamer	Ladder 8 B Shift	SFD
Megan Bott	Social Worker	Virginia Mason
Donovan Brown	Assistant Program Manager	PHS
Chloe Gale	REACH Supervisor	REACH
John Allen	ESP Supervisor	BHRD
Brenda Mayer	CDITS	BHRD
Jim Vollendroff	Director	BHRD
Janna Wilson	Director	Public Health
Jenna Wolfstone	Program Manager	BHRD

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an**

existing MIDD strategy? If so, how?

This concept paper combines four new concept papers involving the range of services available to adults at the Dutch Shisler Service Center (DSSC), specifically sobering services, transportation services and case management services. The center's target populations are adults (people aged 18 and older) experiencing homelessness, chronic substance use disorders (SUD), including alcoholism, and other behavioral health disorders. Individuals in need of service face persistent or chronic factors such as social isolation, poverty, and extreme chronic stressors. Care is complicated and requires multiple providers with multiple funding streams.

With regard to new concept 138 calling for a sobering center unique to -24 year olds: this new concept is partially addressed in this paper as DSSC services are available to adults 18 years and older. Although DSSC has not historically served people younger than 18, the vulnerabilities and issues involving homeless youth are complex. When compared to their peers in the general population, homeless youth experience a disproportionately higher rate of mental illness and substance abuse (Christiani et al., 2008). They are further exposed to, if not targeted for, victimization when navigating the adult-oriented safety net system, given their ignorance from lack of experience (Ammerman, S. 2004). Briefing papers 27, 89, 86 put forward concepts to serve homeless youth and young adults to age 24. This paper does not address developing a separate sobering center for people ages 0-24 as suggested by the new concept author.

As with any additional resource, a sobering center would enhance King County's service system in better meeting needs specific to individuals aged 0 to 24. Further discussion beyond the limited briefing paper development process is needed among city and county partners to determine the services for youth – in a specialized center or enhanced capacity within the current youth shelter and services system.

Sobering services strengthen the availability, quality, and coordination of services for homeless persons with chronic SUDs. Services have been provided at DSSC since 1999, serving as a safe and secure place for persons to sleep off the acute effects of intoxication, and a recovery access point where individuals receive case management services, outpatient behavioral health treatment, and assistance to move towards greater self-determination. Services are designed as low barrier, so individuals can access them without regard to funding or motivation for change. Services are currently provided by a non-profit agency, Pioneer Human Services (PHS). From 2004 through 2014, DSSC served 13,185 unduplicated adults with 241,333 admissions to the center.

Transportation services are provided by the King County Emergency Service Patrol (ESP), a 24/7 engagement and transportation unit. The main duty of the screeners is to relieve first responders - fire, police, and medics - in caring for people who are acutely under the influence of substances, including alcohol. The screeners patrol the downtown Seattle core, seeking out persons in need of service and intervening before a crisis develops. The screeners also transport people away from sobering to other service providers and from hospitals to the Crisis Solutions Center. Transportation services are referenced throughout this briefing paper and not treated as a stand-alone concept.

Case management services are provided by two non-profits; Pioneer Human Services (PHS) and Evergreen Treatment Service's REACH team. PHS services are provided under contract by the City of Seattle; MIDD 1a funding supports the latter. The case management services described in this paper are intended to be site specific.

Phase 1 of this concept is to use MIDD funds to enhance the range of harm reduction services at the sobering center – through improved case management, expanded ESP services, improved staff training, crisis intervention behavioral health counseling, and peer to peer services. Funds are included to expand the catchment area of the Emergency Service Patrol by adding two more vans to increase the ability of the unit to transport people to other service areas, such as Ballard and White Center. MIDD funds are proposed to purchase an electronic health record to replace the County supported data base. A study of services needed to enhance medical capability at the center to further reduce the use of emergency rooms and first responders is needed, along with a review of services and staffing to determine whether the center is a suitable fit for enhanced withdrawal management services, including a safe injection site. Phase 1 also includes a review of the physical layout of the sobering center and funds to make improvements to the admission area, camera system and sleeping bays.

Phase 2 of this proposal is to use MIDD funds to potentially re-site the sobering center near the downtown Seattle core, a plan that should include the full, enhanced provision of other onsite services such as transportation, crisis intervention, behavioral health services and/or withdrawal management services. DSSC is located in the Denny Regrade neighborhood. This area is impacted by urban density with 14 new hotels, condominiums and office space being built or in the development stage in a four block radius of DSSC. The property occupied by sobering is owned by a local non-profit. Phase 2 should imagine a larger center with the ability to serve more people for sobering services, along with space for medical services, case management services, transportation services and administrative services.

This concept relates to the current MIDD strategy 1a in the availability of outreach services and to the current MIDD 10b strategy in the accessibility of a facility-based crisis diversion program. The program provides Seattle first responders with a therapeutic community-based alternative to jail and hospital settings when engaging with adult individuals in behavioral health crisis. In addition, this program expands accessibility to include referrals from the Emergency Service Patrol, as well as self-referrals, with the intention of reducing impacts on first responders and hospitals by providing services and supports pre-crisis or earlier in the crisis cycle that are available in the moment, in the community. REACH coordinates with a mental health provider from HMC who is funded under MIDD Strategy 1b.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

The goal of the programs at DSSC is to improve recovery entry for persons with mental health or substance use disorders (SUDs) and reduce cycling through the legal, emergency medical and crisis systems. These individuals are frequently struggling with increased symptoms that significantly impact their ability to manage daily activities and need supports to be safely maintained in their communities. Often these individuals lack a specific diagnosed condition or connection to on-going treatment services. By focusing on an individual's immediate needs, and through facilitating engagement in services and supports in the community, DSSC reduces the need for first responder involvement. It also facilitates appropriate community-based connections that support resiliency and recovery for the individual by connecting them to the level of services they need. In addition, by providing alternatives to jails and emergency departments in the moment of crisis/contact with first responders, the focus can be on

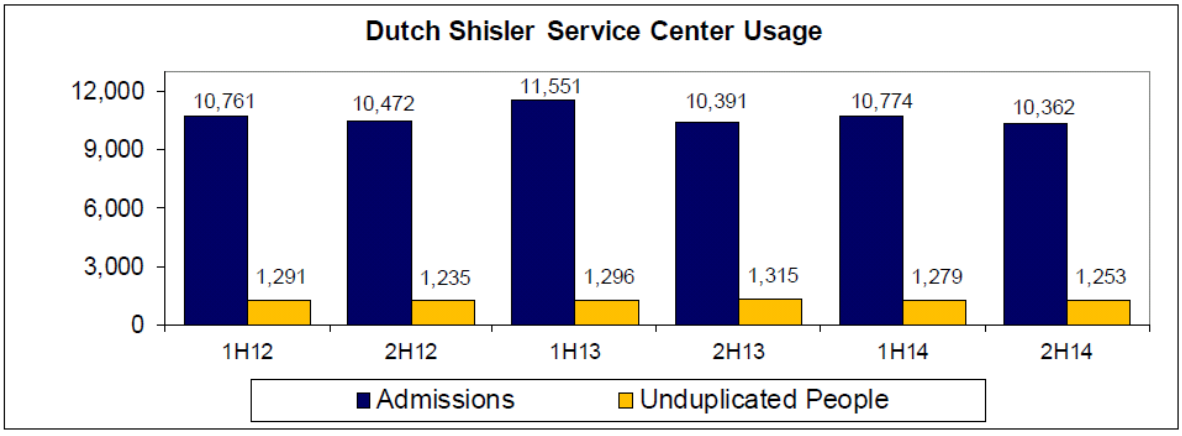
providing re-entry support: linking individuals with behavioral health treatment, primary care, housing services and other basic needs/re-entry supports.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

King County is seeing an increase in the number of individuals who are without permanent or stable housing. The Point-In-Time count noted a significant increase in homelessness in early 2015. "Last winter's One Night Count found more than 3,772 men, women, and children without shelter on the streets of Seattle – a 21 percent increase over 2014. People are homeless, on average, about 100 days. So far in 2015, more than 66 homeless people have died on the streets and in unpermitted encampments across the county. The state now reports that 35,000 people in King County become newly homeless at some point during the year." Although homelessness is not a behavioral health issue, behavioral health conditions and homelessness go hand-in-hand and often complicate the process of a person achieving stabilization.

The chart below shows the unduplicated number of individuals and their number of admissions for six month periods from 2012-2014.[1]



A small number of individuals who are high utilizers of DSSC account for the majority of center admissions. In the last half of 2014, 8.8 percent (110) of the 1,253 people admitted accounted for 64 percent of the total admissions. These 110 individuals averaged 60 admissions each during the six month period, with a range from 25 to 164 admissions[2]. This speaks to the severity and chronicity of the substance use disorders experienced by these individuals, which lead to further complications in their

[1] King County MHCADSD Substance Abuse Prevention and Treatment Annual Repor 2014
[2] Ibid.

lives, both social and medical. Frequent users of the center are often involved in multiple systems, such as primary and behavioral health, social services, criminal justice, and housing. These individuals have complex and chronic needs and are generally not served effectively by the high-cost settings, such as the emergency departments, they tend to access.

Increasingly the center is faced with the prospect of serving people with more challenging medical conditions and situations. Starting in November of 2015, a comprehensive primary care clinic that serves people who are experiencing homelessness was established on site at DSSC. Primary care services are available to people who use DSSC and to homeless people in the larger community, including those at day centers such as Recovery Café and Mary's Place, shelters (Immanuel Lutheran, Orion Center and First Church) the Urban Stop and people who are housed in Permanent Supportive Housing in the neighborhood. The medical clinic will benefit people using DSSC as described below; however, the clinic's current limited hours of operation (mornings, M-F) make it not useful for addressing the medical complications presented during the sobering center's busiest evening hours. People who do not meet medical criteria for sobering (high blood pressure, blood alcohol level above .40, heart issues, etc.) are taken to local emergency rooms for triage and stabilization.

Demand for ESP services is consistently high. During 2014, ESP responded to 12,107 calls from 911 Dispatch, engaged 29,513 people, transported 21,982 people and relieved first responders 2,034 times. Law enforcement and first responders outside of the ESP catchment area have been expressing desire for a similar service; current resource levels do not allow for a larger geographic response area.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

Sobering services in King County date back to 1999 in their present location.

The sobering center serves up to 60 adults at a time. The service never closes for new admissions; when the 61st person arrives at the door, someone in the original 60 is discharged. This might be a person who has been on site the longest, has housing or can access other shelter options. In 2014, the sobering center served 2532 unduplicated persons for 21,136 admissions.

The sobering center layout needs to be examined to determine a more efficient, trauma informed and private way to engage people for admission and to maximize the center's limited space. Having a private area for admissions will lead to increased detail from people regarding their health care and behavioral health needs. This paper proposes that examination be conducted with the building landlord, stakeholders and architectural support.

As mentioned above, sometimes individuals present as too medically fragile to be kept at the sobering center and are transported to hospitals for care. An evaluation of these people's needs and an examination of staffing changes that could keep people on site will happen during 2016. PHS will be asked to track all cases of people unable to stay at sobering due to medical risk and these cases will be examined by a group, to include PHS, MHCADSD staff and community medical leaders. New MIDD funds would be necessary to hire other medical staff, such as nurses, to be present during the evening hours if the center's procedures and protocols can be written to accommodate people with compromised medical conditions.

The presence of the medical clinic, funded through a a federal Health Resources Services Administration

(HRSA) New Access Point grant to Public Health Seattle-King County (PHSKC) and operated by Neighborcare, will benefit people using the sobering center. All programs sited at DSSC will inform people about the new available health and behavioral health services and how to access them. People who are unable to independently follow through setting up and attending a clinic visit will be able to receive assistance from the REACH nurse or case manager depending on the individual's needs.

These positions work with this population on site at the DSSC, and provide service continuity for many of the people in other locations where they sleep, mostly outside. The nurse and case management emphasis at DSSC "includes active outreach to prospective people and engagement services- including capturing prospective peoples' interest in a variety of homelessness services, as well as substance abuse, medical, mental health, and social services; gaining the prospective person's trust; and increasing motivation for change." Using a person-centered, harm reduction approach, they support people to successfully access needed resources, services and housing. People are provided services through the on-site staff, and once engaged, many are screened into the larger REACH programs' case management services, based on chronicity of substance use and the person's inability to independently access needed community resources.

A REACH case manager and nurse conduct early morning outreach to identify individuals who are not engaged in services, people who have returned to DSSC after having reached a level of stability that allowed them to stop coming to DSSC, or who are in need of health assistance or interested in getting help in addressing their substance use. People often contemplate going to treatment but won't act on it without counseling or help getting into inpatient or outpatient chemical dependency treatment. The REACH team at DSSC consists of 1.0 FTE made up of .50 FTE RN and a consistent group of case managers who come on different mornings. Having a culturally diverse group of case managers creates more choices for people. Some people are referred to other case managers on the REACH team who do not regularly come to DSSC but may be a better match for a particular client, or have more time to devote to engagement and relationship building. In addition to these two positions, REACH coordinates with a mental health provider from HMC who is funded under MIDD Strategy 1b. This provider coordinates with the REACH team to work with dually diagnosed people who have not been successful in obtaining needed mental health services. REACH provides interdisciplinary, chemical dependency and nursing case management focused on the person's needs. This will include intensive long-term case management for a portion of the people who are chronically homeless and have an extensive history of alcohol abuse, co-occurring health and/or psychiatric problems and cognitive impairments who are unable to independently access needed community resources. These positions work with this population on site, and in other locations where they sleep, mostly outside. Using a person-centered, harm reduction approach, their goals are to assist people to attain needed resources and services including mental health recovery and chemical dependency services, non-emergent health care, entitlements/financial stability and housing.

In 2014, 233 individuals were provided 1119 visits, including nursing, outreach and engagement and case management.
199 referrals were made for chemical dependency treatment.
48 referrals were made for mental health treatment.
70 referrals were made for primary care and other medical services
11 referrals were made for dental care
109 referrals were made for housing

PHS operates case management services on site, funded by the City of Seattle. This concept proposes a new MIDD funded position for PHS that will continue to serve people on site. The hours of the new case manager should be flexible, to best sync with the times people are using the center. Service numbers for PHS in 2014 indicate a continued focus on providing and connecting individuals to appropriate services in the community:

- 332 persons referred to medical detoxification services, with 179 admissions achieved;
- 203 persons, identified as having high utilization of crisis services, received case management services;
- 97 persons admitted to treatment at Pioneer Center North through King County's involuntary SUD treatment process; and
- 348 persons referred to other SUD treatment services.

ESP services are frequently requested outside the current downtown Seattle catchment area. Traffic is the main impediment to spreading the existing team further – the team will not be able to return from further call areas to relieve first responders in the downtown core. This paper proposes working with the Seattle 911 response team and police department and King County Sheriff to determine other areas that ESP should respond to, such as White Center and Ballard. To increase the catchment area of ESP will require hiring more staff and purchasing more equipment.

During 2014, ESP responded to 12,107 calls from 911 Dispatch, engaged 29,513 people, transported 21,982 people and relieved first responders 2,034 times.

An EHR will improve communication at the site and allow for more creative gathering of data and reports on the population to help inform system improvements. This proposal includes purchase of an electronic health record (EHR) system from Agency Software. This company provides EHR services to other local agencies, including REACH, DESC and Recovery Café. The health record will feature individual person screens with better detail on medical conditions, recovery planning, case managers involved in care, and dates and times of service. It will include report functions. Agency Software will work with the County IT department on system requirements and maintenance.
Current functions, such as admission data would be retained.

The need is addressed through increased staffing, increased staff training, possible physical changes to the center, and a new database/EHR.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

A 2008 paper co-authored by Jim Vollendroff, MHCADSD Director, and Janna Wilson, Public Health Director of Health Policy and planning, recommended seven areas for change at DSSC:

1. Strengthened leadership, accountability and evaluation.
2. Broadening the target population.
3. Coordinate Outreach and Engagement.

4. Modify the role of ESP.
5. Incorporate the use of Safe Harbors Data.
6. Recasting the "sobering center" to a "service center".
7. Strengthen case management services.

Many of these recommendations have been implemented in some fashion over the past seven years, although work remains to achieve full implementation. Improved staff training, adding more medical personnel, adding more case managers, and critically, adding a new data system, are all necessary.

There is some consensus that if treatment for this population is to be successful it must be long-term.[3] A 1998 University of Washington study was conducted to test whether an intensive case management intervention would be effective with a group of homeless individuals who were chronically publicly inebriated. Repeated measures MANCOVAs showed significant group differences favoring the case-managed group in all three areas targeted by the intervention: total income from public sources, nights spent in own place out of the previous 60 nights and days drinking out of the previous 30 days. The results held whether the three variables were analyzed jointly or separately and for alternative measures of drinking and homelessness.[4] This study was applied to REACH early in the development of REACH and DSSC.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

   Harm Reduction Theory—Employs the quality of community life and well-being, rather than the cessation of drug use, as the criteria for successful interventions and policies.[5]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Potential outcomes include:

- Continued relief of first responders from over 2000 situations annually
- Relief of first responders in a broader geographic area of King County
- Fewer intoxicated people on the streets
- Avoidance of emergency department use by center clients
- Avoidance of jail by center clients
- Engaging more individuals with drug & alcohol treatment
- Linking more individuals to primary care
- Admission of medically high-risk individuals to the center

Indicators for people engaged in REACH case management would demonstrate the benefits of being enrolled in primary care, mental health services, substance use treatment and housing by their reduced involvement in the criminal justice system, emergency and inpatient health systems.

[3] Blower 1978, institute of Medicine(IOM),1990, Willenbring et al 1990

[4] Outcome of a Controlled Trial of the Effectiveness of Intensive Case Management for Chronic Public Inebriates, Journal of Studies on Alcohol, Cox, Gary | Walker, R. Dale | Freng, Steven | Short, Bruce | Meijer, Lucia | Gilchrist, Lewayne

[5] The Harm Reduction Coalition. The Principles of Harm Reduction. Available at http://www.harmreduction.org/section.php?id=62. Accessed May 12, 2010.

Reductions in emergency services and jail would be distinct cost offset outcomes for this population. Increases in housing or improvements in shelter/housing would be positive outcomes.

ESP will continue to seek out new interventions with people, to bring them to recovery locations prior to a community crisis. ESP has a history of seeking out new partners, such as the Crisis Solutions Center and Operation Nightwatch, to assist people using those services in making community connections.

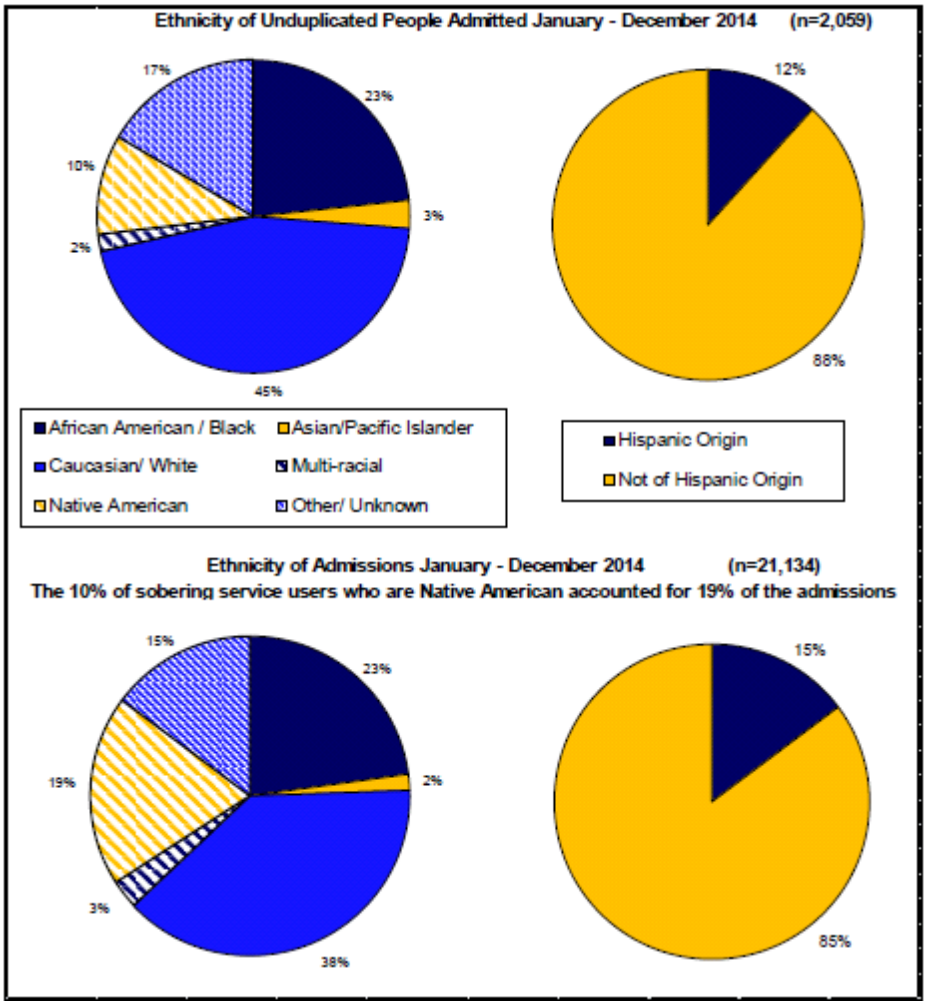
C. Populations, Geography, and Collaborations & Partnerships

1. What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program: (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☒ **Older Adults**
- ☐ **Families**
- ☒ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☒ **Racial-Ethnic minority (any)**
- ☒ **Black/African-American**
- ☒ **Hispanic/Latino**
- ☒ **Asian/Pacific Islander**
- ☒ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☒ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**
- ☒ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

DSSC serves adults who are primarily homeless and suffer from substance use disorders, along with other behavioral health issues. This population is impacted by health disparities, a type of difference in health that is closely linked with social or economic disadvantage. This negatively affects groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability.



[6]

Ethnicity of DSSC 2014 admissions were:
10 % American Indian/Native American
2% Asian
23% African American/Black
45% Caucasian/White
17 % Mixed Race/Other

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: Seattle

   DSSC is located in the Denny Regrade neighborhood of Seattle. The center serves the downtown Seattle core – a critical area for 911 calls and established through partnership with the Seattle Police Department and the Seattle Fire Department. Should the center need to relocate under

[6] MHCADSD, Op. Cit

Phase 2 of this proposal, collaboration with the City of Seattle should determine the best neighborhood to site the center.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

DSSC services require extensive partnerships. These include internal partnerships with the agencies directly serving people at the site. They also include a network of community partners that overlap care with the population, including first responders, hospitals, jail staff, community behavioral health providers, and housing and shelter programs.

The High Utilizer Group is a twice-monthly collaboration of service providers and local government staff. The group focuses on persons with chronic substance use disorders who appear frequently for services at hospitals, jail and sobering services or are particularly challenging to serve. The complex and chronic needs of these persons cannot be met effectively or efficiently in these high-cost settings. Frequent users are often involved in several systems of care (primary and behavioral health, social services, criminal justice, and housing systems).

The group seeks to clarify service planning goals to consolidate services and direct people towards the most effective service system. It also serves to keep staff in routine touch with each other to expedite contact and communication. Cases are staffed after written consent from people is obtained.

Participating organizations include Pioneer Human Services (sobering, case management, SUD, MH treatment), DESC (SUD, MH, housing), Harborview (emergency medical, SUD), Swedish Hospital (emergency medical), Virginia Mason Hospital (emergency medical), Recovery Centers of King County (SUD, medical detox), Catholic Housing Services, Plymouth Housing Services, DSHS (benefits), REACH, and King County (Jail, ESP, CDITS, program facilitation).

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Health care reform will play a significant role in the work of the DSSC. Washington's recent application to the federal Centers for Medicare and Medicaid Services for a Section 1115 Medicaid waiver and the movement towards full integration of physical and behavioral health integration could have a great impact on the work. While the Medicaid expansion brought new health coverage that includes a mental health and SUD treatment benefit to many who lacked this resource, limitations still exist around how those benefits are provided and do not address the challenges associated with location and the ability to meet the population where they are.

Medicaid funding does not cover sobering or transportation services; however, more work needs to continue on case management and outreach to ensure Medicaid funds are maximized. The work to integrate physical and behavioral health will be a positive step in being able to meet individuals' needs whenever, wherever, and however works best for that person; however, limitations will still exist. The

waiver will allow for new flexibilities in how care is provided to achieve better outcomes, and will further the ability of providers to be able to deliver the right care at the right time and to some extent, in the right place.

Enhanced medical integration at DSSC will only further enhance the ability of the community to be able to deliver the right care at the right place, when the individual needs it. The services provided through these programs are an initial step in enhancing the ability of the community to deliver services along the continuum of care, wherever an individual may be in the County, whether they are in need of immediate crisis stabilization services or are in need of connection to longer term services that help them to maintain stability. Without the benefits obtained through healthcare reform, many of these individuals would have been deemed ineligible for Medicaid or other health coverage based on exclusionary factors no longer in place and, without access to benefits, most of the more therapeutically appropriate services needed for stabilization would not have been available to them – treatment, medications, housing – and they would continue to cycle through the hospital and jail settings.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

   Phase 2 (re-siting of sobering) of this concept will face challenges, beginning with siting issues. Recent discussions in South King County regarding siting of facilities that respond to individuals with mental health and/or SUDs, for crisis or on-going services, have met with local resistance. Collaborative efforts need to be established to address community concerns regarding programmatic eligibility and neighborhood impacts. Similar neighborhood engagement, along with stigma reduction efforts, would be recommended prior to the siting of this facility. Local law enforcement, community behavioral health providers, community-based groups, local municipal governments and neighbors would be an integral part of this process.

   Other desired program outcomes, such as access to housing, withdrawal management and residential treatment services are dependent upon capacity in the community. Specialized housing services that readily work with the DSSC population are in short supply. Having available treatment on demand is a desired approach to match the changing motivations of people to access care.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Expanding the catchment area of the Emergency Service Patrol will lead to increased capacity problems at sobering. Currently the center is at capacity most nights of the year, save some periods during the summer. In order to continually serve new people, the center rotates out people who have been on site longest, are housed or who are judged capable of accessing other shelter services for the evening. Agreements will need to be made with other shelter providers to take referrals from sobering throughout the evening; however, it is likely that shelter capacity throughout the system will not be enough to cover the need.

Wait times for community based treatment and housing services could continue to increase.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Individuals with behavioral health disorders will continue to utilize costly resources such as EDs and jails due to the symptoms of their disorder(s). Law enforcement and other first responders would have limited access to resources to assist in the field and would rely on jail and hospital settings to address the needs of this population. There continues to be focus every day in local and national news on the number of individuals in jails and prisons with mental health and/or SUDs, as well as on how law enforcement is responding to these individuals. Without resources that officers can use as alternative options for appropriately addressing those in need, there will continue to be an over-reliance on jails and hospitals to manage this population.

Information obtained from a fact sheet on the development of Sobering Services in Tacoma, Washington found that when an individual who has chronic homelessness and alcoholism is transported to a local emergency room, the cost incurred can range from $1,200 to $2,500 per incident and can utilize the services of a combined 15 professional staff from police, fire and emergency medical services.[7] This can impact service provision at local hospitals for both this population and for any other individual who is attempting to access emergency services through their local ED.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Seattle has shelter providers, notably DESC, Mary's Place and the Union Gospel Mission that could serve the DSSC population; however, those agencies would need to evaluate their admission criteria, staffing patterns, and ability to assess and assist acutely intoxicated persons.

Enrollment in outpatient behavioral health services is another resource to help stabilize and support individuals in the community, and provide coordination of care to address unmet needs resulting in crises or behavioral problems in the community, and subsequent law enforcement response. This also includes crisis response for individuals who are enrolled in the King County Behavioral Health Organization (BHO). The intent of crisis services is to respond to urgent and emergent mental health needs of persons in the community with the goal of stabilizing the individual and family in the least restrictive setting appropriate to their needs, considering individual strengths, resources, and choice. The current crisis response system for individuals enrolled in the BHO does not require an outreach to the community to assess the individual's needs or determine what services and supports could be provided to assist the individual with remaining in the community. Additionally, many contracted providers subcontract their crisis response services to other agencies, which often includes telephone access only to an individual, with limited outreach availability into the community to directly address a crisis need, and with little direct knowledge about the individual. Finally, enrollment in the BHO is limited to individuals eligible for publicly funded behavioral health services, and there are limited response options for other populations in need.

[7] The Development of a Sobering Service in Tacoma, Washington: Sound Social and Fiscal Policy in Managing and Assisting Chronic Street Alcoholics.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

All programs at DSSC link with Behavioral Health Integration, especially given the high levels of co-occurring disorders in the population served, which will allow for more integrated and streamlined access to services. DSSC frequently removes barriers to access by allowing individuals in behavioral health crisis, regardless of whether the crisis is related to mental health, substance use or co-occurring disorders.

DSSC services will help the County achieve its Health and Human Services Transformation vision - By 2020, the people of King County will experience significant gains in health and well-being because the community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities. DSSC's practice of embracing recovery at the individual level helps move the community towards that goal.

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

The intent of the programs at DSSC is to meet the individual where s/he is, rather than expecting the individual to be ready for services, housing, etc. Recovery is a process, and DSSC honors the many paths to recovery that individuals walk. DSSC works with individuals on a repeat basis in order to work on motivation for treatment, while also focusing their efforts on what is important for the individual. Without basic needs being met, and a little human compassion, individuals will likely be moving from crisis to crisis, rather than moving down a path of recovery. After focusing on identifying and addressing the most pressing needs – behavioral health or medical crisis, DSSC services work on engagement, such as obtaining identification, obtaining health benefits, and completing housing applications. The facility will be able to take the extra steps to ensure an individual has access to services and the support they need to help them maintain stabilization.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

In 2014, 55 percent of the persons using sobering services identified as other than white. There are long-standing, widely known issues with the lack of services and diversion opportunities available to persons experiencing homelessness and behavioral health issues. Many people of color and people living in poverty access services at DSSC. Often when these individuals come into contact with law enforcement because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies), they are taken to jail in lieu of addressing the root cause of the matter: access to treatment, housing, jobs, support, healing and recovery, and a community of people who care and value them as people. At its core, DSSC addresses equity and social justice (ESJ) by allowing individuals to not be criminalized, and families torn apart, due to their social services and access needs, but rather assisted to meet and fulfill those needs.

Overall demographic data were presented in a previous section. It should be highlighted that the DSSC is a particularly important resource for Native Americans in the Seattle area. Among the 2,059 people admitted to DSSC anytime in 2014, the percentage who are Native American (10 percent) is much higher than the percentage of Native Americans in either the general population (2 percent) or in any other drug/alcohol program, other than Involuntary Commitment Services. In addition, a disproportionate number of the frequent users of DSSC are Native American: 19 percent of those admitted five times or more in the last biennial quarter were Native American and 19 percent of the 21,134 admissions in 2014, were for Native Americans. This disproportionate frequent use of the center by Native Americans is a long-standing issue, speaking to the need to develop and deliver tailored intervention programs to this group.[8]

DSSC's efforts on promoting stability through referral to housing services and supports is in line with the King County's All Home initiative, which aims to make homelessness rare, brief, and a one-time occurrence by addressing crises quickly and tailoring housing and supports to individual needs,[9] and addresses the state of emergency regarding homelessness declared by the City of Seattle and King County in November 2015.[10] The individually tailored program, designed to connect people to housing and services, also relates to two determinants of equity identified by the King County ESJ work: access to health and human services and affordable, safe, quality housing.[11]

The United States Department of Justice asserted in a statement of interest that "[i]t should be uncontroversial that punishing conduct that is a universal and unavoidable consequence of being human violates the Eighth Amendment...Sleeping is a life-sustaining activity—i.e., it must occur at some time in some place… Criminally prosecuting those individuals for something as innocent as sleeping, when they have no safe, legal place to go, violates their constitutional rights… Needlessly pushing homeless individuals into the criminal justice system does nothing to break the cycle of poverty or prevent homelessness in the future. Instead, it imposes further burdens on scarce judicial and correctional resources, and it can have long-lasting and devastating effects on individuals' lives."[12] Criminalizing homelessness is not the answer. Programs such as the DSSC, that work with local community partners, will help ensure individuals have the resources and services they need to obtain and maintain permanent and stable housing and reduce legal system involvement.

Additionally, a significant problem for homeless individuals is the constant concern of how to address hygiene. The simple act of washing one's clothes, taking a shower, keeping your hands, face and body clean when living in a place without a roof, running water, electricity, or plumbing is very difficult. If someone's only access to a bathroom is through a gas station, coffee shop or public library, life becomes very difficult. By providing free access to a safe, clean, welcoming facility, where services are provided without judgement or ideology, in a clear, consistent, respectful, fair and dignified manner, people can begin to relax and gain some peace and begin the process of establishing trust, eventually leading to possible reconnection with services.

[8] MHCADSD, Op. Cit.
[9] http://allhomekc.org/the-plan/#fndtn-brief-and-one-time.
[10] http://www.seattletimes.com/seattle-news/politics/mayor-county-exec-declare-state-of-emergency-over-homelessness/.
[11] http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2015/The_Determinants_of_Equity_Report.ashx?la=en .
[12] *Bell v. City of Boise et al.* was filed in the District of Idaho in 2009. United States Department of Justice **STATEMENT OF INTEREST OF THE UNITED STATES** Case 1:09-cv-00540-REB Document 276 Filed 08/06/15, page 3 of 17.

The DSSC focuses on both reducing the criminalization of behavioral health disorders, and reducing the reliance on jails and hospitals to address a community need. An enhancement to the existing service continuum is staffing to include more trained and certified peer counselors to assist with the individual's engagement and to promote the recognition that recovery is possible. Peer counselors bring a level of understanding and empathy to help individuals engage with services and to reduce those individuals from feeling alone or different from others. The program will also work to coordinate and collaborate with a wide variety of systems and community supports that have not been available or responsive to individuals' needs, and work to break down barriers to access that may have prevented successful interactions with community based services.

Provide an Equity and Social Justice Framework for Services Provided under DSSC
Programs must ensure to track disproportionality as well as commit to having active and open conversations about race, take note of the White people in power/decision-making positions, especially White men; track if individuals served in outreach programs (various interventions listed above) are involved in program implementation planning and, if not, make active efforts to remedy; ensure that race and racism, disability and homelessness are understood and honest conversations about what equity means, what being culturally responsive means, and remaining committed to continuous improvement.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

For Phase 1; resources needed include funds for the purchase and maintenance of an electronic health record, staff positions and staff training, funds to remodel the current space.

For Phase 2; In the event the center needs to move, resources to re-site the service include construction or remodel cost, funds for neighborhood engagement.

2. **Estimated ANNUAL COST. $2,500,001-$5 million Provide unit or other specific costs if known. Phase 1:**

Specific known cost –
Sobering: 1.0 FTE CM – $80,000
Sobering: 1.0 FTE peer -$80,000
Sobering: $250,000 annually for overall service package
ESP: $600,000 annually for six new positions.
ESP: $75,000 one-time cost for new van.
REACH: $175,000 for 1.0 FTE nurse and 1.0 FTE CM
Agency Software: estimated $50-75,000 cost. (new data system)
Annual staff training - $20,000

Unknown cost – medical staffing such as nursing to mitigate the number of people unable to stay at the center for medical reasons. Cost to potentially remodel the center and cost of a new camera system for the facility

Phase 2 potential cost – up to $5,000,000 for re-siting the services.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

Medicaid can fund case management and outreach services in many cases, and should be the primary fund source. DSSC currently receives funding from the King County Veteran's and Human Services Levy, the City of Seattle, MIDD and state SUD funds. Neither ESP nor sobering services have a secure, dedicated fund source.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

Phase 2 would need time to implement – up to two years to secure a new location and prepare a building to serve the center's needs.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

New Concept papers

#97 Working Title of Concept: Seattle sobering Service enhancement and potential replacement
Name of Person Submitting Concept: Dan Floyd
Organization(s), if any: King County MHCADSD
Phone: 206-263-8961
Email: Daniel-dchs.floyd@kingcounty.gov
Mailing Address: Mailing Address Here

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Phase 1 of this concept is to use MIDD funds to enhance services at the sobering center – through improved case management, behavioral health counseling, nutrition and peer to peer services. The Seattle sobering center is located in the Denny Regrade neighborhood. This area is impacted by growth with a number of new hotels, condominiums and office being built or in the development stage. The property occupied by sobering is owned by a local non-profit. Phase 2 of this proposal is to use MIDD funds to potentially re-site the sobering center near the downtown Seattle core, a plan that

should include the full, enhanced provision of other onsite services such as transportation, crisis intervention, behavioral health services and/or withdrawal management services.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

The sobering center is called the Dutch Shisler Service Center (DSSC). It serves as a safe and secure place for persons to sleep off the acute effects of intoxication. It also serves as a recovery access point where people receive case management services, outpatient behavioral health treatment, and assistance to move towards greater self-determination. Pioneer Human Services has provided sobering and outpatient treatment services since January 1, 2009. Sobering services in King County date back to 1999 in their present location.

The sobering center serves up to 60 adults at a time. The service never closes for new admissions; when the 61st person arrives at the door, someone in the original 60 is discharged. This might be a person who has been on site the longest, has housing or can access other shelter options. In 2014, the sobering center served 2060 unduplicated persons for 21,134 admissions.

3. How would your concept address the need?
Please be specific.

Phase 1 funding would include funding to enhance services through hiring FTE staff and funds to enhance nutrition capability at the center. Phase 2 funds are capital funds needed to re-site sobering. Funds are necessary to locate, secure and renovate an appropriate property. The center needs to be located near downtown Seattle due to contractual requirements with the City to serve the downtown core.

4. Who would benefit? Please describe potential program participants.

Sobering services benefit the 2000 different people who annually directly receive care through providing them a safe and secure place to sleep, along with access to services to further their individual recovery goals. The services benefit local hospitals and jails that would end up serving many of these individuals if sobering services are not available. The services benefit the community through improved livability of downtown Seattle. The services benefit the community through improved access for first responders who are able to do other work while people needing sobering services are cared for elsewhere. Additionally, the new sobering center should include other needed services, such as withdrawal management. These services are critically needed in the Seattle area as an entry to treatment and recovery.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Sobering services are currently recorded through King County MHCADSD and MIDD evaluation should help track cost offset for people receiving services (savings in emergency room use and jail days). Another important outcome measure is tracking the numbers of people receiving other recovery services.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Sobering services strengthen the health of individuals and the community, especially for those individuals with severe SUD issues who face barriers to recovery.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Partnerships already exist with the necessary local partners – contracted provider, police, fire, hospitals. MHCADSD will need to develop a partnership with the neighborhood selected for the site.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ 250,000 per year, serving 25,000 people per year
Full Implementation: $ 10,000,000 per year, serving 25,000 people per year

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#74 Working Title of Concept: Outreach and interdisciplinary case management for chemically dependent adults who utilize Dutch Shisler Service Center
Name of Person Submitting Concept: Trudi Fajans
Organization(s), if any: Public Health/ Health Care for the Homeless
Phone: 206-264-8344
Email: Trudi.fajans@king county.gov
Mailing Address: Mailing Address Here

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

This is a continuation of MIDD funding for interdisciplinary, intensive social and nursing case management focused on homeless and chemically dependent single adults who frequent the Dutch Shisler Service Center (DSSC). Clients are screened into REACH services based on chronicity of substance use and the client's inability to independently access needed community resources. These positions work with this population on site,and in other locations where they sleep, mostly outside. Using a client-centered, harm reduction approach, they support clients to successfully access needed resources and services including mental health and chemical dependency services, non emergent

health care, entitlements and housing.
Under MIDD I, this program was funded under MIDD Supplantation.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Significant numbers of chronically homeless adults, who are significantly impaired by their alcohol and/or drug addiction and may be physically, psychologically and/or socially disabled, have tried and failed chemical dependency treatment, often multiple times. These individuals have suffered many losses in addition to their loss of housing, including financial security, family, cognitive abilities, and health and mental/emothional well being. They often live in a state of crisis that can lead to life threatening situations and high utilization of costly health, chemical dependency and criminal justice services and facilities, and with little or no self-regard they sometimes manifest behaviors that infringe on others in the community-at-large. This is a service deemed critical by DSSC.

3. How would your concept address the need?
Please be specific.

The Dutch Shisler Service Center is designed to allow people who are intoxicated in public areas to have a place to sleep off the effects of their substance use. The REACH team at the DSSC, consisting of a case manager and a community nurse, engage the clients who use the DSSC and ask the clients what services they need, and using a motivational approach, engage the clients by having a consistent and non-judgemental presence. Having a nurse who can respond to questions or dress a wound has been a very effective way to engage many clients at the site. Clients are asked if they would like to work with a case manager and address their goals. CD assessmnets can be conducted by REACH chemical dependency providers or other CD staff sited at the DSSC. The nurse is an important resource to the case manager when dealing with clients who have many health issues resulting from, or exacerbated by long term substance use. Whether the client initially engages with the nurse or with the case manager there is collaboration between the two staff contributing to a more comprehensive set of services to be available to the clients. Clients can prioritize their needs; they may want help in finding a primary care provider in the community to address a health issue before they will broach their substance abuse. Housing placement is often a longer term process, especially when there are barriers to overcome, such as lack of ID or other documentation, eviction or criminal history and debt. This client-centered approach engenders trust and has been effective in creating long term relationships and successful goal setting. This model was developed, based on a University of Washington study that found that intensive long term case management using a harm reduction approach resulted in the best outcomes for Chronic Public Inebriates.

4. Who would benefit? Please describe potential program participants.

The program participants are frequent users of the DSSC, chronically homeless with a long history of drug and/or alcohol use, often with severe co-occurring mental health, and medical conditions that have been neglected for years.They often have mental health diagnoses that will notgain them access to mental health treatment such as traumatic brain injuries, dementia, personality diorders, or PTSD. Many have a criminal history, record of evictions, and have been in and out of the chemical dependency treatment systems numerous times. Additionally a large portion have health conditions related to their extensive alcohol use and have cognitive impairments related to both alcohol use and traumatic brain injuries. The REACH team prioritizes services to those clients who cannot advocate for themselves.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

When clients sustain their commitment to working with a case manager the results include engagement in a range of substance abuse services including inpatient and outpatient chemical dependency treatment, chemical depency related group participation and individual harm reduction counseling. Other significant outcomes are housing improvements, permanent housing, and housing stability. Improving financial stability through entitlements, guardianship of client funds and working with clients on budgeting. Lastly, assisting in linkages to a primary careand specialty provider to address complex medical problems. Most of this data is currently collected by REACH in an Access database.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The Health Care for the Homeless definition of health for services provided by its partners/sub contractors has always operated under the assumption that behavioral health is included in the definition of health and that services to the extent possible (limited only by available resources) are provided in an integrated model. the REACH program which as been the provider for this concept for close to 20 years draws upon the resources of their entire team when providing services at a specific site, such as this concept for clients using the Sobering Center. once engaged with the two providers at the site other case managers may be brought in as a long term case manager when the needs of the client are considered over time. For example a client who was Spanish speaking may be matched with a case manager who is both fluent in Spanish and immersed in Latino culture to work with the client. Different case managers have or develop strong relationships agencies in the community that reflect the different cultural needs of the clients, such as Thunderbird Treatment Center, Consejo, Chief Seatlle Club and Asian Counseling and Referral services.Case manges develop expertise is certain areas and both provide resources to the team as a whole and work with certain clients as warranted. at the Sobering Center REACH, where Native American clients are overrepresented, case managers work with an even more disproportionately high number of Native American clients. The team as a whole has worked to recruit case managers from the population and to develop team wide knowledge, sensitivity and competence to bring to their work.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

REACH has extensive relationships and partnerships including a range of RSN providers, convenes Seattle outreach programs on a monthly basis for case finding and case conferencing, participates in the High Utilizer, has a HMC mental health provider imbedded at REACH home office who can see REACH clients including those who have diagnoses that preclude them from RSN services, consults with providers at community health centers/Primary care, works with Public Health Needle exchange to collaborate and cross refer, participates in the VIP program where case managers can assist their clients to get dental services at the Downtown Public Health Dental Clinic, has been involved in jail diversion programs and more recently is the Social Services provider for the LEAD program, has a cas manger imbedded with the South King county mobile medical van, provides ongoing case management for the most complex clients at the medical respite program and works with them to be placed in housing and continues to provide case management once housed, has a case management who is expert in the Veterans system and is a resource to the whole team when working with veterans.They also coordinate with the palliative care for homeless adults operated by HMC.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: **$ 112,000 per year, serving 160 people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

#137

Working Title of Concept: Sobering Center Transportation

Name of Person Submitting Concept: Darby DuComb
Organization(s), if any: Seattle City Attorney's Office
Phone: 206-684-8228
Email: darby.ducomb@seattle.gov
Mailing Address: 701 Fifth Avenue, Suite 2050, Seattle, WA 98104-7097
Please note that county staff may contact the person shown on this form if additional information or clarification is needed.
Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.
Fund more vans to transport intoxicated people to sobering centers, hospitals, and home as needed.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.
Public agencies report that more transportation is needed for intoxicated people who present to police, fire and shelter agencies and need a place to sober up.

3. How would your concept address the need?
Please be specific.

People who are chronically alcoholic and/or drug addicted have very little control over their lives. They are challenged to contact the right service provider, maintain appointments, get places on time, or manage public transportation. And when these folks are homeless, they are often turned away from shelters due to their intoxication.

4. Who would benefit? Please describe potential program participants.
Police agencies, fire agencies, hospitals, shelter providers, transportation companies, and individuals. Anyone who encounters someone in need of transportation to a safe place to sober up, and the individuals in need of such transportation.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.
Fewer people impacting high cost services like police, fire, and hospitals. An improvement in the health, safety and welfare of the general public.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)
X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
X **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
X **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?
To be able to help people become sober without overtaxing our police, fire, and hospital resources, it is necessary to transport them to sobering centers. Keeping these people out of these high cost services, the criminal justice system and jail is a long-term harm reduction strategy.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.
Dutch Shisler Sobering Center, Downtown Emergency Services.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Seattle City Attorney Peter S. Holmes

Working Title of Concept: Sobering Center Unique to 0-24 year olds
Name of Person Submitting Concept: Darby DuComb
Organization(s), if any: Seattle City Attorney's Office
Phone: 206-684-8228
Email: darby.ducomb@seattle.gov
Mailing Address: 701 Fifth Avenue, Suite 2050, Seattle, WA 98104-7097
Please note that county staff may contact the person shown on this form if additional information or clarification is needed.
Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.
Fund more sobering centers throughout the county for people aged 0-24 that serve all different drug users..

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.
Public agencies report that more sobering centers are needed for intoxicated people who present to police, fire and shelter agencies and need a place to go to in order to become sober.

3. How would your concept address the need?
Please be specific. People who are chronically alcoholic and/or drug addicted have very little control over their lives. They are challenged to contact the right service provider, maintain appointments, get places on time, or manage public transportation. And when these folks are homeless, they are often turned away from shelters due to their intoxication. The one sobering center we do have in Seattle is overtaxed and overburdened. More sobering centers should exist throughout the county so that fire agencies do not have to spend so many resources transporting people to Seattle

4. Who would benefit? Please describe potential program participants.
Police agencies, fire agencies, hospitals, shelter providers, homeless providers, individuals and then general health safety and welfare of the community. Anyone who encounters someone in need of a safe place to sober up, and the individuals in need of such service.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.
Fewer people impacting high cost services like police, fire, and hospitals. Long-term recovery for young people.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)
X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
X **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

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

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?
To be able to help people become sober without overtaxing our police, fire, and hospital resources, it is necessary to get them to sobering centers. Keeping these people out of the criminal justice system and jail is a long-term harm reduction strategy.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.
Dutch Shisler Sobering Center, Downtown Emergency Services, Department of Social and Health Services

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?
Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?
Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.
If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.