MIDD Briefing Paper

BP 48 Peer Bridgers for the Community Corrections Division Working Title Here

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 program proposes changes to enhance the Center for Community Alternative Program (CCAP) through the provision of peer to peer services. The Department of Adult and Juvenile Detention's Community Corrections Division (CCD) operate several programs that provide alternatives to secure detention and treatment services. CCAP is a CCD program that serves over 150 individuals each day—of whom majorities have either mental illness, chemical dependency or both. The CCAP already has several contracts with agencies that provide direct assessment, treatment, and case management services to these individuals. In addition, many of the individuals in CCAP also enroll in education and job readiness programs associated with The Learning Center operated by the South Seattle Community College. Many of these mentally ill and/or chemically dependent individuals begin their recovery in CCD programs. Many of them also successfully complete their court-ordered requirements.

Collaborators:

Name		Department
Vince Collins	Program Manager	DBHR
David Jefferson	Community Health Analyst	Skagit County
Clifton Curry	County Council	

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

Name	Role	Organization
Dave Murphy	Project Manager	Behavioral Health and Recovery

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 program proposes changes to enhance the Center for Community Alternative Program (CCAP) through the provision of peer to peer services. The Department of Adult and Juvenile Detention's

Community Corrections Division (CCD) operate several programs that provide alternatives to secure detention and treatment services. CCAP is a CCD program that serves over 150 individuals each day—of whom majorities have either mental illness, chemical dependency or both. The CCAP already has several contracts with agencies that provide direct assessment, treatment, and case management services to these individuals. In addition, many of the individuals in CCAP also enroll in education and job readiness programs associated with The Learning Center operated by the South Seattle Community College. Many of these mentally ill and/or chemically dependent individuals begin their recovery in CCD programs. Many of them also successfully complete their court-ordered requirements.

This concept would create peer bridgers in the CCD for the CCAP program—using successful program graduates. These individuals would be in recovery, while also understanding the requirements (and benefits) of CCD programs and have experience with the criminal justice system. The peer bridgers—like the other MIDD-supported Peer Bridgers staff—would support the existing treatment and case management elements of existing CCAP programs. Peer bridgers would work with CCAP participants throughout the course of the program, helping to engage participants upon entry and helping people transition into the community as services are completing. Peer bridgers are paid members of the CCAP treatment team. Peer bridgers will assist with many of the CCAP goals including:

- Helping people obtain publicly funded benefits.
- Ensuring services and interventions are strengths-based and promote recovery and resiliency.
- Promoting linkage to ongoing treatment, aftercare, and/or other appropriate community-based services.

Forensic peer bridgers have recovery experience with behavioral health issues and may also have a criminal justice history (Randall, Megan and Ligon, Katharine. 2014. From Recidivism to Recovery: The case for Peer Support in Texas Correctional Facilities). Peer support re-entry programming can play an important role in reducing human suffering and containing costs by ensuring that inmates successfully transition from correctional facilities into more cost-effective and clinically appropriate community-based services post-release – keeping individuals in their homes and communities and out of the jails and prisons.

Peer-to-peer support services expand the capacity of the formal treatment system by promoting recovery, reducing relapse, and intervening early when relapse occurs. Trained peers assist in supporting recovering people and their families to stay in recovery longer and become part of the recovery community. King County has extensive experience in the delivery of peer to peer services. Peer to peer support has been implemented statewide in mental health services. In SUD services, peers have not been recognized by the State of Washington as a credentialed group to assist in service delivery. King County has been working with local agencies to support the provision of peer services in the community for the past four years. Peer-to-peer services are designed as an element of the King County Recovery Oriented System of Care (ROSC). This concept would also place King County in a leadership position statewide to formalize the process of funded peers for people with SUD issues, as well as mental health. Individuals receiving CCAP services frequently have both needs..

Quality, well-trained, and supervised peers have the potential to decrease the severe complications associated with managing complex issues. Peers can help navigate systems of care, connect people with recovery resources, understand the criminal justice system and help people on paths toward long term recovery. Peers can provide much needed “executive functioning” capacity, which is often impaired in people with SUD. Peers can help provide the key problem-solving skills needed to be successful. Peers

can serve as another linkage in the system of care and provide advocacy and guidance for people who often have lost their ability to stand up for themselves and negotiate on their behalf. Often people early on in the recovery process trust peers more than formal treatment professionals as those who have "been there and done that" or will confide in peers as "one of us".

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).

Crisis Diversion: A task of peers is to help with the development of crisis plans (through evidence-based Wellness Recovery Action Plans) and resources for engagement that will prevent behavioral health crisis, especially those involving SUD.

Recovery and Re-entry: Peer-to-peer support services expand the capacity of the formal treatment system by promoting the initiation of recovery, reducing relapse, and providing early intervention when relapse occurs.

System improvement: Peers will help decrease cost by working to end the revolving door of SUD treatment, allowing for comprehensive engagement, and smoother entry to and exit from services, and assist individuals with mental health treatment engagement when indicated. Participants will engage in services faster, stay engaged longer, and have a trained person to assist with recovery checkups and engagement in community living. Upon discharge from services, peers will have an opportunity to have continued employment in the recovery community by becoming trained peers themselves in King County's Recovery Oriented System of Care (ROSC).

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.**

Peers are people with lived experience who have initiated their recovery journey and are able and willing to assist others who are earlier in the recovery process. As described in SAMSHA's *Recovery and Recovery Support* paper, recovery support services also include access to evidence-based practices such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services. Recovery support services may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support services. These services are delivered through a variety of community and faith-based groups, treatment providers, schools, and other specialized services. (SAMSHA, 2015). Peers will allow for an ongoing improvement of a person's overall health status by focusing on the person and not his/her symptoms (sobriety).

There are limitations on the scope of services CCAP treatment and program staff can provide. Participant volume is great; intensive individualized services, such as one-on-one mentoring, and community based support activities, such as aiding participants with obtaining state issued IDs or accompanying clients to medical and/or treatment appointments, are simply beyond program capacity given staff: client ratios. The ability to provide these types of services via peers could make a difference in the lives of those attempting to reset the course they are on. Without someone in a role oto provide this type of hands-on assistance, individuals who have limited coping and follow-through capacity will continue to fall through the cracks, remain unengaged with appropriate care, and be less than successful at following through on court orders and getting their lives on track.

CCAP Participants who successfully complete the program often face obstacles to regular employment due to their mental illness or drug dependency issues as well as their criminal justice involvement. Becoming a paid peer is one way individuals can overcome these obstacles and prove themselves as employees. Working as a peer benefits the peers themselves, and is likely to keep them from recidivating, as they will not need to engage in "survival crimes." They will also provide an example of employment hope. Peers can help participants early in the process by assisting withjob searches and preparing participants for interviews. Ideally CCAP will begin to cultivate successful program participants for future peer work in the program.

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

Peer bridgers can help those leaving jail or CCD programs with engaging in services and finding natural supports in in the community. The Peers would also be a "force multiplier" for the existing CCD program service providers. The development of peer bridgers will be another type of job training for a population with significant employment barriers that the County can provide through CCD.

Peers will help link CCAP participants to other community based services, such as behavioral health treatment, housing, and community based services for support. Peers will help link people throughout the SUD system – in residential and withdrawal management facilities, in outpatient agencies and potentially in other places that CCAP participants touch, such as courts and jail and stand-alone recovery community organizations (RCO), such as Recovery Café and Seattle Area Support Groups or in more formal treatment agencies.

The fore-mentioned RCOs present contracting options for initial peer training. These agencies have been strong leaders in developing a peer to peer infrastructure in King County, including current FTE positions through the MIDD 1A strategy, and substantial work through the Access to Recovery federal grant.

The addition of peers aligns with the goals of healthcare reform to improve collaborative care, improve health outcomes, and ensure choices are available in healthcare.

Peers will help decrease the stigma faced by persons with substance use disorders. There is a growing recognition that people don't just have issues with accessing recovery: they often suffer from a broad range of social, psychological, economic and health problems (Miller and Miller, 2009). The provision of a wider range of 'wraparound' care or interventions has been associated with better treatment outcomes (McLellan et al., 1998) and has led to calls for treatment to be multifaceted (Miller andMiller, 2009). Therefore, people's access to employment, education, training, accommodation and psychiatric

services is likely to be key to their rehabilitation. Stigma can be a significant stumbling block: both in terms of the internalization of blame and difference on the part of the person, and in the stigmatization of people by employers and professionals.

Peers help to reduce stigma through strategic sharing of their own recovery stories with the people they work with and through their broader advocacy and visibility to the community. If there is a single condition that has spawned the historical involvement of recovering people in service work, it is the contempt with which society and mainstream service professionals have viewed those suffering from substance use disorders. By altering these conditions, peer-based supports provide adjuncts or alternatives to professional assistance that can expand help-seeking, enhance the quality of the helping experience, and improve the stewardship of scarce community resources (Reissman, F., 1990. Restructuring Help).

Peers in CCAP will share their experiences as returning offenders and model the ways they advanced in recovery.

If there is an inner core to the experience of addiction, it is a core of shame and the anguish and despair that flow from it (White, W. 2009. Peer-Based addiction Recovery Support). That shame has many sources—the stain of experiencing oneself as unworthy and unlovable, the sins committed in the worship of one's sacramental drug, and the pariah status of anyone forced to embrace the caricatured label of alcoholic or addict. Those so condemned can catch the briefest condemnation in the eyes, the faintest tone of judgment and condescension in the voice, and the slightest hesitation to reach for an extended hand. Peers understand such shame. Professionals who have not experienced stigma can offer many things, but one thing they cannot add to the suffering person is the word "we". The experience of "we" is the connector that allows peers to enter relationships with people and help break down the barriers experienced along the path to recovery (White, W. 2009. Peer-Based addiction Recovery Support).

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.**

   The largest body of evidence that this approach will be successful is the work of peers in the King County mental health system. Peers have been accepted parts of the treatment system for the last several years and demand for training of new peers remains high.
   Access to Recovery has spent over $50 million on building a system that focuses on helping participants stay in recovery, which has included a range of peer supports from Recovery Specialists to Recovery Coaches. Evidence shows that programs that include peers and provide support beyond the prescribed treatment episodes are associated with improved outcomes and higher rates of metrics associated with long-term recovery. This grant is time limited and funding has decreased dramatically throughout the state. Published research is available at the Department of Social and Health Services Research and Development- ATR site. (https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-11-217.pdf)

King County funds a Peer Bridger program that has been successful in serving individuals with complex needs who are being discharged from psychiatric hospitalizations. Nearly half of the participants are ethnic minority and about half are homeless. The program serves about 50 participants per month, who receive referrals and linkages to mental health services and other services and supports.

Outcome analysis showed that the program is meeting its goals of reducing hospital use and increasing engagement in community-based mental health and other services. Specifically:

- Participants significantly reduced hospital episodes and days, reducing hospital days an average of 23.4 days per participant and hospital length-of-stay by an average of 18 days per participant. Reductions are greater for participants than a comparison group.
- Jail stays were rare both before and after Peer Bridger enrollment and they showed little change over time
- Participants increased their rate of enrollment in outpatient mental health services and in Medicaid within 90 days of hospital discharge.

Survey responses indicated that Peer Bridgers were particularly helpful in providing information and resources, providing an understanding, trusting relationship, and helping participants stay motivated for recovery. The only areas for improvement reported by more than one person were more assistance with getting transportation needs met and increasing the program staff time.

While the population and focus of that Peer Bridger program is slightly different than the one the one being proposed, the value added of the Peer Service would be transferable. It is reasonable to assume a forensic Peer Bridger program could lead to improved outcomes fortreatment linkage and reduced criminal justice involvement.

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.**

SAMHSA has long noted that peer/consumer services are evidenced-based.
(samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP)
Peer support relationships have been repeatedly found to positively affect individual recovery (Breier & Strauss, 1984; Neighbors & Jackson, 1984; Powell, 1988; Davidson et al., 1999). People who have common life experiences also have a unique capacity to help each other based on a shared affiliation and a deep understanding that may go beyond what exists in their other relationships (Carpinello, Knight, & Jantulis, 1992; Zinman, 1987). Peers often can help each other in an egalitarian manner, without designating who is the “helper” and who is the “helpee” (Constantino & Nelson, 1995; Riessman, 1990).
Further, the roles may shift back and forth within a relationship or occur simultaneously, with both parties benefiting from the process (Roberts et al., 1999; Mowbray & Moxley, 1997; Solomon, 2004; Clay, 2005). In self-help and mutual support, people offer their experience, strength, and hope to their peers, which allows for natural evolution of personal growth, wellness promotion, and recovery (Carpinello et al., 1992; Schubert & Borkman, 1994).

Consumer-operated services are grounded in values and traditions inherent in the history of self-help in general and, more recently, the mental health consumer self-help movement. Basic principles include belief in “peer-based support and assistance; non-reliance on professionals; voluntary membership; egalitarian, non-bureaucratic, and informal structure; affordability; confidentiality; and nonjudgmental

support" (Van Tosh & del Vecchio, 2001, p. 11). Other core values include empowerment, independence, responsibility, choice, respect and dignity, and social action (Zinman, 1987; Chamberlin et al., 1996).

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?**

Development of peer support programs for CCD will provide new community resources for re-entry services, support and enhance existing treatment programs, and aid in the successful continuing recovery of the peers themselves. Peer services improve the health, social and justice outcomes for people living with, or are at risk of mental illness and SUD by improving access to services and the quality of care received, as well facilitating stronger community connections post treatment.

Peers will improve the system through:

- better linkages with the participant and treatment team;
- increasing efficient use of personnel and agency resources;
- improved communication and follow through by the participant; and
- increases in performance measures both with treatment metrics and participant satisfaction metrics.

Peers will also help:

- Increase the number of people coming back after assessment who connect with treatment programs.
- Increase the number of individuals completing programs.
- Increase the number of individuals connecting with recovery support services.
- Individuals navigate the criminal justice system.
- Access medication assisted treatment.
- Provide opportunities to find alternative paths to recovery.
- Engage and retain individuals in treatment, freeing treatment staff focus on the task for providing clinical services.
- Improve engagement of persons into treatment;
- Improve retention of persons in treatment;
- Improve connections of persons between levels of care;
- Improve discharge planning and development of community support post-treatment;
- Reduce stigma for persons in treatment and recovery; and
- Increase employment opportunities for persons in recovery.

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**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☒ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**

- ☒ **Adults**
- ☒ **Older Adults**
- ☒ **Families**
- ☒ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☒ **Other – Please Specify: Persons in recovery**
- ☒ **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.

This concept paper details peers that will work exclusively with the CCAP team and with CCAP participants.

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

   CCAP is a Seattle based program, however, program participants may live throughout the county. Peers would be based in Seattle, but may travel throughout the county to advocate for participants.

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.**

Partnerships are necessary with CCD, the CCAP provider and the larger criminal justice serving system..

Partnerships are necessary with behavioral health agencies, local peer-supportive agencies and the larger recovery community. Behavioral health agencies need to be willing to hire, train, supervise and support peer counselors.

This is also an opportunity to partner with local colleges and universities to introduce training opportunities into their programming. Currently this effort is underway in Southwest Washington under the leadership of Dr. Marcia Roi at Clark College.

Ultimately, a partnership with the State, specifically the Department of Health and Division of Behavioral Health and Recovery (DBHR) is necessary to integrate peer work fully into the system.

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?**

Nationwide, there is broad realization that this country's long running experiment of using costly mass incarceration as a solution for drug use and as a stop-gap in place of mental health treatment has failed miserably. Policy makers are finally realizing that treatment, rather than punishment is a more appropriate response to behavioral health problems.

The Familiar Faces initiative, a component of the King County Health and Human Services (HHS) Transformation Plan, promotes systems coordination for individuals who are high utilizers of the jail (defined as having been booked four or more times in a twelve-month period) and who also have a mental health and/or substance use condition. Creating system-wide approaches that are person-centered, trauma-informed, and recovery oriented are key elements of this initiative. Getting agreement from multiple stakeholder groups, such as DAJD, the courts, community treatment agencies, DCHS, and others creates an enabling environment for this type of initiative.

Senate bill 6312 clearly set out the expectation that the new state behavioral health organizations (BHO's) will integrate clinical care with the intent of improving chronic illness management through better integration of care and social supports. Peer support is a necessary vehicle for this integration.

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?**

CCD and other criminal justice leadership may not support the concept of brining ex-offenders in as peers. There may be stigma from other CCAP staff to address – although the role modeling of peers with lived experience would ultimately greatly benefit the CCAP culture.

Recruiting peers with criminal justice specific experience and the right combination of training and experience will take some time. Recruited peers will need the correct level of jail clearance – or duties requiring clearance would need assigning elsewhere.

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?**

The peer relationship needs solid support and supervision to avoid the peer slipping into old habits based on the influence of people they are supporting.

The criminal justice system is not oriented towards recovery and this dynamic may make for a frustrating work environment for peers.

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?**

Participants in CCAP may have less success engaging in services without a peer voice as part of the process. This will lead to more frequent incarcerations.

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?**

State-certified peers could be candidates for CCAP programming, with specialized recruiting for CJ involvement and training for the CCAP environment.

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?**

   Peers 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. Peers will remove barriers to access by promoting recovery for individuals, regardless of whether their issues are related to mental health, substance use or co-occurring disorders. Peer support is invaluable throughout the continuum of care, prior to treatment, during treatment, and as after-care support.

   This program occurs late in a continuum of care. Participants will already have experienced negative consequences, such as CJ involvement from their disorders and have already been sentenced to some form of treatment. This is providing treatment support and intensification, and hopefully also serves secondary prevention of even more severe consequences. Hopefully it diverts people from future legal crisis and incarceration.

   Peer 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 our 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." Peers embrace recovery at the individual level, helping move the community towards that goal.

Additionally, CCAP peers fit within a continuum of care and accountability in adherence to the following initiatives in King County:

- 2015 Declaration of State of Emergency for Homelessness - King County and City of Seattle; Coordinated Entry for All;
- Health and Human Services Transformation Initiative, specifically Familiar Faces, Physical-Behavioral Health Integration, and Communities of Opportunity (geographic focus options);
- Law Enforcement Assisted Diversion Operations and Policy; and
- King County Veterans and Human Services Levy, which funds forensic programs targeted and veterans and non-veterans involved with the local criminal justice system.

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

Peers will become a critical part of the King County Recovery-Oriented System of Care (ROSC).. A ROSC meets people where they are at on the recovery continuum, engages them for a lifetime of managing their disease, focuses holistically on a person's needs, and empowers them to build a life that realizes their full potential. This person-centered system of care supports a person as they establish a healthy life and recognizes that all people need a meaningful sense of membership and belonging in community. Recovery initiation and entry is at the heart of peer services.

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

Individuals living in extreme poverty, likely to be experiencing homelessness and having untreated behavioral health and primary care issues, are coming through local jails at unprecedented rates. CCAP peers will provide and promote access to treatment, housing, jobs, support, healing and recovery for individuals who are booked for quality of life crimes. At its core, this will address equity and social justice by assisting individuals in meeting and fulfilling those needs.

Diversion and Re-entry staff from the King County BHRD will work closely with partners and selected providers to address the need for broad-scale cultural change in human services and criminal justice system agencies related to harm reduction. Harm reduction training is critical, as substance use tends to be a large driver of criminalization. It is important to move towards a recovery-oriented, person-centered system that is also responsive to the individual's needs as King County moves toward a Future State with ready access to needed services in the community.

The greatest impact of disproportionate incarceration in the U.S. and Washington State involves the Black community, particularly Black men. According to a publication by Black Minds Matter, African American/Black people are 20 percent more likely to experience serious mental health conditions than the general (U.S.) population and experience disparity across several social determinant factors, including increased rates of homelessness, poverty, unemployment, food insecurity, exposure to violence and incarceration.[1] Black people comprise 13 percent of the U.S. general population, but 38 percent of the U.S. prison population.

In a study conducted by Beckett, Nyrop, & Pfingst (2006), University of Washington professor Dr. Katherine Beckett found that racially disproportionate drug arrest rates in Seattle cannot be explained by comparing commission rates, but are actually the result of policing practices that have a racially disparate impact. Furthermore, there are long-standing, widely known issues with the lack of culturally responsive and culturally specific services and re-entry opportunities available in King County for individuals from nonwhite racial and ethnic groups.

Many people of color in the jails are also living in extreme poverty and experiencing homelessness. Often, when these individuals come into contact with law enforcement because of these and other issues (living on the street, experiencing behavioral health crises, engaging in survival economies), they

[1] Fact Sheet: *How Does Mental Health Challenges Impact the African American Community?*" Black Minds Matter, January 2015. Web. http://www.cibhs.org/sites/main/files/file-attachments/how_do_mh_concerns_impact_af_am_community.pdf.).

are taken to jail in lieu of addressing the root cause of the matter: lack of access. Providing peer support to individuals who are justice involved would be a valuable addition to the County's social justice work.

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.)**?**

Resources are needed to recruit and hire full-time employees, a program coordinator/supervisor and on-going support administrative for the program. These FTE positons should be funded at a comparable level with the peers for mental health services.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

   Estimated $590,000 annually for peers to serve 200 participants. This would fund six fulltime peers and coordination/supervision.

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

Peers from the existing MH Medicaid plan could be considered for this project. Other criminal justice funds could also be explored to support the concept.

4. **TIME to implementation: 6 months to a year from award**
   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?**

Time will be necessary to engage community agencies, plan training, time to hire peers and incorporate them into services. An RFP should not be necessary.

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?

#48

Working Title of Concept: Peer Bridgers for the Community Corrections Division

Name of Person Submitting Concept: Clifton Curry
Organization(s), if any: County Council
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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.

The Department of Adult and Juvenile Detention's Community Corrections Division (CCD) operate several program that provide alternatives to secure detention and treatment services. The CCD's Center for Community Alternative Program (CCAP) serves over 150 individuals each day—of whom a majority have either mental illness, chemical dependency or both. The CCAP already has several contracts with agencies that provide direct assessment, treatment, and case management services to these individuals. In addition, many of the individuals in CCAP also enroll in education and job readiness programs associated with The Learning Center operated by the South Seattle Community College. Many of these mentally ill and/or chemically dependent individuals begin their recovery in CCD programs. Many of them also successfully complete their court-ordered requirements. This concept would create peer bridgers in the CCD for the CCAP program—using successful program graduates. These individuals would be in recovery, while also understanding the requirements (and benefits) of CCD programs and have experience with the criminal justice system. The peer bridgers—like the other MIDD-supported Peer Bridgers staff—would support the existing treatment and case management elements of existing CCAP programs.

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.

While CCAP treatment and program staff do work with participants in the existing program—nevertheless, they are limited in services that can be provided because there are som many participants enrolled in program and they cannot perform important one-on-one mentoring, aid particpants in the community (such as getting state issued IDs or accompanying clients to medical and/or treatment appointments). In addition, program participants who successfully complete the CCAP program have obstacles to regular employment (because of their mental illness or drug dependency issiues). These peer bridgers can help those leaving jail or CCD programs with their reentry needs, just like the Peer Bridgers who perform similar tasks for those leaing psychiatric hospitalization.

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

These peer bridgers can help those leaving jail or CCD programs with their reentry needs, just like the Peer Bridgers who perform similar tasks for those leaing psychiatric hospitalization. The peers would also be a "force multiplier" for the existing CCD program service providers. The develop of peer bridgers could also be another type of job training that the county can provide through CCD.

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

As noted in the previous answer, the peer bridgers can help those leaving jail or CCD programs with their reentry needs. The peers would also be a "force multiplier" for the existing CCD program service providers. The develop of peer bridgers could also be another type of job training that the county can provide through CCD.

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.

Development of peer support program for CCD would provide new community resouces for reentry services, supportand enhance existing treatment services in the CCD program, and aid in the successful continuing recovery of the peers themselves.

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 peers themselves would be mentally ill or chemically dependent who are in recovery helping others with the same problems who enrolled in CCD programs to successfully complete these programs.

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.

The Department of Adult and Juevnile Detention's CCD would run the program in cooperation with existing peer services programs.

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

Pilot/Small-Scale Implementation:	**$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation:	**$ 590,000 per year, serving 200 people per year**
Full Implementation:	**$** # of dollars here **per year, serving** # of people here **people per year**