BP 113: Increase Adult and Youth SUD/COD Residential Treatment, Detox and Recovery House Facilities

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

SUMMARY: This proposal seeks MIDD funds for capital and start-up funds for substance use disorder (SUD) residential treatment facilities, step-down Recovery Houses and withdrawal management (detoxification) facilities. King County currently has five adult SUD residential facilities with a total bed capacity of 130 and one 16-bed withdrawal management (detoxification) program. Youth residential programs are limited to two facilities that can house 22 young people at any one time. There are two youth detox beds in the County.

Collaborators:

Name	**Department**

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

Name	**Role**	**Organization**
Margaret Soukup	Concept Writer	King County
Brad Finegood	Deputy Director, BHRD	King County

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 proposal seeks MIDD funds for capital and start-up funds for substance use disorder (SUD) residential treatment facilities, step-down Recovery Houses and withdrawal management (detoxification) facilities. King County currently has five adult SUD residential facilities with a total bed capacity of 130 and one 16-bed withdrawal management (detoxification) program. Youth residential programs are limited to two facilities that can house 22 young people at any one time. There are two youth detox beds in the County.

This concept is aligned with the general goal of MIDD Strategy # 1, *Increase Access to Community Mental health and SUD treatment* as well Strategy 3a, *Support Services for Housing Projects.*

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).

This proposal would improve the King County SUD service system by increasing residential bed capacity and targeting this increase to priority needs and underserved populations. The total number of currently available beds is inadequate and the number targeting co-occurring disorders, transition age youth or transgender individuals is nearly non-existent, or totally absent. Individual must oftentimes wait days or weeks to enter treatment, travel great distances or – in the most egregious cases – try to manage their disorder without the treatment deemed necessary.

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.**

The current SUD residential network is a statewide system of providers. Unfortunately, the bed capacity of this network is inadequate to meet the needs of individuals requiring 24-hour SUD care. Admission to a SUD residential program frequently requires multiple phone calls to facilities across the state and lengthy waiting periods. Providers must sometimes place an individual in outpatient treatment despite an evaluation recommending residential services, simply because a bed is not available. The potential for relapse and poor treatment outcomes is increased when client need and available treatment are not aligned.

Slightly more than 2,000 King County adult residents were admitted to SUD residential facilities across Washington State in 2014. Approximately 34 percent of those individuals entered facilities outside of King County, primarily because of the County's limited bed capacity. County residents sometimes have little choice but to travel considerable distances from their home community – sometimes across the state – to receive treatment. Exacerbating an already difficult situation was the 2015 closure of Recovery Centers King County (RCKC). This 32-bed, sub-acute detoxification facility housed 20 percent (468) of the 2014 adult admissions. King County restored 16 detoxification beds in November 2015 but the availability of this critical emergency service remains woefully lacking. Similar capacity concerns apply to adult SUD Recovery House beds. Recovery Houses provide a cost efficient option for individuals who do not require more intensive inpatient treatment, but still benefit from the support of 24-hour residential care. King County currently funds only four of the 30 available Recovery House beds in Washington State. Twenty-three of the remaining 26 beds are in Spokane. That the majority of these facilities are such a distance from a resident's community is especially antagonistic to the Recovery House goals of helping the individual "adjust to abstinence and transition to the community".

King County's residential capacity for youth is even more problematic. Only 37 percent of young people admitted in 2014 were placed in King County facilities. The remaining youth were placed in Spokane, Bellingham, Vancouver and Yakima. Though removal from friends and familiar surroundings can sometimes assist treatment goals, they also pose considerable obstacles to family support interventions and community re-integration. King County currently has one facility that provides residential treatment and detoxification services for youth with the state contracting for only 1.2 Medicaid eligible beds at any given time. Furthermore, King County has no Recovery House beds for youth. Nearly a third of the 37 available state beds are in Spokane. Once again, the disconnect between the "community integration" goal of Recovery House services and the distance required to access this treatment is concerning. Based on the most recently available Treatment Episode Dataset (TEDS) on public admissions of adolescents (ages 12-17), approximately 12 percent of the youth admitted to publicly funded treatment in the King County area were placed in residential treatment. This is significantly less than the rest of Washington State (26 percent) and the U.S. (15 percent).

It is estimated that 42.8 percent of adults with substance use disorders have a co-occurring mental illness.[1] Yet King County has the only adult co-occurring residential treatment facility in the state. There is no such facility for youth. The ability of the remaining SUD facilities to properly serve co-occurring disorders is severely limited. They do not possess the personnel or program designs required to effectively treat both mental health and SUD issues. There are also no facilities targeting the special needs of transition age youth (18 – 24 years of age) or transgender individuals.

Important Note: The utilization data provided in this section does not reflect those individuals who are not admitted to residential services due to insufficient bed capacity. Though we do not know the exact numbers, anecdotal reports suggest they are signficant.

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

The new concept will address the need in the following manner.

- Medicaid does not reimburse residential treatment in facilities that are larger than 16 beds. These programs - which are classified as Institutions for Mental Disease (IMDs) - comprise the majority of facilities in Washington State and are funded through a limited source of federal and state block grant funds. This proposal recommends the use of MIDD monies to fund the capital expenses and start-up costs for non-IMD residential treatment and detoxification facilities targeting priority needs and currently underserved populations. Once established, Medicaid would be used to support ongoing treatment services. This proposal will increase the number and type of SUD residential beds currently available thereby improving service access.
- The development of more non-IMD facilities (whose services are Medicaid supported) will potentially allow the reallocation the state and federal monies that currently fund IMD programs to other pressing needs. King County could use these monies to purchase more IMD-beds and/or fund services that are not Medicaid reimbursable.
- Allocate MIDD monies to ongoing costs that are not Medicaid-reimbursable, such as transportation, room and board expenses and child care for facilities that treat parenting and

[1] SAMHSA. (2010) Results from the 2009 National Survey on Drug Use and Health: Mental health findings. *Office of Applied Studies, NSDUH Series H-39*, No. SMA 10-4609,

pregnant women (PPW). These services are critical to the successful operation of SUD residential facilities.

- Apply MIDD funds to the renovation and improvement of existing facilities. Such improvements might be used to increase overall bed capacity, create capacity for special populations and support improved care.

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.**

This concept would address the lack of SUD residential treatment beds by funding new facilities and innovative programs that target priority needs and underserved populations. This proposal would also help stretch the County's treatment dollars by decreasing the current demand on federal and state block funds. King County could then reallocate these monies to purchase more IMD-beds and/or fund services that are not Medicaid reimbursable.

An analysis of research conducted between 1995 and 2012 suggests a "moderate level of evidence for the effectiveness of residential treatment."[2] According to the authors of this study, "Residential treatment for substance use disorders shows value and merits ongoing consideration by policy makers for inclusion as a covered benefit in public and commercially funded plans." A 2007 study found that residential treatment is associated with better outcomes than outpatient treatment for those with more severe substance use disorders[3].

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

See above

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?**

King County 2014 SUD residential treatment costs were nearly $8.5 million. Approximately 70 percent of those expenses were funded through federal and state block grant money. Should MIDD fund this proposal, it is important that King County properly evaluate its SUD residential programs to ensure that these limited and valuable funds are well spent. Again quoting the aforementioned 2014 study, rigorous research is recommended "to determine which clients benefit from residential treatment, what duration

[2] Reif, S., Preethy, G., Braude, L., Dougherty, R., Daniels, A., Ghose, S., & Delphin-Rittmon, M. *Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence.* Psychiatric Services, March 2014, Vol 65 No 3
[3] Tiet, Q., Ilgen, M., Byrnes, H., Harris, A., Finney, J. Treatment Setting and Baseline Substance Use Severity Interact to Predict Patients' Outcomes. Addiction, 2007, 102, 432 - 440

of treatment confers positive effects and….examine the components of residential treatment that might relate to effectiveness."[4]

Should this proposal be funded, the County could assess the following measures.

- Number of individuals that complete treatment
  - Data source – residential providers records and MHCADSD IS
- Percentage of discharged individuals that maintain abstinence for 30, 60 and 180 days
  - Data source – outpatient provider records and MHCADSD IS
- Percentage of discharged individuals that enroll in SUD outpatient treatment and complete treatment
  - Data source – MHCADSD IS
- Reduction in future residential treatment admissions, hospitalizations and emergency room visits.
  - Data sources – MHCADSD IS and EDIE data
- Reduction in future jail admissions
  - Data sources – Jail booking report

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**

[4] Ibid

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.

King County residents who are in need of withdrawal management (detoxification) services or residential treatment.

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**: County-wide

The locations available for SUD residential facilities may be limited due to high costs of housing, zoning restrictions and potential neighborhood resistance. Five of the six King County SUD residential programs and the one County detoxification facility are located in a general ten mile area between downtown Seattle and south King County. It is recommended that priority be given to locations outside this area – perhaps in northern or eastern King County.

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.**

Treatment continuity requires the coordination of SUD outpatient providers and SUD residential facilities. Many of these service collaborations are already in place due to the current presence of SUD residential providers. Other important partners include the Department of Judicial Administration (DJA), which administers criminal justice treatment account funds (CJTA), and drug diversion courts. These entities fund SUD residential services for individuals under their supervision.

The development of residential programs will also require the participation of behavioral health agencies that possess the internal systems and resources necessary to purchase (or lease) property, effectively develop and manage such property and deliver quality residential treatment. King County Housing Authority (KCHA) and/or Seattle Housing Authority (SHA) may be helpful in identifying and developing properties for this effort.

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?**

Current federal rules do not allow Medicaid reimbursement for services in facilities with more than 16 beds. Such programs are classified as Institutions for Mental Disease (IMD). (This Medicaid exclusion does not apply to people older than 65 or younger than 21.) Washington State recently submitted a waiver request to the Center for Medicare and Medicaid Services (CMS) that would allow Medicaid reimbursement for IMD-based services. If approved, this new revenue source could positively impact the availability of SUD residential facilities for Medicaid recipients and "free up" state and federal block

grant monies that are currently allocated to fund IMD beds. A decision about the waiver is expected before April 1, 2016.

CMS also recently submitted a proposal that would allow Medicaid reimbursement for fifteen days of SUD residential treatment. Research has not yet determined optimal lengths of stay for SUD residential services, but it is generally viewed that two weeks is insufficient to produce adequate outcomes. Nevertheless, Medicaid support for even partial lengths of stay could assist the development and sustainability of SUD residential services. This writer was unable to locate updated information regarding the status of this proposal.

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?**

The barriers are not insignificant; they are certainly surmountable. They include the following.

- It is yet unclear how many behavioral health providers would be willing to assume the time and effort required to establish and sustain a residential treatment program. The investment of resources to locate and develop properties, as well as the long-term commitment to a complex service model may dissuade many organizations. It is important that King County actively participate and assist agencies during the development phase of the project, as well as ensure long-term County commitment to residential treatment. It is encouraging, however, that one or two providers stated they would have pursued the County's recent solicitation for detoxification (withdrawal management) services if King County had provided the capital funds or buildings for the project. Perhaps MIDD funds would provide the necessary "carrot".
- Locating property/buildings that are affordable, available and welcomed (or, at least, tolerated) by neighbors is no easy task. Property values continue to rise in King County as vacancy rates diminish. But with the support of KCHA, SHA (and a good realtor) it would seem that locations could be found. It is also possible that some behavioral health providers currently possess properties or buildings that are underutilized or vacant due to needed renovations.
- MHCADSD and its provider network have sometimes encountered neighborhood resistance to the introduction of programs that are viewed as attracting dangerous or disruptive individuals. Eventually, the majority of these projects have been allowed to go forward. But the process can require a fair amount of time, energy, patience and legal support.
- Providers must also face the sometimes onerous task of obtaining the necessary permits and licenses required for residential treatment services. Fortunately, King County can leverage the experience of a provider network that is very familiar with such administrative tasks.

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 potential danger of this initiative is that the County simply replicates "what is" rather than promoting innovative, evidence-based models of care. The current SUD residential service system has operated largely absent any robust oversight by Washington State. The resulting programs are based upon the organization's perception of quality care with a great deal of variance among facilities in applying evidence-based, client-centered treatment. The County also has a number of populations that are underserved by the SUD residential system, such as persons with co-occurring disorders, transitional age youth and transgender individuals. Research has not yet answered many questions about optimal

client profiles, treatment strategies, or length of stays in SUD residential treatment. King County must take this funding opportunity to support creative residential treatment models that explore these issues and target priority populations.

Another potential consequence is that monies devoted to this project might – in the long term - divert funds from current SUD residential programs. It is unclear if such a development would benefit or harm the overall service network.

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?**

The consequences would be most directly felt by those individuals – and by extension, their loved ones - who are unable to access residential treatment or must commute hundreds of miles for services because of limited bed capacity.

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?**

King County may wish to explore the following alternatives.

- One option is to allocate MIDD funds to developing its current SUD residential network. Rather than expand bed capacity, the County could focus on improving the quality and innovation of its current residential network. Residential providers and regional administrators agree that the current residential system is underfunded thereby limiting the range, quality and intensity of services. One might argue that enhancing current programs would improve current outcomes and eventually decrease service need across the system.
- Partial hospitalization (or day treatment) has largely fallen out of favor in the mental health world. But it is an American Society of Addiction Medicine (ASAM)-recognized service level with specific admission criteria. There is some evidence that partial hospitalization is more cost effective than intensive inpatient treatment and produces similar outcomes for some individuals[5], [6].

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 Hom the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

[5] McCrady, B., Longabaugh, R., Fink, E., Stout, R., Beattie, M., Ruggieri-Authelet, A. *Cost Effectiveness of Alcoholism Treatment in Partial Hospital Versus Inpatient Settings After Brief Inpatient Treatment*. A. Journal of consulting and Clinical Psychology, Oct. 1986, Vol 54(5), 708-713

[6] Fink, E., Longabaugh, R., McCrady, B., Stout, R., Beattie, M., Ruggieri-Authelet, A., McNeil, D. *Effectiveness of Alcoholism Treatment in Partial Versus Inpatient Settings: Twenty-four Month Outcomes.* Addictive Behaviors, 1985, Volume 10(3), 235-248

This initiative directly supports several BHO and BHI outcomes, such as the following:

- Expanding range and number of SUD residential beds thereby creating more flexibility in providing services for those with SUD
- Increasing access to treatments for co-occurring disorders
- Helping to improve health and social outcomes
- Helping to reduce avoidable emergency room and criminal justice involvement

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

SUD residential treatment may or may not be rooted in rooted in principles of recovery, resiliency, and/or trauma-informed care. It all depends on the manner in which this service model is provided. Should this concept be funded, King County must ensure that these priority values and treatment approaches are embedded in the resulting programs. Providing this service closer to the home community, family, and natural supports for the individual in residential treatment is supportive of recovery and resiliency practices.

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

Substance abuse and dependency crosses all social strata and impacts members of every racial and ethnic group. Yet, it is also true that behavioral health is impacted by a variety of biological, cultural and environmental factors. Poverty, isolation, unemployment, mental illness, financial instability and childhood trauma can elevate the risk for substance abuse and dependency. To the extent that the County is able, it is important that the full range of behavioral health services be made available to the most vulnerable County residents. The proposed concept would fill a large gap in current SUD residential bed capacity. It would help improve access to health and human services for those that currently must wait days or weeks for treatment, travel significant distances or simply try to manage without treatment. Lower income families face the greatest burdens attempting to support family members who may be in treatment far away. Private insurance companies are increasingly funding (or forced to fund because of the ACA and parity requirements) SUD residential treatment. Such treatment must not be limited to the wealthier members of the County or those with the "right" insurance.

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.)**?**

The resources required for capital costs and start-up funds may be substantial, including such items as: the purchase or lease of property; property renovation and repairs; legal fees; acquisition of permits and licenses; bedroom and office furnishings; utilities; and the costs associated with the initial hiring and training of staff. Ongoing costs that are not Medicaid reimbursable include room and board, child care for PPW programs and transportation.

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

The potential costs depend on a range of factors, primarily – but not limited to – the cost and availability of property. The submitted concept paper outlined the following cost expectations.

- Pilot/Small-Scale Implementation : $2 million per year, serving 50-75 people per year
- Partial Implementation: $ 6 million per year, serving 200-300 people per year
- Full Implementation: $ 10 million per year, serving 500-700 people per year

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

Capital funds for treatment facilities that temporarily house individuals are scarce. A primary source of capital funds for housing is the federal Department of Housing and Urban Development (HUD). But such monies typically target the development of permanent housing. This writer is unaware of any current funding that would be available for this concept.

Potential new sources for service dollars that may indirectly help improve overall funding of SUD residential services include the following.

- Current federal rules do not allow Medicaid reimbursement for services in facilities with more than sixteen beds. Such programs are classified as Institutions for Mental Disease (IMD). Washington State recently submitted to the Center for Medicare and Medicaid Services (CMS) a waiver request that would allow Medicaid reimbursement for IMD-based services. If approved, this new revenue source could positively impact the availability of SUD residential facilities for Medicaid recipients and "free up" state and federal block grant monies that are currently allocated to fund IMD beds. A decision about the waiver is expected before April 1, 2016.
- CMS also recently submitted a proposal that would allow Medicaid reimbursement for fifteen days of SUD residential treatment. Research has not clearly determined optimal lengths of stay for SUD residential services but two weeks is generally viewed as insufficient to achieve adequate outcomes. Nevertheless, Medicaid support for even partial lengths of stay could assist the development and sustainability of SUD residential services. This writer was unable to locate updated information regarding the status of this proposal.

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?**

This project would require an RFP to identify a provider agency or agencies. The implementation timeline could be lengthy, depending in large measure upon property availability. Should the participating provider agency have a readily available building then the implementation time would be relatively short – perhaps no more than six months. But such a timeline would be significantly extended if a suitable property is not immediately available and/or major renovations are required. It could take months to locate a site and negotiate a purchase or lease. The time required to complete property renovations and address neighborhood concerns (or active resistance) would add additional months. In addition, the processes required to obtain the necessary permits and licenses, hire staff and purchase furniture are fairly straightforward but frequently time-consuming.

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?

Prior to April 1, 2016, residential substance abuse treatment was the State's responsibility. This is a new service area that the County is required to take on managing as a Behavioral Health Organization.

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Working Title of Concept: Increase SUD/COD Residential Treatment, Detox and Recovery House Facilities in KC

Name of Person Submitting Concept: Brad Finegood /Margaret Soukup
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1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Increase the availability of Capital Costs for Substance Use Disorder (SUD) and Co-Occurring Mental Health Residential facilities, Step down Recovery Houses and Detox facilities in King County (KC).

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

This strategy will address the lack of capacity to adequately meet the needs of King County (KC) for residential treatment, recovery house and withdrawal management (detox) in KC.

In 2014, 2,107 KC Adults residents were admitted to residential substance use disorder (SUD) facilities across Washington State, only 45% of those admitted were admitted to facilities within KC, thus forcing people to go to treatment far away from support systems and their reintegration back to the community.

Recovery Centers King County (RCKC) provided 32 detox beds in King County before they closed in 2015. That provided 800 bed days of sub-acute detoxification per year in addition to maintaining significant waitlists. Loosing this facility created a crisis in KC because although it did not adequately meet the need, it at least provided some of the necessary services. Seadrunar is scheduled to open a 16 bed detox facility in November of 2015, only half of the capacity we had with RCKC. The County is in need of detox facilities in strategically placed geographic areas to meet the needs of our residents in our large, diverse county.

As of 2014 KC has only 4 adult recovery house beds out of 30 in Washington State.

This provides ongoing sober housing for those who completed treatment but do not have a sober environment to transition into immediately. Expansion of recovery house beds provides a cost efficient option for people to not have to stay in more expensive residential or detox treatment beds versus being released to the community without supports.

In 2014, 242 KC youth residents were admitted to residentail SUD facilities across Washington State, Only 37% of those were admitted to a KC facility. Currently there is only one facility in KC that provides residental treatment and detox for youth and the state contracts for only 1.2 Medicaid eligible beds at any given time. There are no youth recovery house beds in KC, 37 Beds are available statewide, thus often taking youth and adolescents away from their families if they want treatment.

Based on the most recently available Treatment Episode Dataset (TEDS) on public admissions of adolescents (ages 12-17), approximately 12% of the youth admitted to publicly funded treatment in the King County area were placed in residential treatment. This is significantly less than the rest of Washington State (26%) and the U.S. (15%). Washington State contributes Target data to the TEDS data set. These numbers do not include the percentage of youth or adults who were assessed with the recommendation of residential treatment and did not receive it due to tha lack of capacity.
Currently there is one adult facility that provide SUD and Co-occurring Mental Health Treatment in KC, and no existing youth COD facility.

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

Create capital and start up funding for non-IMD residential treatment, recovery houses and detox. Ongoing treatment will be provided via Medicaid and other state and local treatment funds. Provide funding for child care in pregnant and parenting facilities; Provide room and board cost unmet by medicad; provide funding to build new facilities or renovate existing facilities based on the need. Build/renovate 2 detox facilities across the county. Provide recovery house's for up to 40 adults and 24 youth leaving residential facilities for appropriate clients. Provide 1 SUD/COD facility for adults and 1 SUD/COD facility for youth and 1 SUD/COD residential facility for Transition Age Youth (TAY) 18-24.

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

Youth, transition age youth (TAY) and adults requiring and needing treatment participating in the justice system; sexually exploited youth and adults needing detox, treatment and recovery house on demand; Pregnant and Parenting women, youth and adults suffering from opiate addiction needing detox, treatment and Recovery house; youth needing treatment and sober housing in order to return back to school.

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.

Decreased incarceration as a response for SUD and mental health treatment needs, decreased emergency room and hospital use, increased high school completion, job retention and decreased cost to society. Yes, this data is available locally and nationally.

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?

This concept meets all of the objectives of the MIDD II

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.

First responders, MH and SUD providers, courts, specifically Therapuetic Courts, jails, detention, schools , hospitals, homeless shelters, Child Welfare, Juvenile Rehabilitation Administation, DOC and MHCADSD.

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:	**$ an estimated 1 million per year, serving 50-75 people per year**
Partial Implementation:	**$ 6 million per year, serving 200-300 people per year**
Full Implementation:	**$ 10 million per year, serving 500-700 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*.