MIDD Briefing Paper

ES 1b Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities
BP 34 Multi-Disciplinary Encampment Outreach Team
BP 39 Applying Equity & Social Justice to Outreach and Engagement/Increasing Culturally Responsive Treatment & Penetration
BP 63 Bridges
BP 72 ETS Reach Program – Outreach Teams
New Title: Outreach & Institutional In-reach System of Care (Combines existing strategy with multiple new concepts)

Existing MIDD Program/Strategy Review ☒ **MIDD I Strategy 1b Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities (Attach MIDD I pages)**
New Concept ☒ (combining four new concepts)
(Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: This paper is a combination of four new concepts and existing strategy 1b. It outlines an integrated outreach framework that is focused on individuals across King County who are experiencing homelessness and crisis system involvement. This paper is focused on the integration of various outreach efforts suggested for MIDD II. Successful outreach requires tailoring based on the needs of the populations of focus. Initial and ongoing coordination with all agencies who are touching the various focus populations is paramount. It is critical to capitalize on the opportunities to link outreach efforts to various coalitions focusing on homelessness and any initiatives focusing on the populations or social determinant issues. This includes efforts focused on ending homelessness in Seattle and broader King County, reducing criminalization of behavioral health conditions that results in incarceration, reducing hospitalizations of individuals with behavioral health, and increasing health and human services care coordination and service integration to better serve the whole person.

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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 paper is a combination of four new concepts and existing strategy 1b. It outlines an integrated outreach framework that is focused on individuals across King County who are experiencing homelessness and crisis system involvement. This paper is focused on the integration of various outreach efforts suggested for MIDD II. Successful outreach requires tailoring based on the needs of the populations of focus. Initial and ongoing coordination with all agencies who are touching the various focus populations is paramount. It is critical to capitalize on the opportunities to link outreach efforts to various coalitions focusing on homelessness and any initiatives focusing on the populations or social determinant issues. This includes efforts focused on ending homelessness in Seattle and broader King County, reducing criminalization of behavioral health conditions that results in incarceration, reducing hospitalizations of individuals with behavioral health, and increasing health and human services care coordination and service integration to better serve the whole person.

The Outreach System of Care Team that arises from this outreach framework in envisioned to have the following staff composition, based on the population and geographic focus:

- Community Health Workers/Behavioral Health Workers ("peer support staff")
- Mental Health Professionals (social work/counseling)
- Substance Use Disorder focused staff (may include Chemical Dependency Professionals)
- Nursing Staff (registered nurses (RNs))
- Staff with prescribing authority (MD, ARNP, MD-Psychiatrists)
- Housing focused staff – link with Coordinated Entry and Housing assessor role

Background

Existing Strategy (ES) 1b

Existing services provided under MIDD 1b1 for this strategy are provided through two agencies: 1) Harborview Medical Center (HMC) in downtown Seattle and 2) the Valley Cities Counseling and Consultation (VCCC) in south and east King County, and known as the Bridges program[1]. Providers in both agencies target individuals who have a recent history of cycling through hospitals, jails, other crisis facilities, psychiatric hospitals, or residential substance use disorder (SUD) treatment facilities. They

[1] http://www.valleycities.org/services/outreach/bridges/.

work with individuals who do not have or are not eligible for Medicaid, and clients with mental health problems who are not eligible for enrollment in the Regional Support Network (RSN) that has provided publicly funded mental health services, or who are disconnected from their RSN case manager or program. The services are community-based mental health/SUD-based outreach, engagement and service linkages, including advocacy for individuals with mental health and substance use conditions, mental health assessments and linkage to counseling.

The service models differ somewhat due to geographic differences, but are similar in the degree to which they are integrated and coordinated with staff at the sites where they have established a regular presence. In Seattle, HMC outreach (ES 1b) staff, which HMC requires to be Mental Health Professionals (MHPs), provide outreach to several sites, including Peter's Place Compass Day Center[2], YWCA Angeline's Day Center[3], and Chief Seattle Club[4]. HMC staff partner with the REACH Team[5] at the Markham Building.

The HMC MHP outreach workers receive referrals from the King County Jail and the HMC Emergency Department (ED) for individuals experiencing homelessness who are high-utilizers of the ED and the HMC Medical Respite Program[6]. Staff engage with individuals at these various sites and work to help them connect to SUD treatment services, publicly-funded mental services, as well as primary health care services, legal assistance, public entitlements and benefits, housing and shelter, and employment resources. Individuals working with HMC outreach workers in the downtown Seattle area have access to psychiatrist appointments for medication management.

In north, south, and east King County, VCCC Bridges program outreach workers seek clients at The Sophia Way[7], Angeline's Eastside Women's Center[8], Congregations for the Homeless Day Center[9], Shoreline Veteran Center[10], and Avondale House[11]. They attempt to go to meal programs concurrently when the South King County Mobile Medical Van is scheduled to be parked adjacent to the site for mutual referral.[12]

Housing Coordination | Outreach System of Care staff would be trained as Housing Assessors under Coordinated Entry and Assessment (CEA)[13] – Housing assessors are staff from designated community agencies. *Housing Assessors* may work out of Assessment Hubs, be designated as the Assessor for his/her agency, or may be part of a mobile outreach team. All housing assessors are required to complete a Homeless Management Information System (HMIS) intake and housing assessment with individuals in need of housing and pull, from HMIS, "housing matches" available to each individual. The

[2] http://www.compasshousingalliance.org/what-we-do-top/day-services/peters-place/.
[3] https://www.ywcaworks.org/Page.aspx?pid=389.
[4] http://www.chiefseattleclub.org/.
[5] http://www.evergreentx.org/reach/Pages/Default.aspx.
[6] http://www.kingcounty.gov/healthservices/health/personal/HCHN/respite.aspx.
[7] http://www.sophiaway.org/shelter.html.
[8] http://www.stlouisescc.com/angelines-eastside-womens-center.html.
[9] http://www.cfhomeless.org/day-center/.
[10] http://shorelineveterancenter.weebly.com/.
[11] http://www.kcha.org/housing/property.aspx?PropertyID=5.
[12] http://www.king5.com/story/news/local/seattle/2016/01/05/new-mobile-medical-van-helping-homeless-get-health-care/78336570/. Accessed 1/7/16.
[13] U.S. Department of Housing and Urban Development Office of Community Planning and Development "Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status." (2014).

housing assessor will then pass the referrals to the individual's case manager or a housing navigator. Housing assessors' responsibilities include, but are not limited to the following:

- Operating as the initial contact for the Coordinated Entry for All[14];
- Conducting housing assessments;
- Notifying clients of eligibility and referral decisions;
- Submitting referrals to the *Receiving Program* through HMIS;
- Participating in case conferences as needed; and
- Responding to requests by the system manager, as appropriate.

Regarding New Concept #34; Multidisciplinary Encampment Outreach Teams: People who are living in encampments are largely those who have not been successful in advocating for themselves due to their substance use, mental health conditions and/or their criminal justice system history. Outreach supported by MIDD should provide effective linkage to a system of care and not operate independently in lieu of the larger system. Effective linkage requires both knowledge and access to a wide range of resources, including a range of housing options from Rapid Re-housing to Permanent Supportive Housing, appropriate shelter with storage, ongoing case management and clinical services for individuals with behavioral health and medical needs. Outreach is intended to identify suitable options for individuals with behavioral health issues living in encampments, and outreach teams endeavor to build relationships that can continue after they leave the encampment and sustain support for individuals while other housing options are developed. Outreach supported by MIDD II must be based in the understanding of the situation the individuals contacted are experiencing and from an equity and social justice perspective.

For this outreach system of care, linking outreach with forced encampment closure places expectations on short term engagement (identification of adequate alternatives for all individuals in the encampment) by outreach workers that they are not equipped to deliver on, and current housing and shelter systems do not yet support. MIDD II support for outreach should be contingent on outreach workers having access to qualified clinical supervision within their agency, and should be linked to ongoing support strategies for the individuals engaged.

Right Fit & Connection to Broader Outreach Efforts County-wide

It is also important to address *right fit*. It is critical that all outreach/engagement teams provided under MIDD II (in coordination with other outreach programs across King County that are not MIDD-funded) identify a population focus and a service system (e.g., shelters, day programs, etc.) to target for each individual being served. Outreach services must be provided in relation to the oppression and marginalization individuals with behavioral health disorders without housing experience; outreach workers from agencies that are most culturally responsive to provide outreach services must be utilized. Outreach teams focused on populations experiencing the most disparities, and by geographic region across the county (with flexibility to remain a person-centered, need-based approach) that are comprised of staff that reflect the need of each group, will be deployed across the county under this framework.

Common staffing of outreach teams will include behavioral health clinicians, including MHPs and staff with SUD expertise, peer support staff or community health worker staff, RN's/medical personnel, case managers with housing expertise, and staff with culturally responsive and culturally informed training

[14] http://allhomekc.org/coordinated-entry-for-all/. Accessed 1/7/16.

for the communities they are serving. All staff will have a solid grounding and training in core and foundational service frameworks of:

- Motivational Interviewing (MI),
- Trauma Informed Care,
- Anti-oppressive Practices, and
- Harm Reduction

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).

Outreach teams are intended to work with individuals in community settings who are not yet involved in the crisis system; however, when individuals are incarcerated, hospitalized, or living in forced street encampments, outreach teams will be in-reaching for individuals in all facilities and location-specific sites. Indeed, according to a United States (U.S.) Department of Justice News Release, "…making it a crime for people who are homeless to sleep in public places, when there is insufficient shelter space in a city, unconstitutionally punishes them for being homeless."[15]

In the Existing Strategy 1b, many of the individuals served are engaged as they leave the jail, hospitals, or emergency services and this allows behavioral health outreach workers to operate from a harm reduction approach and meet them where they are at,[16] both literally, by not requiring that individuals attend office appointments, and figuratively, by having individuals identify their own priorities in changes they want to make in their own lives. Providers work with the individuals they serve to assess their needs, including primary care, housing and behavioral health – and work to re-engage them in programs and services that support their stability in the community and reduce crisis system utilization. It is critical that providers have sufficient and ongoing training to maintain both a framework and excellent clinical skills to work most effectively with the target population. Outreach MHP staff engage individuals utilizing MI and operating from harm reduction approaches to care. The Adverse Childhood Experiences (ACE) Study[17] is one of the largest investigations ever conducted to assess the associations between childhood maltreatment and later-life health and well-being. The MHP's score the level of trauma individuals have experienced and use this data to discuss this impact with the some of the individuals they work with and develop strategies to respond to the impact of this trauma on their lives. They also utilize their trained skill in Trauma Recovery and Empowerment Model (TREM) group intervention[18] and implement this knowledge in both one-on-one interventions and within therapeutic groups.

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**

[15] United States. Department of Justice. *Justice Department Files Brief to Address the Criminalization of Homelessness*. *Justice News*. The United States Department of Justice, 6 Aug. 2015. Web.
[16] Jackson, K. *Harm Reduction – Meeting Clients Where They Are*. Social Work Today, 4(6); 20041. Originally posted 11/6/2014; accessed 12/29/15 from http://www.doctordeluca.com/Library/AbstinenceHR/HR-MeetClientsWhereTheyAre04.pdf
[17] https://en.wikipedia.org/wiki/Adverse_Childhood_Experiences_Study. Accessed 1/8/16.
[18] http://www.communityconnectionsdc.org/web/page/657/interior.html. Accessed 1/8/16.

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.

Summary of the Problem

A costly criminal justice response and crisis/emergency system is currently being applied to health and human services/public health issues. The Drug Policy Alliance purports the War on Drugs drives mass incarceration and racial disparities in U.S. judicial systems.[19]

A more robust health and human services system is paramount, as society cannot criminalize and hospitalize its way out of this problem: that only fills the courts and jails with individuals—most often poor people of color—who need access to housing, treatment resources, and life chances (employment, relationships of support, connection to the community and family). Existing Strategy 1b programs have found that outreached populations need continued engagement to ensure connection to entitlements and ongoing services. Outreach to individuals in their current community and institutional settings is critical and is particularly needed to reduce the number of "Familiar Faces"[20] (people with four or more jail bookings in the prior year and a behavioral health condition), and prevent future Familiar Faces.

Data below are from the document, *"King County One Night County Summary of 2015 Data"* provided by All Home (formerly the Committee to End Homelessness). According to the 35th annual One Night Count of people who are experiencing homelessness in King County, which took place on the night of January 22, 2015, the following was the resulting data of those individuals.

Table 1: Summary of 2015 One Night Count[21]

2015 One Night Count	
Unsheltered	3,772
Emergency Shelter	3,282
Transitional Housing	2,993
TOTAL	**10,047**

Table 2 breaks this population down by mental health disability condition.

Table 2: Reported disabilities and selected health conditions[22]

2015 One Night Count			
	Emergency Shelter	**Transitional Housing**	**All**
Mental illness	529	539	**1,068**
(serious mental illness: a subset	*344*	*251*	*595*
Alcohol or substance abuse	434	445	**879**

[19] Drug Policy Alliance. New York. (2015). *The Drug War, Mass Incarceration and Race* fact sheet. From web at http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf.
[20] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx
[21] http://www.homelessinfo.org/what_we_do/one_night_count/2015_results.php. Accessed 1/8/16.
[22] http://www.homelessinfo.org/resources/one_night_count/2015_ONC_Poster-web.pdf. Accessed 1/8/16.

(chronic substance abuse: a subset	*242*	*178*	*420*
Physical disability	330	359	**689**
HIV/AIDS	15	9	**24**

Familiar Faces

The following data depicted in Tables 4-8[23] show the problem of criminalization and incarceration of individuals with behavioral health conditions, who are often experiencing homelessness, because of lack of outreach, right service fit and other social service supports/access needed to address the social determinants of health.

Table 3: Familiar Faces Summary Results

	2013		2014		Total	
Defining Familiar Faces	N	**%**	N	**%**	N	%
People who had at least 4 bookings	1348	100.0%	1330	100.0%	2678	100.0%
….of those, had JHS BehHealth[1] or CD flag[2]	1134	84.1%	1124	84.5%	2258	84.3%
plus others who had MH or CD tx	139	10.3%	128	9.6%	267	10.0%
TOTAL with behavioral health indication	**1273**	**94.4%**	**1252**	**94.1%**	**2525**	**94.3%**

[1]Jail Health Services - Behavioral Health "flag" = mood, psychosis or trauma diagnosis or psychiatric meds
[2]Jail Health Services - Chemical dependency (CD) "flag" = alcohol diagnosis, drug diagnosis, alcohol detox, opiate detox, referred for CD treatment while in jail, or at risk for alcohol/drug detox upon jail intake

FINDING: nearly all people with 4+ bookings in a year have a behavioral health indicator.

Twenty percent of the people identified as Familiar Faces were female and 80 percent were male. Fifty-eight percent of Familiar Faces were between 18 and 34 years old; 80 percent were between 18 and 44 years old.

Summary of Familiar Faces Data

2013 cohort: 1,273 individual; 2014 cohort: 1,252 individuals

- 94 percent of all people with 4 or more jail bookings have a behavioral health indicator.
- More than 50 percent were experiencing homelessness (under-estimate)
- The Most Serious Offenses (MSO) were:
    - Non-compliance (41%) – Failure to appear for court, supervision violations, etc.
    - Property crime (18%)
    - Drugs (13%)

The Familiar Faces are disproportionally people of color *(Black/African American and American Indian/Native American)* compared with King County as a whole and the overall jail population.

Single Adult and Veteran Coordinated Entry[24]

Single adults experiencing homelessness in Seattle and King County have significant mental illness and SUDs that impact their ability to access and secure linkage with services and housing. Providers in the

[23] Srebnik, D., *Familiar Faces: Current State – Analyses of Population*. (September 28, 2015), data summary packet provided to the Familiar Faces Design Team Current State Mapping.
[24] http://allhomekc.org/the-progress/#fndtn-single-adultsveterans

Existing Strategy 1b program meet the clients where they are at and perform a psycho-social assessment, and identify the most pressing needs that the clients have. They have access to medical and psychiatric care within their larger organizations (HMC and VCCC). Using a case management and counseling approach to care, these MHPs help directly address the needs of the clients through referrals and counseling on site.

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

This system-wide approach to outreach will address the need in three primary ways plus system-level and policy impacts:

(1) Relationship-based Services and Harm reduction Service Delivery

According to interviews with individuals who currently meet Familiar Faces criteria and those who have formerly been Familiar Faces, they often do not respond to compliance-driven models. An ongoing, trusting, trauma-informed relationship with one person or a small team is critical. Multiple handoffs/referrals are further traumatizing and alienating, as has been shown by the Familiar Faces initiative interviews with current Familiar Faces as part of the *Embedding Familiar Faces in Familiar Faces*[25], one sub-strategy under the Familiar Faces initiative efforts. Part of this information is also from individuals with lived experience as a former "Familiar Face" (now represented in the Familiar Faces Advisory Group). Indeed, only 25 percent of the Familiar Faces in the 2013 and 2014 cohorts studied currently access any publicly-funded mental health and/or SUD services.[26]

(2) Offers *Alternatives* to Deep-End Criminal Justice System Options

Over a third of Familiar Face bookings are associated with Washington State Department of Corrections filings – all for non-compliance charges. Only 8.5 percent of 2014 Familiar Faces had opted-in to any of the three behavioral health specialty courts in the County in 2014, while a total of 22 percent of the 2014 Familiar Faces had some type of involvement with these courts.

Specialty Courts are a "deep end" of the criminal justice system solution for many individuals. Up-front pre-jail booking diversion options that focus on changing police culture and working with prosecutors (to not file new cases and also help troubleshoot warrants and existing cases) is a new way to approach this. Existing specialty court structure is limited in harm reduction options that offer a MI-based, trauma-informed, right fit service option that is also culturally informed and responsive. Looking to the courts to address root causes of inequity and health and human service issues is unrealistic.

All criminal courts, including specialty or problem-solving courts to some degree, are adversarial and require a high degree of self-organization for stringent treatment requirements and reporting to probation/court. Often, when individuals are not in compliance with court requirements, they are revoked long before the probation terms ends. Abstinence is expected by the court and harm reduction related to substance use is not part of the framework. Maintaining sobriety from all substances may be difficult for many individuals.

Courts expect treatment to also be a compliance model, not allowing for harm reduction or long engagement/relationship building processes. Recovery is defined in a very particular way and courts are risk aversive. Certain behavior (e.g., substance use or not taking psychiatric medications) is viewed as

[25] Benet, J. Embedding Familiar Faces in the Familiar Faces Initiative (August 2015), DCHS HHS briefing document.
[26] Ibid, Srebnik, D., *Familiar Faces: Current State – Analyses of Population*. (September 28, 2015).

"criminal" behavior, and often punitive sanctions, including the use the jail, are applied when individuals engage in these behaviors.

Specialty courts do serve some individuals well and have a place, but are not a system-wide response/option. For individuals who are able to self-organize and maintain sobriety, and who have been matched with appropriate treatment that meets their needs and goals, these courts can be a viable option. Community-based outreach and engagement via this Outreach System of Care can catch individuals prior to court involvement or be a treatment alternative. Many individuals do not enter into criminal justice system responses, such as specialty courts, when they have health and human service needs, as demonstrated by Familiar Faces data, and often return to the streets after release from jail still in desperate need of connection to treatment, housing and community.

(3) Provides an Equity and Social Justice Framework for Agencies Providing Outreach Services
Outreach programs funded to provide services under this Outreach System of Care should track disproportionality as well as commit to exploring how to increase the cultural responsiveness of the organization and its staff. Requirements will be in place to track if individuals served in outreach programs (with various population foci) are involved in program implementation planning (client voice) and, if not, make active efforts to remedy this. In concert with County administrative staff, providers shall ensure that race and racism, disability, homelessness, and poverty are understood as marginalized identities and honest conversations are given space and are continued about what equity and being culturally responsive means. A commitment to continuous improvement will be required and supported by County oversight, through the use of equity review tools, training and organizational development and performance measures embedded in contract outcomes. Many Familiar Faces already receive treatment in the current behavioral health system, but many are missed. Outreach and engagement efforts or services that meet their needs are not available.

System Level & Policy Impacts
Outreach efforts funded by MIDD II should, in addition to providing individual engagement, inventory the reasons why particular unsheltered individuals are not getting their needs met in the existing array of shelter and housing options. These reasons may include: concern about storing, maintaining and having access to personal property; active drug use; being affiliated with other individuals who will not be accommodated in the same facility; having a pet; mental or physical illness that precludes group shelter or housing; trauma-based mistrust of certain supervision arrangements or group settings; or other specific conditions. The Existing Strategy 1b outreach team found that understanding the cultural context of the clients they were attempting to engage and having the skills to adapt to a variety of cultures is critical to their outreach and engagement efforts. Building relationships with agencies and individual providers who are part of particular cultures has been a successful strategy, in addition to hiring staff who reflect the individuals they serve.

In order to ensure that outreach does not just overlay an inadequate system of care for this population, outreach teams should, as a regular part of their work, report on conditions that make it impossible or very difficult to find appropriate services for the individuals they are engaging. That information shall inform policy analysis and adjustment of other MIDD II supported strategies to better respond to the needs of those people.

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.

From the evaluation of the Law Enforcement Assisted Diversion Program (LEAD), the following outcomes are an important connection to this Outreach System of Care because they demonstrate the approach of harm reduction, trauma-informed care, MI and culturally informed outreach.

Findings: Analyses indicated statistically significant recidivism improvement for the LEAD group compared to the control group on some shorter- and longer-term outcomes. [27]

LEAD Shorter-term outcomes were assessed for the six months prior and subsequent to participants' entry into the evaluation:

- Compared to the coparison group, the LEAD group had 60 percent lower odds (likelihood) of arrest during the six months subsequent to evaluation entry. The effect of LEAD on getting arrested during the 6-month follow-up was statistically significant (p = .03).
- This finding reflected the fact that—comparing the six months prior and subsequent to entry into the evaluation—the proportion of comparison participants who were arrested increased by 51 percent, whereas the proportion of LEAD participants who were arrested plateaued (+6%).
- Further, there were no statistically significant LEAD effects on total charges or felony charges filed over this shorter-term period.

LEAD Longer-term outcomes were assessed during the entirety of the LEAD evaluation time frame, ranging from October 2009 through July 2014. Analyses took into account the fact that participants had been in the program for differing amounts of time by statistically controlling for this factor.

- Compared to the comparison group, the LEAD group had 58 percent lower odds of at least one arrest subsequent to evaluation entry. The LEAD effect on arrests over time was statistically significant (p = .001).
- Although there was no statistically significant effect for total charges, the LEAD group had 39 percent lower odds of being charged with a felony subsequent to evaluation entry compared to the control group. This effect was statistically significant (p = .03).
- The proportion of LEAD participants charged with at least one felony decreased by 52 percent subsequent to evaluation entry. The proportion of comparison group participants receiving felony charges decreased by 18 percent.

Interpretation of findings: These statistically significant reductions in arrests and felony charges for LEAD participants compared to control participants indicated positive effects of the LEAD program on recidivism.[28]

Year 6 Long term outcomes compiled by the MIDD evaluation staff showed that for Strategy 1b with the combined downtown Seattle and Bridges programs, the number of days in King County operated and regional misdemeanor jails was reduced by 25 percent and visits to HMC ED were reduced by 17 percent. Despite a low incidence of psychiatric hospitalizations for those served by Existing Strategy 1b,

[27] Collins, SE., Lonczah, HS., Clifasefi, SL. *LEAD Program Evaluation: Recidivism Report*. Harm Reduction Research and Treatment Lab, University of Washington – Harborview Medical Center. March 27, 2015. Obtained 12/18/15 direct from UW LEAD Evaluation Team.

[28] Ibid, Collins, Lonczah and Clifasefi (March 27, 2015). Obtained 12/18/15 direct from UW LEAD Evaluation Team.

about 75 percent of those with system usage had reached zero visits to community inpatient psychiatric hospitals and Western State Hospital by the third year after their MIDD start date.[29]

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.**

Existing Strategy 1b program staff utilize a number of evidence-based practices within the framework of the outreach and care they provide for these vulnerable clients.

MI (Evidence-based practice) Motivational interventions aim to respect and promote client choice. It is a directive, client centered approach for eliciting behavior change by helping clients to explore and resolve ambivalence. [30] The flexiblesupport system or team works together to plan engagement strategies and is creative in their attempts to meet people "where they are at" in readiness for change.

Harm Reduction (Best Practice)
A harm reduction framework will be applied to all Outreach System of Care services. Harm reduction is a strategy directed toward individuals or groups that aims to reduce the harms associated with certain behaviors. When applied to substance use, harm reduction accepts that a continuing level of drug use in society is inevitable and defines objectives as reducing adverse consequences.[31] Harm reduction incorporates a spectrum of strategies to address conditions of harmful behavior along with the behavior itself (often referred to as "meeting people where they are at").

There is no universal definition or formula for harm reduction implementation, given the multiple different interventions and policies designed to serve an individual. However, there are some key principles such as accepting the individual regardless of the behavior, understanding the complex continuum of behaviors and acknowledging that there are clearly safer ways to engage in certain behaviors, and establishing quality of individual/community life and well-being as the criteria for successful interventions. Furthermore, this should be a nonjudgmental, non-coercive provision of services and resources; this strategy should promote self-efficacy, recognize the realities of poverty, class, racism, social isolation, past trauma, sex-based discriminations and all other social inequalities that affect an individual's vulnerability to, and capacity for, effectively changing behavior.[32]

Harm Reduction Housing Options: Permanent Supportive Housing from a *Housing First approach* (Evidence based practice)
Housing First is an approach that centers on providing individuals experiencing homelessness with housing as soon as possible and regardless of involvement in any other services. Once housed, other services can be provided as needed. This housing is provided as quickly as possible, the housing is not time-limited (preferably permanent) and services offered are time-limited or long-term depending on level of need. Services should be able to adjust as need adjusts. Housing and other services are not connected to each other, and housing cannot be removed due to lack of utilization of services offered.[33]

[29] Kimmerly, L. *System Utilization Reduction Goals and Preliminary Effectiveness Results*, 2015 Mental Illness and Drug Dependency (MIDD) Evaluation Document.
[30] Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, 325-334. Cited from http://www.motivationalinterview.net/clinical/whatismi.html
[31] Harm reduction: An approach to reducing risky health behaviours in adolescents, Pediatrics & Child Health, 2008 January; 13(1): 53–56.
[32] http://harmreduction.org/about-us/principles-of-harm-reduction/.
[33] http://www.endhomelessness.org/page/-/files/1425_file_WhatisHousingFirst_logo.pdf

The program will also use a Housing First approach engage and rapidly house frequent institutional users who are experiencing homelessness.

Assertive Outreach/Engagement (Best practice) Motivational interventions, which aim to respect and promote client choice, are the hallmark of assertive engagement. The support system members work together to plan engagement strategies and are creative in their attempts to meet people "where they are at" in readiness for change. Clinical judgement is used to determine when these assertive engagement techniques need to be applied and to what degree. When motivational interventions have not worked, therapeutic limit-setting and other alternatives may be needed in the on-going planning process for assertive outreach and engagement.[34] Ongoing assessment of the individual's need and the corresponding level of care will be done at regular intervals.

Trauma Informed Care (Evidence-based practice). The experience of arrest, incarceration, and possible conviction is traumatic. For persons who have a mental illness this experience is often layered on a history of trauma, both in adulthood and childhood. Research suggests up to 50 percent of persons with a severe mental illness have a rate of three or more adverse childhood experiences (including abuse, neglect, and witnessing violence).[35] These traumatic experiences can be dehumanizing, shocking or terrifying, and often include betrayal of a trusted person or institution and a perceived loss of safety. Trauma can induce powerlessness, fear, recurrent hopelessness, and a constant state of alertness. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection.
Trauma-informed services are based on an understanding of the vulnerabilities or triggers for trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. This includes understanding that people need to be respected, informed, connected, and hopeful regarding their own recovery and the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression and anxiety).

This is further exemplified by Existing Strategy 1b programs' approach to meet individuals where they are at in the beginning of the outreach and engagement process. Outreach workers develop trusting relationships and ensuresuccessful care transitions via warm hand-offs (face to face introductions to new providers, often including overlapping time spent with a client to the most impactful and needed services: primary care, mental health and SUD services, housing and shelter, application for needed public entitlement/benefits. All services are trauma-informed, influenced by the understanding of the impact of interpersonal violence and victimization on an individual's life and development.[36] It is essential that providers recognize when trauma histories are present, and understand how trauma histories impact how they provide treatment of significant behavioral health disorders. Providers approach the individuals they serve in a supportive manner and help them identify and follow up on their own self-management goals. They also use the Adverse Childhood Experiences Study (ACES)[37] to score the level of trauma that clients have experienced and use this data to discuss this impact with the

[34] *TMACT Protocol for Assertive Engagement & Consumer Self-Determination & Independence.* Cited from TEAGE, G., Monroe-Devita, M (2008, May) *Enhancing Measurements of ACT Fidelity: The Next Generation* as presented at the 24th Annual Assertive Community Treatment Association Conference, Indianapolis, Indiana, May 14-17, 2008.
[35] Lu, Weili, Mueser, Kim T., Rosenberg, Stanley D., Jankowski, Mary Kay. *Correlates of Adverse Childhood Experiences Among Adults with Severe Mood Disorders.* Psychiatric Services. 2008 (59)"1018-1026
[36] D E. Elliott,, DE., Bjelajac, P., Fallot, RD, Markoff, LS., Reed, BG. *Trauma informed or trauma-denied: Principles and implantation of trauma0informed services for women*. Journal of Community Psychology, 07/2015; 33(4):461-477.
[37] http://www.acestudy.org/.

individual and develop strategies to respond to the impact of this trauma on their lives. This approach allows providers to deal directly with the current impact of trauma (often the main concern of the individual) in a direct way that helps to focus on making changes now. A provider shared that an individual reported that she sometimes felt that, in the past, talking about the trauma itself (what happened) felt like "pulling a scab off and I was left bleeding." By focusing on the impact of trauma, not the event, they can validate its importance but not focus on the horror of it.
Illness Management and Recovery (IMR)[38] is a set of specific evidence-based practices for teaching people with severe mental illness to manage their condition in collaboration with providers and other key supports, in order to achieve key personal recovery goals. Peer support is an IMR activity.

Peer Support[39] Peer support services shall be available to project participants. The peer specialists are trained staff who are in recovery from mental illness and have past involvement with the criminal justice system, including incarceration. They may provide recovery-oriented, direct support to other peers, and assist participants in becoming fully integrated into all aspects of community life. Peer specialists may assist participants with exploration of transferable skills. Peer specialists will be working in collaboration with other supports to coordinate with a variety of assistance linking to treatment services in the community, securing public entitlements, transportation to both legal and community-based treatment and resource related appointments, navigating and assisting with housing needs, and assistance with education and/or employment opportunities.

Institutional In-Reach: The APIC Model of jail reentry (**Best practice**).
The APIC Model—Assess, Plan, Identify and Coordinate[40]—describes elements of re-entry planning associated with successful reintegration back into the community for people with mental illnesses or other special needs who are being discharged from jails to the community. The model is particularly important for breaking the cycle of repeated homelessness and incarceration.

Anti-oppressive Practices (Culturally Responsive, Culturally Informed **Best Practice**)
Anti-oppressive practices in order to address individual-level discrimination Familiar Faces and others in need of outreach encounter in their daily lives by recognizing and challenging institutional and structural racism, classism, and ableism. This includes providing behavioral health treatment that addresses historical and cultural trauma as sources of SUD and other behavioral health conditions as well as the biopsychological model..[41]

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?**

A Results-Based Accountability[42] framework is for identifying the high/population level outcomes for all MIDD II work. At the system and program level, results should be aligned with broader Health and

[38] Mueser, K., MacKain, S. The National GAINS Center for Systemic Change for Justice-involved People with Mental Illness. (2005). *Illness management and recovery*. Concord, NH. Retrieved from www.naco.org.
[39] Davidson, L., Ph.D., Rowe, M., Ph.D. (2008). *Peer Support within Criminal Justice Settings: The Role of the Forensic Peer Specialists.* Delmar, NY: CMHS National GAINS Center, May 2008.
[40] http://eenet.ca/wp-content/uploads/2014/04/APIC-summary-addendum_March2014.pdf. Accessed 1/8/16.
[41] White, W. & Sanders, M. (2004). *Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities*. Posted at www.bhrm.org.
[42] http://resultsaccountability.com/about/what-is-results-based-accountability/.

Human Services Transformation results as well as the *Washington State Performance Measures Starter's Set* recommendations approved December 2014.[43]

At the individual Outreach System of Care program level, each population focus and institution focus should have related measures. Specific program outcomes include:

- A reduction in public health and public safety indicators associated with individuals sleeping outside;
- A reduction in the number of individuals in a given population focus who are experiencing homelessness;
- An increase in access to care and care coordination;
- Reduced criminal justice involvement demonstrated by reduced arrests, jail bookings and jail days for individuals receiving services;
- Reduction of preventable emergency room visits for individuals receiving services;
- Increase in use of alternative/diversion options (e.g. sobering, Crisis Solutions Center, Drop-In Centers);
- Improved quality of life including meaningful activity that is economically sustaining;
- Right fit for care/service linkage demonstrated by culturally responsive services and individuals feeling their cultures are centered in the outreach relationship; and
- Reductions in emergency services and jail by service recipients would be distinct cost offset outcomes for this population. Increases in housing or improvements in shelter/housing would be positive outcomes.

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.

[43] http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf. Accessed 1/8/16.

The populations of focus include individuals with chronic substance use disorders and mental health conditions. The population is described in more detail in question B2 above and in question E3 below. Instituitons of in-reach focus are indentified below.

Institutions of In-Reach Focus
All Jails in King County
Emergency Shelters
Sobering Centers
Withdrawal Management Centers (Detox) Sobering Center Chief Seattle Club
Psychiatric Hospitals (Evaluation & Treatment Facilities)
Day Centers Robert Cllewis Center (Needle Exchange)

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

Street Outreach in underserved geographic regions in King County and specific neighborhoods
Downtown Seattle (some addressing ES MIDD 1b)
Specific areas of South King County (Kent, Federal Way, and Renton)
North King County specific areas

The existing Bridges project through Existing Strategy 1b is an example of strategically locating providers geographically in areas of King County outside of Seattle, where services and people experiencing homelessness are more concentrated. The program's two mental health outreach specialists provide services to these individuals at various emergency shelters, community church dinners, transitional housing sites, motels, jails, hospitals, and at various community locations including, libraries, coffee shops, food banks, parks, street corners, and some wooded areas.

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.**

It is critical that this strategy is linked to larger systems of care, including the homelessness service system, All Home strategy planning and CEA efforts in King County being developed. Also, it is closely linked with physical and behavioral health integration systems being facilitated through Health and Human Services Transformation, including the Familiar Faces individual level strategy.

Using a flexible team model, collaborative partnerships can be designed to fit the outreach needs. For instance, in South King County where there are few resources, the Mobile Medical Van program relies on meal programs in churches to help connect with individuals primarily camping outside. In order to stay current with services and locations of potential clients, the VCCC Bridges staff maintains relationships with regional homelessness planning groups such as South County Forum on Homelessness and the Auburn Task Force on Homelessness.

In downtown Seattle, outreach teams from several organizations meet monthly for a Seattle Outreach Coordination Committee meeting to share resources and reduce duplication of services. Possible partnerships may include:

- Homelessness service agencies.
- Primary care and Behavioral Health Organization (BHO) providers,
- City and County Parks Staff,
- First Responders countywide,
- Community partners (city staff, neighborhood groups),
- City and County department staff, and
- Emergency departments.

Outreach teams could make social contact referrals to LEAD, though those need to be approved by law enforcement under the current LEAD referral protocol. If LEAD is funded and expanded (via BP 23 Law Enforcement Assisted Diversion Maintenance and Expansion), this is a recommended option for those individuals being outreached to who are coming into contact with law enforcement and could benefit from LEAD services.
Both components of the Existing Strategy 1b teams, Seattle and King County outside of Seattle, are part of the HealthCare for the Homeless Network. This network includes, other outreach workers (the REACH program), health care partners such as nurses in shelters and day centers and chemical dependency specialists. This Network creates a robust referral system that emphasizes collaboration and continuity.

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?

(1) Health and Human Services Transformation Initiative, specifically Familiar Faces, Physical-Behavioral Health Integration, and King County Accountable Community of Health

- The implementation of the Affordable Care Act has brought new opportunities for the community to work together to achieve the Triple Aim of better health, better care, and lower costs for this initial focus population. These changes include expanded Medicaid coverage creating access to health care for large numbers of Medicaid-eligible individuals.
- Washington's statewide move towards integration of the mental health, chemical dependency, and physical health systems, and the emerging Accountable Communities of Health and system delivery reform efforts.
- While there is no shortage of programs in the region to try to address the needs of individuals needing outreach as evidenced by the Familiar Faces work (Current State mapping), many of which produce excellent results as stand-alone programs, overall fragmentation, uncoordinated care, poor outcomes and growing costs to the health, social services, criminal justice systems,

and our community at large continue to abound. Most importantly, despite the number of programs the overall health and social outcomes for the Familiar Faces has not improved.

(2) All Home Strategy Plan and other Homelessness Initiatives

- The growing extent of homelessness in King County, having grown to emergency proportions and precipitated a 2015 Declaration of State of Emergency for Homelessness - King County and City of Seattle.
- The lack of affordable housing/long waits lists for low-cost housing creates challenges to successful outreach.
- The Housing and Urban Development expectation for outreach and day centers (Hubs) will also impact this Outreach System of Care by offered more site-based outreach options/locations. Single Adult Coordinated Entry efforts underway

(3) Law Enforcement Assisted Diversion (LEAD) Operations and Policy

(4) 1115 Global Medicaid Waiver, options for Demonstration Programs

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?**
   - Appropriate affordable housing – Secure and dedicated housing resources (both respite and permanent housing) is needed to support any care models. Many of the individuals who will receive outreach services will be experiencing homelessness as this is a target population.
   - Challenge of co-tracking multiple efforts and funding streams at federal, state, county and city levels. An inventory of local programs that serve people who frequently encounter jails and hospitals, jail and hospital diversion initiatives, and the use of local, state and federal dollars can bring outreach to scale county-wide.
   - A large-scale need for major cultural change in human services and criminal justice system agencies related to harm reduction, and not criminalizing behavioral health (moderated by race, class, and homelessness). Harm reduction training is key, as is MI techniques and moving towards a recovery-centered/person-centered system that is also responsive to the individual's needs. This is a long-term effort, but a cadre of outreach teams that all align along this framework is one place to begin.
   - **A shortage of qualified and seasoned outreach workers in the behavioral health direct service system may impact implementation and start-up times for the outreach teams in this Outreach System of Care.**

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

By focusing on marginalized communities and individuals with limited access to resources, the "right fit" for outreach may not be known or well-understood and may further alienate some people. Culturally responsive services are a key, but mistakes will be made in moving in this direction.

<u>Regarding New Concept # 34</u>

For this MIDD II outreach system of care, linking outreach with encampment closure without adequate time allotted for client engagement and linkages to housing and services, places expectations on short

term engagement (identification of adequate alternatives for all in the encampment) by outreach workers that they are not equipped to deliver on, and that existing housing and shelter systems may not yet support. To address, this outreach system of care will extend the period of outreach from the mandated three-day period, which is insufficient for the present housing and shelter systems to support, to a two week period of outreach and engagement in the encampments to increase successful linkages with indoor sleeping places and a more realistic timeline to identify adequate alternatives for all in the encampment.
While courts increasingly recognize that civil rights may be violated when encampments are forcibly shut down and property seized without providing viable alternative housing arrangements, this practice is also counterproductive (unless driven by particular site-specific safety issues that cannot be rectified with assistance on-site). Scattering groups of people who have been engaged by outreach workers splinters relationships, breaks continuity of care, and often results in loss of important personal property and documents. It often results in relocating individuals to a new encampment location with less security and less adequate equipment. It can be a new traumatic experience that makes it harder for the individual to organize his or her life and make productive connections.

There is the possibility that by closing encampments, camp residents who were not referred to a safer or more stable place to sleep will be scattered, and they may move to areas that are no better than their original location, more remote, they will be more difficult to find and will be further from existing services such as behavioral health treatment and other health care, and meals. Many who are in Ballard or South King County now report that they had been moved from one or more encampments in years past. Isolation and reduced visibility, especially for those who are ill or disabled, may put people at greater risk.

This perspective is supported by a report from the Allard K. Lowenstein International Human Rights Clinic, Yale Law School and the National Law Center on Homelessness and Poverty about the rise of tent cities across the US and various legal and policy responses to that growth; homeless encampments often reflect the lack of adequate housing or shelter in the community.[44] Courts increasingly recognize that civil rights may be violated when encampments are forcibly shut down and property seized without providing viable alternative housing arrangements unless driven by particular site-specific safety issues that cannot be rectified with assistance on-site.

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?**

A limited and fragmented outreach system that does not reach those who need supports and services the most will be perpetuated. Disparate outcomes for incarceration and access to alternatives will continue. People who are homeless and unserved are more likely to experience higher levels of mental health decompensation, more drug related deaths, and more emergency room visits.

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**

[44] Hunter, J., Linden-Retek, P., Shebaya,S., & Halpert, S. *Welcome Home: The Rise of Tent Cities in the United States*. Report by National Law Center on Homelessness and Poverty, March 2014, accessed 12/29/15 on the web at http://www.nlchp.org/documents/WelcomeHome_TentCities

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?

Several New Concepts were merged and this work relates to existing MIDD Strategy 1b. This could provide an important service and equity and social justice framework to move that strategy forward.

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?**

   - 2015 Declaration of State of Emergency for Homelessness - King County and City of Seattle;
   - Housing and Urban Development expectation for outreach and day center;
   - Single Adult Coordinated Entry;
   - Health and Human Services Transformation Initiative, specifically Familiar Faces, Physical-Behavioral Health Integration, and Communities of Opportunity (geographic focus options);
   - LEAD Operations and Policy;
   - 1115 Global Medicaid Waiver, options for Demonstration Programs; [45]
   - MIDD Strategy 1B downtown project fits well into Behavioral Health Integration. Mental Health Practitioners work very closely with the King County Regional Support Network, often referring patients for care within the system. They also make referrals to substance use treatment providers for services and often for medication assisted treatment. They partner with the REACH program, providing mental health outreach for patients with serious, long-term substance use disorders. Bridges is also involved in behavioral health integration through close collaborations at Valley Cities sites co-located with HealthPoint community health centers.
   - Existing 1b MHPs outreach workers refer individuals through the Single Adult Coordinated Entry system and have experience using vulnerability assessment tools. The Senior Manager for the downtown Seattle Mental Health Team also participates in the Coordinated Entry Leadership team in the development of the All Home system.
   - Existing Strategy 1b MHPs often work with Familiar Faces of the jail as well as individuals who often present at the HMC ED. The MHPs are located within shelters so they outreach to clients as needed within the shelter system. They can function as the "golden threads" who shepherd the Familiar Faces through the system of care to keep them out of the criminal justice system and help them adjust to housing and treatment according to their needs.

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

As noted extensively herein, this entire Outreach System of Care is person-centered and rooted in all the principles of recovery and self-determination. Trauma Informed Care is a vital and critical aspect of the framework and a fundamental service delivery approach for this system of care. Also, see answer to Question B.4.

[45] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html

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

Culturally Responsive and Culturally Informed

Many individuals needing street and/or community-based outreach and engagement have behavioral health conditions and need access to culturally-informed and culturally responsive care in ongoing behavioral health treatment. Critical aspects of outreach and engagement include relationship building with individuals who may have been deemed by providers/systems as "difficult to serve." Indeed, in order for the system to be person-centered and trauma-informed, it is critical to reframe "difficult to serve": It is the service system that does not meet the individual's need and is the "difficult" party. Outreach must operate from a trauma-informed, harm reduction framework, where individuals do not have to achieve or sustain sobriety from substances in order to be outreached to,or receive ongoing services that are also culturally responsive and culturally informed. Underserved populations can be identified through disparities in service access. A flexible, relationship-based approach can be adapted to be effective with each targeted sub-group.

All outreach and engagement efforts will be provided from an anti-oppressive practice and harm reduction framework that is culturally responsive and culturally informed to people of color and people with other marginalized identities including undocumented, immigrant, transgender, queer, lesbian, gay, bisexual , and those experiencing homelessness, living on the streets and engaging in survival economies. There has been recent documentation by the Harm Reduction Coalition of a need for racial justice in harm reduction services [46] that will need attention by this outreach system of care.

This also relates to the vast majority of these individuals who have come into contact with the criminal justice system and have increased barriers to access because of court requirements, legal-financial obligations, and the increased stigma of a criminal record when trying to access housing, jobs, behavioral health treatment and primary care. Individuals coming into contact with the criminal justice sysem are disproportionaly, people of color, especially those who have the most frequent contact with the criminal justice. System. The table below shows that the Familiar Faces are disproportionally people of color *(Black/African American and American Indian/Native American)* compared with King County as a whole and the overall jail population.

Table 4: Race of Familiar Faces

Race	**2013 N**	%	2014 N	**%**	Total N	%	2013 unique persons in jail*	KC adult population (census)
White	603	47.4%	679	54.2%	1282	50.8%	63.7%	69.6%
Black	544	42.7%	456	36.4%	1000	39.6%	26.6%	6.1%
Native	51	4.0%	51	4.1%	102	4.0%	2.6%	0.8%
Asian	70	5.5%	59	4.7%	129	5.1%	6.3%	16.8%
Other/U	5	0.4%	7	0.6%	12	0.5%	0.6%	2.3%
	1273	100.0%	1252	100.0%	2525	100.0%		

*Percent of White goes down by ~4 percent when examining bookings rather than unduplicated people (i.e., Whites are less likely to have multiple bookings)

[46] Harm Reduction Coalition. *A Need for Racial Justice in Harm Reduction: Where A Racial Justice Agenda Matters!* [Webinar]. Retrieved from http://harmreduction.org/publication-type/webinar/racial-justice-harm-reduction/

<u>FINDING:</u> Familiar Faces are somewhat more likely to be male and non-white than overall jail population
Individuals who are homeless and who are likely recipients of these services are also dsporpotionately people of color. The following table is also from the 2015 One Night Count.

Table 5: Race and ethnicity of individuals served in emergency shelters (ES) and transitional housing (TH) programs[47] (by percentage of homeless and general populations)

2015 One Night Count					
	Sheltered Homeless Population				General Population
	ES	TH	Combined		
African American/Black	41%	45%	2,665	42%	6.6%
White	45%	37%	2,561	41%	70.8%
Multi-racial	6%	11%	526	8%	4.7%
Native American/Alaska Native	3%	2%	184	3%	1.9%
Asian/Pacific Islander	6%	6%	351	6%	16.7%
Hispanic	11%	13%	761	12%	9.2%
	Total number of people			6,275	

Notes: General Population data from: http://quickfacts.census.gov/qfd/states/53/53033.html. Totals are more than 100 percent and exceed the total number of individuals in shelters and transitional housing because individuals are identified by race and ethnicity separately in the data, while both race and ethnicity are presented in this table. For the Point-in-Time Count, HUD does not allow unknown race to be reported; data are extrapolated for all individuals based on individuals for whom race is identified.

To further equity and social justice principles, outreach must be explicitly uncoupled from forced encampment closure. Outreach workers must inventory and report the reasons they are unable to identify suitable living arrangements for individuals they engage, should that occur.

The Existing Strategy 1b program furthers the county's equity and social justice initiative by working directly with individuals who have been disenfranchised by a system that disproportionally incarcerates people of color and those who live in poverty on the streets of Seattle. Existing Strategy 1b staff support and advocate for individuals dealing with legal challenges and assist them with negotiating a complicated system of care and housing in the downtown Seattle core. They work with these patients with a philosophy of respect and accept them as they are.

It is critical that all providers, partners and stakeholders share community-wide, common understanding that outreach is for the purpose of identifying suitable options for individuals living in encampments. Outreach teams continue to build relationships and sustain support for individuals while other housing options are developed.

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.)**?**

Currently there are many more individuals experiencing homelessness in need of behavioral health care in the downtown area than in preceding years and the current staffing levels only allow for services for a few. Additional Existing Strategy 1b staff would significantly advance the goals of the initiatives listed in item E.1. For aspects of New Concepts embedded in this Outreach System of Care, the following will be needed:

[47] http://allhomekc.org/the-problem/#the-numbers. Accessed 1/8/16.

- County Administrative/Oversight resources to assist in procurement of additional services, clinical oversight of evidence-based and anti-oppressive practices and contract monitoring;
- Outside training and ongoing consultation from experts in anti-oppressive practices and culturally competent behavioral health treatment;
- Community-based organizations (ideally culturally specific providers or providers with an organizational commitment to racial and social justice) to provide the direct outreach services (in addition to existing outreach programs); and
- A continuum of housing resources from Coordinated Entry prioritization efforts, shelter and transitional housing resources for immediate jail releases, sponsor-based vouchers from Seattle and King County Housing Authorities, and set-aside Permanent Supportive Housing units.

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

Existing MIDD Strategy 1b currently has an annual budget of $329,000. Depending on the number of outreach teams deployed to expand Existing Strategy 1b and address the various geographic areas and institutionals needing in-reach, many more outreach teams can be implemented; however, with connection to other care management reams (e.g. Familiar Faces Cultural Care Management) and agency-based resources in behavioral health treatment, cost may vary by team. At a minimum, a team of outreach workers with both nursing and staff with prescribing authority is needed, at a cost of approximately $500,000 per team. This includes funding for training and flexible funding for individuals served. At the program oversight level, a county position to oversee this body of work and ensure equity and social justice organizational work with the selected providers, will also be needed at $150,000 per year. The total for implementing one outreach team is $650,000 and the total for two outreach teams is $1.2 million.

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

There are some options under behavioral health integration and the new Behavioral Health Organization to fund some of the outreach activities described in this Outreach System of Care. Health Care for the Homeless is the only program at this time that targets clients not served by the Regional Support Network and are not served well by existing medical services.

4. TIME to implementation: Currently underway

a. What are the factors in the time to implementation assessment?

Factors include determining what existing outreach programs can be expanded and what new work will need to be procured.

b. What are the steps needed for implementation?

An Request for Proposals (RFP) will be required for direct services and training/consultation. Additional contract monitor staffing may be needed in the King County Mental Health, Chemical Abuse and Dependency Services Division to oversee/administer this work.

c. Does this need an RFP?

Yes.

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?

MIDD II support for outreach should be contingent on outreach workers having access to qualified clinical supervision within their agency, and should be linked to ongoing support strategies to move people out of homelessness for the individuals engaged through outreach programs in this Outreach System of Care. (Strong linkage to BP 3 Education Time).

The current Existing Strategy 1b teams are too small to generate the resources needed to impact the large numbers of people with behavioral health conditions who lack housing. A significant investment in robust teams that could leverage more partnerships, housing, and staff support would significantly improve the care for our most vulnerable populations in King County.

Connects to:

- *BP 23 Law Enforcement Assisted Diversion Maintenance and Expansion*
- *BP 115 Eastside Homelessness Outreach Team*
- *BP 35 Homeless Outreach Coordination*
- *BP 37 51 64 66 South County Crisis Center*
- *BP 73 Mobile Medical Program*
- *BP 74 Outreach and Interdisciplinary Case Management for Chemically Dependent Adults who Utilize Dutch Shisler Service Center*
- *ES 11a ES 12a BP 52 79 80 Jail Reentry System of Care*
- *BP 44 Familiar Faces Cultural Care Management Teams*
- *BP 114 Familiar Faces*
- *BP 118 133 136 Competency Continuum of Care*
- *BP 3 Education Time Yang*

King County

Mental Illness and Drug Dependency Action Plan

Strategy Title: Increase Access to Community Mental Health and Substance Abuse Treatment

Strategy No: 1b – Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

The One Night Count, conducted on January 25, 2008, estimated that there are 6000 individuals using emergency shelter and transitional housing on any given night in King County. This strategy was proposed during the original development of the Mental Illness and Drug Dependency Action Plan (MIDD) as a way of addressing the needs for ongoing case management for homeless individuals being discharged to shelters from jails and hospitals, as well as for those who would be discharged from the new crisis diversion facility that is being planned as part of the MIDD. The original concept was to build upon the success of Healthcare for the Homeless in engaging and assisting individuals at several shelters in King County with mental health, chemical dependency, and primary health needs.

At the time the MIDD plan was initially adopted, a final service design was not proposed for this strategy because other initiatives related to homeless persons were in the process of being implemented, and staff wanted to assure that this investment was well coordinated with them.

In winter 2008-09, two assessments occurred to help inform the programming of these funds:

(1) Health Care for the Homeless conducted a needs assessment that included an on-line survey (253 respondents); four focus groups with homeless people, and individual interviews with 106 homeless and formerly homeless people.

(2) Public Health conducted an analysis of the numbers and characteristics of homeless people seen in the King County Jail, using data from Jail Health Services intake screenings.

Needs assessment results. The community survey found that mental health and substance abuse services were the top 2 areas of increased services needed by homeless people. Mental health services was the highest ranked need: 172 of 211 respondents (82%) said it was a "very high" need. Substance abuse ranked second, with 75 percent of respondents indicating that it was a very high need. Other types of health services, such as medical, dental, vision, and specialty care were all ranked as lower priorities than mental health/substance abuse services.

Numerous respondents indicated the need for more services specifically in South and East King County. Follow up dialogue with east and south King County planners identified several potential high priority homeless sites that currently lack any connection with mental health/substance abuse services. Several Seattle homeless program sites were also identified as being in need of on-site services and indicate that they frequently are asked to take people into their programs who are leaving Western State or other hospitals, as well as jail discharges.

Jail Health Services study. In October-November 2008, Jail Health Services (JHS) assessed the housing status of all persons that they screened at booking into the King County Jail (both sites). JHS screens over 90 percent of persons booked. They found that 28 percent of all persons booked were homeless. Of those who were homeless, 38 percent were identified at booking to have a history of psychiatric disorder or treatment. The table below shows the percentage of screenings for which the person was homeless, by city. While Seattle had the highest percentage of homeless, cities throughout the county appear to have homeless people with criminal justice involvement. Because so many of these individuals return to the community homeless after release, it is essential to have engagement points in shelters and other homeless service sites in order to engage with them on accessing mental health and chemical dependency services.

King County Cities with Highest Percentages of Receiving Screenings that were Coded as Homeless (Among Those Cities with <u>10 or More</u> Homeless-Coded Screenings)

Patient City	Homeless-Coded Screenings	Total Intake Screenings	percent of Total Screenings That Were Homeless
Seattle	1,106	3,064	36%
Auburn	45	148	30%
Des Moines	29	112	26%
Kent	78	317	25%
Redmond	14	57	25%
Federal Way	48	210	23%

SeaTac	23	105	22%
Shoreline	19	89	21%
Tukwila	19	90	21%
Renton	57	305	19%
Burien	23	119	19%
Bothell	17	88	19%
Bellevue	27	150	18%

◊ *B. Reason for Inclusion of the Strategy*

Shelters and other homeless programs do not have the resources to provide the mental health and chemical dependency assessments and case management needed to help individuals access treatment and permanent supported housing. Providing these services will help individuals access housing and escape the cycle of chronic homelessness and repeated involvement in the criminal justice and emergency medical systems.

◊ *C. Service Components/Design*

Based on the assessment work described in Section A, King County DCHS and Public Health proposed that the MIDD funds in this strategy be applied as follows:

(1) Increase homeless program-based mental health/chemical dependency outreach and engagement services at selected homeless program sites in East King County, South King County, and Seattle. Services will be prioritized for those sites with the highest numbers of people with histories of jail and/or hospital involvement.

Service sites will be selected as noted below:

For South and North/East King County, the service sites will be identified through negotiation with suburban city human service planners and local homeless service agencies. Sites to be prioritized will be shelters/day programs that lack behavioral health services and that demonstrate they have significant numbers of clients with unaddressed mental health/substance abuse conditions and their clients have involvement with hospitals, jails, and/or other crisis facilities.
For Seattle, the expanded mental health capacity will be based in downtown Seattle homeless service locations to be determined by Pioneer Square Clinic and Health Care for the Homeless staff, but will accept referrals from a broad range of homeless services providers. The service will be prioritized for homeless people with mental illness or co-occurring disorders and have come from hospitals, jails, or crisis facilities but have no other case manager/care coordinator currently working with them on behavioral health services. Referrals to this service may be made, for example, by discharge or release planners, homeless agency staff, or others.

And

(2) Increase chemical dependency outreach and engagement for homeless Native Americans ? (Include needle exchange case management and any additional services contracted through MHCADSD

◊ *D. Target Population*

Homeless adults being discharged from jails, hospital emergency departments, crisis facilities and in-patient psychiatric and chemical dependency facilities. Current data shows that 28 percent of people in jail are homeless at time of discharge. Because there are so few housing options for the hundreds of homeless people leaving hospitals and jails, discharge planners often end up informing clients about local shelters and day programs. Shelter staff report that they regularly receive people recently released or discharged from these institutions.

◊ *E. Program Goal*

Increase availability of outreach, engagement, and case management services for homeless individuals.

◊ *F. Outputs/Outcomes*

In contract negotiations target percentages will be established to demonstrate the following outputs/outcomes:

1. Percentage of clients linked to needed treatment and completing treatment
2. Percentage of clients that improved housing stability
3. Percentage of clients in shelters being placed in services
4. Percentage of clients experiencing reduced mental health and substance abuse symptoms

HCHN will explore the potential use of the Mental Health Integrated Tracking System (MHITS), a web based registry, to track clients' MH/CD system utilization and demonstrate clinical improvements.

2. Funding Resources Needed and Spending Plan

The mental health and substance abuse service enhancement for homeless individuals in Downtown Seattle and South and East King County will have an annual cost of $550,000.

Dates	Activity	Funding
April - Dec 2009	Start-up (staff hiring and training), phasing in ongoing services	$ 270,000
	Total Funds 2009	**$ 270,000**
2010 and onward	Ongoing outreach, engagement and case management services to create more access to community mental health and substance abuse services	$360,000
MHCADSD		$190,000
Ongoing Annual	**Total Funds**	**$550,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers*

1. The equivalent of a minimum of 3.6 FTE licensed mental health professionals who are experienced in working with individuals who are living with a co-occurring disorder will be added to Health Care for the Homeless Network mental health services staff. The Agency will subcontract with two existing contractors of the Network to provide the expanded services and associated psychiatric services: Harborview Medical Center-Pioneer Square Clinic will provide services in Seattle (estimated 1.6 FTE expansion); and Valley Cities Counseling and Consultation will provide services in South and North/East King County (estimated 2.0 FTE expansion).
2. MHCADSD

◊ *B. Staff Resource Develop Plan and Timeline*

Dates	Activity
April 1 – June 30, 2009	Contract agencies hire staff
April 1 - Sep 30 2009	Startup activities including training of new staff
Oct 1, 2009 – Dec 31,2009	On-going training activities
January 1, 2010	Fully operating programs

◊ *C. Partnership/Linkages*

Stakeholders include The Committee to End Homelessness in King County, The Veterans and Human Services Levy Boards, United Way of King County, Eastside Homeless Advisory Committee, Eastside Human Services Forum, South King County Forum on Homelessness, shelter providers, jails, and hospitals throughout King County, the King County Department of Community and Human Services, and Public Health – Seattle and King County.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

As this is an addition to existing programs, the planning is substantially complete. Project scope was based on a comprehensive series of surveys, interviews and focus groups used to gather community input on barriers to health care for homeless people in King County. This information, combined with quantitative data gathered from local homeless data sources, is documented in HCHN's *2008 Data Summary* available for review at www.kingcounty.gov/health/hch. HCHN's *2008 Local Data Summary* highlighted the need for expanded mental health services available to clients in shelters and supportive housing in throughout King County (but especially in South and East King County.)

◊ *B. Procurement of Providers*

The providers are currently under contract with King County. A competitive bid process was conducted for ongoing HCHN services in early 2009.

◊ *C. Contracting of Services*

Contract amendments will be in place by April 1, 2009

◊ *D. Services Start Date(s)*

Services will begin no later than May 30, 2009

New Concept Submission Form

Please review the preceding pages before completing this form.
Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#34

Working Title of Concept: Multi-Disciplinary Encampment Outreach Team

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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.

Expanding on the current outreach programs – the REACH Program operated by Evergreen Treatment Services (ETS), the Metropolitan Improvement District Multi-Disciplinary Team (MID/MDT), coordinated by the City of Seattle Mayor's Office and the Law Enforcement Assisted Diversion (LEAD) program, we are proposing a concept that will focus on unauthorized encampments. In order to address the immediate mental health, drug/alcohol addiction and housing service needs for this difficult to reach population, this expanded and dedicated "Multi-Disciplinary Outreach Team" (MDOT) would be comprised of police officers, expanded REACH personnel licensed with the ability to provide mental health and/or drug/alcohol counseling, and MID/MDT outreach staff. In addition, this program would create a coordinating structure under which these staff come together to improve communication and coordination. In order to provide immediate intervention, this program would have access to additional dedicated shelter beds and dedicated capacity at authorized encampment sites. Lastly, the program would establish a single centralized storage location for belongings when encampment sites are disassembled.

This program would work in concert with other proposed services that focus specifically on the health care needs of this population. As Public Health – Seattle & King County (PHSKC) works to stand-up a mobile medical van for instance, the MDOT would work side-by-side with this team to ensure meaningful services at the encampments including on-site Buprenorphine treatment and prescribing of medication for those in an active psychotic state who have a previous diagnosis.

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 growth of unauthorized encampments in Seattle has reached crisis levels and the potential for harm to the individuals living in them continues to rise. Some of these encampments have become a center for heroin use driving a significant public health problem. At a visit to some unauthorized encampment sites you will see large numbers of used needles strewn everywhere. A progressive engagement model that meets people where they are, focused on harm reduction, is the preferred choice of moving people out of these camps and into stable housing and treatment. Through the use motivational interviewing, the goal is to meet the pre-contemplative and contemplative where they are, assisting them to consider options. Having them go directly into treatment is a big jump and often not accomplished. Meanwhile, the unauthorized encampments have become base for criminal behavior as well as posing large safety issues. Efforts to avoid criminalizing homelessness is still the priority though there is a need to find a balance and not tolerate clear criminality and detriments to personal and public health.

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

Traditionally, the approach to individuals living in unauthorized encampments has been law enforcement or outreach services with minimal ability to provide direct services. This model brings together police, mental health/drug alcohol counselors, outreach staff and individuals responsible for ensuring a safe environment. Members of these teams would work collaboratively to provide on-site services with the goal of engagement and then movement out of these unauthorized encampment sites. With set-aside space at authorized encampment sites and shelters, as well as the ability to safely store personal belongings, individuals will be more likely to move out of unsafe sites. Having teams be made up of consistent individuals will go a long way to ensure connectivity between team members and clients, increasing the likelihood for acceptance of housing, drug/alcohol intervention and mental health services, as well as holding individuals accountable for criminal behavior.

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

Individuals in unsheltered encampments with mental health and substance use disorders, by receiving coordinated harm reduction services through a team that knows them and builds upon an existing and ongoing relationship, will have a greater likelihood of taking the step to care and sobriety. In addition to these individuals, the community benefits by addressing a very large public health problem created by these unauthorized encampments. The sanitation and exposure to drug paraphernalia poses a serious problem for all encampment residents regardless of the activities they are, or are not, engaged in. Lastly, the system of services working to assist homeless individuals, and those with mental health and/or substance use disorders, benefits by having an outreach team that is always aware of hot spots and trends and drug use activities and needs.

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.

1. Increased number of individuals accessing sectioned encampments or other shelter/housing [data is collected by those operating sanctioned encampment sites – pre and post intervention numbers collected].

2. Fewer unsanctioned encampments existing in the City of Seattle specifically ones in unsafe locations [survey existing encampment sites before and after intervention – information maintained by existing REACH staff and SPD)
3. Increased number of individuals engaged in treatment services [data to be collected by treatment sites regarding most recent living situation – data is collected currently]
4. Decreased costs related to unauthorized encampment sites after first year of program [collect first year costs of clean-up for baseline]
5. Decrease over dosage among those in unauthorized encampments [determine if data is currently collected from hospital sites – begin collection if not – pre and post intervention data studied].
6. Improved health status (measures to be determined) over course of intervention period and, possibly, through sheltering/treatment process [health measurements taken by mobile van services' staff – measurements taken in shelter clinic/treatment sites].

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 is aimed at the most vulnerable due to being both unsheltered and living with mental health and/or substance use disorders. Through progressive engagement and on-site treatment we are not waiting for individuals to come to us but bringing the concepts of health and social justice directly to individuals focusing first on harm reduction.

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.

Coordination among the proposed players exists, to some degree, today based on the Metropolitan Improvement District Multi-Disciplinary Team (MID/MDT) model and the REACH/LEAD programs. We would be bringing these three programs in greater alignment and adding police officers, staff for collection and coordination of personal belongings and staff to oversee the program. We would also develop specific commitments for specific shelter bed space and encampment space with the respective operating entities. We would coordinate with mental health and drug/alcohol treatment organizations for direct referrals on a clinician-to-clinician basis. Assuming a Seattle-based mobile medical van gets up and running, we would also coordinate schedules and, more importantly, a system to integrate care plans.

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: $ 250,000 per year, serving 250 people per year
Partial Implementation: $ 435,000 per year, serving 500 people per year
Full Implementation: $ 770,000 per year, serving 1,000 people per year

New Concept Submission Form

#39

Working Title of Concept: Applying Equity and Social Justice to Outreach and Engagement/Increasing Culturally Responsive Treatment & Penetration

Name of Person Submitting Concept: Jesse Benet, Chloe Gale, Maria Yang, Trudi Fajans, Travis Erickson,
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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.

Component 1: Provide outreach and engagement efforts from an anti-oppressive practice and harm reduction framework that is culturally responsive and culturally informed to people of color and people with other marginalized identities including undocumented, immigrant, transgender, queer/LGB, and/or experiencing homelessness/living on the streets and engaging in survival economies. A vast majority of these individuals have come into contact with the criminal justice system and have increased barriers to access because of court requirements, legal-financial obligations and the increased stigma of a criminal record when trying to access housing, jobs, and some treatment.

Many individuals needing street and/or community-based outreach and engagement also have behavioral health conditions and need access to culturally-informed and culturally response in ongoing behavioral health treatment. Critical aspects of outreach and engagement include relationship building/trust with individuals who have been perceived as "difficult to serve" and changing the services system to one that operates from a trauma-informed, harm reduction framework, where individuals do not have to achieve/sustain sobriety from substances in order to be outreached or receive ongoing services that are also culturally responsive and culturally informed. Underserved populations can be identified through disparities in service access. A flexible, relationship-based approach can be adapted to be effective with each targeted sub-group.

Right fit. It is critical that outreach/engagement teams identify a focused population and a system to target each person and what aspects of their identities to engage around and who to do this work.

Component 2: Building Organizational Capacity of Providers to do Culturally Responsive/Informed Harm Reduction Services.

It is critical that outreach/engagement teams are working in close coordination with the receiving ongoing services provider and when possible are part of that provider's continuum of services. Many providers offering culturally specific, culturally responsive services may need assistance developing their organizational capacity in three important ways:

1. Building equity and social justice capacity at an institutional level in direct service behavioral health agencies, including leadership development, evaluation of internal policies, procedures and practices that perpetuate inequity. This is in addition to staff training, and requires leadership commitment to equity.

2. Harm reduction is a critical component of service delivery, especially for those individuals who have historically been under-served by the existing behavioral health system. Many individuals need both a culturally responsive treatment approach that also operates from a harm reduction frame.

3. Development of Outreach/Engagement Teams is an area that many providers who already provide culturally specific/responsive services, need assistance with. Often the providers are limited to clinic-based outpatient services, and do not have teams doing robust outreach in street and other community settings, including hospitals, jails and primary care clinics. It is important that these teams are not spread too far over a geographic region in order to preserve robust coverage.

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.

Enhancing outreach and engagement teams will not serve individuals well if the providers they are connecting to aren't also culturally responsive, culturally informed and offering harm reduction approaches that are trauma-informed. Often when chronic substance use and chronic homelessness are combined, traditional abstinence-based outreach and treatment approaches are unsuccessful, and individuals are labeled as "difficult to serve," or "resistant" or "un-engageable" when actually it is the system that is not equipped to meet their needs from a person-centered lens.

The result is that communities with high needs show up disproportionately in jail and emergency services, but are not enrolled successfully into supportive services and housing. An increase in barriers to access occur when individuals are coming through the criminal justice system and getting needs met becomes close to impossible – perpetuating homelessness, substance use and engaging in survival economies.

A two-prong approach outlined above addresses both serving individuals better through culturally responsive, harm reduction practices that truly meet individuals where they are at an in the cultural context they know, as well as the necessary development of organizational provider capacity for equity and social justice as well as harm reduction.

3. <u>How would your concept address the need</u>?
Please be specific.

• Providing Outreach in the Language of the Individual - Need for services/outreach done in Non-English languages and conducted by language appropriate staff, who understand the culture and linguistic needs workers who also have cultural understanding and can be responsive.

• Addressing a regional focus need in King County where there are concentrations of communities of color/marginalized communities, who are also experiencing homelessness and criminalization, outside the downtown Seattle corridor. This would include a specific focus on immigrant and undocumented communities.

• Trans-Competency – understanding how to work with Trans and gender nonconforming people, helping with access to Trans competent behavioral health, primary care and housing options.

• Harm Reduction framework – not having an expectation of sobriety for outreach/engagement, which is an unsurmountable barrier for individuals to accessing much of the existing behavioral health and primary care services systems. Providing harm reduction training to organizations that will address the

institutional barriers to service access as well as providing training to direct support staff.

• Outreach/Engagement teams will be able to link to providers that already provide culturally responsive services (e.g., Consejo, ACRS, Cowlitz, Seattle Counseling Service) and providing resources to those agencies to do outreach and have more non-clinic based services. Working with these providers to develop more harm reduction strategies for individuals who are actively using substances and do not desire to be clean and sober.

• Implementation of a Cohort Model - In addition to organizational advocacy and training to create better access for excluded populations, development an organizational cohort model where programs learn together about ESJ, harm reduction and outreach strategies is critical for sustainability.

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

• Individuals with behavioral health needs dwelling (sheltered or unsheltered) in communities of color concentrated in south and north King County, who are not being outreached currently nor have access to culturally responsive behavioral health services

• Young people, especially youth of color and queer/trans youth experiencing homelessness

• African American, Native American and Latino individuals who need access to harm reduction oriented behavioral health/supports in order to engage in treatment, gain access to housing, become employed, reduce jail and hospital visits and become self-sustaining.

• Behavioral health provider agencies who need assistance with developing outreach/engagement teams and who want to have organizations that address inequity.

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.

Structural level change at all organizations doing outreach and providers that provide services after outreach. A shift for communities disproportionately served in jail and emergency services into appropriate housing, primary care, and behavioral health services. An additional shift in system-wide stigma related to serving individuals with criminal records and increased racial equity analyses applied to this issue of mass incarceration and racial profiling that is widely studied and proven that our jails are filled poor people of color, often with disabilities. This is true for jails in King County as well.

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?

There are long-standing, widely known issues with the lack of culturally responsive and culturally informed treatment opportunities available in the publicly-funded behavioral health service system in

King County, especially areas outside of downtown Seattle, in the north and south end of the County. Many people of color and poor people are experiencing homelessness, coming into contact with first responders and cycling through our jails and hospital emergency departments. Often, when these individuals come into contact with law enforcement it is because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies). Culturally informed and culturally responsive outreach teams can interrupt this cycle, especially when access to resources and supports are from a harm reduction framework.

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.

Organizations that employ and adhere to culturally responsive policies and procedures and have an ESJ philosophy as a guiding principle of their operations will be sought for this work and engaged. King County cannot continue to provide training to individual providers and hope for the culture shift that is required for this work to be successful and responsive to the needs of our diverse communities. Organizations that want to do this work will be held accountable to be harm-reduction in focus, culturally sensitive, and invest in the resources and infrastructure to sustain this approach. Organizations with trained teams and who have leadership capacity to meet and respond to the needs of the diverse communities, are highly sought and will be viewed favorably for this work.

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: $ $250,000 per year, serving 120 people per year
Partial Implementation: **$** # 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**

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#63

Working Title of Concept: Bridges

Name of Person Submitting Concept: Sonia Handforth-Kome
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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.

MIDD dollars fund a two person team to provide street-based outreach mental health services to homeless individuals. The Bridges program staff provides site based mental health engagement, screening and assessment services on an outreach basis to individuals who are enduring homelessness located in South, East and North King County (not Seattle). The target population focuses on those who tend to cycle through hospitals, jails and/or other crisis facilities and clients without Medicaid. The Bridges program staff makes referrals to community mental health and substance abuse treatment agencies for clients with Medicaid. For some clients, direct clinical services are provided to those individuals requiring more intensive engagement efforts when clients is not able to be referred to other publically funded mental health and/or substance abuse service programs. An important aspect of the service delivery model is to coordinate care, as appropriate, with collateral service providers and service systems to ensure optimal client care.

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.

The unique services and benefits the Bridges program provides includes:

- Ability to meet people where they are as opposed to having them come to an office (removing transportation barrier).
- Ability to serve people who do not have a medical benefit.
- Able to provide non-time limited Mental Health as well as Case Management services to homeless adults.
- Focus on high utilizers of jails, hospitals, and emergency rooms, as well as those who are isolated or not currently connected to services of any kind.
- People are able to access mental health services and benefits that would not be able to do so otherwise (lack of transportation, illiteracy, intimidated by the system, scared to go into an office, etc.).
- Bridges program staff are able to see clients in the jail to engage in services.
- Ability to keep working with clients for a year after they enter housing; able to have longer period of care continuity.

This program is for the underserved.

3. <u>How would your concept address the need</u>?
Please be specific.

Expanding supportive employment, an evidenced based practice, would allow more consumers more access to employment. More access to employment improves recovery outcomes and decreases the use of high cost services (intensive outpatient, hospitalizations).

4. <u>Who would benefit</u>? Please describe potential program participants.

Adults who have difficulty accessing services.

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

Here is a recap of some of the successes experienced by our clients during 2014:

- Clients who worked with Bridges to apply for or maintain their Medicaid benefits: 8
- Clients who worked with Brides to apply for or maintain their SSI/SSDI benefits: 3

- Clients who had psychiatric evaluations: 7
- Clients permanently housed: 11
- Clients moved into transition housing: 4
- Clients who obtained employment: 8
- Clients who started school/training program: 4
- Clients that completed 12 months of being successfully housed: 2

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?

Outreach improves the lives of our most vulnerable populations.

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 with housing, social service organizations, employment, educational institutions and service providers. consumer voice and choice.

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*.

New Concept Submission Form

Please review the preceding pages before completing this form.
Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#72 Working Title of Concept: Evergreen Treatment Services' (ETS) REACH Program – Outreach Teams

Name of Person Submitting Concept: John Gilvar & Travis Erickson
Organization(s), if any: Public Health Seattle & King County – Healthcare for the Homeless Network
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Mailing Address: 401 Fifth Avenue, Suite 1000, Seattle, WA 98104
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.

Evergreen Treatment Services' (ETS) REACH Program provides outreach, engagement, case management, housing stabilization, and supportive services to high need, chemically dependent, chronically homeless individuals. REACH engages the most visible and complex homeless community members through flexible, client-centered services, meeting with clients where they are located and responding to their priorities. This respectful, individually tailored approach has inspired many individuals with extensive histories of trauma, homelessness and addiction to work with the program to address their housing and chronic health (physical and behavioral) needs, resulting in increased stability and improved quality of life. A key component of this program is the Street Outreach Team that engages clients and provides key supports and connections to the larger health and human service delivery system. Unfortunately, current resources only can support one of these critical teams, which limit the area of the county that the team can serve and the number of clients. Since the need for this unique program is county-wide, this concept would fund additional Street Outreach Teams and allow for a concerted approach to addressing the needs of King County citizens county-wide. Additional teams would allow for this best practice to be replicated in other regions of King County, especially South King County where these services are in greatest need and not currently supported. Expansion of this program would allow those teams to foster greater connections and relationships with the clients that they serve which is a proven concept to help these unstable citizens achieve better physical and behavioral health stability and support.

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.

Currently the Street Outreach Team focuses their efforts in the areas of Belltown, SODO, the University District, Ballard, and Lake City. While needed in these areas, because of capacity limitations this leaves other critical areas of the county, mainly south King County severely underserved and missing this

critical program support. As more and more individuals are residing in areas outside of the downtown Seattle corridor, these services need to be expanded to meet the needs of the clients where they are residing. It is completely unrealistic to believe that people with severe substance use and/or mental health treatment needs who are living camped out in Federal Way, for example, will travel to Seattle to engage with outreach workers or case managers, no matter how helpful, friendly, or connected to resources these staff may be. As the County regional maps show, there is a dire need for supportive services in all areas of King County, but especially in the south. By not deploying proven programs to the area's most in need, we will continue to perpetuate the trend. Funding an expansion of this program can help mitigate that.

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

This proposal would address the large deficiency and community need that currently exists in regions of King County where this critical program currently doesn't touch. While deployment of new teams would go to the area(s) most in need like South King County, having resources to create catchment regions of King County for this program is most ideal. This would allow for greater coverage and reach for all of King County and allow regional teams to foster relationships with local clients, providers and network partners which will help stabilize and increase the stability of the region and clients they serve.

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

As mentioned, REACH provides outreach, engagement, case management, housing stabilization, and supportive services to high need, chemically dependent, chronically homeless individuals. REACH engages the most visible and complex homeless community members through flexible, client-centered services, meeting with clients where they are located and responding to their priorities. Expansion of this program would help all citizens of the King County region that are dealing with challenges described above. In addition, there is significant overlap between this model of care and the model proposed by the Familiar Faces Initiative to intervene with the population that has 4 or more jail stays per year and a behavioral health diagnosis. Familiar Face's future state vision calls for mobile outreach teams that use a client-centered, non-linear approach to engaging and maintaining engagement with high-risk frequent jail stayers until they can establish an effective linkage with ongoing behavioral health providers and meet pressing social needs such as housing. The Familiar Faces target population and goals align extremely well with the MIDD population and goals. Over half of the Familiar Faces are homeless, and Familiar Faces research has revealed that nearly all of people with 4 or more jail stays per year have a behavioral health diagnosis.

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.

Successful implementation of the proposed expansion would allow for Street Outreach Teams to be assigned to the critical regional areas of King County and accountable for the unique outreach needs of those areas of the County. Ideally there would be enough resources to ensure sufficient engagement and opportunity in all sections of King County, but immediate success would allow for 4-5 key teams to be developed and assigned to the most critical areas of King County. These new teams would collaborate and respond to the needs of each region and the clients they serve. The teams would be assembled to address the cultural and demographic needs of the regions they serve and would embody the core principles of Harm-Reduction, Trauma-Informed–Care and other person-centered care approaches. Long-term success of expanding this program would be seen by a reduction in number of homeless and high-risk individuals in all of King County with unmet health needs. Specific outcome

measures would include the number of homeless people with chronic substance use disorders who (1) engage in case management around harm reduction, linking to ongoing services, and increasing their personal stability, (2) improve their housing by, for example, moving into shelter or permanent supportive housing.

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?

In order for REACH to effectively support Familiar Faces in implementing this model it requires additional outreach and case management staff who would form additional teams and cover a broader geographic area than the current teams can cover. Such an expansion would help the following MIDD strategies: Crisis Diversion, Recovery and Reentry, System Improvements.

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.

In order to be successful, this concept would require investment and support by many sectors and regions of King County, as the issues being addressed are not confined to one singular area or system of health and human services. Key supporters and influencers on the effectiveness of this implementation would be Evergreen Treatment Services, REACH, PHSKC, DCHS, King County and most municipalities in which the service teams would work in. Success in the program will also require collaboration with first-responders, ER's, hospitals, CHC's, housing and other homeless services providers, and most physical and behavioral health providers, along with other social-determinant of health programs and supports.

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: $ 250,000 for one new outreach team per year, serving the region and as many 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**

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