MIDD Briefing Paper

BP 76 County Opioid Response

MIDD I Strategy Number __76_____ (Attach MIDD I pages)
New Concept × (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This new concept would strengthen King County's ability to understand and prevent deaths due to use of opioids. This would be accomplished by providing epidemiologic assessments and collaborate with key partner agencies and programs to develop prevention strategies to reduce deaths caused by prescription opioids and street drugs. An FTE position either in Public Health – Seattle & King County's (PHSKC) or in a community agency could accomplish this work. An example of a position similar to this is the current expert with the University of Washington-Alcohol and Drug Abuse Institute (UW-ADAI).

Collaborators:

Name	**Jennifer DeYoung**	**Department Public Health**
	David Bibus	**Department Public Health**
	Jeff Duchin	**Department Public Health**
	Michael Hanrahan	**Department Public Health**

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

Name	Role	Organization
David Bibus	Health Provision Administrator	Public Health – Seattle & King County
Caleb Banta-Green	Senior Research Scientist	University of WA, Alcohol and Drug Abuse Institute
Jeff Duchin	Health Officer	Public Health – Seattle & King County
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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 new concept would strengthen King County's ability to understand and prevent deaths due to use of opioids. This would be accomplished by providing epidemiologic assessments and

collaborate with key partner agencies and programs to develop prevention strategies to reduce deaths caused by prescription opioids and street drugs. A position in Public Health – Seattle & King County's (PHSKC) would accomplish this work (this work could also be put out for RFP to a community organization). An example of a position similar to this is the current expert with the University of Washington-Alcohol and Drug Abuse Institute (UW-ADAI).

This concept will build upon existing work and allow PHSKC to better understand factors contributing to opioid related deaths, develop corresponding intervention strategies, and work collaboratively with partner agencies and stakeholders to design a comprehensive approach to the problem of opioid use.

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

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

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

Please describe the basis for the determination(s).

This fits under three categories.

MIDD Strategy #1 Prevention and Early Intervention by keeping people healthy by stopping problems before they start and preventing problems from escalating. This concept will allow PHSKC PHSKC to develop strategies to prevent opioid overdose and promote optimal medical management for persons addicted to opioids.

MIDD Strategy #2 Crisis Diversion by assisting people who are in crisis or at risk of crisis to get the help they need. This concept will allow PHSKC to implement activities to reduce morbidity and mortality from opioid overdose, such as identifying best practices to optimize distribution of Naloxone to reverse an overdose and prevent associated disability and deaths; improving access to and successful retention in medication-assisted treatment through policy and program strategies.

MIDD Strategy #4: System Improvements: Strengthen the Behavioral Health System to become more accessible and deliver on outcomes. This concept will lead to program recommendations and improvements to increase accessibility of services and treatments to minimize morbidity and mortality from opioid overdose and to improve success of medication assisted treatment.

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

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

Heroin use has increased across the US among men and women, most age groups, and all income levels. Some of the greatest increases occurred in demographic groups with historically low rates of heroin use: women, the privately insured, and people with higher incomes. Not only are people using heroin, they are also abusing multiple other substances, especially methamphetamine and prescription opioid painkillers. As heroin use has increased, so have heroin-related overdose deaths. Between 2002 and 2013, the rate of heroin-related overdose

deaths nearly quadrupled, and more than 8,200 people died in 2013. States play a central role in prevention, treatment, and recovery efforts for this growing epidemic.[1]

In King County there were 314 drug related deaths in 2014, with a substantial increase over the past five years, and the greatest number since 1997. Opioid related deaths account for the highest number of drug-related deaths, and heroin-related deaths have been increasing. Heroin was involved in 156 deaths in 2014, up from 99 the year before and 49 in 2009. Prescription-type-opioid involved deaths totaled 98 in 2014 the fifth year of continuous declines in prescription-type-opioid involved deaths.[2] While deaths from prescription-type-opioids show a decrease, the heroin-related deaths have increased, supporting the overall increase in opioid related deaths.

Data from the UW Alcohol and Drug Institute shows treatment admissions for heroin has doubled since 2010 and increased 32 percent from 2013 to 2014. [3]

Data from the Washington State Department of Behavioral Health and Recovery, System for Communication, Outcomes, Performance and Evaluation (SCOPE) shows that for King County, the current client caseload/census for Medication Assisted Treatment (MAT) clients in opiate treatment (primarily methadone) programs (OTP) are 3,733 for October 2015. This represents an increase of 576 from November 2014.[4] The need for MAT continues in an upward trend. The ability for the County to respond to the increasing need is limited by several factors. Siting an MAT service takes time and must be negotiated with community stakeholders. Federal restrictions are also a limiting factor; the number of clients that can be served in a location are monitored by the Federal Government, with some flexibility for the County to approve waiver requests to exceed the 350 clients per license limit. This all must be balanced by ensuring there is adequate staff to provide the service and the actual physical location can adequately adjust for a census increase. The results are the MAT need surpasses the ability to provide treatment. This is supported by the current wait-list for MAT services. At the time of this writing the waitlist was at 145, and continuing to grow. This list consists of clients who are not considered a priority population. The highest priority population is women who are pregnant and injecting or using substances.

Without the capacity requested through this concept, PHSKC is not able to determine if there are potential steps that could be taken to improve health outcomes among opioid users and prevent overdoses, or to provide evidence for siting new treatment facilities. Currently, PHSKC does not have staff capacity to engage in or lead the activities as described. PHSKC would not be able to participate in enhanced data extraction and analysis, or providing or analyzing data for inter-agency planning collaborations.

[1] Centers for Disease Control, "Todays Heroin Epidemic", July 7, 2015.
[2] http://adai.washington.edu/pubs/cewg/Drug%Trends_2014_final.pdf, "Drug Abuse Trends in the Seattle-King County Area: 2014"
[3] http://adai.washington.edu/pubs/cewg/Drug%Trends_2014_final.pdf, "Drug Abuse Trends in the Seattle-King County Area: 2014"
[4] Washington State DBHR Substance Abuse Treatment Reports, Opiate Substitution Caseload, "*Persons Served between November 2014 and October 2015*".

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

   PHSKC has an important role, but does not have adequate resources to support a comprehensive, collaborative approach along with the Department of Community and Human Services (DCHS) and community stakeholders to address key public health problems associated with persons who inject drugs and other users at-risk for opioid deaths. At present, only 0.2 FTE of staff time at PHSKC supports the epidemiological analysis, inter-agency collaboration, program coordination and policy activities.

   While DCHS has a primary role in providing behavioral health services including medication-assisted treatment, PHSKC has a critical role in monitoring and describing the opioid epidemic and factors contributing to poor health outcomes, including overdose, but lacks resources for the necessary epidemiologic work, and successful collaboration and coordination with DCHS and others. PHSKC currently provides critical complementary services to DCHS that address specific public health problems related to drug users (e.g. needle exchange, triage for healthcare and social services, methadone vouchers, injection-related wound treatment). PHSKC, to a very limited extent, provides policy support to the extent possible with limited resources (collaborations with Washington State Department of Health (DOH), DCHS, UW Alcohol and Drug Institute), and coordinates harm reduction initiatives (e.g. naloxone distribution and use through Jail Health, Needle Exchange, Health care for Homeless, Emergency Medical Services, etc.) and tracks opioid-related deaths (Medical Examiner Office and Injury Prevention Program). The proposed services would improve data collection and analysis, reporting and dissemination of results, and the ability to collaborate with key partner agencies and programs to develop and/or adjust intervention strategies and provide multi-layered responses to address the need. PHSKC, in collaboration with UW Alcohol and Drug Institute, DCHS, and DOH, can further develop policies and programs and build on the ongoing work of various agencies such as the DOH-sponsored Unintentional Poisoning Workgroup. Strong partnerships are needed to make an impact on the problem that includes mental health and substance use disorder treatment providers, Jail Health, agencies serving the homeless, law enforcement and Emergency Medical Services, among others. Public Health does not have the resources to provide enhanced epidemiologic assessment, and leadership and collaboration roles needed to address the problem.

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

   The proposed program is based on a well-established public health model of engaging affected communities to address problems through

   1) data assessments,
   2) collaborations with affected constituencies to
      a. plan interventions, and to
      b. implement and
      c. evaluate interventions in partnership with community allies.

This ongoing sequence of activities has led to well-supported and effective interventions for many years in local HIV prevention interventions and HIV care services. For example, epidemiological support assisted with establishing needle exchange in Seattle, one of the first municipalities in the nation to embrace this life-saving intervention. The result is that Seattle/King County has one of the lowest rates of HIV infection among injection drug users in the country.

Data and analysis of drug-related deaths is generated by the King County Medical Examiner, which is a part of PHSKC. An annual report includes overview data, and special reports can be and are generated for trend analysis in collaboration with other agencies. (No resources currently exist for special reports).

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

   Best practice and evidence-based practice are used. In other major areas such as New York City, for example, opioid deaths have been reduced through public health leadership using multi-agency collaborations, health care provider and emergency room education, and increased access and distribution of Naloxone.[5]

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

   The key outcome desired is a reduction in the number of opioid related deaths resulting from the epidemiologic assessments and collaborations with key agencies and programs; a process outcome will be the key strategies developed to target specific problems that result in opioid related deaths.

   Other potential outcomes could be expansion of naloxone distribution; increase in persons receiving MAT, and identification of other potential intervention strategies to reduce opioid related overdoses.

   The data sources that are available to use currently and following the investment in this new concept are the King County Medical Examiner reports, Department of Community and Human Services treatment data, agency program data, data on the distribution of naloxone, data from local and national Community Epidemiology Work Groups (CEWG), the Centers for Disease Control and Prevention (CDC) and reports/data from the King County Emergency Medical System.

C. Populations, Geography, and Collaborations & Partnerships

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

   ☐ **All children/youth 18 or under** ☒ **Racial-Ethnic minority (any)**

[5] http://www.nyc.gov/html/doh/html/pr2014/pr029-14.shtml

- ☐ **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:**
- ☒ **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.

Public Health estimates there are 23,000 people in King County who used drugs by injection within the last year, most of whom injected opiates such as heroin. The following details of this population are from the 2015 Needle Exchange Client Survey. This is a brief intercept survey conducted at all Public Health needle exchange sites during a two week period in June. All clients who presented at a site to acquire or dispose of syringes during the survey period were approached and invited to take the survey.

The survey data, which is specific to the populations that are at risk for opioid related overdose death, strongly supports the need for comprehensive details on each opioid related death.

Age	N=406	
<20	6	1.5%
20-29	121	29.8%
30-39	122	30.0%
40-49	90	22.2%
50-59	51	12.6%
60+	14	3.4%
Median	35	
Mean (std)	37.0 (11.3)	
Range	16-66	
Race	N=405	
White	289	71.4%
Black	25	6.2%
AI/AN	24	5.9%
NH/PI	1	0.2%
Asian	2	0.5%
Hispanic	18	4.4%

Other	6	1.5%
Hispanic/Latino	N=404	
Yes	38	9.4%
No	366	90.6%
Gender	N=405	
Male	256	63.2%
Female	147	36.3%
Female-to-Male	1	0.2%
Male-to-Female	1	0.2%

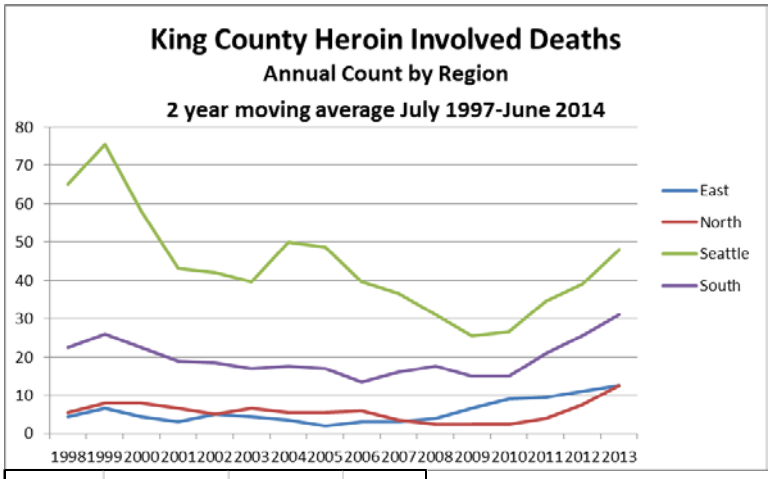
[6]

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

   The geographic distribution of heroin/opioid deaths in King County appears to have increased over time. Mortality rates have increased in all health planning regions of King County for the past three years and are up in all regions except Seattle over the last 16 years. While Seattle consistently has the highest rate of heroin involved overdoses, the rate in 2013 was down 33 percent from 1998.[7] The attached slides show that all other areas South, North and East are experiencing increases in opioid related deaths. The attached slide shows that the death rate is alarming over all considered regions. The data presented support the need for a comprehensive review surrounding opioid related deaths that captures the entire King County area.

[6] "Personal communication from Michael Hanrahan, Manager, HIV/STD Education and Prevention Services, Public Health-Seattle & King county, December 15, 2015."

[7] Banta-Green C, Opioid Overdoses: Responses & Data Needs, presentation to the King County Board of Health, March 18, 2015. Dr. Banta-Green is a Senior Research Scientist at the Alcohol and Drug Abuse Institute, Affiliate Associate Professor in the School of Public Health, and Affiliate Faculty at Harborview Injury Prevention & Research Center, University of Washington.



	1998 Rate per 100,000	2013 rate per 100,000	% change in rate
Heroin			
East	1.1	2.4	116%
North	3.2	7.7	143%
Seattle	12.5	8.3	-33%
South	3.7	4.4	18%

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.**

   This requires an enhanced collaboration of partners across the entire County. These partners are DCHS, PHSKC, Jail Health, Health Care for the Homeless, King County Needle Exchange, Emergency Medical System (First Responders) and the Medical Examiner. Community partners should include UW-ADAI, DOH, Law enforcement, mental health, drug treatment, medical care, and other service providers, as well as grassroots community and faith-based organizations.

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?**

   The impact of health care reform has increased the number of individuals who are eligible for treatment. The largest increase is among those individuals who now have Medicaid coverage, who before health care reform, were not previously eligible. This is creating increased demand for medication assisted treatment that exceeds the system's current capacity to respond..

   "With the advent of the Affordable Care Act in January 2014, concomitant effort to enroll poor folks in Medicaid, and increasing approved capacity at publicly-funded treatment agencies, Public Health King County Needle Exchange was able to abandon the list after only three months into the year. This resulted in treatment being available on demand for much of the ensuing 14 months. Demand began exceed capacity in June 2015 and wait time between referral and

intake appointment reached five to six weeks. Consequently, the Needle Exchange was forced to reinstate the waitlist in July. As of the time of this writing, there were 159 people waitlisted for treatment in King County; wait time on the list is currently about two to three months." [8] Health care reform, along with the epidemic of heroin and opioid prescription drug use, supports the need for a comprehensive review of opioid related deaths to support a solution-focused response dedicated to reducing the number of individuals who die under these circumstances.

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?**

   A primary barrier to implementation is patient confidentiality for individuals in treatment for substance abuse disorders. Federal Code of Regulations: 42.CFR Part 2 states: Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.[9] The identified barrier would prohibit the disclosure of confidential patient information. This prohibits a treatment facility from disclosing patient information without a specific signed release of information from the patient giving permission to share or disclose that patient information to any entity who is not identified on the release. The laws, which are in place to protect the substance use records of all clients, would present a barrier that could be vital to implementing the new concept. SAMHSA has recently proposed modifying this regulation to facilitate information sharing and delivery of coordinated care. The proposed changes are open for public comment through April 2016.[10] If they are implemented, this would significantly the barrier described herein.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**
   Enhanced coordination among agencies and partners to share information, clarify roles, avoid duplication of services and maximize resources is needed.

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?**
   Opioid addiction is a non-discriminatory disease, impacting individuals of all ages, genders, racial backgrounds, and sexual identity. A review of opioid related deaths to determine what responses could have prevented them will support development of effective prevention approaches.

[8] "Personal communication from Michael Hanrahan, Manager, HIV/STD Education and Prevention Services, Public Health-Seattle & King county, December 15, 2015."

[9] http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2#se42.1.2_11

[10] https://www.federalregister.gov/articles/2016/02/09/2016-01841/confidentiality-of-substance-use-disorder-patient-records

This strategy has the potential to impact the identified populations with interventions and preventative strategies resulting from a complete review of opioid related deaths. For example, it is known that individuals recently released from prison having a history of opioid addiction have a high risk of overdose death shortly following release.[11] Specialized programs for this population may be indicated. A review of opioid related deaths is necessary to determine epidemiological patterns and develop targeted, effective, preventative responses..

The consequence of non-implementation is missing the opportunity to develop and implement response strategies with the greatest potential to turn the tide on mounting opioid related deaths.

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

As previously stated in Section A.1.:

"An example of a position similar to this is the current expert with the University of Washington-Alcohol and Drug Abuse Institute (UW-ADAI)".

It is possible that this new concept could be merged with the work that is already being done by the UW-ADAI It is unknown what impact this would have on the existing efforts.

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?**

Ideally this new concept fits Accountable Communities of Health by bringing together collaborative partners to share health priorities and strategies for this population. Additionally, this new concept fits Behavioral Health Organization Development by targeting improved coordination of care and improves the experience of clients resulting from a review of opioid related deaths.

The comprehensive review of opioid related deaths as an approach to overdose prevention as presented here fits within the County's efforts to integrate behavioral health. If implemented in a coordinated manner, this concept would help these program elements provide "whole person" care, flexibility in where and how services are delivered, overall improved health and social outcomes, and a better experience for the clients.

[11] Merrall, E. L. C., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., Hutchinson, S. J. and Bird, S. M. (2010), Meta-analysis of drug-related deaths soon after release from prison. Addiction, 105: 1545–1554. doi: 10.1111/j.1360-0443.2010.02990.x

This concept supports the Health and Human Services Transformation with a critical review to determine what solutions can be implemented to reduce the costs of the current crisis response systems to an approach that focuses on prevention.

It falls under the prevention spectrum within the continuum of care, as the intention is to prevent death and other morbidity resulting from opioid use.

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

Understanding patterns contributing to opioid deaths would allow for creation of interventions that support recovery and resiliency and reduce the likelihood of negative outcomes, such as overdose and death.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**
   King County's equity and social justice is about reducing disparities, including disparities in indicators and outcomes such as life expectancy. Individuals who are dying from opioid overdose are disproportionately young. Understanding the determinants of who is dying from opioid use and under what circumstances will allow the County to develop intervention strategies that can help reduce life expectancy disparities for individuals who become drug-involved.

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.)**?**
   - One FTE

2. **Estimated ANNUAL COST. $100,001-500,000 Provide unit or other specific costs if known.**

   As stated above, this estimate is based on funding a staff position. An estimate that is closer to the actual cost is approximately 160,000.

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

   Unknown

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

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

   b. What are the steps needed for implementation? Develop a job description; recruit an individual, interview process, etc.

   c. Does this need an RFP? Potentially if there is a decision to take this work out of King County to community agencies.

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?

Because there is more than one proposal for addressing opiate deaths and harm reduction issues, it will be helpful to convene stakeholders to assure collaborative and effective strategies.

New Concept Submission Form

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Working Title of Concept: Public Health Opiate Response

Name of Person Submitting Concept: Jennifer DeYoung
Organization(s), if any: Public Health – Seattle & King County
Phone: 206-263-8642
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1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

There is a need for a stronger public health role in preventing deaths due to opiates. Public Health – Seattle & King County would like to fund a leadership position to assure epidemiologic assessment, collaborations with key agencies and programs, and development of prevention strategies to reduce or eliminate deaths caused by opiate prescription and street drugs. Public Health is also involved in preventing disease spread among drug users, and an enhanced effort at preventing drug-related deaths would complement the disease-spread work already being done. This leadership position could be contracted through an outside expert such as one with the UW Alcohol and Drug Institute.

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.

In King County there were 314 drug related deaths in 2014, with a substantial increase over the past five years and the greatest number since 2009. Opiate related deaths account for the highest number of drug-related deaths, and probable heroin-related deaths have been increasing. Heroin was involved in 156 deaths in 2014, up from 99 the year before, and 49 in 2009. Prescription-type-opioid involved deaths totaled 98 in 2014 the fifth year of continuous declines in prescription-type-opioid involved deaths. For comprehensive data, see "Drug Abuse Trends in the Seattle-King County Area: 2014".
http://adai.washington.edu/pubs/cewg/Drug%20Trends_2014_final.pdf

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

One of the areas where Public Health has a role but does not have adequately established resources pertains to persons who inject drugs and other users at-risk for opiate deaths. While DCHS has a primary role, Public Health has a critical partnership role in several ways but lacks resources for overall collaborative leadership and coordination. PHSKC provides some services that address public health

problems related to drug users (e.g. needle exchange, triage for services, methadone vouchers, injection wound treatment), provides policy work (collaborations with DOH, DCHS, UW Alcohol and Drug Institute), coordinates harm reduction initiatives (e.g. naloxone distribution and use through Jail Health, Needle Exchange, Healthcare for Homeless, Emergency Medical Services, etc.), and tracks opiate-related deaths (Medical Examiner Office and Injury Prevention Program).

The proposed service would improve data collection and analysis, and serve to convene key agencies and programs to provide multi-layered responses to address the need. PHSKC in collaboration with UW Alcohol and Drug Institute, DCHS and WA Department of Health (DOH), can further develop policies and programs and build on the ongoing work of various agencies such as the DOH sponsored Unintentional Poisoning Workgroup. Strong partnerships are needed to make an impact on the problem that includes mental health and chemical dependency agencies, Jail Health, agencies serving the homeless, law enforcement and Emergency Medical Services, among others. Public Health does not have the resources to provide enhanced epidemiologic assessment, and leadership and collaboration roles needed to address the problem.

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

An enhanced effort to address opiate-related deaths would immediately impact drug using populations. PHSKC in collaboration with UW Alcohol and Drug Institute, DCHS and WA Department of Health (DOH), can further develop policies and programs and build on the ongoing work of various agencies such as the DOH sponsored Unintentional Poisoning Workgroup. Strong partnerships are needed to make an impact on the problem that includes mental health and chemical dependency agencies, Jail Health, agencies serving the homeless, law enforcement and Emergency Medical Services, among others.

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.

Data and analysis of drug-related deaths is generated by King County Medical Examiner, which is a part of Public Health – Seattle & King County. The UW Alcohol and Drug Institute collect and analyzes this and other drug-related data. See data description in question #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?

This concept proposal directly addresses the problem of an increasing number of drug-related deaths among drug-using populations, particularly focusing on opiate-related deaths.

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.

An enhanced collaboration of partners is needed that would include DCHS, Public Health-Seattle & King County (Injury Prevention, Jail Health, Health Care for the Homeless, Needle Exchange, EMS, Medical Examiner), UW Alcohol and Drug Institute, Department of Health, law enforcement, mental health, chemical dependency and other community partners.

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: **$ 160,000 per year, serving 20 0000 people per year**