MIDD Briefing Paper

BP 120 Opioid Treatment and Overdose Prevention, #82 Jail based Inmate Naloxone Program

New Concept ☐X (Attach New Concept Form)
Type of category: New Concept

SUMMARY: Heroin-linked overdose fatalities have increased by 58 percent in the Seattle-King County area within the last year, and the number of treatment admissions with heroin as the primary drug doubled from 2010-2014. Thirty-nine percent of those entering treatment are aged 18 through 29, a markedly younger population than in years past.[1] In light of this data, it is unsurprising that multiple new strategies were proposed to address prescription opioid and heroin use, addiction, and deaths in King County. This briefing paper is an amalgamation of seven separate concepts, which together represent a continuum of health services and supports for opioid users in King County.

Collaborators:

Name	**Department**

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

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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?**

   Heroin-linked overdose fatalities have increased by 58 percent in the Seattle-King County area within the last year, and the number of treatment admissions with heroin as the primary drug doubled from 2010-2014. Thirty-nine percent of those entering treatment are aged 18

[1] http://adai.washington.edu/pubs/cewg/Drug%Trends_2014_final.pdf, "Drug Abuse Trends in the Seattle-King County Area: 2014"

through 29, a markedly younger population than in years past.[2] In light of this data, it is unsurprising that multiple new strategies were proposed to address prescription opioid and heroin use, addiction, and deaths in King County. This briefing paper is an amalgamation of seven separate concepts, which together represent a continuum of health services and supports for opioid users in King County.

1. In line with *MIDD II Strategy One*, Prevention and Early Intervention, it is proposed to pilot educational campaigns directed at pediatric and adolescent medical providers. The goals of the campaign are get providers to first, prescribe opioids cautiously; and second, to have conversations with patients and families regarding the role of medicines in health, reasonable expectations for pain relief, and the limited role for opioids. Parallel and complementary educational campaigns will be directed at patients and families in clinical settings.
2. A proposal to expand the existing model of community access to Medication Assisted Treatment (MAT) aims to improve the existing system, thus supporting *MIDD II Strategy Four*, System Improvements. A reported 80 percent of people addicted to opioids are not in treatment.[3] In King County, where waitlists for opioid treatment are kept by needle exchange organizations, it is a question of treatment capacity. This strategy increases access to MAT by minimizing barriers as follows:
    a. Expand capacity through the startup of two additional MAT clinics, strategically located in King County where the need is greatest; and
    b. Partner with the medical community to increase the number of doctors who have a waiver to prescribe buprenorphine, thus increasing service access for individuals with Apple Health Benefits, and maximizing the current allowable capacity as defined by the Office Based Opioid Treatment (OBOT) prescribing practices.
3. Increasing access to Naloxone, an opiate overdose antidote, supports *MIDD II Strategy One*, Prevention and Early Intervention, in that it keeps people healthy by stopping problems from escalating; *MIDD II, Strategy Three,* Recovery and Reentry, by allowing people to safely reintegrate after crisis; and *MIDD II Strategy Four,* in that it enhances current substance-use tertiary-prevention, in two mutually exclusive proposals:
    a. Recipients of publicly funded treatment for opioid use disorder or needle exchange services, and those in their social and familial networks, may be enrolled in an overdose education and take-home-Naloxone program. As envisioned, the University of Washington's Center for Opioid Safety Education at the Alcohol and Drug Abuse Institute (ADAI) could provide technical assistance on implementation. Contracting with ADAI could additionally allow for the evaluation of the impact of overdose education and take-home Naloxone distribution on subsequent treatment engagement, overdose risk environment and overdose occurrence. This may be subject to RFP.

[2] http://adai.washington.edu/pubs/cewg/Drug%Trends_2014_final.pdf, "Drug Abuse Trends in the Seattle-King County Area: 2014"

[3] Saloner B, Karthikeyan S. Changes in Substance Abuse Treatment Use Among Individuals With Opioid Use Disorders in the United States, 2004-2013. *JAMA.* 2015;314(14):1515-1517.

   b. A voluntary, jail-based inmate Naloxone program would similarly provide training in the use of Naloxone, and a take-home Naloxone kit upon release. This is an expansion of a current and successful pilot program that operates within the Maleng Regional Justice Center (MRJC). Additionally, it is proposed to implement this program at the King County Correctional Facility (KCCF). This program places Naloxone in the hands of those who are most likely to encounter opioid overdoses at a time when fatal overdoses are most likely, which is upon release from incarceration.[4]

4. The introduction of Medication Assisted Treatment (MAT) in jail supports *MIDD II Strategy Three, Recovery and Reentry*, by empowering people to become healthy, and safely reintegrate to the community after crisis. Currently, MAT services are provided only to Individuals who enter detention already engaged in MAT. However, the numerous high-acuity opioid users who enter jail without a current MAT prescription are denied enrollment access in MAT. This greatly increases the risk of opiate overdose upon discharge: the imposed abstinence while in jail decreases the physiological tolerance of opioids. Thus, upon reentry to the community, the individual easily overdoses when they return to opioid use. The allowance of new enrollees for MAT in the jail system would require in-jail prescribers, and/or a community MAT clinic contracted to provide services within the jail. To succeed, anyone on MAT in jail must be able to seamlessly continue treatment upon release, which is reliant on community capacity, a currently unsustainable service without the expansion of MAT treatment providers in the community.
5. Falling within the *MIDD II Strategy Four* classification, it is proposed to expand current substance use treatment service to implement a pilot project to provide homeless opioid injectors with buprenorphine induction and ongoing dosing in community based settings. This proposal draws on a treatment model developed by the ADAI to target the highest acuity heroin and opioid users who are often homeless and difficult to engage. In this harm-reduction proposal, it is suggested that community-based service-providers operate mobile care teams within places with significant numbers of opioid users, such as homeless encampments. The mobile care team would prescribe buprenorphine MAT, injector health services such as wound and abscess care, and attempt to engage people in the behavioral health care system for services such as housing. By contracting between the community service provider and the ADAI, it would be possible to evaluate the impact of the intervention on mortality, emergency medical service (EMS) utilization, subsequent addiction counseling and primary care engagement, and other biopsychosocial outcomes. This may be subject to RFP.
6. The enhancement and expansion of services at Public Health and community needle exchanges to serve people with opioid use disorders by providing wound and abscess care and other case management services also falls under *MIDD II Strategy Four*. In the past ten years needle exchange services in King County has grown from 1,809,378 needles exchanged in 2006 to a projected 6,788,489 needles exchanged in 2015. Funding has not kept up with the growing need and the amount and complexity of ancillary services that have accompanied the growth.

[4] Ingrid A. Binswanger et al., Mortality After Prison Release: Opioid Overdose, and Other Causes of Death, Risk Factors, And Time Trends From 1999 To 2009, 159(9), Annals Internal Med. 592, 592–93 (2013).

In 2016, King County Executive Dow Constantine and Seattle Mayor Ed Murray will be convening a Joint, Seattle City and King County, Taskforce to address the Opioid issue in the area. One question this group will be tasked with answering is whether or not user health services can be expanded at Needle Exchange locations, including safe use areas. A collaborator on this strategy requested this MIDD briefing paper include safe user health services at existing needle exchanges, if expanded user health is part of the recommendations of the taskforce.

7. Another enhancement of current services and *MIDD II, Strategy Four,* is a proposal to expand housing for people with opiate use disorder. Currently low barrier housing for opioid users is little to non-existent. This strategy would partner with a local provider of housing and behavioral health services to provide dedicated housing capacity for people with opiate use disorder. There would be an expectation to coordinate with community based buprenorphine treatment to provide services and medication at housing facilities.

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).

See section A.1.

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.

In King County there were 314 drug related deaths in 2014, which is a substantial increase over the past five years, and the greatest number of drug related deaths since 1997. The majority of these deaths were opiate-related. Prescription-opioid deaths continue their five-year decline and represent 98 of these deaths, whereas heroin-related deaths have increased: 156 of the 314 deaths in 2014 were heroin-related, an increase from 99 deaths in 2013, and 49 deaths in 2009. [5] The demographics of heroin-users is also changing, and groups with historically low rates of heroin use, such as women, the privately insured, and people with higher incomes, are seeing the greatest increase of use. [6] Additionally, data from ADAI show that the number of treatment admissions with heroin identified as the primary drug doubled from 2010-2014 and are higher than any drug since at least 1999. Washington, like much of the United States, has seen increases in the number of unique people served in publicly funded MAT. This number accessing publically funded MAT, almost entirely methadone, increased 11 percent from 2013 to 2014.[7] Data from Washington State

[5] http://adai.washington.edu/pubs/cewg/Drug%Trends_2014_final.pdf, "Drug Abuse Trends in the Seattle-King County Area: 2014"

[6] Centers for Disease Control, "Todays Heroin Epidemic", July 7, 2015.

[7] http://adai.uw.edu/pubs/cewg/Drugpercent20Trends_2014_final.pdf

Department of Behavioral Health and Recovery, System for Communication, Outcomes, Performance and Evaluation (SCOPE) shows that in King County the current client caseload/census for MAT clients served in King County's methadone-only agencies has increased by 15 percent from 2014 to 2015.[8] The increase would be larger if there were more agency capacity. There is currently a waiting list of about 150 people.

King County currently does not reimburse for the dispensing of buprenorphine. At present methadone is the primary MAT that is available to the opiate-addicted low-income population. Buprenorphine would increase the ability of the County to access and engage those in need of opiate treatment, and additionally reach more individuals in need via a mobile buprenorphine team.

The need to establish housing resources is evident in MAT. Clients have reported that they are eliminated from housing resources, specifically those housing resources that are based on a model of recovery. The recovery house model or abstinence based self-help supportive housing communities are non-receptive to those individuals receiving MAT. Individuals receiving MAT need to have the same opportunities as any individual in recovery from substance use disorder. In order to provide this opportunity, housing resources need to be developed that are welcoming and receptive to to the individual who is receiving MAT.

As for the jail-based inmate naloxone proposal, studies have shown that an individual is most at-risk for drug overdose in the two-week window after incarceration.[9] Therefore, inmates being released from jail are an appropriate target audience for training on overdose reversal. Upon release, inmates who receive training in the use of Naloxone can teach their friends and family how to respond to their own potential overdose. Following release, inmates may also associate with other drug users who are at risk of overdose, creating an even wider safety net to respond quickly to opioid overdose in the broader community.

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

There has been a dramatic increase in the number of opiate prescriptions written and dispensed, and this greater availability of opioid prescribed drugs has been accompanied by increases in drug-abuse[10]. This can be addressed by educating medical practitioners with accurate information to share with individuals at risk of opiate addiction in the clinical settings, and will provide prescribing and dosing information to patients and their families.[11] Educating opiate prescribers and patients addresses the need for complementary educational resources that provide medical practitioners and families with accurate information to share with individuals at risk of opiate addiction in clinical settings. Further education directed at families of opiate involved individuals and their families is needed.

[8] Washington State DBHR Substance Abuse Treatment Reports, Opiate Substitution Caseload, "Persons Served between November 2014 and October 2015".
[9] Ingrid A. Binswanger et al. (2013)
[10] Volkow, Nora. America's Addiction to Opioids: Heroin and Prescription Drug Abuse. Congressional Testimony 2015.
[11] http://wPainManagementww.doh.wa.gov/LicensesPermitsandCertificates/MedicalCommission/MedicalResources/

Increasing the capacity of MAT through the addition of buprenorphine and expansion of methadone services will address part of the opioid problem identified above. A mobile team providing MAT could better reach populations that are challenged in accessing MAT in a more traditional way.[12] Increasing the current methadone treatment to include two more clinics address the need above by providing treatment interventions that will respond to the individual needs of opiate involved individuals in or close to their communities. Having multiple approaches in a treatment toolkit provides a responsible approach to engaging clients. The expansion of medical practitioners would provide much need relief to the methadone clinics, which are currently at maximum capacity. Massachusetts, facing a similar problem, developed a buprenorphine study and clinic, and saw a marked increase in annual admissions, thus treating more people, and within capacity.[13]

An expansion of current harm reduction models will also address several of the above identified needs in opioid treatment. It would be beneficial to expand capacity for overdose prevention education in conjunction with naloxone scale-up efforts, and at the needle exchange, along with take home Naloxone, along with promotion of user health activities. Additionally, increasing other services offered through the Needle Exchange will address the above need; additional services including vein care, proper injection techniques, wound and abscess care, and case management to facilitate access to needed resources, which may include safe use areas.

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.**

Opioid Treatment and Overdose Prevention Prescriber Education: Initial research has shown that providing education to prescribers that supports educational efforts directed at patients and families has positive outcomes regarding safer prescribing practices and increased knowledge of opioid medicines. [14]

Naloxone distribution and additional harm reduction services: Naloxone has proven effectiveness in saving lives and reducing costs for heroin users, with effectiveness having been shown at the population and individual levels.[15] [16] Numerous studies demonstrate that

[12] Treating homeless opioid dependent patients with buprenorphine in an office-based setting, http://www.ncbi.nlm.nih.gov/pubmed/17356982

[13] Office Based Opioid Treatment with Buprenorphine: Statewide Implementation of Massachusetts Collaborative Care Model In Community Health Centers, http://www.ncbi.nlm.nih.gov/pubmed/26233698

[14] SCOPE of Pain: An Evaluation of an Opioid Risk Evaluation and Mitigation Strategy Continuing Education Program. http://www.ncbi.nlm.nih.gov/pubmed/26304703

[15] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., Ozonoff, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. Bmj, 346(January).

harm reduction strategies and services provided to injection drug users are not only effective, but cost efficient. "Needle syringe programs (NSPs) are relatively inexpensive to implement and highly cost-effective" according to a study of cost-effectiveness of harm reduction.[17] This study supports bundling of services provided by NSPs. Expansion of naloxone, providing wound care and abscess care, along with syringe exchange, is responsive to the need. "These interventions can be cost-effective by most thresholds in the short-term and cost-saving in the long-term."[18] Additionally, the Center for Disease Control review of overdose training in the US indicates that 152,283 lay persons received take-home-Naloxone and 26,463 opioid overdoses were reversed.[19] [20] A research study conducted in the State of Massachusetts found that the greater the number of heroin users trained in a community, the greater the reduction in opioid overdose deaths.[21] Preliminary data from the Public Health Seattle and King County syringe exchange distribution program indicates that 477 kits were distributed to injectors and 106 people reported reversing 256 overdoses.

Naloxone in jail: As stated above, studies have shown that an individual is most at-risk for drug-overdose in the two-week window after incarceration[22]. Therefore, inmates being released from jail are an appropriate target audience for training on overdose reversal. Upon release, inmates who receive training in the use of Naloxone can teach their friends and family how to respond to their own potential overdose. Following release, inmates may also associate with other drug users, who are at risk - creating an even wider safety net to respond quickly to opioid overdose in the broader community. Research supporting jail-based Naloxone programs includes evidence that opioid users are willing to be trained and willing to respond to opioid overdoses with Naloxone, once they are trained and given a kit.[23] The MJRC has distributed 231 kits and has learned of several post-release reversals from returning inmates, although it is difficult to obtain follow up data from those released from incarceration as opposed to ongoing users of syringe exchange services.

Expansion of MAT to include buprenorphine: Buprenorphine has proven effectiveness in reducing ER visits, hospitalizations, mortality and costs for those with opioid dependence.[24] The research examining programs that reduce barriers to treatment by providing free buprenorphine and methadone via mobile medication units shows that the mobile units enrolled a greater proportion of African American, homeless, and uninsured individuals than

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[16] Coffin, P. O., & Sullivan, S. D. (2013). Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. Annals of Internal Medicine, 158(1), 1-9.
[17] http://www.ncbi.nlm.nih.gov/pubmed/25727260
[18] The cost-effectiveness of harm reduction, http://www.ncbi.nlm.nih.gov/pubmed/25727260
[19] Centers for Disease Control, "*Todays Heroin Epidemic*", July 7, 2015.
[20] Wheeler, E., Jones, T. S., Gilbert, M. K., & Davidson, P. J. (2015). Opioid Overdose Prevention Programs Providing Naloxone to Laypersons - United States, 2014. MMWR. Morbidity and Mortality Weekly Report, 64(23), 631–5.
[21] Walley, et al. (2013).
[22] Ingrid A. Binswanger et al.,(2013).
[23] Seal, K. H., Downing, M., Kral, A. H., Singleton-Banks, S., Hammond, J. P., Lorvick, J.,Edlin, B. R. (2003). Attitudes about Prescribing Take-Home Naloxone to Injection Drug Users for the Management of Heroin Overdose: A Survey of Street-Recruited Injectors in the San Francisco Bay Area. Journal of Urban Health, 80(2),
[24] (R. E. Clark, Samnaliev, Baxter, & Leung, 2011; Lo-Ciganic et al., 2015)

fixed-site methadone clinics.[25] Locally, those who are homeless have the greatest difficulty accessing MAT. The King County Needle Exchange program found that there were marked differences in successful treatment admission from the waiting list based on housing status: three quarters of permanently housed individuals successfully entered whereas less than half of clients who were homeless at the time of referral made it through the intake process. Unstable housing is a common issue for clients seeking entry into methadone treatment: only 31% of clients referred during this period were permanently housed (115 out of 367).[i26]

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.**

   This multi-pronged approach would be considered a best practice for all approaches that are covered in the concepts, with the exception of the Naloxone in Jails, as detailed below.

   The expansion of MAT treatment, specifically expanding methadone, is supported through years of research. "A Consensus Panel convened by the National Institutes of Health in 1997 concluded that, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity."[27] Additionally expanding buprenorphine is supported by research, including cost saving and reduced mortality, but all efforts point to the effectiveness of buprenorphine.[28] A recent review of medication assisted treatment indicated that "in the midst of an epidemic of opioid overdose and opioid use disorder, all evidence-based medications should be accessible to patients and considered by their healthcare providers. The research literature generally shows that methadone and buprenorphine have a strong evidence base supporting their clinical effectiveness."[29]

   As previously stated, the need to establish housing resources is evident for individuals receiving MAT. Clients have reported that they are eliminated from housing resources, specifically those housing resources that are based on a recovery model. The recovery house model or abstinence based self-help supportive housing communities are non-receptive to those individuals receiving MAT, as they don't consider individuals on MAT to be "drug free" and in true recovery. Evolving understandings of the brain science of addiction and the role of MAT may eventually lead to policy change for these programs, but treatment philosophies and attitudes are slow to evolve. The individual receiving MAT needs to have the same opportunities as any individual in recovery from substance use disorder.
   Opioid addiction and overdose are major social, medical and public health problems for which there are proven interventions that improve the quality of life, reduce costs, and reduce mortality.

[25] Mobile Opioid Agonist Treatment and Public Funding Expands Treatment for Disenfranchised Opioid Dependent Individuals, http://www.ncbi.nlm.nih.gov/pubmed/24468235

26 [26] Hanrahan, Outreach, Engagement & Referral Services to Persons with Opiate Dependency and/or HIV, 2015 Outcomes Report, Needle Exchange Social Work Program

[27] http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2003-02.pdf

[28] Robin E Clark, Samnaliev, Baxter, & Leung, 2011

[29] June 2015. http://adai.uw.edu/pubs/infobriefs/MAT.pdf

The Naloxone in Jail program would be considered a promising practice. The medication Naloxone is highly effective at reversing opioid overdoses. Population level studies show significant decline in mortality[30]. Trials of overdose education and Naloxone distribution are ongoing, including one currently in progress being conducted by the ADAI. [31] There is, however, not published research on the effectiveness of jail based Naloxone distribution programs.

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?

Six anticipated outcomes are anticipated, all of which are either currently tracked or can be tracked:

1. Decrease in opioid related deaths in King County. This is data that is currently tracked and monitored by the ADAI, along with other Public Health data resources.
2. Increase access and utilization of MAT. This data is partially collected through a number of different resources, including MHCADSD and the other state data on prescription utilization (Prescription Drug Monitoring Program).
3. Increase ancillary service utilization, i.e. harm reduction housing, injector health utilization, etc. There are multiple potential data sources, but nothing comprehensive in place at this time.
4. Quantifying prevention activities geared specifically to prevention activities of first initiation. This is not currently tracked
5. Reduction of emergency medical services via hospital or ambulance, and associated cost offsets.
6. Reduction in post-release opioid deaths and post-release emergency department/hospital care related to opioid overdose in King County.

C. Populations, Geography, and Collaborations & Partnerships

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

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☒ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian /Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☒ **Homeless**

[30] Wheeler, E., Jones, T. S., Gilbert, M. K., & Davidson, P. J. (2015). Opioid Overdose Prevention Programs Providing Naloxone to Laypersons - United States, 2014. *MMWR. Morbidity and Mortality Weekly Report*, *64*(23), 631–5. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/26086633

[31] 1R01DA030351-01A1 Banta-Green).

☐ **Anyone**
☒ **Offenders/Ex-offenders/Justice-involved**
☐ **Other – Please Specify:**
☒ **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.

These interventions are beneficial for any individual who presents with opioid misuse or opioid use disorder and those in their social networks.

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

Opioid Treatment and Overdose Prevention:
Individuals will come from all parts of King County area. Services will be provided to at risk and/or opiate addicted individuals in need of publicly-funded MAT services.

Jail Based Inmate Naloxone Program:
Inmates of the King County Correctional Facility come from all parts of the county. Therefore, the entire county would benefit as inmates are released back into their communities.

Expanded Needle Exchange Services:
It is not the intent to site any new needle exchange services, but to enhance the existing service locations.

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.**

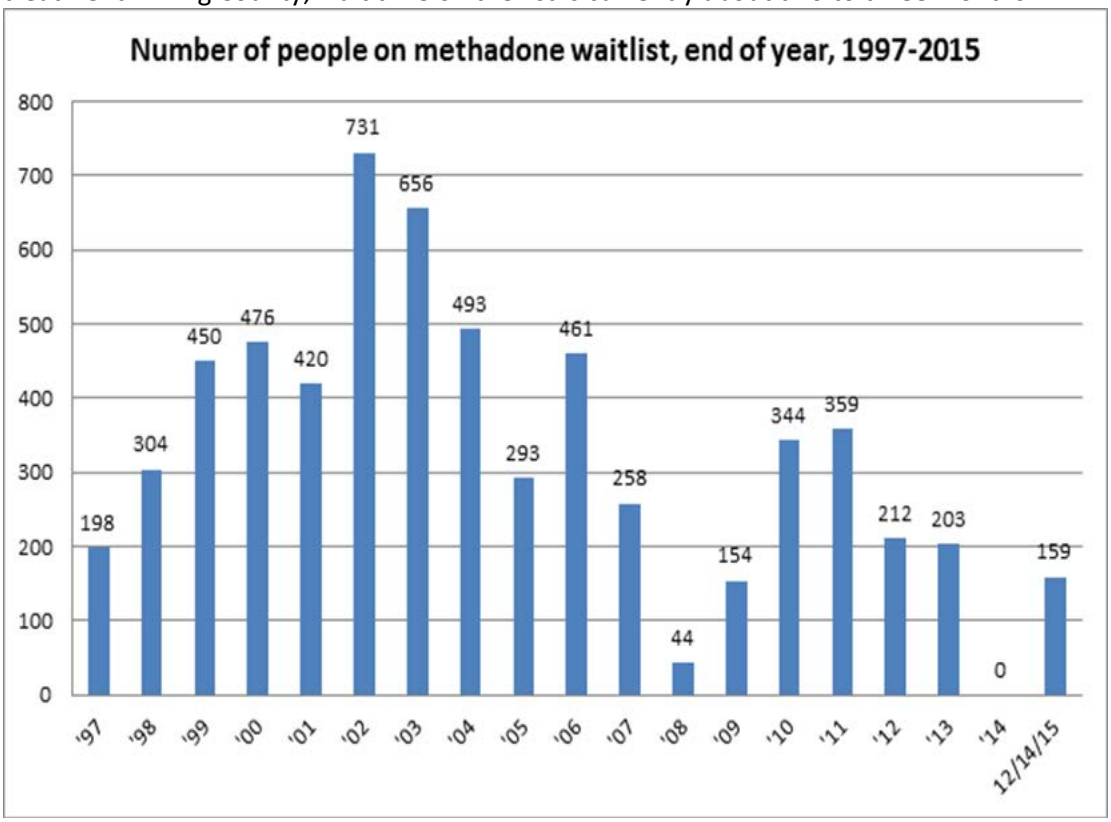
Opioid Treatment and Overdose Prevention:
Partnerships for full implementation include physicians, jails, all community based treatment providers, University of Washington, Public Health, the City of Seattle, Washington State Department of Health, Washington State Prescription Monitoring Program, City and County law enforcements, King County Housing Authority, Oxford Housing, MHCADSD, amongst many others.

Jail Based Inmate Naloxone Program:
D. This includes collaboration from the jail, Public Health, and among users and their personal networks. **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?**

Opioid Treatment and Overdose Prevention:
Health Care Reform originally increased access to MAT by making Medicaid available to many in need of MAT, and the MAT waitlist that had been kept since 1997 went to zero in 2014. By 2015 it had driven requests for access to MAT beyond capacity and required the system to re-implement the MAT waitlist. Opioid users represent a diverse population with diverse needs; implementing multiple strategies, as suggested here, will better serve the people of King County.

The return of the waitlist to enter treatment is a significant indicator of need. A personal communication with HIV/STD Education and Prevention Services Manager at Public Health-Seattle & King County, Michael Hanrahan states the following: "With the advent of the Affordable Care Act in January 2014 and the simultaneous effort to enroll those individuals who are low income, having no health benefits, in Medicaid, and increasing approved capacity at publicly-funded treatment agencies, the County was able to abandon the list after only three months into the year. Treatment was available on demand for much of the ensuing 14 months. Demand began to exceed capacity in June 2015 and wait time between referral and intake appointment reached five to six weeks. Consequently, we reinstated the waitlist in July. As presented in the table below, there were 159 people waitlisted for treatment in King County; wait time on the list is currently about two to three months. "



"The 2002 peak as seen in the table above was unexpected. It was during this year the City of Seattle first awarded the needle exchange funding for methadone treatment vouchers. The award was only about $400,000, but it surfaced a huge previously unrecorded demand among homeless and street-involved heroin users. Word on the street was that needle exchange staff could get folks into treatment quickly and we were overwhelmed with requests for assistance. For the next few years after that, wait time was typically 18 to 30 months. The list approached zero in 2008 after two years of concerted expansion efforts lead by Jim Vollendroff and receipt of new federal dollars to expand capacity. "[32]

It is important to bear in mind that every day someone is in on the wait list is a day they are at risk of fatal overdose or of acquiring life-threatening infections such as HIV and hepatitis C.

Jail Based Inmate Naloxone Program:
If Naloxone were as widely accessible as Automated External Defibrillators (AEDs), this program would not be necessary. There are many factors that would affect the availability of Naloxone. Standard changes would need to be imposed by the legislature and could be carried out by healthcare reform, if a payment mechanism were also included. Additionally, reformulation or redesign of the Naloxone device could eliminate the necessary training for correct use that accompanies the currently-available formulations of Naloxone.

Growing awareness of and concern about the rising heroin epidemic, and the wake of death and suffering it leaves in its path, may lead to availability of additional resources and greater political will among policy makers and the public to initiate interventions that will make a difference, even if those interventions may make them uncomfortable.

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?**

Opioid Treatment and Overdose Prevention:
The ability for the County to respond to the increasing need is limited by several factors:

a. Stigma is a massive barrier. The siting of additional methadone clinics has historically been challenged by the geographic area/community where the methadone services will be provided. The initial reaction of the community to any methadone clinic is "Not in My Back Yard." "Communities have opposed having MAT located in their neighborhoods. Some officials have proposed legislation in violation of the Americans with Disabilities Act that would change zoning to exclude MAT." "Even some clinicians have acted as though MAT clients are still on drugs, missing the distinction between addiction and the treatment of addiction." [33] This can be addressed via town forums, which would educate the community members. Additionally, working with local officials to ensure that concerns are addressed is essential to overcoming the barriers.

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

[33] Confronting the Stigma of Opioid Use Disorder and Its Stigma, http://jama.jamanetwork.com/article.aspx?articleid=1838170

b. Government restrictions are also a limiting factor. For example, the Federal Government restricts the number of clients that can be served per methadone location, with some flexibility via a waiver to exceed the 350 clients per license limit. Federal regulations restrict the maximum number of patients a physician can prescribe buprenorphine for to 100, and prohibit mid-level providers from prescribing it.
c. Greater capacity at clinics requires adequate staffing to provide the service. There is currently a shortage of qualified SUD treatment staff.
d. Current facilities may not be able to accommodate a census increase.
e. Stigma also affects housing. While individuals in MAT are protected under the Americans with Disabilities Act, there is still a barrier to access housing resources. "The Fair Housing Act (FHA) makes it illegal to discriminate in housing and real estate transactions because of someone's disability. People in MAT are protected from housing discrimination under the FHA – just as are people with other disabilities." Most recovery based housing requires abstinence and those individuals in MAT are not abstinent by the definition of the individual recovery house policy. Providing assistance with housing resources that include advocacy and training to open the door to these needed resources for opiate addicted individuals is one means of overcoming housing barriers. [34]

Jail Based Inmate Naloxone Program:
Apart from the cost of the medication and administration device "kits" and the staff time required to perform the training and process the prescriptions, the primary barrier to expansion of the program is the space required to complete the training and relatively short periods of incarceration for jail inmates, both of which limit the numbers of potentially-eligible people that can actually complete training and receive the prescription.

The involvement of leaders from the Department of Adult and Juvenile Detention (DAJD) would be necessary in identifying the appropriate space and times for the trainings, given that there are many programs already in place in the jail—such as education, spiritual recovery, health promotion, etc.—that compete for the limited space, available times, and available custody personnel for escort.

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?

In Maine, the demand for buprenorphine prescribers expanded "to the point where many agencies maintain waiting lists and clients struggle to find a provider." [35] As word gets out about treatment availability, demand may increase, providing additional strain on the treatment system. This is further supported by the growing waiting list for MAT managed by the Needle Exchange.

[34] Know Your Rights: Rights for Individuals on Medication-Assisted Treatment. HHS Publication No. (SMA) 09-4449. http://www.samhsa.gov/shin/.
[35] https://www1.maine.gov/dhhs/samhs/osa/pubs/treat/2010/MAT%20Final%20Report%20March%202010.pdf

Additionally, there is a shortage of Chemical Dependency Professionals (CDPs) with the training and expertise to provide treatment services. CDPs are discrete health care professionals having the education and hands on experience to deliver substance use disorder services. Since 2008, King County has offered workforce development by reimbursing educational costs for individuals who want to become a CDP. The County reimburses individuals working in substance abuse disorder agencies for tuition, books, and all testing and licensing fees associated with becoming or maintaining a CDP credential in Washington State. While this effort has increased the number of CDPs, it has not kept up with the need. There is also a shortage of medical personnel with addiction specialties or who want to work with opiate dependent individuals.

The unintended consequence of increasing the treatment waitlist is likely to be addressed by the expansion in services that this concept is requesting. However, workforce development will need continued effort to keep up with the demand of the service expansion.

For the jail-based naloxone program, there could be some small duplication of effort and distribution if both the jail and community-based programs provide naloxone to the same individual when they are in different settings. No harm would result from this. duplication.

It is a myth that Naloxone provision might somehow lead a person to "use more opioids;" there is no data to support this. This will *not* be an unintended consequence.

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

   The expected consequences of not implementing the concept are an increase in opiate related deaths. The dispensing of Naloxone is effective in the prevention of overdose.

   The expected consequences of not expanding treatment capacity are a larger number of individuals waiting for treatment. This is supported by a waitlist that is increasing at the time of this writing. Additionally, the lack of housing resources for clients in MAT will continue to keep these clients at a high risk of unsuccessful treatment. The consequences will be felt directly by families, youth, adults, and our systems. Anyone or any system that has a relationship with any opiate involved individual will experience the consequences of not implementing the multi-pronged approach to MAT.

   For the jail based naloxone program, the expected consequences are a continued number (as yet undefined) of cases of opioid overdose following release, some of which are fatal. Naloxone doses dispensed in the jail have been used by the former inmates themselves to help others in the community, and by friends and family of the former inmates to reverse opioid OD in the former inmate. Thus, the consequences accrue to opioid users who experience overdose and secondarily to friends/family of the users if the antidote is *not* available when it's needed.

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?

There are alternative approaches for addressing the opioid epidemic that are either less palatable or less efficacious than those proposed here and/or would require substantial federal policy change that is beyond what we can control locally. For example, the federal government could amend policy to allow for a wider net of providers to be able to prescribe buprenorphine, which would increase treatment access. While antagonist treatment (medication that makes you sick if you use the substance you are attempting to abstain from), such as Vivitrol, and medication-free talk-therapies may be appealing, the evidence is that 85 percent of opiate dependent individuals relapse in Medication-free treatment,[36] and a recent study of 150,000 individuals with opiate dependency found the outcomes for those in medication-free treatment were the same as the no treatment group.[37] The evidence base for antagonist treatment for opiate dependency is not robust at this time. Providing MAT within all prisons and jails in the state, along with community linkages on release is another alternative that would require significant funding, political will that is currently absent, and a great deal of time to implement.

Calab-Banta Green from ADAI, in a letter recently published in *Addiction,* writes, "Opiate Agonist Pharmacotherapy (OAP)[38] is the gold standard treatment. Alternative treatments, including detoxification and out-patient counseling, may be preferred by some and should be available, with two important caveats. First, selection of non-medication treatments for opuate use disorder should be by informed choice, rather than due to an inability to access OAP. Secondly, overdose prevention services, including take-home naloxone, should be made available to mitigate the documented risk of these non-OAP therapies. No patient would be forced to accept a medication for cardiovascular disease that increased mortality. People with substance use disorders deserve the same respect and quality of care."[39]

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?

E.1.a. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care

The breadth of this proposal is such that it fits in well into most stages of the Continuum of Care:

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[36] Journal of Psychoactive Drugs, Volume 21, Issue 4, 1989, Special Issue: Integrating AIDS Prevention and Chemical Dependency Treatment

[37] http://onlinelibrary.wiley.com/doi/10.1111/add.13193/abstract (accessed 2/3/16)

[38] OAP is another name for MAT; it is clarifying that the medication involved is an agonist.

[39] http://onlinelibrary.wiley.com/doi/10.1111/add.13228/full (accessed 2/3/16)

- Prevention: Through the piloting of educational campaigns to pediatric and adolescent medical providers regarding opioid prescribing and educating families on the role of opioids in medical treatment, opioid misuse and its consequences can be reduced;
- Intervention: Through the education of inmates pre-release, and distribution of Naloxone upon release, individuals have the opportunity to intervene and arrest opioid overdoses; enhanced services provided by Seattle/King County Public Health and local needle exchange could increase engagement opportunities, education about safer needle use, and an introduction to treatment; and
- Treatment: An expansion of medication assisted treatment facilities throughout the County, as well as within the criminal justice system, will reduce barriers and increase access to treatment.

E.1.b. How does this fit 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?

The multi-faceted approach to opioid treatment and overdose prevention as presented here fits within the County's efforts to integrate behavioral health in that, if coordinated, these program elements provide "whole person" care, flexibility in where and how services are practiced, overall improving health and social outcomes and providing a better experience for the clients.

These programs support the Health and Human Services Transformation in that it shifts from a costly, crisis-oriented response to health and social problems such as opioid overdoses, to an approach that focuses on prevention and embraces recovery.

This fits within All Home, as it proposes to fill a housing gap for an underserved population in the community.

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

Although all treatment models and strategies would benefit from the incorporation of trauma-informed care principles, the proposed model is not rooted in this approach.

The multi-faceted approach presented here to address opioid treatment and overdose prevention relies on the coordination of the network of community-based services such as medical and behavioral health providers, housing providers, and the criminal justice system and builds on individual strengths and resiliencies by empowering individuals through Naloxone education and training.

Opioid treatment and overdose prevention are rooted in the principles of recovery and resiliency. These principles have strong support by those who are directly affected, the individual who seeks a better quality of life for from the negative consequences of opiate addiction, and are built on acceptance of addiction, the belief that life is meaningful and recovery from addiction is achievable, and the ability to problem solve in times of stress.

These principles, altogether working toward abstinence and improved health, wellness, and quality of life for those enrolled within these programs, are thusly rooted in the principles of recovery and resiliency.

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

The proposed programs support the broad-strokes of the County's Equity and Social Justice work, which is the principle of fairness and justice for all. The economy and the quality of life in King County are dependent on the ability of everyone to contribute to their fullest ability. To do so would require removing treatment barriers. For example, improving and/or initiating opioid treatment and education for the incarcerated, or creating more treatment facilities, thus reducing waitlists for medically assisted opioid treatment. Another way to work with individuals to reach their fullest potential would be mitigating the troubling fact that race, income, and neighborhood can predict health outcomes by targeting specific populations and proactively engaging all individuals and families in the discussion of opioid dependence via primary care physicians.

As mentioned above, mobile MAT is likely to provide more equitable access to treatment for those living on the street and for those who are black. Most importantly from an ESJ lens, this proposal moves the County toward providing parity in access to effective treatment for opiate dependency as access to treatment for any medical condition. There are no waiting lists kept for people who need insulin or blood pressure medication, regardless of whether they continue to eat sugar or salt. Treating individuals with opiate dependency the same way individuals with other chronic health conditions are treated will go a long way towards advancing equity among some of the County's most disenfranchised residents.

G. Implementation Factors

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

Resources needed are dependent on the number of and which of the above strategies are selected to pursue; this could range from needing staff and training to building or remodeling physical structures.

2. **Estimated ANNUAL COST. More than $5 million Provide unit or other specific costs if known.**

The annual cost of implementing the concept will be dependent on what King County will fund and still needs to be determined, but some considerations include. The more than $5 million dollars listed is for full funding of all approaches in this paper. :

a. Adding two Methadone clinics approximately $1,500,000 per year per site start up and capital.
b. Increasing the number of physicians providing office based dispensing of Buprenorphine, between $500,000 to $1,000,000 per year.
c. Wide availability of Naloxone for King County residents dispensing. $500,000 per year.

d. Starting MAT in-jail inductions. These would be individuals that are in need of MAT and not already receiving care from one of the clinics. $2,000,000 initial startup, capital and licensing. $750,000 per year for medication following.
e. Increase access to Naloxone to all of King County, and increase services to the Needle Exchange. (unknown) $2,000,000
f. Housing resources (Could vary greatly depending on the model)
g. Increase in the number of CDP's for the potential treatment demand. (unknown)
h. Full implementation of the Jail–based Inmate Naloxone Program is estimated to cost $46,000 per year, serving 365 people per year.

Narcan Kit*:

Naloxone hydrochloride 2mg	$25.41
MAD mucosal atomizer device	$3.00
Nitrile gloves	$.06
BD alcohol swabs #2	$.04
Laedal Face Shield	$2.00
Laminated disclaimer card	
Preprinted pencil bag	$2.00
Total:	$32.51

*Courtesy of Muckleshoot Behavioral Health

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

Implementation of the multi-pronged approach supports the use of other fund sources. Current MAT treatment in King County combines MIDD funding with State Block Grant funding. Medicaid is a major payer for treatment. State funding is limited in that it reimburses direct client services only. MIDD funding permits the use of funding for the strategies needed to implement the approaches that are presented and doing so with limited barriers. This would allow the use of MIDD to bridge funding for services that are not permitted by the limits of State Block Grant funding.

4. TIME to implementation:

a. What are the factors in the time to implementation assessment?
b. What are the steps needed for implementation?
c. Does this need an RFP?

Time to implementation would be dependent on the degree to which the above strategies are selected. The jail has begun piloting Naloxone education and distribution,so this could be in place quite rapidly. Some strategies require infrastructure development, credentialing, or similar. The County's internal RFP process will also affect the needed time to implement, as will the work involved in siting new facilities. This could take six to 18 months.

H. 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?

No additional comments.

New Concept Submission Form

#82

Working Title of Concept: Jail-based Inmate Naloxone Program

Name of Person Submitting Concept: Bette Pine
Organization(s), if any: Jail Health Services | Public Health-Seattle & King County
Phone: 206.263-8284
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Mailing Address: 401 5th Ave, Suite 1000, Mailstop: CNK-PH-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.

The jail-based inmate naloxone program will provide training in the use of naloxone, a medicine that reverses the effects of opioid overdose, and will provide a naloxone administration kit to inmates upon release from jail. The pilot program, run by Jail Health Services pharmacy staff, teaches inmates (who sign up voluntarily) how to recognize and respond to an opioid overdose. Participants watch a short film outlining the steps to take in case of overdose, including how to administer naloxone. Upon completion of the training program, a naloxone kit is added to the personal possessions collected by the inmate upon release. This program places naloxone in the hands of those who are most likely to encounter opioid overdoses. This proposal expands the successful pilot program within MRJC and implements the program at KCCF.

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.

Studies have shown that an individual is most at-risk for drug overdose in the two-week window after incarceration.[1] Therefore, inmates being released from jail are an appropriate target audience for training on overdose reversal. Upon release, inmates who receive training in the use of naloxone can teach their friends and family how to respond to their own potential overdose. Following release, inmates may also associate with other drug users, who are at risk - creating an even wider safety net to respond quickly to opioid overdose in the broader community.

[1] Ingrid A. Binswanger et al., Mortality After Prison Release: Opioid Overdose, and Other Causes of Death, Risk Factors, And Time Trends From 1999 To 2009, 159(9), Annals Internal Med. 592, 592–93 (2013)

3. How would your concept address the need?

Please be specific.

Inmates will be notified about the jail-based naloxone program via signage and in-jail video. Inmates can self-refer to the program by submitting a written request to the jail pharmacy. A Pharmacist will teach inmates how to recognize and respond to an opioid overdose, including how to administer naloxone to reverse opioid overdose. The training will also emphasize the benefits of "Good Samaritan" laws, which provide immunity to most criminal charges when someone witnessing an overdose calls 911. Following training, a naloxone kit containing two doses will be placed in the inmate's personal property, to be collected by the inmate upon release.

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

Potential program participants will be any inmate in the King County Correctional Facility or the Maleng Regional Justice Center who self-refers to the program. Inmates with substance use issues will be most likely to self-refer. Additionally, inmates who associate with family or friends with opiod substance use issues outside of jail may self-refer. The individuals who will benefit most directly from the program will be either the inmates themselves (through family/friend administration of naloxone), or other opioid drug users who overdose and are treated with naloxone by participating inmates after release.

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.

Decrease in opioid overdose deaths and decrease in high-cost service utilization (e.g. emergency and hospital care)

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?

Preventing death from opioid overdose directly improves health outcomes for people with substance use disorders. By some estimates 60-80% of the County jail population experiences problems with substance use, and is therefore an appropriate target for this intervention.

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.

This concept relies upon community involvement for success: inmates can teach their family and friends to recognize signs of opioid overdose, and can train them in administration of life-saving naloxone. Additionally, inmates will themselves become trained community members who can help others in the community in opioid overdose distress.

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: **$ $46,141 per year, serving 375 people per year**

New Concept Submission Form

#120

Working Title of Concept: Opioid Treatment and Overdose Prevention

Name of Person Submitting Concept: Brad Finegood, Dr. Maria Yang, Michael Hanrahan and Dr. Caleb Banta-Green
Organization(s), if any: King County MHCADSD, Public Health and University of Washington
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Email: brad.finegood@kingcounty.gov
Mailing Address: 401 5th Ave., Seattle, WA

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

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

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

The following concept is a multi-pronged approach to working on the growing epidemic of opioid overdose and the need to increase access and engagement to Medication Assisted Treatment (MAT) and opioid user health. The multiple approaches presented are a collaboration of ideas by the people noted above as submitting agents, but also from other entities. The proposal for jail based opiate treatment was developed in concert with Public Health, Jail Health Services, and the Director of the King County Jail. The "Bupe First" proposal was developed in conjunction with and leveraging resources from the City of Seattle, along with stakeholder support from Evergreen Treatment Services REACH team and medical staff from the University of Washington Harborview.

The multi-faceted interventions proposed leave out multiple other interventions, treatment activities and prevention mechanisms that are in response to the rampant opioid issue facing King County and the nation. Although there are seven ideas presented, this proposal was still an attempt to combine ideas into interventions that can be implemented, that has the largest impact on the community and has the ability to be measured for efficacy.

The following are the seven strategies:

1. New substance use prevention activity

Pilot educational campaigns to pediatric and adolescent medicine providers to 1) prescribe opioids cautiously and 2) have conversations with patients and families regarding a) the role of medicines in

health and b) reasonable expectations for pain relief and the limited role for opioids. Parallel and complimentary educational campaigns will be directed at patients and families in clinical settings.

2. Expand Community Access to Medication Assisted Treatment (MAT). (Expanded substance use disorder treatment activity)

This strategy would allow people to get into MAT with little to no barriers due to limited capacity. According to a recent article published in the Journal of the American Medical Association, 80% of opioid addicts are not getting into treatment (http://www.theatlantic.com/health/archive/2015/10/why-80-percent-of-addicts-cant-get-treatment/410269/). Additionally, in a recent survey of needle exchange participants across the state by the University of Washington, only 25% of people surveyed said they did not want treatment. Improving the capacity to treat individuals when they want treatment is imperative. Currently there is a wait list managed by the Needle Exchange at Robert Clewis Center in King County that only 3 months ago was at 0 people, now is over 100, and growing.

This strategy would have two approaches A) provide capital and startup for 2 MAT clinics over the next three to five years based on data and geomapping of where the need is most prevalent and B) work with the medical community to increase the number of doctors that have a waiver to prescribe buprenorphine and use it to the capacity that the law allows through Office Based Opioid Treatment (OBOT) prescribing practices. The second intervention listed will allow persons receiving treatment to utilize the Apple Health benefit and be seen in a collaborative treatment model with nurse care managers and Chemical Dependency Professionals (CDP).

3. Increase access to Naloxone, the Opiate Overdose Antidote. (Expansion and enhancement of substance use tertiary prevention)
Implement overdose education and take-home naloxone for all people in King County receiving publicly funded treatment for opioid use disorder or needle exchange services, or who use opioids or who have opioid users in their social / familial network. The UW's Center for Opioid Safety Education at the Alcohol and Drug Abuse Institute will provide technical assistance on implementation based on a recent NIH funded study of overdose prevention education in King County. Contract with ADAI to evaluate the impact of overdose education and take-home naloxone distribution on subsequent treatment engagement, overdose risk environment and overdose occurrence.

4. Provide access to Medication Assisted Treatment in Jail. (New expanded substance use treatment service)
In collaboration with Public Health, Jail Health Services and the King County Jail Director's Office, all who have been consulted on this project, provide induction of MAT in jail. Currently those coming in on Methadone MAT can be continued on medication through a guest dosing arrangement. The numerous people who enter jail who are high acuity opioid users have no access to beginning MAT. This highly increases the risk of overdose for those leaving jail if not on treatment. This is due to decreased physiological tolerance from being opioid abstinent while in jail, returning to a use environment without the tolerance built up in the system.

Depending on the implementation of this strategy it will either take the form of a standalone MAT clinic (contracted to a provider in jail) or doctors prescribing buprenorphine in jail. This strategy is tied to strategy two above. A person who starts MAT in jail must be able to continue seamlessly upon release. Without community capacity currently, this will not be able to happen.

5. Fund ongoing "bupe first" treatment, injector health and care management team. (New expanded substance use treatment service)

Implement a pilot project to provide homeless opioid injectors with buprenorphine in community based settings. This was a model developed by the UW's ADAI to target the highest acuity heroin and opioid users that are often homeless and difficult to engage. This intervention would partner with the City of Seattle (who would provide seed startup funding) to provide a mobile care team that would travel to places such as homeless encampments, where there are significant numbers of opioid users. These care teams would prescribe buprenorphine (MAT), provide injector health services such as wound and abscess care and attempt to engage people in behavioral health and housing resources, in a harm reduction model. Contract with the UW's Alcohol and Drug Abuse Institute to evaluate the impact of the intervention of mortality, EMS utilization, subsequent addiction counseling and primary care engagement and other biopsychosocial outcomes.

6. Enhance and expand services at Public Health and Community Needle Exchanges. (Enhancement to services for people with substance use disorder people)

Part of this strategy is incorporated above in expanding naloxone kits in needle exchanges for those that currently do not have them due to funding limitations. Additional enhancement of needle exchange services include providing wound and abscess care along with case management to engage persons into treatment or other resources for needle exchanges where this resource does not exist, or funding does not allow services to occur for everyone.

In the past ten years needle exchange services in King County alone have grown exponentially from 1,809,378 needles exchanged in 2006 to a projected 6,788,489 needles exchanged this year (2015). Funding has not kept up with the growing need and the amount and complexity of ancillary services that have come along with the growth. Further, utilizing data from National HIV Behavioral Health Surveillance surveys of PWID in King County, as well as surveys of clients in local needle exchange programs, it was found that 88% of local injectors regularly use heroin and that 83% identify heroin or other opiates as their primary drug.

7. Housing first program for people with opiate use disorder. (New expanded housing service substance use disorder populations)
Currently low barrier housing for opioid users is little to non-existent. This strategy would partner with a local provider of housing and behavioral health services to provide dedicated housing capacity for people with opiate use disorder. There would be an expectation to coordinate with community based buprenorphine treatment to provide services and medication at housing facilities.

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.

This proposal relates to the growing need of opiod overdose prevention (heroin overdose rate peaked in 2014) and the lack of treatment capacity in King County for evidenced based Medication Assisted Treatment in King County with increasing demand for treatment. The number of treatment admissions with heroin as the primary drug doubled from 2010-2014 and are higher than any drug since at least 1999. This information is according to the 2014 Drug Trends Report published by the University of Washington (June, 2015).

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

The concept would address 3 specific needs:
1. Increased resources to limit preventable opiate overdose death.
2. Increase availability and access to evidence based Medication Assisted Treatment for Opiod dependent clients

3. Increase resources to mitigate negative health consequences from intraveneous drug use.

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

Opiod users, particularly heroin addicts; families and friends of those who use opiates; the greater King County community.

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.

Four anticipated outcomes are anticipated all of which are either currently tracked or can be tracked:
1. Decrease in opiod related deaths in King County. This is data that is currently tracked and monitored by the University of Washington ADAI, along with other Public Health data resources.
2. Increase access and utilization of MAT. This data is partially collected through a number of different resources, including MHCADSD and the other state data on prescription utilization (Prescription Drug Monitoring Program).
3. Increase ancillary service utilization, i.e. harm reduction housing, injector health utilization, etc. Thiere are multiple data sources, but nothing coordinated.
4. Quantifying prevention activities geared specifically to prevention activities of first initiation. This is not currently tracked

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

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

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

The concepts presented address all of the MIDD II objectives improving health, social and justice outcomes for those with substance use disorders and often have significant mental health disorders.

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 for full implementation include physicians, jails, treatment providers, University of Washington, Public Health the City of Seattle amongst many others

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: $ Due to the vast differences in approaches proposed a cost estimate was not provided. Each strategy has different scale possible and different costs associated. 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**