MIDD Briefing Paper

ES 1b1 Outreach, engagement, and referral services to individuals with opiate dependency and/or HIV

Existing MIDD Program/Strategy Review ☑ MIDD I Strategy Number 1b1 (Attach MIDD I pages)
Note: Strategy 1b1 was previously subsumed under Strategy 1b, "outreach and engagement to individuals leaving hospitals, jails, or crisis facilities". The specialized scope of work supported in 1b1 is not described in the MIDD I Action Plan and the original Core Strategy explanations included in the original adopted MIDD Action Plan. It was recommended that a separate MIDD II briefing paper for 1b1 would be beneficial to understanding this complex work. Along with the adopted 2008 Action Plan pages, the Revised 2009 1b strategy pages are attached.

New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: This paper describes current MIDD Strategy 1b1 and its expansion. MIDD Strategy 1b1: Outreach, engagement, and referral services to special populations, such as individuals with opiate dependency, people who inject drugs (PWID), or people living with Human Immunodeficiency Virus (HIV). Opiate Dependency and/or HIV Outreach is specifically designed to encourage PWID and other high-risk groups, such as opiate-dependent and HIV-positive individuals, to undergo treatment and to reduce transmission of HIV disease. The strategy engages opiate dependent individuals, primarily heroin injectors, HIV-positive drug injectors, and other users of injection drugs, and provides stabilizing services, brief problem-focused counseling, crisis intervention, service brokerage and facilitated referral to substance abuse treatment. The program operates in conjunction with Seattle-King County Public Health's needle exchange program[1], a low threshold service entry point for people throughout King County who inject drugs. The vast majority of Seattle-King County Public Health's needle exchange clients report using heroin (94 percent in the last three months) and 27 percent report recent use of prescription-type opiates. The strategy is currently staffed by 1.5 FTE Licensed Independent Clinical Social Workers (LICSW) who are jointly supported by MIDD and general funds from the City of Seattle Human Services Department. MIDD II funds are requested to expand the program to 2.5 LICSWs starting in 2017. Expanded capacity is needed due to the increased need.

Collaborators:

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

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[1] Needle exchange programs are syringe exchange programs, a public health approach intended to slow the spread of diseases among IV drug users, in which sterile needles are exchanged for dirty, potentially contaminated needles by IV drug users when shooting heroin or other substances.

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This paper describes current MIDD Strategy 1b1 and its expansion. MIDD Strategy 1b1: Outreach, engagement, and referral services to special populations, such as individuals with opiate dependency, people who inject drugs (PWID), or people living with Human Immunodeficiency Virus (HIV). Opiate Dependency and/or HIV Outreach is specifically designed to encourage PWID and other high-risk groups, such as opiate-dependent and HIV-positive individuals, to undergo treatment and to reduce transmission of HIV disease. The strategy engages opiate dependent individuals, primarily heroin injectors, HIV-positive drug injectors, and other users of injection drugs, and provides stabilizing services, brief problem-focused counseling, crisis intervention, service brokerage and facilitated referral to substance abuse treatment. The program operates in conjunction with Seattle-King County Public Health's needle exchange program[2], a low threshold service entry point for people throughout King County who inject drugs. The vast majority of Seattle-King County Public Health's needle exchange clients report using heroin (94 percent in the last three months) and 27 percent report recent use of prescription-type opiates. The strategy is currently staffed by 1.5 FTE Licensed Independent Clinical Social Workers (LICSW) who are jointly supported by MIDD and general funds from the City of Seattle Human Services Department. MIDD II funds are requested to expand the program to 2.5 LICSWs starting in 2017. Expanded capacity is needed due to the increased need.

The social work staff provide the following services: management of the county-wide wait list for methadone treatment (a wait list is necessary due to the lack of methadone treatment available within King County), provide interim services to waitlisted clients (early intervention and treatment services), and facilitate access and linkage to publicly-funded methadone treatment. Engagement services for about half of the clients served are minimal: a brief assessment to determine service needs, harm reduction[3], health insurance, and health/social service/ treatment needs, then follow-up contact and referral when a treatment slot becomes available. However, service needs for the balance of clients are complex: needle exchange clients are disproportionately homeless and dually affected by mental illness and substance abuse; they are disproportionately involved with criminal and incarceration systems and disproportionally impacted by sexual assault and street/intimate partner violence. Many clients require crisis services such as suicide prevention or protection/respite from volatile, violent and sexually assaultive life circumstances or de-escalation intervention. Some need assistance enrolling in health care insurance and accessing non-treatment health and social services. Many use multiple substances; those with concomitant use of depressant drugs such as benzodiazepines and alcohol often face prohibitive challenges when attempting to enter treatment. Past treatment histories and prior discharge

[2] Needle exchange programs are syringe exchange programs, a public health approach intended to slow the spread of diseases among IV drug users, in which sterile needles are exchanged for dirty, potentially contaminated needles by IV drug users when shooting heroin or other substances.

[3] Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs. http://www.ihra.net/what-is-harm-reduction

circumstances also present challenges for many clients who are attempting to re-engage treatment services. For clients who face greater challenges, social work staff provide crisis intervention and de-escalation support; advocacy and strategic problem solving support; brief problem-focused counseling; trauma-informed emotional, self-efficacy and esteem-building counseling; brokerage activity to secure treatment funding; facilitated retrieval of past treatment records; care coordination across systems; and, often, mediation/negotiation services between clients and treatment providers.

The primary goal of the program is to assure and facilitate equitable access to medication-assisted treatment for opiate dependent residents of King County who want treatment.

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 most clearly under the Recovery and Re-entry strategy area. The primary focus for this intervention is assisting opiate-dependent King County residents' access 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.**

There are an estimated 23,000 people who use drugs by injection in King County.[4] Of clients seen at Public Health – Seattle and King County's Needle Exchange Program, 89 percent report having used heroin in the lastthree3 months, and 47 percent of these heroin users report being "hooked on prescription-type opiates" before they started using heroin. Ninety-six percent report incomes below 400 percent of the Federal Poverty Level, making many of them eligible for Medicaid or subsidized health insurance.[5] An estimate of the number of non-heroin injecting opiate users in King County is not available, though available use indicators for prescription-type opiates as well as heroin are alarmingly high across all of Washington State. Accelerating opiate use has been documented by increased treatment admits, increased heroin overdose deaths, an increase in heroin evidence tested by the State Crime Lab, and increased use of prescription-type opioids by 10th grade students.[6] King County has seen an increase in calls to the Recovery Help Line related to heroin and prescription pain pills over the last three years. Heroin involved overdose deaths in King County increased from 49 individuals in 2009 to

[4] Thiede H and Buskin S, *Updated men who have sex with men (MSM) and people who inject drugs (PWID) population estimates for King County*, HIV/AIDS Epidemiology Unit, Public Health – Seattle & King County and the Infectious Disease Assessment Unit, Washington State Department of Health, HIV/AIDS Epidemiology Report 2014, Volume 83, p59-62, http://www.kingcounty.gov/healthservices/health/communicable/hiv/epi/reports.aspx.

[5] Hanrahan M, Kummer K, Thiede H, unpublished results of a comprehensive intercept survey conducted at PHSKC needle exchange sites in June 2015.

[6] Banta-Green C, *Heroin Trends Across WA State*, ADAI Info Brief, UW Alcohol & Drug Abuse Institute, June 2013, http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2013-02.pdf.

156 individuals in 2014, the highest number ever recorded.[7] The volume of syringes exchanged in King County in 2015 topped seven million, almost a four-fold increase in the last ten years, and an increase of 18 percent compared to 2014.

While capacity for Medication Assisted Treatment has increased in King County, it has not kept pace with need: the number of treatment admissions for heroin in King County doubled between 2010 and 2014 and increased 32 percent from 2013 (2,187 admits) to 2014 (2,886) (2015 data are not yet available).[4] King County has an interest in assuring equity and fairness in access to limited treatment resources, and at the same time assuring that residents whose heroin use is chaotically and expensively impacting other publicly funded resources (such as emergency medical care, psychiatric hospitalizations, criminal courts and incarceration facilities) have access to less expensive and responsive treatment services.

Continued and expanded funding for Strategy 1b1 will help address all of these public interests.

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

A centralized single waiting list for publicly-funded Medication Assisted Treatment providers contracted through King County Behavioral Health and Recovery Division (BHRD) will promote and facilitate fairness in treatment access.

Advocacy, intercession and personalized strategic support provided by skilled clinical professionals will help assure equity of access for marginalized opiate dependent King County residents who face disproportionate challenges when trying to enter treatment.

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 needle exchange social work/treatment access program has a proven track record of successfully linking opiate-dependent individuals to medication-assisted treatment since 2003. Prior to 2003, needle exchange line staff, with limited resources, struggled to assist marginalized, high needs clients navigate the inordinate hurdles that unfortunately still characterize the County's Medication Assisted Treatment (MAT) treatment systems (formerly known as Opiate Substitution Treatment or OST). Public Health needle exchange social workers successfully link more people into methadone[8] and buprenorphine[9]

[7] Banta-Green C et al, Drug Abuse Trends in the Seattle-King County Area: 2014, Alcohol & Drug Abuse Institute, University of Washington, June 2015, http://adai.washington.edu/pubs/cewg/Drug%20Trends_2014_final.pdf.

[8] Methadone works on parts of the brain and spinal cord to block the "high" caused by using opiates (such as heroin). It also helps reduce cravings and withdrawal symptoms caused by opiate use. The action of methadone is similar to other synthetic (man-made) medicines in the morphine category (opioids). Substances that are derived directly from the opium plant (such as heroin, morphine, and codeine) are known as opiates. Methadone is commonly used to treat addiction to opiates (such as heroin). Taken once a day, methadone eases opiate withdrawal for 24 to 36 hours, decreasing the chance of relapse. http://www.webmd.com/mental-health/addiction/methadone

[9] Buprenorphine is an opioid partial agonist. This means that, like opioids, it produces effects such as euphoria or respiratory depression. With buprenorphine, however, these effects are weaker than those of full drugs such as heroin and methadone.

treatment than any other entity in all of King County. As noted in the recent MIDD evaluation report, the needle exchange social work program accounted for two-thirds of all unduplicated people served by Strategy 1b in MIDD Year 6. Collectively, clients served by strategy 1b who had any jail use achieved a reduction of 25 percent in average jail use during the outcomes study period, from 32 days (Pre) to 24 days (Post 3). And of the 1,253 people eligible for jail stabilization analysis, over half reached zero jail bookings by their third post period.

The Washington State Institute for Public Policy (WSIPP) lists both buprenorphine and methadone treatment as highly cost effective, evidence-based practices.[10] Opioid maintenance therapies are the subject of numerous reviews in peer-reviewed scientific literature (over 19,000 accessible currently on Google Scholar) and are endorsed by the World Health Organization.[11] However, accessing this modality of treatment is necessary in order to realize its benefit. The advocacy, intercession, and accompaniment services provided by Strategy 1b1 social workers assure access for marginalized and disenfranchised segments of the population who are unable to access treatment on their own.

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

The proposal is evidence based, the Washington State Institute for Public Policy list of EBP and World Health Organization endorsements references are footnoted. See response to question B.3. and accompanying footnotes 9 and 10.

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?**

As noted in the response to question A.1., the primary goal of the proposal is to assure and facilitate equitable access to medication-assisted treatment for opiate dependent residents of King County who want treatment.

With current constraints on licensed treatment capacity, 1.0 FTE Social Worker can reasonably expect to interact with 700 unduplicated clients per year, refer 300 clients per year to Medication Assisted Treatment and successfully place 200 clients in treatment. At the proposed staffing level of 2.5 FTE, and assuming further expansion of Medication Assisted Treatment, the program should be able to place 500-700 people in treatment in 2017. Specific placement goals will be determined based on clearer prospects for actual expansion of treatment capacity as well as implementation of the new "obligation to serve" framework to be required for integrated behavioral and medical health care.

Buprenorphine's opioid effects increase with each dose until at moderate doses they level off, even with further dose increases. This "ceiling effect" lowers the risk of misuse, dependency, and side effects. Also, because of buprenorphine's long-acting agent, many patients may not have to take it every day. Approved for clinical use in October 2002 by the Food and Drug Administration (FDA), buprenorphine represents the latest advance in medication-assisted treatment (MAT). http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

[10] http://www.wsipp.wa.gov/ReportFile/1556/Wsipp_Inventory-of-Evidence-based-Research-based-and-Promising-Practices-Prevention-and-Intervention-Services-for-Adult-Behavioral-Health_Inventory.pdf, Accessed 01-05-16.

[11] WHO Guidelines for the psychologically assisted pharmacological treatment of opioid dependence. Geneva: WHO, 1999. http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf. [PubMed].

While service intensity levels vary by individual, on average clients have required three in-person, phone or collateral social work interactions/activities in order to access needed services within a given year, with a range of one to 30 interactions/activities per person.

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**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**

☒ **Other – Please Specify:** (1) people who are opiate dependent and/or using drugs by injection; (2) people dually diagnosed with chemical dependency and mental illness

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.

The population served via Strategy 1b1 is illustrative: This program served 858 unduplicated people in 2015 and referred 499 of them to medication-assisted treatment. Of these, 59 percent had a co-occurring mental health condition, 43 percent were homeless, and an additional 27 percent were temporarily or unstably housed. Ages ranged from 19 to 80, with 10 percent between the ages of 19 and 25 and16 percent over 55. Thirty-seven percent were women and 29 percent were people of color. Ninety-four percent reported using heroin and 27 percent reported using prescription-type opiates. Forty percent reported at least one episode of incarceration within the last year (of these, 28 percent reported three or more separate incarcerations during this period) and 88 percent reported ever being incarcerated. Seventy-one percent were regular clients of the needle exchange program.

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

Currently, social work staff are stationed M-F at the needle exchange storefront in downtown Seattle, and two evenings per week at the Capitol Hill needle exchange. Services are available by phone, walk-in and appointment. In 2015, 68 percent of clients resided or lived homeless within the City of Seattle, 26 percent were in King County outside Seattle, and six percent were from other areas. Given increasing service demand as well as wider geographic diversity among clients requesting assistance, there is a need to increase social work availability at both the downtown and Capitol Hill needle exchange

storefronts, as well as add social work staffing to van-based needle exchange services in South Seattle & South King County.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Essential collaborations and partnerships are already firmly established. In addition to co-location and integration with needle exchange services provided by Public Health – Seattle & King County, the program has strong working relationships with medication assisted treatment providers in King County including Evergreen Treatment Services, Therapeutic Health Services, CRC Renton Clinic, Harborview Adult Medicine, and Harborview Mental Health & Addictions Services; detox services at Seadrunar; and intensive case management and housing/shelter access services provided by REACH and the Law Enforcement Assisted Diversion (LEAD) Programs at Evergreen. The program also works closely with discharge planning, pharmacy, and medical staff at Jail Health Services, discharge social workers at area hospitals, Behavioral Health and Recovery Division (BHRD) leadership and BHRD contract monitors for Medication Assisted Treatment.

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?**

Facilitating timely and equitable access to opiate substitution and other treatment modalities in King County is more than a notion. Expanding treatment capacity is essential, but many of the County's most marginalized heroin users will continue to need assistance negotiating the many hurdles and requirements that hinder or forestall successful entry into treatment.

Health Care Reform: Strategy 1b1 social workers are certified In-Person Assisters and provide enrollment assistance to uninsured treatment seekers so they can access insurance, including coverage for MAT treatment, through Washington State's health benefits exchange. This service could conceivably be provided by In-Person-Assisters hired directly by treatment agencies.

MAT Treatment Capacity: For most of the last 25 years, demand for Medication Assisted Treatment in King County has outstripped capacity. Public Health's needle exchange started a waitlist for publicly-funded methadone treatment in 1991. It became the official single list for all of King County in 1997. MIDD funds were first used to support waitlist management and facilitated treatment referral in 2009. As the graph below shows, the list has functioned continuously since its inception except for a 15-month period in 2014-2015. This brief interlude was the result of Medicaid expansion under the Affordable Care Act that temporarily afforded ready access to treatment. The County reinstated the waitlist in July 2015, having reached physical capacity in currently licensed facilities; by the end of December 2015 the list had grown to 159. During this most recent six month period of the re-instated wait list, Strategy 1b1 social workers referred 352 individuals from the list to treatment. The total number of treatment-seeking clients engaged during this six month period exceeded 500. Even with further significant growth in treatment capacity, the need to equitably manage access at a systems level will likely continue.

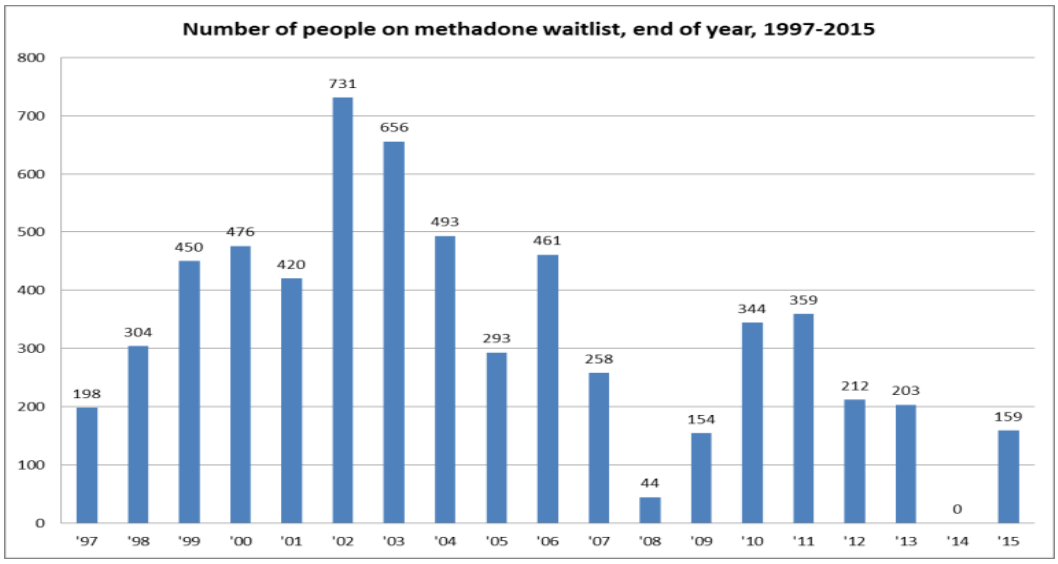

Figure 1. MAT waitlist by year, 1997-2015

Assuring equity in treatment access for the most-marginalized clients: Many of the clients who seek services through the program simply cannot access treatment on their own; they benefit greatly from the coaching, guidance, advocacy, brokerage, negotiation, intercession, accompaniment, and follow-along services this program provides. In an environment of growing excess demand and continued limited capacity, continued oversight/access facilitation from an outside party will continue to be necessary to assure that "most-marginalized" and "challenging" clients have an equitable chance at entering treatment. Without this role, treatment agencies would likely be more inclined to offer preferential entry to clients who face fewer barriers (e.g., those who are stably housed, have intact support networks, are able to navigate systems with minimal assistance, have shorter drug use histories and fewer prior treatment attempts, etc.). It may be that appropriate safeguards and protections can be devised under the new "obligation to serve" requirements in the emerging integrated behavioral health managed care environment, but at both the system and individual client level, the equity safeguard function of this 1b1 Strategy will continue to be necessary for the immediate future.

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?**

Systems are in place to maintain the current strategy. Service expansion in response to increasing demand and need for better geographic distribution will entail hiring additional staff and likely developing collaborations/partnerships with new service providers in an evolving system. In the past, Strategy 1b1 has relied heavily on partnership and collaborative relationships with Medication Assisted Treatment providers, BHRD leadership, and other service providers – these existing collaboration models are flexible, robust, and adaptable to new and emerging challenges.

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?**

Continued funding for and expansion of this strategy will facilitate greater equity in treatment access. This likely will require further training, skills enhancement and case load adjustments for provider staff at MAT agencies as more clients with more complex service needs get admitted into treatment.

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?**

Heroin use is growing at an alarming pace in King County. Assuming accelerating treatment demand in excess of capacity, Strategy 1b1 mitigates against the treatment system's tendency to prefer providing services to higher functioning clients at the expense of heroin users who are homeless, mentally ill, poly-drug and criminally involved, and high utilizers of expensive emergency medical care and criminal justice resources. This is both an equity/social justice and a resource consumption issue. It is less costly to assure access to needed services on an equitable basis than to continue to incur the consequence of inappropriate use of more costly publicly-funded services by default.

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?**

Alternative approaches are not currently available. Past de-centralized management of client entry into MAT provided greater and more ready access to treatment by higher functioning clients. In addition to greater costs to ancillary systems (e.g., emergency departments, criminal justice systems, crisis services, first responder time), there is also a cost in human lives due to more frequent overdoses and overdose deaths.

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?**

This strategy fits within King County's strategic plan goals related to health and human potential. It provides advocacy, facilitated referral, and practical support to marginalized, disproportionately homeless and dually diagnosed opiate-dependent King County residents who are attempting to negotiate systematic hurdles required to successfully enter publicly-funded medication-assisted treatment in existing systems. Once they've entered (or re-entered) treatment, these individuals are better positioned to live healthier, longer lives with greatly reduced engagement in criminal activity, criminal justice systems, and costly inappropriate use of emergency medical and psychiatric/mental health services.[12]

[12] Nordlund DJ, Estee S, Mancuso D, Felver B, *Methadone Treatment for Opiate Addition Lowers Health Care Costs and Reduces Arrests and Convictions*, Washington State Department of Social & Health Services, Research & Data Analysis Division, Report Number 4.49fs, June 2004, https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-49.pdf.

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

Effectiveness of medication assisted treatment for opiate dependency is well documented. Aside from capacity constraints at publicly-funded treatment agencies, many of King County's more marginalized opiate dependent residents do not have the wherewithal to navigate treatment entry on their own. Skilled clinical social workers in this program provide advocacy, strategic/clinical guidance, interim support and intercession services to help individuals access the services they need and assure they are treated equitably within the County's capacity-constrained medication-assisted treatment systems.

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

This program aligns with King County's Equity and Social Justice framework by promoting and facilitating equitable access to capacity-limited publicly-funded treatment services for opiate-dependent individuals who are more marginalized due to mental health, homeless status, and past histories of challenging engagement with punitive treatment practices.

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.)**?**

This existing strategy is currently staffed by 1.5 FTE Licensed Independent Clinical Social Workers. Systems are in place, but staffing is inadequate to meet growing demand. At minimum 1.0 FTE additional staff is required.

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

2.5 FTE MSW, LICSW salary & fringe plus clinical supervision, occupancy, operating and indirect costs Total estimate is $323,723/year.

		FTE	extended cost
Salary	64,677	2.5	161,693
KC benefits @ 49%	31,692	2.5	79,230
Clinical supervision (contracted)	2,500	2.5	6,250
Occupancy/operating	5,286	2.5	13,215
Subtotal Direct			**260,388**
Indirect @ 26.27% of salary for actual hrs worked			33,085
KC differential & central rates			30,250
Subtotal indirect & KC supplemental charges			**63,335**
Total			**323,723**

Table 1. Estimated annual budget

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

Seattle Human Services Department is currently contributing $110,000/year to support this body of work. Requested MIDD contribution for 2017 is $213,723.

4. **TIME to implementation: Currently underway**
    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?**

The program currently employs 1.5 FTE Social Workers. To meet increasing demand and assure geographic reach for these services, one additional FTE is needed. It will take three to four months to recruit, hire and provide initial orientation for a new hire. No RFP is required.

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?

It will be helpful for the County to consider this strategy together with the proposed multi-pronged opioid treatment and overdose prevention concept. Many of the proposed new efforts provide opportunities for integration with the existing and successful strategy 1b1 and achieve economies of scale.

Attachment 1. MIDD Strategy 1b Final, 2008

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

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

County Policy Goals Addressed:

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

1. Program/Service Description

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

The One Night Count, conducted on January 25, 2007, estimated that there are 6000 individuals using emergency shelter and transitional housing on any given night in King County. This strategy was proposed during the original development of the Mental Illness and Drug Dependency Action Plan (MIDD) as a way of addressing the needs for ongoing case management for homeless individuals being discharged to shelters from jails and hospitals, as well as for those who would be discharged from the new crisis diversion facility that is being planned as part of the MIDD. The original concept was to build upon the success of Healthcare for the Homeless in engaging and assisting individuals at several shelters in King County with mental health, chemical dependency, and primary health needs.

◊ *B. Reason for Inclusion of the Strategy*

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

◊ *C. Service Components/Design*

There are several strategies being considered, but a final service design is not being proposed at this time. There are a number of programs targeting this homeless population that are being developed in the next year, and it is critical that these efforts be well-coordinated in order to reduce duplication of effort and to achieve the most efficient and effective results. A major effort that is underway to serve homeless individuals who are frequently involved with the criminal justice and hospital emergency systems is the High Utilizer Referral System, with funding provided by the Veterans and Human Services Levy and the United Way Campaign to End Chronic Homelessness. The Service Improvement Plan that is being developed this year includes a redesign of the Emergency Services Patrol and Dutch Shisler Sobering Center, increased outreach and service engagement for individuals with chemical dependency and improved coordination among key stakeholders to identify high utilizers of criminal justice and emergency medical services in order to facilitate placement into dedicated supported housing. Below is an excerpt from the Veterans & Human Services Levy Service Improvement Plan 2.1 (a-2) that describes the intent of the plan:

"This procurement plan is the third in a series of three that address this objective. The first, a procurement plan to enhance outreach and engagement of homeless people in South King County was approved in 2007 (SIP 2.1(b)). The second procurement plan, approved in March 2008, calls for development of a county-wide database that will identify high utilizers of public safety and emergency medical systems. The database will ultimately facilitate coordinated entry into existing and new housing, services and supports, and is a tool that will be used by the staff and programs to implement the strategies described in this procurement plan.

This third plan describes a set of proposed investments that will improve coordination of homeless outreach, engagement, and entry into treatment and housing for a subset of homeless single adults in Seattle, as described on page 19 of the Service Improvement Plan.

In this Procurement Plan, we first describe a group of current services that target homeless people with substance abuse problems – the *King County Emergency Service Patrol or ESP*, which picks up intoxicated people off the streets; the *Dutch Shisler Sobering Support Center*, which provides a safe place to sleep off the effects of intoxication; *REACH Case Management*, an intensive case management service provided to the most frequent users of the Sobering service; and the *High Utilizer Group or HUG*, that meets to conduct individual case planning for the most challenging clients.

While this redesign is somewhat complex, the Levy's SIP called for strategies to "challenge existing fragmentation," to "fill existing gaps in services and continuums of care" and to "build on existing successful programs or structures." This redesign meets all of these criteria."

Since the final design for the high utilizer system has not yet been fully developed, we propose to use the funding dedicated to this strategy to fill any gaps identified in the high utilizer service system, once other programs dedicated to this target population are implemented.

◊ *D. Target Population*

Homeless adults being discharged from jails, hospital emergency departments, crisis facilities and in-patient psychiatric and chemical dependency facilities.

◊ *E. Program Goal*

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

◊ *F. Outputs/Outcomes*

1. Linkage of individuals to needed community treatment and housing.
2. Expected outcomes include reduced use of emergency medical services, reduced jail bookings, and increased number of people in shelters being placed in services and permanent supported housing.

2. Funding Resources Needed and Spending Plan

To be determined

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

◊ *A. Number and type of Providers*

To be determined

◊ *B. Staff Resource Develop Plan and Timeline*

Still to be developed

Will depend on the model developed through the planning process

◊ *C. Partnership/Linkages*

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

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

To be determined

◊ *B. Procurement of Providers*

Exact timeline to be determined

◊ *C. Contracting of Services*

Exact timeline to be determined

◊ *D. Services Start Date(s)*

To be determined

Attachment 2. MIDD Strategy 1b Revised, 2009

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

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

County Policy Goals Addressed:

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

1. Program/Service Description

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

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

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

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

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

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

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

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

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

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

Patient City	Homeless-Coded Screenings	Total Intake Screenings	percent of Total Screenings That Were Homeless
Seattle	1,106	3,064	36%
Auburn	45	148	30%
Des Moines	29	112	26%
Kent	78	317	25%
Redmond	14	57	25%
Federal Way	48	210	23%
SeaTac	23	105	22%
Shoreline	19	89	21%
Tukwila	19	90	21%

Renton	57	305	19%
Burien	23	119	19%
Bothell	17	88	19%
Bellevue	27	150	18%

◊ *B. Reason for Inclusion of the Strategy*

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

◊ *C. Service Components/Design*

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

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

Service sites will be selected as noted below:

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

And

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

◊ *D. Target Population*

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

◊ *E. Program Goal*

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

◊ *F. Outputs/Outcomes*

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

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

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

2. Funding Resources Needed and Spending Plan

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

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

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

◊ *A. Number and type of Providers*

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

◊ *B. Staff Resource Develop Plan and Timeline*

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

◊ *C. Partnership/Linkages*

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

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

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

◊ *B. Procurement of Providers*

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

◊ *C. Contracting of Services*

Contract amendments will be in place by April 1, 2009

◊ *D. Services Start Date(s)*

Services will begin no later than May 30, 2009