MIDD Briefing Paper

Behavioral Health Workforce Development Plan
BP 7 Supporting and Sustaining EPB
41 Opioid Prescriber Training and Education
43 Training Trainers for Evidence Based Practice
47 Just In Time Classes for All
54 Expansion of Professional and Education Training (Current MIDD strategy ES 1e)
95 Substance Abuse Workforce Development
139 Suicide Prevention for CDPs and CD Agencies

New Concept □ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION and new concepts

SUMMARY: The original MIDD strategy responded to the workforce shortage of CDPs and provided reimbursement for Chemical Dependency Professional Trainees (CDPTs) for: tuition, books for CDP-related classes and testing fees. Due to CDP credential requirements mandating CDP clinical supervision, the agencies were also reimbursed for CDPT specific clinical supervision. CDPs received reimbursement for annual license fees and obtained free Continuing Education Units (CEU) to maintain their credentials. In addition, this strategy funded Evidence-Based Practices (EBP) training, quality assurance (QA) for EBPs, and a CDP certificate program through the University Of Washington School Of Social Work.

The following proposed expansion to the original MIDD strategy is to create a full continuum for a Behavioral Health Workforce Development Plan (WDP). This would include:

- Investment into initial credentials for behavioral health professionals, including psychiatric nurse practitioners and psychiatrists; (All concepts)
- CEUs for credentialed staff and ongoing training of EBP and Practice Based Evidence (PBE) for mental health and SUD treatment including Medication Assisted Treatment (MAT); (All but #47)
- Increases in the number of dually credentialed (LMHP and CDP) staff;(#47, #54 and #95)
- Additional training and initiation of Opioid Prescribing Training Program (OPTP) for professionals with prescriptive authority to assist in treatment opioid addiction (#41); and
- Initiation of a train-the-trainer program to build a work force that can train other clinical staff on adopted EDPs and PBEs. (#41 and #43)

Collaborators:

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

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Margaret Soukup	Submitted NC #54	DCHS
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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?**

The existing 1e strategy detailed summary is attached followed by eight new concept papers:

- #3 Protected Educational Time for Agency Staff
- #7 Sustaining and Supporting Evidence-based Practices (treatment and prevention)
- #41 Opioid Prescriber and Training and Education Concept
- #43 Training for Trainers in Evidence-based Practices (for culturally specific populations)
- #47 Just in Time Classes for All
- #54 Expansion of Education, Training and Workforce Development
- #95 Substance Abuse Workforce Development Expansion

The existing strategy 1e MIDD strategy goals included:

- Increase the number of Chemical Dependency Professionals (CDP) in King County, and increase their access to professional development and cultural competence consultation.

The modification/expansion would **add** the following goals:

- Increase the number of dually certified CDPS and Licensed Mental Health Clinicians (LMHC) in King County. (#54 and #95)
- Increase the retention of CDPs, LMHCs, Advanced Registered Nurse Practitioners (ARNP), and psychiatrists in King County. (All concepts)

- Increase access to emerging Evidence-based Practices (EBP) and culturally specific Practice-Based Evidence (PBE) training and certification. (#43, #7 #54, #41 and #95)

Overall Goals:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
- Increase the qualified King County behavioral health workforce
- Increase capacity to provide quality behavioral health services in King County
- Increase adoption of evidence-based practices

Proposed Behavioral Health Workforce Development Plan (WDP):

The original MIDD strategy responded to the workforce shortage of CDPs and provided reimbursement for Chemical Dependency Professional Trainees (CDPTs) for: tuition, books for CDP-related classes and testing fees. Due to CDP credential requirements mandating CDP clinical supervision, the agencies were also reimbursed for CDPT specific clinical supervision. CDPs received reimbursement for annual license fees and obtained free Continuing Education Units (CEU) to maintain their credentials. In addition, this strategy funded Evidence-Based Practices (EBP) training, quality assurance (QA) for EBPs, and a CDP certificate program through the University Of Washington School Of Social Work.

The following proposed expansion to the original MIDD strategy is to create a full continuum for a Behavioral Health Workforce Development Plan (WDP). This would include:

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- Initiation of a train-the-trainer program to build a work force that can train other clinical staff on adopted EDPs and PBEs. (#41 and #43)

Due to the legislation integrating SUD and Mental Health (MH) care by 2016, the need for dual certification (SUD and MH), consultation with psychiatry, training in MAT, and other on-going training is essential for a quality, sustained workforce. This comprehensive WDP, including psychiatry, will include training to prepare the behavioral health workforce for the 2020 integration with primary care. Many behavioral health professionals have not traditionally worked within a primary care setting and will need mentoring/training regarding the unique culture and structure.

This proposal requests resources for the existing Strategy with proposed modifications:

Continue to provide reimbursement for tuition, books, testing fees, and license renewal, up to a capped amount per person, for CDPTs to achieve their CDP certification and sustain credentials with free CEUs (specifically required CEUs i.e., Suicide Prevention Training and Ethics). The modification would add the following professions to receive similar compensation up to a capped amount: Mental Health

Professionals (MHP), Social Workers, and Psychiatrists and ARNPs to enter/stay in the behavioral health field to serve the most vulnerable populations in King County. The publicly funded agencies would submit a Workforce Development Plan (WDP) application based on the organization's need.

Increase the number of LMHPs in community based agencies that also have a CDP certification by providing expedited organized classes and covering some or all educational costs designed for fulltime employed agency LMHPs. This may include working with a college or university to have weekend courses or a week long academy to expedite acquiring specific course work in an expedited manner for working professionals. This would quickly increase the number of dually trained LMHPs/CDPs in the County. In addition, provide a similar track for CDPs who have been in this profession with years of valuable experience to have a streamlined process for dual credentials in the same way that LMHPs have for obtaining their CDP credential. This track would provide a capped amount towards a Bachelor of Arts degree for a CDP.

Develop and/or implement a County-wide Opioid Prescribing Training Program (OPTP) for healthcare workers (modeled after the mandated federal program where all federal healthcare providers will be required to receive opioid prescribing training). This training will be a County priority and help address the high rate of overdose deaths in the County. This also includes educating providers who prescribe opioids regarding risks, prevention measures, alternative pain management strategies and overdose reversal (naloxone. Training would also increase awareness of f SUD treatment services and resources in the public and private sectors. This training should follow the Department of Health (DOH) guidelines that are in place for Healthcare Professionals providing Pain Management.[1]

Sustain and support evidence-based practices (EBPs) in treatment and prevention to elevate and maintain a state of the art behavioral health organization/system.

- Provide investment for successful implementation and diffusion of any identified intervention as defined by the Washington State Institute for Public Policy (WSIPP) Inventory of Evidence-Based, Research-Based and Promising Practices for Prevention and Intervention Services or SAMHSA's National Registry of Evidence –based Programs Practices (NREPP);
- Provide technical assistance to agencies, including strategic and implementation planning to prepare staff, organizations and systems;
- Involve appropriate persons and organizations/systems throughout the change, and monitor the diffusion efforts;
- Provide both initial training and ongoing, regular supervision, either within the agency or externally (e.g., clinician obtaining supervision from the clinical expert at the University of Washington).

The elements above will provide the infrastructure to sustain and support EBP that include mental health and SUD treatment, prevention, and diversion, crisis, and recovery services.

Develop a "train the trainer" training program on EBP and PBE models that are culturally informed and relevant in minority communities. Developing a sustainable training program would ensure a stronger transition of research into actual widespread practice.

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):

[1]http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PainManagement

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

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

Please describe the basis for the determination(s).

It is **a system improvement** that will impact the workforce working within **Prevention and Intervention**, **Recovery and Re-entry** and **Crisis Diversion** settings.

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.**

Pre-service education, continuing education, and training of the workforce have been lacking, as evidenced by the long delays in adoption of evidence-based practices, underutilization of technology, and lack of skills in critical thinking (SAMHSA, 2007). These education and training deficiencies are even more problematic with the increasing integration of primary care and mental or SUD treatment, and the focus on improving quality of care and outcomes. (SAMHSA)[2]

Many King County SUD and mental health agencies providing behavioral health services in King County for Medicaid clients cannot pay staff a living wage and benefits, which contributes to high turnover and a shortage of trained and licensed mental health professionals (LMHP) and Chemical Dependency Professionals (CDP), ARNPs and psychiatrists in the public treatment system.

There are severe workforce issues in mental health and substance use disorder treatment programs in King County. The Behavioral Health and Recovery Division (BHRD) at King County conducted a workforce survey. Twenty-nine agencies responded, 18 of which provide both mental health and substance use disorder services. At the time of the survey (9/28/2015 to 11/2/2015), 23 agencies had at least one open job position. Some jobs were open for as little was one week; others were open for 15 or more weeks. Most jobs (31%) had been open for one to three weeks, but had been posted for between four and seven weeks (44%). Most of the open positions were for psychiatrists or ARNPs; licensed mental health professionals, and CDPs. Over 80 percent of the agencies reported that they lost employees to programs that offered better pay or benefits. Across the 29 agencies there were a total of 168 open clinical positions.

This informal survey highlights that even a resource-rich area like King County struggles with behavioral health workforce recruitment and retention. Community agencies cannot compete with hospital systems or private practice in recruiting or retaining experienced, licensed staff, as they offer greater pay or benefits. As a consequence, there is frequent turnover of new graduates or other inexperienced staff in agencies, which adversely affects continuity of care and the experiences clients have in the publicly funded system. The problem is even more severe for bi-lingual and bi-cultural staff.

[2] US Department of Health and Human Services SMAHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues January 24, 2013

The workforce shortage in King County is a reflection of a nationwide problem. SAMHSA issued a *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues in 2013*, which described the workforce crisis in behavioral health. The report discusses "key issues and challenges such as staff turnover, aging of the workforce, inadequate compensation, worker shortages, licensing and credentialing issues, and recruitment, retention and distribution of the workforce".[3]

Supporting professionals' choosing to work in these programs will help improve recruitment and retention, which results in more stable and consistent care for clients enrolled in the publicly funded system. Currently behavioral health professionals leave agencies due to lower wages, fewer benefits, and increasing caseloads. They often serve the most ill clients in the region. Some agencies grant clinical staff a small stipend (around $200) and limited time (two days) per year to pursue educational activities. This amount typically does not roll over to the following year if unused. Some clinical staff have reported not using this educational fund because the amount of money was insufficient to cover the trainings and events they wished to attend. For example, the annual conference registration fee is $500 to attend the National Association of Mental Health Counselors and is three days in length. Furthermore, some staff report feeling too overwhelmed with clinical work to take time away for professional development. While other training resources are also available (e.g., online Relias learning, specific trainings related to motivational interviewing that are currently offered through King County, etc.), the challenges of balancing clinical work with on-going education persist. Clinicians may also find in-person, interactive trainings more useful, particularly given the nature of behavioral health interventions.

The Mental Health Parity and Addiction Equity Act and the Affordable Care Act require insurers, including Medicaid, to provide behavioral health care as an essential health benefit, increasing system demand. Also, if any of the proposed MIDD outreach or screening and early intervention programs or funded, they will also create additional demand on the system, straining the current workforce. Additionally, the State's plan to integrate behavioral healthcare with primary care will lead to additional cross-training needs.

Providing professional staff regular opportunities to think, learn, and develop their skills will give them greater tools to help the population and grow as professionals. This should promote job satisfaction, improve the quality of services clients receive, and, ultimately, help clients "graduate" from the behavioral health system.

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

Subsidizing pathways to obtain clinical credentials is an important way to increase the size of the behavioral health workforce. This is likely to be especially true for non-white and immigrant students desiring to work in the field. Given low wages in the field, particularly for CDPs, many individuals cannot afford to go into significant debt to obtain their required educational credentials to work in the field, or to obtain a second credential to become dually-certified. This strategy helps overcome the financial barriers to growing a qualified workforce.

[3] United States of America. US Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*. N.p., 24 Jan. 2013. Web. 7 Dec. 2015. <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>.

Clinical staff recognize when agencies invest in them, which can increase workforce recruitment and retention. Staff at all levels are more likely to stay at agencies, even after they obtain licensure, if they receive useful and accurate clinical supervision, have on-going opportunities for education and professional growth, and can advance their clinical skills. When supported in this manner, professionals experience mastery in their fields of expertise and can work with more complex individuals, which elevates the quality of care the agency can provide to its clients.

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.**

MIDD evaluation data reported in the MIDD Year Six Progress Report found that 127 of 303 CDPTs (42%) gained their CDP credential since MIDD funding began. Of the 393 professionals with at least one reimbursement, 217 (55%) had other mental health or counseling credentials.[4] According to the County, there was a steady increase of King County residents per month identifying with co-occurring mental health and substance abuse receiving Medicaid services: 5,665 (23%) per month 2013; 6,090 (21%) per month 2014; 7,479 (23%) per month in 2015.[5] By increasing the number of dually trained Mental Health and Chemical Dependency professionals, these residents would be able to get improved, holistic treatment.

This WDP modification allows the individual agency to ascertain workforce gaps and request funding within a set criterion. Additionally, this proposal will create a significant number of additional behavioral health providers who are able to serve individuals more holistically, addressing both their mental health and SUD issues. It is a departure from the current common practice of providing separate services for each of these issues and facilitates behavioral health integration efforts underway.

The SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues included recommendations for addressing the workforce shortage in behavioral health. Two recommendations included "promoting cross training for the behavioral health workforce to enhance capabilities to serve individuals with co-occurring disorders and how to work in complex multi-disciplinary teams". It also suggested "disseminating and promoting the adoption of evidence-based practices to reduce the delay in adoption of science-based interventions, including ongoing supervision to ensure treatment fidelity".[6] Both recommendations encompass continuing education for front line staff that would directly benefit clients.

[4] Implementation and Evaluation of Progress for October 1, 2013 –March 31, 2014.
[5] KCRSN 2015 Second Quarter Mental Health Report Card
[6] United States of America. US Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*. N.p., 24 Jan. 2013. Web. 7 Dec. 2015. <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>.

A Cochrane review of 81 studies suggests that educational meetings, particularly those that combined both interactive and didactic education, can improve professional practice and help clients achieve treatment goals.[7]

One study examined the role of one-day continuing education training on suicide assessment, specifically, in community mental health settings.[8] Findings from this study included that this training increased knowledge and confidence in suicide assessment and intervention, even for clinicians who had undergone the training in the past or have had many years of experience in the field. The paper also references past research that demonstrated the ability of continuing education workshops to increase knowledge and confidence in clinicians.

While neither study specifically looked at the role of continuing education in workforce retention, it is reasonable to conclude that increasing staff knowledge and practice and helping clients reach treatment goals through the investment of education can improve job satisfaction. This can result in improved workforce recruitment and retention. Also, when employers invest in employees, it increases employees' sense of being valued, which also contributes to retention.

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.**

According to Substance Abuse and Mental Services Administration (SAMHSA), Congress has called the lack of qualified/sustained clinical staff as the "workforce crisis." The need for an educated and seasoned workforce stems not only from demand, but also high turnover rates, a shortage of professionals, aging workers, and low compensation. With the advent of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act, insurance coverage (including Medicaid) for mental and/or substance use disorders, behavioral health services and supports must be covered, just like other medical care.

In its 2013 Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, SAMHSA outlines how these laws are reshaping the workforce and delivery of services by moving the field toward improved coordination and integration of behavioral health care with other health care in primary, specialty emergency, and rehabilitative care settings, and, with that, the need to apply team approaches to address an individual's health concerns."[9]

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?**

- Per 1.0 CDP – 25-30 people suffering from SUD needs will be served at any given time (AAGT).

[7] Forsetlund L, Bjørndal A, Rashidian A, et al. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database Syst Rev. 2009;(2):CD003030.
[8] Mirick R, Mccauley J, Bridger J, Berkowitz L. Continuing Education on Suicide Assessment and Crisis Intervention: What Can We Learn About the Needs of Mental Health Professionals in Community Practice?. Community Ment Health J. 2015; May 9.
[9] http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/building_the_behavioral_health_workforce/

- Per 1.0 MHP – 25-30 people suffer from MH disorders will be served AAGT.

- Per 1.0 Dually certified MHP and CDP 25-30 people suffering from SUD and Co-occurring MH Disorders will be served AAGT.

- Per 1.0 psychiatric nurse practitioner or Psychiatrist – 250 people suffering from SUD and Co-occurring MH Disorders will be served AAGT.

  If more opportunities for professional development were available to clinical staff, potential outcomes include:

  - Increased staff retention at agencies and more effective recruitment, which would result in fewer vacancies at agencies;
  - Increased collaboration and more uniform quality of care across agencies for clients who may use different services in different locations;
  - Decreased emergency department visits (there is evidence that provider continuity of care reduced the number of emergency department visits in the Medicaid population[10]);
  - Decreased hospitalizations due to decreased emergency department visits and improved clinical interventions in the outpatient setting;
  - Agencies accepting more complex clients into care due to greater effectiveness and skills of clinical staff;
  - Increased job satisfaction at the agency level; and
  - Increased quality of care and more use of evidence-based and promising practices across the system of care.

C. Populations, Geography, and Collaborations & Partnerships

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

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☐ **Transition age youth 18-25**
- ☐ **Adults**
- ☐ **Older Adults**
- ☐ **Families**
- ☒ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☐ **Immigrant/Refugee**
- ☐ **Veteran/US Military**
- ☐ **Homeless**
- ☐ **GLBT**
- ☐ **Women**

[10] Gill JM, Mainous AG, Nsereko M. The effect of continuity of care on emergency department use. Arch Fam Med. 2000;9(4):333-8.

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.

Providing a comprehensive WDP will impact all areas of the behavioral health workforce and therefore impact anyone providing or receiving services in King County. Increased clinical staff recruitment and retention and having a better educated workforce will benefit all clients due to increased clinical competence and continuity of care.

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

The existing strategy provided these resources for all providers across the county that were awarded a contract with BHRD and provided Medicaid services. This enhanced strategy should continue to provide resources to those agencies working with the most vulnerable populations in 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.**

Mental Health Counselors, Chemical Dependency Professionals, Social Workers, Psychiatrists, Psychiatric Nurses, community colleges, universities and behavioral health agencies across regions and the Department of Community and Human Services. In addition, include DBHR & DOH, or other state-level agencies to collaborate regarding best practices in workforce development.

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?**

Behavioral health integration and full integration highlight the need for continuing education. Clients benefit if clinical staff are cognizant of the full spectrum of behavioral health conditions and how to best intervene. Coordinating services with primary care also requires training and education; this again will facilitate clients receiving optimal services. Integrated care benefits from staff stability, confidence, and knowledge. The current workforce shortage, evolving clinical knowledge, as well as a desire to provide culturally appropriate services by staff who are reflective of populations being served, all contribute to the need for this strategy.

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?**

One barrier could be the initial high cost to address all the competing needs within a comprehensive WDP and the potential political process to prioritize the elements of the proposal.

Potential barriers to implementation would include:

- lack of willingness of colleges to respond to an RFP to create streamlined coursework for an LMHC, Nurse or MSW to obtain their CDP;
- resistance of agencies to support their employees taking time off for training/classes; and
- lack of additional time, in addition to work hours.

Methods to overcome these may include:

- design the RFP to incentivize colleges to compete for this service;
- provide incentives in the contract for staff directly for longevity;
- market to agencies the benefits of encouraging their staff to participate; and
- provide training workshops on weekends and during evenings.

It may be too costly to implement all concepts, especially when you add psychiatrists and nurse practitioners to the mix. The amount of time and cost for a CDP to obtain a second credential (and MHP to obtain a CDP credential) may be prohibitive, given the realities of current salaries and work demands.

Leadership across all agencies struggle to fund current services for clients. Given the demand for services and the workforce shortage, it may be difficult for agencies and staff alike to carve out time for professional development. Some supervisors may demonstrate resistance to enhancing their own skills.

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?

Unintended consequences might include:

- Staff may feel like they are being forced into additional training, and not feel they have power/choice.
- Because primary care and medical settings are also recruiting for behavioral health staff, the proposed system may "backfire" because people may earn their credential, serve the requisite time, and then jump ship to work for a managed care organization, which continues the drain on this system.
- Agencies may become reliant on this funding and if it does go away for whatever reason, there could be a precipitous decline in the number of staff who choose to work in the public sector.
- Agencies will still only have new, untrained staff, given that the incentive is primarily for staff completing school. There will still be a dearth of experts within each agency.

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 status quo will continue: New graduates will work in agencies for short periods of time, often just to complete supervision hours to obtain licensure. They then will leave to work for other agencies with higher pay and better benefits. Clients will continue to suffer from on-going turnover in clinical staff, and from appropriate services not being available due to staffing shortages, both of which can contribute to increases in use of crisis and other costly services. Agencies will continue to spend significant sums of

money to recruit new staff. Clinicians will have difficulties learning about, adopting, and practicing evidence-based and promising practices. Clinicians will not have regular and structured opportunities for ongoing education and professional development.

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?**

1e currently exists, as already noted. This modified strategy would add eight new concepts: # 3, Protected Education Time for Agency Staff; #41 Opioid Prescribing Training and Education Concept; # 47, Just in Time Classes; #54 Expansion of Professional and Educational Training; #95, Substance Abuse Workforce Development Expansion; #139 Suicide Prevention for CDPs and CD Agencies; #7 Sustaining and Supporting EBPS for Treatment and Prevention; and #43 Training Trainers for EBPs. All of these concepts would increase the number of people who are eligible for this strategy, which will in turn cost more money. New concept #41 is also related to BP #82 120, Opiate Treatment and Overdose Prevention, which also proposes specific education for opioid prescribers.

An alternative might also be to change state licensing requirements to make it easier for people to achieve a dual credential.

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?**

Anne Herron, SAMHSA's lead for the new Workforce Development Strategic Initiative, says, “The inclusion of behavioral health services which are covered by health insurance means people will have greater access to the help that they need. But right now, 55 percent of U.S. counties do not have any practicing behavioral health worker and 77 percent reported unmet behavioral health needs. It’s clear our robust effort in promoting relevant professions, building skills, and making sure that communities in need have support will have a positive effect on many.” (SAMHSA)

This is relevant for King County because as of April 2016, mental health and SUD services will be integrated and these services will be purchased by the regionally operated Behavior Health Organizations (BHO) through managed-care structures. This proposal would enhance the quality and quantity of behavioral health professions in the workforce to respond to the increasing number of consumers receiving Medicaid insurance.

As noted above, behavioral health integration and full integration highlight the need for continuing education for clinicians. Investing in front line staff will help improve their interactions and interventions with clients, which can help improve outcomes for clients, and for any County initiative that involves direct service to clients. This also applies to efforts related to Best Starts for Kids.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**
   - It is often traumatizing for clients to have to retell their stories to new staff. Investing in the workforce helps with retention, which facilitates more stable client-clinician relationships. Anecdotal stories from the behavioral health field have described clients having multiple counselors over the course of their treatment, each time having to retell their story and re-establish therapeutic trust.
   - A skilled and more stable workforce allows for the delivery of care that is focused on recovery and resiliency.
   - Investing in the workforce in of itself shows trauma-informed care to staff, who may experience secondary trauma in providing services to this population.
   - Providing training to staff on trauma-informed care and recovery principles increases their ability to provide care that is trauma-informed and rooted in recovery principles. Individuals who have worked in the field a long time, especially in substance abuse, are likely to have been trained in more punitive treatment philosophies, and need to be updated on evolving knowledge and principles in order to evolve their practice.

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

A skilled and competent workforce should reflect the clients being served. Sometimes the individuals who want to work with this population do not have the opportunities or resources to pursue the training required to do this work. This proposal will increase the likelihood that under-represented populations, including bi-cultural individuals and linguistic and ethnic minorities, can have opportunities to serve this population, which promotes equity and social justice for the workforce and for the population served.

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.)**?**

It will require 1.0 -2.0 FTEs, at minimum, to coordinate the Behavioral Health WDP. Training space will be needed and many of the agencies that will be receiving these services may offer training space with the incentive of free continuing education hours and additional training slots.

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

The following table represents the <u>original</u> resources for existing strategy 1e:

RESOURCE	COST	Funding Source
	Annual	
1 FTE - PPM III	$133,000.00	MIDD
Tuition, Books, testing fees, license fees; and	$400,000.00	MIDD

Clinical Supervision for CDPTs and License Renewal Fees for CDPS		
Training and QA on EBPs	$121,105.00	MIDD
Continuing Education Units (CEU) Hours for CDPs and LMHC	$ 51,280.00	MIDD
TOTAL	**$681,260**	

The following table represents the recommended modified resources to further enhance the Behavioral Health Workforce Development Plan for King County services.

RESOURCE	COST	Funding Source
	Annual	
1 FTE - PPM III	$133,000.00	MIDD
1 FTE - PPM II	$105,000.00	MIDD
Tuition, Books, testing fees, license fees; and Clinical Supervision for CDPTs and	$375,875.00	MIDD
License Renewal License Fees for: CDP ($230/yr) MHC ($106/yr) MSW ($116/yr) MFT ($156/yr) Psychologist ($226/yr) Psychiatrist ($657/2yr) ARNP ($96/2yr) RN ($97/yr) If one agency has 3 CDPs, 3 MHCs, 1 psychologist, 1 psychiatrist, 1 ARNP, and 1 RN, then the yearly cost would total: $1356 If 20 agencies with the same staffing participate in this workforce development plan:	$27,120.00	MIDD
Training and QA on EBPs	$250,000.00	MIDD
Strategic Workforce Development Plan including: continuing Education Units (CEU) Hours for CDPs and LMHC and Continuing Medical Education (CME) credits and specialty expenses for Psychiatrists, Psychiatric Nurses and ARNPs including MAT training.	$150,000.00	MIDD
TOTAL	**$1,040,995**	

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

The Best Starts for Kids may be a resource for funding prevention training.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?** Currently the base implementation is in place and can continue with contract amendments in 2017.
    b. **What are the steps needed for implementation?** Currently in place.
    c. **Does this need an RFP?** It may need an RFP since the first MIDD required one for the Continuing Education trainings and if a College or University may want to partner in offering classes for initial credentialing

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?

The fable of the goose that laid the golden egg applies here: If the system does not take care of the goose, the golden eggs will disappear. Because behavioral health workforce recruitment and retention are significant problems in the country, King County can emerge as a leader through adoption of this proposal. Investing in people who choose to work with the most vulnerable people in the County fosters community, promotes public service, and inspires others to join the workforce.

King County

Mental Illness and Drug Dependency Action Plan

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

Strategy No: 1e – Chemical Dependency Professional Education and Training

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

There is a significant shortage of chemical dependency professionals.[11] By 2010, the demand for addiction professionals and licensed treatment staff with graduate-level

[11] Abt Associates. (2007). *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce*, Rockville: Substance Abuse and Mental Health Services Administration (SAMHSA)/DHHS. http://www.samhsa.gov/Workforce/WorkforceReportFinal.pdf

degrees is projected to increase by 35 percent.[12] This shortage limits access to treatment. The lack of certified chemical dependency professionals (CDPs) makes it challenging for King County substance abuse providers to meet their treatment expansion goals and to increase the number of clients admitted to and receiving needed substance abuse services.

◊ *B. Reason for Inclusion of the Strategy*

A well trained and sufficient supply of substance abuse counselors means better access to and higher quality substance abuse treatment. This funding will provide stipends to treatment agencies and additional workforce development activities to help support staff with the education and training needed to become CDPs. Increasing the supply of CDPs will ensure that we have a sufficient and properly trained workforce in King County to increase the number of clients served.

◊ *C. Service Components/Design*

Treatment agencies will be able to offer chemical dependency professional trainees (CDPTs) reimbursement for tuition and books for course work meeting the educational requirements to become a chemical dependency professional. The requirements are 45 quarter hours or semester hours of course work specific to the assessment, treatment and case management of individuals with substance use disorders. Courses may be taken at accredited community colleges, universities,

National Association of Alcoholism and Drug Abuse Counselors (NAADAC), and/or at all Association for Addiction Professionals approved education providers. Individuals taking advantage of the tuition and books reimbursement will be asked to commit to staying at the treatment agency for one year post graduation. Funds will also be used to pay for training needs of the workforce, cultural competency consultation, clinical supervision and additional workforce development activities. Reimbursement for staff time to attend trainings and/or classes is not included in phase one implementation. Reimbursement for this time may be considered in future workforce development strategies funded through this initiative.

◊ *D. Target Population*

Individuals working at any King County contracted treatment agency who are in the process of becoming certified CDPs.

◊ *E. Program Goal*

Increase the number of Chemical Dependency Professionals in King County, and increase their access to professional development and cultural competence consultation.

◊ *F. Outputs/Outcomes*

[12] National Association of State Alcohol and Drug Abuse Directors (NASADAD). (2003). *Recommendations related to closing the treatment gap, NASADAD policy position paper, 2003*. www.nasadad.org/resource.php?base_id=37.

1. 45 CDPTs testing at each test cycle offered by the Washington State Department of Health;
2. Up to 125 new certified chemical dependency professionals annually.
3. An expected outcome of increasing the number of CDPs is that individuals will be able to access treatment sooner and more readily, and this will, in turn, reduce criminal justice involvement and admissions to emergency rooms and inpatient units.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
July – Dec 2008	Start-up (initial tuition reimbursement will begin after completion of first courses)	$160,000
	Total Funds 2008	**$160,000**
Jan – Dec 2009	Continuing Tuition Reimbursement	$615,625
	Total Funds 2009	$615,625
2010 and onward	Ongoing Continuing Tuition Reimbursement and additional workforce development activities	
Ongoing Annual	**Total Funds**	$615,625

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

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

Dates:	Number of Treatment Providers:	Activity/Number of CDPTs enrolled:
September 1 – December 31, 2008	32	• Tuition and books reimbursement begins/125 CPDTs enrolled for tuition reimbursement
2009 and continuing	32	• Tuition and books reimbursement continues/150 CPDTs enrolled for tuition reimbursement/ tests and CDP status awarded for 45 CDPTs

◊ *B. Staff Resource Develop Plan and Timeline (e.g. training needs, etc.)*

Current County contracted outpatient providers would be able access funding immediately and increase their pool of qualified CDPs.

◊ *C. Partnership/Linkages*

Linkage with local community colleges, interested universities, and other appropriate entities, including Seattle Central Community College, Edmonds Community College, Highline Community College, Bellevue Community College, Tacoma Community College, University of Washington Extension, and National Association of Alcoholism and Drug Abuse Counselors (NAADAC) The Association of Addiction Professionals Approved Education Providers.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Dates:	Activity:
April – June 2008	• Meeting with local community colleges, universities and development of a list of other approved education providers who are able to meet the educational requirements to become a CDP.
May – June 2008	• Development of Contract Exhibit outlining tuition and books reimbursement for agencies. List of education resources provided to the agencies.
July – Sept 30 2008	• Contract Exhibits are signed by all parties and agencies are aware of how to bill for tuition and books reimbursement for staff who qualify.
August 1, 2008	• Training for Agencies related to contractual expectations for tuition and books reimbursement.
Oct – Dec 31, 2008	• Tuition and books reimbursement is made available for all CDPTs at King County contracted agencies.
2009 and continuing	• Contract Exhibit included in all contracts. Portions of the funds will be carved out for a Request for Proposals to interested community colleges, universities, and other appropriate entities to develop an institute of condensed classes for advanced degree clinicians. Additional workforce development activities will be added.

◊ *B. Procurement of Providers*

Providers are currently under contract with King County and contracts are managed by the Mental Health, Chemical Abuse and Dependency Services Division. No additional procurement or recruitment of providers is planned.

◊ *C. Contracting of Services*

May 2008 -- Contract Exhibit developed, reviewed and made available to review by contracted treatment agencies

June 2008 -- Contract Exhibit amended into current contracts

September 2008 – December 2008 -- Tuition reimbursement begins prior to the end of 2008.

January 1, 2009 -- Contract Exhibit included in all 2009 agency treatment agency contracts.

◊ *D. Services Start Date(s)*

September 2008

#7
Working Title of Concept: Sustaining and Supporting Evidence-based Practices (treatment & prevention)
Name of Person Submitting Concept: Andrea LaFazia-Geraghty with Geoff Miller and Jim Vollendroff
Organization(s), if any: King County BHRD
Phone: 206-263-8993
Email: andrea.lafazia-geraghty@kingcounty.gov
Mailing Address: 401 5th Ave Suite 400

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.

Sustaining and supporting evidence-based practices in treatment and prevention is critical for a behavioral health organization/system. Successful implementation and diffusion of any EBP change requires careful strategic and implementation planning. Considerations are involving appropriate persons and organizations/systems throughout the effort, planning for diffusion after a small test of change (if appropriate), preparing staff, organizations/systems throughout the change, and monitoring the diffusion efforts. Despite the apparent simplicity of such recommendations, many practice change efforts have been thwarted by inattention to these important strategies. Sustaining and supporting EBP crosses over both mental health and SUD treatment, prevention, diversion, crisis and recovery services.

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.

Sustaining and supporting EBP addresses the community need/opportunity of providing quality care within the BHO system, ensuring that individuals, families and communities are receiving treatment, prevention, diversion, crisis and recovery services that are grounded in evidence and designed to produce outcomes.
Providing ongoing training and fidelity measures/monitoring coaching for EBPs will provide staff and communities the opportunities and skills to build provide quality healthcare to our clients based on evidence.

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

Agencies, staff and communities will be more likely to implement EBPs with ongoing to support (training, fidelity monitoring/coaching), resulting in professional development growth and advancement in skills of staff and increased quality care of individuals, families and communities.

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

Many will benefit, including staff from ongoing professional growth and clients through implementation of EBP (better quality healthcare) and communities through prevention EBPs.

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.

We would create fidelity measures for all of the EBPs that are implemented in KC and then monitor, we would also use the outcome measures designed for the specific EBPs.

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?

Supports the MIDD objectives by improving client health and quality of life.

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.

Agencies will be willing to implement EBPs and participate in fidelity monitoring/coaching

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$ 250,000 per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$ 1,000,000 per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#41
Working Title of Concept: Opioid Prescriber Training and Education concept
Name of Person Submitting Concept: Andrea LaFazia-Geraghty, Brad Finegood
Organization(s), if any: BHRD
Phone: 2062638993
Email: Email Address Here
Mailing Address: Mailing Address Here

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.

King County will develop and/or implement a county-wide Opioid Prescribing training program for healthcare workers model after the Federal program (President Obama has mandated all federal healthcare providers will be required to receive opioid prescribing training). This training will be a county priority and help address our high rate of overdose deaths. The concept also includes education to public who are prescribed opioiods on the risks and prevention measures and to increase awareness on availability of treatment of substance abuse treatment services in the public and private sectors. NOTE: Swedish Medical center currently has a 4 hour course that they offer for free and we plan to approach them to partner on this concept, we plan to use the funding to reimburse backfill/overtime (similar to the CIT training). The training is based on the Interagency Guideline on prescribing Opioids for Pain
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

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

The new concepts addresses the opioid overdose epidemic by providing a training to prescribers on safe prescribing and recognizing the signs of misuse, abuse and overdose.

According to the National Survey on Drug Use and Health (NSDUH) — 2014):
•4.3 million Americans engaged in non-medical use of prescription painkillers in the last month.
•Approximately 1.9 million Americans met criteria for prescription painkillers use disorder based on their use of prescription painkillers in the past year.
•1.4 million people used prescription painkillers non-medically for the first time in the past year.
•The average age for prescription painkiller first-time use was 21.2 in the past year.

According to SAMHSA's 2014 NSDUH (PDF | 3.4 MB):

•4.8 million people have used heroin at some point in their lives.
•Among people between the ages of 12 and 49, the average age of first use was 28.
•212,000 people aged 12 or older used heroin for the first time within the past 12 months.
•Approximately 435,000 people were regular (past-month) users of heroin.

According to the CDC, 44 people die every day in the United States from overdose of prescription painkillers.

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

The Opioid Prescriber Training and Education concept addresses the need because it will be a public and private partnership aimed at addressing the prescription drug abuse and herion epidemic. Partnership will be formed with healthcare (such as, Swedish who is currently implementing a training program and the University of Washington Alcohol and Drug Abuse Institute.
The training and education concept will help address the need for action to address opioid use disorders and overdose, while ensuring that individuals with pain receive safe, effective treatment.

https://www.whitehouse.gov/the-press-office/2015/10/21/fact-sheet-obama-administration-announces-public-and-private-sector

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

Potenital participants include youth, parents, families, schools and community members from all areas in King County and all prescribers in King County, along with other health care professionals (such as, physical therapist).

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.

Increase in the number of people training
Reduction in the number of overdose
Increase in referrals to SUD treatment from healthcare providers
Reduction in quantity of opioid RX (that is, amount within a single prescription)

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 concept fits within MIDD II in that it will prevent overdose, guide individuals with SUD into treatment and into recovery and provide prevention resources on safe/effective use of opioids.

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.

There are many partners needed for this concept to be successful and they will all be interested in participating and include the following: Healthcare systems, hospitals, phsyicians, pharmacists, dentists, ARNPs, RNs, etc...
The concept envisions providing backfill/overtime for healthcare providers to attend the training, similar to the CIT training strategy.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ 250,0000 per year, serving 3,000 people per year
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ per year, serving people per year

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#43 Working Title of Concept: Training Trainers for Evidence-based Practices
Name of Person Submitting Concept: Claudia D'Allegri, Vice President of Behavioral Health
Organization(s), if any: Sea Mar Community Health Centers, Department of Behavioral Health
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Email: ClaudiaDallegri@seamarchc.org
Mailing Address: Claudia D'Allegri, VP Behavioral Health, Sea Mar Community Health Centers (Dental Building, 8915 14th Avenue South, Seattle WA 98108

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.

Sea Mar Behavioral Health is proposing the use of funds to develop a "train the trainer" training program on Evidence-Based Practices (EBP). While EBP models are prevalent in research, their

implementation in community health settings is inconsistent. Developing a program that trains the trainer would ensure a stronger transition of research into actual widespread practice. There are also specific EBP models that are culturally informed and thus usable in minority communities. Sea Mar Behavioral Health serves a large population of African America and Latino clients, all of whom would greatly benefit from treatment that is relevant and practical to their needs and to who they are.

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

The state has issued new requirements for there to be an increase of organizations offering client services that use EBP models. Despite these requirements, there are insufficient resources available for organizations to be able to train staff on the EBP models that are most pertinent to the community of people they serve. At Sea Mar, this would be EBP models that have been proven to be effective in communities of color. We would like to develop opportunities to obtain solid expertise in evidence-based practice models for people of color. Our concept addresses mental health, substance abuse, youth delinquency and reentering the community. This model has been proven to be very effective in working with High Risk youth with criminal history.

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

By using the train the trainer model, we will train a specific amount of staff in EBP models. We would also like to use the funds to ensure fidelity of implementation follow-up. In order to track guarantee fidelity, we need to have specific supervision and follow up that ensures staff have been trained on the model as required, and are implementing it within their community health setting.

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

The beneficiaries of this concept would be our clients at Sea Mar Behavioral Health; specifically our minority youth participants who identify as Latino and/or African American.

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.

At this time, we are not collecting data, however if we begin to use the model we will be able to collect data for outcomes – who follows fidelity and what is the impact of the population served. We will be able to collect data around substance abuse, delinquent behavior, and imrovements in social and adapting skills

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?

Our concept improves health outcomes for those who are risk of mental illness and substance abuse disorders by guaranteeing the training of new staff to democratize EBP models, creating specific intervention methods that are pertinent to our clients, and improving the services that provide mental health care to our clients. Our concept responds to justice by providing new avenues for people of color to receive their appropriate treatment; through open access and the provisions of new, alternative treatment for underserved populations. These are available treatments that match cultural needs and that are proven to be effective for that culture, instead of merely utilizing what is available or trying to provide blanket care.

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.

Our concept would function successfully in partnership with the University of Miami, who are the creators of the train the trainer model. The University of Miami trains a specific amount of people on EBP models, and also conduct clinical follow up for 6 months to ensure fidelity is implemented). Sea Mar Behavioral Health has all of the providers necessary to be able to carry out this concept, and we are currently serving a large amount of Latino and African American clients.

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: **$ 25,000 per year, serving 300 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#47 Working Title of Concept: Just In Time Classes for All
Name of Person Submitting Concept: Donnie Goodman and Theresa Winther
Organization(s), if any: Organization(s) Here
Phone: (206) 323-1768x109 or 425.653.4918
Email: donnieg@seattlecounseling.org and theresaw@smh.org
Mailing Address: Mailing Address Here

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 concept is to expand the present workforce development through increasing the availability of Chemical Dependency Professional classes presently offered. The goal is to offer more classes over a shorter time period and with larger attendance options. Most Master's level clinicians need to get one years' worth of hours and the classes could take a year as well with this concept. The scope of attendees would be limited to King County provider and system counselors/clinicians. Courses would be the topics from the Dept of Health such as Understanding Addiction and Pharmacological Actions of Alcohol and other Drugs.

Under this proposal, the classes would be offered in two and three day seminars to meet the content and time requirements. Credits are aligned with how many hours of class and work is anticipated. Most classes are three credits with the present community colleges. The requirements for seminars would include pre-reading, assessment of clinician knowledge and then classroom attendance and participation. The classes would be two or three 8 hour sessions back to back and have a comprehensive assessment at the conclusion. The Course Level Learning Objectives (CLO's) would be utilized to rate the successful completion of the course.

The instructors would be contracted or work through an entity, such as ATTC, to provide approved curriculum. The class objectives and content already exist, it just needs a mechanism to getting the students in without waiting. The partnership with a community college for credit approval and obtainment is essential so that the clinician/students have credits from an approved school.

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

The need is for clinicians to get the required coursework completed in a more timely manner. The present system relies on students waiting until school has openings, space available in classes and is dependent on when they are offered ie: Fall, Winter or Spring. A clinician can wait for months to get in to a class at a particular school which delays the completion of the required classes. The delay then prevents the clinician from applying and getting their CDP certificate. This concept would provide the opportunity for classes to be more efficient and to be offered locally.

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

The concept of JUST IN TIME classes would mean that any person who wants to get their classes completed has a schedule specific to King County for demographics and accessibility. The courses would be layed out over a year and clinicians could plan accordingly and anticipate their program. Master's level clinicians are spending years to get the classes done while most are working fulltime. This concept would allow working clincians to get their classes completed in an expedited manner.

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

The communities receiving the Behavioral Health services would benefit. All of the provider agencies would benefit by expediting the educational options for their staff.

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.

Outcomes would include both a significant increase in the amount of community agency staff being duel trained in providing both mental health and substance abuse treatment, improved comprehensive services for dual diagnosed (co-occurring) individuals, and a reduction or elimination of current Chemical Dependency Professional staff shortages.

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 services would be more holistic, would address co-occurring disorders and would integrate MH and SUD practices. This would improve health and social outcomes for all. Giving providers access to an efficient, more intensive means of obtaining their Chemical Dependency Professional License would allow more timely and effective treatment of individuals with co-occurring disorders and with seamless integration of Mental Health and Substance Use Disorders pracices. This would ultimately support the objective of improving health and social outcomes for all.

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.

A partnership with one or more local community colleges is highly encouraged. The work of approving the curriculum and content can be already set if utilizing the present programs. The concept agency/entity could also apply with the state to get approval for the classes to give credit.

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:	**$ 137,350 per year, serving 1250 people per year**
Partial Implementation:	**$ 274,700 per year, serving 2500 people per year**
Full Implementation:	**$ 412,050 per year, serving 3750 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#54 Working Title of Concept: Expansion of Professional and Education Training; Workforce Development Strategy MIDD 1e
Name of Person Submitting Concept: Margaret Soukup
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

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

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

Continue to provide incentives for Chemical Dependency Counselors to achieve their certification and sustain their credentials and add the following professions to receive similar compensation: Mental Health Counselors, Social Workers and Psychiatrists to enter/stay in the Behavioral Health field to serve the most vulnerable populations in King County.

Provide tuition, books, testing, continuing education in promising and evidence-based practices and licensing reimbursement for the above professionals to support talented professionals to remain in the field. Many of our most qualified and talented counselors, Psychiatrists are leaving the publicly funded sector to work for higher pay or are leaving the field entirely to earn a living wage to remain in the King County area.

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.

There is a shortage of CDP's in the field and it is difficult to recruit due to the low salary range/Medicaid rates. Providing tuition reimbursement has proven to be an effective recruiting tool for non-profits trying to fill vacant positions. In anticipation of Integration of SUD and MH systems many Mental Health Counselors are seeking their CDP credential to gain dual certification which increases their salary potential. CDP's are concerned that their credential without additional education may push them out of the field but if tuition assistance is available they are more likely to remain in the field. Due to a shortage of Psychiatrists in King County for adult and especially children/adolescents many of our most vulnerable do not get the comprehensive care they need. Psychiatrists typically have a lot of debt due to tuition costs and any cost off sets for school loans may increase talent in the public sector.

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

Provide funding for providers to reimburse staff for classes and books that contribute towards CDP, MHC, MSW or Psychiatry with verified documentation to be reimbursed based on agency need up to an available amount per year (through agency contracts). Agencies can develop an education and

training plan that meets the needs of their agency and the funding will be dispensed based upon actual need for workforce. This reimbursement will require a certain time commitment at the agency from the individual receiving the assistance.

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

Children, Youth, Adults, Families and Communities in King County will benefit from this strategy. The clients that are served in the Behavioral Health agencies will receive quality care and the service providers will be able to fund their professional growth, remain in King County with their families and enjoy a fulfilling career serving the most vulnerable residents in their own 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.

Per 1.0 CDP – 25-30 people suffering from SUD needs will be served at any given time (AAGT)
Per 1.0 MHP – 25-30 people suffer from MH disorders will be served AAGT.
Per 1.0 Dually certified MHP and CDP 25-30 people suffering from SUD and Co-occurring MH Disorders will be served. AAGT.
Per 1.0 Psychiatrist – 250 people suffering from SUD and Co-occurring MH disorders will be served. AAGT.

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?

Meets all of the objectives by providing a better workforce to assist our KC residents involved in behavioral health care to improve in all of the areas above.

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.

Mental Health Counselors, Substance Use Counselors, Social Workers, Psychiatrists, community colleges, universities and behavioral health agencies.

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: **$ 500, 000 per year, serving 440-775 people per year**
Partial Implementation: **$ 750, 000 per year, serving 750-2,500 people per year**
Full Implementation: **$ 1,000,000 per year, serving 1,200-3,500 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#95 Working Title of Concept: Substance Abuse Workforce Development Expansion
Name of Person Submitting Concept: Ramona K. Graham
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

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

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

Substance Abuse Workforce Development Expansion. While the present funding for education, training, and supervision is appreciated, the funding is inadequate for the staff who are preparing to enter this field of work. More funding is needed so that King County Providers can hire and retain staff to deliver the SUD services to our clients. Most non-profit agencies have been unable to provide living wages to our CD counselors who work daily to help the most vulnerable population to become productive citizens of our communities. More than ever before, we need to strengthen our system to become more accessible and deliver on outcomes. A well-trained, robust Substance Abuse staff will allow this to happen. The need for education funding is two fold during this time of Behavioral Health Integration. CDPs who have been in this profession with years of valuable experience need to be able to have a streamlined process for dual credentials in the same way that LMHPs have for obtaining their CDP credential. Substance Abuse Services are a specialty and it takes specialized skills to make our programs work and produce desirable outcomes.

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

The problem is a shortage of Chemical Dependency Professionals and those who can work with our COD clients. This concept provides an opportunity for King County to be on the cutting edge of the development of a healthy pool of counselors to better serve our substance abuse and COD clients. An increase in the access to education funding will expedite the production of CDPs and dual credentialed staff. An increase in funding for the salaries of our staff will assist in retaining staff in their present

jobs. Non-profits cannot compete with hospitals who are paying 30% more than they are making working with a nonprofit agency.

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

The education funding would allow more people to enter the Substance Abuse Profession. The increase in salaries and reimbursement of credentialing will help to retain the experienced Substance Abuse Staff we presently have onboard.

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

The community, the clients, the agencies, and the County. The community will prosper from more clients recovering from their Substance Use Disorders and becoming productive citizens. The clients will benefit from having adequate staffing for their treatment programs, more accessibility to services, and quality care. The agencies will have fewer turnovers, more staff, better morale and less costs for retraining new staff on a continual basis. The County will have stronger partnerships, more services for the clients in the county, and greater accessibility.

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.

More CDPTs entering the field, more internships available, more supervision, more CDPs obtaining higher education, better outcomes. Data from the DOH regarding numbers of CDPTs and CDPs. Data from agencies regarding the number of interns, data from the county regarding supervision hours submitted for invoicing, and agency reports of staff working on higher education.

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

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

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

This concept will allow people in recovery to give back to the most vulnerable clients in our community who suffer from Substance Use Disorders and mental illness. Therefore, increasing the ability of staff to make a difference in the health, the emotional support, and the recidivism of our clients involved in the criminal justice system. Those people suffering from substance use disorders will have more of the right treatment, at the right time and in the right amount.

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.

Substance Abuse Providers, Community Colleges and local universities, department of health, King Ciounty.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#139 Working Title of Concept: Suicide Prevention for CDPs and CD Agencies
Name of Person Submitting Concept: Lauren Davis
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

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

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

In 2012, the Washington state legislature enacted House Bill 2366, making Washington the first state in the nation to require suicide prevention training for behavioral health professionals. Numerous trainings that meet this requirement have since been developed that target mental health professionals. Despite the fact that chemical dependency professionals were included in the legislation, there is no suicide prevention curriculum designed specifically for CDPs that meets the requirement of the law.

Forefront proposes to develop a suicide prevention curriculum specific to CDPs that meets state statutory requirements of covering suicide recognition and referral in three hours. The curriculum would teach CDPs how to assess and manage suicidality in inpatient and outpatient settings, while remaining within their scope of practice. This curriculum would then be offered at no cost to

behavioral health treatment agencies in King County.

In addition, Forefront would develop model protocols for suicide identification, intervention, re-entry, and postvention for inpatient and outpatient substance abuse treatment agencies. Forefront would then offer individualized technical assistance to a group of self-selected inpatient and outpatient substance abuse treatment agencies to enhance their suicide prevention protocols and to adapt the model protocols to meet their specific needs.

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.

Suicide has long been considered an issue that resides primarily within the mental health realm. However, substance use disorder is the second most high risk diagnosis for suicide, next to mental illness. Specifically, substance use disorder is even more highly correlated with suicide than schizophrenia. It is second only to depression in terms of specific diagnoses associated with suicide.

Drug/alcohol intoxication affects the prefrontal cortex, leading to increased impulsivity and decreased inhibition, that fear of harm that keeps many individuals from attempting suicide. Substance abuse often increases suicide risk factors in an individual's life including loss of job, break-up of romantic partner, and hopelessness that they will never find recovery. Chemical dependency is associated with suicidal ideation, even in the absence of clinical depression.

Individuals in an intoxicated state are at 90 times greater risk for suicide than a person who abstains (Hufford, 2001). This correlation is also seen in youth. Youth who engage in binge drinking are more likely to report attempting suicide than their peers who abstain or who drink but do not binge (Miller et al, 2007). Studies vary widely on the percentage of people who are intoxicated at the time of their suicide death—from 10-69% (Cherpitel et al, 2012). According to Thomas Joiner's interpersonal theory of suicide, drug/alcohol intoxication increases acquired capability, which is one of the three chief components of suicide risk, along with perceived burdensomeness and thwarted belongingness. Numerous studies have indicated that individuals who are intoxicated are more likely to use lethal means of suicide, particularly firearms (Kaplan et al, 2012; Brent et al, 1987; Sher et al, 2009). Approximately one-third of Army suicides are substance abuse related (2010 Army Suicide Prevention Task Force Report).

To date, suicide prevention efforts have missed the population of individuals with substance use disorders. In chemical dependency treatment settings, suicide is typically only addressed upon intake and intakes are often conducted by chemical dependency professional trainees (CDPTs), who are the least trained staff. Clients are frequently prohibited from attending chemical dependency treatment if they express suicidal ideation or behavior. Many substance abuse treatment agencies lack extensive protocols for preventing suicide among their clients. For example, clients are allowed to leave inpatient substance abuse treatment at any time, even if it is against medical advice, but suicide assessments are not routinely conducted before a client leaves.

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

Forefront would leverage our staff expertise, as well as our network of local and national experts in the development of the suicide prevention curriculum for CDPs and the development of the model

protocols. This curriculum would address issues unique to chemical dependency and suicide. It would cover when and how to assess for suicidality, apart from upon admission, which is when assessments typically take place. CDPs often shy away from addressing a client's suicidality out of concerns of practicing out of scope. This interactive curriculum would specifically address how to assess and manage suicidality without straying outside of a CDP's scope of practice.

Forefront staff will be assigned to participating inpatient and outpatient chemical dependency agencies who will self-select to work with us to enhance their protocols across four areas: suicide risk identification, intervention, re-entry, and post intervention. Forefront staff would travel to the various sites for in-person meetings, as well as be in email and phone contact as needed throughout the protocol development process.

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

Clients of inpatient and outpatient chemical dependency treatment settings, many of whom are not receiving mental health care.

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.

Outputs: Model protocols developed for chemical dependency agencies, number of hours of TA provided to agencies for protocols development, training curriculum completed, number of trainings conducted in new curriculum

Outcomes: Decrease in suicide attempts and deaths among current and former clients of substance abuse treatment agencies. We are not aware of this data being collected currently.

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

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

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

This concept is focused on improving health outcomes by reducing suicides among individuals with substance use disorders, who are at high risk for suicide and are often not engaged in specialty mental health care.

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.

Inpatient and outpatient chemical dependency providers, as well as mental health providers and medical care facilities with CDPs on staff

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: $ 200,000 per year, serving 8 SUD treatment agencies per year people per year
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

#3 Working Title of Concept: Protected Educational Time for Agency Staff
Name of Person Submitting Concept: Maria Yang
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

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

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

Staff who work in mental health and substance use treatment disorder programs will receive at least one hour of "protected" educational time per week. Uses for this time include formal clinical supervision, journal clubs, case presentations and discussions, external educational speakers, etc.

Staff will also have sufficient coverage during these protected hours, so they will not have a "backlog" of work to do during their protected education time. Agencies will have funds to provide staffing coverage so that all clinical staff, regardless of credential type, have opportunities for ongoing learning and professional development.

Agencies will receive funds to send staff to conferences for ongoing learning and to provide clinical

coverage during staff absences.

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.

There are severe workforce issues in mental health and substance use disorder treatment programs in King County. Agencies only earn revenue when clinical staff see patients. Thus, there are no incentives for agencies to invest in the professional development of clinical staff, as any time clinical staff spend in meetings is money lost. Supporting the staff who choose to work in these programs will help improve recruitment and retention, which results in more stable and consistent care for clients enrolled in the publicly funded system. Staff currently leave agencies due to lower wages, fewer benefits, and increasing caseloads, often with the most ill clients in the region. Giving staff regular opportunities to think, learn, and develop their skills will give them greater tools to help the population and grow as professionals. This should promote job satisfaction, improve the quality of services clients receive, and, ultimately, help clients "graduate" from the behavioral health system.

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

Staff are more likely to stay at agencies if they receive useful and accurate clinical supervision, have ongoing opportunities for education and professional growth, and can advance their clinical skills so that they can work with more complex individuals. This elevates the quality of care the agency can provide to its clients.

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

Staff would benefit from the specific education and more clinical support. Supervisors would benefit due to staff having more advanced skills and less burnout. Agencies would benefit from reduced staff turnover. Clients would benefit from reduced staff turnover, more advanced clinical skills, and useful interventions.

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.

Reduced workforce turnover, increased recruitment and retention of agency staff, hopefully improved outcomes for clients. I don't think the County currently collects workforce data outside of occasional surveys.

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?

Supporting the workforce will give them the skills to reach all the objectives of MIDD II.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Agencies must be willing to spend the funds on their staff.

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: $ 100,000 per year, serving # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.