SEATTLE CITY COUNCIL
CENTRAL STAFF

M E M O R A N D U M

To:	City Council
From:	Alan Lee, Central Staff
Date:	July 11, 2016
Subject:	Joint Self-Assessment (Report) by Law Enforcement Assisted Diversion (LEAD) and Multi-Disciplinary Team (MDT) Programs per SLI 87-1-A-2

In preparation for the Wednesday, July 13 Human Services and Public Health Committee meeting, this memo reviews the 32-page joint self-assessment (see attached report) by the Law Enforcement Assisted Diversion (LEAD) and Multi-Disciplinary Team (MDT) programs to achieve (1) greater collaboration and operational efficiencies and (2) improve neighborhood-level public health and safety conditions where the programs operate.

The report includes a number of suggestions to augment the programs' efficacy, ranging from implementing innovative new programming (Mental Clubhouse) to increasing low-barrier, higher quality shelter stock. See below for a summary of the nine questions outlined in SLI 87-1-A-2.

Summary of Report

1. **Evaluate ways to streamline and create efficiencies within and between the LEAD and MDT programs, and specifically describe potential costs and benefits of integrating or more closely coordinating LEAD and the MDT.**

   The joint report notes that LEAD and MDT have sharply contrasting service models with mutually exclusive operational model and differing geographic and population sets. The programs share many programmatic similarities, such as coordination with the Seattle Police Department (SPD), governance structures composed of government and community group stakeholders, and, especially, client populations comprised of individuals who are homeless and in need of addiction treatment and/or mental health counseling. However, LEAD has expanded its service area to include Skyway, with discussions underway to expand into other King County cities such as Renton, Kent and Auburn. Furthermore, the report notes that while coordination and clarity about division of labor would be advantageous, they are not the only programs providing such services.

   The programs assert there are few if any benefits in operational or programmatic integration. For example, holding joint LEAD/MDT meetings or realigning programs to serve the same clients would not be practical. Instead, greater efficiencies lie in (1) producing co-branded outreach material (double-sided one pager) to ensure SPD and community partners refer individuals to appropriate programs; and (2) using a shared LEAD database to facilitate coordination for both programs with SPD and other partners, and enhance the

LEAD and MDT cross-referral process. Outside of these adjustments, which are currently being enacted, and other existing collaborative functions, the authors have no further proposals.

2. **Explore ways to create meaningful change at the neighborhood level where LEAD and MDT are operating, and what should be measured going forward to track changes at the neighborhood level (e.g., crime statistics, 911 calls, environmental indications of crime or street disorder, etc.).**

   The report contextualizes creating meaningful change at the neighborhood level with external factors impacting the programs' service populations, namely, lack of low-barrier housing and chemical dependency treatment beds, high case manager/client ratio, and underfunding and understaffing. With this in mind, the programs identify transparency and accountability as critical to success, and both programs stress the importance of their dedicated direct outreach staff to continue building relationships with community stakeholders. Tracking neighborhood-level impact can involve a relatively low-cost evaluation in which community awareness about and perceptions of MDT and LEAD is compared with felt indications of crime or street disorder.

3. **Estimate the average cost per participant for both programs, separated out for (1) case management, (2) support services (e.g., housing, detox), and (3) program administration. Provide both the total costs and the City-funded portion.**

   Table A provides a monthly cost per client breakout by cost category. Tables B and C show city-funded portions for each program.

Table A: Total LEAD and MDT Monthly Cost per Client

<table>
<tr><th>COST CATEGORY</th><th>LEAD</th><th>MDT</th></tr>
<tr><td>Case management</td><td>$266</td><td>$741</td></tr>
<tr><td>Client support services*</td><td>$100</td><td rowspan="2">$170</td></tr>
<tr><td>Program administration</td><td>$110</td></tr>
<tr><td>Total monthly cost/client</td><td>$476</td><td>$910</td></tr>
</table>

**Support services overlap and differ between programs*

Table B: LEAD Monthly Cost per Client

	Costs calculated on averages		
LEAD COST CATEGORY	**NON-CITY $/%**	**CITY $/%**	**LEAD TOTAL**
Case management	$100 (38%)	$166 (62%)	$266
Client support services	$53 (53%)	$47 (47%)	$100
Program administration	$110 (100%)	$0 (0%)	$110
LEAD Monthly Cost / Client	$264 (55%)	$213 (45%)	$476

Table C: MDT Monthly Cost per Client

	Costs calculated on averages		
MDT COST CATEGORY	**NON-CITY $/%**	**CITY $/%**	**MDT TOTAL**
Case management	$319 (43%)	$422 (57%)	$741
Client support services Program administration	$0 (0%)	$170 (100%)	$170
Total Monthly Cost / Client	$319 (35%)	$592 (65%)	$910

LEAD costs may be slightly under target due to the recent inclusion of the attorney position. There is a substantial discrepancy between programs across cost categories. Budget comparison between harm reduction and social service programs may not be appropriate given that the different population groups with contrasting operational/theoretical models are in play. Therefore, more information about staffing levels, operational descriptors, etc., is needed in order to draw any meaningful conclusions.

4. **Define the theory of change used by each program. For LEAD, describe any recommended revisions to the theory of change to respond to recent City and County changes to arrest and prosecution policies for prostitution and drug dealing.**

   The programs' theories of change demonstrate the critical difference between the two programs: LEAD = harm reduction law enforcement program; MDT = social service program with an accountability structure. LEAD does not address its theory of change to respond to lessened arrest and prosecution policies for prostitution and drug dealing. One question arises however: Can the LEAD model continue to function with lessened arrest and prosecution policies (i.e., without the "lever")?

5. **Engage with community representatives from Downtown and Capitol Hill, including the Special Task Force on Chinatown-International District (See SLI 80-1-A-4) to support program success.**

   Engagement and direct outreach with community are key functions in both programs, and LEAD and MDT describe their substantial efforts in communicating with neighborhood stakeholders, including Capitol Hill and Chinatown-ID.

6. **Identify potential operational changes that could be made by government agencies to make these programs more effective, as well as the expected behavioral changes in the programs' participants that correspond to these operational changes.**

   The two programs suggest several notable changes, such as creating a LEAD-dedicated Assistant City Attorney position, or establishing a Mental Health Clubhouse in the downtown area. LEAD suggests avoiding conflicting models or strategies that "cloud public understanding of the most effective approach to chronic addiction-driven law violations." Which specific models may contribute to this confusion is left unanswered.

7. **Propose recommendations for how to take these programs to scale, both in their current geographies and beyond. Incorporate lessons learned from the 2014 expansion of MDT and LEAD into the Chinatown-International District.**

   Lessons learned from the Chinatown-ID are not explicitly addressed in the response, but, generally, both programs cite limitations of case management capability, service provision and outreach capacities, as factors; taking to scale would require additional staff, office space (for MDT) and other resources on top of external barriers already discussed, such as availability of housing and alignment of policing strategy with program operations.

8. **With regard to expansion to Capitol Hill: (A) Recommend strategies for incorporating youth into the LEAD and MDT programs to help youth detention. (B) Evaluate whether the expansion of the LEAD and MDT programs into Capitol Hill would affect public safety issues in the Little Saigon neighborhood, and if so, how?**

   (A) For LEAD, expanding client scope to include youth would require hiring appropriate staff as well as operational changes to accommodate parental consent, which may not be possible. MDT refers youth to appropriate services but does not provide case management for anyone under 18.
   (B) LEAD will be expanded into all of the East Precinct; outreach to Little Saigon is currently in its infancy. MDT acknowledges a need for an increased presence in the area.

9. **Propose recommendations to revise the LEAD and MDT governance structures to reflect the changing mix of funders.**

   The LEAD and MDT governance structures already incorporate multiple stakeholders, including the City.

Conclusion

The authors make claim that MDT and LEAD are separate programs with little opportunity for further integration or efficiencies outside of cross-referrals, proper coordination with SPD and community stakeholders, and participation in meetings. The subsequent discussion of scope, efficacy and other factors shows some overlap in terms of external circumstances (such as lack of low barrier housing) impacting those factors, but we otherwise see two different responses for nearly every question—comparing these programs, particularly without overlap in service populations or similar measurable outcomes, is an apples and oranges situation.

Attachment:

Attachment A: Statement of Legislative Intent 87-1-A-2

cc: Kirstan Arestad, Central Staff Executive Director
Dan Eder, Central Staff Deputy Director

ATTACHMENT A - Respose to Statement of Legislative Intent 87-1-A-2

Adjustment to 2016 Contracts with the Law Enforcement Assisted Diversion (LEAD) and Multi-Disciplinary Team (MDT) programs

Context

In the 2015 budget process, by a Statement of Legislative Intent (SLI), the Seattle City Council directed that the Human Services Department (HSD) provide in its 2016 contracts with the Public Defender Association (PDA) for Law Enforcement Assisted Diversion (LEAD), and with the Downtown Seattle Association (DSA) for the DSA Outreach Team and Multi-Disciplinary Team (MDT) meetings, that each program assess what resources and operational steps (either by the programs themselves or by cooperating City agencies) would maximize their positive impact on neighborhood health, order and safety; and what opportunities exist for increasing coordination between the two programs. The SLI directed that PDA, DSA and HSD report the results of that planning and assessment process to the Council by May 31, 2016.

Response

At the Council's request, the LEAD (PDA staff plus Evergreen Treatment Services' REACH program) and DSA teams have worked together this spring to identify programmatic efficiencies, enhance communication and data sharing, and to troubleshoot potential roadblocks to desired outcomes (for both the individuals on the street and neighborhoods at large).

In the pages that follow, please find the programs' responses to the questions raised in the SLI, as well as a summary and an overview of quick-wins, longer-term objectives and bigger systemic issues that impact the efficacy of the programs.

1. **Evaluate ways to streamline and create efficiencies within and between the LEAD and MDT programs, and specifically describe potential costs and benefits of integrating or more closely coordinating LEAD and the MDT.**

   At the outset, it is important to note that, while the DSA Outreach Team and LEAD thus far have been deployed in the same neighborhoods, this cannot be assumed for the future. DSA does not anticipate working outside the center city, and its contiguous neighborhoods, which includes the immediately adjacent Capitol Hill area. LEAD, however, is already at least nominally available in Skyway in unincorporated King County, and to Metro police wherever they patrol. Planning discussions are underway to explore LEAD expansion to other King County cities (currently Renton, Kent & Auburn), in keeping with the King County Executive's proposal to the MIDD oversight committee to commit additional funding to support LEAD expansion in King County. Thus, the coordination and integration analysis below pertains to LEAD's operation in the center city, where the DSA currently operates.

Further, we are mindful and urge others to bear in mind that the same coordination and clarity about division of labor that we are trying to bring to bear on the work of LEAD & the DSA Outreach Team would be advantageous if applied to a wider array of programs, services and providers. We are aware of and are glad to know of efforts at both the City and the County to move toward planning *integrated systems of care* rather than "pockets of excellence" and good programs developed in isolation. While we are proposing concrete ways in which the DSA Outreach Team & LEAD can be more closely coordinated, these are not the only two programs which can be more effective when they operate within a planned, mutually respectful, well-understood division of labor and with appropriate information sharing. Where possible, we have developed coordination strategies that could also be used by other Downtown Seattle and regional programs and service providers.

Need for greater clarity that these programs focus on different populations

Both the DSA Outreach Team & LEAD share a "theory of change" that meeting unmet service needs and reducing the duration of time that it takes for clients to access those service needs may positively impact the numbers of unsheltered individuals and motivate those labelled as "service resistant" toward change which will be evidenced in: attainment of sobriety, stabilization of mental health symptoms and acquisition of permanent housing of people whose poverty and illness pose problems both for them and for neighborhoods where they spend time in public spaces. In our planning process this spring, however, PDA/REACH & DSA have achieved greater clarity about differences between the methodologies we use and the populations for whom our respective approaches provide an effective response. Therefore, there are limitations to directly comparing and contrasting program volumes, costs and outcomes, as we are working with people with very different characteristics and use somewhat different strategies to improve the situation of our respective clients/participants.

(1) Different populations: law violations. The DSA Outreach Team is focused primarily on individuals who are homeless within the designated service boundaries of the program. DSA works with all populations save for juveniles. In cases where a DSA case manager identify clients with needs which would most appropriately be met by another service organization, those appropriate referrals are made. The MDT meetings and DSA Outreach do not presently feature systematic coordination with justice system players (via prosecutors). LEAD in contrast requires that potential participants be suspected of drug-related criminal activity or sex work, and features systematic coordination with the justice system via prosecutors. LEAD, however, is not presently open to individuals who suffer extreme poverty, alcoholism or mental illness unless they are also engaged in drug-related crime or sex work (note that these eligibility criteria were set narrowly because LEAD was a first-of-its-kind police diversion program trying to achieve proof of concept, and there have since been proposals to expand those criteria), while the DSA Outreach Team is able to work with such individuals.

(2) Different methodologies: compliance structure. LEAD intentionally works with individuals who may, at least initially, be unable to comply with any particular program

requirements. There are no per se requirements to remain in LEAD after a participant has signed a required Release of Information and completed a 2 hour intake session. (The reasoning behind this approach is laid out in the Theory of Change discussion.) DSA Outreach case managers, however, do use compliance and accountability requirements. A client upon intake and assessment is expected to review the program guidelines which stipulate that all DSA Outreach clients are to make contact with their case manager at least once weekly. Any DSA Outreach client who fails to comply with the weekly check-in rule is issued an intent to discharge notice after the 2nd week of failure to check-in. If this behavior persists to 30-days the client is then administratively discharged from the program. By contrast, the LEAD program does not require their participants to make weekly meetings, particularly when first referred, and LEAD case managers use longer-term relationship building. Both programs use proactive outreach, and connection with police officers to increase engagement by reluctant or skeptical participants.

(3) Time in the program. DSA Outreach clients engage with program staff on average for four months until the completion of the collaboratively developed service plan goals. LEAD participants typically are engaged for considerably longer, and sometimes for years. This likely reflects differences in methodologies, theories of change and the target populations.

Inter-Agency Collaboration, Information Sharing and Referral Protocols

The ongoing relationship between direct care staff at different agencies is extremely important to the success of these programs and their clients. As noted above, though this SLI focuses only on LEAD and the work of the DSA Outreach Team, and while we have focused on coordination between these two programs, improving and developing a framework for coordination and appropriate information exchange with staff from other providers and programs would also be valuable.

DSA staff now attend LEAD operational workgroup meetings; REACH and PDA staff also attend the MDT meetings. There is a need for clearly articulated protocols for fluid MDT-to-LEAD social contact referrals. DSA is currently developing protocols that will address this and will fine-tune that process with PDA's Neighborhood Safety Advocate, Sokha Danh, who coordinates LEAD social contact referrals.

Integrated Meetings

LEAD operational workgroups are held bi-monthly, staff up to 40 clients' situations in each meeting, and troubleshoot any challenges in coordinating responses with three police agencies and two prosecutors' offices. DSA representatives attend these. Likewise, DSA currently holds monthly MDT meetings, which REACH staff (who provide case management services for LEAD) attend.   MDT meetings are usually staffed by a variety of agencies including:

- Seattle's Union Gospel Mission (UGM)
- King County Veteran's Administration

- Catholic Community Services of Western Washington
- Operation Night Watch
- New Horizons Ministry
- Harborview Housing First
- DESC-HOST
- ETS-REACH
- SCIDpda
- ORION-YouthCare
- Downtown Public Health-Robert Clewis Center
- Heroes for the Homeless
- Human Services Department of Seattle
- DSA Outreach Team

The structure of the monthly MDT meeting provides ninety minutes for collaboration amongst agencies engaging in similar activities in the same area. Due to geographic constraints, the number of agencies at the table, and the differences in the tasks undertaken at the meetings, integration of these meetings isn't currently advantageous.

Shared Database

A paramount outcome of the collaboration between DSA Outreach and LEAD must be a coordinated platform for information sharing amongst key partners conducting services and outreach in the center city. Since earlier this year, staff from PDA, DSA and REACH have been engaged with a contract database administrator for the database "Agency" to develop a shared portal for various service providers and law enforcement/criminal justice practitioners to share case information at a shallow level to facilitate inter-agency collaboration and improved outcomes for individuals with complex housing, legal and service needs. This information sharing platform is referred to as the "LEAD Database." DSA will have access as a LEAD operational partner. Other service providers may have access on the same basis, should they desire it. (PDA funded creation of the LEAD database with private grant funds, at the request of various operational partners and the Mayor's Office.)

In order to share personal information about clients (even at a high level) all operational partners with access to the database will have to agree to established protocols for information sharing to protect the clients, as well as the providers who are entrusted with client information. All users of the database will sign an agreement dictating who can access the information and for what purpose.

While the LEAD database will have a shared portal, each agency will only input information that they are comfortable sharing with the larger network of operational partners. This third-party database will be accessible by each of the following agencies:

- King County Council
- Seattle City Council
- Seattle Mayor's Office

- King County Executive
- King County Sheriff
- Seattle Police Department
- DSA
- Public Defender Association
- Seattle Human Services Department
- Seattle City Attorney's Office
- King County Prosecutor's Office
- REACH
- ACLU

Possible others:

- DESC
- LIHI
- Plymouth Housing

Integration of Outward-Facing Communication

Both LEAD and DSA Outreach have proactively engaged neighborhood organizations about the services and response offered by our respective programs. In our shared assessment, however, it is unhelpful to neighborhood and business organizations to be educated about and asked to interface with the MDT & LEAD as separate programs. (The same is also true of law enforcement officers.) It requires those untrained in case management to do too much differentiation and categorization about client needs and characteristics that they may not have the information or expertise to assess in any event. These programs are similar enough in target population and methods that having information sessions on the two programs at different times may cause confusion, apathy, skepticism, and a potential delay in assistance. It also conveys a lack of integrated response.

Recognizing that this is not optimal, we are creating and plan to distribute a double-sided and co-branded information sheet that explains both programs, whom they serve, what they offer, and how they can be accessed. (See attached prototype.) Both programs will distribute the double-sided information sheet rather than single-program information.

Down the road, we suggest this approach be explored for additional features of the service and diversion landscape (e.g., the Crisis Solutions Center, DESC's HOST program, REACH encampment outreach teams, Intensive Care Management Team, and others).

2. **Explore ways to create meaningful change at the neighborhood level where LEAD and MDT are operating, and what should be measured going forward to track changes at the neighborhood level (e.g., crime statistics, 911 calls for service, environmental indications of crime or street disorder, etc.).**

When offered an alternative to traditional enforcement-only approaches to crime and disorder driven by extreme poverty, addiction and untreated mental illness, Seattle's neighborhoods

have supported the paradigm shift represented by LEAD and DSA Outreach. It is imperative that these approaches both succeed, and be seen by community leaders to succeed, in delivering improved neighborhood conditions on the ground.

There are four components to delivering on the promises of these models:

1. Transparency with and accountability to community partners
2. Adequate resources to achieve change in individual circumstances (particularly access to housing & treatment resources at scale)
3. Committing to coordinate all City resources to see that all appropriate candidates in involved neighborhoods are connected to these programs, rather than a small fraction of the population which could appropriately be engaged in LEAD/MDT
4. Clarity about how the individual and neighborhood-level impact of each program will be assessed

Transparency with and accountability to community partners; capacity for community engagement

An intentional, staffed, community engagement function, in which the program managers continually engage members of neighborhood, business and public safety groups, receive information from them, and provide information back to them, is essential to maintain community confidence in both the MDT and LEAD. For the MDT, that function has been provided in kind (to date) by DSA. For LEAD, that function has been provided in kind (to date) by PDA. The community engagement function includes both general information-sharing, and also, identification of specific individuals as possible candidates for both programs to work with. (In LEAD, this is referred to as the social contact referral process, which is the source of many LEAD referrals and is coordinated by PDA's Neighborhood Safety Advocate.)

In the interest of furthering a feeling of community ownership and confidence in these programs, it is important to continuously inform street level business and neighborhood stakeholders about work that is being done with those who have a high impact street presence. For example, if a person suffering from untreated mental illness routinely comes to a specific place in the neighborhood, a program representative should visit the street level business in that area and let them know there is some work being done with the person and reiterate that there is a plan in place to assist the individual. This can be done without breaking client patient confidentiality, HIPAA laws or privacy acts. Client confidentiality guidelines should also be explicitly explained to street level businesses and neighborhood stakeholders so as to manage the expectation that they have of providers and information sharing.

As discussed above, in our planning work to respond to this SLI, we identified the need to deliver a unified message to community and neighborhood organizations about the two programs, rather than separately engaging neighborhood groups, which can engender confusion, frustration and lack of confidence simply because neighborhood leaders cannot discern the difference in the programs or remember how to access each of them for

appropriate purposes. Joint, co-branded communication is our proposed immediate step to improve this situation.

Going forward, it is uncertain the extent to which private grants will continue to support PDA's community engagement work to facilitate community access to LEAD; consequently, the LEAD project management and community engagement function has been identified as a core cost of maintaining the program in the MIDD II funding proposal (as well as funding for prosecutor coordination regarding LEAD participants' cases).

Additional Housing Resources Needed

Much like the need for services, without housing options on demand, moving people from outdoor living into stable housing is difficult. Despite the successes of the DSA outreach team in housing clients, they continue to regularly face impediments to housing such as adverse credit history, adverse rental history and criminal history. LEAD case managers report, on a wide scale, having to place clients who still use drugs in clean and sober housing in the absence of any alternative that does not require sobriety; often, these participants are then evicted because they were not ready to move to sobriety when they entered. LEAD case managers also report that housing participants with significant criminal history is all but impossible under current circumstances. The Landlord Liaison Program does not, and changes coming with Coordinated Entry for single adults through All Home are not expected to, fully compensate for the disadvantage participants with criminal history have in finding housing. PDA will soon complete an analysis of the Hardest to House (people with criminal history & active drug users) for consideration of City and County planning efforts to bring an end to people living in public spaces. Many LEAD and DSA Outreach Team clients are camping and living in tents, despite being "housing ready" and willing to accept services, because their criminal or adverse financial background disqualifies them from being tenants. A planned response for this population is imperative before these programs can maximize the results of their approach.

Additionally, it is critical that the City and its providers look at how to create additional beds that incentivize people to relocate from the street. Providers regularly hear from clients that they are not eager to enter into shelters that are perceived as unsafe or unsanitary, prohibit pets and partners, close down during the day, lack adequate storage space for possessions, and where they are not certain they will be able to return night after night. The reassessment of the current array of shelter options begun under the State of Emergency must continue and shelter options must be significantly revised before we can expect to see many of those now sleeping on the streets enter emergency shelters.

Improved Access to Treatment

Both programs have experienced barriers for individuals who are seeking chemical dependency treatment being made to wait long periods; when they reach the top of the wait list, sometimes they are discouraged or can no longer be located. We understand that, for heroin & opiate users, important recommendations for increasing access to treatment will be forthcoming in September from the Heroin & Opiate Task Force co-convened by King County, the City of Seattle and certain other King County cities. Beyond those recommendations, effective

treatment for other drugs is still in short supply.[1] We recognize that improving the array and scope of treatment options available to those with whom both programs work is beyond the scope of City of Seattle partners alone, we call it out because limits on volume and efficacy of treatment limit the outcomes that both programs can achieve with clients with Substance Use Disorder.

Focused attention on engaging all the individuals in each involved neighborhood who are appropriate for these programs, neither of which presently has capacity to absorb that level of need

Downtown Seattle community groups have been told for several years now that LEAD and MDT are operating in their neighborhoods -- yet neither of these programs have been scaled with staffing, funding and the needed resources to truly address the broad scope of the need. Until we achieve this saturation-level response to the actual need for these programs, neighborhood satisfaction can be expected to be partial and eventually quite disappointed. That reaction would not reflect a failure of these approaches -- rather, it would reflect a failure to truly utilize these responses at scale.

Going to scale in the neighborhoods where LEAD and the DSA Outreach Team currently operate will require improvement in three areas, in addition to the housing & treatment resource scarcity for these clients flagged above:

1. <u>Prioritization and understanding of these approaches by all relevant City departments</u>. Despite the successes of LEAD and MDT, and widespread community support for and interest in both programs, there has been only intermittent focus on these approaches in internal and external messaging by involved City departments. To some extent, those departments also continue to utilize strategies that are at cross-purposes with the theory of change of both programs. This results in diffused efforts by, in particular, Seattle police officers, who try to use these programs but are also sometimes directed to use other approaches not necessarily in keeping with this paradigm of achieving change.

   On the service/care management side, we support what we understand to be a movement in both HSD and the County Division of Community & Human Services to

[1] While an appropriate standard of care for heroin/opiate users is being identified by the Heroin-Opiate Task Force, relevant to the populations engaged by both LEAD and the MDT, improvement also is needed in the array of treatment options available for users of stimulants, including cocaine/crack. A recurrent theme in addressing needs of individuals whose primary drug of choice is a stimulant (either amphetamines or cocaine [especially crack]), is the lack of effective treatment options and a belief that relatively lengthy inpatient treatment (>30 days) in necessary. Over the past few years, however, there have been advances in both types of treatment available. In terms of types of treatment outpatient, contingency management and behavioral approaches have been shown to be more successful than 12-step based programs. Research by Dr. Carl Hart and others has shown that contingency management combined with housing and other quality of life improvements is also effective. Finally, although still in clinical phases, types of agonist replacement therapies (analogous to opiate replacement therapy) have shown success and hold out promise. We should promote the system expansion and availability of contingency management combined with housing as well as working with local researchers to explore the viability of trial agonist replacement treatment.

move toward integrated systems of care for this population. Deeper coordination between the service/care approach now used in both programs with system design by HSD & DCHS may eventually require changes in how care is provided in both LEAD and the DSA Outreach Team. So long as that care approach is consistent with the core principles of LEAD and MDT, LEAD and MDT partners and case managers likely will welcome this development.

2. Increased proactive police capacity or clarification of current mission of proactive units. The recently-commissioned Berkshire Report on SPD staffing seems to show that proactive resources would need to be significantly augmented and/or relieved of responsibility for special events and demonstration policing, in order to step up the level of proactive capacity in SPD. Both LEAD and the MDT benefit from coordination with proactive policing resources, and LEAD depends on police referrals and ongoing daily coordination.

   The current state of affairs is that the bike squads and NCI officers make LEAD referrals and the CPT and the Neighborhood Response Team regularly coordinate with the DSA Outreach Team. We would like to see all squads in the West Precinct, including patrol, as well as the CRT and CIT, receive training in how to utilize and make diversion referrals to both programs. After a beta testing period introducing both programs to the East Precinct, we would like to see a similar approach taken with all East Precinct squads. (LEAD operational training for all East Precinct officers is planned for roll calls in June and July.)

3. Increased capacity for case management and services. LEAD is near maximum capacity with current funding as well, using a 25 client per case manager ratio and not including inactive clients in that calculation. While certain efficiencies can be achieved by leveraging Medicaid reimbursement for some case management and direct services costs, ideally, housing options will develop for this population than may draw on LEAD program funds to pay housing costs to a greater extent than occurs now (since housing is the main expense not reimbursable by Medicaid).

   Thus, to go to scale in neighborhoods now nominally served by both programs, it will be necessary to increase capacity for case management. The DSA Outreach Team as currently staffed is able to serve the needs of currently screened clients particularly due to the accountability approach. Clients who are absent from the program for 30-days are administratively discharged; case managers do not include on their caseloads clients who are inactive in the process. Clients can petition for readmission after an administrative discharge. Furthermore, the average 4-month duration of time in the program reflects relatively fluid movement through the DSA Outreach Team's case management process. It should be noted that DSA continues to struggle with the appropriate referrals, most notably individuals needing assistance in recovery from substance use disorder. DSA is mindful that if they were to expand services to the adjacent neighborhoods this would require additional

staffing and funding. LEAD would also require augmentation of our outreach coordination staff. See below for an estimate of cost per person, which will inform any decision to expand capacity, noting that economies of scale drive down the cost per person with program expansion.

Clarity as to how individual and neighborhood-level impact will be assessed going forward
LEAD project managers obtained $500,000 in funding from the Arnold Foundation to conduct a systematic, non-randomized control design study of the effectiveness of LEAD with respect to stated primary (reduction in recidivism) and secondary (reduction in justice/emergency health system utilization and cost; individual psycho-social benefits) program goals that had been set by all the LEAD governing partners. That evaluation is nearly complete, finding system cost reductions (though not to the City of Seattle, possibly due in part to lack of dedicated staff in the City Attorney's Office to parallel system reductions achieved by dedicated staff at the King County Prosecutor to manage cases of LEAD participants), psycho-social progress, and significant recidivism reductions.

PDA/REACH (for LEAD) and DSA (for the MDT) recognize and embrace the City's and in particular the Council's interest in ensuring that investments in programs such as these pay off in desired results. However, we note that there presently is no source of funding identified for evaluation going forward. Thoughtful evaluation capable of establishing a causal connection between interventions and outcomes requires significant planning and funding. We would welcome suggestions from CBO, HSD, Council central staff and possibly the City Auditor's office regarding a sustainable ongoing plan for thoughtful evaluation of both programs, with an eye to continuous improvement and identifying areas for modification and improvement.

For LEAD, because the program is inter-jurisdictional and involves independently elected stakeholders, it is important that those City entities engage with the LEAD Evaluation Advisory Group (on which Council central staff and the Mayor's Office currently sit, and which is open to representatives of all LEAD governing partners) to devise a strong ongoing plan for evaluation. The LEAD Policy Coordinating Group met on May 27, 2016 and supported an effort to obtain significant funding from MIDD II, the Arnold Foundation (which funded evaluation of the pilot program) or other funder(s) to look longitudinally at the long term differences in the LEAD pilot participants compared to the original control group, if that group remains largely outside of LEAD; and to plan a way to establish a control design evaluation, if possible, and a rigorous within-subjects analysis if a control group is not possible, regarding effects of LEAD on substance use over time.

Our thinking so far about how best to conduct ongoing evaluation of both programs' effectiveness at a neighborhood level, at a relatively low cost, involves conducting a neighborhood survey to gauge community awareness about and perceptions of both programs, to include questions to identify felt indications of crime or street disorder. Because there can be a gap between community perceptions and actual effectiveness of work with individuals, some plan for measuring effectiveness of both programs' approaches with individual participants is also essential, albeit challenging if there is no defined control group.

It is critical, however, that neighborhoods not be introduced to programs with the understanding that they are operating at saturation level engagement/service and then asked to assess the effectiveness of the programs. The methods used may be effective (and at an individual level, the methods used in LEAD have been proven effective through rigorous evaluation), but using them in insufficient concentration will result in little discernable impact at a neighborhood level.

3. **Estimate the average cost per participant for both programs, separated out for 1) case management 2) support services (e.g., housing, detox) and 3) program administration. Provide both the total costs and the City-funded portion.**

For DSA/MDT:

The following cost breakdowns for the DSA Outreach Team are for the time period between January 1, 2014 to March 31, 2016. According to Safe Harbors records, the DSA has served 308 enrolled clients during this time period.

The cost for case management (including salaries, benefits and overhead) for a DSA client is $2,962.85 for the 27-month time period specified above, or $740.71 per client per month based on the average length of time a client is enrolled in the program, which is four months.

The cost for client support services (including housing, shelter/motel, identification, etc) is $678.45 for the 27-month time period specified above, or $169.61 per client per month based on the average length of time a client is enrolled in the program, which is four months.

The overall cost for the program to serve a client is $3,641.30 per client, or $910.33 per client per month based on the average length of time a client is enrolled in the program, which is four months.

Case Management Costs:

	Amount
CCI/City-Funded Salaries and Benefits (City)	$ 400,990.38
DSA-Funded Salaries and Benefits (DSA)	$ 394,298.28
Overhead (City)	$ 117,270.57
TOTAL	**$ 912,559.23**

Client Support Services:

	Amount
Housing	$ 79,502.71
Shelter/Motel	$ 79,357.91
Relocation	$ 20,877.66
Clothing	$ 5,666.82
Identification and Records	$ 4,979.28
Hygiene	$ 4,923.30
Phones	$ 4,832.47
Local Transportation	$ 3,613.28
Legal Fees	$ 2,835.50
Food	$ 2,375.09
TOTAL	**$ 208,964.02**

For LEAD:

Attached is an independent evaluation of LEAD costs, funded by the Arnold Foundation, and advised during the research design and analysis stages by City and County Council central staff, a health economist for the King County Executive's Office, King County Office of Performance Strategy & Budget, and a program manager for the Department of Adult and Juvenile Detention. That evaluation found that, after initial ramp-up costs, total LEAD costs per client per month during the pilot program (October 2011 through January 2014), inclusive of project management and dedicated prosecution staffing as well as all case management and direct services costs, ran at $532 per month.

These costs should be reduced as greater use of Medicaid reimbursement for client services and case management comes on line, including through the Medicaid waiver process recently approved for Washington State (although should there be additional housing resources for participants with criminal history and other circumstances similar to the LEAD cohort, housing costs per client could increase). Current program figures, however, show that costs per client are already lower than those reflected in the University of Washington study, reflecting economies of scale:

LEAD case management

	2015	2016	total
Personnel/City	$448,521	$587,329	$1,035,850
Overhead & admin/City	$196,685	$173,947	$370,632
Total City	$645,206	$761,276	$1,406,482
Personnel/ other funds	$262,258	$409,032	$671,290
Overhead & admin/other funds	$57,690	$121,139	$178,829
Total other funds	$319,948	$530,171	$850,119
Total	$965,154	$1,291,447	**$2,256,601**

LEAD client services

	2015	2016	total
Shelter/City	$93,384	---	---
Housing/City	$57,390	---	---
CD treatment/ City	$793	---	---
ID assistance/ City	$1,313	---	---
Education & employment/ City	$1,523	---	---
Basic needs/City	$16,261	---	---

Transport/City	$10,652	---	---
Total/City	$181,316	$218,724	$400,040
Shelter/other funds	$93,138	---	---
Housing/other funds	$70,754	---	---
CD treatment/ other funds	$5,846	---	---
ID assistance/ other funds	$527	---	---
Education & employment/ other funds	$1,238	---	---
Basic needs/ other funds	$39,085	---	---
Transport/ other funds	$15,674	---	---
Total/other funds	$231,262	$219,829	$451,091
Total	$412,578	$438,553	**$851,131**

LEAD program management, dedicated prosecution, police OT, legal services & community engagement*

2015	2016	total
$410,000	$525,000**	$935,000

* no City funds except in kind police OT
** adds dedicated Assistant City Attorney for half year

Cost per client
2015: 308 clients; cost per client per month = $484
2016: 400 clients; cost per client per month = $470

In addition to City and foundation funding for 2015 and City/County funding for 2016, the LEAD services model relies on in-kind clinical staff funded through the Healthcare for the Homeless Network. The staff work directly at the LEAD program offices, or provide outreach services in the community to find individuals and link them to care. The current HCHN staff include an RN through Harborview Medical Center, a Mental Health Specialist through Harborview, and two Groups and Activity Coordinators.

4. **Define the theory of change used by each program. For LEAD, describe any recommended revisions to the theory of change to respond to recent City and County changes to arrest and prosecution policies for prostitution and drug dealing.**

LEAD Theory of Change
LEAD's theory of change (TOC) for individual behavior is based on harm reduction principles and motivational interviewing techniques. Harm reduction focuses on reducing or changing individual behavior considered harmful to that individual, without establishing complete cessation of that behavior as the only marker of success. Harm reduction approaches are particularly well-suited to people who have experienced trauma, find trust and hope difficult to come by, and for whom shaming and rigid success/failure frameworks are barriers to progress. LEAD, as other harm reduction programs, begins by engaging an individual where he or she presently is in terms of goals and aspirations, using motivational interviewing techniques that identify goals to which the participant herself subscribes and is willing to work toward. Addressing immediate actual and felt needs (such as housing, in a program where over 80% of referrals are homeless) often establishes trust and a sense of strength that allows harder tasks, like reducing drug use, to seem more achievable. Needle exchanges and "wet housing" are well known examples of harm reduction strategies.

LEAD also applies an unprecedented level of system coordination between law enforcement, prosecutors (and through them, the courts and defenders), service providers and neighborhood leaders, all making discretionary decisions wherever possible to support behavior change by the individual, rather than following rigidly prescribed decision-making guidelines with a blind eye

toward the actual impact on the individual. Prosecutors make decisions whether to file charges, whether to support or seek release, whether to dismiss or reduce charges, depending on the progress and ongoing situation of the participant/defendant. Officers make decisions whether to approach someone in the field and how to engage that person based on information they would otherwise not have access to. Community leaders can contribute to community-based engagement by officers and social workers, rather than making emergency calls for service. All of this strategic coordination is done on a routine, rather than crisis, basis, regarding individuals whose law violations are largely due to behavioral health issues or extreme poverty.

LEAD's TOC further posits that if such engagement strategies help a sufficient number of individuals, positive neighborhood level and public safety impacts will be realized, in part through changes in behavior of a sufficient number of individual participants, and in part through system change, as previously fragmented systems work together in a way that is transparent, rational and defensible.

Effectiveness objectively assessed. This theory of change has proven effective in achieving the agreed primary aim of LEAD: reducing criminal involvement of LEAD participants compared to individuals processed through the justice system as usual. A 2015 independent evaluation funded by the Arnold Foundation and guided by analysts for City and County government found that LEAD participants' odds of recidivism were 58% lower than those of similarly-situated control group members who were booked and prosecuted as usual. (The recidivism evaluation is attached.) **LEAD is now listed by the National Institute of Justice's CrimeSolutions.gov as a promising practice. The Arnold Foundation evaluation, if replicated in other jurisdictions, meets the Office of Justice Programs' standard for an evidence-based practice, and based on this evidence, the Bureau of Justice Assistance (BJA) is making technical assistance grants to assist jurisdictions replicating LEAD nationally.**

DSA Outreach Theory of Change

DSA Outreach Theory of Change stresses a collaborative working relationship between Outreach Worker/Case Manager and Client.

The Five Core Values of DSA Outreach are:

1. Presence – We value being available both physically and emotionally for those who we serve.
2. Advancement – We actively seek out opportunities to advance those who we serve, self, our Organization and the community.
3. Collaboration – Our efforts would be futile if we fail to work collaboratively with those whom we serve, service providers, law enforcement and the community at large, all in the effort to provide the best possible care.
4. Empowerment – We do not seek to assume the responsibility for the lives of those we serve. Rather, we aim to partner with them as they reclaim power over their own lives. Giving the client the tools to reclaim power over their own lives.

5. Sensitivity. With the understanding that we serve a multicultural and diverse population, we are committed to providing services that strive to meet the individual needs of those we serve.

DSA Outreach believes that homelessness is a symptom of both internal and external issues that have their roots in biopsychosocial-spiritual perpetuating factors such as: conflict in one's family of origin; trauma related to domestic violence, sexual abuse, physical abuse, emotional and psychological abuse, conflicts of faith; insufficient access to medical care; genetic predispositions; unresolved grief and loss; lack of support networks; insensitive rendering of services; lack of financial resources; insufficient access to resources.

DSA Outreach believes that recovery occurs as a result of: the client's desire to change (internal motivation); identified reasons for change and client sensitive reward and support network (external motivation); continuous, ongoing presence and belief in client's ability to change (unconditional positive support); firm boundaries defined by the client and provider and adhered to throughout the process of change (accountability); adaptability to life's daily circumstances and the ability to be fervent in the pursuit of goals (resilience); ability to attain and presence of recovery needs (resources); surroundings conducive to change, and understanding of plight and responsive to efforts (environmental sensitivity).

Furthermore the DSA Outreach theory of change stresses accountability, ownership, agency and resilience. Relying on client ownership, DSA Outreach focuses on internal and external systems with the view that individuals who acquire the necessary social skills and resiliency have the ability to overcome the challenges of a system that my not necessarily be responsive to their social and multicultural needs.

The outreach process begins with initial contact either by means of an outreach effort or referral either by a community partner, resident, business of law enforcement. The prospective client is then assessed for suitability for the program and evaluation of service plan needs. The client is then connected with a case manager with whom they develop a collaborative service plan goal. The approach utilized is ongoing time-rich engagement which stresses relationship and trust building and accountability on the part of both client and case manager. The working/therapeutic relationship and progress are constantly being evaluated under the direction of the manager.

DSA Outreach identifies several barriers to change. These include: criminal addictive behavior and thinking; substance use disorders; mental illness; and chronic homelessness. In addition, the theory of change highlights additional focus on the internal system of the individual which is steeped in predisposing, precipitating and perpetuating factors. Skilled mental health staff work with clients to identify these often overlooked factors and work toward overcoming the effects of unaddressed factors. In the therapeutic relationship we stress a Rogerian approach that regards the client positively whilst utilizing cognitive behavioral strategies to identify, evaluate and rectify faulty thinking patterns.

As the client grows in resilience and ownership we believe that protective factors develop. Those factors include: self-esteem; improved social skills, improved communication skills; accountability; sense of connectedness to society; development of prosocial peer groups; engagement in prosocial activities. As a result of the acquirement of those skills the following results will be observed: prosocial lifestyle and community engagement; sustained recovery from substance use disorder or insight into severity of disorder; acquirement and maintenance of stable housing; stable mental health symptoms with ongoing support.

5. **Engage with community representatives from Downtown and Capitol Hill, including the Special Task Force on Chinatown-International District (see SLI 80-1-A-4) to support program success.**

LEAD

Staff from the Seattle Chinatown-International District Preservation and Development Authority (SCIDpda) as well the Chinatown-International District Business Improvement Association (CIDBIA) historically have attended LEAD's Operational Work Group meetings. Efforts to refer individuals involved in drug related crime and/or sex-work in the neighborhood continue through regular communication and coordination with the Public Defender Association's Neighborhood Safety Advocate and community public safety leaders in the Chinatown-International District (C-ID).

The Community Police Team (CPT) in the West Precinct, which includes the C-ID neighborhood have been "LEAD-trained". REACH's LEAD Outreach and Screening Coordinator has also engaged with the C-ID neighborhood's current Community Police Officer to plan a "ride-along" to learn more about the neighborhood's public safety issues and high-impact individuals. LEAD's expansion into the East Precinct, which includes the Little Saigon neighborhood, provides an opportunity to more comprehensively serve the needs of the C-ID. LEAD project managers have clarified with the Mayor's Office and SPD that expansion will be to the entire East Precinct, not just to the Capitol Hill neighborhood, which addresses some initial concerns about racial and ethnic disparity in neighborhoods to be served by the program. Thus, the East Precinct operations lieutenant is presently planning with LEAD program managers a training for all of East Precinct patrol, to occur in late June/early July.

In April, PDA, REACH and the Mayor's Office partnered with Councilmember Sawant, representing Council District 3, and Capitol Hill Community Council to convene a community conversation about LEAD and its introduction to the East Precinct, held at Miller Park Community Center. Over 50 community members attended and participated in an informative Q & A, which was covered in the Capitol Hill Times.

PDA's Neighborhood Safety Advocate serves on the Special Task Force on C-ID and is closely working with SCIDpda, an organization that is one of the community co-chairs of the Task Force, to build an intentional outreach and engagement strategy for LEAD that is realistic and able to meet neighborhood expectations for improving public safety. Maximizing use of LEAD is among recommendations emerging from the Task Force.

Constant engagement with other downtown neighborhoods has been critical for LEAD's overall program success, and for community "buy-in" and support. Time is allotted and prioritized in the Operational Work Group meetings for community report-outs in particular emphasis areas, new community-generated social contact referrals into the LEAD program, and to help assist in the coordination of law enforcement personnel and REACH's outreach with potential and/or existing LEAD clients in emphasis areas. Other active community partners involved in LEAD's neighborhood current outreach plan and engagement includes, but is not limited to the following organizations: SCIDpda, Belltown Community Council, Friends of the Waterfront, Pioneer Square Residents' Council, West End Neighborhood Association, Capitol Hill Community Council and Capitol Hill Housing.

In December 2015, DSA contracted with SCIDpda to rent a conference room located in the C-ID to host the monthly MDT meetings. One of the purposes of this physical move was to help human service providers build familiarity and relationships in the community. However, due solely to room capacity issues, the MDT meeting will relocate to a bigger venue outside of the district in June of 2016.

MDT
As a response to the observed and reported need for greater collaboration between human service providers and law enforcement the DSA Outreach Team designed an outreach position specific to working with SPD. The Public Safety Outreach worker is a non-traditional team based approach to seek out homeless individuals in the Capitol Hill and Downtown neighborhoods to connect them with services and provide ongoing case management.

A significant amount of the Public Safety Outreach Worker's time is spent embedded with police officers during their normal patrol. The patrol units are Downtown's *Neighborhood Response Team* and Capitol Hill's *East Precinct Bike Unit*. Finding innovative solutions for individuals who present a chronic street presence due to homelessness, addiction and mental illness, identification of the chronic issues that perpetuate street presence and collaborating for the development of public safety strategies are paramount. The Public Safety Outreach Worker spends a significant amount of time outside in the neighborhood attempting to identify and build relationships with the homeless individuals living on the street or places not meant for human habitation.

The Public Safety Outreach Workers attend the LEAD Workgroup meetings, Multidisciplinary Team Meetings, Capitol Hill Clean and Safe meetings, Capitol Hill Multidisciplinary Team meetings and the CID Public Safety meetings. The Capitol Hill Public Safety worker's work is supplemented by support from a licensed mental health professional. Together the Public Safety Outreach Worker, Outreach Worker and Mental Health Outreach staff member perform outreach services with a specific goal of identifying and engaging with those identified as dealing with mental health challenges among the homeless population. In addition, both the Public Safety Outreach worker and Mental Health specialist compile and provide reports to be made available to representatives from SPD-East Precinct. These reports do not include

specifics or descriptors but detail the extent of the outreach work, identified public safety or mental health concerns and recommendations for community partners.

The DSA Outreach has forged a good working relationship with the Capitol Hill Chamber of Commerce and have collaboratively envisioned and implemented the Capitol Hill Multidisciplinary Team meeting which is currently staffed by: Operation Night Watch, Capitol Hill Housing Authority, SPD-East Precinct, Orion/YouthCare, Capitol Hill Chamber of Commerce and DSA Outreach. Invitations have been extended to: Peace on the Streets by Kids on the Streets (PSKS) and Capitol Hill Needle Exchange among others. Currently, the Capitol Hill MDT meeting is on the first Thursday of the month for an hour in a format very similar to the downtown MDT meeting.

DSA Outreach maintains a strong working relationship with the Program Manager of IDEA Space, who serves as a point of contact for outreach staff. The DSA Outreach Team has dedicated one outreach worker with specific duties for performing outreach in the Chinatown-International District. This neighborhood has proven particularly challenge due to the fact that there are very few service providers in that community--specifically no homeless shelters nor any hygiene or laundry access facilities. Furthermore the partners in this community continue to site public safety as their primary concern--this includes staff at Uwajimaya, Parks and Recreation employees and Kobe Terrace workers. As a response to these expressed and identified public safety concerns, DSA staffing for this community has been changed and the Downtown Public Safety Worker has assumed the primary responsibility for outreach and reporting efforts in the C-ID.

6. Identify potential operational changes that could be made by government agencies to make these programs more effective, as well as the expected behavioral changes in the programs' participants that correspond to these operational changes.

LEAD

1. Dedicated Assistant City Attorney position. While the UW research team found that LEAD participants' felony filing rate was 27% lower than that of the similarly-situated control group, there were no significant differences between the groups in the Seattle Municipal Court filing rate. Operational partners attribute the difference to the fact that the King County Prosecutor has a dedicated senior prosecutor tracking LEAD participants' referred cases and making intentional decisions in those cases to coordinate with and support as much as possible the individual intervention plan for LEAD participants. The volume of LEAD participants' cases in Seattle Municipal Court exceeds that in Superior Court; it is evident to operational partners that added capacity in the City Attorney's Office to dedicate a senior Assistant City Attorney to make intentional filing, release, dismissal and disposition recommendation decisions would significantly enhance the effectiveness of LEAD. Presently, LEAD participants' cases are often dealt with (or warrants issued or served, or filing decisions made) without reference to the participant's progress or current situation as known to the LEAD operational partners, solely because of a lack of dedicated capacity in the City Attorney's Office.

Recognizing this need, PDA and the King County Office of Performance, Strategy & Budget (PSB) identified a dedicated City Attorney position to support LEAD as a funding priority if LEAD were to be funded, as the Executive is recommending, by MIDD II. For the remainder of 2016 and the first portion of 2017, PDA will allocate private grant funds to support a dedicated LEAD City Attorney position.

2. SPD LEAD "flag" to be visible to all officers, with instructions on how to access LEAD information for participants encountered in the field. Not all neighborhoods presently can make LEAD referrals, but for existing LEAD participants, it would prevent officers from inadvertently working at cross purposes with the Individual Intervention Plan if all officers could seee the LEAD "flag" in SPD's Records Management System. That flag can be turned "on" as soon as all officers receive a basic bulletin explaining how they can readily access LEAD information (through a LEAD-trained sergeant) should they encounter a LEAD participant in the field.

3. Systematic training for officers on harm reduction principles and LEAD operational protocols in West and East Precincts (including patrol) and all CIT/CRT officers. The Albany Police Department, one of the first cities to replicate LEAD, developed and has now provided highly-regarded training on harm reduction which shortly will be available for use by SPD and the King County Sheriff's Office/Metro. While training time for SPD is at a premium, commitment to providing harm reduction training, possibly in conjunction with the Crisis Intervention Committee, will provide officers a framework for making discretionary choices in everyday (non-crisis) contacts that are trauma-informed and support positive change over time for individuals with behavioral health issues, especially addiction. SPD West Precinct LEAD-trained sergeants, PDA, REACH and the King County Prosecutor's Office will also provide roll call trainings on LEAD operations and goals throughout the West & East Precinct, as well as refresher conversations with already-trained staff about operational changes officers would like to see.

4. Systematic examination of drug and prostitution arrests not diverted from eligible neighborhoods. LEAD may be underutilized for arrest referrals for various reasons; and because it depends on officer discretion using officers' training and experience, it also should be monitored by supervisors to ensure that discretion is being used consistent with the operational protocols, fairness and community trust. To facilitate supervisor review (as well as possibly for identification of control group members for evaluation), it is important that all officers complete a "LEAD Referral Cover Sheet" for each VUCSA and prostitution arrest. If the arrest is diverted to LEAD, the cover sheet indicates that; if not diverted, the cover sheet indicates why, and the officer's reason for exercising his discretion not to divert, if applicable.

5. Avoid conflicting models or strategies that cloud public understanding of the most effective approach to chronic addiction-driven law violations. Understandably, from time to time, community or political pressure for action with respect to public homelessness and/or drug-related activity creates an appetite for "quick fix" solutions. However, LEAD has shown superior success with long-term engagement of individuals living on and/or using and dealing on the

streets. Confusion as to the primary paradigm in which such behavior will be handled creates cynicism and lack of clarity about what plan, if any, is truly in effect. Doubling down to make LEAD -- which combines enforcement with case management -- as effective as possible is more comprehensible to the public than a blend of LEAD, partially implemented, along with traditional enforcement practices, and increases accountability and trust.

MDT

1. *Enhance quality of and expand capacity of existing shelter stock for couples and pet owners.* Shelters must be a place that will be more desirable than remaining on the street. Safety, privacy, cleanliness and a welcoming environment are key factors, however our city has some facilities that were converted from space available into shelter that unfortunately do not maintain a clean, healthy or supportive atmosphere. While well-meaning, the agencies that run these facilities inadvertently alienate clientele that does not feel safe or comfortable in these facilities.

In addition to shelter quality, we need low-barrier shelter options that are equipped to serve couples and those who own pets--populations that currently have great difficulty accessing the current shelter options and consequently remain unhoused. Funding for facilities like this must include staff who will build relationships and support case management plans for their residents as well as committed to maintaining a clean, inviting facility. Without this commitment to compassionate and recovery-minded staff the facility will be little more than a place to sleep.

Two examples of well-run and desirable facilities are the Blaine Center (shelter for men),[2] UGM-Hope Place (shelter for women and their minor children, if applicable),[3] and Peter's Place (shelter and day center for men and women). These have a unique blend of design and staff approaches that entice people to stay there as well as support an atmosphere of change. Furthermore the Blaine Center staff regularly interface with DSA case managers while providing ongoing support to both programs toward client's attainment of goals set through the MDT meetings.

2. *Integrate housing of mentally ill with a Mental Health Clubhouse in Downtown Seattle.* Symptoms of untreated mental health often induced from trauma are major drivers of homelessness. Those suffering have a history of burning bridges with their family and support systems and often end up on the streets of Downtown because they are unable to self-manage their symptoms without support. Providers who house this population are not necessarily equipped to support or treat these issues which creates a gap that not only threatens this population, but creates friction between these providers and the communities in which they operate.

[2] http://firstchurchseattle.org/blainecenter
[3] http://www.ugm.org/site/PageServer?pagename=programs_housing

Mental Health Clubhouses are an evidenced based approach that could be funded and immediately implemented that would bridge this gap, foster community and acceptance while focusing on ability rather than disability.[4] Additionally, they are community based and support available psychiatric treatment. Establishing a Mental Health Clubhouse in Downtown Seattle would provide a non-traditional and relatively low-cost solution at a time when resources to fully address mental health issues remain scarce from the City, County and State. Mental Health Clubhouses offer people who have mental illness hope and opportunities to achieve more of their full human potential. They provide a place where people with serious mental illness can participate in their own recovery process by working and socializing together in a safe and welcoming environment. They operate on standards coordinated by Clubhouse International that have been proven effective in over 300 Clubhouses worldwide since 1989--including one in Bellevue, Washington.

Many people with mental illness struggle with social, proximity and shared space issues. Integrating housing with companionship to individuals who are recovering from an acute episode of mental illness a Clubhouse could break the cycle of hospitalization and homelessness and provides a positive alternative to the disruption that results from this population self-managing their symptoms on the street.[5]

3. *Establish/expand treatment beds for individuals with substance use disorder.* Even with Medicaid expansion our clients, generally low-income or no income individuals, are simply finding it difficult to get into treatment. As practitioners we understand that the window of opportunity where an addict gains the insight into their addiction so as to subsequently desire treatment can close as quickly as it opens. In addition, those who do find treatment at times have to travel often unaccompanied away from their local communities to secure desperately needed assistance in recovery from substance use.

One struggling with substance use disorder who desires to discontinue this lifestyle should have provisions available to them. Attempting to recover from long-term substance use disorder while continuing to endure the realities of environments where substance use and trafficking can be rampant makes this almost an impossibility. Access to immediate treatment beds addresses two key issues: people who want to get clean should have options available to them and a supportive shelter environment that removes people from the chaos of street-based living can better facilitate their recovery.

4) Enhanced support for wound care and additional medical needs: With the rise of chronic injection drug use and long-term exposure to outdoor living, the need for on the spot wound care and other basic medical care is growing. Addressing these minor wounds before they become life threatening is key to survival for many on the street. This will also greatly reduce the number of emergency room visits and 911 calls. An existing model of success for this type of work is the REACH Nurse who is funded through Health Care for the Homeless.

---

[4] http://www.clubhouse-intl.org

[5] http://www.plyhc.org/Default.html

7. **Propose recommendations for how to take these programs to scale, both in their current geographies and beyond. Incorporate lessons learned from the 2014 expansion of MDT and LEAD into the Chinatown-International District.**

LEAD

Why are many LEAD-appropriate candidates not yet in the program?

As noted above, LEAD's expansion since 2014 into downtown neighborhoods beyond Belltown likely could have achieved greater neighborhood-level impact with a higher referral volume. By all accounts, there remain many individuals addicted to drugs who engage in low level law violations in downtown neighborhoods and who are not in LEAD. If all individuals appropriate for LEAD case management and justice system coordination were in the program (*"everyone in!"*), it is likely that neighborhoods would -- as did Belltown from 2011-2014 during the concentrated pilot project -- have seen significant street-level improvement over time. There have been three major impediments to this "*everyone in!*" goal:

- *Insufficient case management & civilian outreach capacity:* for the past two years, REACH has declined or not been able to engage new social contact referrals toward the end of the calendar year because of a need not to exceed budget. Turning down or delaying referrals is problematic in the effort to build officer and neighborhood buy-in;

- *SPD capacity:* as documented in the recent Berkshire SPD staffing analysis, SPD's proactive capacity is strained, all the more so because proactive units are often deployed to staff demonstrations and for other special assignments. Further, for a large portion of 2015, many proactive resources in the West Precinct were allocated to the 9.5 Blocks strategy surrounding 3rd Avenue & Pike Street. The resulting constraints on proactive resources to be used to engage and refer candidates to LEAD were and remain a significant constraint for a program that keys off of law enforcement referrals. (Two strategies to partially mitigate this limitation are identified below, however: reducing officer involvement up front in social contact referrals; and expanding access to LEAD to patrol units.) With additional proactive resources, there is little doubt that LEAD referrals would have come in at a higher rate.

- *Diffusion of neighborhood-based strategies & priorities:* officers and supervisors who have "bought in" and are dedicated to making LEAD work are often tasked to support other priorities and, in some cases, other strategies to engage the same set of problems. Without suggesting that these other directions are inappropriate, they do detract from the efficacy of LEAD as the primary paradigm in which law violations driven by behavioral health conditions are addressed.

What strategies have been developed to increase referrals of LEAD-appropriate candidates?

Within existing resources, several strategies have been devised to increase referral volume.

- S*treamline community-generated social contact referral process.* PDA hired Sokha Danh in early 2016 as Neighborhood Safety Advocate, to coordinate information flow to and from LEAD-involved neighborhood leaders and groups and to streamline the social contact referral process. Sokha previously had engaged with LEAD from the neighborhood perspective while focused on public safety issues at SCIDpda. In addition, the LEAD operational workgroup adjusted to remove the requirement that officers necessarily be the initial point of contact for community-generated social contact referrals. Law enforcement still vets social contact referrals to validate that they are individuals engaged in drug-related crime or sex work in LEAD neighborhoods. However, except under circumstances where officers are unfamiliar with the individual and want an in-person assessment, and unless officers are better-situated to make the overture, LEAD outreach staff and/or community members can engage the individual and make the offer of LEAD enrollment without an officer directly involved.

- *Immediate approval of law enforcement-generated social contact referrals.* With the approval of SPD, KCSO/Metro and DOC commanders, a prior protocol to obtain consensus of LEAD-involved law enforcement supervisors on new social contact referrals recently was revised to allow for on-the-spot approval by any LEAD-trained sergeant of a social contact referral.

- *New practical referral guide for officers prepared by West Precinct Sergeant Rob Brown.* SPD West Precinct Day Bikes sergeant Rob Brown has drafted a practical how-to guide for officers considering making LEAD referrals. The guide is being edited now. When distributed, it should increase officer confidence that they understand and can navigate the referral process. It will also be shared for adaptation by KCSO/Metro.

- *Expand referring squads to patrol as well as CIT/CRT.* West Precinct patrol squads recently were trained to make LEAD referrals at the request of some patrol officers, and have now made several referrals. SPD commanders have observed that it is logical to train CRT/CIT units in LEAD referrals; though they respond to crisis situations, it may be evident that the individuals to whom they are responding are good candidates for LEAD engagement on a chronic/ongoing basis.

- *Increased Medicaid utilization.* Case management capacity can be expanded without additional resources by increasing Medicaid utilization to reimburse some current case management costs. REACH is in the process of establishing a contract for Substance Use Disorder treatment through Medicaid under the King County BHO. Once this is established, REACH will provide Medicaid funded CDP time to eligible individuals. Currently 89% of LEAD clients are eligible for Medicaid, although some have not completed their enrollment. Medicaid funded services will include case management and outpatient treatment. We expect that up to 4.0 FTEs can be funded under Medicaid to serve LEAD clients, allowing us to expand our existing city dollars to new clients.

What strategies within existing resources can increase efficacy?

- *Dedicated Assistant City Attorney capacity.* Grant funding has been secured to support a dedicated Assistant City Attorney to replicate the staffing assigned by the King County Prosecutor's Office since LEAD's inception. It is evident to all operational partners that increased City Attorney capacity to coordinate discretionary decisions with LEAD participants' Individual Intervention Plans will likely both reduce filings and increase efficacy of LEAD in changing participant behavior.

- *Consider moving to 24/7 response capacity by REACH case management staff.* When LEAD launched, night shifts were planned so that case managers would be available to respond immediately in high arrest shifts/hours. As time as passed and practices have evolved, it has become clear that this sequesters staff in hours when they have less ability to play other case management functions (coordinating services during business hours) while arrest volumes are down so the immediate response capacity is rarely used. Officers from early on have asked for 24/7 immediate response capacity; there are now enough case management staff that that capacity might not impose a great hardship. PDA is exploring with REACH the feasibility of 24/7 on-call response capacity replacing fixed night shifts. This way, whenever an officer wants to make a referral, the answer can be "yes," increasing satisfaction and confidence for officers.

- *Improved data-sharing.* As explained above, improved data-sharing (using Agency as well as a new group texting app) is expected to allow more precise and well-informed decision-making by all operational partners.

- *Improved group texting*. In June 2016, LEAD operational partners are moving from GroupMe, a group texting application that unfortunately drops users who do not respond during a fairly short window of time, to Celly, a group texting app expected to work better particularly for law enforcement partners.

What strategies to increase volume and efficacy require added resources?

- *Increased case manager capacity.* Beyond what can be achieved through Medicaid billing, it is clear that increasing case manager capacity for immediate response, particularly to social contact referrals, in turn encourages officers and community members to make referrals.

- *Dedicated housing resources for active drug users and people with criminal history.* As explained above, LEAD case managers presently are forced to put some individuals who are not yet ready or able to stop using drugs into clean and sober housing in the absence of any alternative. These participants often then lose their housing because they were not an appropriate fit to begin with, despite attempted to comply with housing rules. Also, numerous LEAD participants who are "housing ready" are nonetheless living outdoors in tents because of housing barriers, pre-eminently, criminal history. With support from The Seattle Foundation and King County's Transformation Plan through a Communities of

Opportunity grant, PDA is analyzing strategies to increase housing options for LEAD participants and those similarly situated who are active users and/or have extensive criminal history.

MDT

Currently the potential of the work has been limited due to the limited resources outlined in question five. Scaling for DSA Outreach work in neighborhoods contiguous to the DSAs' program area will need to have adequate funding for staffing, resources, administrative costs and office space. The DSA Outreach work that began on Capitol Hill in January of 2016 has shown some early successes but has been hampered by available resources and an office to screen clients in the Capitol Hill Neighborhood. The limited funding provided enough to staff three qualified outreach workers and that for direct client services but not enough for an office space. An additional factor has been the lack of a staff position to perform community outreach and education around addiction, mental health and homelessness and the role that DSA Outreach can play in this continuum of care. At current clients who are contacted in the Capitol Hill neighborhood are either unwilling or unable to financially afford to travel to the DSA Outreach base in Pioneer Square. Despite some funding being available for transport, the cost of purchasing METRO bus tickets simply does not make it feasible to have tickets available for all who express interest in coming into the offices. The presence of a DSA Outreach transport vehicle would facilitate the process of connecting clients in the Capitol Hill neighborhood with the appropriate case management services following assessment and screening into the program.

The DSA's newly approved Strategic Plan directs the organization to expand with appropriate and tailored services into other center city neighborhoods adjacent to the DSA assessment area. Capitol Hill Community stakeholders and program outcomes guide the DSA Outreach work connecting the street population with services in Q1 of 2016. DSA Outreach work could be scaled to include additional center city neighborhoods. With Capitol Hill as the model, similar governance structures could be established and coordinated with neighborhood business improvement areas and community development organizations. Additional city and neighborhood generated dollars could potentially fund this additional DSA Outreach work.

8. With regard to expansion to Capitol Hill:
A. Recommend strategies for incorporating youth into the LEAD and MDT programs to help prevent youth detention.

LEAD

Until now, LEAD referral has been limited to adults. Strategies for police diversion of youth, however, are an emerging focus with the City's Zero Youth Detention goal and County commitment to reducing both detention and racial disparity in the detained youth population. Officers have long commented that is seems incongruous that, with LEAD, they have diversion options to avoid charging an adult with a felony for drug possession or delivery, but have no similar option for youth.

The King County Prosecutor's innovative 180 diversion program presently takes only misdemeanor drug/alcohol offenses, and not respondents with multiple prior diversions. Recent data show that the PAO filed 50 misdemeanor drug/alcohol charges and 29 felony drug/alcohol charges in 2015; and, of course, many more filed cases with other charges are related to drug involvement. PAO Deputy Chief of Staff Leesa Manion recently confirmed to the City of Seattle Office of Civil Rights lead on youth detention issues that the PAO is open to diverting felonies if there were an appropriate program to which they could be diverted. Thus, there appears to be a significant opportunity to use LEAD to increase youth diversion.

Diversion to LEAD case management and services would require clearing the hurdle of parental/guardian permission, which may or may not be forthcoming. To divert or make social contact referrals of drug-involved youth to LEAD, the Policy Coordinating Group would need to adopt a "to the extent possible" expectation of the degree of involvement a diverted youth would have with case managers. In other words, if and when parents/guardians consented, the referred youth could work with a case manager as would an adult participant. Until and unless parental or guardian permission was forthcoming, however, LEAD program staff would be limited to providing information that does not require parental consent. To assist in making this shift:

- A legal analysis of where that line lies (what information that can be provided without parental consent) from the King County Prosecutor and/or the City Attorney would be valuable; and
- If LEAD were to take youth referrals, REACH would likely need and want to hire specifically to staff those participants with case managers with particular expertise in engaging youth. The LEAD Policy Coordinating Group would engage with the Office of Civil Rights, the King County task force on youth detention issues and the Department of Public Defense for guidance on programming deemed to be most effective for youth diverted to LEAD, before contracting with REACH or other provider(s) to staff youth referrals.

MDT

DSA Outreach and ORION Center/YouthCare regularly work together to connect the youth population with services, however per policy DSA Outreach does not provide case management services for individuals under the age of 18.

8. **With regard to expansion to Capitol Hill:**
   B. Evaluate whether the expansion of the LEAD and MDT programs into Capitol Hill would affect public safety issues in the Little Saigon neighborhood, and if so, how?

<u>LEAD</u>

LEAD's imminent shift into the East Precinct (roll call trainings planned for June and July) has been expanded from the originally announced focus area (Capitol Hill), with support from many who have participated in Capitol Hill Community Council meetings, in an intentional effort to serve racially and ethnically diverse communities, as well as to unite responses to the entire Chinatown-International District. One goal with this expansion and integration of work in the two precincts is that there should be less displacement of individuals or groups engaged in drug-related crime and sex-work from one adjoining neighborhood to another. PDA's Neighborhood Safety Advocate will work with community public safety leaders and organizations in Little Saigon and Capitol Hill to acquaint them with LEAD methods and to serve as a direct channel to streamline referrals, assist in troubleshooting community issues involving public safety and make programmatic changes as necessary to ensure program success.

<u>MDT</u>

DSA Outreach does not have sufficient information to evaluate any impact to the public safety in Little Saigon. While DSA Outreach staff works closely with the East Precinct, there is a need for increased outreach presence in the Little Saigon and a need to identify and better understand the contributing factors to the areas homelessness.

9. **Propose recommendations to revise the LEAD and MDT governance structures to reflect the changing mix of funders.**

<u>MDT</u>

The DSA Outreach work is funded by HSD and the ratepayers of the Metropolitan Improvement District (MID), which the DSA administers. HSD governance provides oversight for public funding directed in the contract for monthly, quarterly and annually reporting. The MID Advisory Board provide funding and program recommendations for private funding oversight. The DSA leadership staff provides direct oversight and management. Much like LEAD, the DSA Outreach work would benefit from greater coordination other agencies and government partners, in addition to an operational framework to guide policy and decision making. To offer context a detailed description of the MDT meetings downtown and on Capitol Hill are as follows:

The MDT meetings serve as a point of connection for individuals and agencies engaged in similar work and facilitates discussions and strategizing toward the goal of addressing community concerns and needs among the homeless population. There is joint ownership of

both the Downtown and Capitol Hill MDT meetings and equal opportunity for all providers to solicit or provide information pertinent to their daily operations.

The Downtown MDT meeting convenes once monthly and are staffed by the following partners: HSD, SUGM, Catholic Community Services, REST, Catholic Community Services-CReW, VA, Parks & Recreation, DESC-HOST, REACH, LEAD, Operation Nightwatch, Harborview Medical Center-Housing First Program, SCIDPDA, Heroes for the Homeless, New Horizons Ministry, ORION/YouthCare and Downtown Public Health. The group does not have a formal governance structure. The meetings are chaired by the DSA Outreach team manager and are designed to be collaborative and interactive. The group has focused on orienting partners as to the competencies of each organization so as to reduce duplication of tasks, increase collaborative work and grow in knowledge of the resources available to a commonly served population. Reports of every meeting are completed by the DSA Outreach manager and submitted to the following parties: DSA VP of Public Area Management, SCIDPDA, HSD, UGM Director of Mental Health Programs, HOST, Director of OOC, Community Support and Assistance.

The Capitol Hill MDT meeting convenes once monthly as well with representatives from the following organizations: SPD-East Precinct, Capitol Hill Chamber of Commerce, Capitol Hill housing Authority, First Covenant Church, Operation Nightwatch, ORION/YouthCare, PSKS, Seattle Fire Department and DSA Outreach. The Capitol Hill MDT meeting is currently monthly and does not currently have a formal governance structure. The meetings are currently chaired by Sierra Hanson, executive director of the Capitol Hill Chamber of Commerce. No formal reports are produced or disseminated as part of this meeting.

<u>LEAD</u>

LEAD has a formal governing structure established by MOU in 2011 (attached) among the Mayor of Seattle, the Seattle City Attorney, the Seattle Police Department, the King County Executive, the King County Sheriff, the King County Prosecutor, the Public Defender Association and the ACLU of Washington. When the program launched, as now, each of these parties was deemed operationally or politically necessary to operate LEAD effectively. In addition, the MOU provided for representation on the governing body -- the LEAD Policy Coordinating Group (PCG) -- for the Seattle City Council and the King County Council. The City Council presently is represented formally by Councilmember Bagshaw. Each PCG member can staff meetings with as many representatives as they feel necessary and appropriate. Recognizing the necessity of all the partners, decision-making by the PCG is by consensus. This ensures that the program goes only so far as all partners are willing and able to go at any given time, in recognition of its innovative quality and the need to move forward together.

LEAD governing partners have agreed to a set of media guidelines and principles of cooperation, foremost among them that no one partner "owns" LEAD and all credit for program achievements and responsibility for any difficulties must be shared. Partners have adhered scrupulously to these principles for the nearly five years of program operation.

The unique inter-jurisdictional nature of LEAD both requires a shared governance structure and is largely responsible for the promising outcomes seen to date. More than 98% of all LEAD referrals to date pertain to criminal activity known to have occurred in the City of Seattle; thus, the primary public safety benefit seen from the program has accrued to the City of Seattle and its residents. Yet most of the fiscal savings the program has seen have accrued to King County, as felony filings and County-responsible jail utilization decreased markedly for the LEAD cohort compared to the control group (though the City may also realize similar savings once a dedicated Assistant City Attorney is assigned to coordinate filings, release motions and dispositions for LEAD participants' filed cases in Seattle Municipal Court, as discussed above). The King County Sheriff's Office has chosen to beta-operate LEAD intensively first with their Metro units working primarily in the City of Seattle. The Public Defender Association and ACLU have contributed over a million dollars in in-kind staffing to the development and operation of LEAD. The interwoven contributions and benefits of City, County and community partners necessitate a collaborative, inter-jurisdictional governing structure.

The Public Defender Association serves as project manager for LEAD, and additionally, provides community engagement and civil legal services to support the program. Other partners have also provided considerable in-kind support and staffing. The MOU governing structure and an arm's length project manager responsible to all the governing partners equally, are both recognized LEAD "essential principles" derived by LEAD operational partners in Seattle/King County and Santa Fe, New Mexico (the second national LEAD site). (See attached "Essential Principles for Successful LEAD Implementation.")

Beginning in 2017, the King County Executive is recommending increased support for LEAD from the MIDD II fund. Because MIDD is a county-wide resource, it is expected that other King County cities may be able to draw on this funding pool, though it is also expected that they, like Seattle, would contribute to the cost of LEAD operations in their cities. At the May 27, 2016 LEAD Policy Coordinating Group meeting, governing partners agreed that additional cities should have one or more franchised Policy Coordinating Group(s), in which County partners would participate but the City of Seattle partners would not, recognizing the need for them to evolve the same shared culture of collaboration that has come to characterize the Seattle-King County LEAD partnership.

<u>Additional Attachments</u>:

1. LEAD Evaluation: Recidivism (April 2015)
2. LEAD Evaluation: Cost & System Utilization (July 2015)
3. LEAD MOU
4. LEAD operational protocol
5. "Essential Principles for Successful LEAD Implementation"