THE REGIONAL STEERING COMMITTEE ON HOMELESSNESS AND HOUSING

for the San Francisco Bay Area

HEALTH AND HOMELESSNESS: BUILDING SERVICE PARTNERSHIPS TO ACHIEVE HOUSING STABILITY

FRIDAY, FEBRUARY 9, 2018
10:00 AM – 2:00 PM

ASSOCIATION OF BAY AREA GOVERNMENTS
YERBA BUENA CONFERENCE ROOM, 1ST FLOOR
375 BEALE ST. #700
SAN FRANCISCO, CA 94105

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1. SPOTLIGHT: BAY AREA SAMHSA GRANTEES
   Learn about SAMHSA grant programs that support behavioral health and homeless services and how local grantees are utilizing these opportunities.

2. MENTAL HEALTH ASSESSMENT TOOLS & COORDINATED ENTRY
   Compare best practices for factoring measures of mental health into housing assessments.

3. WHO CAN CERTIFY A CLIENT'S DISABILITY?
   Learn which healthcare professionals are licensed by the state of California to certify disabilities for purposes of program applicant eligibility documentation.

4. WHOLE PERSON CARE: TARGETING HOMELESSNESS
   Explore how communities are using health care dollars to respond to homelessness.

5. THE OPIOID CRISIS: WHAT COC'S NEED TO KNOW
   Review Bay Area data on the epidemic and discuss strategies for identifying and responding to abuse and addiction.

6. BEYOND HEALTHCARE: INNOVATIVE CROSS-SECTOR PARTNERSHIPS
   Discover new and unlikely allies across multiple fields.

Since 1986, members of the RSC have identified problems that cross county borders and searched for solutions that prevent and end homelessness in all our communities. RSC members collectively participate in policy development, peer support, information sharing, training, strategizing, and planning. For more information, please visit http://bit.ly/2IUUn7f.

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Commonly Used Acronyms

Acronym	Definition
AHAR	Annual Homeless Assessment Report
APR	Annual Performance Report (for HUD homeless programs)
CDBG	Community Development Block Grant (CPD program – federal)
CSBG	Community Services Block Grant
Continuum of Care	Continuum of Care approach to assistance to the homeless
CoC	Federal grant program stressing permanent solutions to homelessness
Con Plan	Consolidated Plan, a locally developed plan for housing assistance and urban development under CDBG and other CPD programs
CPD	Community Planning and Development (HUD Office)
ESG	Emergency Solutions Grant (CPD – federal program)
FMR	Fair Market Rent (maximum rent for Section 8 rental assistance/CoC grants)
HCD	Housing and Community Development (State office)
HEARTH	Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009
HPRP	Homeless Prevention and Rapid Re-Housing
HMIS	Homeless Management Information System
HOME	Home Investment Partnerships (CPD program)
HOPWA	Housing Opportunities for Persons with AIDS (CPD program)
HUD	U.S. Department of Housing and Urban Development (federal)
MHSA	Mental Health Services Act
NOFA	Notice of Funding Availability
PHA	Public Housing Authority
SAMHSA	Substance Abuse & Mental Health Services Administration
SNAPS	Office of Special Needs Assistance Program (HUD office overseeing CoC)
SOAR	SSI/SSDI Outreach, Access, and Recovery (SSI/SSDI Application program)
SRO	Single-Room Occupancy housing units
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TAY	Transition Age Youth (usually ages 16-24)
VA	Veterans Affairs (U.S. Department of)
VASH	Veterans Affairs Supportive Housing

SPOTLIGHT ON SAMHSA GRANTS & BAY AREA GRANTEES

INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA), is an agency housed within the U.S. Department of Health and Human Services. SAMHSA offers grant funding, technical assistance resources, and research that focuses on reducing the impact of substance abuse and mental illness in the U.S. Included in this work are funding opportunities that support communities in partnering health and homeless services. Below is an overview of what these health and homeless grant opportunities are and examples of how communities in the Bay Area and beyond are utilizing this funding.

SAMHSA GRANTS FOR HEALTH AND HOMELESS SERVICES

GRANTS FOR THE BENEFIT OF HOMELESS INDIVIDUALS – SERVICES IN SUPPORTING HOUSING (GBHI-SSH)

Purpose	GBHI-SSH grants strengthen and support community efforts to provide treatment and recovery services for veterans experiencing homelessness and non-veteran individuals and families experiencing chronic homelessness.
Target Population	Veterans experiencing homelessness and non-veteran individuals and families experiencing chronic homelessness.
Eligible Activities	Outreach and engagement; Behavioral health screening & assessment; Direct treatment for substance use disorders; Assistance in accessing permanent housing; Case management and recovery support services; Enrollment in health insurance, Medicaid, SSI/SSDI and other mainstream benefits; Access to recovery support services.
Eligible Applicants	Community-based public or non-profit entities.
Grant Cycle	Grants are awarded for three-year period. Grants were awarded during FY2017, FY2015, and FY2014. Requests for applications are typically posted in February and due in April.
Website	https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/gbhi-program
Bay Area Grantees	**FY2015 Encompass Community Services, Santa Cruz, CA:** Housing for the Homeless (H4H), led by Encompass Community Services (Encompass) in collaboration with Homeless Services Center (HSC) in Santa Cruz County,

	created a county-wide behavioral health model that provided a continuum of services to increase the wellbeing and quality of life for veterans who experience homelessness or chronic homelessness, and other individuals (non-veterans) who experience chronic homelessness. Clients of the project receive treatment and services for substance use, mental health, and/or co-occurring disorders. H4H uses evidence-based practices (EBPs) embedded in an integrated treatment model that employ the four dimensions of recovery. The primary EBPs used are: Integrated Dual Diagnosis Treatment and Housing First. Additional EBPs utilized will be: Motivational Interviewing, Cognitive Behavioral Therapy, Matrix Model, Mindfulness Based Awareness, and Seeking Safety. **FY2015 Santa Clara Valley Health and Hospital System, San Jose, CA:** Santa Clara County of California implemented the Valley Healthcare and Housing for the Homeless (VH3) Project to serve 240 chronically homeless individuals and families, including veterans, who experience substance use disorders, as well as co-occurring mental and substance use disorders. The VH3 project offers placement into permanent housing and substance abuse treatment within a comprehensive system of integrated services that support recovery. The project developed an Enhanced Screening, Brief Intervention, and Referral to Treatment (Enhanced SBIRT) program design that expands and extends the traditional SBIRT approach to respond to the multiple health, behavioral health and other problems experienced by the population of focus.

COOPERATIVE AGREEMENTS TO BENEFIT HOMELESS INDIVIDUALS (CABHI)

Purpose	CABHI grants support states and local communities in helping ensure the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment, and recovery support services.
Target Population	People experiencing homelessness and chronic homelessness along with serious mental illness, serious emotional disturbance, co-occurring mental and substance use disorders.
Eligible Activities	Permanent housing support for program participants; Outreach and engagement; Behavioral health screening and assessment; Direct treatment for substance use disorders, serious mental illness, serious emotional disturbance, or co-occurring disorders; Peer support services and peer support specialists; Case management and recovery support services; Enrollment for health insurance, Medicaid, SSI/SSDI and other mainstream benefits.
Eligible Applicants	Community-based public or non-profit entities and tribal and state organizations.
Grant Cycle	Grants are awarded for three-year period. Grants were awarded during FY2017, FY2016, FY2015, FY2014, FY2013, and FY2011. Requests for applications are typically posted in winter or early spring. Note, certain funding years restricted applicant eligibility; in FY2014 and FY2015 funding was only open to States, in FY2016 and FY2017 funding was open to States and Territories, Local Governments, and Communities, which included non-profits.

Website	https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/cabhi-program
Effective CABHI Grantee	**FY2011 Skid Row Housing Trust in Los Angeles, CA:** Skid Row Housing Trust (SRHT) utilized CABHI funding in its Community Initiative for Integrated Care Services (CIICS). CIICS serves the most vulnerable people experiencing chronic homelessness and identified as having a mental health or substance use disorder. Using evidence based programs and practices, like Housing First and motivational interviewing, CIICS works to house all eligible program participants as quickly as possible. Once housed, participants meet with case managers every week to support their transition to permanent housing and address their current needs. Case managers also supported participants by assessing their mental health and substance use and referring them to needed benefits and services. The program served approximately 20 individuals each year.

PROJECTS FOR ASSISTANCE IN TRANSITION FOR HOMELESSNESS (PATH)

Purpose	PATH is a formula grant program that provides financial assistance to States to support services for people with serious mental illness experiencing homelessness
Target Population	Individuals experiencing homelessness or at-risk of homelessness who have serious mental illness and co-occurring substance use disorders.
Eligible Activities	Outreach services; Screening and diagnostic treatment; Habilitation and rehabilitation; Community mental health services; Alcohol or drug treatment; Staff training; Case management services; Supportive and supervisory services in residential settings; Referrals for primary health services, job training, educational services, and relevant housing services.
Eligible Applicants	Local public or non-profit organizations receive funding from their state or territory.
Grant Cycle	Each year, SAMHSA's Center for Mental Health Services issues a funding opportunity announcements that state contacts complete a non-competitive application process for funding. The federal PATH application process for states and territories is noncompetitive, but local public or nonprofit organizations may compete for grant award funding. All PATH grant recipients, except U.S. territories, are required to contribute one dollar for every three dollars of federal money received.
Website	https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path
PATH Contacts	https://www.samhsa.gov/homelessness-programs-resources/grants-programs-services/path-program/state-provider-contacts

Example of Successful PATH Partnerships	**Transitional Living Program in Butler County, OH:** This program partners with local law enforcement and mental health systems via the Ohio PATH Program. The program's partnerships promote educating and involving the community to expand their reach. This has included PATH staff participating in ride-alongs with law enforcement and regularly going out to homeless camps. Utilizing evidence-based practices, like motivational interview, the PATH team provides behavioral health services, staged interventions, assertive outreach, and comprehensive services. In addition, the program provides trainings to local law enforcement on mental health and how to approach, engage, and refer those experiencing homelessness and displaying signs of mental illness.

TREATMENT FOR INDIVIDUALS EXPERIENCING HOMELESSNESS

Purpose	This new funding opportunity, due March 9, 2018, is meant to support the development and/or expansion of the local implementation of an infrastructure that integrates behavioral health treatment and recovery support services for individuals, youth, and families with a serious mental illness, serious emotional disturbance or co-occurring disorder.
Target Population	Individuals, youth, and families with a serious mental illness, serious emotional disturbance or co-occurring disorder and who are experiencing homelessness.
Eligible Activities	SAMHSA will support three types of activities: (1) integrated behavioral health treatment and other recovery-oriented services; (2) efforts to engage and connect clients to enrollment resources for health insurance, Medicaid, and mainstream benefits (e.g. Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), etc.); and (3) coordination of housing and services that support sustainable permanent housing.
Eligible Applicants	Eligible applicants are domestic public and private nonprofit entities.
Grant Cycle	This is the first year this grant opportunity is being offered. It was posted on January 8, 2018 and is due to SAMHSA on March 9, 2018.
Grant Opportunity	https://www.samhsa.gov/grants/grant-announcements/sm-18-014

OTHER SAMHSA PROGRAMS AND RESOURCES

SSI/SSDI OUTREACH ACCESS, AND RECOVERY (SOAR)

SOAR provides participating case managers with tools, resources and publications to help increase access to SSI/SSDI benefits for people with behavioral health disorders who are experiencing homelessness. Case managers are trained through the SOAR Stepping Stones to Recovery training curriculum. Training can take place either in person or online. Those interested can learn about SOAR in their state and whether a two-day, in-person version of the course is available, or access the free, self-guided SOAR online training curriculum.

SOAR Resources: *https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/soar*

HOMELESSNESS AND HOUSING INFORMATION

SAMHSA offers background information on homelessness and its work that supports finding permanent housing for those experiencing mental health and/or substance use disorders. Included in these resources is information on: poverty and housing, trauma and trauma-informed care, SAMHSA policy and program work, and links to publications and resources on evidence-based practices and national resources.

Homelessness and Housing Information: *https://www.samhsa.gov/homelessness-housing*

SAMHSA'S NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS AND PRACTICES (NREPP)

SAMHSA funding opportunities emphasize the use of evidence-based programs and practices. The NREPP offers a searchable database of resources related to evidence based practices, programs, and evaluation, including:

- **Housing First**: Housing First is a homeless assistance approach that prioritizes finding permanent housing for clients first, as that is the first step in allowing them to pursue other activities to improve their quality of life. It reflects the belief that people need basic necessities like food and a place to live before attending to other needs, like getting a job, budgeting properly, or attending to substance use issues. Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.
- **Motivational Interviewing**: Motivational is a goal-oriented, client-centered counseling method that encourages behavioral change by helping people explore and resolve ambivalent feelings. Motivational interviewing is meant to be non-judgmental, non-confrontational and non-adversarial.
- **Trauma Informed Care:** Trauma informed care and interventions are designed to address the consequence of trauma in an individual and facilitate healing.
- **Assertive Community Treatment (ACT)**: ACT is a service delivery model with the goal of facilitating recovery through community treatment and habilitation. ACT teams bring together individuals experienced with psychiatry, psychology, nursing, social work, rehabilitation, substance-abuse treatment, and employment to work with clients in their home or neighborhoods. The ACT teams work together to address a client's needs rather than referring the client to individual services.

- **Critical Time Intervention**: Is a time-limited intervention that supports vulnerable individuals during periods of transition. CTI is a phased approach that utilizes an individual's community in helping support them during a critical transition in their life, providing continuity of care while gradually passing responsibility on to community supports.

NREPP Resources: https://nrepp.samhsa.gov/

FOR DISCUSSION

- How familiar are you with SAMHSA funding opportunities and resources on behavioral health and homelessness?
- Does your community currently engage with SAMHSA on any behavioral health and homelessness programs?
- Has your organization or another organization in your community applied or considered applying for the GBHI-SSH or CABHI grant?
- Are there any current or upcoming projects in your community that these sources of funds might support?
- Does your community make use of PATH funding?
- Have you found ways to engage PATH in the work of your CoC?
- Have you considered applying for this funding opportunity in your community? Why or why not?
- What infrastructure would you want in place in order to pursue this funding opportunity?
- What outstanding questions do you have about SAMHSA funding opportunities?
- How do you see these SAMHSA resources as help support your work?
- Would you consider applying for SAMHSA funding opportunities in the future? Why or why not?
- What resources or planning might it take for your community to pursue a SAMHSA grant?
- What EBPs are you currently using that align with SAMHSA's expectations for grantees?
- If you are not interested in a SAMHSA grant funding, how might you utilize their resources, particularly related to EBPs?

MENTAL HEALTH AND COORDINATED ENTRY ASSESSMENT TOOLS

OVERVIEW

HUD requires Continuums of Care (CoCs) to establish Coordinated Entry Systems (CES) that use a common process to assess the vulnerability of all households who request help through the housing crisis response system.[1]

Under CES, designated access points use a standardized assessment tool to gather information on people's needs, preferences, and the barriers they face to regaining or maintaining housing. HUD guidance explains that the term "assessment" should not "be confused with assessments often used in clinical settings to determine psychological or physical health."[2] However, because assessment tools are used to prioritize the most vulnerable people for assistance, assessments must be able to detect psychological or physical issues that impact homelessness.

How then can communities ensure that their CES processes properly account for mental health issues, often in the absence of the precision and expertise that comes with a clinical evaluation?

Below is a brief description of some of the assessments mental health and homeless services providers use to identify mental health issues. This document also provides a comparison of these tools and the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)[3] for single adults – a CES assessment tool used by many CoCs.

MENTAL HEALTH ASSESSMENT EXAMPLES

KESSLER10 ADULT MENTAL HEALTH SCREENING TOOL

The Kessler 10 Adult Mental Health Screening Tool (K-10) is a self-administered assessment recognized by the federal Substance Abuse Mental Health Services Administration and California Department of Health Care Services as a validated mental health screening source that adheres to best practices in the mental health services field.[4]

SANTA CLARA COUNTY INITIAL MENTAL HEALTH ASSESSMENT

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[1] See 24 CFR 578.7(a)8 and U.S. Department of Housing and Urban Development (HUD) Notice CPD 17-01.
[2] HUD Notice CPD 17-01, "Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System." January 23, 2017.
[3] Created by OrgCode Consulting, Inc. Available at http://www.orgcode.com/products. The VI-SPDAT asks yes or no questions that generate a score to reflect the household's vulnerability. All information collected on the VI-SPDAT is based on the households self-reporting of their circumstances.
[4] See http://www.dhcs.ca.gov/individuals/Documents/StakeholderAdvisoryCommittee/SAC_Att_C_MH_Screen_Tools.pdf; https://www.integration.samhsa.gov/clinical-practice/screening-tools.

The Santa Clara County Initial Mental Health Assessment is a tool used by mental health providers to assess and diagnose clients based upon their observations and the client's self-reported answers to questions. Rather than asking yes or no questions, it asks for the client's narrative response to open-ended questions. It does not generate a score, but requires that the assessor provide a diagnosis, along with a narrative about their findings and any other conclusions they come to. The assessment also asks about cultural factors that might impact a client's treatment.

SOLANO COUNTY HEALTH AND SOCIAL SERVICES CRISIS INTERVENTION TOOL

The Solano County Health and Human Services Crisis Intervention Tool is used by a range of providers, including case managers,[5] when a client presents in a crisis and they need to assess the severity of the situation. The source of information may be the client or someone else identified in a notes field. This tool provides a brief assessment of emergency mental-health needs, with a focus on imminent safety risks to the client or others. Depending on the yes or no answers, the assessor determines how high the level of risk is to the client, and then based on that risk level the assessment recommends possible interventions, such as hospital admission, developing a safety plan, or referral to outpatient services. Providers cannot release the information gathered in the tool without a singed HIPAA release or other release of information except for in certain emergency situations.

SILICON VALLEY TRIAGE TOOL

The Silicon Valley Triage Tool[6] (SVTT) is a tool for government agencies that uses linked databases and a predictive algorithm to identify individuals or groups who are likely to be high-utilizers of public services and therefore more vulnerable and in need of housing support. The SVTT can be used by CoCs to assess an individual's need for services, or to analyze the needs of a group of people in a database. The SVTT does not rely on client-provided information but pulls data from various health care and justice system databases to gather information about the individual, including their diagnoses, hospital stays, use of emergency services, criminal justice history, mental health treatment, and any public benefits they receive. The SVTT also includes a questionnaire for service providers that asks about a client's criminal justice history, mobility, independent living capacity, medical needs, and need for respite care.

It asks the client to rate how often they have had certain feelings within the last 30 days, as well as how those feelings have impacted daily functioning. The assessment should provide the clinician with a sense of the client's current mental state and whether they need treatment.

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[5] Note that the mental status exam section of the tool is usually performed only by certified clinicians.
[6] Created by Santa Clara County and Destination: Home. See https://destinationhomesv.org/the-silicon-valley-triage-tool.

COMPARISON OF MH TOOLS WITH THE SINGLE ADULT VI-SPDAT

Issue	K-10	VI-SPDAT	Santa Clara County Initial Mental Health Assessment	Solano County H&HS Crisis Intervention Tool	SVTT
General Mental State	Asks about in detail using different phrases and a scale to determine severity of situation.	Not asked.	Asks for narrative on "presenting mental health problem," including symptoms, behaviors, and stressors. Also includes a "mental status exam" that looks at current status.	Not asked.	Not asked.
Emergency/Crisis Mental Health Services Usage	Not asked.	Asks about general emergency health services usage within the last six months.	Asks for narrative on "mental health history," including hospitalizations and prior treatment.	Not asked.	Asks about general emergency health services usage within the last two years.
Mental Health Hospitalizations	Not asked.	Asks about general hospitalizations within the last six months.	Asks for narrative on "mental health history," including hospitalizations and prior treatment.	Not asked.	Asks about general hospitalizations within the last two years.
Outpatient Mental Health Treatment	Not asked.	Not asked.	Asks for narrative on "mental health history," including hospitalizations and prior treatment.	Not asked.	Asks detailed questions about number of outpatient and inpatient mental health treatments received within last two years.
Mental Health Diagnoses	Not asked.	Does not ask for specific diagnoses. Asks if you have "mental health or brain issues that would make it hard for you to live independently	Asks for narrative on "presenting mental health problem," including symptoms, behaviors, and stressors. Purpose of	Not asked.	Asks for specific mental health diagnoses.

		because you'd need help."	assessment is to diagnose.		
Threat to Self or Others	Not asked.	Asks "have you threatened to or tried to harm yourself or anyone else in the last year."	Asks whether client has "homicidal/ assaultive" or "suicidal/ self-harm" risk factors.	Asks detailed questions about current and past suicidality. Asks detailed questions about intent and plans to hurt others, as well as past violence.	Asks if the client has "serious suicidal or assaultive risk."
Disability Benefits and Insurance	Not asked.	Asks "do you get any money from the government." Asks what type of insurance the household has.	Has field for insurance number.	Not asked.	Asks whether receiving public benefits within last year.
General Functioning	Asks how often have you been "totally unable" to work or "carry out your normal activities" due to feelings within the past 30 days.	Asks "are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?"	Asks whether client's ability to carry out daily activities is impaired.	Not asked.	Asks whether the client has a "mental impairment that substantially limits one or more of the major life activities."
Mental Health - Related Housing Stability	Not asked.	Asks if you have had trouble maintaining housing due to a "mental health issue or concern."	Asks about living arrangement and whether impacted or likely to be as result of mental health.	Asks if homeless.	Not asked.
Mental Health Medication	Not asked.	Asks generally about whether you are prescribed medication in general that you are not taking or not taking the way prescribed.	Asks for medication prescriptions, dosage, side effects, and whether there are any "compliance/ adherence issues."	Asks if there has been a change in psychotropic prescriptions.	Not asked.
Client Strengths	Not asked.	Not asked.	Asks for narrative on factors such as resiliency, insight, and	Asks about "protective factors" such as goals, family responsibilities,	Not asked.

			skills.	social supports, coping skills, and insight.	
General Psychosocial History	Not asked.	Not asked.	Asks for narrative on client's development, family history, social relationships, and support.	Asks whether client has history of physical, sexual, or other trauma.	Not asked.
Medical Provider Information	Not asked.	Not asked.	Asks for provider information.	Not asked.	Not asked.

FOR DISCUSSION

- What sort of coordinated entry assessment does your community use?
- How does this assessment identify mental health issues?
- Does your community's assessment adequately account for mental health issues when prioritizing households for services?
- Which mental health assessments are being used in your community?
- What can we learn from looking at these other assessments?
- Is there anything you plan to consider changing about your assessment as a result of this discussion?
- How can communities share information and assessments from mental health providers while protecting client privacy?
    - How would releases of information need to be changed?
    - How would this information be stored? In HMIS?
    - How can communities ensure that clients understand how and where their information is being shared?
- How can communities share information and assessments from mental health providers while honoring client choice and self-determination?
- What would it look like to use your coordinated entry assessment to identify and refer clients in need of a clinical mental health assessment to your behavioral health system?

WHO CAN CERTIFY A CLIENT'S DISABILITY?

BACKGROUND

In order to certify someone as Chronically Homeless, agencies must be able to prove to the Department of Housing and Urban Development (HUD) that the Head of Household has a disabling condition. A disabling condition is defined by HUD as a "diagnosable substance abuse disorder, serious mental illness or disability, including the co-occurrence of two or more of these conditions." For many cases, evidence of the disabling condition must include third-party documentation of the disability, such as a signed declaration from a qualified healthcare professional. However, it is not always clear ***who*** counts as a suitable professional.

24 C.F.R. § 578.103(a)(4)(i)(B)(1) states that acceptable evidence includes "written verification of the disability from a professional licensed by the state to diagnose and treat the disability." HUD later clarified this to state that professionals "must be licensed to treat whatever disability it is that they are confirming."[1]

To determine who in California is licensed to diagnose and treat disabilities, HomeBase reviewed state law and analyzed current CoC practices to reach a general consensus of what professions fall into this category. Based on this research, the professions addressed below are considered eligible to diagnose disabilities under the HUD definition.[2]

DOCTORS AND PSYCHOLOGISTS

All medical doctors, osteopaths, psychologists, psychotherapists, and psychiatrists are qualified to diagnose and treat disabilities, so all of these professions are allowed to sign off on a disability verification form.

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Physician Assistants are qualified to certify and treat disabilities, under the supervision and collaboration with a physician or surgeon consistent with the act. State law does not state that they can "diagnose" a disability but it does allow them to "certify" for purposes of state disability, and it does allow them to treat

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[1] Defining Chronically Homeless Final Rule, Combined Q&A Transcript. Regions 1 and 2. January 13, 2015. Webinar: Page 13.

[2] A cautionary note: Because this is an area of state law, rather than federal regulation, there are some discrepancies in how HUD staff members interpret the state's licensing requirements. Areas in which HUD has raised questions are highlighted.

with consultation by a physician/surgeon or pursuant to a delegation of authority by a physician or surgeon.

Nurse Practitioners are also qualified to certify and treat disabilities. Under state law they have the same requirements as Physician Assistants in that their diagnosis requires collaboration and examination by a physician. However, please note that a HUD field officer once told Santa Clara County CoC that Nurse Practitioners are not considered a licensed professional suitable to certify a disability.

There is no evidence to suggest that Registered Nurses are allowed to certify or diagnose disabilities. Although they "assess patient condition" and "supervise patient care," state regulations do not use the words "diagnose" or "treat" when describing what duties registered nurses may perform. Further, it is not the current practice in CoC communities to employ Registered Nurses in the performance of these duties.

SOCIAL WORKERS

California state law does not explicitly state that Licensed Clinical Social Workers (LCSWs), Licensed Professional Clinical Counselors (LPCCs), Licensed Marriage and Family Therapists (LMFTs) and Licensed Educational Psychologists (LEPs) may diagnose and treat disabilities rooted in mental or behavioral health conditions. HUD guidance, however, as well as practices and policies in other states, including Washington State, state that certification by such professionals is acceptable so long as the disability they are certifying is related to those conditions they are licensed to treat and diagnose. This is the current practice in many CoCs, including San Francisco and Santa Clara County.

Please note, however, that in 2017 HUD notified the Santa Clara CoC in an agency monitoring that LMFTs are not authorized to perform diagnosis of disabilities.[3] This finding is still being researched at the CoC level.

Further, ordinary social workers who do not have a clinical license, even if they have a master's degree and/or many years of experience, are not authorized to certify disability for HUD purposes. Although case managers and residential counselors may need to assess a client's disabilities in order to do their jobs, California has not written any regulations that would give these social workers the legal power to diagnose or treat a disability, and so non-clinical social workers should not be used to sign disability verification forms.

ALCOHOL AND DRUG COUNSELORS

California law recognizes a category of Addiction Counselor called the "alcohol or other drug counselor." These counselors are typically required to complete over a hundred hours of addiction-specific education, plus over a thousand hours of supervised clinical experience, and then pass a formal licensing exam.

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[3] Language from monitoring report: *"The State of California Business and Professions Code does not define LMFTs as being authorized to perform diagnosis of disabilities. Additionally, the State of California Employment Development Department does not allow LMFTs to certify claims for disability insurance or Paid Family Leave".*

The only three organizations authorized to offer this exam in California are:

1. Addiction Counselor Certification Board of California, affiliated with the California Association for Alcohol/Drug Educators (CAADE)
2. California Association of DUI Treatment Programs (CADTP)
3. California Consortium of Addiction Programs and Professionals (CCAPP)

Drug and alcohol counselors who have a properly accredited certificate from one of these three organizations may sign a disability verification form for HUD as long as the conditions they are licensed to treat and diagnose is related to the disability.

SUMMARY

Can Certify a Disability	
Medical Doctor	Cal. Labor Code Section 139.2
Osteopathic Doctor	Cal. Labor Code Section 139.2
Psychiatrist	Cal. Labor Code Section 139.2
Psychologist	Section 2903 of the Business and Professions Code
Nurse Practitioner	Section 2835.7 of the Business and Professions Code; CA Dept. Consumer Affairs Board of Registered Nursing
Physician Assistant	Section 3502.3 of the Business and Professions Code; SB 1083
Licensed Clinical Social Worker (LCSW)	Cal. Business and Professions Code Section 4996.9
Licensed Professional Clinical Counselor (LPCC)	Cal. Business and Professions Code Section 4999.2
Licensed Marriage and Family Therapist (LMFT)	Cal. Business and Professions Code Section 4980.2
Licensed Educational Psychologist (LEP)	Cal. Business and Professions Code Section 4989.14
Addiction counselors with certificates from CAADE, CADTP, or CCAPP	CCR Chapter 8, Div. 4, title 9, subchapter 2, section 13015

FOR DISCUSSION

1. Which person in your agency or CoC currently certifies that the head of household has a disability?
2. Has your organization ever received guidance from HUD on this issue?
3. For healthcare organizations, has someone from a CoC or homeless agency reached out to you to diagnose a disability?
4. Does the practice of certifying disabilities occur at each agency, or for those with a robust Coordinated Entry system is that role being centralized?

WHOLE PERSON CARE: TARGETING HOMELESSNESS

OVERVIEW ON WHOLE PERSON CARE PILOTS

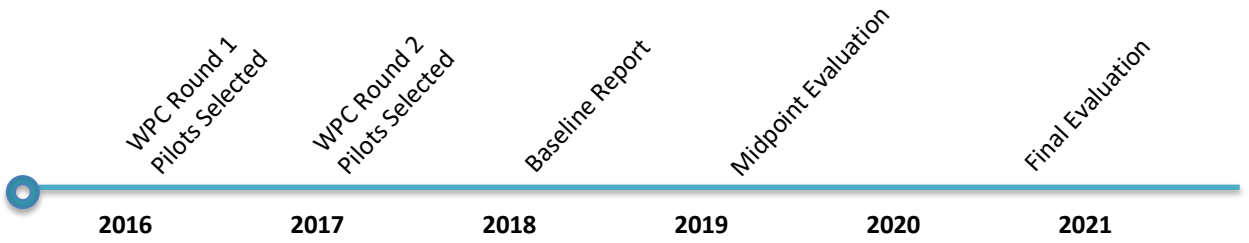
BACKGROUND

Whole Person Care (WPC) is based on the understanding that the most effective way to help a person with complex needs is to address the whole person – physical health, behavioral health, social service needs – with a coordinated approach. Coordination of care alleviates the burden on individuals who otherwise must navigate multiple systems and enhances efficiency in providing care, thereby making of the most of scarce community resources.

Launched in 2016 as part of the Medi-Cal 2020 waiver, the 5-year WPC pilot provides $1.5 billion in federal match funding to help communities break down silos that prevent systems of care from working together. WPC supports collaborations among service providers aimed at improving health outcomes for high-need individuals who use multiple systems of care. Many of the individuals who could benefit most from a "whole person care" approach are those individuals at risk of, or who have experienced, homelessness.

Purpose	WPC pilots are intended to test locally-based initiatives to coordinate physical health, behavioral health, and social services.
Target Population	High-risk, high-utilizing Medi-Cal beneficiaries touching multiple systems who continue to have poor health outcomes, including individuals: • With multiple incidents of avoidable emergency use, hospital admission, or nursing facility placement • With two or more chronic conditions • With mental health and/or substance use disorders • Who are currently experiencing homelessness • Who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions such as hospitals, sub-acute care facilities, skilled nursing facilities, rehabilitation facilities, institutions for mental disease, county jails, or state prisons
Activities	Through collaborative leadership and systematic coordination among public and private entities, WPC pilots identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress.
Funding Amount	Up to $1.5 billion in federal funds is available over five years to match local public funds for WPC pilots.
Eligible Applicants	Counties, cities/counties, health hospital authorities, public hospitals, federally recognized tribes/tribal health program, consortiums

TIMELINE



FAQ ON WHOLE PERSON CARE AND HOMELESSNESS

Under the Affordable Care Act, California is one of 32 states and the District of Columbia that expanded Medicaid (Medi-Cal) to cover adults without children. This means that nearly all adult individuals experiencing homelessness or living in supportive housing in California are eligible for Medi-Cal coverage. In addition to providing basic health care benefits, Medi-Cal can play an important role in addressing homelessness by funding mental health and substance abuse treatment, case management, and implementation of Coordinated Entry.

How can WPC pilots support housing needs?

- **Who can be targeted:** WPC pilots may target individuals who are experiencing, or are at risk of, homelessness who have a demonstrated a medical need for housing or supportive services.
- **Participating entities** could include local housing authorities, local Continuum of Care (CoC) programs, and community-based organizations serving homeless individuals.
- **Housing services** that may be offered may include individual housing transition services, individual housing and tenancy sustaining services, and other transition services.
- **Services may also include** outreach to people experiencing homelessness where they live to form trusting relationships with service providers.
- **Federal funding may be used for** housing-related collaborative activities between public agencies and the private sector that assist WPC entities in identifying and securing housing for the target population.
- **Federal Medicaid funds may not be used to** cover the cost of room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. However, state or local government and community entity contributions are separate from federal matching funds, and may be allocated to fund support for long-term housing, including rental housing subsidies.
- **Flexible Housing Pool:** WPC pilots may utilize a county-wide Flexible Housing Pool to structure funding to pay for housing services and supports.

To what extent can a WPC pilot be used to fund the implementation of Coordinated Entry for Local Continuums of Care (CoC), including Homeless Management Information Systems (HMIS)?

- **Pilot entities may apply for WPC funds to coordinate existing resources available to provide housing and services to people in the WPC pilot target population experiencing homelessness, and to enhance data sharing between partner agencies.**
- Additionally, housing-related activities available through WPC pilots **may include assessing the housing needs of the target population**. These services and activities may be included in WPC pilots to the extent they do not duplicate services and activities for which federal funding is available through other sources.

- To the extent that WPC funds are not duplicating any federal funding for the creation, strengthening, or implementation of coordinated entry and assessment or data matching systems, pilot entities **may use WPC funds to fund many of the specific activities of a coordinated assessment and entry system** in support of the WPC pilot target population. In addition, WPC pilot activities may include matching HMIS with health plan data to identify a health plan's homeless members to coordinate housing, CoC, and health partners and partner resources, and to assess the housing needs of the target population.
- If proposals are put forward to leverage dollars on building coordinated entry infrastructures, the coordinated entry systems must have one consolidated assessment tool that measures housing and health care, behavioral health and LTSS needs across the entities included in the pilot.
- In addition, the coordinated entry must weigh the member's vulnerability, ensuring members with the highest utilization, who obtain high-cost services from multiple systems with the highest care needs, are having their services coordinated and accessing available housing first.

Source: California Department of Health Care Services, http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

EVALUATION

Each WPC pilot community will undergo a mid-point and a final evaluation conducted by an independent entity in order to understand how communities have used WPC interventions to increase care coordination among providers, enhance data and information sharing, improve health outcomes for individual beneficiaries, reduce overuse of emergency room and other health services, extend access to social services, and increase housing stability.

WHOLE PERSON CARE AWARDS IN THE BAY AREA

A number of communities in the Bay Area have been selected as Whole Person Care (WPC) pilot sites following a competitive application process. Lead entities of WPC pilots are counties, health authorities, public hospitals, or consortiums. Participating entities include physical and mental health agencies, human services providers, public health departments, justice systems, housing authorities, and community care providers.

WPC pilots are tailored to meet the unique needs of their communities. The following community spotlights derive from select Bay Area WPC applications and other publicly available materials.

ALAMEDA

Lead Entity	Alameda County Health Care Services Agency
Participating Entities	Alliance for Health, Health Care Services Agency, Behavioral Health Care Services, Community Development Agency, Housing Authority, East Oakland Community Project, Community Health Center Network, Alameda Health System, Anthem Blue Cross, Kaiser Permanente, Sutter Health Alta Bates Summit Medical Center, Adobe Services, Consumer/Community Advisory Board, City of Berkeley, City of Fremont, City of Oakland, EveryOne Home, Alameda County Information Technology Department, Satellite Affordable Housing Associates, Social Services Agency
Number of Beneficiaries	20,000
Total 5-Year Budget	$283.4 million
Target Population	Individuals experiencing homelessness; individuals who are high users of multiple systems of care; individuals who have complex conditions requiring care coordination across multiple systems.

Activities to Address Homelessness	Enhanced housing transition to help individuals secure supportive housing, residency retention services for patients in permanent supportive housing, housing navigation for residents of skilled nursing facilities, expanded street outreach, quality improvement for community living facilities, tenant legal assistance, client move-in fund, landlord recruitment fund, care coordination system.

CONTRA COSTA

Lead Entity	Contra Costa Health Services
Participating Entities	Contra Costa Health Plan, Regional Medical Center and Health Centers, Public Health, Emergency Medical Services, Behavioral Health, Contra Costa County Housing Authority, La Clinica De La Raza, LifeLong Medical Care, Kaiser Permanente, Health Leads, NAMI, Re-Entry Success Center, Bay Area Legal Aid
Number of Beneficiaries	52,500
Total 5-Year Budget	$203.9 million
Target Population	Individuals who are primarily and repeatedly accessing health care services in high-acuity settings due to the complexity of their unmet medical, behavioral health and social needs. These are patients who are facing extreme social and economic issues such as lack of housing/housing instability, unemployment, food insecurity, transportation and dominant language competency, and lack of other social support systems.
Activities to Address Homelessness	Integrated and coordinated data system, enhanced and coordinated case management, sobering center, housing navigation and support services.

MARIN

Lead Entity	County of Marin Department of Health and Human Services
Participating Entities	Partnership HealthPlan of California, Marin HHS, Behavioral Health and Recovery Services, County of Marin Probation, Marin Housing Authority, Healthy Marin Partnership, Ritter Center, Marin City Health and Wellness Center, Marin Community Clinics, Coastal Health Alliance, Community Action Marin, St. Vincent de Paul Society, Homeward Bound, Marin Center for Independent Living, Downtown Streets Team, Marin Community Foundation
Number of Beneficiaries	3,516
Total 5-Year Budget	$20 million
Target Population	Individuals who experience homelessness or are precariously housed; individuals who experience complex medical conditions, behavioral health issues; and/or individuals who lack social supports that interfere with standards of care and result in high utilization and costs.
Activities to Address Homelessness	Information and referral, screenings and assessments, housing-based case management.

NAPA

Lead Entity	Napa County
Participating Entities	Partnership Health, Health and Human Services Agency, City of Napa Housing Authority, Ole Health, Catholic Charities, Napa Police Department, Napa Fire Department, Alcohol and Drug Services, Napa County Probation
Number of Beneficiaries	800
Total 5-Year Budget	$22.9 million
Target Population	Individuals who are homeless or at risk of homelessness who are identified as high systems users and have a physical disability, serious mental illness or substance use disorder, or co-occurring disorders.
Activities to Address Homelessness	Engagement partnering peer outreach with medical assistance, Coordinated Entry and housing navigation, tenancy care coordination.

SAN FRANCISCO

Lead Entity	SF Department of Public Health
Participating Entities	SF Health Plan, Anthem Blue Cross Partnership Plan, SF Health Network, Behavioral Health Services, Department of Homelessness and Supportive Housing, Human Services Agency, SF Department of Aging and Adult Services, Institute on Aging, HealthRIGHT 360, Baker Places
Number of Beneficiaries	16,954
Total 5-Year Budget	$161.7 million
Target Population	Adults experiencing homelessness who rely on public healthcare services provided by SF Department of Public Health
Activities to Address Homelessness	Establish data sharing platform, develop and implement universal assessment tool to evaluate needs of individuals, strengthen care coordination through assessment and prioritization of individuals with greatest needs, provide foundation for citywide navigation system to align shelter and housing resources and match people in need with right housing interventions.

SAN MATEO

Lead Entity	San Mateo County Health System
Participating Entities	Health Plan of San Mateo, Behavioral Health and Recovery Services, Human Services Agency, Institute on Aging, Brilliant Corners, Correctional Health Services, Housing Department and Housing Authority, Public Health, Policy and Planning, StarVista, Horizon Services, HealthRIGHT 360, LifeMoves, Stanford University Medical Center and Clinics, Voices of Recovery, Heart and Soul
Number of Beneficiaries	5,000
Total 5-Year Budget	$165.3 million
Target Population	Individuals who are high users of systems of care with mental illness and/or medical conditions who present frequently to emergency departments, psychiatric emergency services; individuals whose substance use disorders interferes with their ability to manage medical

	and behavioral conditions and care; individuals who are either experiencing homelessness on the streets or recently discharged from jail.
Activities to Address Homelessness	Integrated medication-assisted treatment, community care settings pilot, collaborative care, homeless outreach team (HOT), bridges to wellness.

SANTA CLARA

Lead Entity	Santa Clara Valley Health and Hospital System
Participating Entities	Santa Clara Family Health Plan, Santa Clara Valley Medical Center, Santa Clara Valley Behavioral Health Services Department, Housing Authority, Community Health Partnership, Hospital Council, Anthem Blue Cross, Public Health Department, Office of Reentry Services, Social Services Agency, Office of Supportive Housing, Probation Department, Custody Health Services, Valley Health Plan, Behavioral Health Contractors Association, El Camino Regional Hospital
Number of Beneficiaries	10,000
Total 5-Year Budget	$250.1 million
Target Population	Individuals who are high users of two or more systems of care, a significant percentage of whom have co-occurring medical and behavioral health conditions, and are likely to experience health disparities due to social determinants and psychosocial stressors such as poverty, homelessness, few social supports, and cultural group membership.
Activities to Address Homelessness	Peer respite, incentivizing providers for additional integrated medical-psychiatric skilled nursing facility beds, assess service needs and assign selected participants to a case management program to coordinate care, development of secure data exchange to provide real time information to service coordinators and healthcare providers and to inform continuous program and outcome improvement.

SOLANO

Lead Entity	Solano County Health & Social Services
Participating Entities	Partnership Health Plan, Public Heath, Behavioral Health, Medical Services, Substance Abuse Services, Coalition for Better Health, NorthBay Medical Center, NorthBay VacaValley Hospital, Kaiser Permanente, Vallejo Medical Center and Vacaville Medical Center, Bay Area Community Services, Fairfield Housing Authority
Number of Beneficiaries	250
Total 5-Year Budget	$4.6 million
Target Population	Residents with the highest medical utilization, repeated incidents of avoidable emergency department use, and two or more chronic and serious health conditions, at least one of which are mental health and/or substance use disorders. Many of these individuals are likely experiencing homelessness or at high risk of homelessness.
Activities to Address Homelessness	Engagement and assertive outreach with point of engagement at emergency departments, inpatient medical hospital units, outpatient clinics, SUD/MH programs, home, and field locations. Data sharing to facilitate coordinated care.

SONOMA

Lead Entity	Sonoma County Department of Health Services, Behavioral Health Division
Participating Entities	Not publicly available
Number of Beneficiaries	3,040
Total 5-Year Budget	$16.7 million
Target Population	Individuals experiencing, or at risk of, homelessness with serious mental illness who also have co-occurring health conditions, such as substance abuse, who use emergency services at a high rate, and who receive services from multiple agencies. Pilot will have special focus on elderly individuals, who often face long waits for services and create a significant cost burden on the healthcare system.
Activities to Address Homelessness	Expand and enhance services in rural and geographically isolated areas, including outreach to underserved populations to engage in mental health treatment, and expanding community health center partner outreach and case management capacity.

FOR DISCUSSION

- Has your Continuum of Care (CoC) drawn on WPC funds to address homelessness in your community? If so, in what specific ways? If not, why not?
- Is your community's WPC lead entity an active participant in your CoC?
- For CoCs that been successful in drawing on WPC funds to address homelessness, how do you attribute your success? Is it because the CoC had existing relationships with departments of health?
- How have communities used WPC funds to enhance Coordinated Entry?

GUIDEBOOK FOR HOMELESS SERVICE PROVIDERS: IDENTIFYING AND RESPONDING TO OPIOID ABUSE, ADDICTION, AND OVERDOSE

INTRODUCTION

In October 2017, the opioid crisis was declared a United States public health emergency. Years of rising prescription opioid use and misuse, followed by a surge in the use of illicit opioids, have resulted in a spike in overdoses and deaths, particularly among those most vulnerable: persons experiencing homelessness.

Substance abuse is often identified as one of the top causes of homelessness or an individual's primary reason for homelessness.[i] To compound the problem, opioid use disorders are particularly hard on homeless populations, where prevalence of mental health conditions and substance misuse is high and access to health care is often limited:

- A 2013 Boston study showed that overdose has surpassed HIV as the leading cause of death among homeless adults and found that opioids are responsible for more than 80% of these deaths. Homeless adults, 25-44, were nine times more likely to die from an overdose than their counterparts who were stably housed.[ii]

- A 2015 study of veterans initiating medication-administered treatment (MAT) found that the prevalence of homelessness among veterans with an opioid use disorder is approximately 10 times that of the general veteran population accessing care at VA.[iii]

To aid you in developing a strategy to address the opioid crisis on the individual and community levels, this document includes information regarding:

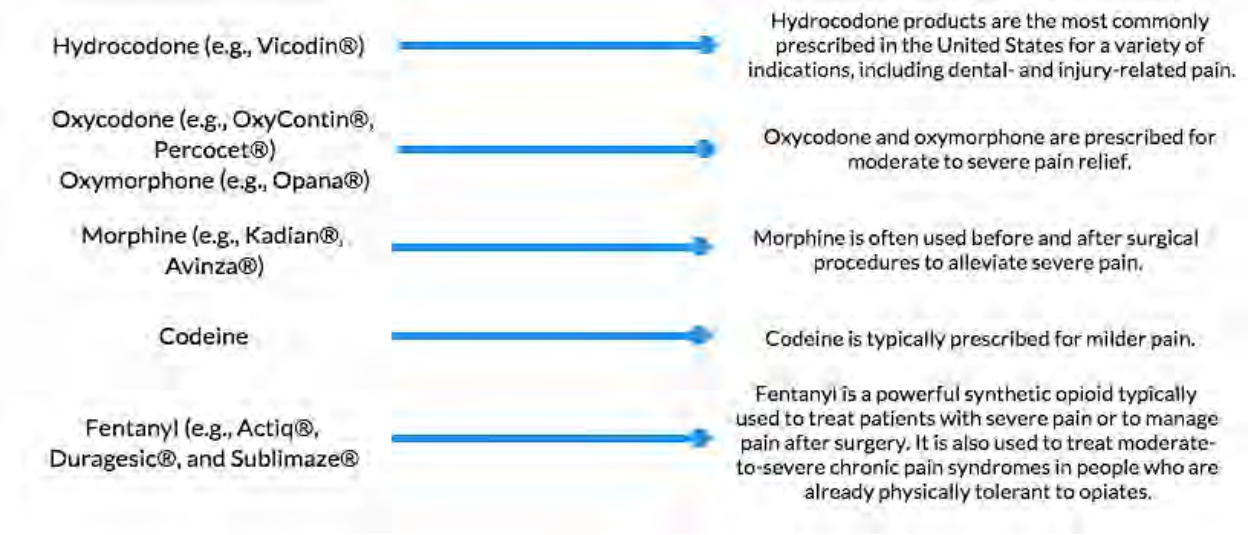
- Types of opioids
- The history of the crisis
- Risk factors for opioid abuse and addiction
- Co-occurring disorders with opioid addiction
- Signs, symptoms, and effects of opioid abuse and addiction
- Strategies for recognizing and responding to an opioid overdose
- Recommendations for addressing the intersection of homelessness and the opioid crisis

WHAT ARE OPIOIDS?[iv]

Opioids are a broad group of pain-relieving drugs that work by interacting with opioid receptors in cells. When used as directed and prescribed by a doctor, opioid medications safely help control acute pain.

In addition to relieving pain, opioids also activate reward regions in the brain causing the euphoria—or high—that underlies the potential for misuse and addiction.

PRESCRIPTION OPIOID MEDICATIONS[v]



ILLICIT OPIOIDS

HEROIN[vi]

Heroin is an illegal, highly addictive opioid drug made from morphine. People may inject, sniff, snort, or smoke heroin. Heroin enters the brain rapidly and binds to opioid receptors on cells located in many areas, especially those involved in feelings of pain and pleasure and in controlling heart rate, sleeping, and breathing.

Research suggests that misuse of prescription opioid pain medicine is a risk factor for starting heroin use.

THE RISE OF THE CRISIS[vii,viii]

Several factors are likely to have contributed to the severity of the current prescription opioid abuse problem. Since the early 1990s, there has been a drastic increase in the number of prescriptions written and dispensed for pharmaceutical grade opioids to manage pain, greater social acceptability for using medications for pain management, and increased marketing by pharmaceutical companies of opioids for prescription use.

Prescription opioid pain medications like hydrocodone, oxycodone, and morphine can elicit similar effects to heroin when taken incorrectly and at higher doses than prescribed. Growing evidence suggests that abusers of prescription opioids are shifting to heroin as prescription drugs become less available or

harder to abuse, and heroin may be cheaper and, in some communities, easier to obtain than prescription opioids.

These factors together have been linked to dramatic rises over the past 25 years in opioid use, misuse, addiction, overdoses and deaths in the United States:

- As of 2012, an estimated 2.1 million people in the United States are suffering from substance use disorders related to prescription opioid pain relievers and an estimated 467,000 individuals are addicted to heroin.[ix]
- There were 259 million opioid prescriptions written in U.S. in 2012 alone, enough for every adult to have a bottle of pills.[x]
- More people died from drug overdoses in 2014 than in any year on record, and the majority of drug overdose deaths (more than six out of ten) involved an opioid.[xi]
- Since 1999, the rate of overdose deaths involving opioids—including prescription opioid pain relievers and heroin—has nearly quadrupled, and over 165,000 people have died from prescription opioid overdoses.[xii]
- Heroin-related deaths more than tripled between 2010 and 2015, with 12,989 heroin deaths in 2015.[xiii]
- The U.S. Department of Health and Human Services (HHS) reports that on an average day in the United States[xiv]:
    - More than 650,000 opioid prescriptions are dispensed;
    - 3,900 people initiate nonmedical use of prescription opioids;
    - 580 people initiate heroin use; and
    - 78 people die from an opioid-related overdose.
- It is estimated that 23% of individuals who use heroin develop opioid addiction.[xv]
- The CDC estimates that 91 Americans die every day from an opioid overdose.[xvi]

RISK FACTORS FOR OPIOID ABUSE AND ADDICTION

Research shows that some risk factors make people particularly vulnerable to opioid abuse and overdose, including:

FOR PRESCRIPTION OPIOID MEDICATIONS[xvii]

- Obtaining overlapping prescriptions from multiple providers and pharmacies.
- Taking high daily dosages of prescription pain relievers.
- Having mental illness or a history of alcohol or other substance abuse.
- Living in rural areas and having low income.

Medicaid Patients

- Inappropriate prescribing practices and opioid prescribing rates are substantially higher among Medicaid patients than among privately insured patients.
- In one study based on 2010 data, 40% of Medicaid enrollees with prescriptions for pain relievers had at least one indicator of potentially inappropriate use or prescribing:[1]
    - overlapping prescriptions for pain relievers,
    - overlapping pain reliever and benzodiazepine prescriptions,
    - long-acting or extended release prescription pain relievers for acute pain, and
    - high daily doses.

FOR HEROIN[xviii]

- Addiction to prescription opioid pain relievers.
- Addiction to cocaine.
- Lack of insurance or enrollment in Medicaid.
- Addiction to marijuana and alcohol.
- Living in a large metropolitan area.

Populations Most at Risk for Heroin Addiction

Non-Hispanic whites
Males
18-25 year olds

CO-OCCURRING DISORDERS WITH OPIOID ADDICTION[xix]

There are a number of disorders that co-occur with opioid addiction. The most commonly co-occurring disorder with any substance abuse disorder is another substance abuse disorder. Disorders that are co-morbid to opioid addiction include:

- Tobacco use
- Alcohol abuse
- Cannabis abuse
- Stimulant abuse
- Benzodiazepine abuse
- Depression
- Dysthymia
- Anxiety
- Insomnia
- Antisocial Personality Disorder
- Post-traumatic Stress Disorder
- History of conduct disorder in childhood or adolescence

Signs, Symptoms & Effects of Opioid Abuse and Addiction[vii]

Mood/Psychological Symptoms

- Increased general anxiety
- Anxiety attacks
- Euphoria
- Psychosis
- Improved self-esteem
- Depression
- Irritability
- Lowered motivation

Behavioral Symptoms

- Opioids are used for longer or at a greater amount than intended
- Unsuccessful attempts to decrease the amount taken
- Large amount of time spent obtaining, using, or recovering from the drug
- Abandonment of important activities

Physical Symptoms

- Improved alertness
- Increased sensitivity to sensory stimuli
- Constricted blood vessels
- Increased heart rate
- High blood pressure
- Increased energy
- Decreased appetite
- Increased sexual arousal
- Physical agitation
- Difficulty sleeping
- Over arousal and hyper-vigilance

Side Effects of Opioid Abuse

Side effects of opioid abuse to be aware of include:

- Fatigue
- Constipation
- Noticeable sense of elation/euphoria
- Breathlessness
- Bronchospasm
- Physical and psychological dependence
- Nausea
- Confusion
- Depressed respiration and difficulty breathing
- Chest pain

Signs and Effects of Opioid Withdrawal

Signs and symptoms that an individual is going through withdrawal from opioid use include:

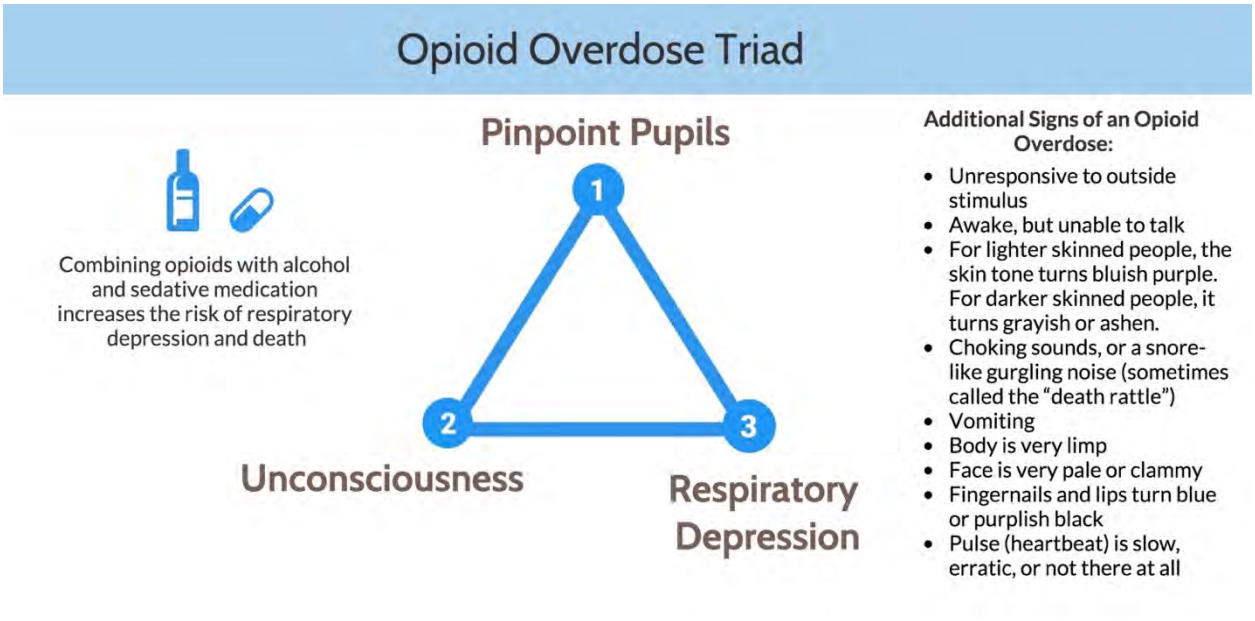
Note: Withdrawal symptoms can mimic flu symptoms and include:

- Nausea
- Stomach pain
- Cold sweat
- Chills
- Vomiting
- Diarrhea

- Physical and psychological cravings
- Agitation
- Anxiety
- Muscle tension
- Shaking or quivering
- Trouble sleeping
- Enlarged pupils
- Pain in the bones

RECOGNIZING AND RESPONDING TO AN OPIOID OVERDOSE

An opioid overdose can be identified by a combination of three signs and symptoms referred to as the **"opioid overdose triad"**[xxi]**:**



THE CORE COMPONENTS OF RESPONDING TO AN OPIOID OVERDOSE[xxii]

FROM THE HARM REDUCTION COALITION[1]

ASSESSMENT AND STIMULATION	

Assess the signs:
• Is the person breathing?
• Is the person responsive?
• Do they answer when you 'shake and shout' their name?
• Can the person speak?
• How is their skin color (especially lips and fingertips)?
	Stimulation:
	• If the person is unconscious or in a heavy nod, try to wake them up: Call the person's name and/or say something that they might not want to hear, like "I'm going to call 911" or "I'm going to give you naloxone."
	• If this does not work, try to stimulate the person with pain by rubbing your knuckles into the sternum (the place in the middle of your chest where your ribs meet). If the person is in a position where you cannot get to their sternum easily, or if they are wearing multiple layers of heavy clothing, rub the upper lip area.
	• If this causes the person to wake up try to get them to focus.
	  ○ Can they speak to you?
	  ○ Check their breathing. If this is shallow or the person tells you have he or she has shortness of breath, or chest tightness call 911.

[1] **DISCLAIMER:** The information here is not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. All content, including text, graphics, and information, contained in this document is for general information purposes only. You are encouraged to confirm any information obtained from this document with other sources and review all information regarding any medical condition or treatment with your physician. Never disregard professional medical advice or delay seeking medical treatment because of something you have read in this document.

	○ Continue to monitor them, especially the breathing and pulse and try to keep him or her awake and alert. • If the person does not respond to stimulation and remains unconscious or the condition appears to get worse, **do NOT try a different or alternative form of stimulation. Treat this as an emergency and call for help.**

CALL FOR HELP

It is important to call 9-1-1 in the case of an overdose to have trained medical professionals assess the condition of the overdosing person.

RECOVERY POSITION

If you must leave the person experiencing an overdose to call 9-1-1, make sure you put them in the **Recovery Position**: laying the person slightly on their side, their body supported by a bent knee, with their face turned to the side. This will help to keep their airway clear and prevent them from choking on their own vomit if they begin to throw-up.

WHAT TO SAY TO 9-1-1

It is important to learn the local emergency response to overdoses (ex: do police respond along with ambulances to all 9-1-1 calls). **In every community, it is important to report that the person's breathing has slowed or stopped, he or she is unresponsive, and give the exact location.** Inform the dispatcher if Naloxone was given and did not work.

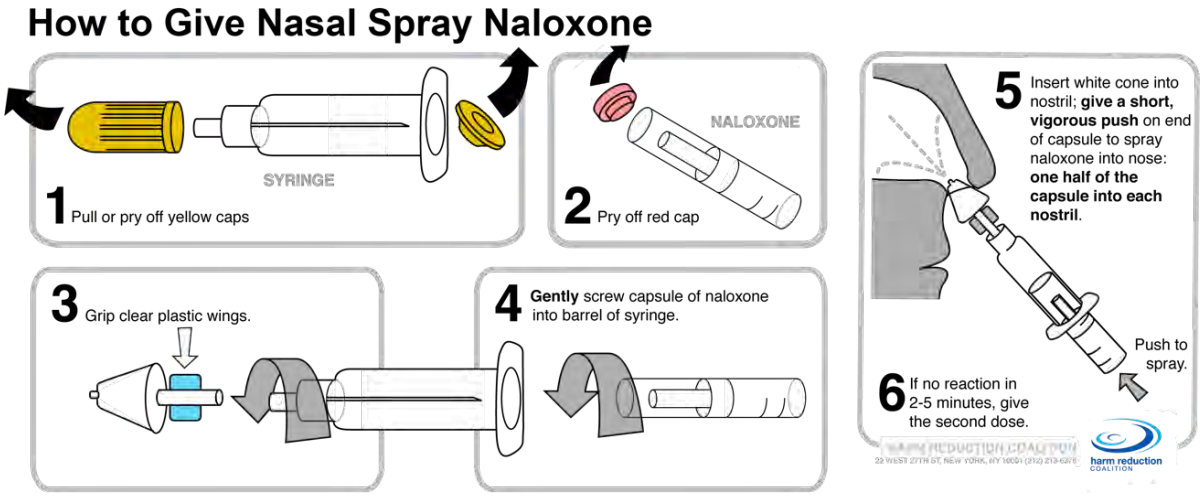
When making the call:

- Tell the dispatcher exactly where you and the person experiencing an overdose are located. Give them as much information as possible so that they can locate you quickly (i.e., 3rd floor, or in the bathroom).
- Avoid using words like drugs or overdose. Rather, describe what you see and the person's current condition: "Not breathing, turning blue, unconscious, non-responsive, etc." This makes the call a priority.
- When the paramedics arrive, tell them what you know about what drugs the person may have been using with as much detail as possible. If the paramedics suspect opioids, they will give the victim an injection or intranasal dose of naloxone.

ADMINISTER NALOXONE

NASAL NALOXONE

1. Do rescue breathing for a few quick breaths if the person is not breathing.
2. Affix the nasal atomizer (applicator) to the needleless syringe and then assemble the glass cartridge of naloxone (see diagram).
3. Tilt the head back and spray half of the naloxone up one side of the nose (1cc) and half up the other side of the nose (1cc).
4. If there is no breathing or breathing continues to be shallow, continue to perform rescue breathing for them while waiting for the naloxone to take effect.
5. If there is no change in 3-5 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else is wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (the latter can happen with Fentanyl, for example).



INJECTABLE NALOXONE

Injectable naloxone comes packaged in several different forms: a multi dose 10 mL vial and single dose 1mL flip-top vials with a pop off top. With all formulations of naloxone, it is important to check the expiration date and make sure to keep it from light if it is not stored in a box. To use injectable naloxone:

1. Do rescue breathing for a few quick breaths if the person is not breathing.
2. Use a long needle (1 – 1 ½ inch, called an IM or intramuscular needle). Needle exchange programs and pharmacies have these needles.
3. Pop off the orange top vial.
4. Draw up 1cc of naloxone into the syringe (1cc=1mL=100u).
5. Inject into a muscle – thighs, upper, outer quadrant of the butt, or shoulder are best.
6. Inject straight in to make sure to hit the muscle. If there isn't a big needle, a smaller needle is OK and inject under the skin, but if possible it is better to inject into a muscle.
7. After injection, continue rescue breathing 2-3 minutes.
8. If there is no change in 2-3 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else may be wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (the latter can happen with Fentanyl, for example).

ONCE NALOXONE HAS BEEN DELIVERED AND IF THE PERSON IS NOT BREATHING, CONTINUED RESCUE BREATHING IS IMPORTANT UNTIL HELP ARRIVES.

If a victim is not responsive to stimulation, not breathing, and has no pulse after receiving naloxone and rescue breathing, then the victim needs cardiopulmonary resuscitation (CPR) via a trained bystander and the emergency medical system. Call 9-1-1.

AFTERCARE

Because naloxone blocks opioids from acting, it is possible that it can cause withdrawal symptoms for individuals with addiction or opioid tolerance. Therefore, after giving someone naloxone, they may feel dopesick and want to use again right away. It is very important that one does not use again until the naloxone wears off so that a re-overdose does not occur.

Bystanders who deliver naloxone often report that it works immediately, however it may take up to 8 minutes to have an effect. Naloxone's effect lasts for about 30 to 90 minutes in the body. Because

most opioids last longer than that, the naloxone may wear off before the effects of the opioids wear off and the person might go into an overdose again. Naloxone administration may be repeated without harm if the person overdoses again. In addition, if the person uses more heroin or opioids when there is still naloxone in the system, he or she may not feel it at all – naloxone will knock it out of the opioid receptors and the person will have "wasted" their drugs.

The likelihood of overdosing again depends on several things including:

- How much drug was used in the first place and the half-life of the drug(s) taken
- How well the liver works to process things; and
- Whether the person uses again.

If the person cannot walk and talk well after waking up, it is very important that they are taken to the hospital. If possible, stay with the person for several hours, keeping them awake.

RECOMMENDATIONS FOR ADDRESSING THE INTERSECTION OF HOMELESSNESS AND THE OPIOID CRISIS[xxiii]

In February 2017, the United States Interagency Council on Homelessness (USICH) published Strategies to Address the Intersection of the Opioid Crisis and Homelessness, which identifies strategies that communities, providers, and policymakers can use to address the intersection of homelessness and the opioid crisis. Below we have highlighted some of the strategies presented in this USICH document to support homeless service providers in addressing the opioid crisis locally and identifying and responding to opioid use and addiction among the individuals experiencing homelessness they serve.

WORK WITH OTHER STAKEHOLDERS TO ASSESS THE PREVALENCE OF OPIOID USE DISORDERS (OUDS) AND OPIOID ADDICTION AMONG INDIVIDUALS EXPERIENCING HOMELESSNESS

Representatives from homelessness assistance and housing programs can work with other stakeholders to help assess the scope and complexities of the issue locally and provide insight into the assessment and planning process based on their experiences with individuals experiencing homelessness with OUDs and opioid addiction. Homelessness outreach teams should also be engaged and involved in overdose response planning to identify and map the strategies necessary to build or strengthen a shared, community-wide response.

DEVELOP AND IMPLEMENT OVERDOSE PREVENTION AND RESPONSE STRATEGIES

Access to naloxone, a medication that is used to counter opioid overdoses, should be a critical component of opioid overdose prevention and responses. Maximizing the number of housing providers, homeless service providers, emergency services, health care providers, and others who are frequently engaged with individuals experiencing homelessness who have access to naloxone should be a key strategy for responding to the local opioid crisis.

According to the Prescription Drug Abuse Policy System, 40 states have laws that allow for naloxone to be dispensed based on standing orders. A standing order is a broad general prescription that allows naloxone to be dispensed to anyone who meets the criteria of the standing order without the need for a handwritten/faxed prescription for every single person. The guidelines of a typical naloxone standing order generally state that anyone at risk for an opioid/opiate overdose, anyone who may be in a position to assist someone experiencing an overdose, or anyone who requests naloxone, may receive naloxone.

Additionally, 41 states allow for third parties to receive a prescription, allowing for caregivers or community members to be equipped should they witness an overdose.

STRENGTHEN PARTNERSHIPS BETWEEN HOUSING AND HEALTH CARE PROVIDERS TO PROVIDE TAILORED ASSISTANCE

Overwhelming evidence shows that, when paired with services and supports tailored to their needs, individuals experiencing chronic homelessness who have long histories of homelessness, substance use disorders, and other co-occurring complex care needs, can achieve stability and improved health outcomes in supportive housing. A less intensive but tailored pairing of services and housing supports — such as implementing rapid re-housing in tandem with Medication-Assisted Treatment — is more likely to be appropriate for individuals or heads of household with opioid use disorders who do not otherwise have complex care needs or multiple, extended lengths of homelessness.

Homelessness service providers should also strengthen their partnerships with health care providers, particularly those in the federally-supported Health Center network, where patients are offered comprehensive and complete care, funded by the Health Resources and Services Administration.

IMPROVE ACCESS TO MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT), an evidence-based approach to care, combines behavioral therapy and medications to treat substance use disorders. MAT programs that use methadone, buprenorphine, or extended-release injectable naltrexone are effective strategies for addressing opioid use disorders among any population, including those experiencing homelessness. Homelessness service providers should connect with health care providers at the local level, as well as landlords and housing providers, to consider how individuals experiencing homelessness who have opioid use disorders can be connected to effective treatment.

REMOVE BARRIERS TO HOUSING

Individuals experiencing homelessness should be offered access to permanent housing options using a Housing First approach with few to no treatment preconditions or other unnecessary barriers, which will help individuals establish housing as the foundation upon which they can build healthier, stable lives. Additionally, individuals receiving or eligible to receive Medication-Assisted Treatment should be allowed to do so within the housing programs in which they're participating.

CASE STUDY: PATHWAYS TO HOUSING, PHILADELPHIA, PA[xxiv]

In late 2016, Pathways to Housing PA in Philadelphia launched a pilot program designed to focus on chronically homeless individuals with long-term opioid addiction. Pathways combines a traditional Housing First model with new strategies in street outreach, including needle exchange, Narcan disbursement and training, and immediate access to Medication Assisted Treatment (MAT). These strategies are designed to meet the needs of individuals experiencing chronic homelessness with opioid use disorders.

Pathways created a specialized assertive community-based team of peer specialists, substance abuse counselors, doctors, nurses, and case-managers to assist with the permanent housing of individuals with long histories of addiction, trauma, and chronic homelessness. The program targets high-risk, high-need individuals with a harm-reduction strategy, and enforces no preconditions for housing. Staff place clients in permanent housing (fully furnished units chosen by the participants) and then provides services such as home-based intensive case management and care coordination, psychiatry and mental health counseling, nursing, medical care, and additional supportive services such as MAT.

To date, the team has placed 75 individuals experiencing chronic homelessness with an opioid addiction in permanent, scattered-site housing with the following outcomes:

- 100% of the participants retained housing through the first year.
- 52% of the housed participants received MAT or were abstinent during November 2017.
- 100% of participants received Narcan training, as well as individualized overdose prevention plans. When overdoses do occur, the support team works with participants to strengthen overdose prevention plans.

The Pathways initiative is funded by the U.S. Department of Housing and Urban Development, the Philadelphia Department of Behavioral Health, Community Behavioral

Health, and the Office of Homeless Services. Pathways recently expanded their Integration Care capabilities thanks to grants from the Substance Abuse and Mental Health Services Administration and the Pennsylvania Center of Excellence for Opioid Use Disorders.

RESOURCES AND FUNDING OPPORTUNITIES

SAMHSA'S NATIONAL HELPLINE

SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders: 1-800-662-HELP (4357)

STATE TARGETED RESPONSE TO THE OPIOID CRISIS GRANTS

SAMHSA administers the State Targeted Response (STR) to the Opioid Crisis grants, a two-year program authorized by the 21st Century Cures Act. By providing $485 million to states and U.S. territories in fiscal year (FY) 2017, this program allows states to focus on areas of greatest need, including increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of the full range of prevention, treatment and recovery services for opioid use disorder. States are able to use Opioid STR funds to purchase and distribute naloxone. The President's Budget requests $500 million for this program in FY 2018, the full level authorized by Congress.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SABG)

The Substance Abuse Prevention and Treatment Block Grant (SABG), first authorized in 1992, is a source of funding for states that accounts for approximately 32 percent of total state substance abuse agency funding. For many people seeking to recover from opioid addiction, this public funding represents the only support for treatment. In addition, the block grant's flexible structure enables states to use the funds to address pressing challenges within their communities, such as the opioid crisis. Some states are also using a portion of their SABG funds for opioid overdose prevention activities.

GRANTS TO PREVENT PRESCRIPTION DRUG/OPIOID OVERDOSE RELATED DEATHS

SAMHSA is currently providing $11 million per year in Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths to 12 states. The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

MEDICATION ASSISTED TREATMENT FOR PRESCRIPTION DRUG AND OPIOID ADDICTION (MAT-PDOA)

SAMHSA's Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) program expands MAT access by providing grants to states with the highest rates of treatment admissions for opioid addiction. Twenty-two states are currently funded by MAT-PDOA, and in September 2017, SAMHSA awarded $35 million dollars over three years in additional MAT-PDOA grants to six states.

SERVICES GRANT PROGRAM FOR RESIDENTIAL TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN

Under SAMHSA's Pregnant and Postpartum Women's (PPW) program, which serves women with opioid or other substance use disorders who are pregnant and/or newly parenting, grantees are encouraged to ensure access to MAT for opioid addiction, which has been shown to improve birth outcomes. In September 2017, SAMHSA awarded $9.8 million over three years for new State Pilot PPW grants authorized by the Comprehensive Addiction and Recovery Act (CARA) and $49 million over five years in new PPW service grants to support the recovery of pregnant and postpartum women struggling with substance abuse, including opioid addiction.

COMPREHENSIVE ADDICTION AND RECOVERY ACT: BUILDING COMMUNITIES OF RECOVERY

SAMHSA's Building Communities of Recovery program grants, created by the Comprehensive Addiction and Recovery Act (CARA), works to mobilize resources within and outside of the recovery community to increase the availability and quality of long-term recovery supports for individuals in or seeking recovery from addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services as well as promotion of and education about recovery. Programs will be principally governed by people in recovery from substance abuse and addiction who reflect the community served.

PRESCRIPTION DRUG OVERDOSE: PREVENTION FOR STATES

Prescription Drug Overdose: Prevention for States is a program that helps states combat the ongoing prescription drug overdose epidemic. The purpose of Prevention for States is to provide state health departments with resources and support needed to advance interventions for preventing prescription drug overdoses. CDC currently funds 29 states through the program. Through 2019, CDC plans to give selected states annual awards between $750,000 and $1 million to advance prevention in four key areas. Awarded states are collaborating with key partners to maximize efforts and address issues that impact prescribing and drug overdoses.

PRESCRIPTION DRUG OVERDOSE: DATA-DRIVEN PREVENTION INITIATIVE (DDPI)

The Prescription Drug Overdose: Data-Driven Prevention Initiative (DDPI) awards funds to 13 states and Washington D.C. to support efforts to end the opioid overdose epidemic in the United States. This program aims to help states advance and evaluate their actions to address opioid misuse, abuse, and overdose, including by increasing their ability to:

- improve data collection and analysis around opioid misuse, abuse, and overdose;
- develop strategies that impact behaviors driving prescription opioid dependence and abuse; and
- work with communities to develop more comprehensive opioid overdose prevention programs.

CDC began investing over $50 million in state health departments in support of the agency's overarching Overdose Prevention in States (OPIS) effort to address this public health crisis. DDPI awardees beginning in 2016 are: Alabama, Alaska, Arkansas, Georgia, Hawaii, Idaho, Kansas, Louisiana, Michigan, Minnesota, Montana, New Jersey, and South Dakota, and Washington D.C.

ENHANCED STATE OPIOID OVERDOSE SURVEILLANCE (ESOOS)

CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) program funds 32 states and Washington, D.C. Started in 2016, ESOOS aims to improve the timeliness of reporting both fatal and non-fatal opioid overdoses and associated risk factors to inform public health responses within and across states.

States will use the funding to:

- increase the timeliness of reporting nonfatal opioid overdoses through syndromic surveillance (emergency department and emergency medical services data);
- increase the timeliness and comprehensiveness of reporting fatal opioid overdoes through the State Unintentional Drug Overdose Reporting System (SUDORS), which captures detailed information on toxicology, death scene investigations, route of administration, and other risk factors that may be associated with a fatal overdose associated risk factors; and
- disseminate surveillance findings to key stakeholders to inform prevention and response efforts for opioid-involved overdoses.

ESOOS uses emergency department and emergency medical services (EMS) data to track and analyze morbidity data and to establish an early warning system to detect sharp increases (e.g. potential outbreaks) or decreases (e.g. successful intervention efforts) in non-fatal overdoses.

RURAL HEALTH OPIOID PROGRAM

The Health Resources and Services Administration (HRSA) Office of Rural Health Policy manages the Rural Health Opioid Program, which is designed to reduce the incidences of morbidity and mortality related to opioid overdoses in rural communities through the development of broad community consortiums to prepare individuals with opioid-use disorder (OUD) to start treatment, implement care coordination practices to organize patient care activities, and support individuals in recovery through the enhancement of behavioral counselling and peer support activities. This program brings together health care providers (i.e., local health departments, hospitals, primary care practices, and substance abuse treatment providers) and entities such as social service and faith-based organizations, law enforcement, and other community-based groups to respond to the opioid epidemic in a rural community.

RURAL HEALTH AND SAFETY EDUCATION (RHSE) COMPETITIVE GRANT PROGRAM

In March 2016, U.S. Department of Agriculture (USDA) Secretary Vilsack announced that the Rural Health and Safety Education (RHSE) grant program could be used for communities to conduct drug addiction awareness efforts. The USDA's National Institute of Food and Agriculture (NIFA) in November 2017 awarded $2.8 million in grants to support rural health through the RHSE grant program. Of the nine awards funded, six were designed specifically to prevent and reduce opioid abuse. The projects include education programs in Arkansas, Indiana, and Virginia; an intervention program in Iowa; and community engagement in Mississippi.

DISTANCE LEARNING AND TELEMEDICINE GRANTS

USDA's Distance Learning and Telemedicine program helps rural communities use the unique capabilities of telecommunications to connect to each other and to the world. Distance Learning and Telehealth Medicine Grants have been used to help hospitals in rural communities use telemedicine to better treat individuals struggling with addiction.

COMMUNITY FACILITIES GRANTS AND LOAN PROGRAM

USDA's Community Facilities Grants and Loan Program offers direct loans, loan guarantees, and grants to develop or improve essential public services and facilities in communities across rural America. The program has allowed communities to build treatment and recovery facilities to help address local incidences of opioid use, addiction, and overdose.

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[xii] Ibid.

[xiii] Centers for Disease Control and Prevention (CDC), "Opioid Overdose: Understanding the Epidemic", December 16, 2016, https://www.cdc.gov/drugoverdose/epidemic/index.html

[xiv] U.S. Department of Health and Human Services, "Fact Sheet – The Opioid Epidemic: By the Numbers," June 2016, https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf; original sources of data include IMS Health National Prescription Audit, SAMHSA National Survey on Drug Use and Health, and CDC National Vital Statistics System

[xv] National Institute on Drug Abuse. (2014). Drug Facts: Heroin. Bethesda, MD: National Institute on Drug Abuse. Available at http://www.drugabuse.gov/publications/drugfacts/heroin

[xvi] Centers for Disease Control and Prevention (CDC), "Opioid Overdose: Understanding the Epidemic", December 16, 2016, https://www.cdc.gov/drugoverdose/epidemic/index.html

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[xviii] Centers for Disease Control and Prevention, "Today's Heroin Epidemic: Risk Factors," https://www.cdc.gov/drugoverdose/opioids/heroin.html

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[xxii] Harm Reduction Coalition, "Recognizing Opioid Overdose," http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/recognizing-opioid-overdose/

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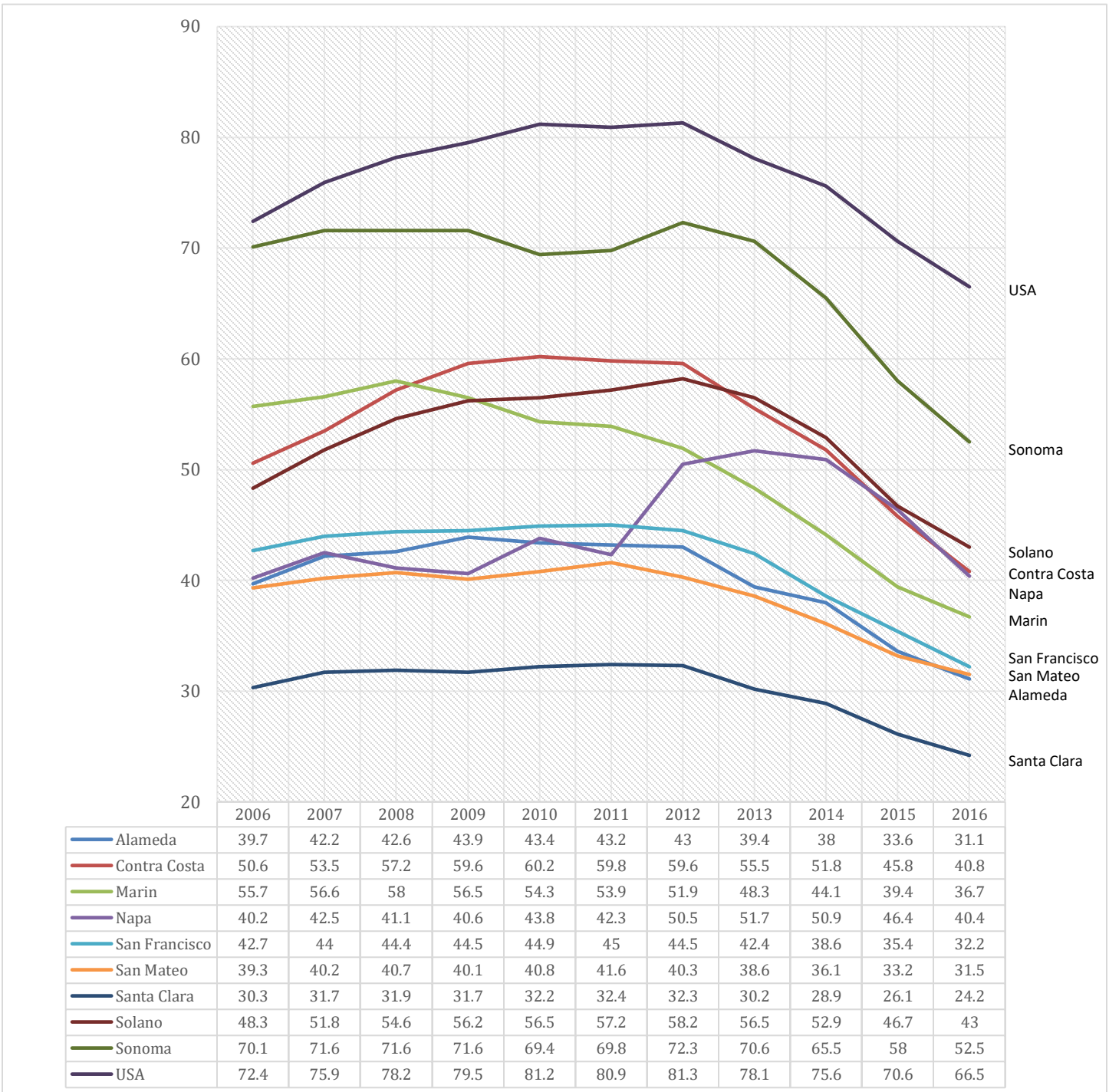
OPIOIDS BY THE NUMBERS

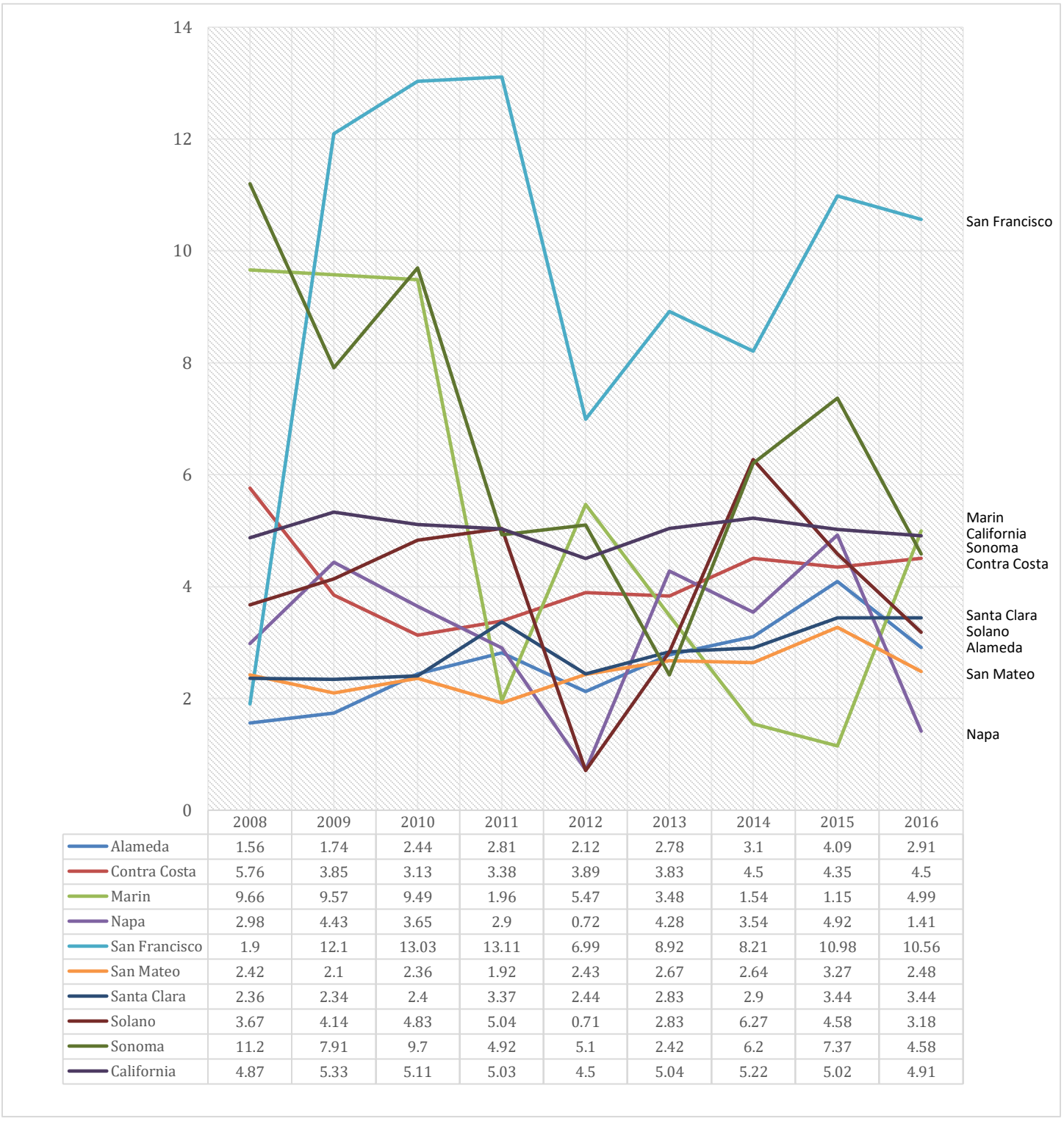
OPIOID PRESCRIPTIONS PER 100 RESIDENTS OF BAY AREA COUNTIES[1]



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Alameda	39.7	42.2	42.6	43.9	43.4	43.2	43	39.4	38	33.6	31.1
Contra Costa	50.6	53.5	57.2	59.6	60.2	59.8	59.6	55.5	51.8	45.8	40.8
Marin	55.7	56.6	58	56.5	54.3	53.9	51.9	48.3	44.1	39.4	36.7
Napa	40.2	42.5	41.1	40.6	43.8	42.3	50.5	51.7	50.9	46.4	40.4
San Francisco	42.7	44	44.4	44.5	44.9	45	44.5	42.4	38.6	35.4	32.2
San Mateo	39.3	40.2	40.7	40.1	40.8	41.6	40.3	38.6	36.1	33.2	31.5
Santa Clara	30.3	31.7	31.9	31.7	32.2	32.4	32.3	30.2	28.9	26.1	24.2
Solano	48.3	51.8	54.6	56.2	56.5	57.2	58.2	56.5	52.9	46.7	43
Sonoma	70.1	71.6	71.6	71.6	69.4	69.8	72.3	70.6	65.5	58	52.5
USA	72.4	75.9	78.2	79.5	81.2	80.9	81.3	78.1	75.6	70.6	66.5

[1] For the calculation of prescribing rates, numerators are the total number of opioid prescriptions dispensed in a given year, state, or county, as appropriate. Annual resident population denominator estimates were obtained from the Population Estimates Program, U.S. Census Bureau.
Centers for Disease Control and Prevention, U.S. Prescribing Rate Maps, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

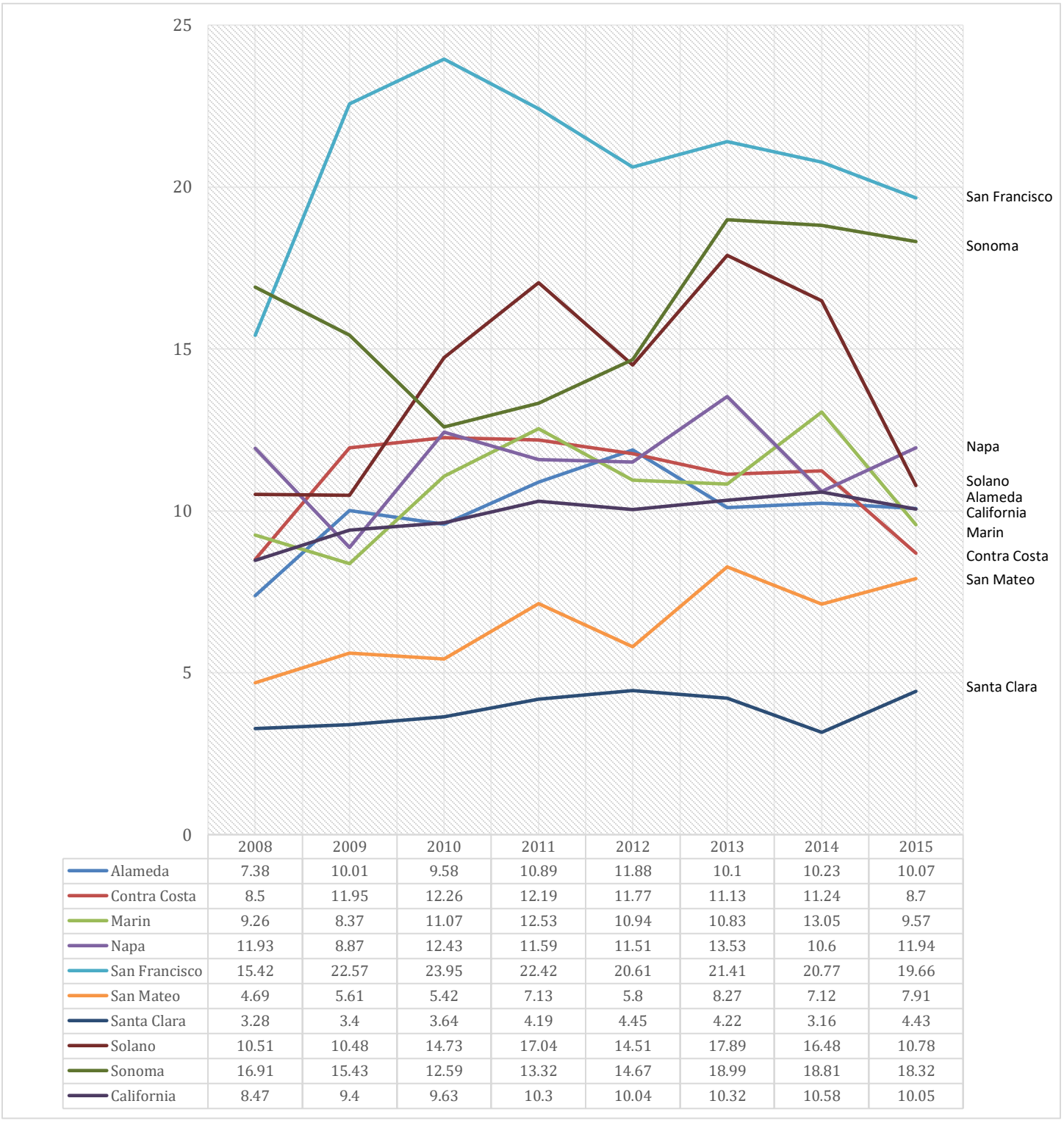
OPIOID-INDUCED DEATHS PER 100,000 RESIDENTS OF BAY AREA COUNTIES[2]



	2008	2009	2010	2011	2012	2013	2014	2015	2016
Alameda	1.56	1.74	2.44	2.81	2.12	2.78	3.1	4.09	2.91
Contra Costa	5.76	3.85	3.13	3.38	3.89	3.83	4.5	4.35	4.5
Marin	9.66	9.57	9.49	1.96	5.47	3.48	1.54	1.15	4.99
Napa	2.98	4.43	3.65	2.9	0.72	4.28	3.54	4.92	1.41
San Francisco	1.9	12.1	13.03	13.11	6.99	8.92	8.21	10.98	10.56
San Mateo	2.42	2.1	2.36	1.92	2.43	2.67	2.64	3.27	2.48
Santa Clara	2.36	2.34	2.4	3.37	2.44	2.83	2.9	3.44	3.44
Solano	3.67	4.14	4.83	5.04	0.71	2.83	6.27	4.58	3.18
Sonoma	11.2	7.91	9.7	4.92	5.1	2.42	6.2	7.37	4.58
California	4.87	5.33	5.11	5.03	4.5	5.04	5.22	5.02	4.91

[2] Acute poisoning deaths involving opioids such as prescription opioid pain relievers (i.e. hydrocodone, oxycodone, and morphine) and heroin and opium. Death related to chronic use of drugs excluded from this indicator. California Department of Public Health, California Opioid Overdose Surveillance Dashboard, https://pdop.shinyapps.io/ODdash_v1/

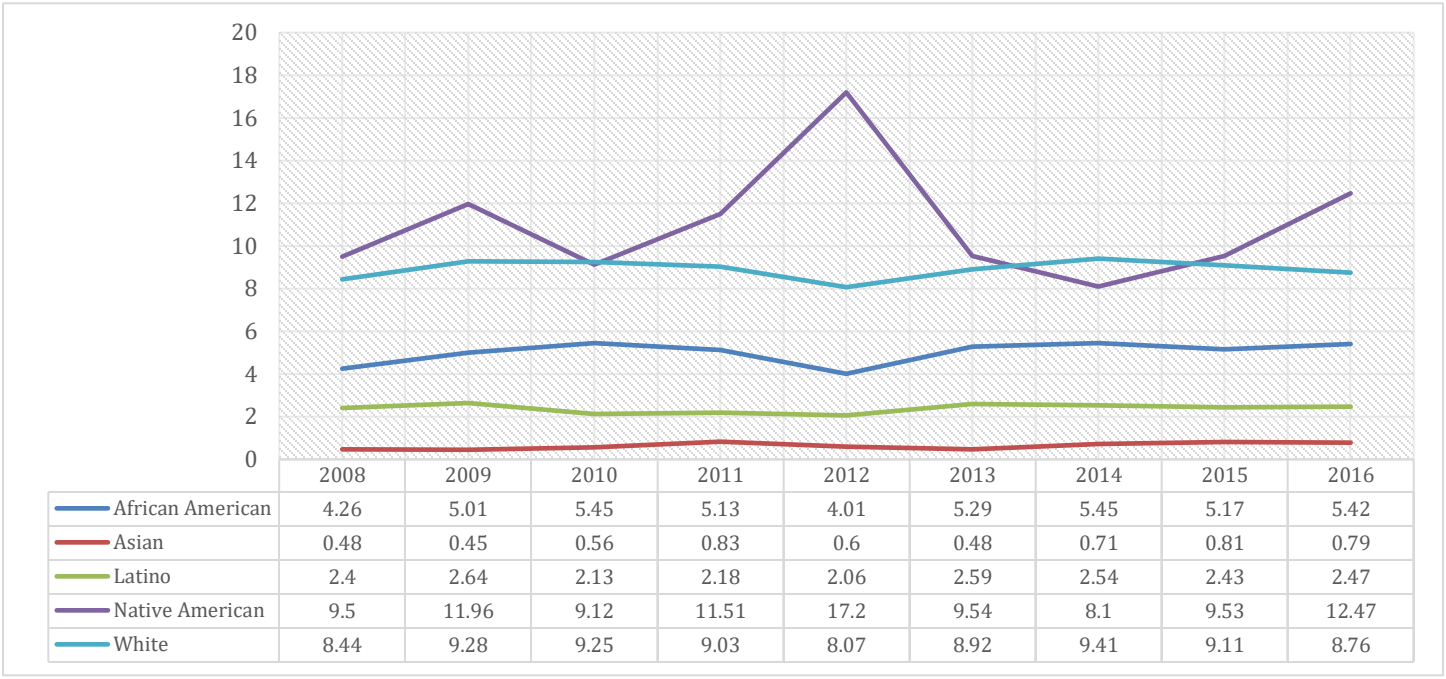
EMERGENCY DEPARTMENT VISITS FOR OPIOID OVERDOSE PER 100,000 RESIDENTS OF BAY AREA COUNTIES[3]



	2008	2009	2010	2011	2012	2013	2014	2015
Alameda	7.38	10.01	9.58	10.89	11.88	10.1	10.23	10.07
Contra Costa	8.5	11.95	12.26	12.19	11.77	11.13	11.24	8.7
Marin	9.26	8.37	11.07	12.53	10.94	10.83	13.05	9.57
Napa	11.93	8.87	12.43	11.59	11.51	13.53	10.6	11.94
San Francisco	15.42	22.57	23.95	22.42	20.61	21.41	20.77	19.66
San Mateo	4.69	5.61	5.42	7.13	5.8	8.27	7.12	7.91
Santa Clara	3.28	3.4	3.64	4.19	4.45	4.22	3.16	4.43
Solano	10.51	10.48	14.73	17.04	14.51	17.89	16.48	10.78
Sonoma	16.91	15.43	12.59	13.32	14.67	18.99	18.81	18.32
California	8.47	9.4	9.63	10.3	10.04	10.32	10.58	10.05

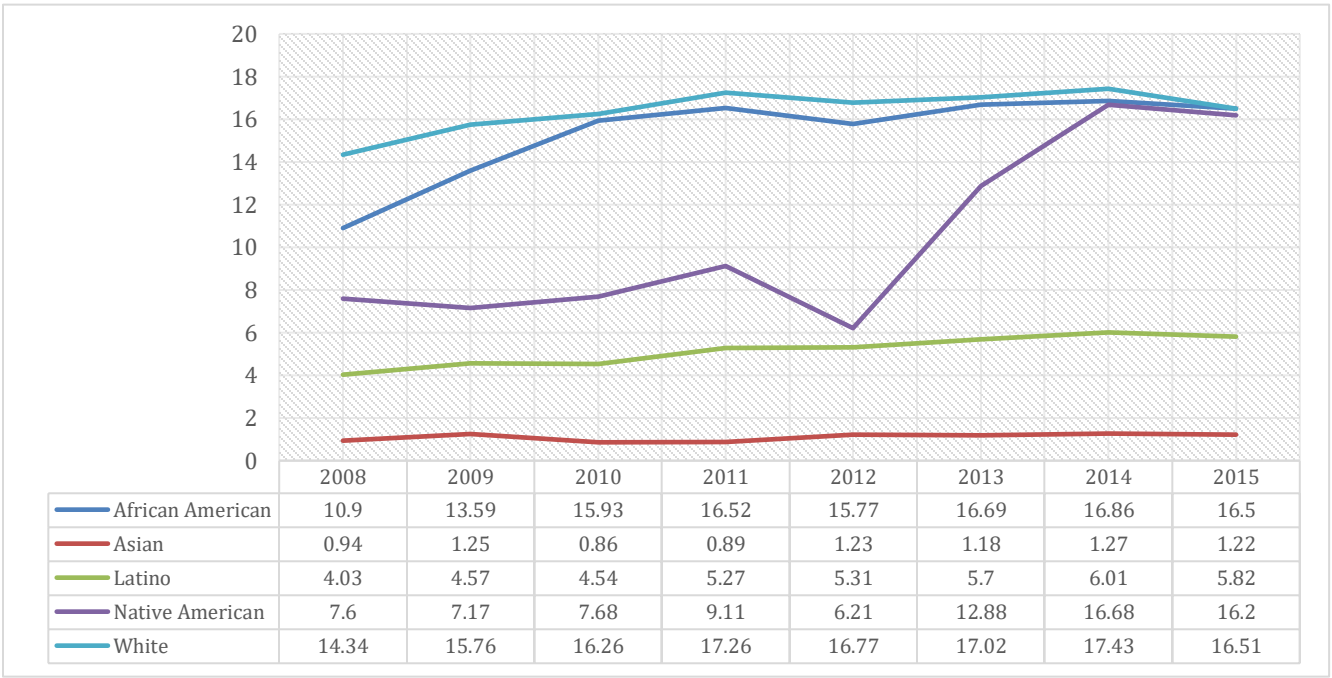
[3] Emergency department visits caused by non-fatal acute poisonings due to the effects of all opioids drugs, excluding heroin, regardless of intent (e.g., suicide, unintentional, or undetermined). Emergency department visits related to late effects, adverse effects, and chronic poisonings due to the effects of drugs (e.g., damage to organs from long-term drug use), are excluded from this indicator. California Department of Public Health, California Opioid Overdose Surveillance Dashboard, https://pdop.shinyapps.io/ODdash_v1/

OPIOID-INDUCED DEATHS PER 100,000 CALIFORNIA RESIDENTS[4]



	2008	2009	2010	2011	2012	2013	2014	2015	2016
African American	4.26	5.01	5.45	5.13	4.01	5.29	5.45	5.17	5.42
Asian	0.48	0.45	0.56	0.83	0.6	0.48	0.71	0.81	0.79
Latino	2.4	2.64	2.13	2.18	2.06	2.59	2.54	2.43	2.47
Native American	9.5	11.96	9.12	11.51	17.2	9.54	8.1	9.53	12.47
White	8.44	9.28	9.25	9.03	8.07	8.92	9.41	9.11	8.76

EMERGENCY DEPARTMENT VISITS FOR OPIOID OVERDOSE PER 100,000 CALIFORNIA RESIDENTS[5]



	2008	2009	2010	2011	2012	2013	2014	2015
African American	10.9	13.59	15.93	16.52	15.77	16.69	16.86	16.5
Asian	0.94	1.25	0.86	0.89	1.23	1.18	1.27	1.22
Latino	4.03	4.57	4.54	5.27	5.31	5.7	6.01	5.82
Native American	7.6	7.17	7.68	9.11	6.21	12.88	16.68	16.2
White	14.34	15.76	16.26	17.26	16.77	17.02	17.43	16.51

[4] Acute poisoning deaths involving opioids such as prescription opioid pain relievers (i.e. hydrocodone, oxycodone, and morphine) and heroin and opium. Death related to chronic use of drugs excluded from this indicator. California Department of Public Health, California Opioid Overdose Surveillance Dashboard, https://pdop.shinyapps.io/ODdash_v1/

[5] Emergency department visits caused by non-fatal acute poisonings due to the effects of all opioids drugs, excluding heroin, regardless of intent (e.g., suicide, unintentional, or undetermined). Emergency department visits related to late effects, adverse effects, and chronic poisonings due to the effects of drugs (e.g., damage to organs from long-term drug use), are excluded from this indicator. California Department of Public Health, California Opioid Overdose Surveillance Dashboard, https://pdop.shinyapps.io/ODdash_v1/

FEEDBACK PLEASE!

REGIONAL STEERING COMMITTEE ON HOUSING AND HOMELESSNESS
FEBRUARY 9, 2018

Your feedback is important to us -- we use it to develop agendas for future events. Please take the time to respond. Thank you!

What was the best part about today?

What can we improve for next time?

What topics would you like to discuss at future RSC meetings?

Other comments/suggestions about this meeting: