**Community Health Engagement Locations in King County**

**Recommended Guidelines for Planning, Implementing, and Operating Supervised Consumption Sites**

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Prepared by the King County Community Health Engagement Locations (CHEL) Design Team

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# I. OVERVIEW

## PURPOSE

In September, 2016 the King County Heroin and Prescription Opioid Addiction Task Force was convened to issue recommendations on short- and long-term strategies to prevent opioid use and overdose and to improve access to treatment and other supportive services for individuals experiencing opioid use disorder. The Taskforce has recommended a number of short and long-term strategies,[[1]](#footnote-1) but this document provides information about one of the recommendations: Supervised Consumption Sites (SCS) to promote safer consumption of substances and ensure immediate treatment when overdoses occur. These sites will be called “Community Health Engagement Locations” (CHELs) in Seattle and King County, in order to recognize the multiple health and social services required to reduce harm and promote health for individuals experiencing substance use disorder, and to use non-stigmatizing language.

## BACKGROUND

Heroin use is a public health crisis in King County. In 2013, heroin overtook prescription opioids as the primary cause of opioid overdose deaths. By 2014, heroin-involved deaths in King County totaled 156, their highest number since at least 1997 and a substantial increase from 49 deaths in 2009. Individuals using opioids and other drugs commonly face obstacles accessing traditional health services due to intersecting challenges, such as homelessness, complex physical and mental health conditions, extreme poverty, trauma, repeated incarceration and social isolation.

CHELs offer critical entry and triage points for health and social services while providing a safe, hygienic, and stigma-free space to use pre-obtained substances under the supervision of a health care provider trained in overdose response and safer drug consumption practices. CHELs are designed to improve the health of persons with substance use disorders by decreasing transmission risk for blood borne viruses like HIV and hepatitis C, preventing overdose deaths, and providing needed medical and behavioral health services, as well as education on safer consumption practices, needle exchange, and wound care.

Supervised consumption services reduce harm and improve outcomes. There are approximately 90 public health sites around the world that provide supervised, safe locations for consumption of drugs. Most of these sites are in European countries and Australia, and many have been operating since the late 1980’s. In North America, Vancouver has a site that has been operating for over 12 years. Sites vary from community to community, but SCSs consistently have positive outcomes, not only for people who use the services, but also for the surrounding community. Multiple studies show that SCSs:

* Prevent overdose deaths and increase access to treatment;[1](https://www.ncbi.nlm.nih.gov/pubmed/19423324),[2](https://www.ncbi.nlm.nih.gov/pubmed/?term=Estimated+drug+overdose+deaths+averted+by+North+America’s+first+medically-supervised+safer+injection+facility), [10](https://www.ncbi.nlm.nih.gov/pubmed/?term=Injection+drug+use+cessation+and+use+of+North+America’s+first+medically+supervised+safer+injecting+facility)
* Reduce high-risk injection behaviors linked to negative health consequences[6](https://www.ncbi.nlm.nih.gov/pubmed/16039335),[7](https://www.ncbi.nlm.nih.gov/pubmed/?term=Changes+in+injecting+practices+associated+with+the+use+of+a+medically+supervised+safer+injection+facility), [8](https://www.ncbi.nlm.nih.gov/pubmed/?term=Self-reported+changes+in+drug+use+behaviors+and+syringe+disposal+methods+following+the+opening+of+a+supervised+injecting+facility+in+Copenhagen%2C+Denmark), [5](https://www.ncbi.nlm.nih.gov/pubmed/?term=The+impact+of+a+supervised+injecting+facility+on+ambulance+call-outs+in+Sydney)
* Increase use of detoxification services and substance use disorder treatment
* Reduce drug use in public spaces[12](https://www.ncbi.nlm.nih.gov/pubmed/?term=Changes+in+public+order+after+the+opening+of+a+medically+supervised+safer+injecting+facility+for+illicit+injection+drug+users), [13](http://www.bag.admin.ch/evaluation/01759/02066/02343/index.html?lang=en&),[14](http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf), [15](https://www.ncbi.nlm.nih.gov/pubmed/?term=Injection+drug+users’+perceptions+regarding+use+of+a+medically+supervised+safer+injecting+facility.)
* Reduce improperly discarded syringes and injection related litter[12](https://www.ncbi.nlm.nih.gov/pubmed/?term=Changes+in+public+order+after+the+opening+of+a+medically+supervised+safer+injecting+facility+for+illicit+injection+drug+users), [13](http://www.bag.admin.ch/evaluation/01759/02066/02343/index.html?lang=en&),[14](http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf)
* Do not contribute to an increase in crime, violence, or drug dealing[16](http://www.bocsar.nsw.gov.au/Documents/BB/bb90.pdf), [17](https://www.ncbi.nlm.nih.gov/pubmed/?term=Impact+of+a+medically+supervised+safer+injecting+facility+on+drug+dealing+and+other+drug-related+crime.)
* Are cost effective[1](https://www.ncbi.nlm.nih.gov/pubmed/19423324), [18](https://www.ncbi.nlm.nih.gov/pubmed/19015565)

## KING COUNTY PLANNING PROCESS

The Task Force recommended that King County establish and evaluate, on a three-year pilot basis, at least two CHEL sites in the County: One CHEL in Seattle and another outside of Seattle to reflect the geographic distribution of drug use across King County. Public Health – Seattle & King County (PHSKC) and King County Department of Community and Human Services (DCHS) assumed leadership for CHEL planning and convened an *ad hoc* CHEL Design Team to develop specific design and implementation standards for CHELs, based on the general guidelines set forth by the Task Force.

The standards subsequently put forth in this document reflect the best advice of the members of the CHEL Design Team, based upon on their collective expertise, review of available research, policy analysis, and local community input. This document was created for and by decision makers, service providers and community stakeholders to guide the design, implementation, operations and evaluation of CHELs within King County, although it could also be used to inform CHEL operations in other communities.

King County also produced the fact sheet *Community Health Engagement Locations: Frequently Asked Questions* (see Appendix A) as a public education tool to explain the concept and rationale behind CHELs and to summarize the evidence on the impact of these models on public health and safety.

**Appendix A:**

CHEL FAQs


## GOALS AND CORE VALUES

CHELs function as an essential, integrated component of a comprehensive community-based harm reduction and health care service continuum. Rather than a stand-alone service, CHELs are an open-door access point to a number of wrap-around services.

CHELs respond to public health and public safety needs, benefitting individuals who use the services, as well as people residing in the communities in which CHELs are located:

|  |
| --- |
| **Goals Of Community Health Engagement Locations** |
| **INDIVIDUALS WHO USE CHELs** | * **Reduce** **drug-related health risks and harms,** including overdose deaths, transmission of HIV and other infections, and other adverse drug-associated health effects.
* **Provide access to substance use disorder treatment and related health and social services** to improve health and social stability and break the cycle of addiction and homelessness.
 |
| **COMMUNITIES** | * **Improve public safety and the community environment** by reducing public drug use and discarded drug using equipment.
* **Use public dollars more efficiently** by reducing costly criminal justice system involvement and burden on emergency medical services.
 |

The following values are fundamental to the CHEL service model:

* **The health and wellbeing of participants is the central focus**

Services and the atmosphere are always inclusive, welcoming, confidential and respectful. All participants have the right to respect and dignity and support to make responsible health choices towards positive behavior change.

 **CORE VALUES of CHELs**

* **Community and peer involvement**

Community members and participants are viewed as essential partners and their opinions, concerns and ideas are genuinely valued and incorporated into service planning, delivery and evaluation on an ongoing basis.

* **Public safety**

Communication channels with the local community and local law enforcement are critical in order to facilitate a rapid response to concerns and ensure that the CHEL successfully reduces outdoor drug use and eliminates injection drug litter.

* **Equity and social justice**

Policies and practices ensure welcoming sites and unrestricted service access for all individuals in need, without disparities based on age, race, ethnicity, culture, religion, language, gender, sexual orientation, disability, developmental/cognitive capacity etc.

* **Effectiveness**

Services are based on best available evidence and/or best practices, and, where evidence is lacking, expert opinion combined with stakeholder input. Rigorous outcome evaluation is required to ensure that services are relevant and effective.

# II. IMPLEMENTATION PLANNING

The following guidelines represent best practice standards for the design and operation of CHELs in King County.

## SITING GUIDELINES

The Task Force recommended establishing at least two CHELs in King County: one site in Seattle and at least one additional site outside of Seattle. During the three-year pilot period, the Task Force also recommended these be fixed, rather than mobile, sites that are preferably integrated into existing locations where people who use drugs already access services. While multiple sites do not need to be launched simultaneously, it is expected that King County and its community partners will seek to open more than one CHEL outside the City of Seattle.

To ensure successful access and utilization, CHELs should be located in areas that are:

* Within, or close to, high-density “hotspots” for public drug use and/or overdose
* close to (or co-located) with existing services utilized by individuals who use drugs (e.g., syringe exchange, supportive housing)
* easily accessed via public transportation

## FACILITY FEATURES

While the physical design of each CHEL may vary, the size and layout of the site should be appropriate to accommodate estimated service volume and ensure confidentiality, without restricting traffic flow within the facility or creating queuing outside.

Each CHEL site should include adequate space for:

* reception and waiting areas
* several drug consumption stations
* post-consumption observation
* confidential health and social service consultation (e.g., medical exam room, case management cubicle)
* administrative functions
* sterile and used supply storage
* separate and properly-ventilated area for inhaled drugs, if permitted

The facility should have the following features and interior design elements to maximize facility cleanliness, security, drug use safety, and staff observation angles such as:

* Easily accessible, fire and safety code compliant, first floor location (ADA compliance and stairs or elevators should be avoided, if possible)
* bright lighting and an open floor plan
* easily disinfected surfaces (consumption stations, chairs, countertops)
* areas for staff and participant hand washing
* proper heating, cooling and ventilation (i.e., exhausted outside or redirected through properly designed, installed and maintained HEPA filters)
* adequate space to ensure good sight-line visibility inside and outside the facility
* secured, one-way sharps disposal boxes
* mirrors in consumption stations to assist safe injections and observation

## COMMUNITY RELATIONS

In the planning phase, it is critical for CHEL operating agencies to consider how the site will constructively involve, interact with, and impact CHEL participants and community neighbors and businesses. Therefore, agencies must develop strategies and policies concerning:

* public safety and neighborhood responsiveness
* community engagement
* peer involvement
* equity and social justice

### Public Safety and Neighborhood Responsiveness

Organizations operating CHELs are encouraged to take the following specific actions to ensure positive local impact:

Develop and implement policies and practices in collaboration with participants and local community stakeholders that will:

* promote pro-social relationships with local neighbors, law enforcement, and public officials (develop program policy and orientation plans to promote buy-in and effectively anticipate, plan for, and address needs)
* address issues immediately, should problems arise (implement rapid interventions when prohibited participant behavior arises, but without creating adversarial dynamics that could reduce utilization)
* avoid overcrowding and outside queuing (inside waiting space, adequate hours of operation, and sufficient consumption stations)
* prevent loitering or drug-related activity (constant staff presence outside the facility and/or frequent perimeter patrols)
* eliminate discarded paraphernalia/litter (regular sidewalk sweeps to collect and safely dispose of trash, including used syringes, that may be found in the vicinity of the CHEL)
* facilitate safe disposal of used needles (install drop boxes outside the CHEL)

Document collaboratively developed expectations and policies in a Good Neighbor Agreement or Neighbor Relations Plan with key neighbors.

The agreement should include contact information for a “Neighborhood Liaison,” a staff person who has been designated to be a visible and friendly ambassador for the CHEL, nurture respectful relationships among community members, attend community events, and receive and respond to neighbor complaints in a timely manner. Asample Neighbor Relations Plan is included in Appendix B.

**Appendix B:**

Sample Neighbor Relations Plan

Establish protocols or MOU in collaboration with law enforcement (or relevant city government) to specify:

* proximity of police presence to permit customary policing functions (i.e. intervention in non-drug related activity)
* appropriate conditions for police entering the facility (e.g., emergencies, pursuit of suspects)
* accurate messaging about the CHEL program that officers can share with community members
* site tours and training for police officers on CHEL objectives and operations
* regular mechanisms for communication between staff and law enforcement to proactively identify, understand and respond to public safety concerns without deterring participants from using the CHEL

Establish protocols or MOU with relevant Emergency Medical Services departments to determine protocols for:

* onsite overdose response, including protocols related to calling 911
* planned transportation after an EMS response

### Community Engagement

It is important for CHEL agencies to develop a thoughtful strategy for how they will engage and inform the community regarding the development and operation of the CHEL.

In general, a comprehensive approach to community engagement includes three key actions:

The Community Engagement Worksheet in Appendix C is a useful document to guide strategic community engagement planning.

**Appendix C:**

Community

Engagement

Worksheet

Inform

Informing means educating stakeholders and shaping public opinion about the purpose and value of CHELs. This is particularly beneficial, prior to opening a CHEL, in order to familiarize stakeholders to this new model, prevent misunderstanding about service objectives and operations, alleviate concerns, correct misinformation, and promote a commitment to transparency and community responsiveness.

Site tours or open house events are especially useful methods to inform decision makers, media, service providers, law enforcement, emergency medical responders, potential participants and community members, especially in this initial pilot phase.

Stakeholders should also receive regular and consistent feedback on the results of the project, perhaps through email list serve updates, a program website, or via quarterly reports during community meetings.

Consult

It is critical to engage community members (including civic and business stakeholders) and potential CHEL participants in planning and implementation. Consultation with these stakeholders will identify needs, highlight concerns, build public understanding, and encourage community investment in solutions and successful outcomes.

Commonly, this consultation process includes listening groups, public meetings, and surveys (in person and online). Establishing and maintaining a community advisory committee is another effective way to facilitate constructive discussions and develop collaborative working relationships. Representation could include, but not be limited to, local business associations, service providers, local officials, law enforcement, neighborhood coalitions, and participants.

Respond

CHEL operators should plan how they will respond to routine requests from government officials, media, and the public. Requests for information, interviews, and site visits are common. Rapid response protocols should be developed to identify the processes, and individuals responsible, for promptly addressing community concerns.

### Peer Involvement

The term “peer” refers to those who have “lived experience” similar to that of CHEL participants. A commitment to incorporating peer knowledge into service delivery and the operational culture of the CHEL ensures that services remain responsive to those in need. Peers could be former, current or potential users of CHEL services in paid or volunteer roles. Peer involvement in CHEL planning, implementation, and evaluation is strongly encouraged. They can help explain and promote CHEL services among the target population, develop meaningful relationships with participants, and promote linkages to additional services and interventions.

CHEL operators should consider how peers may play meaningful, active and visible roles in:

* Planning, by involvement in CHEL design planning, focus groups and advocacy events.
* Operations, filling such roles as greeters, traffic/security monitors, service navigators, health educators, syringe exchangers.
* Evaluation, through qualitative interviews or satisfaction surveys.

A sustainable process and structure, such as a Peer Advisory Panel, can facilitate regular peer input regarding CHEL operations, service gaps, changes in local drug use behaviors, and other trends and issues. Task descriptions for peers are recommended, as well as policies on screening, interviewing, training, supervising and developing the professional skills of the agency’s peer work force.

### Equity and Social Justice

**Appendix D:**

Equity Impact

Review Tool

The Task Force’s equity and social justice charge emphasizes the importance of providing support and services to the most marginalized individuals. All agencies operating CHELs should be strongly committed to incorporating the values of equity and social justice in the design and delivery of CHEL services. Agencies must consider how their policies and practices advance fairness and equal opportunity for all individuals.

To assist in this process, King County offers a useful tool called the *Equity Impact Review* to help organizations identify, evaluate and communicate the potential impact - both positive and negative – of a policy or program on equity. Use of this tool is standard practice for all agencies working with King County. See Appendix D for more about equity impact reviews and a web link to the tool.

# III. CHEL OPERATIONS

## SERVICE MODEL

In addition to the healthcare worker supervision of drug consumption, CHEL sites are expected to provide key health and social services and resources during all hours of operation. Where possible, CHEL sites should also aim to provide enhanced levels of these services on site, as described in the table below:

|  |  |  |
| --- | --- | --- |
| **Type of Service** | **Essential Level Services** | **Enhanced Level Services** |
| **Supervised consumption** | * drug injection
 | * injection *plus* area for inhalation/sublimation
 |
| **Overdose prevention** | * overdose treatment: naloxone and oxygen administration
* distribution of naloxone overdose reversal kits
 |  |
| **Medical care and health care access**  | * medical assessment and linkage to appropriate levels of medical care
 | * on site wound care
* on site basic medical treatment
 |
| **Syringe exchange** | * on site provision of sterile equipment for drug consumption
* collection and disposal of used equipment (e.g., syringes, tourniquets, alcohol wipes, cottons, cookers, pipes)
 |  |
| **Health promotion**  | * harm reduction counseling (drug use, HIV, hepatitis, sexual health)
* health education materials (low literacy print, video, additional languages where appropriate)
* male and female condoms, lubricant
 | * on site testing for HIV, hepatitis C and sexually transmitted infections
 |
| **Behavioral health treatment** | * rapid referral and/or linkage to opioid withdrawal management and medication-assisted treatment
* referral and/or linkage to substance use disorder treatment
* referral and/or linkage to mental health treatment
 | * on site drug and alcohol assessment
* on site mental health screening/psychiatric evaluation, in person or telehealth
* on site buprenorphine induction and linkage to maintenance
* on site case management to facilitate entry into substance use and/or mental health services
* on site mental health/psychiatric services
 |
| **Social services** | * referral and/or linkage to social services
* transportation assistance
 | * on site social services case management
* legal advice
* housing assistance
* employment services
* parenting assessment
 |

The primary or ancillary services above could be 1) provided directly by the operating agency or 2) by partner providers, with whom the operating agency is required to establish agreements or subcontracts and describe the process for provision of services, referral or linkage.

CHEL operating agencies should closely cooperate and/or partner with the following types of service providers to ensure cross-agency planning and coordination:

* medical care, including emergency medical services and primary care
* behavioral health, including withdrawal management, substance use and mental health treatment
* social services case management
* housing assistance
* employment assistance
* legal services
* law enforcement
* child care/parenting support

## SERVICE POLICIES

The delivery of CHEL services will vary based on the service model, location and culture of service provider agencies and the local drug-using community. Nonetheless, CHEL operators should develop specific policies and procedures related to the following aspects of service delivery:

Eligibility

* intent to serve all participants, non-discrimination
* protocols for:
* minors
* pregnant women
* first-time injectors
* those who arrive with children/minors
* those who may be overly intoxicated/drug impaired/physically or mentally ill
* when entry or services may be postponed or denied:
* verbal or physical assault, threatening behaviors
* behaviors prompting removal (violence, unsafe use,)
* suspension of access (terms)

Registration

* tools and process for registration and tracking service use
* participant information required at first and repeat visits, such as:
* name (real or fictitious)
* age/date of birth
* gender
* zip code and housing status
* race/ethnicity
* current drugs used
* drug being used today

Drug consumption

* type of drugs allowed
* use of legal substances including marijuana and alcohol
* prohibited sharing of drugs between participants
* acceptable length of visit, entry cut-offs towards end of operating hours
* number of injections or consumption events per visit
* prohibited assisted injection
* handling, storage, disposal of drugs or possessions left behind by participants

## OPERATING CAPACITY

While the size and operating hours of each CHEL will vary, each CHEL will need to maintain a service capacity that is feasible for the available space, meets service demand and is likely to make a public health impact. Factors that influence sufficient service volumes include:

* Number of consumption stations (size)
* Number of days and hours/day open (access)
* Demand during days and hours open

These decisions can be informed by analysis of 911 overdose response calls, syringe exchange utilization reports, input from participants, and reports from nearby businesses or agencies that serve a similar population.

Managing traffic flow inside and outside the facility will be a high priority. CHEL agencies should implement policies and protocols to:

* reduce wait times to prevent drop outs or outside queuing
* coordinate flow between different areas (reception, consumption, observation)
* maintain reasonable limits on the length of each visit that allow sufficient time to ensure medical safety and give personal attention yet optimize flow and staff availability
* minimize prolonged loitering inside and outside the facility.

## **REQUIRED POLICIES AND PROTOCOLS**

The following five documents are considered essential for all agencies operating CHELs:

* Service Delivery Policies
* Clinical Protocols
* Safety and Crisis Management Protocols
* Administrative Procedures
* Community relations and peer involvement guidelines

The following chart outlines critical content areas for each of these documents, although more could be addressed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Delivery** **Policy Areas**  | **Clinical** **Protocols** | **Safety and Crisis Management****Protocols** | **Administrative** **Procedures** |
| * participant rights and responsibilities
* eligibility
* delay/denial of service
* guidelines for youth, pregnant women, over-intoxicated, first time users
* registration
* visit rules
* police on premises
* community relations
 | * assessment
* supervision of consumption
* overdose management
* respiratory support
* naloxone administration
* cardiac arrest
* follow-up care
* death
* assessment and treatment of other conditions (e.g. soft tissue infections, wound care, acute conditions)
* HIV, hepatitis, STI screening and linkage to care
* risk reduction education and harm reduction counseling
* required equipment and supplies
* documentation
 | * infection prevention and control measures
* standard precautions
* cleaning and disinfection
* waste disposal
* personal protective equipment
* staff training
* occupational exposure
* disaster/fire/earthquake procedure
* evacuation
* crisis management, aggressive behavior or violence
* staff safety
* building and perimeter security
 | * methods of record keeping
* Incident reporting forms
* administrative and clinical documentation
* record storage
* confidentiality
* HIPAA compliance
* neighbor complaint process and resolution
* media inquiries

**Staffing*** job descriptions with required qualifications
* training plan
* key staff responsibilities:
	+ opening and closing
	+ tasks/service area
	+ supply management
	+ managing participant flow
 |

## STAFFING PLAN

Each CHEL will need to determine an optimal staffing model. Staffing plans must ensure adequate coverage based on full utilization during all hours of operations, while maximizing efficiencies in shift scheduling and worker productivity.

Staffing functions include, but are not limited to:

* reception
* medical supervision and clinical intervention
* facility and staff supervision
* syringe exchange, supply maintenance and waste disposal
* supervision of post-consumption space
* participant engagement through social work/case management for health education, treatment and referral services
* security/traffic flow management

CHELs will also need to determine an appropriate staff to participant ratio that ensures adequate staff coverage in each service area of the CHEL (e.g., reception, consumption stations, observation room).

Primary staff positions in a full-scale CHEL are likely to include:

|  |  |
| --- | --- |
| **Facility manager** | Supervises operations, personnel, administrative processes, and financial matters; ensures adherence to all operational, clinical, and safety/security protocols; monitors budget, supply ordering; liaises with community, law enforcement, and local government stakeholders; ensures participant satisfaction and manages response to complaints and feedback from participants and community. Liaison with King County Public Health and DCHS and CHEL evaluation team. |
| **Registered nurse** (or medical provider with higher licensure) | Conducts general medical triage, clinical assessment and treatment of overdose including naloxone and oxygen administration; provides wound care; makes referrals for health care as appropriate. |
| **Health educators and support staff**  | Oversee syringe exchange, provide health education, monitor security and traffic flow; general site maintenance.  |
| **Social worker** | Referrals, linkages and case management for health, substance use disorder treatment, mental health, and social services; provides harm reduction counseling to support participant-driven goals |

All staff are expected to have basic training and current certification (where applicable) in CPR and first aid, blood borne pathogens, HIPAA compliance, and overdose response. Additional training in cultural competency, equity and social justice, and conflict de-escalation are highly recommended.

Volunteers

The scope of volunteer involvement depends on the culture and capacity of the operating agency. While CHEL operators should not rely on volunteers to ensure the minimum level of service, volunteers could fulfill many useful tasks such as greeting, neighborhood sweeps, data management, cleaning or supply management. Many of these roles could be also filled by peers. Volunteers should have the same training as other staff (described above), based on their duties.

Detailed policies are necessary to address volunteer roles (and/or restrictions, if appropriate) and responsibilities, including protocols for screening, training, and supervision.

## BUDGET

Agencies operating CHELs should develop annual, line item budgets detailing capital costs and operating expenses. Staffing and other costs for essential services, along with all available and anticipated sources and amounts of funding, should be detailed. Total budgets will be dependent on particular site locations, renovation requirements, service models and operating hours. Capital costs are expected to be higher in the first year, with operating costs increasing relative to growth in service volume.

Common capital and operating expenses include the following (not a complete list):

|  |  |  |
| --- | --- | --- |
| **Capital Costs** | **Staff and Services** | **Drug Use Supplies** |
| * renovation
* security/utility installation
* furniture
* fixtures/durable goods
* computers/printers

**Medical Supplies*** naloxone (for on-site use and distribution)
* oxygen
* first aid supplies
* pulse oximeters
* sharps disposal containers
 | * salaries
* fringe
* peer stipends
* rent
* insurance
* phone
* internet
* utilities
* printing
* security, alarm
* cleaning service
* community outreach
* legal fees
* facility maintenance
* medical waste disposal
* evaluation
* indirect costs
 | * syringes
* tourniquets
* cottons
* cookers
* alcohol wipes
* water vials
* pipe kits

**Other Supplies*** bus/taxi vouchers
* hand soap/sanitizer
* gloves
* disinfectant
* cleaning supplies
* fire extinguishers, emergency preparedness kits
 |

## GOVERNING AND OPERATING STRUCTURES

The Task Force endorsed three possible governing structures for CHEL operation; each one requires a degree of endorsement or direct involvement by King County.

Option 1: King County as sole operator

Public Health – Seattle & King County, in collaboration with King County Department of Community and Human Services, operates the CHEL and provides all or most of the services.

Option 2: Public-private partnership

King County (either PHSKC or DCHS) contracts with a community-based agency that assumes full or shared responsibility for the provision and evaluation of services. This joint operation model may be more cost-effective and broaden reach and access to the target population.

Option 3: Community agency as sole operator with King County sanction and oversight

A community agency independently operates a CHEL with expressed sanction and oversight by King County. While the community agency would assume full operational and liability for the CHEL, King County would provide oversight to ensure acceptable standards of safety, service delivery and performance measurement. King County would articulate a clear process for community organizations to request sanction from the County as well as criteria for sanction such as:

* provision of essential services and ability to link to other services
* compliance with facility and service model guidelines, as recommended in this document
* detailed written policies and procedures including administrative, clinical and safety protocols
* capacity and plan to conduct robust monitoring and evaluation or ensure necessary data collection to allow evaluation by a partner agency
* adequate staffing plan and budget
* ability to procure liability insurance

Any community organization serving in an operational role should demonstrate the following:

* experience reaching and serving people who use drugs and who have complex social and health problems
* commitment to the goals and core values of the CHEL model
* capacity to provide, supplement or link to essential services
* fruitful and collaborative relationships with other community-based agencies, health care providers and law enforcement
* a strong commitment and capacity to participate in substantial evaluation as designed and directed by King County

A current or previous agency relationship in good standing with King County is beneficial but not mandatory for community agencies considering partnership with King County in CHEL operation.

Any community-based agency considering operating a CHEL, in partnership with King County or independently, should consult with legal counsel to identify potential legal risks. The Task Force recommendations include a summary of legal considerations regarding CHEL operations, which may provide helpful background.

## MEMORANDA OF UNDERSTANDING

In addition to any specific contract agreements, there should be signed Memoranda of Understanding (MOU) between King County, local city government (including local law enforcement) where a CHEL is located, and any community agency involved in CHEL operation. These MOU should clearly outline standards for acceptable use and operation of CHELs and mutual expectations on the roles and responsibilities of each relevant entity regarding issues such as:

* provision of service
* record keeping, reporting and evaluation
* communication with federal and state actors
* legal and political issues (e.g., liability, proper land use)
* fundraising
* neighborhood impact and communication
* adequate and appropriate police presence and agency actions to ensure public safety and order

# IV. PERFORMANCE MEASURES

It is crucial to design and conduct rigorous monitoring and evaluation to measure CHEL service use patterns and the impact of CHEL services on participants and the community. Evaluation is especially critical during the pilot phase. Indicators should be determined prior to operation, and certain measures will be monitored on an ongoing, frequent basis, in order to quickly identify concerns and make timely adjustments in program policy or service design.

**Program Monitoring**

The following are examples of key output indicators that should be tracked with data collection tools as suggested below. The final monitoring plan should be established in collaboration with Public Health and DCHS.

|  |  |
| --- | --- |
| **Outputs** | **Tools** |
| * # and demographics of participants
* # new and repeat visits
* # overdoses reversed on site
* # and type of referrals
* # syringes exchanged
* # naloxone kits distributed
* Facility volume, by day of week and time of day
* # EMS calls
* health issues identified and addressed
* other services provided
 | * registration form
* encounter form
* referral tracking
* overdose report
* syringe exchange tracking
* naloxone distribution and refill form
 |

**Process and Outcome Evaluation**

While operating agencies will be primarily responsible for routine data collection and program monitoring, more extensive process and outcome evaluation will be implemented with the assistance and/or under the direction of PHSKC, DCHS or UW. Third-party evaluators could also be utilized as partners in evaluation design and analysis, including the University of Washington School of Public Health, the Alcohol and Drug Abuse Institute (ADAI), the Harm Reduction Research and Treatment Center (HaRRT), Cardea, and Battelle.

Process evaluation strategies are expected to assess the following:

|  |  |
| --- | --- |
| **Process Measure** | **Sample Questions** |
| **Reach** | * Who is the CHEL reaching demographically?
* Are we reaching and serving all drug-using groups in the local area?
* How far do participants travel to use CHEL services?
 |
| **Quality of implementation** | * Are services delivered properly, according to standards or protocol?
* Do sufficient numbers of participants connect with other services? If no, why not?
 |
| **Satisfaction** | * How satisfied are participants with the services?
* How convenient are the location and hours of operation?
* How well are participants treated by staff?
* How satisfied are partner agencies and community members with CHEL services?
* Complaints received by community members and other public safety incidents
* Is there a process and timeline for responding to concerns?
 |
| **Barriers** | * Which referral services are more difficult for CHEL participants to access and why?
* What prevents potential participants from using CHEL services?
* What challenges prevented us from delivering or scaling up services?
 |
| **Cost Benefit** | * Are costs reasonable in relation to the degree of positive impact?
* Would alternative approaches yield equivalent benefits at less cost?
 |

Outcome evaluation should be linked to the primary objectives of the CHEL. Some examples of outcome measures are outlined below:

|  |  |
| --- | --- |
| **Objectives** | **Recommended Measures** |
| **Reduce** **drug-related health risks and harms,** including overdose deaths, transmission of HIV and hepatitis C infections, and other adverse drug-associated health effects | * prevalence of drug use and injection (by type of drug), syringe and other injection equipment sharing, unsafe injection practices, transition to safer injection and other use practices
* non-fatal overdose, skin and soft tissue infections
* HIV diagnoses, HIV transmission risk among HIV-infect, hepatitis C diagnoses, hepatitis C treatment,
* incidence of fatal and non-fatal overdose
* other drug-related mortality (acute and chronic)
 |
| **Provide access to substance use disorder treatment and related health and social services** to improve health, stability and exit the cycle of addiction and homelessness. | * enrolled and maintained on buprenorphine treatment, enrolled and maintained on methadone treatment,
* referrals, linkages, care coordination for substance use/mental health/primary care/housing, etc.
 |
| **Improve public safety and the community environment** by reducing public drug use and discard of drug using equipment near the CHEL.  | * syringes, paraphernalia and litter around CHEL, property values
* neighborhood perceptions
* visible drug use
* crime data
 |
| **Use public dollars more efficiently** by reducing costly criminal justice involvement and burden on emergency medical services. | * number of OD-related first responder calls, 911 calls
* EMS/ER use
* crime data
* cost-effectiveness - compare to cost of a 911 call, ER visit, one overdose
 |

When and where possible, CHEL utilization and outcome data should be linked with other available datasets (e.g., utilization of housing services, jail admissions, emergency room visits, police department data) to understand the health needs and patterns of care among CHEL participants who interface with other health and social services.

# V. APPENDICES

A. Community Health Engagement Locations: Frequently Asked Questions

B. Sample Neighbor Relations Plan

C. Community Engagement Worksheet

D. King County Equity Review Tool: Introduction

**Appendix A**

### Community Health Engagement Locations: Frequently Asked Questions (FAQ)

1. **What is a Community Health Engagement Location (CHEL site)?**

A CHEL site is a public health service for people with substance use disorders that provides access to medical, behavioral health and social services, either directly on-site or through referrals. CHEL sites also provide space for hygienic consumption of drugs under the supervision of a healthcare professional trained in overdose response and safer drug consumption practices. Similar sites around the world are commonly referred to as supervised consumption sites (SCS) and other similar names. The term “CHEL” is specific to Seattle and King County.

CHEL sites are designed to improve the health of persons with substance use disorders by decreasing the risk of transmission of blood borne viruses like HIV and hepatitis C, preventing overdose deaths, providing needed medical care and social and behavioral health services, and importantly, providing an access point for treatment of drug use disorders (addiction).

Additional health services provided at CHELs include education on safer consumption practices, needle exchange, wound care and medical consultation, counseling and case management, and referral to treatment and other services.

There are approximately 90 sites around the world that, for public health reasons, provide supervised, safe locations for consumption of drugs. Most of these sites are in European countries and Australia and many have been operating since the late 1980’s. Vancouver, BC, Canada, has a site that has been operating for over 12 years.

1. **What are the goals of Community Health Engagement Locations** (**CHEL sites)?**

CHEL sites are intended to achieve the following three main goals:

* **Reduce** **drug-related health risks and harms, including:** overdose deaths, transmission of viral infections such as HIV and hepatitis C, and other adverse drug-associated health effects.
* **Provide access to substance use disorder treatment and related health and social services** to improve health, reduce criminal justice involvement and reduce emergency medical services utilization.
* **Improve public safety and the community environment** by reducing public drug use and discarding of drug using equipment in the area near the CHEL site.

Published studies support the effectiveness of the services provided at supervised consumption sites (SCS) in reducing drug-related health risks and overdose mortality for individuals utilizing the SCSs. Available studies do not reveal an increase in criminal activity or negative impacts on the communities where these sites are located.

1. **Who are CHEL sites meant to serve?**

CHEL sites are part of a network of services to address complex health and social needs of the most vulnerable and marginalized members of our community with substance use disorders, many of whom are also experiencing homelessness.

1. **What are other names for CHEL sites?**

Other names used for these services include: “supervised/safer consumption site” (SCS); supervised/safer injection facility” (SIF); “supervised/safer injection service” (SIS); and “drug consumption room” (DCR). While the names vary, the underlying idea is the same: to reduce the harms associated with drug use by providing a hygienic, supervised space and ready access to treatment as well as other social and health services.

1. **Why are you using the name “Community Health Engagement Location” (CHEL site)?**

While a safe space to consume drugs under the supervision of a health care provider can reduce overdose deaths and transmission of infections like HIV, the King County Heroin and Prescription Opiate Task Force (Task Force) recommended a greater goal: providing more comprehensive services to help people with substance use disorder return to heath and ultimately, to productive lives. Therefore, a number of other key health services are included in the CHEL site, such as access to medical and behavioral health care, social services (such as housing assistance) and, importantly, access to treatment for substance use disorder.

When individuals who are suffering from substance use disorder are engaged in health and social services, their likelihood for positive health outcomes increases. Therefore, the Task Force recommended a more comprehensive health engagement through services like wound and abscess care, social service assistance, and access to treatment for substance use disorder as the best strategy for long term success.

This terminology­– “Community Health Engagement Location”– recognizes the need to use multiple approaches to reduce harm and promote health for individuals experiencing substance use disorder. Promoting safer consumption of substances and immediate treatment of overdoses are two ways to promote health. CHEL sites will utilize several additional of several approaches to further promote the health and well-being of people with substance use disorder.

Equity and social justice considerations emphasize the importance of providing readily accessible support and services to the most marginalized individuals experiencing substance use disorders in King County. The designation “CHEL sites” is a non-stigmatizing term that recognizes that these sites provide multiple health interventions to decrease risks associated with substance use disorder and promote improved health outcomes.

1. **What is the evidence that CHEL sites can achieve these goals?**

The impacts of supervised consumption sites (SCSs) have been studied in Canada, Europe, and Australia. The SCS in Vancouver, BC, has been studied most extensively and the results of evaluations are available online at <http://uhri.cfenet.ubc.ca/content/view/57/92/>

Although the specific impacts of a CHEL site may vary from community to community, papers published in scientific journals show that SCSs have positive outcomes, not only for people who use the services, but also for the surrounding community. The findings of these studies show that SCSs:

*Prevent overdose deaths in the facility*

* Over nearly 30 years of operation, tens of millions of drug consumptions have occurred in SCSs around the world, **but no overdose related deaths have occurred.**
* The SCS in Vancouver, BC prevents an estimated 2-12 overdose deaths every year and has had no reported deaths in over 12 years.[1](https://www.ncbi.nlm.nih.gov/pubmed/19423324),[2](https://www.ncbi.nlm.nih.gov/pubmed/?term=Estimated+drug+overdose+deaths+averted+by+North+America’s+first+medically-supervised+safer+injection+facility)

*Reduce overdose deaths in the community*

* Over 4 years, overdose fatalities within 500 meters of a supervised injection facility in Vancouver, BC, dropped 35% compared to a 9% reduction for the rest of the city.[3](https://www.ncbi.nlm.nih.gov/pubmed/?term=Reduction+in+overdose+mortality+after+the+opening+of+North+America’s+first+medically+supervised+safer+injecting+facility%3A+A+retrospective+population-based+study)
* A study of German drug consumption rooms showed a close statistical relationship between the opening of consumption rooms and a long term reduction in the number of drug-related deaths. In Hamburg, the association wasn’t seen until the opening of the third consumption room. In Frankfurt, the relationship wasn’t seen until a fourth consumption room was opened.[4](http://www.salledeconsommation.fr/_media/evaluation-of-the-work-of-dcr-in-the-federal-republic-of-germany-2003.pdf)

*Reduce demand for emergency services related to overdoses*

* A study in Sydney, Australia found that the number of ambulance call-outs for opioid-related overdoses declined significantly in the vicinity of the SCS after it opened, compared to the rest of NSW. This effect was greatest during operating hours and in the immediate SCS area, suggesting that SCSs may be most effective in reducing the impact of opioid-related overdose in their immediate vicinity.[5](https://www.ncbi.nlm.nih.gov/pubmed/?term=The+impact+of+a+supervised+injecting+facility+on+ambulance+call-outs+in+Sydney)

*Reduce high-risk injection behaviors linked to negative health consequences*

* People who consistently used Vancouver’s SCS were less likely to share syringes, reuse syringes, rush injections, and inject in public spaces. They were more likely to use sterile water, clean the injection site with alcohol, and safely dispose of used syringes.[6](https://www.ncbi.nlm.nih.gov/pubmed/16039335),[7](https://www.ncbi.nlm.nih.gov/pubmed/?term=Changes+in+injecting+practices+associated+with+the+use+of+a+medically+supervised+safer+injection+facility)
* Interviews of visitors to SCSs in Copenhagen, Denmark found: 75% reported reduced high-risk injection behavior, 56% no longer shared syringes, 54% cleaned injection sites more often, and 63% reported fewer outdoor injections.[8](https://www.ncbi.nlm.nih.gov/pubmed/?term=Self-reported+changes+in+drug+use+behaviors+and+syringe+disposal+methods+following+the+opening+of+a+supervised+injecting+facility+in+Copenhagen%2C+Denmark)

*Increase use of detoxification services and substance use disorder treatment*

* After the SCS in Vancouver opened, there was a 30% increase in use of detoxification services.[9](https://www.ncbi.nlm.nih.gov/pubmed/?term=Rate+of+detoxification+service+use+and+its+impact+among+a+cohort+of+supervised+injecting+facility+users)
* People who regularly visited the SCS were 33% more likely to start addiction treatment and those who had contact with an addiction counselor in the SCS were 54% more likely to start.[10](https://www.ncbi.nlm.nih.gov/pubmed/?term=Injection+drug+use+cessation+and+use+of+North+America’s+first+medically+supervised+safer+injecting+facility)
* A study comparing community drug use patterns before and after the opening of the SCS found no substantial increase in relapse rates and no substantial decrease in the rate of stopping drug injecting.[11](https://www.ncbi.nlm.nih.gov/pubmed/?term=Impact+of+a+medically+supervised+safer+injection+facility+on+community+drug+use+patterns%3A+a+before+and+after+study)

*Reduce drug use in public spaces*

* Numbers of people injecting in public in the vicinity of Vancouver’s SCS were counted before and 12 weeks after the opening of the facility. The opening of the service was associated with a reduction in the number of people injecting in public spaces.[12](https://www.ncbi.nlm.nih.gov/pubmed/?term=Changes+in+public+order+after+the+opening+of+a+medically+supervised+safer+injecting+facility+for+illicit+injection+drug+users)
* Multiple studies European have found reduced public drug use as the result of drug consumption rooms.[13](http://www.bag.admin.ch/evaluation/01759/02066/02343/index.html?lang=en&),[14](http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf)

*Reduce the amount of improperly discarded syringes and injection related litter*

* A study measured the amount of discarded syringes and injection related litter in the vicinity of an SCS before and after it opened. There was a significant relationship between the opening of the SCS and a reduction in syringes and other drug related litter found in the area.[12](https://www.ncbi.nlm.nih.gov/pubmed/?term=Changes+in+public+order+after+the+opening+of+a+medically+supervised+safer+injecting+facility+for+illicit+injection+drug+users)
* A survey of SCS visitors found that 71% reported less outdoor injecting as a result of the availability of the SCS.[15](https://www.ncbi.nlm.nih.gov/pubmed/?term=Injection+drug+users’+perceptions+regarding+use+of+a+medically+supervised+safer+injecting+facility.)
* Multiple studies in Europe have found a reduction in syringes and injection related litter result of drug consumption rooms.[13](http://www.bag.admin.ch/evaluation/01759/02066/02343/index.html?lang=en&),[14](http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf)

*Do not contribute to an increase in crime, violence, or drug dealing*

* A study in Sydney, Australia concluded that trends in property crime and drug-related offenses were the same in the area around the SCS and the rest of the city.[16](http://www.bocsar.nsw.gov.au/Documents/BB/bb90.pdf)
* Following the opening of Vancouver, BC’s, SCS, there was no increase in drug trafficking or assaults/robberies. There was a decline in the number of break-ins and vehicle theft in the area.[17](https://www.ncbi.nlm.nih.gov/pubmed/?term=Impact+of+a+medically+supervised+safer+injecting+facility+on+drug+dealing+and+other+drug-related+crime.)

*Are cost effective*

* The Vancouver, BC, SCS saves $5 for every $1 spent. This is based on a conservative estimate that the Vancouver SCS prevents 35 new cases of HIV and 3 overdose deaths per year.[1](https://www.ncbi.nlm.nih.gov/pubmed/19423324)
* Another study estimated that the Vancouver, BC, SCS saves between $14 million and $20 million over a 10-year period.[18](https://www.ncbi.nlm.nih.gov/pubmed/19015565)
1. **Has anyone ever died from a drug overdose in a SCS?**

Over nearly 30 years of operation, tens of millions of drug consumptions have occurred in SCSs around the world, **but no overdose related deaths have occurred.**

1. **Will CHEL sites increase drug use?**

Similar concerns were raised in the past regarding the effect of needle exchange programs, but have not been borne out.  Fear that increased availability of sterile needle exchange programs might exacerbate illicit drug use was a major factor delaying adoption and expansion of these programs.

Research consistently shows that syringe exchange programs reduce transmission of HIV, are cost effective, can increase recruitment of drug users into treatment programs and provide needed medical care, and are not associated with major negative unintended consequences.  For example, studies have searched for and found no convincing evidence that needle exchange programs result in greater injection frequency, increased illicit drug use, recruitment of new users, less motivation to reduce drug use, or increased transition from non-injecting drug use to IDU.[19](http://www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf)

In addition to the substantial experience with syringe exchange programs, evaluation of existing sites where supervised drug consumption occurs has not shown an increase in drug use or major unintended consequences (see 6, above).

1. **Who will work at CHEL sites?**

The Task Force recommended the CHEL sites should be staffed by nurses, social workers, case managers, and peer support workers. Staff are trained in an overdose response protocol.

1. **What is the history of supervised consumption sites?**

The first successful sanctioned drug consumption room (DCR) was established in Berne, Switzerland in 1988, though unofficial services had been operating across Europe since the 1970’s. More DCR’s were established in several European countries, including Germany, The Netherlands, Spain, Luxembourg, Norway, and Denmark, throughout the 1990’s and 2000’s. In 2001 a medically supervised injecting center (MSIC) was opened in Sydney, Australia. In 2003, InSite, currently North America’s only supervised injection facility (SIF) opened in Vancouver, BC. As of 2010, there were approximately 90 official safe SCSs in Europe, Australia, and Canada.[20](http://www.emcdda.europa.eu/system/files/publications/555/downloads/att_101273_EN_emcdda-harm%20red-mon-ch11-web.pdf) The [first SCS in France](http://www.undrugcontrol.info/en/newsroom/latest-news/item/7179-frances-first-injection-room-for-addicts-opens-in-paris) opened in Paris in October 2016 and more are set to open in other French cities.

1. **What is “harm reduction”?**

Harm reduction is a set of practical strategies to reduce risks associated with substance use among people who are actively using substances and not ready to participate in treatment.  For example, harm reduction strategies reduce risks for HIV and other infectious diseases, prevent overdoses, and help engage substance users in treatment.  CHEL sites and other supervised consumption sites are considered a harm reduction intervention.

1. **Will CHEL sites solve the heroin epidemic in King County?**

No. The heroin and opioid drug epidemic is a complex issue that requires a comprehensive, multi-strategy approach to prevent initiation of illicit substance use, expand access to medication-assisted and other types of treatment, reduce health and social harms associated with substance use disorders, and reducing the illicit drug supply.

The [Heroin and Prescription Opiate Task Force](http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/heroin-opiates-task-force.aspx) made a number of [recommendations](http://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-_Force-Report.ashx?la=en) to address the opiate epidemic in King County. The recommendations focus on preventing people from developing opioid use disorders, identifying and treating people with opioid use disorders, expanding and enhancing treatment options for opioid use disorders, and improving the health of opioid drug users including through expanding the distribution of naloxone to prevent overdose deaths.

Another recommendation to improve the health of opioid drug users is to establish and evaluate two CHELs in King County on a 3-year trial basis. The results of the evaluation are to help understand the effect and consequences of the CHEL sites, including how well they are meeting their goals and whether the sites should be continued or not.

The goals of CHEL sites as stated in the Task Force recommendations are to a) reduce drug-related harms and risks, including overdose death and transmission of HIV and hepatitis C, b) provide access to treatment and other health and social services, and reduce involvement with the criminal justice system, and c) to improve public safety by reducing drug use in public spaces and the discarding of syringes in public spaces.

1. **Where can I learn more about CHELs and SCSs?**
	* [Read the full Heroin and Prescription Opiate Task Force Final Report and Recommendations here.](http://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-_Force-Report.ashx?la=en)
	* [Read about information on drug consumption rooms provided by the European Monitoring Centre for Drugs and Drug Addiction](http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms)
	* [Read about SCSs around the world](http://www.drugconsumptionroom-international.org/) and find links to publications under the [Research link](http://www.drugconsumptionroom-international.org/index.php/library/research/library-research).
	* Read about Vancouver’s supervised injection facility “InSite.”

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**Appendix B**

### Sample Neighbor Relations Plan

#### *Molly Carney, Executive Director at Evergreen Treatment Services*

Opiate treatment programs and other locations providing care for individuals experiencing opioid use disorder (for example, syringe exchange programs, community health engagement locations for persons with substance use disorders) should consider the following practices to establish and maintain good neighbor relations.

**Clearly articulated hours and rules of business:** For facilities where medication is being dispensed, hours of dispensing should be publicly available and followed. Any terms that participants must abide by should be readily available to the neighbors and the public.

**Public Safety staff**: Public Safety staff should be employed by the facility who are to be active during the dispensing hours. These staff should be specially trained in how to work with individuals experiencing opioid use disorder, mental health issues, and trauma histories. These staff should also be specially trained to work with participants varying in age, race, ethnicity, gender, sexual orientation, primary language, and cognitive ability.

**Numbers**: There should be sufficient Public Safety staff to lend order inside and outside of the facility to at least the organization’s property line (where authority is explicit) or to nearby manageable landmarks (for example, an intersection). Inside, Public Safety will help the clinic staff maintain any Code of Conduct or admission criteria established by the business. Outside, the staff will be attending to issues of loitering, drug dealing, or behavior that interferes with the neighboring businesses (for example, shoplifting).

**MOU**: Businesses adjacent to the target business may be encouraged to enter into a Memorandum of Understanding (MOU) which is intended to help facilitate communication between the entities. This MOU may permit the target business to allow their Public Safety staff to patrol the business property. The MOU should be reviewed and renewed on an annual basis.

**Monthly rounds to business neighbors**: Public Safety staff should make rounds to business owners or their managers on at least a monthly basis. Inquiries should be made regarding what’s working well, what could be improved and/or escalation information if necessary (for example, who to contact if a business manager desires to escalate a complaint upward). These staff shall summarize their monthly rounds in a written document that is to be circulated to the executives and operation managers of the target business and a review team member who is a participant that represents the intervention population. This summary shall include recommendations for how to rectify any complaints or problems. The target business shall be expected to help the Public Safety staff address or resolve complaints or problems within one week of the original complaint and shall include either a written response to the business owner/manager or a return visit by the Public Safety staff with the proposed resolution. The target business may consider implementing a monthly newsletter to neighboring businesses, which summarizes clinical outcomes (for educational purposes) and the response to neighborhood issues.

**Appendix C**

### Community Engagement Worksheet

**Project Title:**

**Project Lead:**

**Program Name:**

**Timeline:**       to

**How to use this worksheet:**

This worksheet will assist you in thinking about your process, purpose, primary audience, potential barriers, impacts and strategies to inform and involve your intended audience before you begin. Below are some key questions with prompts to guide and direct you before beginning and during your engagement process. You may reference the Community Engagement Continuum to determine the level and methods of engagement that best suit the type work you are doing.

**What is the purpose of your engagement?**

**1. State briefly why you are doing the community engagement:**

What do you hope to achieve? What is your main purpose for involving community members? Where does your engagement fit best on the continuum? Is there enough time to engage properly?

**2. Who are the key stakeholders or partners? Who is affected by, involved in, or has a specific interest in the issue?**

**Stakeholders and audiences**

What steps will you take to ensure impacted communities that have not historically been included in the initial decision making phase be included? Are there specific communities that will impacted/affected by decisions or processes related to engagement? How will you utilize internal staff expertise to provide technical assistance or consultation to ensure inclusive stakeholder involvement? Are stakeholder groups defined (e.g., neighborhoods, topic area, ethnic or racial, language, gender, tribal, etc.)? Do you or others in the county have appropriate partnerships or contacts in place to initiate and support the adequate county level of engagement?

**What strategies will you use to ensure you have information from and research about the relevant groups and communities?**

**3.** Have you gathered adequate background information about the affected populations you intend to reach? (i.e., language or dialect spoken, customs, historical or geographic data, relevant data reports). For example, see [Communities Count – Indicators for King County](http://www.communitiescount.org)). What other research will you need to better know and understand your public? How will you identify community strengths and assets?

**4A. How will you make sure you are effectively reaching all of your audiences?**

A. How do you plan to address language and literacy needs including translations, interpretations and reading levels? (See the [Plain Language Style Guide](http://www.kingcounty.gov/exec/styleguide/plainwriting) and [King County executive order on written language translation](http://www.kingcounty.gov/exec/styleguide/translation.aspx)) and Guidelines for Accessible Printed Materials kcweb.metrokc.gov/dias/ocre/printguide.pdf

**4B. Have you taken into account that alternative and non-traditional approaches to consider before proceeding?**  Does your intended audience have their own engagement practices that should be considered? Alternatively, does your audience or community use new and social media (e.g., web videos, texting), and could this be an effective way of reaching them?

**Barriers and risks**

**5. What do you perceive as barriers and risks to doing this work?**

Are there trust issues among members of the public or a community that may prevent full engagement (i.e., social, political, tribal, gender specific)? How will you address the diverse cultural differences among affected communities? Is there adequate justification for proceeding with your project concept (i.e. time, cost, level of interest)? Is there community and public support for your project? What are some unintended consequences of the project if not done effectively? Are there strategies in place to address unintended consequences?

**Decision-making process and communications**

**6A. If there are decisions to be made, how does the engagement fit into the overall decision-making process?**

Are there processes in place to involve affected communities in decisions at different levels and phases? Do you have representation from affected communities in decisions? What decisions need to be made after the engagement and how will the community be involved in that process? How will the affected community be informed of final decisions? Do you have a standard point of contact for community members?

**6B. What is in place to inform community of benchmarks or progress about your project?**

How will you recognize the contributions of community members? Will there be opportunities for formal project/program updates and feedback (i.e. meetings, website updates, phone calls, e-mail)? Is there budget for printing and circulating a report on the outcomes? Who will inform the community on impacts of final decisions? What steps will be taken to maintain opportunities for future collaboration or engagement?

**7. How will you evaluate the success of your project both in terms of process and outcomes?**

**Evaluation and monitoring of success**

Were you able to successfully reach the intended audience? Did people receive the necessary information they needed to make a relevant response? Did you choose the right type or level of engagement to match the purpose? Was feedback received from the community positive or negative? Did the community feel like they received proper feedback on the results of the engagement? Did they indicate they want to be part of a similar process again? If not, why not? What would you do differently to make the process better, more inclusive, and more impactful?

**Logistics and things to consider for planning community meetings:**

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| ***The logistics of community engagement is critical for turnout and community interest. Paying attention to a number of logistical issues will enhance participation and improve the overall effort. Some things to consider:*** |
| **Venue** | Making meetings geographically close to communities or stakeholders is critical to get a good turnout. Choosing a site that is community centered may more familiar and comfortable for attendees. Does the venue accommodate for public parking and transportation? |
| **Host** | If inviting public officials make sure you have followed appropriate channels before inviting them to participate. Clarify in advance the role for County Executive, Council members, Public Information Officer and community members prior to the engagement. |
| **Staffing**  | Will you use program staff, other King County staff or partner staff to help with set up, welcoming, and meeting facilitation? |
| **Budget**  | Is your budget adequate to provide resources for advertising, communication and promotion, rental space, refreshments/food, transportation, child care, translation/interpretation? |
| **Accessibility** | Is the location wheelchair accessible and code approved for people with disabilities? |
| **Time** | Do you have staff that can attended evening or weekend meetings? Can you accommodate community members to hold evening or weekend meetings? |

**If you have questions or need assistance contact:**

|  |
| --- |
| **Matias Valenzuela 206.205.3331; Matias Valenzuela@kingcounty.gov**  |
| **June Beleford 206.263.8762; June.Beleford@kingcounty.gov** |

**Appendix D**

### Equity Review Impact Tool: Introduction

Through adoption of the King County *Strategic Plan 2010-2014: Working Together for One King County*, King County has transformed its work on equity and social justice from an initiative to an integrated effort that applies the countywide strategic plan's principle of "fair and just" intentionally in all the county does in order to achieve equitable opportunities for all people and communities.

The *Equity and Social Justice Ordinance* establishes definition and identifies specific approaches necessary to implement and achieve the "fair and just" principle. The ordinance calls for King County to “consider equity and social justice impacts in all decision-making so that decision increase fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency or, when decisions that have a negative impact on fairness and opportunity are unavoidable, steps are implemented that mitigate the negative impact.”

The *Equity Impact Review* (EIR) tool is both a process and a tool to identify, evaluate, and communicate the potential impact - both positive and negative - of a policy or program on equity. Relevant definitions from the Equity and Social Justice Ordinance include:

"Equity” means all people have full and equal access to opportunities that enable them to attain their full potential.

"Community" means a group of people who share some or all of the following: geographic boundaries, sense of membership, culture, language, common norms and interests.

"Determinants of equity" means the social, economic, geographic, political and physical environment conditions in which people in our county are born, grow, live, work and age that lead to the creation of a fair and just society. Access to the determinants of equity is necessary to have equity for all people regardless of race, class, gender or language spoken. Inequities are created when barriers exist that prevent individuals and communities from accessing these conditions and reaching their full potential.

This tool, which consists of three stages, will offer a systematic way of gathering information to inform planning and decision-making about public policies and programs which impact equity in King County. The three stages are as follows:

**Stage I: What is the impact of the proposal on determinants of equity?**

The aim of the first stage is to determine whether the proposal will have an impact on equity or not.

**Stage II: Assessment: Who is affected?**

This stage identifies who is likely to be affected by the proposal.

**Stage III: Impact review: Opportunities for action**

 The third stage involves identifying the impacts of the proposal from an equity

 perspective. The goal is to develop a list of likely impacts and actions to ensure that

 negative impacts are mitigated and positive impacts are enhanced.

The complete King County Equity Review Impact tool with guides and worksheets can be found at:

***www.kingcounty.gov/elected/executive/equity-social-justice/tools-resources.aspx***

1. The complete set of Task Force recommendations can be found at: [www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/heroin-opiates-task-force.aspx](http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/heroin-opiates-task-force.aspx) [↑](#footnote-ref-1)