Substance Use Recovery Services Advisory Committee Meeting Notes

September 9, 2022, 9:00am-12:00pm PDT

Meeting Recording

[WA State Substance Use Recovery Services Advisory Committee (SURSAC) September 9, 2022 - YouTube]

Attendance

HCA Executive & Administrative Support

☐	Jason McGill, Executive Co-Sponsor	☒	Tony Walton, 5476 Project Manager	☒	Michael Zayas, Admin Assistant
☒	Michelle Martinez, Administrator	☒	Brianna Peterson, Plan Writer	☒	Sandy Sander, Admin Assistant
☒	Blake Ellison, Meeting Facilitator				

Committee Members (28)

☒	Michael Langer	☒	Amber Daniel	☐	Donnell Tanksley
☐	Amber Leaders	☒	Brandie Flood	☒	Malika Lamont
☒	Sen. Manka Dhingra	☒	Stormy Howell	☒	Addy Adwell
☐	Sen. John Braun	☒	Chad Enright	☒	Kevin Ballard
☒	Rep. Lauren Davis	☒	John Hayden	☒	Hunter McKim
☒	Rep. Dan Griffey	☒	Sarah Melfi-Klein	☒	Kendall Simmonds
☒	Caleb Banta-Green	☐	Sherri Candelario		
☒	Don Julian Saucier	☐	Hallie Burchinal		**Alternates / Optional Attendees:**
☐	Kierra Fisher	☒	Theresa Adkison	☒	Rep. Jamila Taylor
☐	Alexie Orr	☒	Sarah Gillard	☐	Rep. Gina Mosbrucker

Teams Meeting Attachments

- Presenter biographies
- Top polled Policy Options for 09-09 Discussion
- Resources related to possession response_updated 09-08-2022 (updated with information related to Portugal model)
- ACLU presentation
- Pre-Arrest Diversion presentation (LEAD)
- Overview of Safe Supply Initiatives
- Oregon Measure 110 presentation

Subject Matter Expert Presentations

Slides from each presentation are attached to the calendar meeting invitation, and shared via email to SURSAC members.

Mark Cooke (ACLU of Washington)

For full content from this presentation, please refer to Mark's presentation slides, included as an attachment in the calendar invite for this meeting.

Links/resources shared:

- I-1715 (2020)
- HB 1499 "Pathways to Recovery Act" (2021)
- I-1922 "Commit to Change WA"

Q: Appreciate your presentation around the safe supply issue. I am wholeheartedly with you that that's probably the only way to address this really contaminated drug supply that we have. I'm just wondering how a state recommendation would work with federal guidelines around NDA standards around that, and if there is realistically a path through to get that implemented.

A: The short answer is we're at the beginning stages, I think of identifying a safe supply policy answer that's really going to work. But I think there's some lessons we can learn from other contacts. And I would start with marijuana, right? When I-502 passed in 2012, in November, we had no idea if the federal government the next day was going to come shut it down. And they can enforce their law at any point. But I think they realize that it is a balance between States and federal government and that there must be some balance there. If it is a prescriber model, the DEA is going to be in the middle of it. But I think we must start somewhere and start the conversation. And there can be creative ways to get around those issues. I think the call to action would be, let's get experts together and figure out options for doing it because just allowing fentanyl to be the primary source of opioids for many people I think is unacceptable.

Q: You mentioned that the civil infraction wasn't a huge motivator for people. Was that a huge motivator for them to get into treatment*? That's how I took it. What would motivate people get into treatment?*

A: I think it was two things. And I'm excited that Tera Hurst is going to talk about Oregon and that, even then, you saw real variability in terms of who was using civil infractions and where they motivated people. And I think the evidence thus far, and that could change, was that they weren't super successful.

I think in Washington, our civil infraction law does allow people to be criminalized, ultimately, if they don't follow through. So that weighed on us and then ultimately, it was people that had been directly impacted by drug laws. That said, this is just going to make life more difficult for us, it's not going to be a good motivator.

What I truly believe is if you create the low barrier alternatives, people will use them. They are rational, right? And it just can't be some one-size-fits-all abstinence based only program that doesn't work for a lot of people. I think those should be options too. But I think you really must create the infrastructure that's going to do the hard work of engaging with people. Figuring them out as people, as humans and then offering them the alternatives to what they are currently doing. And if we build that, I think people will respond to it. And I think if you talk to people on this call that do that work already, you'll have many, many success stories to learn from. So that is my hope. You can

disagree with it, but I think that if you if you create the right alternative, people will engage with them.

Q: What do decriminalization and legalization mean exactly? What are the implications legally for people who use drugs?

A: The technical difference is that decriminalization just says that it is no longer a crime to possess something. And that's really all the law changes, whereas legalization generally is meant to also create some type of legal access to it where you can sell it and do all these other things. And there's a whole gamut of what legalization is. We should be very careful in saying that alcohol is legalized, marijuana is legalized, but in a different way, and there's all sorts of in-betweens there in terms of what a legalization can model can look like. And that would be what really matters for a person who's using. It's legal. Maybe if you go get some type of prescription from a doctor, it's totally different than we have a store dedicated that anybody of a certain age can go into to buy something. It's very important to be precise when you're talking about these various models.

For additional questions related to this presentation, email Mark at mcooke@aclu-wa.org

"Maximizing Pre-Booking Diversion & Building Consensus after Blake," WA-LEAD Technical Assistance Team

For full content of this presentation, please refer to the WA-LEAD Technical Assistance Team's slides, included as an attachment in the calendar invite for this meeting.

Q: *How can we learn more and see examples of LEAD and/or stories from people that have benefitted?*

A: (Lisa Daugaard) I'll share a link in the chat: Lessons from Seattle: How this alternative to jail may be a solution for Utah - Deseret News

Lisa Daugaard commented that the Recovery Navigator Program is playing out around the state in different ways, and except where it's feeding additional resources into existing LEAD programs, they are all at micro-demonstration level. In no community, including Seattle, is LEAD operating at scale such that it is a system t hat can always respond as needed. But Seattle is a little bit closer to that than in any other community. One of the best things that the criminal legal system has going for it, and why people find it appealing, is that it's always open and at least theoretically, it can always come, and alternatives are not scaled in that way. And that's the gap and that's so important to recognize. There's a reason that there's no visibility of these things in your communities.

For additional questions related to this presentation, contact Lisa Daugaard (lisa.daugaard@defender.org) or Malika Lamont (malika.lamont@defender.org)

"Safe Supply 101," Adam Palayew (UW)

For full content of presentation, please refer to Adam's presentation slides, included as an attachment in the calendar invite for this meeting.

Table Characteristics of different safe supply frameworks under consideration.				
Scenario	Framework 1: Prescription (supervised consumption)	Framework 2: Prescription (unsupervised consumption)	Framework 3: Buyer's Club	Framework 4: Dispensary (not for profit/for profit)
Description	Drugs are prescribed and administered in a supervised setting under the care of health professionals and/or peer workers.	Drugs are prescribed and dispensed by a health care provider at a dedicated facility, but have the option to administer it on their own terms outside of a supervised setting, such as their own home, in take home doses.	Buyers Club: Network of People in the Community. Pool Money and Buy from a Source. Smaller than a Compassion Club . Buyers come together and collective purchasing. (e.g. Dallas Buyers Club; History of HIV Meds). Grassroots, no physical location. Less institutional	Drugs can be made available without prescription in dispensaries and shops (e.g., cannabis, hallucinogenic mushrooms, poppy seed tea, opium bulbs). Liquor Store Model; Compassion Club Model Membership Model)
Delivery	Prescriber	Prescriber	Alternative	Alternative
Population coverage	People with SUD in contact with health system	People with SUD in contact with health system	All people who use opioids	All people who use opioids

Q: (Part 1) You can look at the reduction in death among people who participate in the program. But how about people out in the community? So that's the first question.

A: There is ongoing work to try and find the answers to those questions. It's very hard to evaluate cause then you need to go and find people who got these diverted medications, which isn't always easy. There is some qualitative research around it, nothing quantitative, but the qualitative research is focused on some people getting diverted medications, and it was safer for them. Some people call it diversion, a reframing of it would be like secondary safe supply or secondary treatment.

However, it there is a real concern that people could be getting these medications, and then new people using them. But I think the alternative is that they would just be accessing the street supply instead of these medical grade medications or drugs. The issue becomes that someone who's accessing the illegal supply is at a much higher chance of overdosing and dying and not knowing what they're putting in their body versus one of these diverted medications. I think diversion is a real issue. It's hard to quantify. I think there's both benefits and negative consequences to it.

In some of the ongoing modeling work, there are threshold analyses built in around diversion that address what happens if 50% of drug use increases based off these models, what happens if 100% increase? What happens if there's a 150% increase in people accessing these drugs? You can change the amount of people that will increase and see at what point where your model would say that more overdose deaths are happening because we're implementing this, and so

you can get out a number for what percent increase would need to happen to get to have diversion be an issue where at a population level.

Q: *(Part 2) And the second question is the question about scale. I can see this being extremely helpful for people, but at least my knowledge of the programs in Vancouver, in Zurich, is it's only a small number of people. And given how big this current epidemic is we're in, I think it's important to do everything we can, but it's also important to be realistic about how many people were going to affect.*

A: I think scale is a huge issue and it's been tremendously successful for those who've accessed it. However, as they've tried to scale it up, there's tons of barriers. Some positions have not been willing to prescribe it. They say it goes against their Hippocratic Oath. There are pharmacists who refuse to fill prescriptions. It's hard for people to access it. It's only to people with a substance use disorder. Thinking boldly about models that are widely accessible to people in terms of regulating like cannabis and alcohol is how you're going to have the most scale and impact.

However, that also comes with more extreme options that we have for a safe supply. And I think the prescriber base states supplies can be thought of a lot as a continuation of treatment as we've talked about before, where if you're giving someone heroin three times a day or twice a day, like how they're dispensing methadone. You need to dispense heroin more because it's a shorter half-life, but you basically have just another option for treatment for people.

Q: You had mentioned the prescribe and take-home method and then I think you alluded to some of the difficulties with that, having doctors willing to prescribe and pharmacists. Are there places where that is successful right now? The reason why I ask is, just looking at my community, I can't imagine a location where a clinic could go in where there wouldn't be total outrage by the neighborhood. I'm intrigued by the prescribed-and-take-home option, so are there places where that is being tried?

A: Yes, that's been tried in several places, and it's been very successful. Vancouver is one of them. I presented some of those results. There's published data from Switzerland where they found that both by relaxing the take home requirement instead of having people to come to the clinic every day, they both increase the number of people they were able to expand it to, cause it allowed it to people more people to accommodate it in their lives, as well as they didn't have any increase / they didn't have any overdoses in that program. It's being done successfully. There are multiple places in Canada and those references and evidence are in the slides.

On the other hand, you're talking about, you know, the political reality of this, and would it be acceptable and all of that? And I would say you can't know until you try. I completely agree that there will be a ton of political backlash if one of these are implemented. I think we could all see the headlines already of what would happen. Someone made a comment in the chat about, dare I ask, who's paying for this? And I would say that implementing these, as I said, it's there end up being cost saving these programs because you're reducing the burden on the medical system.

A lot of this evidence now is going to be coming out showing cost effectiveness or cost savings with these programs that have been operating for over a year now in other countries, and the economic impact of them.

It's a tough sell. There will be political opposition. But people's lives are at stake. I think this is something that's been shown to be successful, that has a lot of evidence behind. And I think we should be doing and thinking, doing bold action, and thinking boldly about how to keep our community safest.

Q: Where do supply testing options would fit into any of these models like options for testing street supply?

A: Testing for the street supply is important because people would still be using the street supply in some of these models. But drug testing is a reaction to the fractured street supply and how dangerous it is; we don't go test our alcohol, we don't test our cannabis, we don't test our coffee for dosage. In an ideal world where safe supply is properly implemented, drug testing could take a back seat, which again goes to reinvesting resources that are allocated for different interventions to things that could replace it.

Q: Is there a reduction in crime, in burglaries, and law enforcement issues in those areas where a safe supply was created? Is one of the metrics the number of individuals who have been diagnosed, and those who have become addicted to those drugs? Because a safe supply is great for those who are already in that world, and who are already addicted. But if the safe supply is promoted, and all it does is create more addicts, then I'm not sure that that is quite the direction we want to go. But I do like the idea for addressing the people who already have that addiction.

A: In terms of the reductions in crime, I would say there hasn't been any spatial analysis where they look at the neighborhood level and these programs. However, in the data that I was referring to, they directly asked the participants – how much did you commit, more crime, less crime, did you commit any crime as well for to get your drugs – and asking how their behavior individually changed. But there hasn't been any neighborhood level studies that have been done around crime and burglary and law enforcement, for safe supply yet. There's only the individual level data as of now. It's always hard to look at the neighborhood level data to then extrapolate to the individual level. There's so much going on that influences what's happening at that macro scale.

And in terms of safe supply for those who don't use, I agree that you need to think about the alternative. I know it could be a little uneasy that people who don't use drugs could be accessing these drugs. But if we think about our 20-year-old linebacker who died, in the prime of his life in college, he used the street supply where he didn't know what he was getting, and that's truly the alternative to the safe supplies: our current status quo where people are accessing illegal supply that is very fractured, that has a ton of contaminants.

It may be uncomfortable, but are we OK with letting people use drugs knowing that they're going to use drugs, and giving them a safe alternative, like what we've done with alcohol? Rep Davis made a really good point about the commercialization of alcohol, which I think is a really important point; we need to think about how you legalize these in terms of restrictions on advertisement restrictions on making profits, because when these were more widely available in

the early 2000s, there was a lot of deceit in advertisement that was going on, and it was really dangerous and really damaging to the public health. And so I think we need to be very careful in how we legalize this and offer a safe supply, thinking about designing these systems to better the public health, instead of making it into a type of capitalistic feeding frenzy.

Comment: *Let's remember that's we've had safe supply for 70 years, and that is in the form of other treatment medications. So safe supply isn't really safe supply, it is medications, right? Methadone is a full opiate agonist. All we're talking about is other types of full opiate agonist. We're just trying to fight a fight of a brand new super synthetic high potency drug with tools that are 70 years old and all that we're talking about is bringing their tools and other medications into the mix. The reason why we're in this problem of fentanyl and especially in counterfeit pills, is because we did so much to ramp down on prescribing practices that we took a fully regulated supply on, and we got rid of it. We created this inadvertent marketplace for a really contaminated drugs in public health. One of the questions I get all the time is do we have fentanyl in marijuana and that is such an easy question to answer here in the state of the Washington. And the answer is no. Almost across the board, No. And the reason is because we have end to end quality control on that; when we don't have end to end quality control, we create this marketplace for this toxic drug.*

Links/resources shared:

- Evaluation of an emergency safe supply drugs and managed alcohol program in COVID-19 isolation hotel shelters for people experiencing homelessness (2022)
- Characterizing safer supply prescribing of immediate release hydromorphone for individuals with opioid use disorder across Ontario, Canada (2022)
- Early findings from safer supply pilot projects (2022)
- "People need them or else they're going to take fentanyl and die": A qualitative study examining the 'problem' of prescription opioid diversion during an overdose epidemic (2021)
- "It's helped me a lot, just like to stay alive": A qualitative analysis of outcomes of a novel hydromorphone tablet distribution program in Vancouver, Canada (2021)
- A public health based vision for the management and regulation of opioids (2021)
- Addressing the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19 among people who use drugs: The potential roles for decriminalization and safe supply (2020)

For questions regarding this presentation, contact Adam Palayew at apalayew@uw.edu

"Washington State Drug Laws: Racial Disparity & Disproportionate Impacts," Deaunte Damper (VOCAL-WA)

For full content of presentation, please refer to DeAunte's presentation slides, included as an attachment in the calendar invite for this meeting.

Q: *What would you say to our state representatives that are still stuck in making the same policy repeatedly?*

A: When it all comes down to it, our communities are being impacted. Let's take the privilege mask off and really get down to business. Black people are impacted. A lot of these policies were

built off racism to break families down. My family is just now starting to rebuild from the crack epidemic. Which led to me, as my family got out of the generational curses in the crack epidemic. We continue to try to break generational curses, but there was a generational area of substance use. If we, if people had an opportunity, if my grandfather and my dad and mother had an opportunity to be in the room, I think we would be trying to find better ways to just talk about the wellness and healing in our community.

And I think that we must take more time really getting to, don't utilize this space as a salary, a salary space. Use this space as an opportunity for you to learn. There are so many privileged people on this call, and I appreciate everybody for being here, but let's keep it real. We're more than just the box check; this stuff is happening in the black and brown folks on a daily. I am losing friends in Federal Way and you guys got all the resources going out there to the North End.

I mean, either way, when it comes down to simple possession, when it comes down to access, the functional test strips when it comes down to education for my community members on methamphetamine, we don't have it and it takes HCA. It takes the SURSA committee. It takes City Council representatives to get with the program. Because we're constantly losing people, even in our rural counties. This is happening and we have we have other indigenous community members that it's impacting them as well, in the areas of possession and overdose. And quiet as it's kept, it could have been me.

Links/resources shared:

- Racial disparities in official assessments of juvenile offenders: Attributional stereotypes as mediating mechanisms (1998)

For questions regarding this presentation, contact Deaunte Damper at deante.damper@vocal-wa.org.

Ballot Measure 110 Implementation, Tera Hurst (Health Justice Recovery Alliance)

For full content of presentation, please refer to Tera's presentation slides, included as an attachment in the calendar invite for this meeting.

Q: Within a an individual BHRN [Behavioral Health Resource Network] who is actually responsible for coordinating the care, who is responsible for helping the person access the 40 arms of the Multnomah County BHRN, for instance? And second question to that, is there any element of the $302 million being invested in outreach? So proactively trying to engage with individuals in active addiction, whether that's in encampments, or emergency departments, or correctional facilities?

A: Yes, both great questions. I think one of the things that we were trying to do with BHRNs, is each county has very different needs and different providers who have different levels of relationship. For Multnomah County, the 41 arms have created 3 different BHRNs. One is very culturally specific providers that have been meeting together and trying to figure out how they want to operate and how they can coordinate with each other. There's not one central hub.

There is a lot of outreach funding for outreach and prevention. So just as an example, Miracles Club, which I was talking about earlier, they're part of this BHRN in Multnomah County called Indigenity. This is the culturally specific BHRN, and they have outreach workers. One of them I was talking to yesterday. They go out into encampments. They go find folks that may or may not be looking for services or are open to talking. And depending on what that person needs, these BHRNs are meeting with each other sometimes weekly to go over who's got what and how they're able to connect folks. If I'm an outreach worker going out to an encampment and there's somebody who identifies as LGBTQ+, and they need help and they need housing, I'm going to go over to Quest and say, do you have any housing available for this person? It is that informal collaboration that a lot of our providers are already doing but with more a little bit more structure, because there's money and MOUs done with each other.

You look at a small county like Sherman County, and I think it's only two providers. That's a very different relationship and a very different type of referral base, but for each memorandum of understanding to get your money, you had to show how are we going to do our referrals? How are we going to communicate with each other and how are we reporting out as a BHRN back to the Oregon Health Authority? So, trying to keep it as flexible as possible, recognizing it's also public funds and making sure that we're holding folks accountable as well. And really prioritizing that collaborative relationship between providers so that they can be about trust and relationships.

If I'm at Miracles and I know Quest, and I know that they do a good job with their housing and I can trust sending somebody over there, that is going to be my path, recognizing that we're now opening up more housing spaces more beds. The referral process will be, ideally, much easier.

A lot of our folks applied and received funds for outreach. In Eugene, we have a group who was just able to buy their own space. They've been operating out of tents and in parks serving young adults in the houseless population. And now they've just been able to get their own space so that they can actually host those folks in a safe space. To do all sorts of skill building, peer support, resume building under the whole thing and create this dynamic center. It depends on the people, depends on the needs of the organizations.

Q: Is anyone studying the racial disparity impacts post-implementation?

A: Yes, and the criminal Justice Commission did an initial study before Measure 110 and recognized that the racial impacts would go down 98% if we were able to implement Measure 110. I know that there's some initials studies happening right now looking at that and parsing out the data of who has been arrested or cited and what are the racial breakdowns of that? There are some challenges with that data because it's identified by law enforcement when they do the stop, but we have seen a significant reduction in the targeting of communities of color, at least because you can't stop people for small possession.

Q: You mentioned that there's a lot of misinformation out there and I'm trying to figure out the overdose rates for Oregon. Compared to the rest of the country, it looks like it really spiked in 2021 and is significantly higher than the rest of the country. Is that accurate? And what if it is? What's been the response to that?

A: Right now, we are trying to pull COVID / what is the pandemic, and then isolation, and our lockdowns, what is that impact versus any new laws that you can overlay. When we've done some of the simpler math, when you look at the full West Coast, Oregon's influx of overdose deaths, I think that, you know, we are 50th in access to services and 2nd in addiction rates. Our overdose death rates are going to ultimately be higher. And that first infusion [of Measure 110 funds] that I told you about, the $30 million that came out in July of 2021, 60% of those funds were used for harm reduction services. That's how people utilize those funds and utilize those services.

We're going to need to do more digging into the data to really pull apart what's a global pandemic outcome versus just potentially decriminalization, looking at how many people were able to access those services. I know that just from talking to providers, one provider was able to reverse 500 overdoses because of those 110 funds. I think we probably would have had more overdose deaths if we hadn't had those funds go into our harm reduction services.

Q: You said you're not picking people up, but what we're finding in Seattle is that now our prosecutors are filing charges for folks from things that happen in 2020 and they're now filing those drug charges. Do you guys do any type of data split that looks at folks that it might not be drug charges are getting picked up, but we're seeing people picked up on property damage, trespassing, theft, things that are, to me, related to drug user activity? Are you seeing any increase in that in intangible law enforcement?

A: We haven't been seeing an increased necessarily in what some people have been concerned about and that we need to continue to keep an eye on as are they shifting from being able to arrest for one thing and shifting it over to another. I think that will take longer for us to really be able to parse that out, but it's not from an anecdotal space of like talking to folks, you know on the front lines of this. That's not necessarily what we're hearing, and it depends.

Josephine County has, which is a very small county in Southern Oregon, they've done the most citations out of most of our counties, especially per capita, and I think that everybody is looking at these tools differently. I think for just being county, they feel like this is the best way that they connect folks with services.

And in Multnomah County, which is like King, the voters were clear. You don't want us responding to small drug crimes. We're just going to move on to other issues and that seems to be parsing out when you look at the initial data.

The criminal Justice Commission will be looking at all the different increases and/or decreases of arrests, crime and then breaking that down through racial data.

For additional questions related to this presentation, contact Tera Hurst at tera@healthjusticerecovery.org

Building on Top-Polled Policy Options

Following the presentations, the SURSAC was asked for any additional thoughts, comments, or concerns to be added for consideration to the top voted options from the August 1st meeting, before they are brought forth for a final vote on Monday, September 12th.

These additional comments are captured in the document titled "Top Polled Policy Options with comments from 09-09-2022."

Wrap Up & Next Steps

The four options that will be presented for final voting on September 12th are as follows:

1. Possession as a Misdemeanor (includes diversion & referral options for possession as well as other eligible crimes)
2. Decriminalize possession and related paraphernalia, punishable by fine or other civil penalty (includes diversion & referral options for other eligible charges)
3. Decriminalize possession and related paraphernalia with no penalty (includes diversion & referral options for other eligible charges)
4. Legalization