

Substance Use Recovery Services Advisory Committee Meeting Notes

February 7, 2022, 9:00-11:00am PDT

Meeting Recording

[WA State Substance Use Recovery Services Advisory Committee \(SURSAC\) February 7, 2022 - YouTube](#)

Attendance

HCA Executive & Administrative Support					
<input checked="" type="checkbox"/>	Jason McGill, Executive Co-Sponsor	<input checked="" type="checkbox"/>	Tony Walton, 5476 Project Manager	<input checked="" type="checkbox"/>	Rachel Downs, 5476 Admin Assistant
<input checked="" type="checkbox"/>	Michelle Martinez, Administrator	<input checked="" type="checkbox"/>	Brianna Peterson, Plan Writer	<input checked="" type="checkbox"/>	Sandy Sander, Admin Assistant

Committee Members					
<input checked="" type="checkbox"/>	Michael Langer	<input checked="" type="checkbox"/>	Amber Daniel	<input type="checkbox"/>	Donnell Tanksley
<input type="checkbox"/>	Amber Leaders	<input type="checkbox"/>	Brandie Flood	<input checked="" type="checkbox"/>	Malika Lamont
<input type="checkbox"/>	Sen. Manka Dhingra	<input checked="" type="checkbox"/>	Cheryl Rasar	<input type="checkbox"/>	Addy Adwell
<input type="checkbox"/>	Sen. John Braun	<input checked="" type="checkbox"/>	Chad Enright	<input checked="" type="checkbox"/>	Kevin Ballard
<input checked="" type="checkbox"/>	Rep. Lauren Davis	<input checked="" type="checkbox"/>	John Hayden	<input checked="" type="checkbox"/>	Hunter McKim
<input checked="" type="checkbox"/>	Rep. Dan Griffey	<input checked="" type="checkbox"/>	Marshall Glass	<input type="checkbox"/>	Youth Rep - TBD
<input checked="" type="checkbox"/>	Caleb Banta-Green	<input type="checkbox"/>	Tyler Gagnon		
<input type="checkbox"/>	Victor de los Santos	<input checked="" type="checkbox"/>	Hallie Burchinal		Alternates / Optional Attendees:
<input checked="" type="checkbox"/>	Kierra Fisher	<input type="checkbox"/>	Theresa Adkison	<input checked="" type="checkbox"/>	Rep. Jamila Taylor
<input checked="" type="checkbox"/>	Alexie Orr	<input checked="" type="checkbox"/>	Sarah Gillard	<input type="checkbox"/>	Rep. Gina Mosbrucker

Notes

Notes in this format indicate comments made in the chat

Committee member introductions included:

- Kevin Ballard: Representative of Local Government (Dupont City Council Member)
- Hunter McKim: Youth in Substance Use Recovery
- Kierra Fisher: Adult in Substance Use Recovery

00:14:20 – Defining Harm Reduction

Creating a working definition for Harm Reduction will help inform what types of activities and programs the committee will recommend as part of harm reduction efforts.

It is important to distinguish that people may want to reduce their use and may not want “treatment” now, soon, or perhaps ever. Here are rich data from people who use drugs across WA State from 2019 on this point, “Interest in reducing methamphetamine and opioid use among syringe services program participants in Washington State”:
<https://pubmed.ncbi.nlm.nih.gov/32911134/>

The current recommended definition from the committee for the Plan combines definitions from [SAMHSA](#) and the [National Harm Reduction Coalition](#):

Harm reduction is a proactive, compassionate, and evidence-based set of practical strategies and ideas aimed at reducing the personal and public health impacts of behavior associated with alcohol and other substance use at both the individual and community levels. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

00:26:50 – Recovery Asset Mapping Tool

Background & Context

The Roadmap to Recovery has initiated substantial work to improve recovery services with funds from a CMS grant awarded in 2019. Part of that work has been contracting with Third Horizon Strategies to develop an alternative payment strategy for addiction treatment and recovery support services which factors in social determinants of health, which Medicaid fee-for-service does not currently purchase. The alternative payment strategy also aims to align with the state’s value-based payment targets and incentivize provider networks and MCOs to create more alignment as people move through the continuum of care.

The Recovery Asset Mapping Tool was a response to the state’s request to provide tools for providers and MCOs (and potentially policy makers) to use to assess market capabilities and capacities for addiction recovery services in case the state did adopt the alternative payment model. For example, an MCO could use it to identify geographical areas where they could develop a cluster of services to create a continuum of services.

Data sources in the current beta version include Provide One and professional licensing records from the WA State Department of Health. Provider One data may include billing addresses rather than service addresses, but Third Horizon Strategies is working to mitigate that discrepancy.

There are data quality issues to be worked out prior to launch, which are being actively addressed.

It was not originally designed to be public-facing or for end-user cases, but that possibility is now under serious consideration from HCA.

Due to its potential to locate areas where there are gaps in services, the Recovery Asset Mapping Tool could be of direct use to the work of the SURAC, and HCA seeks the input of the committee for ideas to improve and strengthen this tool.

00:53:50 – Need for Community-Based Services

Expand crisis management and withdrawal management (voluntary and involuntary) in rural areas such as Walla Walla: To illustrate: Amber was faced with a client who had a plan to kill themselves with substance abuse, and there was nowhere to refer him so the only option would be to escort him to the Emergency Room and wait with him there until he could be seen through the ER, which is not appropriate as a peer support person.

Provide at-home, client-administered withdrawal services: Withdrawal services do not have to require use of a facility every time.

Offer peer respite: If feasible, peer respite could be a great service to offer – being in a supportive environment with peer counselors while waiting to get a bed. This could be a game-changer for a lot of people.

Expand medically assisted withdrawal management: There are people who don't go to withdrawal management because there are not options to help them ease out of it gently. Especially in the common situation when substances are being used to cope with trauma and painful feelings, it is a lot to ask of someone to have all their coping mechanisms stripped away and left with nothing. Withdrawal management is not set up to be a very comfortable place to begin with.

Offer co-ed treatment facilities in all areas: There are areas that lack treatment facilities where men and women (e.g., partnered couples) can get clean and sober together, which can be a major hindrance for those who don't want to be separated.

Expand youth-friendly detox services to rural areas that do not have them: Finding detox can be challenging. Obtaining medication may be possible, but there are areas (e.g., Omak) where there are no detox facilities available without driving 3-6 hours to get there, and it's even harder for youth under 18 to find a place – especially one that feels welcoming -- to detox.

Expand inpatient treatment capacity: The lack of inpatient beds for treatment is a problem because it leaves very little for planning and people seeking treatment must be ready to go on the fly as soon as there's availability

There is huge stigmatization around harm reduction in the 12-step community (arguable the most accessible and widespread addiction support community that exists), and recovery housing communities generally also require sobriety.

Create reintegration services for patients returning to society following wilderness therapy: Wilderness therapy can be very effective by offering an opportunity to withdraw from society to regain stability. Reintegrating back into society can be a difficult transition, and it would be helpful to have services to support the reintegration process. 12-step programs might be able to help with this.

Certified peer counselors are a very powerful tool to support people who are walking through the difficult navigation process.

Use social determinants of health as a measure of success (not just sobriety): We look often at whether someone is using drugs as a measure of success, but it's also important to look at the social determinants of health. And as the committee – a policy-influencing body – looks at entities that could

do work in a profound way to impact outcomes such as housing and what types of agencies receive funded to provide housing and addressing trauma as a root cause of substance use. People need a place to live, a community that feels safe, and ongoing support. We don't seem to reimburse for outreach as much as necessary so that's an area where we could provide recommendations, especially addressing gaps in outreach among populations that have been missed in previous outreach efforts.

Expand youth housing options in rural areas: There is very limited housing for youth in Walla Walla, which is related to the laws about what can be done with youth and parent authorization. Many kids get recycled through the juvenile detention system because they don't have access to services, particularly medically assisted withdrawal management, and it becomes a second home for them until they age out. They'd have to go to Yakima or Spokane to find detox locations accepting Apple Health.

Expand substance use crisis management services for youth and adults: Ideally, Walla Walla would have sufficient crisis management services for youth and adults that are primarily substance use. The only one currently available is primarily for mental health crises and cannot manage withdrawal. A permanent supportive housing model integrated into treatment services would also be ideal; currently we have about 2 Oxford houses for men and one for women and children. Having peer support beginning in outreach and lasting throughout the continuum of treatment and recovery services would provide a sense of consistency.

Offer a next step for people when they get out of treatment. If they don't have some sort of transitional support, they are released back into the same neighborhood, same group of friends, same environment as before, and this hurts their chances of long-term recovery. From start to finish, we need a plan and a place for people to go.

True co-occurring services. Incentives for masters-level clinicians to pursue SUDP certification and vice versa.

Incentivizing dual credentialing among clinicians: SUD services and mental health services are not provided in the same groups or the same individual sessions. Finding a dually credentialed clinician is like finding a unicorn. There's not a lot of incentive for a masters-level clinician to pursue and SUDP certification, and for many of those who are SUDP certified, the path to masters-level licensure can be terrifying, long, and costly. There isn't a significant salary increase for those who are dually credentialed.

Pairing ambulatory detox with a peer crisis respite: This would involve providing outpatient medications and then having the patient self-administer the medications in a short-term setting stay that is staffed exclusively by peers. This could scale quickly by using single-family homes, which get around the NIMBY ("not in my backyard") and new construction issues. Generally, it's less likely this approach would run into zoning issues that might otherwise arise with local governments for that type of use case. A couple treatment providers have used this model successfully: Sound Recovery, for example (now defunct), used single-family homes and they had a phased treatment model. Hotel California by the Sea also offers detox through a single-family home in Kirkland.

Integrating NEAR education and science of hope into SUD treatment programs: Standard SUD treatment generally involves 28 days of inpatient and then 8-12 weeks of IOP (intensive outpatient program), and it may be time to revisit what we're teaching people during their time in these programs,

as there are so many innovative treatment breakthroughs out there that have not yet made it into standard SUD treatment. Incorporating education around the NEAR sciences (neuroscience, epigenetics, adverse childhood experiences, and resiliency) could help people understand how trauma has impacted their brains and how they can rewire their neural pathways in a healthier manner. Additionally, it would be helpful to teach the science of hope; it is possible to engender a sense of hope in another human being, which is necessary in sustained recovery. This could involve goal setting, and helping people to create a life worth living, to imagine and dream about possibilities for their careers and futures.

Provide interim services / interim beds in single-family homes: There is often a gap between withdrawal management and inpatient treatment, and between inpatient treatment and recovery housing. Some stopgap measures can be accessed creatively (e.g., Oxford housing), although the single-family home model may be a better solution to provide transition housing.

Lowering barriers to treatment access in SUD treatment by exploring alternatives to the formal treatment system: The SUD treatment system and the healthcare system have high barriers to access. When people in the community who use substances are asked what their experience is like in these systems, many say it is off-putting and very challenging. With this initiative's focus on LEAD, on harm reduction, on low barrier access to care, we have an opportunity to use a customer service orientation rather than trying to scale more of the same – the formal treatment system that we're familiar with.

Offer housing that isn't contingent on sobriety.

Provide compensation to outreach workers. Outreach is the starting point to enter the continuum of care, and it's where relationship-building and trust-building begins.

Provide withdrawal management to people on fentanyl.

Expand services for uninsured and underinsured individuals.

Implement Contingency Management.

We're going to try contingency management in low barrier settings and measure staff and client acceptability in real time. This is an example of adapting a very structured, evidence-based model that we know can work in specialty addiction treatment; how does it work in the "real world"?

Expand 3.1 Level of Care (3-6 month inpatient settings): Two of these are offered in Spokane, one for men, one for women. Each can have up to 15 individuals at one time, who are there for 3-6 months. They are always full, it's true co-occurring, and the timeframe allows for things like housing and employment to get in place before completing treatment.

Create a new designation for recovery communities. These communities do not fit into a formal treatment model, and there's no clear path for ongoing sustainability as they communities rely heavily on grants and donations. The reimbursement for peer support services is so nominal it's almost not worth it to bill Medicaid for the services provided.

Create/expand recovery housing for non-custodial parents, men with children, families, and people using medically assisted treatment. Many faith-based shelters will not allow families with parents who are unmarried. Oxford house communities vote by house whether to allow someone on medically assisted treatment into the house.

1:43:50 – Public Comment

Lisa Daugaard: Asking that this group intentionally make sure that there is an added lens in the design of any interventions or strategies to increase resources or increase access, to make sure that those panels work for those populations that have been primarily engaged by the criminal legal system with respect to behavioral health needs. The system modifications needed to make that work look different than they do for comparatively more affluent people, who have more economic resilience, and people who are, overall, whiter. The criminal-legal system's always there – when this kind of approach fails, it's going to show up and point to the failure of this kind of approach as reason that we have to put people in jail, and we have to prosecute people. So please provide the strongest possible rebuttal to that paradigm by making a system that actually works for that population.

Jessica Blöse: We could do more to require evidence-based care for treatment being offered in behavioral health settings and raise the expectations for outcomes. Our state is doing a lot already to integrate behavioral health and physical health services but there's still so many comorbidities that behavioral health and SUD patients are exposed to.

Zoom Chat Highlights

- 09:18:19 From Tony Walton-HCA : Another definition of Harm Reduction for consideration, <https://www.hri.global/what-is-harm-reduction>
- 09:18:21 From Caleb Banta-Green UW ADAI : good morning, I encourage us to use the harm reduction coalition's language. it's very reasonable and comprehensive. <https://harmreduction.org/about-us/principles-of-harm-reduction/>
- 09:19:51 From Malika Lamont : Second Caleb's recommendation
- 09:20:25 From Caleb Banta-Green UW ADAI : at a 2 day samhsa meeting on harm reduction in December we also went t/ this definitional process. HRC's language is specific, inclusive, and broad. samhsa's is less actionable.
- 09:22:54 From Caleb Banta-Green UW ADAI : harmful seems a find substitute for negative
- 09:23:34 From Amber Daniel : I would just like to see the word compassionate in there somewhere :)
- 09:24:04 From Hallie Burchinal - CAT (she/her) : I agree with amber regarding the word "compassionate"
- 09:26:01 From Hallie Burchinal - CAT (she/her) : I appreciate the "social justice" aspect of the statement. It is very appropriate for the purpose of this committee.
- 09:29:23 From Caleb Banta-Green UW ADAI : It is important to distinguish that people may want to reduce their use and may not want "treatment" now, soon, or perhaps ever. here are rich data from people who use drugs across WA State from 2019 on this point: <https://pubmed.ncbi.nlm.nih.gov/32911134/> Interest in reducing methamphetamine and opioid use among syringe services program participants in Washington State

09:30:25 From Hallie Burchinal - CAT (she/her) : Thank you Caleb

09:31:07 From Amber Daniel : Also it's important to remember that in the RCW's it's NOT a crime to be on drugs, nor is it grounds to remove people's children. Also it's the child's RIGHT to both of their parents.

09:34:45 From Alexie Orr She/Her : Where do Non-profit organizations fit into this?

09:36:24 From Amber Daniel(She/Her) : Thank you Alexie. We have the same issue. If we want to be sustainable, we need to be reimbursed by insurance wherever possible... however we are a 501-c and are facing having to re-designate...

09:40:22 From Jessica Blose, WA HCA : QUESTION- Can we clarify if this recovery index map is still in A pre-production phase, or if there a launch date/timeline established at this time?

09:41:36 From Marshall Glass : Does the recovery index map show which MCOs are contracted with each provider?

09:42:10 From Amber Daniel(She/Her) : I see this as a great tool for referrals.

09:47:15 From Amber Daniel(She/Her) : 211 data

09:48:05 From Caleb Banta-Green UW ADAI : NA meeting schedules is one thing. what about harm reduction sites and hours, what about OTP capacity, what about detox, what about "beds"....? People historically don't push these data or post on the web to "scrape"

09:49:57 From Alexie Orr She/Her : I am with you Caleb. I am always looking for detox centers, meetings, and centers with open beds. Being able to have this info in real time would be so helpful

09:50:20 From Brianna Peterson : Great recommendations!

09:51:38 From Malika Lamont : Your feelings of frustration are valid Hallie. I also share all of Caleb's observations and concerns.

09:52:21 From Sarah Gillard (she/her) GCBH BH-ASO : Thank you Hallie, I agree with what you and Caleb have stated

09:52:36 From Amber Daniel(She/Her) : YES Marshall!!

09:56:43 From Caleb Banta-Green UW ADAI : Greg, the infrastructure looks great, but we need to figure out how much it'd cost to pay for adequate staff to keep it current. My gut says it would require many dozens of people for the whole state to keep this current. At the same time we also need to work to facilitate the relationships within communities between providers, because currently it often comes down to providers sharing their cell # with their colleagues.

09:57:14 From Kevin Ballard : The problem as presented by Greg is a lack of accuracy in where managed care is actually provided. It seems this should be the focus. Providers need input to the system in some fashion. Is it as easy as adding a provider address to a form submitted to billing that would need to be mandatorily added to these databases to improve accuracy?

09:57:41 From Brianna Peterson : Thank you Caleb. Greg did go over the pipes that can be built to get better and more up to date data from the various resources available.

09:58:31 From Greg Williams : Yes, Kevin those kind of simple fixes can be identified throughout data planning.

09:58:45 From Caleb Banta-Green UW ADAI : Hi Brianna, those pipes require providers to push info up those pipes and we found that this wasn't feasible with buprenorphine providers. there's technical capacity and workforce/system reality...

10:00:17 From Caleb Banta-Green UW ADAI : ... it requires Helpline staff calling every provider to determine capacity. Or responding when callers tell them referrals don't work.

10:01:32 From Alexie Orr She/Her : I work for a non-profit called the Foundation for Youth Resiliency and Engagement, and I often have a problem with the time where we are waiting for a bed, and finding Detox Is frustrating because it is in short supply

10:03:21 From Jessica Blose, WA HCA : FYI Only- "Ambulatory withdrawal management" is the term for WM services treatment outside of an inpatient setting. This is a service utilized in other states but not very much in WA.

10:05:42 From Amber Daniel(She/Her) : Hallie I'm hearing you say that we need Trauma Informed Medical Withdrawal Management

10:06:55 From Amber Daniel(She/Her) : Yes, Kierra! It's the same with emergency housing.

10:07:03 From Jessica Blose, WA HCA : An older resource, but still a worthwhile read about withdrawal management services outside of an inpatient setting:
<https://www.mycasat.org/wp-content/uploads/2017/03/Ambulatory-Withdrawal-Management-3.21.17.pdf>

10:07:10 From Malika Lamont : Supportive harm reduction based case management. Supportive and harm reduction based housing.

10:07:27 From Hallie Burchinal - CAT (she/her) : We have Rising Strong in Spokane. It's that type of model that Kierra is talking about. It's an important model.

10:08:08 From Hallie Burchinal - CAT (she/her) : PS: Rising Strong is ALWAYS full.

10:08:48 From Kevin Ballard : To what extent have dollars targeted towards these programs...for all ages...been geared towards advertising and marketing? Ads. Articles. Commercials. Billboards?

10:11:09 From Malika Lamont : It would seem rather than solely focusing on the use of drugs, can we look at all of the social determinants of health.

10:11:10 From Alexie Orr She/Her : Good points, we lack housing, sober living, and our small town is really opposed to Harm reduction. We need more education for the community

10:11:13 From Amber Daniel(She/Her) : Marshall, I agree. I'm one of the few women I know in 12 step recovery that will sponsor people on MAT

10:11:44 From Amber Daniel(She/Her) : (Medically assisted Treatment)

10:13:59 From Amber Daniel(She/Her) : Also in my community, we're trying to normalize non-12 step mutual aid groups such as SMART Recovery and Recovery Dharma.

10:15:12 From Amber Daniel(She/Her) : I agree Hallie, and it's a shame the reimbursement for peer support is so nominal.

10:16:41 From Hallie Burchinal - CAT (she/her) : Amber, yes! And this sets Certified Peer Counselors up to be undervalued in their pay, which is unacceptable.

10:17:45 From Alexie Orr She/Her : Our number one issue is helping youth get their basic needs met, primarily housing

10:19:20 From Marshall Glass : True co-occurring services.

10:19:57 From Marshall Glass : Incentives for masters levels clinicians to pursue SUDP certification and vice versa

10:22:17 From Caleb Banta-Green UW ADAI : we don't have a "place" to support fentanyl dependent people during their initiation on buprenorphine which can require regular support and check-ins for a week. It doesn't need to be jail, IP, or detox.

10:22:55 From Amber Daniel(She/Her) : right, Caleb. It takes longer to transition to buprenorphine from fentanyl than it does from regular opiates.

10:24:45 From Malika Lamont : agreed Caleb. Increased access to low barrier and accessible treatment services i.e. walk in medical and behavioral health treatment, and support groups.

10:25:17 From Caleb Banta-Green UW ADAI : "pre-treatment" needs some definition. I think a lot of care for people with SUD that involves a range of services is supportive, reduces harm, improves quality of life and functioning but may not lead to formal "SUD treatment". and that's ok.

10:25:38 From Tim Candela (WA-DOH) he/him : Integrate physical healthcare (many people have comorbidities that go unaddressed while in tx, e.g. syphilis infection), aftercare upon release, increase access to methadone (this will mitigate some issues related to fentanyl and bupe).

10:25:49 From Amy Dura : Adding onto what Marshall is saying, when you are dually licensed, the yearly license fees to the DOH, is something we should consider.

10:26:00 From Kevin Ballard : Marshall is articulating my thoughts. I would like to see facilitating multiple facets of care/housing for those dealing with SUD.

10:27:39 From Alex Sheehan, HCA : Isabella House in Spokane has that setup, too.

10:28:45 From Amber Daniel(She/Her) : So many places that are so hooked up with drug court services and the corrections pipeline are the lowest quality treatment available

10:29:42 From Amber Daniel(She/Her) : yeah, if you have over 30 days clean, you lose your spot for a bed

10:29:51 From Jessica Blose, WA HCA : Thank you Rep. Davis. Quality of care improvements in existing treatment is an important goal. There should be more parity with how we view physical and behavioral health regarding topics like expectations of successful treatment outcomes and use of evidence based treatment interventions. Things are accepted in BH that would never be accepted in physical health. BH are medical conditions and should be treated as such.

- 10:30:40 From Jessica Blose, WA HCA : Also, as a chronic relapsing disease, some level of relapse can be anticipated, we need treatment that will not "fail" people out who are struggling
- 10:34:26 From Amber Daniel(She/Her) : We need more Recovery Oriented Systems of care instead of Treatment oriented. Also Recovery doesn't always mean complete abstinence. (See SAMHSA definition of Recovery)
- 10:39:01 From Caleb Banta-Green UW ADAI : we're going to try contingency management in low barrier settings and measure staff and client acceptability in real time. this is an example of adapting a very structured, evidence based model that we know can work in specialty addiction treatment, but how does it work in the "real world"?
- 10:41:50 From Malika Lamont : Housing options along the continuum from harm reduction to abstinence only
- 10:41:53 From Wanda Johns : Pet friendly treatment and housing
- 10:42:18 From Malika Lamont : universal income
- 10:42:40 From Hallie Burchinal - CAT (she/her) : At our facility we have zero barrier "Recovery Community". This is a model we've been working on specific to working with people experiencing homelessness. It's pure harm reduction. Many people engage that don't engage in other services. We partner with the health department for HIV, HEP-C, and other testing. This approach has Peer Counselors at the center and is all about building hope, and supporting individuals in whatever their personal goals are.
- 10:43:05 From Caleb Banta-Green UW ADAI : we need permanent supportive housing that is supported by state agencies. That means L&I not fining housing providers who have clients who smoke drugs. Because then the housing providers won't take people who smoke drugs, which is now the majority of people with SUD who use opioids and/or stimulants.
- 10:44:38 From Marshall Glass : Safe and supportive housing for individuals being released from incarceration.
- 10:44:50 From Alex Sheehan, HCA : I have only seen one program in Washington, located in King County, provide supportive housing for non-custodial guardianship.
- 10:46:01 From Tim Candela (WA-DOH) he/him :
<https://endhomelessness.org/resource/diversionexplainer/>
- 10:46:17 From Malika Lamont : Housing and training programs to support people as they heal
- 10:46:25 From Meta Hogan (she/her) : As a member of the public, I think we need to shift from using public and non-profit resources to clean up after a increasingly speculative commodity-oriented housing market, and begin pushing for regulations that keep housing affordable.
- 10:46:50 From Amber Daniel (She/Her) : Yes, Meta!
- 10:46:59 From Meta Hogan (she/her) : 2/2.. is getting a little ridiculous to try to address homelessness via shelter, psh, and other expensive patches.
- 10:47:13 From Jessica Blose, WA HCA : We also still have issues with MOUD medication (methadone, buprenorphine, naloxone) patient access to care in a variety of settings

including settings such as SUD RTF- MH RTF- State hospitals- SNF- LTC settings- Recovery residences- shelters- jails- drug courts- DOC etc. Improvements in these areas through regulatory or financial incentives could still be important goals

10:52:05 From Tim Candela (WA-DOH) he/him :
<https://www.sciencedirect.com/science/article/pii/S0955395921004928> - expand what "tx" is.

10:53:07 From Tim Candela (WA-DOH) he/him :
<https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-019-0351-1>

10:54:02 From Caleb Banta-Green UW ADAI : we also need models of care that support people for 1-3 years, not a few weeks or months. methamphetamine impacts dopamine receptors in the brain for 12+ months, before restored functioning is seen. PCAP, parent child assistance program, lasts 3 years. SUD is chronic... so, a system of care/coordination that supports people for several years, at a minimum is appropriate.