Substance Use Recovery Services Advisory Committee Meeting Notes

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

Meeting Recording

Watch the March 7th SURSAC Meeting Recording on YouTube

Attendance

HCA Executive & Administrative Support					
☐	Jason McGill, Executive Co-Sponsor	☒	Tony Walton, 5476 Project Manager	☒	Rachel Downs, 5476 Admin Assistant
☒	Michelle Martinez, Administrator	☒	Brianna Peterson, Plan Writer	☒	Sandy Sander, Admin Assistant

Committee Members					
☒	Michael Langer	☒	Amber Daniel	☒	Donnell Tanksley
☒	Amber Leaders	☒	Brandie Flood	☒	Malika Lamont
☐	Sen. Manka Dhingra	☐	Cheryl Rasar	☒	Addy Adwell
☐	Sen. John Braun	☒	Chad Enright	☒	Kevin Ballard
☒	Rep. Lauren Davis	☒	John Hayden	☒	Hunter McKim
☒	Rep. Dan Griffey	☒	Marshall Glass	☒	Kendall Simmonds
☒	Caleb Banta-Green	☐	Recovery Housing - TBD		
☐	Adult in SUD Recovery - TBD	☐	Hallie Burchinal		**Alternates / Optional Attendees:**
☒	Kierra Fisher	☒	Theresa Adkison	☐	Rep. Jamila Taylor
☒	Alexie Orr	☒	Sarah Gillard	☐	Rep. Gina Mosbrucker

Resources & References

The Sequential Intercept Model

Recovery Navigator Program – Fact Sheet

Recovery Navigator Program – Uniform Program Standards

New committee members:

- Kendall Simmonds, Youth in SUD Recovery

Discussion Notes

Notes in this format indicate comments made in the chat

00:08:20 – Suggestions for the Structure & Purpose of Peer Respite for SUD

Similar to the model in WA State for mental health peer respite (which do not currently serve people with SUD), peer respite for SUD should be offered typically at a single-family residence staffed by peers, with the purpose of preventing the need for hospitalization. Within these respite homes, people could take prescribed outpatient detox medication, similar to ambulatory detox, that would be self-administered. It would serve as a place to lay their head and have social support while they are going through physical and psychological withdrawal symptoms.

They would not be medically managed facilities, so the peer respites would be best suited for people whose physicians had approved for them to manage their withdrawal at home with prescribed medications.

They would be available also for people who needed a supportive environment to help them avoid a relapse as they realize their risk for relapse / desire to use substances is increasing.

Peer respite for SUD could also be conceived as a type of bed and breakfast run by those with lived experienced in SUD recovery to receive peer support and guidance regarding next steps and how to move forward with recovery. Like calling one's sponsor in Alcoholics Anonymous, these would be places to go to receive peer support during crisis or to prevent relapse.

Another potential use is to provide beds for people who are waiting for inpatient treatment beds to open.

Having a nurse practitioner on staff would enhance safety but, requiring or providing medical staff would also very likely run into legal and policy related barriers that could delay establishment of the peer respites 15-20 years. It is also expensive to have a medical professional on staff, both in terms of salary and the insurance billing process.

Staffing the SUD peer respites with people who are qualified to assist with substance use and co-occurring mental health crises improves safety and effectiveness for the participants and minimizes liability for those running the program. Reimbursement for the services will be higher if staff possess relevant professional qualifications in addition to being peers with lived experience.

The Sobering Center model is another one to consider – as an alternative or in addition to peer respite for SUD -- which is staffed by medical professionals and peer outreach workers. Walla Walla is an area that could use something like this because the nearest detox centers are in Yakima or Spokane.

Ideally there would be a sobering center in every community (and no longer need to drop anyone off at Emergency Departments for SUD), but it also takes a long time to establish, so other resources are also necessary. For example, a peer respite for SUD would be helpful to someone who already graduated from a Sobering Center and needs some acute support.

***Rep. Davis**: Love the sobering model also! To me, the distinction is that sobering is more in the harm reduction space and peer respites have a recovery orientation. From a*

clinical perspective, we can't mix milieu--people who are using and people who aren't. I would argue there is a strong need for both

Is there a possibility to collaborate with low-barrier clinics and nurse care managers, so that there is not necessarily a nurse on site at the peer-based respite but still accessible, to increase access to medications for opioid withdrawal and potentially other medications?

00:26:35 – Diversion Strategies Along the Sequential Intercept Model

Where we meet people along this intercept is not neutral, and it's important to get people out of the criminal legal system as soon as possible, engaged in treatment services. It is important at all intercepts to engage with those with SUD and meet their behavioral health needs, but the overall benefit to, and autonomy of, the individual decreases the further along they are in the model.

It is necessary to start at Intercept 0 (Community Services) to maximize change within communities. Once in the system, the system has all the power and the patient loses autonomy over their path to recovery.

Focusing on Intercept 0 for those on central nervous system depressants may be more effective than for those on central nervous system stimulants (e.g., methamphetamine, phencyclidine) due to the tendency toward more violent crime and impact on the community. Law enforcement officers in WA State are only required to complete two hours of crisis intervention training (CIT) annually. There is a voluntary 40-hour CIT-certification course, and it would be helpful to make this course mandatory for every law enforcement officer of general jurisdiction to better understand the trauma and tragedies that people go through.

SB 5476 (Section 7) has training inserted into basic Law Enforcement Academy for new hires, beginning July 1, 2022. The state house of representatives had a $500,000 budget proviso to the Addictions, Drug, and Alcohol Institute at the University of Washington to teach existing law enforcement how to interface with people with SUD and co-occurring mental health challenges using a co-trainer model that pairs officers with someone with lived experience. The current CIT training has a strong focus on mental health, but less on SUD.

There are issues with people lacking access to MOUD treatment while incarcerated. There are also issues with continuity of care once released into the community.

The state is very close to having contracts in place to put MOUD medication in about 22 jails throughout the state.

The recovery pod model in Walla Walla jails provides a therapeutic community and is working well.

What diversion programs are you aware of that you like / are working, at any point along the intercept model?

The LEAD model – Law Enforcement Assisted Diversion / Let Everyone Advance with Dignity – engages people in Intercepts 0 and 1 and helps connect people with resources that advance social determinants of health, which helps them stabilize and addresses real needs.

Trilogy Recovery Community (Walla Walla) has a contract with the jail where they do outreach before people are sentenced. Twice a week, people who are identified as having SUD and could be getting out shortly, are introduced to Trilogy over a virtual platform. The jail-based social work manager provides them a packet from Trilogy that includes a planner for their first week out, a "welcome to recovery" letter from some a couple peer support specialists, that shares their experiences inside the criminal justice system and navigating recovery, and a pamphlet that describes their services, and this is all

reviewed together over a virtual 30-45 minute meeting. Ensuring they have this information before their first day out is important to their success.

Trilogy is a 501-c non-profit almost entirely funded by community donations and grants

The Housing First model is very effective, and recovery is made so much more difficult when you don't have a safe place to lay your head.

Harm reduction can be a form of engagement, which also serves as a form of diversion along these intercepts. For example, co-location of services (e.g., providing buprenorphine) with harm reduction (e.g. syringe service providers) is important because it provides an engagement point as well as harm reduction. It also sets a tone for harm reduction services to be a point of engagement, as we are seeing in Safer Smoking supplies in Tacoma, which attracted 700 new clients in the first year that hadn't been seen before. (Refer to page 3 of this ADAI report)

The JustCARE model in Seattle shows a lot of promise. It is a low-barrier harm reduction model, where outreach is done with individuals who choose to opt into hotel-based housing. They are then engaged in wrap-around case management, identify the goals they want to progress toward, and connected to services for further stabilization.

Make it possible to go directly from jail/prison release into services. One of the main barriers for those being released from incarceration is the time that they are released, often around 5:00am. This does not allow for providers to provide transport and into services in an efficient manner. Many jails are also not contracted with providers in the community to release people directly to the provider to begin services right away. The first three hours after release are a time of high risk for relapse, and many of these individuals become incarcerated again within a week of release.

Representative Lauren Davis is actively working on a bill proposal related to jail release times, which includes agreed draft language with WASPC.

The Vital Program in King County provides extensive wrap-around services including housing, outreach by medical and behavioral health providers. Something to note is that someone would have to engage at Intercept 3 multiple times (need to be incarcerated 4 times) before they're even eligible for that type of wrap-around service, and it would be helpful to bring those services into a person's life prior to them being incarcerated.

Sarah Gillard: *Yakima and Benton Counties have been implementing Trueblood Diversion services*

It would be helpful to have a workgroup to dig into this more deeply with people outside of this committee. Meeting once a month is not frequent enough to generate meaningful responses that will lead to real change.

Drug Court (Intercept 3)

Drug Court is mainly effective for those who are ready to quit, because abstinence is required at some point. For those who are not ready to quit, Drug Court may be setting them up for failure. A workgroup would be helpful to flesh this out, because this is a population with complex behavior and the plan needs to have enough flexibility to be customized and client-centered.

One of the complications of Drug Court is that people are motivated by the desire to get out of incarceration, not necessarily the desire to quit substance use. In the case where someone can maintain abstinence throughout the program – a process which should be individualized – they are able to avoid significant incarceration time, but not everyone is successful in that. More data or information would be helpful to understand those who do not successfully complete Drug Court, how much prison time they do, and how they are tracked.

Drug Courts do their best to provide housing, mental health care, and medical attention. It's not unusual for someone to enter Drug Court thinking that they will simply beat a charge, and then recovery does become their goal, and Drug Court provides the structure in which they can do that. Autonomy is important, and it can be honored within a structured system that can provide many resources to people.

Harm reduction can be part of, or integrated into, structured recovery.

The war on drugs has been horrible to people of color and this is an opportunity to rectify that, to make changes, and so we want to establish a system that works for the community and makes it better. I don't want us to get stuck on the word "structure" as it has been called in many generations to enforce white supremacy, and that we implement programs that help the community get out of the war on drugs.

Brandie Flood: *There needs to be more equity in services like drug court or any other programs where the power is solely in the prosecutors' hands for participants that are poly substance users, homeless, & have behavioral health issues in addition to navigating the racial disparities in our crisis services systems. They tend to send people to jail instead of culturally competent services.*

Making "SMART" goals for our systems (specific, measurable, attainable, relevant, time-bound) can help provide an objective way of ensuring that our structures are meeting the needs of the community.

What helpful "structure" entails may be different to everyone. Some people need structure to provide resources, others need to be told what to do or how to do it.

No Drug Court participants find themselves arrested and involved in Drug Court with the intent to get into treatment. They entered the system involuntarily. Then they are presented with the choice between the Drug Court track or the traditional track. One of the operating principles of Drug Court is that immediate accountability and response is one of the things that makes it successful. If we could reach people long before their encounters with law enforcement, we'd be a lot better off.

It has become apparent that juvenile drug courts are far less successful than adult drug courts. There are much better ways to reach kids than engaging them after they've entered the court system.

01:09:10 Data Collection Recommendations for Recovery Navigator Programs

Data is being collected at the local BHASO regional level. Each regional recovery navigator program decides what they will be utilizing that data for. Each RNP is given the same data collection workbook that they need to turn in with their quarterly reports.

Individual-level data should be collected that can be linked to outcomes to demonstrate overall impact of each RNP. A year from now, when contracts are re-issued, it will be helpful to have some way of demonstrating how effective the program has been – whether there has been any positive or negative impact, and on whom, particularly regarding racial equity and access.

The RNPs are collecting individually identifying information such as names, dates of birth, Provider One IDs, and will also generate unique client ID.

Q: Does each RNP analyze the data locally with their own resources?

A: Some regions have hired staff to do a deep dive on data; each RNP needs to decide at the regional level how they will analyze their own data. There will be opportunity for the Policy Coordinating Group to have input as to how data is handled as well.

At a minimum, the combined data from each RNP will help us paint a picture of how many people are being served by this program at large and the demographics of those served.

Jen Weinmann and Brianna Peterson are currently working on a data reporting system to be able to report on the broader (statewide) impact of the RNPs with the committee.

There is currently no centralized data collection but the RNP leadership is working through TAs with different jurisdictions to help them paint a better picture of how system change is occurring in their communities, with the intent to eventually do this on a state level.

Q: Will the policy coordinating groups begin meeting before the RNPs begin providing services?

The regional RNPs are being highly encouraged to have their Policy Coordinating Groups begin meeting prior to receiving referrals.

Q: Will the data reflect the lack of diversity in rural regions and not be grouped in with data from Seattle and more diverse areas? Grouping the data together on a state level may not accurately reflect what's happening concerning racial equity.

Yes, the data will be collected by BHASO region, so data related to diversity and equity will be available on a region-to-region basis.

Q: Will there be an indicator in the overall data collection to look at gaps within different systems (e.g., crisis management system, housing, treatment)

The intention in 2022 is to nail down the metrics that we'll be using. When it comes to developing a statewide evaluation of the program, conversations will be happening to assess strengths and weaknesses of service availability and success within those services.

Presenting data within a "cascade of care" is helpful. Looking at HIV in the cascade of care is helpful -- 90% of people tested, 90% of those started on meds, 90% of those virally suppressed – to provide a model for setting specific measurable goals for the 80% treatment gap for substance use disorder in this state. What are those goals? And what are the steps in that cascade of care? What are the proportions? Where are we losing people? We need goals and specific metrics to aim for in those numbers.

Uniform, centralized data is also needed to adequately assess outcomes, and whether we are meeting goals. When the state treatment system was decentralized in 2016, the data were decentralized and we now lack complete, accurate, comparable data on publicly funded treatment across this state.

Data workgroups formed to support other state plans could be leveraged to support data needs for this plan as well.

01:37:45 – Public Comment

Lisa Daugaard: Regarding the Sequential Intercept Model discussion, it is important to think not of programs but in terms of a framework: a global approach that always works best. And that isn't always and only intervene at Intercept 0 – it's always create access to support at the earliest possible intercept. The kinds of supports people need to stabilize and recover should not only or primarily be available when people get late and far into the system. Because when you do design an overall structure like that, you create incentives for well meaning partners to drive people further into the system in order to get help. For example, law enforcement officers are told by lawyers that getting someone into the court system is where help comes. Warm hand-offs in the field must be made easy, because being charged, prosecuted, convicted, serving time, these are all harmful.

01:41:57 – Next Steps: Potential Subcommittees

Subcommittees to continue conversations around (1) **Recovery Housing & Recovery Supports**, (2) **Diversion, Outreach, & Engagement**, and (3) **Treatment** are currently being planned, and the recommendations for additional subcommittees mentioned (**Data**) will be considered as well.

Those who are interested in participating in the committee(s) should email Michelle Martinez at michelle.martinez@hca.wa.gov

Suggestions for Diversion subcommittee representation: On the Diversion committee, it would be a good idea to have a prosecutor, a sheriff/police officer, community members, and a public defender, among others.

The SURSAC supports community members to join the subcommittees/workgroups.