

Substance Use Recovery Services Advisory Committee Meeting Notes

May 2, 2022, 9:00-11:00am PDT

Meeting Recording

[WA State Substance Use Recovery Services Advisory Committee \(SURSAC\) May 2, 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 |
| <input checked="" type="checkbox"/> | Blake Ellison, Meeting Facilitator | | | | |
| Committee Members | | | | | |
| <input checked="" type="checkbox"/> | Michael Langer | <input checked="" type="checkbox"/> | Amber Daniel | <input checked="" type="checkbox"/> | Donnell Tanksley |
| <input type="checkbox"/> | Amber Leaders | <input checked="" type="checkbox"/> | Brandie Flood | <input checked="" type="checkbox"/> | Malika Lamont |
| <input checked="" type="checkbox"/> | Sen. Manka Dhingra | <input checked="" type="checkbox"/> | Vicki Lowe | <input checked="" type="checkbox"/> | Addy Adwell |
| <input checked="" 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 type="checkbox"/> | Hunter McKim |
| <input type="checkbox"/> | Rep. Dan Griffey | <input checked="" type="checkbox"/> | Marshall Glass | <input checked="" type="checkbox"/> | Kendall Simmonds |
| <input checked="" type="checkbox"/> | Caleb Banta-Green | <input checked="" type="checkbox"/> | Sherri Candelario | | |
| <input checked="" type="checkbox"/> | Victor Mendez | <input type="checkbox"/> | Hallie Burchinal | | Alternates / Optional Attendees: |
| <input type="checkbox"/> | Kierra Fisher | <input checked="" 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 |

Teams Meeting Attachments

1. SURSAC Feedback & Plan Writing Process.pptx
2. Committee Recommendation Tracking (updated 4-29-2022).doc

New committee members:

- Vicki Lowe, Representative of Federally Recognized Tribe

Discussion Notes

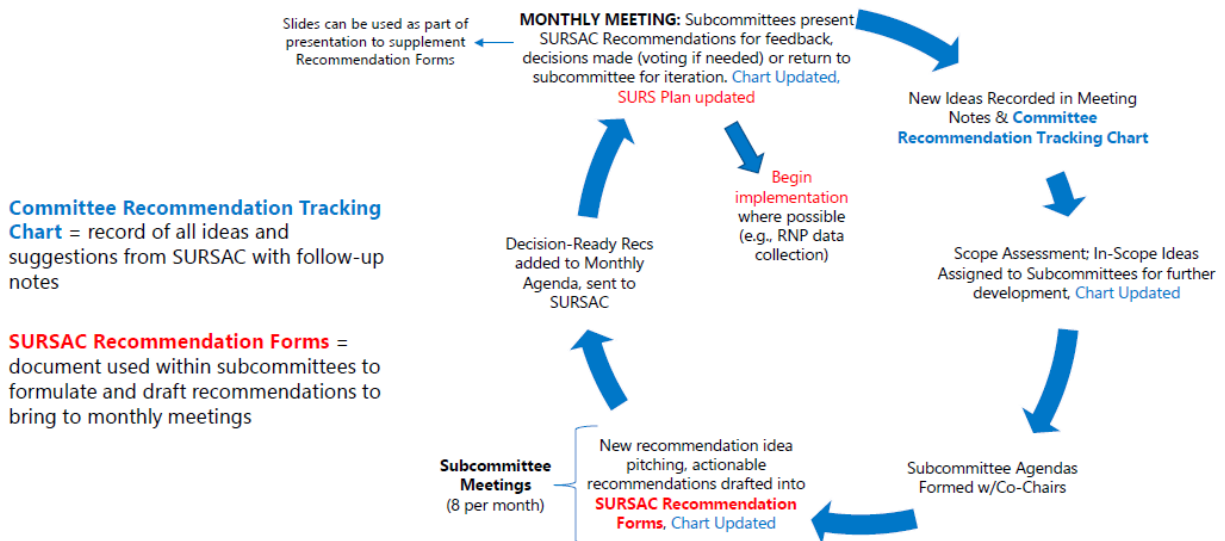
00:07:30 – Additional SURSAC Support

Blake Ellison, Process Improvement Manager, joins the SURSAC meeting as the new meeting facilitator from HCA’s Planning and Performance Division, which supports efforts such as the SURSAC when many voices are contributing, to help ensure that voices from all perspectives are included.

SURSAC meetings will also begin to make use of [Mentimeter](#) (Menti), which will enable live polling during the committee meetings.

00:13:00– Feedback Cycle & Tracking Chart

The SURSAC Feedback & Plan Writing Process slides outline how feedback is received from SURSAC becomes a formal recommendation and is then brought to the monthly meeting for a vote or discussion about whether to include it in the final Substance Use Recovery Services Plan. The cyclical process is as follows:



Updated versions of the Committee Recommendation Tracking document will be provided at least once a month, so committee members can track the progression of ideas across all subcommittees.

The following two elements will be initiated during monthly meetings, rather than within a subcommittee:

- Recommendations regarding the appropriate criminal legal system response, if any, to possession of controlled substances (5476 Section 1.3.i)
- The proposal of a funding framework in which, over time, resources are shifted from punishment sectors to community-based care interventions such that community-based care becomes the primary strategy for addressing and resolving public order issues related to behavioral health conditions (5476 Section 1.3.i)

00:38:04 – Section 1.3(l): Recommended criminal legal response, if any, to possession of controlled substances

The committee was asked to provide what types of information is needed to make an informed decisions regarding Section 1.3.(l). Recommendations included data & other information needed by committee to formulate a recommendation:

- Analysis of the racial impact of decriminalization of possession vs. legalization of supply
- Understand how the criminal legal system is being used: to incarcerate for long periods of time, or as leverage for individuals to enter treatment and successfully complete treatment
 - What are the effects, intent v. outcome
 - Outcome data for the 9,000 possession arrests made; only 3% ended up in Drug Court, what happened to other 97%?
 - Racial impact analysis of Drug Court data
- Research data on whether criminal legal system works and for whom
- Predictive modeling needed to assess additional money needed to add to current system to take care of the individual diverted due to decriminalization into healthcare (# new providers needed)? And what are the costs to DCYF, CPS, foster care when people are incarcerated? *How can some of this money come from money NOT being spent in criminal legal system?*
- Identify gaps in available services, such as in rural areas
- How much money is saved on healthcare costs and ER visits in a community that has harm reduction programs
- Drug Court policies by county (who qualifies, what are disqualifiers) and impact on outcomes
- Which areas in the state are offering diversion programs for youth
- Overdose death rate continues to go up for people under 50. How has rate of overdose deaths been impacted since State v. Blake, and who is most impacted? What is the racial impact? Important to not replace one tragic situation with another tragic situation by doing something different, but not actually better.
- Data on the effectiveness of ITA, crisis stabilization centers, and inpatient treatment programs, outside of the criminal system
 - Need to look ITA versus Least Restrictive Alternatives (LRA). What's the data showing the difference? When people are stabilized through ITA and return to their communities, resources are needed for them when they return. Tribal health efforts are focusing on behavioral health codes and using least restrictive alternatives where possible.

Additional comments and data considerations

- Do not use the funding to create more community court and have folks receive support at intercept 0 [sequential intercept model]

- One of the Plan requirements is to shift funding from criminal legal system to community-based care
- Published evidence is, by definition, looking backward at the past. To create new models of care, we need to do some [predictive] modeling, because we don't yet have a world where we can pull data on widely available kind, humane, effective, comprehensive, community-based care, low-barrier harm reduction services.
- How can we make sure our plan speaks to the social determinants of health and the criminal punishment system?
- Individuals with more financial resources are those that are successful in drug court. Individuals with fewer resources tend to struggle to meet the requirements of the court and remain entangled in the criminal justice system.
- Treatment courts have been largely effective for adults, but there is concern about using criminal charges as leverage to get people into treatment.
- As data from before vs. after Blake decision are compared, important to remember that doing "nothing" in response to use of controlled substances is not the answer, but the last year and a half couldn't be a demonstration of what we CAN do, because we've been trying to stand up systems of response during that time. Not having a response is not good enough. This policy change was a down payment on creating systems of care. We can't undo at least 50 years of policy in a year and a half.
- A prohibition-based response creates a poisonous drug supply and breeds violence from within an unregulated, underground market.
- Indigenous people are most impacted by overdose deaths (4x more likely to die from overdose than a white person). Black men and black people are another group of people experiencing growing overdose death rates.
- Harm reduction is not a lack of structure or response, it is a tool of engagement for people to move along the cycle of behavior change in a self-determined manner to change their lives.
- People do not use opioids and other drugs because they haven't gone to jail enough; they use because they have unresolved trauma.
- Data from the last couple years will also reflect the impact of COVID, not just the Blake decision. It is not appropriate to compare pandemic years to non-pandemic years.
- Around the time of the Blake decision, the People's Republic of China changed the scheduling of fentanyl, and now instead of fentanyl coming from China, it's coming from Mexico, leading to a huge proliferation of fentanyl in the market, and a subsequent massive increase of death from overdose.
- The flagship investment and intervention in response to the Blake decision was the Recovery Navigator Program, which is just now getting stood up in every community around the state. So when we look at data we need to start at the point that this intervention became active and available – which will be Q1 for some communities, and in many others will not be available until Q2 – and not use data from the vacuum that was created between the Blake decision and implementation of the legislative response.

- Fentanyl started increasing in 2016 in WA State, and across all Western United States and were 3 years behind the eastern seaboard, so the fentanyl uptick is unrelated to
- Civil commitment (involuntary treatment) should be a last resort. There is general public perception that the overwhelming majority of [controlled substance users] is not interested in services and the inverse is correct. However, there is a small percentage – about 10% -- for whom involuntary treatment would be appropriate, and that group is not stagnant; on any given day people float in and out of willingness and in and out of crisis.
 - For 90%, access and system navigation is the problem. For 10%, willingness is the problem (that’s the population for whom civil commitment is appropriate)
- [House Bill 1773](#) relates to assisted outpatient treatment (AOT), and impacts who can petition for civil commitment beyond the concentrated power in DCRs (designate crisis responders), such as jail release planners, emergency department physicians, mental health and substance use disorder professionals.
- Some rural areas lack involuntary treatment crisis stabilization services. Voluntary ones are sometimes limited to helping those with mental health crises only, and while they accept people with substance use disorders, they are unequipped to care to people with symptoms (e.g., detox, seizure, withdrawal) of active addiction, in part due to liability concerns as private organizations. Additionally, it can take so long for the system to respond to a crisis with the limited resources/services available that the individual’s window of readiness or willingness to engage with services has closed.
 - The ability to provide help at the time they ask for it, not some time down the line, is imperative

01:35:00 – Voting Process

Reaching consensus around recommendations is ideal. If needed, a simple majority vote process will be used to decide whether to approve a recommendation for inclusion in the SURS Plan. Menti is an anonymous polling tool that can be used for voting in cases where there isn’t consensus or unanimous support for a recommendation.

01:31:55 – Public Comment

Mark Cooke, ACLU of Washington: The CDC map of overdoses for 2020 to 2021 shows that 47 states have seen increases. The largest increases have been in South Dakota, Kansas, and Alaska. So while it is a problem in Washington State, it is also a national problem.

Lisa Dugaard, Public Defender Association: My colleagues and I who work with the LEAD model teach a rule of decision, which is that there is no always true answer. Rather, we should create a system in which the best response is the one that is given. That’s frustrating to people because it is not black and white, and it isn’t automatic. The appeal of a criminal-legal system response is that the system exists, and action is taken. The fact that action is taken means that we don’t think the situation is okay, and we think a response is necessary.

The problem is that the action that is taken is well-known to almost all the time make it harder for people to recover and stabilize. It’s also very expensive because you end up paying a lot of lawyers to oversee people’s attempted recovery. There has been national debate about whether you can coerce treatment. Let’s concede for the sake of argument, that it was true that you can. Some people will

engage in treatment and care through the criminal legal system. The same data show that people will engage in treatment and care outside of the criminal legal system if it is made available. I hope that the committee recommends we do that: engage everyone who can be engaged outside the criminal legal system, because it's more effective, it's less harmful, and we can provide more care for more people with the same funds.

There will also be people who have substance use issues who continue to commit non-divertible crimes, and they will be in the criminal legal system. We need to have trauma-informed practices within that system that are more effective than the ones we currently find there.

Emalie Hurlaux, Washington State Dept of Health: I'm curious if there's been discussion about the connection between physical and mental health and behavioral health. From our work with syringe service programs, the findings from ADAI (Addictions, Drug & Alcohol Institute) with the SSPs (syringe service programs), have really shown that people need one-stop shops where their physical and mental health and substance use services can be provided in one place. I'm curious how the Medicaid system can be leveraged along with the reforms you're talking about, to create these kinds of all-in-one locations where people could have multiple needs attended to. For example, we know having Hepatitis C can cause depression, and depression can cause people to do things they may not normally be interested in doing. We need to create systems of care where people can get all their needs met in one place in a low-barrier, harm reduction-oriented way where they aren't stigmatized, where they trust the staff.

Certain service programs could be a really important place to foster some job training, have community cleanup crews where people are building goodwill with the community, helping to destigmatize low barrier harm reduction programs by being a face in the community. At the same time they're getting some job training, feeling empowered, having self-direction and maybe preparing for the next step in their lives.

***Caleb Banta-Green (chat):** I will be sharing data on a model of care that addresses much of what Emalie mentioned, and we hope to leverage that work to add comprehensive drug checking and staff support for harm reduction.*

Barb Putnam, WA State Dept of Children, Youth, and Families (DCYF): As the committee thinks about the impact of diversion and the need for services across the board, we do have a significant increase in out-of-home placements because of, or as a part of, SUD involvement and not being able to keep their children safe and not being able to get into treatment services. So that is part of a broader story I'm hoping we can address along the way.

Charissa Fotinos, Health Care Authority: The increase in overdose deaths is multifactorial. One thing to understand is that fentanyl is so much more potent than heroin or morphine, it only takes one dose of fentanyl, if you're not used to opioids, to kill you. So this is a different landscape than what we've had to deal with before. And in response to Sen. Braun's comments, I've been an addiction medicine and family medicine doctor for 30 years and most of my career has been taking care of folks who struggle with substance use disorders. And if you think about folks that you've interacted with or know who struggle with substance use disorders, they do not feel very good about themselves. And why should they? None of us treats them very well. They're stigmatized, they're turned away by providers like me, who don't understand addiction, they are shunned. We don't lock people up in jail when they don't take their insulin, we don't. People who are struggling with SUD have often lost most everything that's dear to them and their self esteem is at zero.

It's not just a matter of saying you have a service, or you don't have a service, it's a matter of saying, "What do you need today? I care about you. I want to help you." And maybe that day it's food and maybe the next day it's a warm place to sleep. But we must keep in mind, in addition to the trauma that often leads folks down this road, they don't have any ability to feel good about themselves. And until we can help people do that, they're not going to be interested in treatment. It's a really complex subject.

01:49:00 – Wrap Up & Next Steps

- In-person meetings currently unavailable at HCA, updates will be provided as they are available
- Michelle will take lead on gathering the data requested by SURSAC
- Michelle will send completed SURS Plan Recommendation forms to SURSAC on the Thursday prior to the monthly meeting, to allow committee members 48+ hours to review and prepare feedback

Links Shared

[New ADAI Report: Dramatic Increases in Opioid Overdose Deaths Due to Fentanyl Among Young People in WA | Addictions, Drug & Alcohol Institute \(uw.edu\)](#)