Desk Review on Substance Use Disorder in Washington State and the Olympic Region

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EXECUTIVE SUMMARY

Introduction

- **One of the most harmful effects of addiction stigma is that it creates barriers to treatment, perpetuating Substance Use Disorder (SUD) and other negative health and social outcomes, and further exacerbating stigma.** This desk review scanned data on the scale of problematic substance use, availability of treatment, and policy developments that address addiction stigma in Washington state and the Olympic region. A deeper understanding of the state and regional environment can help inform approaches to addressing stigma.

Scale of problematic substance use

- **An estimated 9% of adults in the Olympic region experience SUD.** Alcohol is the most common substance responsible for SUD, but the prevalence of Alcohol Use Disorder has decreased over the last two decades in Washington.

- **Rising rates of deaths involving opioids and methamphetamine indicate increasing problematic use of these substances.** The share of opioid deaths involving first, heroin, and later, synthetic opioids increased in Washington over the last decade, with synthetic opioids driving a dramatic spike in the overall opioid death rate in 2020. Methamphetamine deaths have also been rising in Washington and are of particular concern in the Olympic region, where the regional death rate was the third highest in the state in 2019-20.

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Scale of problematic substance use (cont.)

- **Clallam and Jefferson Counties have higher drug overdose death rates than Kitsap County and the state overall.** The heroin death rate in Jefferson County and the methamphetamine death rate in both Clallam and Jefferson Counties were substantially higher than state averages in recent years.
- **American Indians and Alaska Natives are over-represented in SUD diagnoses in Washington.** They also experience consistently higher rates of substance-related deaths than other race/ethnicity groups.

Access to treatment

- **More than half of those in need of treatment for SUD are not receiving it in the Olympic region.** The Olympic region faces barriers to treatment access including healthcare workforce shortages and treatment facilities that are geographically disperse and limited in number. Inpatient and withdrawal management facilities are particularly limited in the region, and only a fraction of all facilities provide medication-assisted treatment.
- **Evidence-based and innovative approaches to providing care for individuals with SUD are present throughout the Olympic region.** These include harm reduction approaches, residences and organizations that support individuals in recovery from SUD, and initiatives focused on reaching individuals outside of traditional treatment settings. Some of these approaches are limited in number or accessibility in rural Jefferson and Clallam Counties.

Access to treatment (cont.)

- **Stigma continues to present barriers to implementing policies and services that expand access to evidence-based care in Washington.** Challenges include political and public opposition to expansion of harm reduction approaches; limitations in the extent to which treatment options support patient choice to engage in treatment; and federal health privacy laws that pose a disproportionate barrier to coordinated care for those with SUD.

Policy and structural stigma

- **Washington state strategic planning reflects recognition of the role of stigma in problematic substance use, and state policy has addressed aspects of structural stigma.** Policies have taken steps to expand access to evidence-based SUD treatment, decriminalize SUD, dedicate increased resources to wraparound recovery services, and involve those most affected by SUD in decision-making around how to address it.

Conclusion

- SUD and SUD treatment access represent a recognized challenge in the Olympic region. There is an opportunity to leverage existing state and local stigma-reducing policies and programs to further reduce stigma and increase access to services in geographic areas and among populations where the need is greatest.

OVERVIEW OF PROBLEMATIC SUBSTANCE USE IN WASHINGTON STATE AND THE OLYMPIC REGION

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An estimated 9% of adults in the Olympic region experience Substance Use Disorder (SUD).

- This 9% prevalence of SUD in the Olympic region was similar to WA state and higher than the national average from 2016-18 (Table I).[1]
  - Prevalence estimates are based on the annual National Survey of Drug Use and Health (NSDUH), which estimates the percentage of the population with SUD through a series of questions based on diagnostic criteria.
  - SUD estimates include dependence on alcohol, drugs, and psychotherapeutics.
  - The NSDUH does not collect data from people who are homeless and not staying at a shelter, incarcerated, or active-duty military personnel, and **may underestimate SUD prevalence**.

Table I. Percentage of adults with SUD in the past year, 2016-18

Geographic Area	SUD in the Past Year, Age 18+
Total United States	7.71
Washington	8.70
Olympic (Salish) region	8.99

- The percentage of Medicaid-enrolled adults with **diagnosed** SUD –14.3% of beneficiaries in the Olympic region in 2019 – was higher than the 9% prevalence (of diagnosed and undiagnosed SUD) among the general population estimated by the NSDUH.[2]

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While alcohol dependence is responsible for the majority of SUD in WA and the Olympic region, Alcohol Use Disorder (AUD) prevalence has trended downward.

- The **prevalence of AUD in the Olympic region was estimated at 6.72%** among adults from 2016-18.[1]
- The overall **prevalence of AUD has decreased at the state level** over the past two decades (Figure I).[3]
- Rates of deaths caused by substances are an additional indicator of trends in problematic substance use. **Alcohol-induced deaths in the Olympic region have trended downward** since 2015, rising slightly from 2018-19 (Figure II).[4]

Figure I. Change in past-year AUD among people age 12+, WA and the U.S.

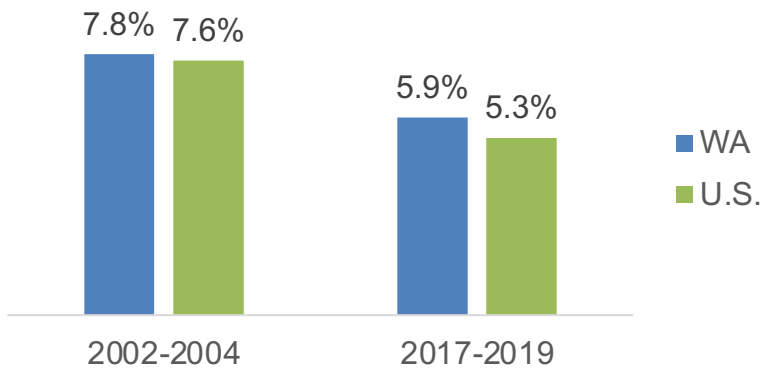
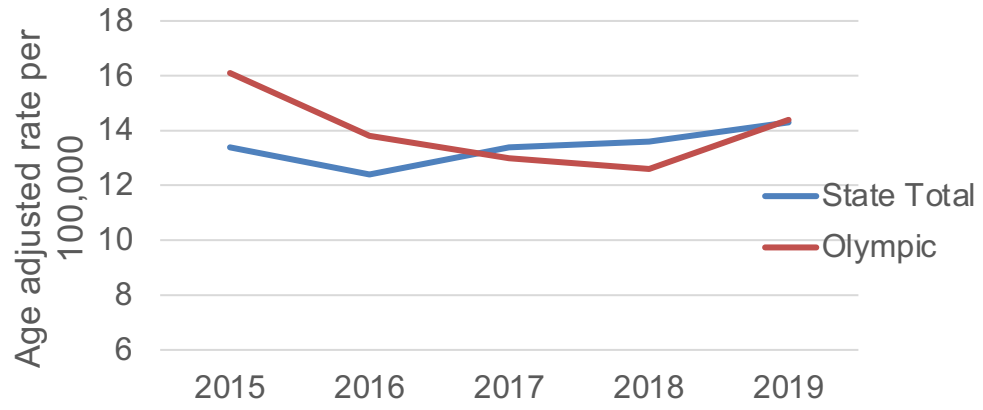


Figure II. Alcohol-Induced Deaths per 100,000 residents, WA State and Olympic region



Death and crime data indicate increasing problematic use of opioids and stimulants like methamphetamine.

- State and regional data on trends in the prevalence of opioid use disorder and stimulant use disorder were less readily available than data on overall SUD and AUD, but death and crime data show increases in problematic use of these substances.

Opioids are responsible for the majority of drug overdose deaths in the state and in the Olympic region, and opioid deaths are increasing.

- In 2019, opioid overdose deaths made up 66% of all drug overdose deaths in WA.[5]
- Over the past two decades, opioids have consistently been the drug type most frequently associated with drug poisonings in WA.[6]
- The **opioid death rate has doubled** since the early 2000s in Washington state as well as in the Olympic region (Table II).[6]

Table II. Opioid-involved deaths per 100,000 residents

Geographic Area	2002-04	2018-20	% increase
Washington	5.71	12.58	120%
Olympic region	5.42	11.12	105%

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The share of WA deaths and crimes involving synthetic opioids like Fentanyl has increased dramatically in recent years and during the COVID-19 pandemic (Figure III, next slide).[6]

- Prescription opioids were largely responsible for the rise in the opioid death rate starting in the early 2000s.
- Heroin-involved deaths have been increasing since 2010, coinciding with a decrease in prescription opioid deaths.
- Deaths involving synthetic opioids began a quick rise in 2015, overtaking prescription opioids and heroin as the type of opioid most frequently involved in overdose deaths in 2020.
- After being stable for over a decade, the overall opioid death rate rose sharply in 2020, driven primarily by the increases in synthetic opioid deaths.
- The number of statewide crime lab cases (i.e., arrests, prosecutions and lab testing) involving Fentanyl has also increased in recent years, from under 50 quarterly cases in early 2018 to a peak of over 200 quarterly cases in late 2020.[7]

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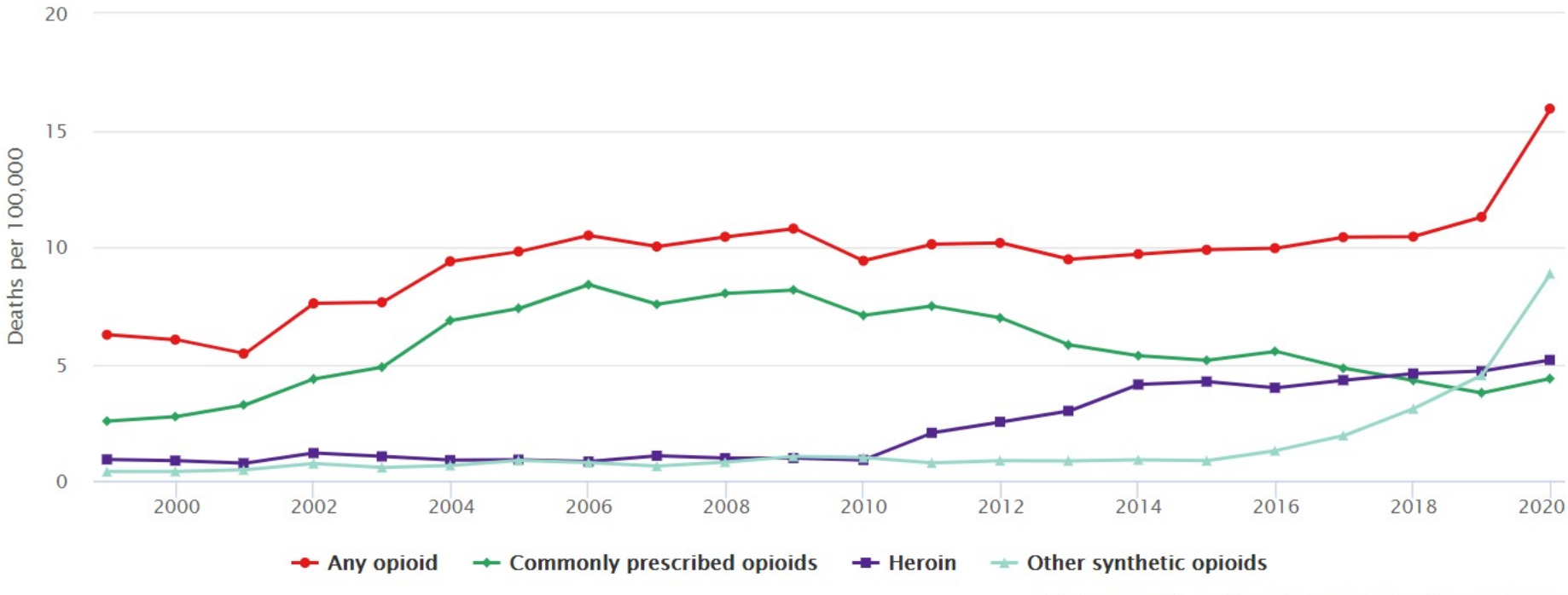
Figure III. Opioid-related death rate by opioid type, Washington 2000-18[6]



2000 → Rise in prescription opioid deaths

2010 → Rise in heroin deaths

2015 → Rise in synthetic opioid deaths

2020: Overall opioid death rate increases sharply, driven primarily by synthetic opioids.

Note: 2020 data are preliminary.

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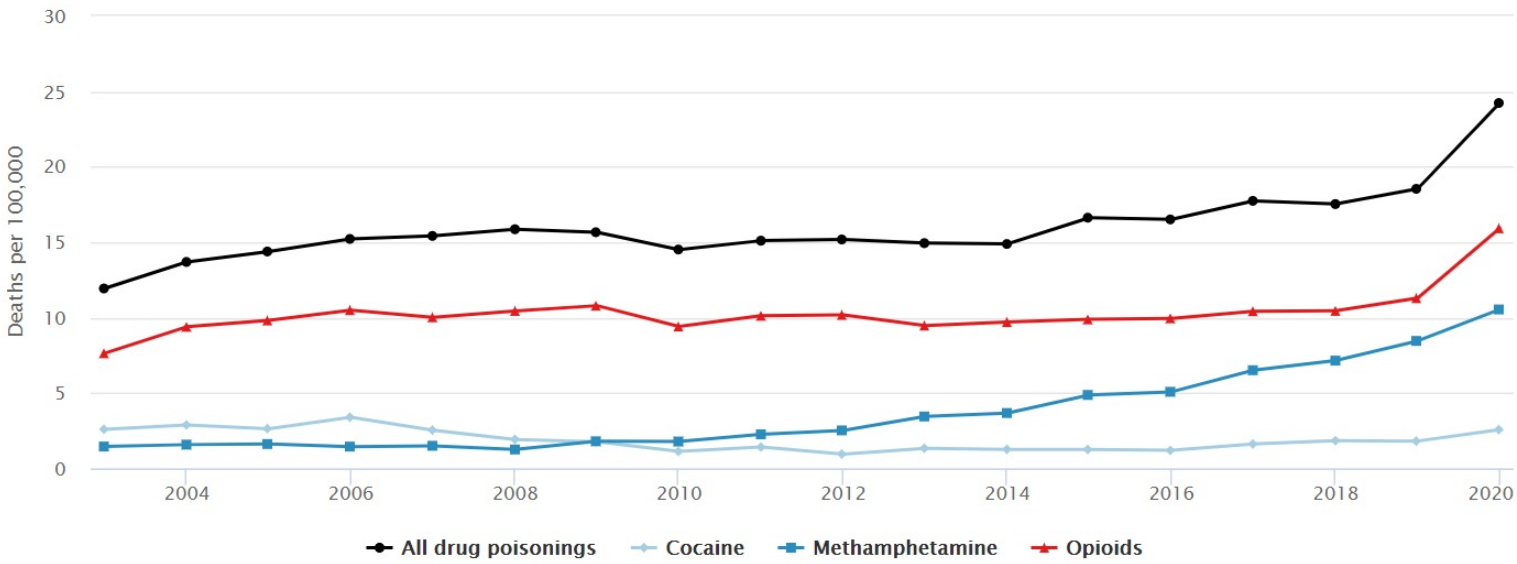
Methamphetamine death rates are also on the rise. The Olympic region had the third highest methamphetamine death rate in the state in 2017-18.

- Although opioids contribute to more deaths overall, methamphetamine death rates have been rising in WA since 2010 (Figure IV).[6]
- The Olympic region had the third highest methamphetamine death rate in the state in 2019-20 (10.27 deaths per 100,000 residents, compared to a state average of 9.50). This rate has more than quadrupled since 2003-04 (2.25 deaths per 100,000 residents).[8]
- Methamphetamine has consistently been the leading substance involved in WA crime lab cases for the past two decades.[9]

Figure IV. Drug caused deaths per 100,000 residents, WA



Note: 2020 data are preliminary.

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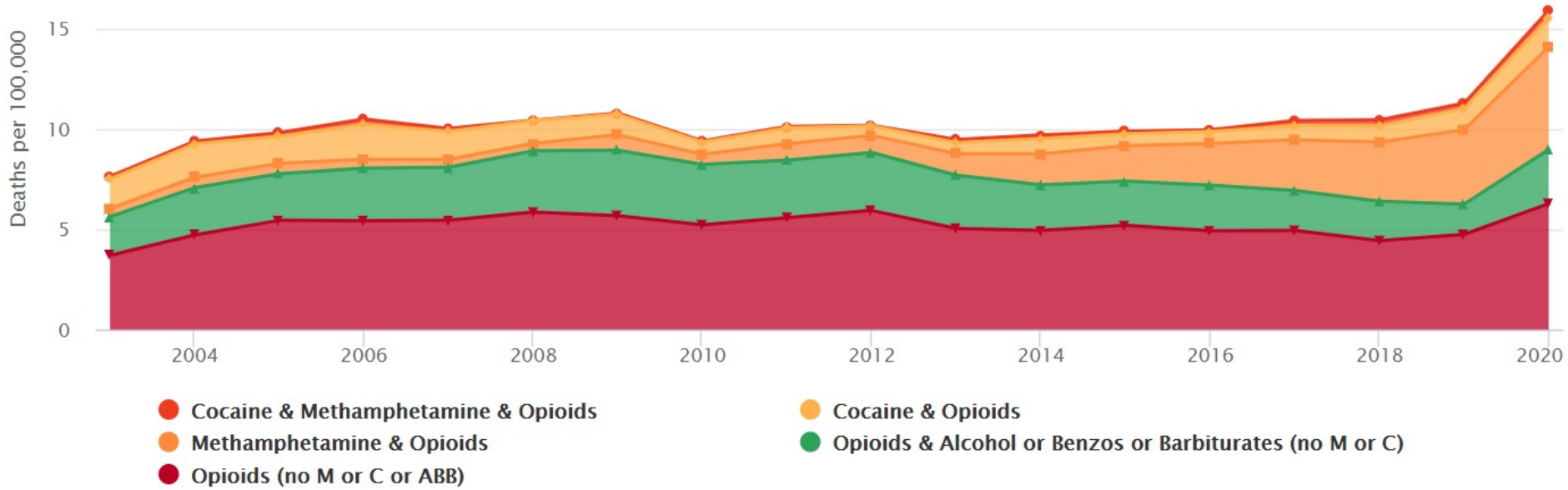
Statewide drug overdose deaths regularly involve multiple substances, suggesting a need to address problematic use of multiple substances.

- Opioid deaths regularly involve other major types of drugs, indicating increasing use of multiple substances.
- Methamphetamine, alcohol/barbiturates/benzodiazepines, and cocaine were among the common drugs that, combined with opioids, were involved in WA deaths in recent years (Figure V). [6]

Figure V. Opioid deaths per 100,000 residents by drugs involved, WA



Note: 2020 data are preliminary.

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Clallam and Jefferson Counties had higher rates of adverse outcomes from substance use than Kitsap County.

- Clallam and Jefferson Counties had higher **drug overdose death rates** than the state average in 2010-14 and 2015-19, as well as larger increases in rates. Kitsap County rates were lower than the state average at both points and decreased over time (Figure VI).[10]
- Clallam County's rate of **drug-related hospitalizations** (fatal and nonfatal) has been increasing since 1990 and was worse than the state trend in the most recent years analyzed (2011-15) (Figure VII).[11]

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Figure VI. Drug Overdose Mortality Rate: Deaths per 100,000, age 15-64

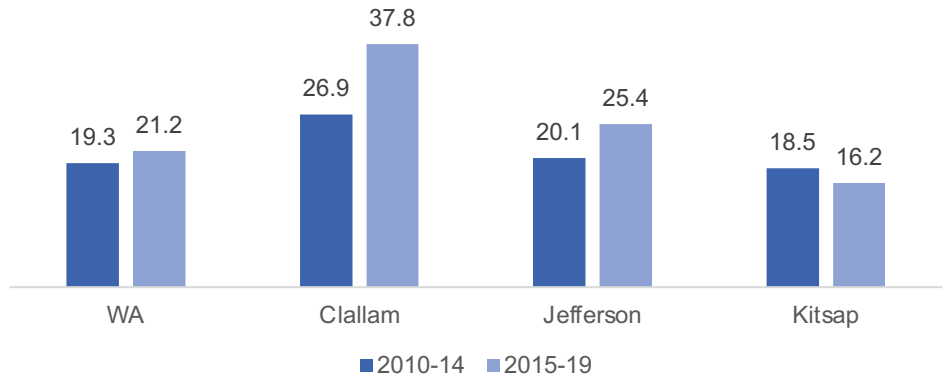
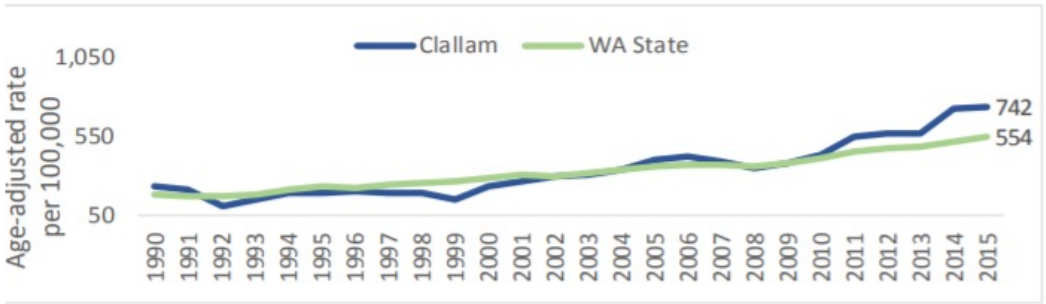


Figure VII. Drug-related hospitalizations per 100,000



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- In 2018-20, **opioid deaths** per 100,000 residents (Table III) were higher in Clallam and Jefferson Counties than Kitsap County and the state average. Rates of prescription/other opioid deaths in both Clallam and Jefferson Counties were above the state average, but only Jefferson County had a heroin death rate higher than the state average.[6]
- Clallam County's rate of **methamphetamine deaths** (Table IV) in 2019-20 was well above the state average and one of the highest rates of all counties in the state. Jefferson County's rate had the largest increase among Olympic region counties since 2003-04 (502%).[8]

Table III. Opioid deaths per 100,000 by opioid type, Washington and Olympic-region counties, 2018-20

State/ County	All Opioid deaths	Heroin deaths	Prescription/ other opioid deaths
Washington	12.58	4.82	10.35
Clallam	14.48	3.95	11.85
Jefferson	15.68	7.32	12.54
Kitsap	9.64	4.82	5.93

Table IV. Methamphetamine deaths per 100,000, Washington and Olympic-region counties, 2003-04 versus 2019-20

State/ County	2003-04	2019-20	% increase
Washington	1.52	9.50	525%
Clallam	3.77	16.36	334%
Jefferson	1.82	10.92	500%
Kitsap	1.87	8.48	353%

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American Indians and Alaska Natives (AI/ANs) are over-represented in SUD diagnoses, have higher rates of substance-related deaths, and experience disparities in timely receipt of treatment in WA.

- AI/AN adults have the **highest rate of identified SUD treatment need** (24%) in the Olympic region, compared to other race/ethnicity groups.[2]
- AI/ANs have **higher rates of overall drug overdose deaths** and deaths due to all opioids, heroin, methamphetamine, or alcohol than other race/ethnicity groups in WA.[12-14]
- Drug overdose **mortality rates have increased at a faster rate** for AI/ANs compared to whites since 2001.[12]
- AI/ANs in WA, and especially those living in economically disadvantaged communities, have **experienced less timely receipt of SUD treatment** than other race/ethnicity groups.[15]

Other populations over-represented in SUD diagnoses include people experiencing homelessness or housing instability and criminal justice involved persons.

- People experiencing homelessness or housing instability were 8% of Medicaid beneficiaries but made up 29% of SUD diagnoses in 2019.
- Criminal justice involved persons were 4% of beneficiaries but made up 20% of SUD diagnoses in 2019.[16]

AVAILABILITY OF AND ACCESS TO SUBSTANCE USE DISORDER TREATMENT IN THE OLYMPIC REGION

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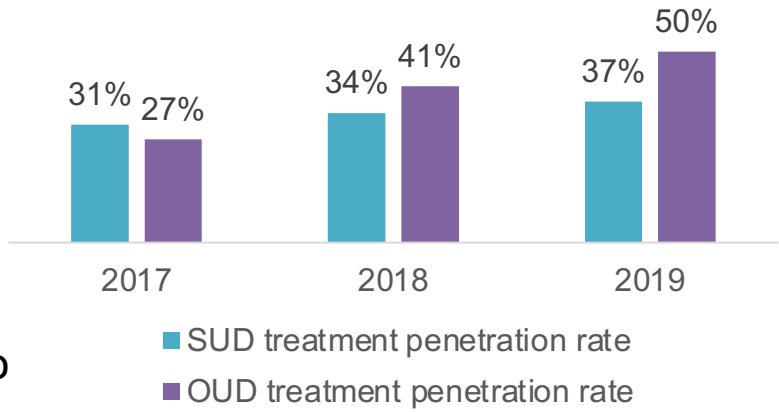
More than half of people in need of SUD treatment in the state and Olympic region are not receiving it, but treatment rates are rising.

- Treatment penetration rates among Medicaid beneficiaries with SUD and with OUD increased from 2017-19 in the Olympic region (Figure VIII), similar to statewide trends.[16]
  - The higher rate and greater increase in OUD treatment penetration reflects an increase in availability of treatments for OUD, especially Buprenorphine, which can be provided in primary care settings by providers who apply for a waiver.
  - Treatment penetration rates do not account for individuals with **undiagnosed** SUD or individuals who are not Medicaid beneficiaries
- Clallam County had the highest treatment penetration rate of Olympic-region counties.[2] Annual rates of individuals enrolled in publicly funded substance use treatment in Clallam County have trended well above the state average and other Olympic region counties since 2007.[17]

Figure VIII. SUD and OUD treatment penetration rates* among Medicaid beneficiaries in the Olympic region, 2017-19



*The SUD treatment penetration rate is the percentage of beneficiaries with a SUD treatment need identified in the past two years who received at least one qualifying SUD treatment during the year. The OUD treatment penetration rate is the percentage of beneficiaries with an OUD treatment need identified in the past two years who received medication for OUD treatment during the year.

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The Olympic region faces challenges related to treatment access.

- **Workforce shortages:** Like most counties in WA state, each of the three Olympic-region counties is designated a geographic Health Professional Shortage Area (HPSA) in the mental health area (which includes providers who treat SUD).[18]
    - Challenges related to the workforce shortage include an aging workforce; salaries that trend lower than the national average; and high housing costs relative to the nation and most of the state.[2]
- **Internet access:** Access to broadband, which is crucial for access to telehealth, is limited in rural areas like Clallam and Jefferson Counties.[2]
- **Limited and geographically disperse treatment facilities:** The geographic distribution and limited number of substance use treatment facilities may contribute to the need to refer or travel outside of the region for treatment.[2, 19]
- **Reduction in funds for uninsured:** The 2020 transition to Integrated Managed Care for Medicaid clients was accompanied by a substantial reduction in available non-Medicaid state general funds available for uninsured individuals in the region in 2020, compared to 2018-19.[2]

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A scan of SUD treatment facilities in the Olympic region demonstrated gaps related to inpatient services, withdrawal management, medication-assisted treatment, and geographic availability of services.

- The characteristics of facilities located in each county (see Table V, next slide) show:
  - The majority of facilities provide outpatient services; **inpatient and residential facilities are limited**.[2, 20]
  - Detoxification services are limited, and the region has **no medically-supported withdrawal management facilities**. There are only two residential, non-medical withdrawal management facilities in the region (both in Kitsap County; total of 12 beds).[2, 20]
  - The region has **no inpatient hospital facilities**, yet Medicare reimbursement is restricted to inpatient hospital facilities.[20, 21]
  - Jefferson County does not have a licensed Opioid Treatment Program or treatment facilities that administer medication to treat OUD.[20]
- The map of substance use treatment facilities and Buprenorphine-waivered providers (see Figure IX, subsequent slide) illustrates that facilities are sparse in areas of Clallam and Jefferson Counties.

Table V: Substance Use Treatment facilities and select characteristics, SAMHSA (accessed June 2021)[20]

	Clallam County	Jefferson County	Kitsap County
Population[10]	75,392	31,285	265,882
Total substance use treatment facilities	11	3	15
Outpatient/intensive outpatient	10	3	13
Residential	1	1	2
Hospital Inpatient	0	0	0
Detoxification (non-residential)	2	0	2
OUD treatment medications used: Naltrexone	3	0	3
OUD treatment medications used: Buprenorphine	2	0	4
OUD treatment medications used: Methadone	1	0	2
Licensed Opioid Treatment Program	1	0	1
Number of buprenorphine-waivered physicians	41	21	56

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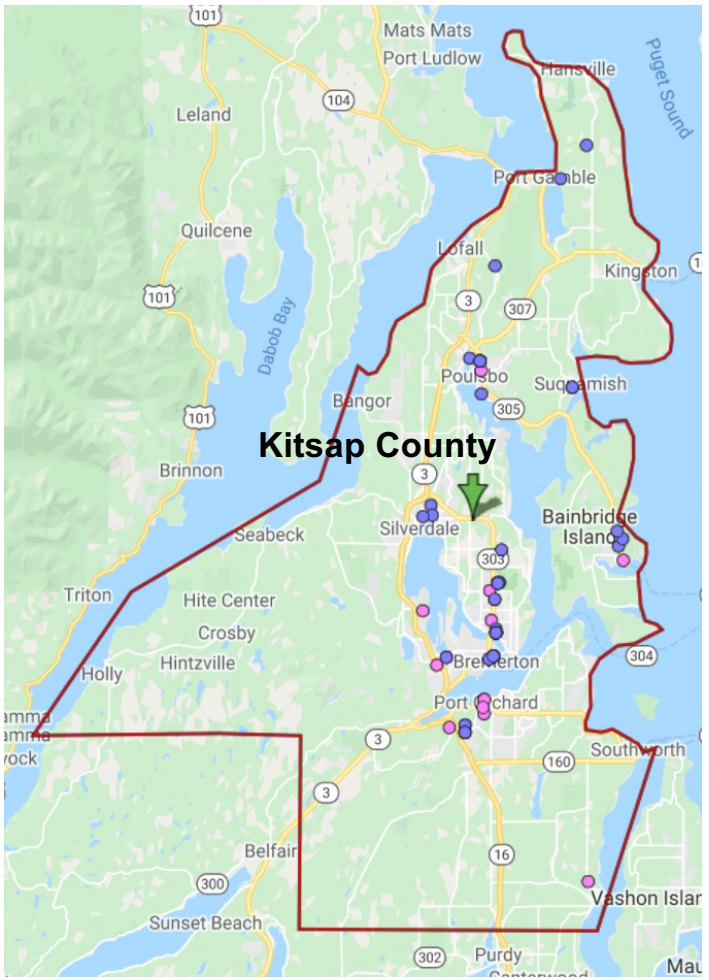
Figure IX: Map of Substance Use Treatment facilities (pink dots) and Buprenorphine-licensed providers (purple dots) in Olympic region counties, SAMHSA (accessed June 2021)[20]



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A variety of harm reduction approaches to addressing SUD are present throughout the Olympic region with varying levels of accessibility.

- **Medication-assisted treatment (MAT) for OUD:** As shown in previous slides, opioid substitution therapies are available at some treatment facilities and from buprenorphine-waivered physicians in each county. Jefferson County lacks a licensed Opioid Treatment Program.

- **Syringe service sites:** Each county has a syringe services program (SSP) offering access to sterile injecting supplies, safe syringe disposal, overdose education, and linkages to other social and health services.

    - Days and hours of services are limited in Clallam and Jefferson Counties.[22, 23]

    - Kitsap County has more accessible services via one public health location and one mobile service, plus four locations with daily hours via Peninsula Community Health Services pharmacies.[24]

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- **Naloxone distribution and education:** WA has a standing order mandating that anyone at risk of overdosing or spending time with people at risk of overdosing can obtain Naloxone, an opioid overdose reversal medication, without a prescription. Naloxone is covered by Medicaid and provided at county syringe services locations and at most substance use treatment facilities in the region.[20, 25]
- **Alternatives to incarceration:** Drug/therapeutic courts are available in each county and advertise alternatives to incarceration through programs involving education and treatment. Kitsap County and the Makah Indian Reservation also have Law Enforcement Assistance Diversion (LEAD) programs in which "police officers exercise discretionary authority at point of contact to divert individuals to a community-based, harm-reduction intervention for law violations driven by unmet behavioral health needs." [26, 27]
- **Good Samaritan Law:** WA's Good Samaritan Law protects individuals seeking medical assistance for drug-related overdose from prosecution for drug charges. [28]

Other harm reduction approaches have been explored in Washington state but are not currently being implemented in the Olympic region.

- **Drug checking and adulterant screening**, a harm reduction approach that aims to prevent consumption of unknown substances, are not currently advertised as being offered in the region. The state successfully piloted distributing Fentanyl test strips through SSPs in 2018 and set aside additional funding for the service in 2019, which ran out in 2020.[29] Some organizations provide educational resources on how to check drugs and where to obtain test strips for drug checking on their web pages.[30, 31]
- **Safe injection sites**, another harm reduction approach, have not yet been implemented in WA. One site was approved for Seattle, but implementation was recently stalled (January 2021) after a court ruled an injection site in Philadelphia violated federal law.[32]
- Studies have been done of other **harm reduction pilot programs for individuals with AUD** in WA, but similar programs in the Olympic region were not located.[33]

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Residences and organizations that support individuals in recovery from SUD are present in the Olympic region but limited in number.

- **Recovery houses** are peer-run living situations that support long-term recovery from substance use disorder. A state registry of accredited residences includes Oxford House locations with capacities ranging from 7-12 individuals in Clallam County (9 houses) and Kitsap County (26 houses), but no recovery residences in Jefferson County.[34, 35]
- The **Recovery Café Network** implements a non-residential model of ongoing support for people in recovery via local community spaces. Jefferson County and Kitsap County are each home to one emerging member organization working towards certification as a Recovery Café. [36]
- **Alcoholics Anonymous** and **Narcotics Anonymous** offices and resource lines are available in each county in the region and advertise that they can provide further information on local meetings to individuals who contact them.[37]
- Coalitions in the region, such as the **Salish Recovery Coalition** and **Washington Recovery Alliance**, are working towards allocation of resources to recovery. The Salish Recovery Coalition is behind Kitsap County's first Recovery Café. [38-40]

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Additional resources and initiatives in the Olympic region reflect efforts to reach individuals in need of treatment outside of traditional treatment settings, build interagency coordination, and address stigma.

- **Toll-free help lines** are available for individuals in crisis in the state (Washington State Recovery Help Line) and region (Salish [Olympic] Regional Toll-Free Crisis Line).[41]
- The **Hub and Spoke** model increases capacity to distribute medications for OUD throughout the state by facilitating integration between sites that can provide medication (hubs) and places where people who need MAT seek other services (spokes).[42]
    - There are two Olympic-region networks with hubs at Olympic Peninsula Health Services in Jefferson County and Peninsula Community Health Services Network in Kitsap County.
- **Opioid Treatment Networks** were created to help emergency departments, jails, and community agencies identify individuals with OUD, initiate MAT, and make referrals for ongoing care.[43]
    - Initiation sites are located at Jefferson County Jail and Kitsap County Jail.
- In Kitsap County, the **Peninsula Community Health Services mobile clinic** travels throughout the county to offer behavioral health care, including MAT, to people who may not access care in clinical settings.[44]

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- Planned for Clallam County with funding from the state and Jamestown Tribe, the **Jamestown S'Klallam Clinic** will be a licensed outpatient opioid treatment program that provides wraparound services and incorporates native practices.[45, 46]

- In Port Angeles, Clallam County, a **team of "Community Change Agent" navigators (REdisCOVERY), a community paramedic working with the fire department, and a police department social worker** respond to crises and conduct outreach to connect community members in need with services, including SUD treatment.[2, 47]

- Clallam County's **Clallam Care Connection (3C)** project is piloting interagency collaboration to address chronic conditions, including SUD. Member organizations meet weekly to improve access to services and referrals for the care of 3C clients.[2, 48]

- The **Jefferson County Community Health Improvement Plan (CHIP) Behavioral Health Consortium (BHC)** received a $1 million federal grant in 2020 to create a plan to address stigma; support the local Recovery Café; expand harm reduction and syringe exchange to south Jefferson County; and explore the feasibility of a Crisis Stabilization facility.[49]

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Despite advancements, stigma continues to present barriers to implementing policies and services that expand treatment access.

(1) Efforts to expand harm reduction approaches have faced opposition from policy makers and the public demonstrating a basis in stigma.

- Save our Sequim (SOS) formed in 2019 to **appeal the planned Jamestown S'Klallam Clinic** in Sequim, stating it "will forever compromise the rural character of the Sequim we love." The appeals were later struck down in decisions that highlighted their lack in factual basis and reliance on "generalized comments and concerns such as loitering, drug use and littering" and "hypothetical or conjectural harm."[46, 50, 51]
- SB 5380 (2019) expanded access to opioid use treatment, but amendments were added to the bill to **prevent the Health Care Authority's promotion of or partnering with safe injection sites**.[52]
- Initiative 27 was a King County public initiative that **aimed to ban public funding of safe injection sites** and gathered enough signatures to make the ballot in 2018. Even though the WA Supreme Court struck down the initiative, implementation of a safe injection site in Seattle has stalled due to a 2021 ruling that a safe injection site in Philadelphia violated federal law.[53]

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(2) Despite the benefits to expanding access to treatment options, some organizations note that involuntary treatment and incarceration alternatives do not go far enough in achieving patient choice to engage in treatment.

- 2018 updates to WA's Involuntary Treatment Act, also known as Ricky's Law, allow **involuntary commitment of individuals with SUD** who are a danger to themselves, to others, or to others' property to withdrawal management facilities, if space is available.[54]
- The **WA ACLU and national Drug Policy Alliance are opposed to forms of involuntary treatment**, seeing them as coercive and prone to "many of the same social and structural issues that contribute to mass criminalization," and instead advocate for access to patient-led, voluntary treatment.[55, 56]
- The **WA ACLU and Drug Policy Alliance voice similar concerns about drug courts but look positively on LEAD programs**. A LEAD website pop-up announces recent changes to the program in recognition of the challenges of involving law enforcement in drug treatment alternatives: "… the flagship LEAD program in Seattle is now known as Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity, and we have developed a new option for LEAD operations that *decenters law enforcement as gatekeepers to LEAD services*." [27, 57, 58]

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(3) Federal health privacy laws have historically posed a disproportionate barrier to coordinated care for those with SUD compared to other health conditions.

- Under federal privacy (HIPAA) regulations passed in 1975, **SUD is disproportionately protected** in comparison to other diagnoses. 42 CFR Part 2 requires SUD patients provide written consent for disclosure of information to non-addiction providers.

- These protections, while intended to protect patients from discrimination, stigma, and law enforcement, **create barriers to exchange of information and coordination** of behavioral and other health care providers, which can produce gaps in patient care.[2]

- Advancements in the understanding of SUD as a health condition, integrated care, and health care technology are not fully reflected in the legislation or its recent updates.

- WA state has published a handbook that strives to facilitate understanding and implementation of HIPAA regulations for individuals with SUD, and a number of previously described **local projects demonstrate ongoing attention to interagency collaboration**.[59]

SUD POLICIES AND INITIATIVES ADDRESSING STIGMA

Washington state strategic planning to address problematic substance use reflects recognition of various aspects of stigma and prioritization of measures and funding to address it.

- The **2021-22 State Opioid and Overdose Response Plan** (SOOR, an update to the plan originally issued in 2016) addresses several areas of stigma.[60] For example, it:
  - Acknowledges the role of social determinants of health and systemic racism and includes a statement committing to addressing inequities.
  - Includes evidence-based treatment and harm reduction in plans for responding to OUD, including low barrier MAT, syringe exchange, and expansion of overdose reversal medication availability and education.
  - Includes improving provider education related to stigma under its treatment goal.
  - Devotes one of its five goals (added 2020) to supporting individuals in recovery.
  - Establishes an AI/AN work group to address the disproportionate impact of OUD on AI/ANs in WA.

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- The state's use of federal **State Opioid Response grants** from SAMHSA, starting in 2017, has prioritized the integration of behavioral health care with other health care through projects like Hub and Spoke, and the creation of an interagency coordinator.[42]
- **WA's 2-year budget**, approved in 2021, expanded funding for behavioral health, including SUD treatment programs.[61]

WA state policy developments demonstrate steps to address structural stigma related to substance use, in alignment with strategic plans.

- The following slides provide examples of policies that address structural stigma in the areas of (1) SUD treatment; (2) decriminalization of SUD; and (3) wraparound recovery supports.

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(1) Policies related to SUD treatment take steps to integrate behavioral health care with other health care, recognize SUD and OUD as health conditions, and expand access to treatment, including MAT.

Integrating behavioral/other health care

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** became a billable medical benefit in 2014 in Washington, recognizing the importance of integrating approaches to identifying and treating substance misuse in a variety of healthcare settings.[62, 63]
- In 2017, HB 1388 **integrated the state oversight of behavioral healthcare with other healthcare** for Medicaid clients, under the Washington State Health Care Authority.[64]

Recognizing SUD as a health condition

- Legislation related to SUD treatment in 2019 (SB 5380) and 2020 (HB 2642) **formally recognized OUD and SUD as chronic health conditions**.[65, 66]

"The legislature finds that substance use disorder is a treatable brain disease from which people recover; that electing to go to addiction treatment is an act of great courage; and that people with substance use disorder who are provided rapid access to quality treatment within their window of willingness, usually recover." (HB 2642)[66]

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Expanding access to MAT

- A 2015 standing order and measures in several subsequent bills **increased access to overdose reversal medication (Naloxone)** by allowing access without a prescription, requiring hospitals to provide it to individuals with OUD upon discharge, and instituting additional measures to facilitate purchasing and distribution.[28, 67, 68]
- In 2017, HB 1427 **eased requirements for licensing and permitting Opioid Treatment Programs (OTP)** in communities in order to streamline licensing and address demand for MAT.[69]
- SB 5380 (2019) and the No Wrong Door bill (HB 2642, 2020) removed barriers to treatment by **requiring that Medicaid and state-regulated plans cover SUD treatment and MAT without prior authorization**.[52, 68, 70]
- SB 5380 (2019) also **required MAT be provided in jails**, if funding is available.[52]
- Recent changes (April 2021) in federal buprenorphine prescribing laws have **eased the federal requirement that doctors undergo eight hours of training to secure a waiver to prescribe buprenorphine**, removing further barriers to the availability of MAT.[71]

Collaborative Consulting
Where Ideas Evolve Into Action

(2) Legislators have made efforts to reduce criminal penalties for substance use, with developments as recent as the current legislative session.

- WA was the second state in the country to pass a Good Samaritan Law, **protecting a person having an overdose and anyone seeking their medical care from prosecution for drug possession**, in 2010.[28]
- In 2020, HB 2793 ("Clean Slate"), would have **automatically expunged criminal records** for eligible offenses. The bill received enough support to pass the legislature but was later vetoed by the governor due to COVID-related budgetary issues.[72]
- Early in 2021, the WA State Supreme Court struck down a law that made possession of a controlled substance a felony, invalidating drug possession convictions. Efforts to address the ruling resulted in the passage of SB 5476, which **reclassified drug possession as a gross misdemeanor** subject to fines up to $125. [73-75]
- Also in 2021, HB 1078 **restored voting rights to people convicted of felonies**, upon their leaving prison. The bill was sponsored by Bremerton state legislator Tara Simmons, who was formerly incarcerated for drug crimes. [76]

Collaborative Consulting
Where Ideas Evolve Into Action

(3) Policy developments over the past couple of years demonstrate increased attention to ongoing SUD recovery by facilitating access to peer support and wraparound recovery services.

- Launched in 2018, Foundational Community Supports (FCS) is a state Medicaid program that provides **supportive housing and employment services** to beneficiaries, including those in recovery from SUD.[77]
- In 2019, HB 1907 made **peer support services** (support from people with a lived experience with mental health or substance use disorders) a covered Medicaid benefit for people in recovery from SUD.[78]
- HB 1907 (2019) also **removed barriers to employment for peer counselors** by prohibiting they be denied employment based on convictions common among those with a history of addiction. [79]
- In 2019, HB 1528 included several provisions to **expand availability of and access to recovery residences**, including increasing the number of residences, maintaining a registry of residences, funding facility improvements, and funding residence vouchers for people in recovery. [79, 80]

Collaborative Consulting
Where Ideas Evolve Into Action

State-level policies, planning, and initiatives reflect progress in allocating resources for addressing SUD and involving local communities and groups most affected by SUD in decision-making around how to address it.

- WA's 2005 Hargrove Bill **allows counties to implement a 0.1% sales tax for mental health and substance use treatment programs and services**. Each county in the Olympic region manages and distributes these funds through an RFP process.[2]

- Via the state's Medicaid Transformation Project, each Accountable Community of Health (ACH) is required to undertake **regional projects to meet the goals of the State Opioid and Overdose Response plan**.[60]

    - The Olympic ACH's project is the Three-County Coordinated Opioid Response Project (3CCORP), focused on increasing naloxone access, promoting OUD awareness, and improving opioid prescribing practices.[81]

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- The SAMHSA grant-funded **Center for Rural Opioid Prevention**, which was founded in 2019, provides training and technical assistance and addresses the importance of allocating resources and support to rural areas. Jefferson County is one of the center's partners.[82]

- The disproportionate impact of SUD on tribal communities has been addressed through AI/AN-specific legislation, such as the Indian Behavioral Health Act (SB 6259, 2020), which **aims to increase access to behavioral crisis care by redirecting management to tribes**.[83]

- WA has established advisory boards to **involve people with a lived experience with SUD in advising on behavioral health services**, for example, through the Behavioral Health Advisory Council, which advises the state Health Care Authority.[84]

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