Washington State Health Care Authority

Substance Use and Recovery Services Plan Recommendation

Recommendation – Assemble a statewide workgroup to make recommendations on a framework for safe supply for inclusion in the Washington State Substance Use Recovery Services Plan to provide a regulated, tested supply of controlled substances to individuals at risk of drug overdoses. The workgroup should center people who use drugs, with lived and living experience, and who have lost loved ones.

This workgroup should consider values of (1) non-commercialization, and (2) alternative lawful income source for people who have been trapped in the illicit distribution economy and could be displaced by a safe supply program, to prevent potential unintended consequences that would disadvantage communities most impacted.

Bill Requirement(s) – Per 5476, this recommendation considers:

- Points of intersection that persons with substance use disorder have with the health care system and locations in which persons with untreated substance use disorder congregate (§1.3.a)
- Barriers to accessing the existing behavioral health system and recovery support services for persons with untreated substance use disorder, and possible innovations that could improve the quality and accessibility of care for those populations (§1.3.d)
- Evidence-based, research-based, and promising treatment and recovery services appropriate for target populations, including persons with co-occurring substance use disorders and mental health conditions (§1.3.e)

Background & Supporting Data

The SURSAC has expressed broad support to establish a system to provide safe supply services in Washington State. With the understanding that there are several models to explore and many important implications and logistics to consider within those models, a special workgroup should be formed to decide on the details for a model that fits the needs and concerns of Washington residents who will be directly impacted by the implementation of a statewide Safe Supply system, including people who use drugs.

On September 12th, 2022, the SURSAC voted to recommend decriminalization of possession of controlled substances in Washington State. To realize the greatest public health, safety, and social benefit of this recommendation, people will need to be able to access their substance(s) of choice in a form that is as safe as possible to consume (safe supply) and to do so without interference (decriminalization). The resulting system reduces harm associated with drug use, including overdose and incarceration.[1]

Safe supply is defined as "A legal and regulated supply of mind or body altering substances that traditionally have only been accessible through illicit markets."[2] Research has shown that:

- Safe supply has been shown to greatly reduce the chance of overdose for those who receive it.[3]
- Safe supply reduces riskier use and promotes safer use over time.[4]
- Safe supply in certain models reduces theft, petty crime, and syringe litter. It also returns autonomy and time to people's day, and increases prosocial engagement with their communities.[5,6]

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[1] Addressing the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19 among people who use drugs: The potential roles for decriminalization and safe supply (2020)
[2] Safe Supply — CAPUD
[3] Evaluation of an emergency safe supply drugs and managed alcohol program in COVID-19 isolation hotel shelters for people experiencing homelessness (2022)
[4] Characterizing safer supply prescribing of immediate release hydromorphone for individuals with opioid use disorder across Ontario, Canada (2022)
[5] Safer supply pilot project findings - Canada.ca
[6] Vancouver's Unconventional Approach to Its Fentanyl Crisis - The New York Times (nytimes.com)

The following qualitative studies also demonstrate the value of these programs to their communities:

"People need them or else they're going to take fentanyl and die": A qualitative study examining the 'problem' of prescription opioid diversion during an overdose epidemic (2021)

"It's helped me a lot, just like to stay alive": A qualitative analysis of outcomes of a novel hydromorphone tablet distribution program in Vancouver, Canada (2021)

Implementation of Safe Supply Alternatives During Intersecting COVID-19 and Overdose Health Emergencies in British Columbia, Canada, 2021 (2022)

Below are four potential models for the workgroup to consider, as presented by Adam Palayew during the SURSAC Special Meeting on September 9th, 2022:

Table 1. Characteristics of different safe supply frameworks under consideration.

Scenario	Framework 1: Prescription (supervised consumption)	Framework 2: Prescription (unsupervised consumption)	Framework 3: Buyer's Club	Framework 4: Dispensary (not for profit/for profit)
Description	Drugs are prescribed and administered in a supervised setting under the care of health professionals and/or peer workers.	Drugs are prescribed and dispensed by a health care provider at a dedicated facility, but PWUD have the option to administer it on their own terms outside of a supervised setting, such as their own home, in take home doses.	Buyers Club: Network of people in community. Pool money and buy from a source and then use that to purchase drugs in bulk, test them, package them and provide them back to the community. Buyers come together and collective purchasing. (e.g. Dallas Buyers Club; History of HIV Meds). Grassroots, no physical location. Less institutional	Drugs can be made available without prescription in dispensaries and shops (e.g., cannabis). This model can be run in a for profit or a non-for profit manner. There can also be restrictions who can access these locations including based on age.
Delivery	Prescriber	Prescriber	Alternative	Alternative
Population coverage	PWUD in contact with health system	PWUD in contact with health system	All PWUD	All PWUD

Some safe supply features can be implemented in any of these frameworks[7]:

1. Licenses for purchasing, coupled with education
2. Signing of waivers acknowledging risk
3. Putting labelling on packaging about health messages and where to seek help if desired
4. Education related to use and accompanying harm reduction supplies

Concerns & Considerations

Some questions and concerns that arose following the Safe Supply 101 presentation on September 9th (starts at 00:55:30 in the meeting recording) are outlined below, with responses from Adam Palayew (University of Washington).

> ***Q: (Part 1) You can look at the reduction in death among people who participate in the program. But how about people out in the community? So that's the first question.***
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> A: There is ongoing work to try and find the answers to those questions. It's very hard to evaluate because then you need to go and find people who got these diverted medications, which isn't always easy. There is some qualitative research around it, nothing quantitative, but the qualitative research is focused on some people getting diverted medications, and it was safer for them. Some people call it diversion, a reframing of it would be secondary safe supply or secondary treatment.

[7] A public health based vision for the management and regulation of opioids (2021)

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

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

Similar concerns have been raised about methadone and past analyses have looked at mortality and poisoning data, particularly for children. Such poisoning events are extremely rare, and OTP's require patients to store take home medications in a lock box.

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

A: I think scale is an important issue. Safe supply has been tremendously successful for those who've accessed it. However, as they've tried to scale it up, there's tons of barriers. Some physicians have not been willing to prescribe it. They say it goes against their Hippocratic Oath. There are pharmacists who refuse to fill prescriptions. It's hard for people to access it. It's also only really been implemented for people with a substance use disorder, which is a limited segment of the population that is at risk of overdose. Thinking boldly about models that are widely accessible to people in terms of regulation like cannabis and alcohol is how you're going to have the most scale and impact.

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

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

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

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

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

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

Cost analyses would need to look at total societal costs, not just health care system costs to see the total impact of such a program.

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

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

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

A: In terms of the reductions in crime, I would say there hasn't been any spatial analysis where they look at the neighborhood level and these programs. However, in the data that I was referring to, they directly asked the participants –did you commit, more crime, less crime, did you commit any crime as well to get your drugs – and asking how their behavior individually changed, but there hasn't been any neighborhood level studies that have been done around crime and burglary and law enforcement, for safe supply yet. There's only the individual level data as of now. It's always hard to look at the neighborhood level data to then extrapolate to the individual level. There's so much going on that influences what's happening at that macro scale. [There are research approaches to investigating neighborhood crime associated with different types of venues such as bars, OTP's, and convenience stores https://www.jsad.com/doi/10.15288/jsad.2016.77.17]

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

It may be uncomfortable, but are we OK with letting people use drugs die knowing that they're going to use drugs? We need to give them a safe alternative, like what we've done with alcohol. Rep Davis made a really good point about the commercialization of alcohol, which I think is a really important point; we need to think about how you legalize these in terms of restrictions on advertisement restrictions on making profits, because when these were more widely available in the early 2000s, there was a lot of deceit in advertisement that was going on, and it was really dangerous and really damaging to the public health. And so I think we need to be very careful in how we legalize this and offer a safe supply, thinking about designing these systems to better the public health, instead of making it into a type of capitalistic feeding frenzy. [Concerns were raised at the meeting and have been raised publicly that the cannabis market in WA State has been very poorly regulated, with profit driving perverse incentives e.g. high potency products and that we would definitely want to avoid the negative impacts of the market structure currently seen with cannabis in WA.]

Comment: *Let's remember that's we've had safe supply for 70 years, and that is in the form of other treatment medications. So safe supply isn't really safe supply, it is medications, right? Methadone is a full opiate agonist. All we're talking about is other types of full opiate agonist. Research in Canada has examined the use of hydromorphone (e.g. Dilaudid) and diacetylmorphine (aka heroin) https://pubmed.ncbi.nlm.nih.gov/27049826/ . We're just trying to fight a fight of a brand new super synthetic high potency drug with tools that are 70 years old and all that we're talking about is bringing their tools and other medications into the mix. The reason why we're in this problem of fentanyl and especially in counterfeit pills, is because we did so much to tamp down on prescribing practices that we took a fully regulated supply on, and we got rid of it. We created this inadvertent marketplace for a*

really contaminated drugs in public health. One of the questions I get all the time is do we have fentanyl in marijuana and that is such an easy question to answer here in the state of the Washington. And the answer is no. Almost across the board, No. And the reason is because we have end to end quality control on that; when we don't have end to end quality control, we create this marketplace for this toxic drug.

Collaboration with Existing Resources: *To implement safe supply services, collaboration will be needed with:*

- *Doctors and other prescribing medical providers*
- *Pharmacies and pharmacists*
- *Insurance providers*

Approximate Financial Support & Staffing Needed: *To be determined by workgroup*

Dollars	FY23	FY24	FY25
Legislative / State Budget Funding			
HCA Grant-Based Funding			
Total Funds			
Staff (FTE)	0	0	0

SURSA Committee Feedback: