King County

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Dear members of the *Blake* negotiating group and the King County legislative delegation:

King County received a request to provide legislators with an assessment of and reaction to the Washington Association of Sheriffs and Police Chiefs' (WASPC) letter to House and Senate members addressing the Conference Report for SB 5536, dated May 4, 2023. We also reviewed the joint letter from the Washington State Narcotics Association and the Washington Council of Police & Sheriffs, dated May 5, 2023. The opioid epidemic affects every community, and law enforcement is one of the entities on the front line. That said, law enforcement's expertise is just that: law enforcement. They do not have healthcare expertise with first-hand knowledge of harm reduction or evidence-based healthcare practices.

In contrast, King County has the expertise and knowledge of what it takes to treat people suffering from substance use disorder at every stage of their disease as well as enforcing laws and housing detained people. With this background, our subject matter experts reviewed these letters, including our Department of Community and Human Services, Department of Public Defense, Public Health – Seattle & King County, the King County Sheriff's Office, and the Department of Adult and Juvenile Detention.

King County strongly urges the Legislature to pass a comprehensive bill addressing the public use of controlled substances. To be successful, legislation must be evidence-based and targeted, capable of being enforced and implemented, and accompanied by the scale of investments in treatment and diversion programs that can deliver the actual help Washingtonians with substance use disorder need. This legislation should support, not hinder, parallel public health strategies working to save lives.

As a result, we have significant concerns–outlined below–with many of the requests made by the law enforcement associations and urge you to reject their inclusion in the final *Blake* legislation.

Public use language

One of the few areas of agreement King County has with WASPC is the "use in a public place" language. Based on existing state law, King County agrees that law enforcement officers would need to witness a person using drugs in a public place to be enforceable, as drafted in the conference committee striker. This requirement is impractical. However, the Legislature could establish drug use as an exception to the requirement that law enforcement personally witness

the criminal behavior. The Legislature has established numerous exceptions that grant law enforcement probable cause when a crime is supported by a witness's report. *See* RCW 10.31.100. Alternatively, the Legislature could require "plain sight" for public possession of drugs to be a crime. If so, we recommend that the legislature adopt the following:

> It is unlawful for a person to knowingly possess drugs in a public place when the object is plainly and immediately apparent, and the object's incriminating nature is apparent.

Drug paraphernalia distribution

The distribution and use of certain items defined as drug paraphernalia are essential to prevent public health harm among people who use drugs. Research shows that public health programs distributing syringes, smoking equipment, fentanyl test strips, and other items included in the definition of drug paraphernalia serve as an important connection point for people who use drugs. When those individuals are ready to enter drug treatment, they can more easily access treatment because of their pre-existing connections and trust in these programs. Before a person who uses drugs is ready to enter treatment, public health distribution of drug paraphernalia—such as smoking equipment—decreases communicable diseases associated with sharing smoking equipment. **Both chambers passed their version of the *Blake* fix with this language, and the Legislature should include it in the final version.**

Public health agency drug testing

Public health agencies provide drug testing resources to identify contaminants in the drug supply, allowing public health agencies to provide accurate information on the risks associated with certain types of drug use. For example, we are seeing an increase in fentanyl and xylazine in the drug supply in our region, resulting in significant injuries and unintentional poisonings among people using drugs and soaring overdose deaths. Missing an opportunity to discover these substances would be a grave mistake. T**he Legislature clearly agreed; the House unanimously passed HB 1006, and the Senate unanimously passed SB 5022. Both bills allowed drug testing but did not proceed because legislators intended to include this provision with the *Blake* fix.** We urge you to keep this provision in the final *Blake* bill.

State preemption of drug paraphernalia

At this time of overwhelming drug overdose deaths, we must eliminate confusion and create continuity across the state with uniform criteria for drug possession and drug paraphernalia, so jurisdictions can instead focus on increasing access to harm reduction and treatment resources for their residents. Allowing local regulation of drug paraphernalia is not a solution to the overdose crisis. Instead, it will increase the stigmatization of drug users, creating additional barriers for people seeking care and treatment. Therefore, please maintain state preemption on drug paraphernalia regulation.

Licensed behavioral health agency conducting substance use disorder (SUD) assessments

Access to available and quality behavioral health treatment is critical for supporting individuals with substance use disorder on a path to recovery. Assessment programs need to be funded through Medicaid, which will already require licensure and credentialing. Therefore, this additional clarification is not needed.

Compliance versus completion of SUD treatment

Setting such a high bar for completion is neither evidence-based nor will it incentivize individuals to enter diversion programs. Everyone's pathway to recovery is distinct, and for many, "substantial compliance" with treatment is the most realistic option. Recovery is a lifelong process, and many may engage in treatment for years to support ongoing and continuous recovery. The diversionary period can be successful when shorter than 12 months. It should be focused on linking people with treatment and other support in the community and requiring agreement to engage in treatment rather than complete compliance with a treatment program. *See, for example,* procedures for Seattle Municipal Court's Community Court, which provides for 14-45 days of court jurisdiction over the community court agreement) https://www.seattle.gov/documents/Departments/Court/SCCPoliciesandProcedures.pdf pg. 8.

Additionally, requiring behavioral health agencies and treatment providers to monitor "compliance" with a treatment plan creates an additional burden on over-stretched behavioral health providers. Treatment providers are clinicians working to support individuals' access to quality behavioral health care. Placing additional monitoring, reporting, and paperwork requirements on treatment agencies will detract from the time available for treating clients and reduce the system's capacity to serve this population.

State-certified SUD treatment providers

As stated above, access to available and quality behavioral health treatment is critical for supporting individuals with substance use disorder on a path to recovery. State law already gives the Department of Health authority to govern licensure and credentialing of behavioral health services. Therefore, this additional clarification is not needed.

Prosecutor termination of pretrial diversion

Revocation of pretrial diversion should occur only if the individual is willfully not engaging in treatment. Prosecutors being able to arbitrarily move to revoke diversion will mean that public defenders will be much less likely to recommend it to their clients. WASPC's concerns regarding revocation for additional crimes are not well-placed. Prosecutors can simply charge those crimes.

Mandatory minimum sentences

Using mandatory minimums to incentivize people who use drugs to complete treatment is an outdated and flawed strategy that will increase the jail and prison populations, racial disparities, crime, and drug overdose harms and deaths. Mandatory minimum sentences have been shown to increase costs for local government, separate families, and rob individuals of rehabilitation opportunities. Countless bodies of research, including from the Washington State Department of Health, have shown that investing in prevention and treatment services has been proven to be less expensive and more effective at reducing rates of drug use. Incarcerating people and imposing harsh and inflexible sentences for minor drug offenses increases stigma and has been shown to disproportionately affect communities of color who do not have equitable access to adequate healthcare and other substance use prevention and treatment resources.

Most jails do not provide access to necessary addiction treatment services or support recovery efforts that many need. For example, a 2015 systematic review from Psychological Medicine found that incarcerating individuals with substance abuse issues was associated with poorer mental health outcomes than receiving non-custodial interventions such as cognitive behavioral therapy. Another study published in the 2014 journal Addiction concluded that incarceration does not reduce drug use or improve treatment outcomes for people with substance use disorders. The study also found that incarcerated individuals had higher relapse rates and worse treatment outcomes than those who received other forms of intervention, such as community-based programs or residential treatment centers. Mandatory minimums will never actually address the underlying causes of drug use or promote healthier outcomes long-term. Instead, they simply stand to increase obstacles to stable housing, employment, and long-term recovery.

Moreover, proposed mandatory minimum sentences have the potential to significantly increase the length of stay and daily population of jails at a time when jails across the state do not have the staffing, capacity, or funds to accommodate an increased jail population. Please do not adopt mandatory minimum sentences.

Law enforcement notification when a patient abandons SUD treatment

The King County Sheriff's Office does not contend that it requires notice when a patient abandons treatment. Any notice would more appropriately be directed to the court, the prosecutor, the patient, and their legal counsel.

Safe consumption site language

WASPC proposes to remove a reference to safe consumption sites in Sec. 26(3)(b) of the conference committee report. This subsection states that "a health engagement hub is intended to . . . be affiliated with . . . safe consumption sites." While Washington does not have any safe consumption sites, they do provide an opportunity for individuals who use drugs to do so in a safe environment with access to medical professionals and social services, significantly reducing the risk of morbidity and mortality. Safe consumption sites are effective at helping

individuals stay alive while providing resources that could lead them toward recovery. At this fragile and pivotal moment, it is essential to keep the door open to connecting individuals who use drugs with services instead of limiting ourselves and further punishing those who are suffering from addiction. The Legislature should not eliminate safe consumption site language.

Harm reduction definition

To ensure that people who use drugs can access treatment and stop using drugs when they are ready, we must reduce the harms of current drug use—people who die from drug overdose will never have an opportunity to access substance use disorder treatment and stop using drugs. Therefore, it is essential to focus on reducing the harm associated with drug use right now without a requirement that harm-reduction strategies directly end the illegal use of drugs. The Legislature should not adopt WASPC's proposed amendment to the definition of "harm reduction program."

Sight and sound barriers for recovery residences

Recovery residences can be a vital support for individuals in recovery or engagement in treatment. According to the Health Care Authority, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines "recovery residences/homes" "as safe, healthy, family-like, **substance-free** living environments that support individuals in recovery from substance use disorder. All recovery residences center on peer support and a connection to services promoting long-term recovery. Recovery housing benefits individuals in recovery by: [(1)] Reinforcing a substance-free lifestyle [and (2)] Providing direct connections to other peers in recovery, mutual support groups, and recovery support services." As a result, it is unclear if a sight and sound barrier between populations would be needed if individuals cannot use substances in the recovery home.

Sight and sound barriers for health engagement hubs

WASPC proposes to amend Section 26 to include a "sight and sound barrier" between youth and adults other than treatment providers at health engagement hubs. Health engagement hubs are a valuable tool in combatting the drug crisis. We support the aim of ensuring that youth are safely able to access these resources without fear of exposure to trafficking and other dangerous activities or behaviors. However, it is essential that this requirement does not result in unreasonable restrictions on service providers that result in fewer youth-serving facilities. If this requirement is implemented in a way that causes providers to serve adults only, youth who need housing and other services are more likely to end up homeless or unstably housed, which makes accessing harm reduction and treatment resources even more difficult. The Legislature should look to state expertise at the Department of Health, Health Care Authority, and Department of Children, Youth, and Family to determine safety requirements for health engagement hubs.

Funding for Arrest and Jail Alternative (AJA) Program

King County agrees that the state must continue to increase funding for alternatives to criminal legal system involvement, and funding to operate an AJA program in King County would be beneficial. Additionally, state law currently limits Law Enforcement Assisted Diversion (LEAD) funding to only jurisdictions outside of King County. The diversity of geographic context and individual substance use needs requires diverse programs.

However, to strengthen the likelihood of successful engagement in treatment, we strongly encourage the Legislature to first prioritize programs that are led by community and expert treatment providers rather than law enforcement. This requires a holistic and comprehensive set of investments, including:

1. funding for apprenticeship and other education benefits that expand both SUD professionals and peers in the workforce;
2. lowering barriers to treatment access through intensive care outreach teams, modeled on Assertive Community Treatment, capacity for same-day/next-day appointments, flexible funding for providers to increase treatment engagement, increasing funding and transition teams to connect individuals between services; and
3. immediate access to a place to go, e.g., housing, shelter, or crisis care clinics.

King County appreciates the opportunity to provide feedback and context. Please let me know if you have any questions or if we can provide additional information. I can be reached at michwhite@kingcounty.gov or 206.351.1674.

Sincerely,

Michael White
State Relations Director
King County