STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Economic Services Administration
Community Services Division
Post Office Box 45440 Olympia WA 98504-5440

October 16, 2023

Dear interested parties and community partners,

We are excited to announce the first publication of the **WorkFirst Performance Measures Report** by the Economic Services Administration (ESA).

For over a decade these performance measures were captured in the WorkFirst Performance Chartbook, supported by the Office of Financial Management (OFM), to assist program administration. With the sunset of the WorkFirst Performance Chartbook effective May 2023, ESA's Management Analytics and Performance Statistics Team took responsibility of this important work. EMAPS has done an outstanding job graphing performance measures required by statute (RCW 74.08A.400 and 74.08A.410) for program evaluation in a simplified format. This report captures historical data starting July 2016 through the current work quarter.

The WorkFirst Performance Measures Report will be updated and posted on a quarterly basis on our WorkFirst Performance Measures website.

We would like to extend gratitude to everyone that helped with the transition of this workload from the OFM to ESA/DSHS.

In partnership,

Babs Roberts / Director / Community Services Division
Economic Services Administration
Department of Social and Health Services
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Transforming Lives

WorkFirst Performance Measures

Fourth Quarter 2023

Produced on October 20, 2023

Washington State Department of Social & Health Services

Transforming lives

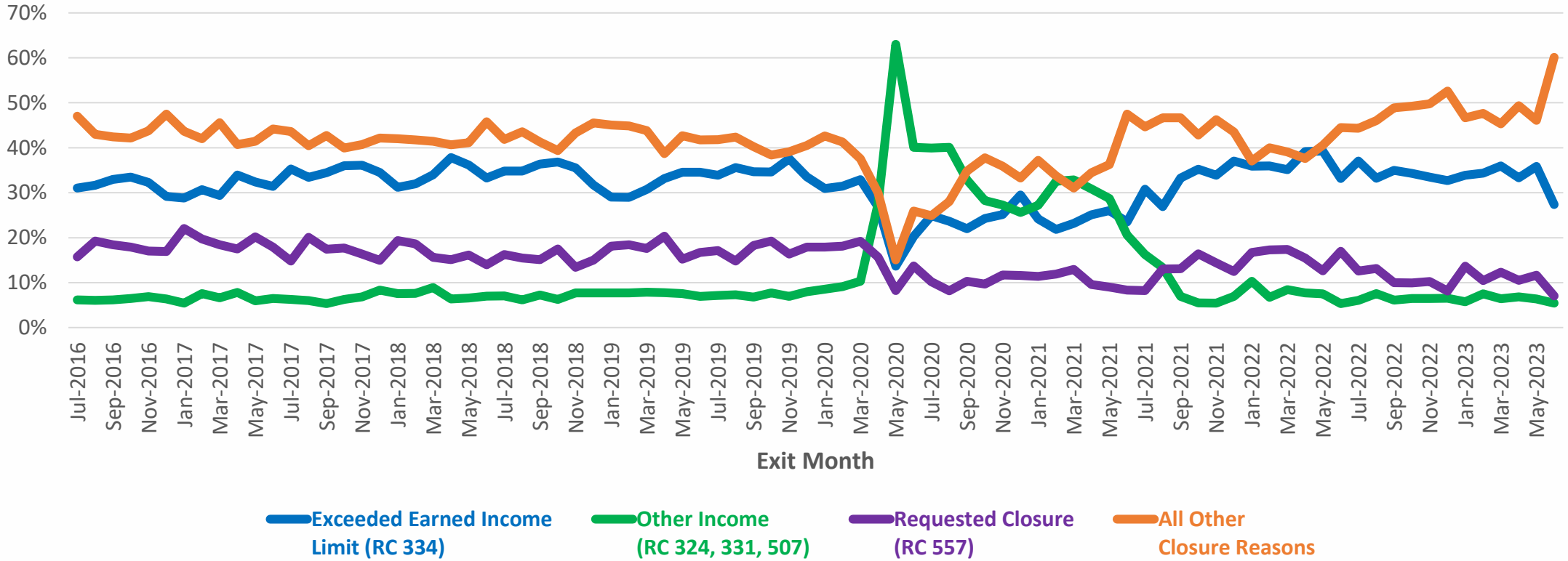
State and Federal Statutes Governing WorkFirst Performance Measures

- State statute calls for WorkFirst performance measures for use in program evaluation (RCW 74.08A.400 & 74.08A.410). Measures suggested in statute include:
  - Program exits
  - Employment, job retention, and earnings
- Performance measures by contractor/partner must be reported quarterly (RCW 74.08A.410)
- Fiscal Responsibility Act of 2023 (H.R. 3746) requires states to report metrics related to employment and earnings after program exit

Performance Measures for Families and Adults Exiting WorkFirst

WorkFirst Families - Reasons for Exit

July 2016 – June 2023

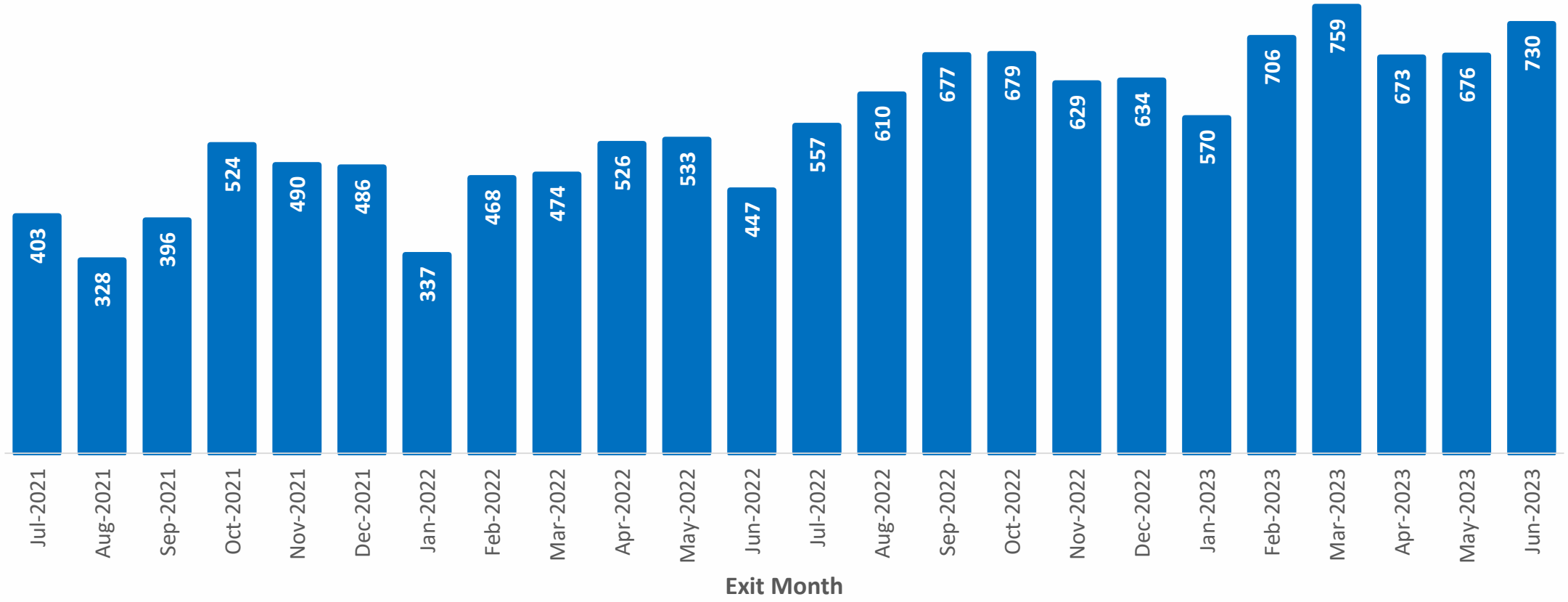


Note: Exit is defined as case closure followed by three months with no TANF/SFA receipt. Exits are measured at the household or assistance unit level. Only households with adult recipients participate in WorkFirst. The last month that the household received a TANF/SFA issuance is the exit month. The percentages in each month add up to 100%. The spike in Other Income exits from March 2020 to September 2021 is due to pandemic Unemployment Insurance benefits; the June 2023 spike in All Other Closure Reasons reflects the first month that the 60-month time limit was enforced after the pandemic. Reason codes (RCs) are used to explain why cases close.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023

WorkFirst Families - Number Exiting Due to Earnings

July 2021 – June 2023

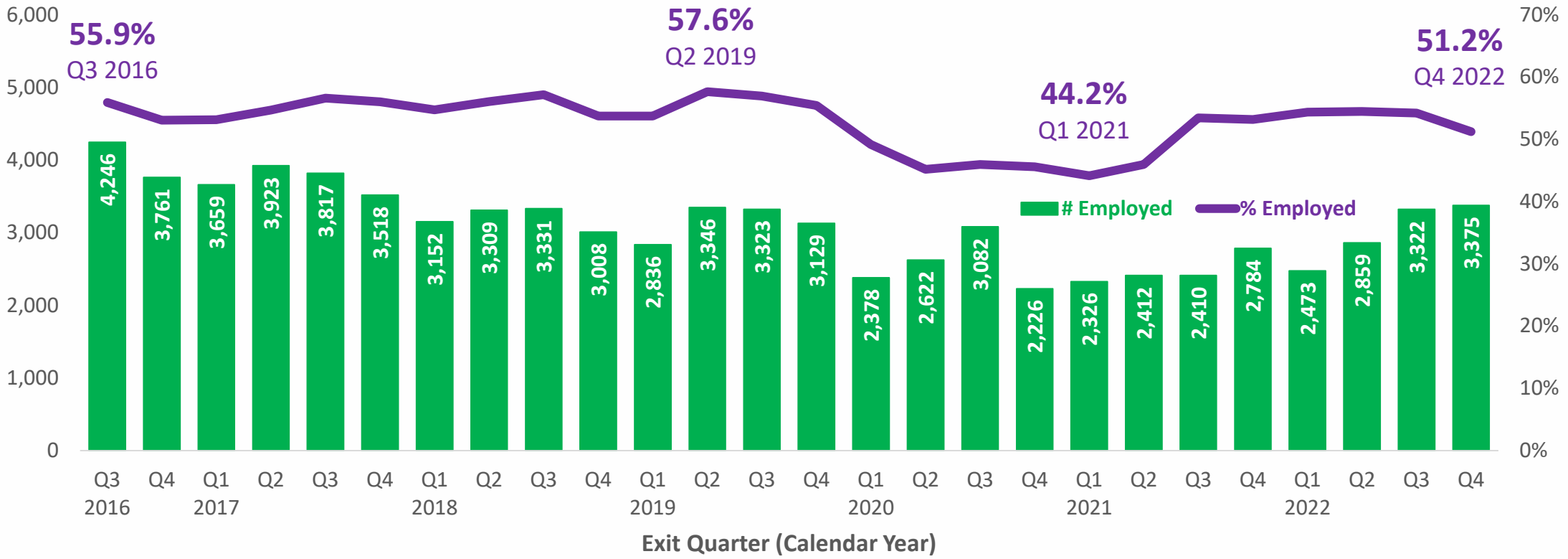


Note: Exit is defined as case closure followed by three months with no TANF/SFA receipt. Exits are measured at the household or assistance unit level. Only households with adult recipients participate in WorkFirst. The last month that the household received a TANF/SFA issuance is the exit month. Exiting due to earnings is defined as an exit with a 334 – Exceeded Earned Income Limit reason code.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023

WorkFirst Adults - Employed at Exit

Exit Quarter and First Quarter after Exit

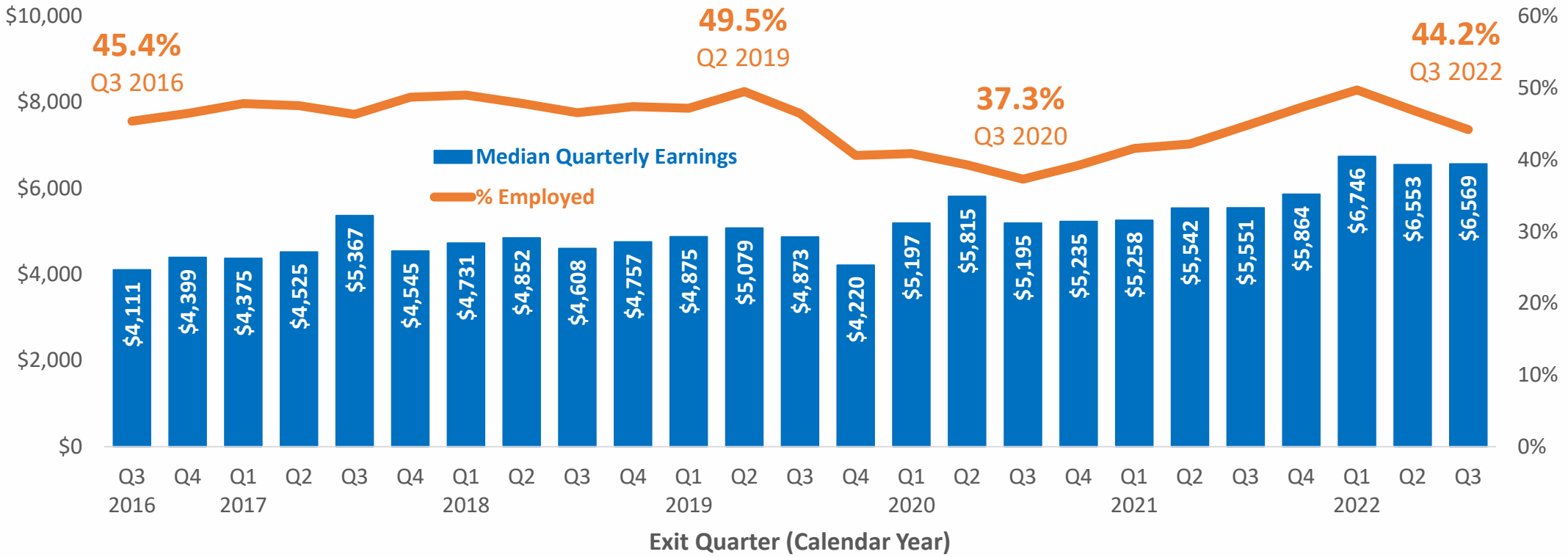


Note: Exit is defined as at least one month with a TANF/SFA issuance followed by at least three months with no TANF/SFA issuance. The exit quarter includes the last month of TANF/SFA receipt. For percent employed, the denominator is the number of adults who exited TANF/SFA during the listed quarter; the numerator is the number of those exiting adults who had any employment recorded in the Unemployment Insurance (UI) system in either the exit quarter or the quarter after exit.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023 and ESD's UI wage data

WorkFirst Adults - Employment & Earnings

Second Quarter after Exit

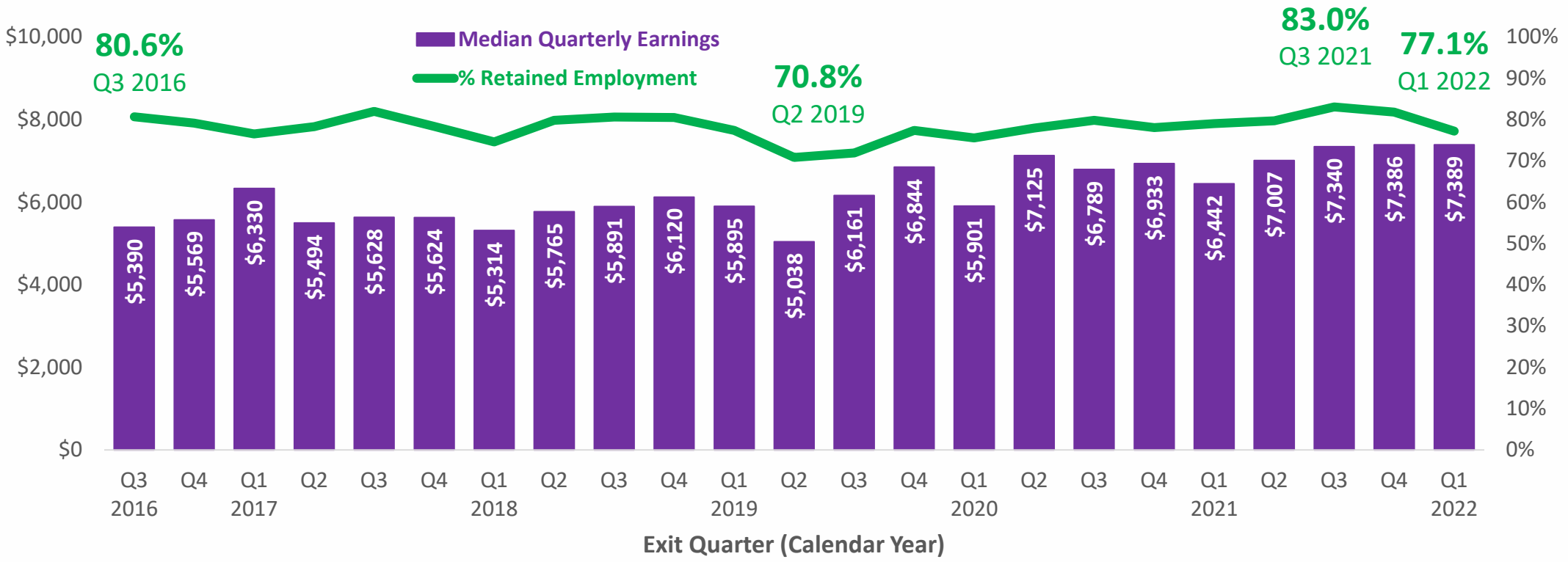


Note: Exit is defined as at least one month with a TANF/SFA issuance followed by at least three months with no TANF/SFA issuance. The exit quarter includes the last month of TANF/SFA receipt. For percent employed, the denominator is the number of adults who exited TANF/SFA during the listed quarter; the numerator is the number of those exiting adults who had any employment recorded in the Unemployment Insurance (UI) system in the second quarter after exit. Median earnings are based on earnings recorded in the UI system in the second quarter after exit. Those with no earnings in the quarter are excluded.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023 and ESD's UI wage data

WorkFirst Adults - Employment Retention & Earnings

Fourth Quarter after Exit

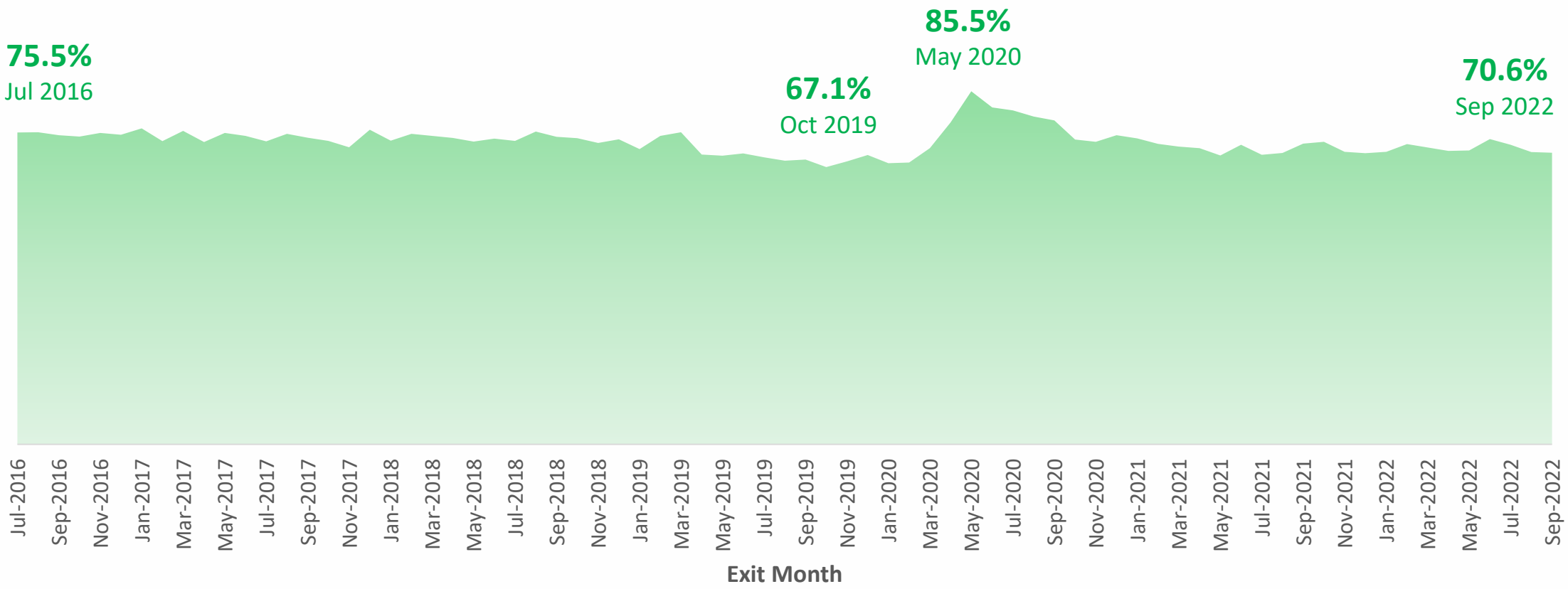


Note: Exit is defined as at least one month with a TANF/SFA issuance followed by at least three months with no TANF/SFA issuance. The exit quarter includes the last month of TANF/SFA receipt. For percent retained employment, the denominator is the number of adults who exited TANF/SFA during the listed quarter and had any employment recorded in the Unemployment Insurance (UI) system in the second quarter after exit. The numerator is the number of those exiting adults who had any employment recorded in the UI system in the fourth quarter after exit. Median earnings are based on earnings recorded in the UI system in the fourth quarter after exit. Those with no earnings in the quarter are excluded.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023 and ESD's UI wage data

WorkFirst Adults - Exits Lasting at Least One Year

July 2016 – September 2022



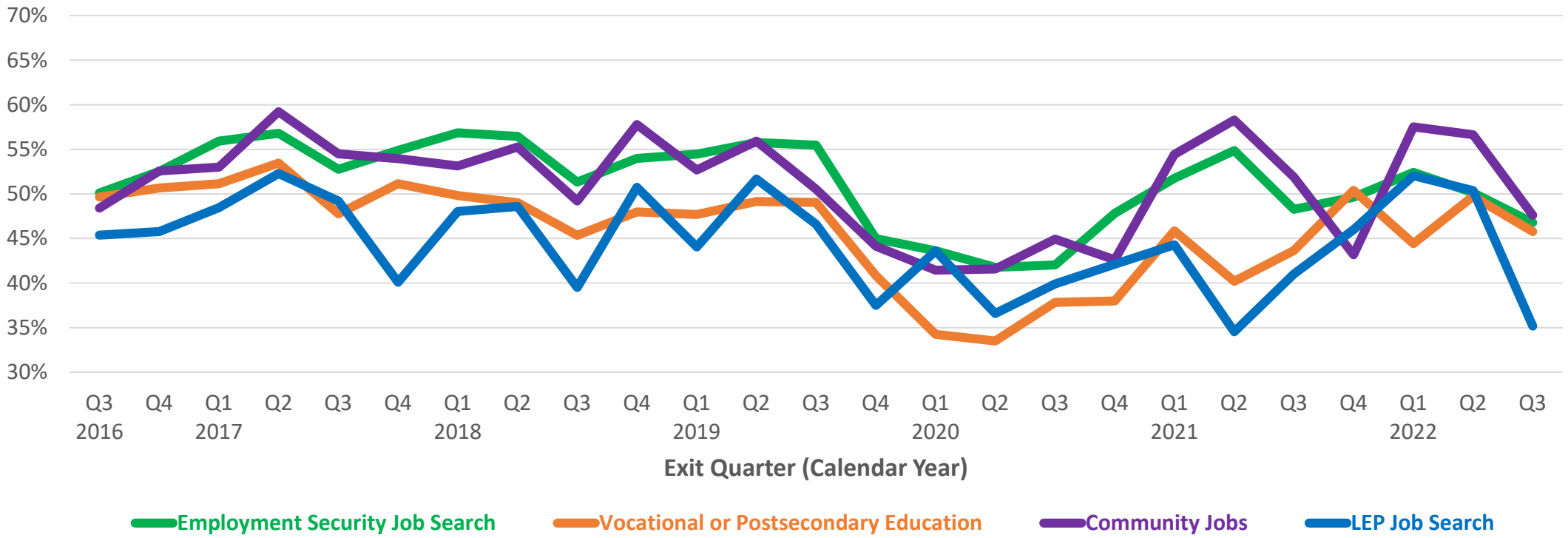
Note: Exit is defined as at least one month with a TANF/SFA issuance followed by at least one month with no TANF/SFA issuance. The exit month is the last month of TANF/SFA receipt. The denominator is the number of adults who exited TANF/SFA in the listed month; the numerator is the number of those exiting adults who did not return to TANF/SFA for at least 12 months following that exit.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023

Performance Measures for Adults Exiting WorkFirst Service Pathways

Employment after Exiting WorkFirst Service Pathway

Percent Employed in Second Quarter after Pathway Exit

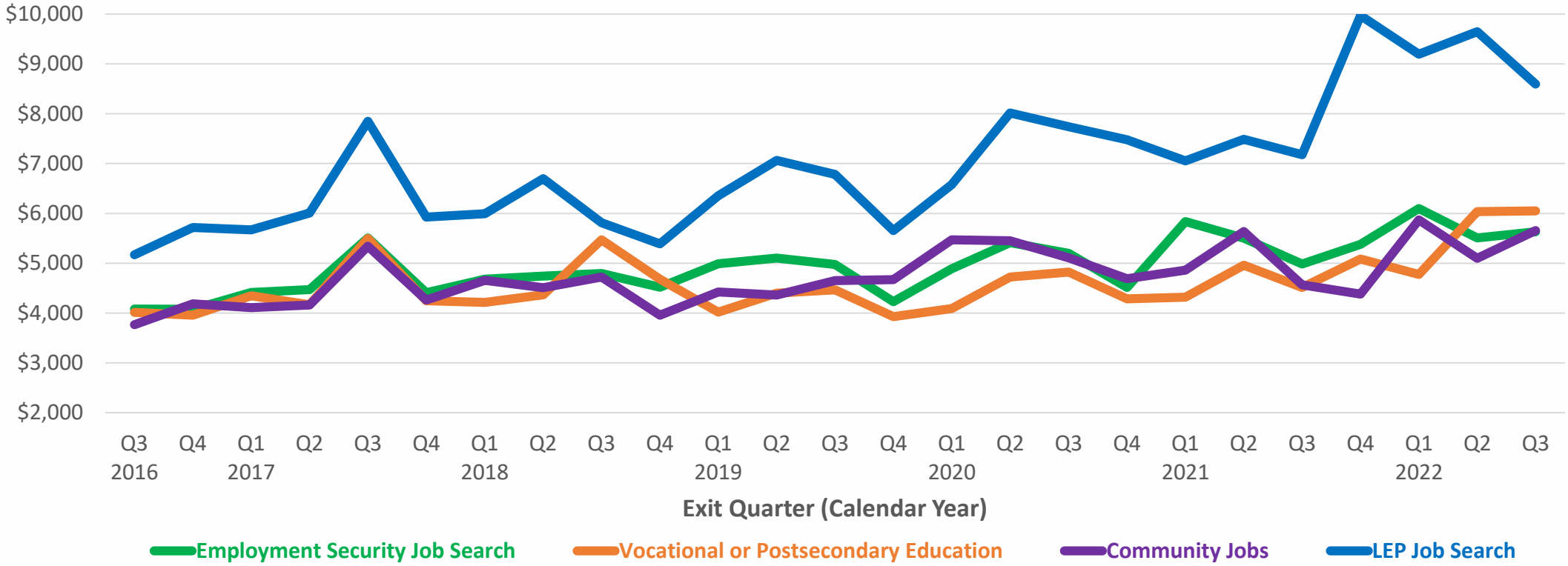


Note: Exiting WorkFirst service pathway is defined as not being enrolled in the WorkFirst service pathway for three months after being enrolled for at least one month. The exit quarter includes the last month of enrollment in the WorkFirst service pathway. The denominator is the number of adults who exited that WorkFirst service pathway during the listed quarter; the numerator is the number of those exiting adults who had any employment recorded in the Unemployment Insurance (UI) system in the second quarter after exit.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023 and ESD's UI wage data

Quarterly Earnings after Exiting WorkFirst Service Pathway

Median Quarterly Earnings in Second Quarter after Pathway Exit

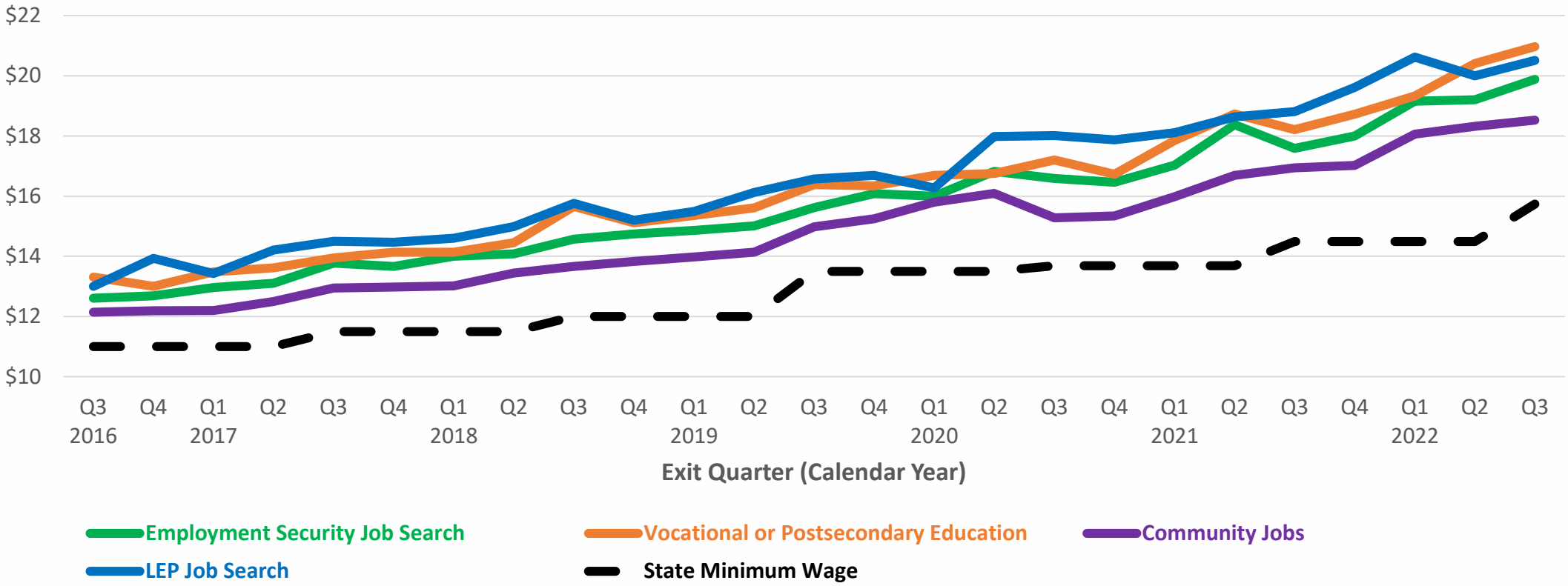


Note: Exiting WorkFirst service pathway is defined as not being enrolled in the WorkFirst service pathway for three months after being enrolled for at least one month. The exit quarter includes the last month of enrollment in the WorkFirst service pathway. Median earnings are based on earnings recorded in the Unemployment Insurance (UI) system in the second quarter after exit. Those with no earnings in the quarter are excluded. Adults in LEP Job Search typically work more hours in the quarter than adults in the other three pathways.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023 and ESD's UI wage data

Hourly Wages after Exiting WorkFirst Service Pathway

Median Hourly Wages in Second Quarter after Pathway Exit



Note: Exiting WorkFirst service pathway is defined as not being enrolled in the WorkFirst service pathway for three months after being enrolled for at least one month. The exit quarter includes the last month of enrollment in the WorkFirst service pathway. Median hourly wage is based on earnings and hours worked recorded in the Unemployment Insurance (UI) system in the second quarter after exit. Those with no earnings or hours worked in the quarter are excluded. State minimum wage reflects the minimum wage in effect two quarters after the quarter listed on the horizontal axis.

Source: ESA-EMAPS using the ACES Data Warehouse as of October 2023 and ESD's UI wage data

For any additional questions, please contact:

Lisa Nicoli

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STATE OF WASHINGTON

September 21, 2023

State leaders, healthcare providers, and all other Washingtonians

SUBJECT: National Opioid Awareness Day

To our fellow Washingtonians:

Today, on National Opioid Awareness Day, we remember those who have lost their lives to overdose, honor those who have tirelessly worked to prevent and treat overdose and resolve to do all we can to save lives from a public health crisis that kills five to six Washingtonians every day.

Overdose deaths involving opioids and/or stimulants are at unprecedented levels across our state. Opioids and overdose impact all Washingtonians. Communities of color and tribal communities have been especially devastated by this crisis that has touched people of all races, ethnicities, and socioeconomic groups in both rural and urban areas throughout Washington.

The causes of the opioid and overdose crisis are many. The first wave of deaths started in the mid-1990's from prescription opioid medications. The second wave was driven by heroin, ensnaring many who had become addicted to prescription opioids. We are in the third wave of deaths that is largely fueled by fentanyl, a synthetic opioid that comes in many forms. A single counterfeit pill bought on the street can contain enough fentanyl to kill. More and more deaths are also occurring when opioids are mixed with methamphetamine, cocaine, stimulants, and other drugs.

The increased supply of illegal drugs has exploited the underlying structural and systemic roots of the opioid and overdose crisis. These include poverty, lower education rates, and housing insecurity. Lack of access to health care and mental/behavioral health services lead many to self-treat their physical and emotional pain with drugs. Trauma from adverse childhood experiences and intergenerational and historical trauma driven by racism have also been powerful underlying forces that increase rates of substance use disorder, as they do for many other chronic conditions such as heart disease, cancer, and diabetes.

Preventing substance use disorder means we must invest more in addressing these social drivers that influence the health of individuals throughout the life course from the prenatal period extending through early childhood and into adolescence and adulthood.

To respond to the increasing rates of death due to fentanyl in recent years, we must focus on saving lives from opioid overdose by urgently expanding our efforts in the following three areas.

Although we believe there is a need for a quick and rapid response to the opioid crisis, we also agree that we need a long-term plan to ensure success.

Our three priorities for the immediate term are:

1. **Treatment medications:** Medications such as buprenorphine and methadone are our most powerful tools to save lives from opioid use disorder. Most people who use opioids want to reduce their use and start treatment medications. Yet there are major gaps in access to treatment medications. Some of these gaps are due to the lack of capacity or willingness to serve people who actively use drugs in the existing care systems. We need to lower the barriers to treatment, expand the number of health care providers offering treatment medications, and support people in their recovery during treatment. Healthcare providers have an ethical imperative to treat people with opioid use disorder with the same dignity, respect, and quality of care as patients with other medical conditions. That means not only starting or referring to specialty care and counseling for people who use drugs, but also continuing to care for people who keep using drugs, because studies show that continuous treatment leads to better health and faster recovery.

2. **Naloxone:** Naloxone can reverse the symptoms of opioid overdose when given as either a nasal spray or injection. For naloxone to save a life, a person suffering from an opioid overdose must have someone with them who can give naloxone. We need to make sure that everyone who uses substances and the people around them have naloxone, which can be obtained from pharmacies without a prescription through a statewide standing order. We should expand community organizations and harm reduction services throughout the state that engage people at high risk for overdose, give them naloxone, and provide an array of life-saving services.

3. **Awareness:** We need to raise awareness of the risks of opioid use disorder and overdose, give people accurate information, and reduce stigma. Many people, including teens and parents, are not aware of the potentially lethal effects of a counterfeit pill or a white powder containing fentanyl. There is low public awareness that medications for opioid use disorder are by far the most effective treatments, and that naloxone can save lives from opioid overdose. And even though around 50% of Americans know someone with substance use disorder, shame and stigma force individuals and families affected by substance use into the shadows, making it harder for them to get the help they need.

We all must get involved with this work. You don't have to be a health care provider to use one of the most powerful tools we have: social connection. Reach out to people. Ask them, "Are you okay?" And if the answer is, "no," listen with love and understanding, and connect them with help.

On National Opioid Awareness Day, we give our deep gratitude to our fellow Washingtonians in social services, health care, education, and first responders who have been on the front lines of the opioid and overdose crisis. You have saved countless lives while working in extremely difficult circumstances, often thanklessly and without the resources you need. We appreciate all you are doing and have done. For those of you not yet prescribing, we ask that you please do so. You can save a life tomorrow.

And to all people who are caught in the grip of opioids and other drugs, you are our friends and loved ones who deserve our compassion and our commitment to get you the prevention and treatment services you need to live a healthy life.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Director
Health Care Authority

Umair A. Shah, MD, MPH
Secretary of Health
Department of Health

Ross Hunter
Secretary
Department of Children, Youth, & Families

Jilma Meneses
Secretary
Department of Health & Human Services

Ingrid Ulrey
Chief Executive Director
WA State Health Benefits Exchange

Caleb J. Banta-Green, PhD MPH MSW
Research Professor, Addictions, Drug & Alcohol Institute
School of Medicine, University of Washington

Darcy Jaffe
Senior Vice President, Safety & Quality
Washington State Hospital Association

Cheryl Strange
Secretary
Department of Corrections

Integrated Case Management

A program of Catholic Charities Eastern Washington

For community members who have taken the brave step out of homelessness and into supportive housing, the Integrated Case Management (ICM) program provides tools and supports to achieve self-sufficiency and economic mobility.

Focus on Outcomes

Our person-centered approach honors clients' dignity by helping them access the services that further their goals. Our work with each client starts by asking them where they want to be. It ends when they achieve their goals. ICM focuses on outcomes that helps individuals and families not just stabilize, but thrive.

- ICM supports more than **450** units of supportive housing across the Spokane Community.
- **Reducing Vulnerability:** ICM PSH clients in supportive housing see a 28.6% reduction in vulnerability index score after their first year in housing, indicating significant whole-person health improvements.
- **Housing Stabilization:** 91% of clients remain stably housed after entering permanent supportive housing.

Peer Pathfinder

ICM offers outreach services for individuals with substance use disorders through its Peer Pathfinder program. Peers outreach clients in shelters, meal sites, encampments, and hospitals. Peers walk along side clients, assisting with navigating treatment options, housing, employment services, benefits, and other services to assist individuals in their stability and recovery.

What is Permanent Supportive Housing -- Client-driven Stabilization through Supportive Housing

The ICM program supports vulnerable individuals who have exited homelessness, including chronic homelessness, the emergency shelter system, mental health treatment, and incarceration. Circumstances of ICM clients vary greatly, and supportive services are tailored to each individual through collaborative goal-setting completed upon move-in to a Permanent Supportive Housing unit.

What is Supportive Housing:

- Our wraparound supportive services strategy rests on the concept that housing functions as a whole-person/whole-family healthcare delivery system, encompassing all the social determinants of health. Our ICM program links Care Coordinators, Peer Supports, Behavioral Health Specialists, Substance Use Disorder Professionals, Supported Employment Specialists, and Healthcare Specialists on a collaborative team supporting client-centered goal achievement.
- Our services assist people in realizing their goals, up to and including helping clients gain the stability to move on from our services. We intend for supportive housing to function not as the end point of crisis response, but as a platform for access to services and opportunities that promote client-driven progress toward lifelong success. ICM staff help individuals and families take steps to achieve their goals of stabilization, recovery, to increase their income, and move to their own safe permanent housing.

INTEGRATED CASE MANAGEMENT | (509) 340-9329 | 25 W. 5th Ave., Spokane, WA 99202

How ICM Helps Those Who Have Exited Homelessness Build Self-Sufficiency

Most community resources and services are not designed for clients who have exited chronic homelessness, creating gaps in service for this vulnerable population. ICM creates a culture of recovery where clients pursue their personal goals, gather a community of support, and access resources in the context of the safety of and responsibility for their own homes.

- **ICM leverages community resources.** Community partnerships are critical to our efforts to help clients create new pathways for connections to recovery, educational opportunities, and skill-building. On-site service partners include counseling services, substance use disorder resources, behavioral health services, healthcare partners, and local psychiatric care providers.
- **ICM connects a whole-person team of caregivers.** The ICM team includes professionals from the case management, peer support, behavioral health, treatment, and employment fields. The ICM team meets regularly to coordinate care for each client. By bringing this cross-disciplinary team together, ICM can help clients remove their most fundamental and persistent barriers in ways that professionals working independently cannot.
- **ICM places clients at the center of services.** Clients set their own goals, like learning to manage their public benefits, finding a bible study or recovery group, connecting to appointments, or finding a job, and a private apartment in the community. This client-centered care provides purpose and meaning. And rather than sending clients to multiple locations to receive care, each member of the ICM team meets clients in their homes to provide case management, recovery, and medical services that help clients meet their goals.

Coordinating Care Through an Integrated Team

The ICM team comprises professionals from across disciplines who collaborate to provide whole-person care that supports clients' long-term goals. They meet regularly to coordinate each client's care, and their combined expertise finds creative ways to help clients overcome the biggest barriers to their stability.

ICM team members meet with clients at their supportive housing apartment to reduce barriers to accessing services. Some clients do not want to go to doctor's offices because of past traumas. Some clients are not able to meet at a case manager's office because of mental health challenges. Providing services to clients in their homes increases access, and improves outcomes.

Care Coordinator

- Develops case plan with client, including specific goals
- Keeps service notes
- Provides crisis response to prevent return to homelessness

Peer Support Specialist

- Has lived experience with substance use disorder, behavioral health conditions, and/or homelessness to relate to client
- Helps clients access service systems, like healthcare, public benefits, and employment
- Helps clients navigate daily tasks, like shopping and picking up prescriptions

Employment Specialist

- Helps clients access income benefits
- Helps clients with job search, applications, and on-the-job support and training
- Assists client with accessing educational, training, and certification programs

Behavioral Health Specialist

- Credentialed substance use disorder professional
- Provides mental health assessments and treatment
- Refers clients to outside services and coordinates care
- Provides crisis intervention to support stability

Healthcare Coordinator

- Engages clients in their own health management
- Creates follow-up plan for any treatments
- Coordinates care with ICM team members to address all social determinants of health

Secure housing is fundamental to one's dignity. When you have a home and a place you can call your own, you become a part of your community in a more meaningful way. Catholic Charities housing staff, property managers and social services team work collaboratively offer a safe, supportive, and inclusive environment where people can thrive and live to their highest potential.

Since 2000, Catholic Charities has developed 18 new affordable housing communities, and expects to complete at least three more by 2024.

To view a full list of Catholic Charities affordable housing properties, please visit **www.housing.cceasternwa.org**.

CATHOLIC HOUSING COMMUNITIES
Sponsored by Catholic Charities Eastern Washington

For information, contact us:

housing@cceasternwa.org

509-456-2279

EQUAL HOUSING OPPORTUNITY

CATHOLIC HOUSING COMMUNITIES
Sponsored by Catholic Charities Eastern Washington

Stabilizing lives with affordable housing

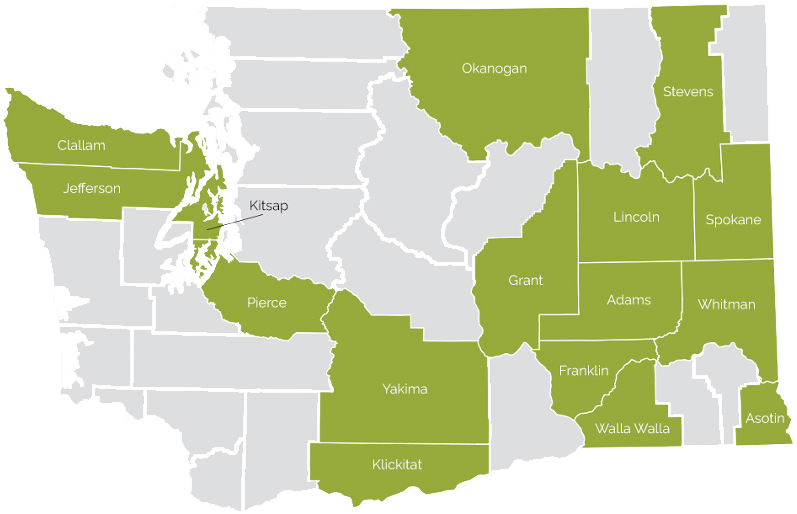
Catholic Charities Eastern Washington affirms the dignity of every person, partnering with the community to serve and advocate for those who are vulnerable, bringing stability and hope to people throughout Eastern Washington.

Catholic Housing Communities, a program of Catholic Charities, is a leading provider of affordable housing in Eastern and Central Washington.

With 67 affordable housing properties in 16 counties, Catholic Housing Communities provides more than 3,000 affordable apartment units to:

- Families
- Individuals
- Seniors
- Veterans
- People living with disabilities
- Agricultural workers and their families

Of the 60+ properties owned and managed by Catholic Housing Communities, 10 are Permanent Supportive Housing (PSH) properties that offer comprehensive, wraparound services to support individuals and families moving out of homelessness and taking the next steps toward self-sufficiency.



About Permanent Supportive Housing

Combining affordable housing and supportive services, Permanent Supportive Housing (PSH) helps vulnerable individuals and families take the next steps to break the cycle of chronic homelessness. The stability that comes with a home becomes the foundation for personal growth.

Catholic Housing Communities has prioritized The Permanent Supportive Housing model and now managers 10 PSH properties. Here's what makes it work:

- **Permanent** – Residents may live in their home as long as they meet the obligations of tenancy
- **Supportive** – Residents have access to support services that they need and want to retain housing
- **Housing** Residents have a private and secure place to make their home, just like other members of the community with the same rights and responsibilities.

Supportive services provided by Catholic Charities and community partners include:

- Case management
- Mental health counseling
- Substance abuse counseling
- Employment skills
- Headstart and Early Childhood Education
- Parenting classes
- Food preparation and nutrition education

Rising Strong

A program of Catholic Charities Eastern Washington

Rising Strong provides housing, residential services, and family-centered wraparound support to help families reunify and stay together while they begin to recover from addiction, heal from trauma, and rebuild their lives. Catholic Charities originally partnered with Empire Health Foundation in 2017 in a 5-year grant to design, launch, and sustain this transformative program.

Rising Strong continues working to stop intergenerational cycles of poverty, abuse, and neglect stemming from substance misuse and/or mental health disorders. Our goal is to help families grow stronger together while maintaining their daily lives, gaining new structure and stability as a family, and working towards lifelong sobriety.

Holistic, Intensive Residential Program

Substance Use Disorder (SUD) Treatment, Wraparound with Intensive Services (WISe) Support & Clinical Services offered through Catholic Charities Community Behavioral Support Team

The families we serve at Rising Strong face complex challenges. The majority of parents were abused and neglected as children. Many of them watched their own parents struggle with substance misuse. Parents receive intensive, daily, and wide-ranging services that provide them with the skills and support to lead healthy, stable lives.

Rising Strong provides its residents **SUD** programming on site, consisting of:

- Intensive Outpatient: 9 hours of weekly group, individual therapy, treatment planning, Urinalysis, and case management as needed.
- Outpatient: one or more hours of weekly group, individual therapy, community engagement, Urinalysis, treatment planning and case management services.

All SUD services are provided by licensed Substance Use Disorder Professionals/Trainees, who have a passion for working with families struggling with addiction and focused on reunification.

In addition to SUD, **WISe services** are provided to families during their stay. WISe is an approach to helping children, youth, and their families with intensive mental health care. Based on a team approach to care that is guided and driven by youth and their family, WISe offers a system of care based on the individualized needs of the child or youth and working to support their families in growing together towards their life goals. Care Coordinators and Peer Support Specialists work closely with families to support legal, clinical/recovery and program compliance.

Multiple **clinical services** are also offered daily for families. Classes are designed to support parents in thoughtfully engaging in change practices that support holistic healing & recovery.

In addition, **Family Skills Coaches** (FSC)'s are on-site and available 24/7 to support families in modeling, coaching, and incorporating new and healthier family practices–along with supporting families in maintaining compliance with programming and community living expectations.

When Families STAY TOGETHER, *They Heal Better* & GROW STRONGER

Offering Two Generational (Parents + Children) Family Supports

Children placed in foster care often experience high levels of trauma that result in adverse childhood experiences (ACEs). When children age out of the foster system, they are more likely to live in poverty and experience their own substance use disorders as adults. When they have their own children, the intergenerational cycle of trauma often continues. Studies show that when families are separated, children experience trauma and parents are less likely to overcome their substance use disorders.

Rising Strong is a better solution – designed for long-term healing and growth -- to strengthen families and to reduce relapse and recidivism, trauma for children, and public costs. Rising Strong addresses the trauma children have already experienced.

The parents we serve at Rising Strong desperately want to become good parents. Rising Strong believes in the inherent value of each of our residents, and provides an innovative approach to treatment, giving the court system a better alternative to separating children from their families, and giving parents the resources to begin long-term recovery.

Rising Strong's **children's services programming** helps children thrive. Parents learn to meet their children's emotional needs through Circle of Security, Play N' Learn, and other parenting classes that forge stronger bonds between parents and children, and help decrease abuse and neglect. Early Riser staff members provide enriching childcare while parents attend therapy and programming. FSC's support children by providing transportation and coaching parents in new parenting and life skill practices.

Rising Strong's two-generational approach is the key to giving children the bright future they deserve, and their parents want for them. Parents prepare for work and family life, getting the support, skills, and credentials they need to provide a stable, loving home. Children prepare for the future, getting the care, love, stability, and education they need to reach their potential.

RISING & STAYING Strong TOGETHER

Most Rising Strong families spend 12-15 months living on-site. At graduation from Rising Strong, parents are well established in their recovery, many have jobs/enrolled in school and have embraced and practiced new life and parenting skills. Every family is offered the opportunity to move into stable housing.

Staying Strong–our Aftercare program--is designed to help provide continuity of care between our program and a family's next housing opportunity--providing trusted, consistent support as family's re-engage in healthy community integration and activities.

Rising Strong helps break the cycle of intergenerational poverty. We are honored to support families through this journey.

lighting PATHWAYS TO HOPE

CCS/CHS 2022 GRATITUDE REPORT

CATHOLIC COMMUNITY SERVICES
CATHOLIC HOUSING SERVICES
SERVING PEOPLE OF ALL BELIEFS

OUR IMPACT

Throughout western Washington *3,866* CCS/CHS staff and *2,749* volunteers provided services to *84,693* men, women and children

CHILDREN AND FAMILIES

12 REGIONAL FAMILY CENTERS located throughout western Washington offered an array of programs to **44,890** people, including emergency services, shelter, transitional and permanent housing, mental health and chemical dependency counseling, as well as pregnancy support, case management and volunteer services.

AGING AND DISABLED

The CCS **LONG TERM CARE SYSTEM** provided **2,034,397** hours of in-home personal care to **18,066** individuals, including help with ambulation, bathing, foot care, transferring, nurse-delegated tasks, meal preparation, senior transportation, senior meal sites and "meals on wheels" for homebound seniors.

HOUSING AND SHELTER

CATHOLIC HOUSING SERVICES provided **4,788** individuals with permanent housing in **2,633** affordable housing units for single adults, veterans, families, seniors and people with special needs.

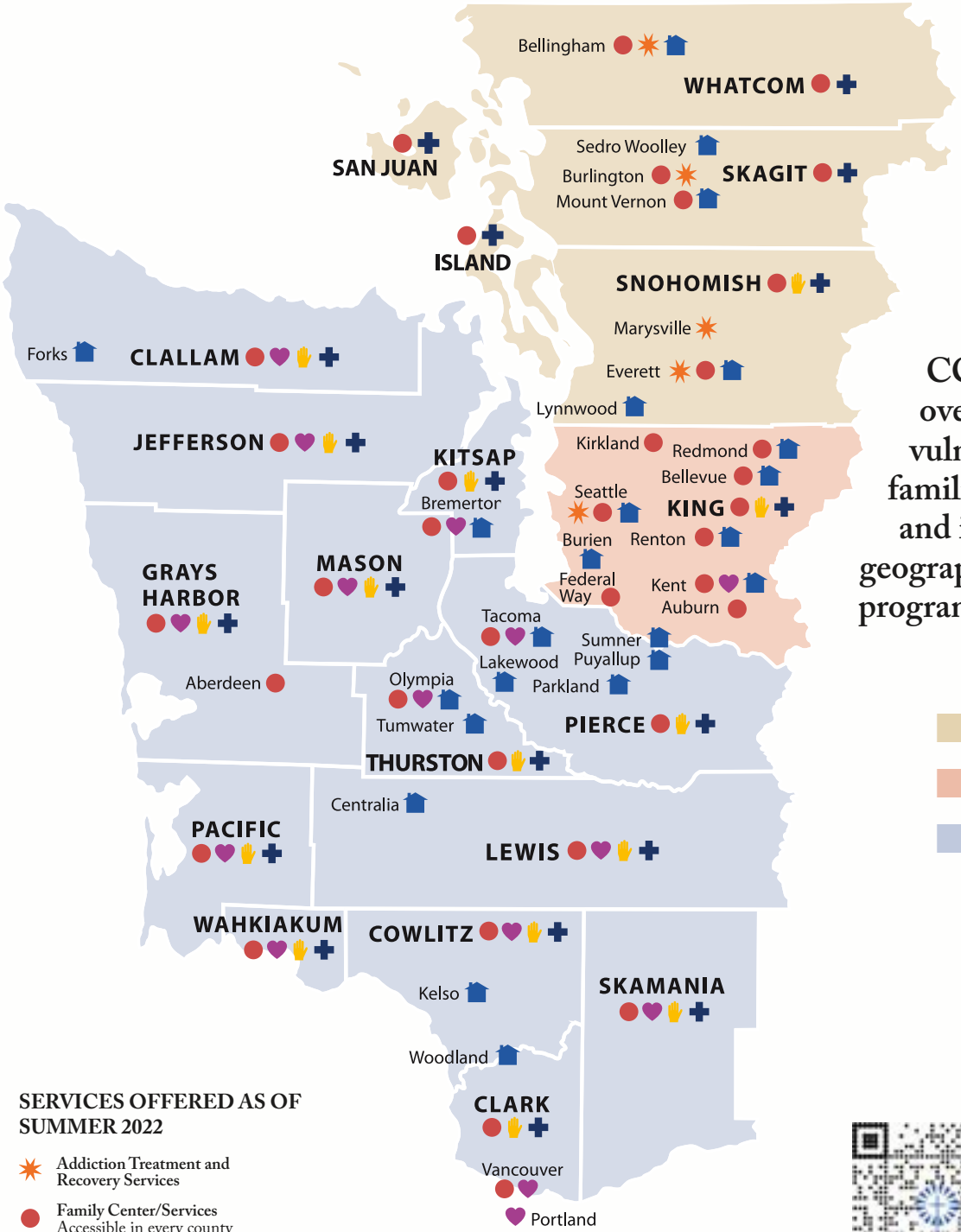
22 CCS shelters offered **288,705** emergency bed nights for single adults and families experiencing homelessness. An additional **23,829** bed nights were provided at **24** hotels/motels.

MENTAL HEALTH AND RECOVERY

FAMILY BEHAVIORAL HEALTH SYSTEM provided **209,835** hours of in-home behavioral health services to **16,859** children, youth and family members experiencing family conflict due to mental health issues.

An additional **18,929** individuals accessed mental health services and **3,443** clients received addiction recovery counseling from regional CCS providers.

OUR PRESENCE



CCS/CHS provides over 190 programs to vulnerable individuals, families and communities and is divided into three geographical regions, offering programs uniquely relevant to local needs:

- **Northwest**
- **King County**
- **Southwest**

SERVICES OFFERED AS OF SUMMER 2022

- Addiction Treatment and Recovery Services
- Family Center/Services Accessible in every county
- Family Behavioral Health System
- Housing
- Volunteer Services
- Long Term Care Services (available in every county)

Contact information by county or go to https://ccsww.org/view-contact-information-by-county/

PROGRAMS & SERVICES

Northwest

City of Everett Public Works Utility Assistance Program
Community Mental Health
Coordinated Entry - Snohomish County
Family Immigration Services
Farmworker Center
Hope House
Latino Network Builder
Layette Services
Network Builder
Permanent Supportive Housing Snohomish County
PREPARES - Pregnancy and Parenting Support
Rapid Re-Housing Snohomish County
Recovery Centers
- Bellingham
- Burlington
- Everett
- Marysville

Retired and Seniors Volunteer Program
Volunteer Services and Transportation
Wraparound Intensive Services (WISe)

King County

African American Elders Program
Aspiring Social Services Employment Training (ASSET)
Bakhita Gardens
Bob G Shelter
Bridge Shelter Program
Bunny Wilburn Home
Catholic Immigration Legal Services
Cedar Park Program
Coming Home
Community Engagement Center
Counseling, Recovery & Wellness (CReW)
Covington Safe Parking
Dorothy Day House
Emergency Assistance
Engage Health
Family Services & Housing to Access Recovery (F-Sharp)
Federal Way Day Center
Foundational Community Supports
Frederic Ozanam House
Home 4 Good
Housing and Essential Needs (HEN)
Hunthausen - Threshold Fund
Issaquah Meals Program
Josephinum Apartments
Junction Point
Katherine's House
Kent Coummunity Engagement Center
Kent Family Center
Kinship Services
Martina Apartments
Matt Talbot Center
Matt Talbot Center at Immanuel Lutheran
Michael's Place
Native American Men's House
Network Builder
New Bethlehem Day Center
New Bethlehem Place Shelter
Nido Familiar - Pregnancy and Parenting Support
Noel House
ORCA LIFT
Palo Studios
Parke Studios
Patrick Place
PREPARES - Pregnancy and Parenting Support
Program to Encourge Active, Rewarding Lives (PEARLS)
Project Rachel
Randolph Carter Family Center
Rita's House
Sacred Heart Shelter
Seattle Community Outreach & Engagement (SCOPE)
Seattle Housing & Resource Effort (SHARE)
Short Term Housing Stabilization
Sidney Wilson House
Social Service Provider Academy
Solanus Casey Center
South King County Shelter (Anchor) System
Spirit Journey House
St Martin de Porres Shelter
St Martin's on Westlake
Sunset Court
Supportive Services for Veteran Families (SSVF)
Tenant Law Center
The Inn Shelter
Thea Bowman Apartments
Traugott Terrace
Volunteer Services
Wintonia
Youth Tutoring

Southwest

Adult Behavioral Health
- Grays Harbor County
- Pierce County

Arrest and Jail Alternatives (AJA)
Benedict House
Bertha's Place
Bertha's Place Too
Coordinated Entry Pierce County
Community Kitchen
Drexel House Permanent Housing
Drexel House Shelter
Family Housing Network
- Family Day Center
- Permanent Supportive Housing
- Rapid Rehousing Pierce

Feed the Hungry
Foster Care
- Community
- International

Holy Rosary Safe Parking Site
Hope Village
Housing and Essential Needs (HEN)
- Kitsap County
- Thurston County

Latino Network Builder
Nativity House Shelter
Network Builder
PREPARES - Pregnancy and Parenting Support
Puyallup Pilot Program
Quince Street Village
Stability Site - City of Tacoma
Supportive Services for Veteran Families (SSVF)
Volunteer Services

Family Behavioral Health

Behavioral Rehabilitation Services (BRS)
Child & Youth Mobile Crisis Services
Community-Based Intensive Treatment (CBIT)
Crisis and Transition Services (CATS)
Crisis Stabilization (FAST)
Family Search & Engagement (FSE)
Foster Care Crisis Response
Health Homes
Hospital Diversion
Intensive In-Home Behavioral Health Treatment (IIHBHT)
Pediatric Integrated Care
Transition Age Youth (TAY)
Wraparound Intensive Services (WISe)

Long Term Care

Caregiver Training
Home Care
Home-Delivered Meals
Senior Nutrition Program
Senior Transportation Program

Catholic Housing Services

110 14th Ave Apartments
Bridges Village
Catherine of Siena
Champion House
Chancery Place Apartments
Clare's Place
Dorothy Day House
Drexel House I
Drexel House II (for Veterans)
Emma McRedmond Manor
Emmons Apartments
Fournier Court Apartments
Francis Place
Franciscan Apartments
Frederic Ozanam House
Guadalupe Vista
Halcyon House
Highland Court Apartments
Josephinum Apartments
Kateri Court
Katharine's Place
Kincaid Court
La Casa de la Familia Santa
La Casa de San Jose
La Casa de San Juan Diego
La Casa de San Juan Diego II
La Casa de Santa Rosa
La Casa del Padre Miguel
Manresa Apartments
Martina Apartments
Matsusaka Townhomes
Maurice G. Elbert House
Max Hale Center
Monica's Village Place I
Monte Cristo
Mount Baker Apartments
Nativity House Apartments
Noel House at Bakhita Gardens
Patrick Place
Pioneer Court
Rose of Lima at Bahkita Gardens
Santa Teresita
Sebastian Place
Spruce Park Apartments
St. Martin's on Westlake
Sumner Commons
Sumner Townhomes
Sunrise Court
Thea Bowman Apartments
Traugott Terrace
Tucker Apartments
Tumwater Apartments
Villa los Milagros
Villa San Isidro
Villa San Juan Bautista
Villa San Martin
Villa Santa Fe
Villa Santa Maria
Washington Grocery Building
Wintonia
Woodland Meadows

Summary Report

Overview of key findings and recommendations

June 09, 2023

Washington State Health Care Authority

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Executive Summary

On May 22 and 23, Lummi Nation hosted the first Washington State Tribal Opioid/Fentanyl Summit: Strengthening Pathways to Healing. At the government-to-government summit, Tribal leaders, Governor Jay Inslee, and State Agency leaders engaged as partners to discuss the impact of the opioid/fentanyl crisis is having on American Indian and Alaska Native (AI/AN) communities across Washington State.

During the first day of the summit, the participants had the opportunity to learn about the state of the opioid/fentanyl Tribal Crisis Response. They also heard the stories of individuals with lived experiences, who stepped forward to share their profound narratives of the personal impact opioids addition has had on their lives and those of their loved ones; these stories served as a grounding force to enter the active solutions discussions that were core to the Summit. These stories also served as a poignant reminder of the real-world impact the Summit sought to remind us that behind every statistic or policy decision, there are lives deeply impacted by the opioid/fentanyl epidemic.

> "We are self-determined people; we know how to care for ourselves. When provided adequate support and resources, we can address this drug epidemic in a way that promotes our culture, teachings, and way of life. Our vision is that one day we will heal ourselves from the atrocities that have happened to us. That one day, we will break the cycles of trauma, and our children and grandchildren will grow up unhindered by the negative aspects of the world. This summit is a step toward unity to address the drug epidemic on all levels of government and the community. We are looking forward to collaborating with this state, Indian Country, and the United States of America to come up with effective solutions for the betterment of all people."
>
> - Anthony Hillaire, Chairman of the Lummi Indian Business Council
>
> Washington State Health Care Authority. (2023 May 10). Washington State an honored partner in upcoming Tribal Opioid/Fentanyl Summit [Press release]. https://www.hca.wa.gov/about-hca/news/announcements/washington-state-honored-partner-upcoming-tribal-opioid/fentanyl-summit

Summit participants then engaged in breakout sessions to discuss challenges and opportunities in combating the opioid/fentanyl crisis within Tribal communities, which often reflected additional lived experiences including potential solutions. The four breakout tracks were: (1) Justice, (2) Treatment, Recovery, and Prevention, (3) Housing and Homelessness, and (4) Community and Family. The purpose of these discussions was for Tribes and the State to come together as partners and develop plans and recommendations to address this crisis.

The Justice breakout session highlighted the need for establishing Tribal warrants reciprocity, expanding access to diversion programs (e.g., detox, in-patient treatment, and intensive outpatient treatment), increasing coordination with Tribal diversion/wellness courts, supporting Tribal drug task forces, addressing missing and murdered indigenous persons (MMIP) issues, strengthening traditional judges and cultural practices, improving detox programs, including Tribal representatives on the Jail Standards Task Force, addressing legislative veto, and enhancing collaboration between Tribal police and other law enforcement agencies.

The discussion in the Treatment, Recovery, and Prevention session explored multiple priorities including raising awareness about the dangers of fentanyl among youth, continuing the State-Tribal collaboration, and declaring a public health emergency. The group also identified priorities that could be pursued and effective over longer timelines, such as integrating culture into treatment programs, empowering Tribes with independent funding decision-making, and improving the accessibility and capacity of treatment services. Future opportunities included those that require regulatory, legislative, or programmatic efforts were also acknowledged including advocating for adjustments to the methadone loading dose given the potency of fentanyl, focusing on youth-oriented programming, and expanding residential care infrastructure that accommodates families for individuals in active treatment/recovery programs.

In the Housing and Homelessness session, the key barriers and opportunities highlighted included the lack of affordable and accessible housing, the need for increased access to housing with medically assisted treatment (MAT) and other support including wraparound services (e.g., transportation, child-care, workforce development, counseling programs, addiction treatment, mental health counseling, and culturally appropriate care), and access to lower-barrier or harm reduction housing solutions. The participants also discussed how funding should be provided directly to Tribes with discretion to decide how to best allocate resources. The participants acknowledged these efforts would improve the Tribal-State partnership by establishing a consultation policy at the Washington State Department of Commerce, conducting listening sessions with Tribes, and moving towards government-to-government agreements that ensure a focus on Tribal needs and sovereignty.

Lastly, the Community and Family session focused on the current negative impacts of the opioid/fentanyl epidemic, the disproportionate data showing increased use and negative effects amongst AI/ANs, strategies to educate the community of the epidemic at the same level as COVID-19, strategies to improve communication between State and Tribal entities, explore and enhance interstate compacts for treatment, the need for a Declaration of Public Health Emergency, permanent authorization for telemedicine, build capacity for providers and law enforcement officers, assessment of laws to strengthen and loosen where applicable, and licensure streamlining. Focused efforts discussed included programs that provide a continuum of care for those struggling with addiction, increasing the focus on prevention through low or no-barrier activities for children, partnering to address issues like trauma and homelessness, and strengthening family units.

On the final day of the summit, Tribal and State-elected officials participated in a bi-directional working session with Governor Jay Inslee and presented the key opportunities where the State could further partner with Tribes to make meaningful progress in combating the opioids/fentanyl crisis.

Tribal leaders shared the findings and recommendations from the breakout sessions of Housing and Homelessness, Treatment, Recovery and Prevention, and Community and Family with Governor Jay Inslee and his staff.

Summit participants acknowledged that this collaborative effort is the first step in a long journey to addressing the challenges posed by the opioid/fentanyl epidemic. It was recognized that the work done will provide a foundation for future initiatives, led by focused groups, to carry forward the discussions and

findings and identify opportunities for further progress. The outcomes of this session will also be brought forward at the upcoming National Tribal Opioid Summit hosted by the Tulalip Tribes.

Day 1: Breakout Sessions

In order to capture perspectives and experiences from Tribal and State partners, breakout sessions were assembled to focus discussions on the select determinants of health related to the opioid crisis: Justice, Treatment, Recovery, and Prevention, Housing and Homelessness, and Community and Family.

The four breakout sessions aimed to:

1. Identify Tribal areas of concern and change that can happen with current powers in our Governor's Cabinet system
2. Identify areas where legislative intervention may be needed
3. Begin to formulate what a Tribal-State partnership to combat the opioid/fentanyl crisis looks like
4. Create recommendations for institutional and systemic change that is to be brought directly to the Governor for the Day 2 work session

Below are details on the key findings of each breakout session. **Appendix A** provides a summarized view of the priorities, corresponding jurisdictions, category of action (e.g., programmatic, legislative, operational), and implementation timeline.

Justice

The unacceptably high rates of opioid/fentanyl use challenge local, State, and Tribal justice systems in all aspects. This breakout session focused on the complex multi-jurisdictional issues when addressing opioids/fentanyl use in Indian Country within the State of Washington to identify where the justice gaps threaten American Indian / Alaska Natives. These discussions also explored short-term and long-term solutions for the Governor and Tribal Leaders to consider and provided real-life examples, experiences, and scenarios that incorporated the perspectives of law enforcement, diversion programs, courts, individuals within the justice system, and those in detention facilities (Tribal and non-Tribal).

Collectively, this breakout session explored:

- How can State departments/agencies improve existing relations with Tribes to reduce opioid/fentanyl use on and off reservations?
- How can we ensure that treatment, particularly diversion treatment, is both immediately available and proximate?
- How can State departments/agencies provide greater freedom for Tribes to design and run their justice systems?
- How can State departments/agencies enhance cooperation among Tribes in key areas to improve outcomes through training, technical assistance, data, and interagency agreements?

The facilitators for the Justice breakout session were:

- John Hillman, Division Chief, Criminal Justice Division, Office of the Attorney General
- Asa Washines, Tribal Liaison, Office of the Attorney General
- Councilman Nickolaus Lewis, Lummi Nation
- Commissioner Marlin Fryberg, Tulalip Bay Fire Department
- David Newsome, Prosecutor, Lummi Nation
- Eric Ritchie, Prosecutor, Whatcom County

Key takeaways

1. There is insufficient immediate access to proximate diversion programs (e.g., detox, in-patient treatment, and intensive outpatient treatment)

- The speakers discussed the issue around people with substance use disorders (SUD) who often have legal trouble that crosses jurisdictional boundaries; when these boundaries are tribal, it complicates release to services, pretrial diversion, and supervision – legislation or policy coordination is needed to address jurisdictional transfers between county and Tribes
- When individuals with SUD are arrested and sent to corrections facilities, they do not receive adequate treatment for their addiction
- Diversion programs may be effective when immediately used with low-level offenders, however access to diversion programs, particularly detoxification, is often difficult for Tribal Nations as there are insufficient beds or not accessible
- Recent legislative action which addressed the "Blake Court Ruling" makes diversion programs viable at scale again in Washington
- Coordination for bed availability is often executed by phone through relationships rather than a database and, as a result, diversion candidates either cannot secure a bed or are driven long distances only to discover the bed is no longer available
    - It was noted that the State in partnership with AIHC and Volunteers of America have created a Native Resources Hub that has access bed reports twice daily and should be called to find where the open beds are
    - There needs to be better investment into ensuring Tribal leadership and their staff are aware of this resource built for them
- Corrections facilities should not be used for detoxification; they are insufficient and do not replace proper detoxification programs

"There's a lot that I could say. That when my son was incarcerated in the correction center, they then gave him $40 and set him loose, where he then ran down 1,000 feet to the nearest drug house and relapsed after 13 days of being in protective custody as a material witness, after I begged them not to give him that money. This session, I don't have enough time to tell you where I've been let down by the legal system, by law enforcement, by the courts, by the judges." – Anishinaabe Member

"The Blake bill allows the State government to override city and county resistance to citing treatment facilities and behavioral health facilities, and I'm hoping that we are incredibly aggressive about taking advantage of that." – Secretary, Department of Children, Youth and Families

2. Increase coordination with Tribal Diversion/Wellness Court for diversion with healing focus vs. State diversion process

- The speakers emphasized the need for State and Tribal courts to work together to address opioid addiction and related issues in indigenous communities
- Participants noted the importance of coordinating with Tribal diversion and wellness courts to provide alternative sentencing options that focus on healing rather than punishment because they have been shown to be effective in addressing drug-related cases and promoting healing and wellness in tribal communities
    - A healing and wellness court like a drug court was very effective but ceased following lost funding when the grant ran out
- Participants discussed the effectiveness of integrating traditional and custom sentencings in drug cases
- There were prior discussions identified about regional jail facilities involving tribes, but the group was unclear on what happened with those plans over time

> "Our grant ran out of funding and the Tribe didn't pick up the funding, so we lost their [traditional] program. But a lot of Tribal members were asking if we can have it back, and that's when I started sentencing them to traditional services such as sweats, meeting with our peacemaking, doing community service for our elders, talking with our elders about their life, and getting mentorship for them." – Associate Judge, Colville Tribes

3. There is a need to increase funding to support traditional judges and their culture and legacy

- The speakers emphasized the vital role that traditional judges play in preserving indigenous culture and legacy by incorporating traditional practices into legal proceedings
- Providing more funding to support traditional judges could help ensure that indigenous communities have access to culturally appropriate legal services
- It is important to incorporate the value of traditional knowledge and practices in addressing issues such as opioid addiction and MMIW
- Integrating traditional practices into drug treatment programs and other initiatives is proposed to help improve outcomes for indigenous communities

> "When I was the acting chief judge, I oversaw a lot of the cases, and I find that integrating traditional and custom sentencings had more effect. We did use to have healing in the wellness court similar to a drug court, and that was very effective as well." – Associate Judge, Colville Tribes

"I always wonder why somebody doesn't talk to the one that's in the hospital. Maybe they'll tell where they're getting their drugs. I just want to be here and try to learn what I can to bring back to our tribe… I want our traditional action, our spiritual – nobody talks about spiritual. So many things are being lost, and instead of natives capturing their young, they're being captured by outsiders, the outsiders coming in." – Chairman, Squaxin Island Tribe

4. It is important to have Tribal representatives on the Jail Standards Task Force

- The speakers discussed the issue that indigenous communities are often disproportionately affected by issues such as over-incarceration and inadequate jail conditions
- They also noted that having Tribal representatives on the Task Force could help ensure that the needs and perspectives of indigenous communities are taken into account when developing jail standards
    - This issue needs to be addressed in order to improve outcomes for indigenous individuals who are incarcerated and prevent further harm to their communities

"Back in the day, we did have a member of the Lummi Nation police department on the task force, and I think now may be a time to have that conversation again and would certainly welcome that collaboration and that partnership to try and address this fentanyl epidemic that is affecting all our communities" – Undersheriff, Whatcom County Sheriff's Office

5. There is a need for tribal warrant reciprocity that is recognized in jurisdictions throughout the State

- Tribal law enforcement officials expressed concerns about the lack of recognition for Tribal arrest warrants in State courts
- The speakers pointed out that when a person subject to a warrant issued by a Tribal court is found by Washington State law enforcement, they are not always arrested because Washington State law does not allow for it
- This issue may require a legislative fix and emphasized should be addressed to ensure public safety and justice for indigenous communities

"There was a Tribal law enforcement section that is not getting Tribal arrest warrants honored in State courts when somebody who's the subject of a warrant that's been issued by a Tribal accord and that person's found by Washington law enforcement and they're not arrested. There's a statute that says Washington law enforcement can arrest for felony warrants from out of State, but it doesn't address the Tribe. So, if that's an issue, there would need to be a State legislative fix to fix that" – Director of Governmental Affairs, Nisqually Tribe

6. Proactively address the reality of joint policing through Memorandums of Understanding

- The speakers discussed Tribal and State policing partnerships including the legal frameworks for addressing jurisdictional control are notoriously complex on Tribal Lands; there are several common scenarios that create complexities:
    - County roads that run through Tribal lands
    - Trust vs. Fee land rights
    - Tribal members encountering the law off Tribal Lands
    - Tribal members or the general public banned from Tribal Lands
- They also noted that chronic shortages of police officers, both in Tribal, County, and State forces, have created a *de facto* need for coordination
    - Staffing challenges need to be addressed to ensure that Tribal police have adequate resources to carry out their duties effectively
- County and Tribal police forces need to have active Memorandums of Understanding (MOUs) in anticipation of joint policing needs

"We have issues with shortages of personnel. Of the 21 task forces that used to exist within the State, we were a part of 19 of those. I only have eight people now that are within drug task forces throughout the State. I'm 257 people short (that's troopers that I need)" – State Police Chief

"In Yakama Nation, we have about 11,000 members, and based on FBI guidance, we should at least have 76 officers to cover our 1.4 million acres, and all that includes on the reservation, but we also have trust allotments down in the Klickitat County…So you can see we're spread thin when it comes to our officers, fish and game, and public safety. I think that's a struggle overall we're all seeing, is losing officers to different city departments" - Law and Order Chair, Yakama Nation

"We all know no matter what we work out there, there just are not enough people out there to hire as officers. So, we can decide what they can enforce, and who they can arrest, but we just literally don't have enough people to do the work. And I think everybody in here is probably in that situation, and there's not a light at the end of the tunnel. When you're telling me you're still 200 short, I mean, that's not something that we're just going to fix overnight, so I would like to see something documented out of this to just talk about what's the long-term plan there to make sure that we don't stay in this problem forever" – General Manager, Swinomish

7. Address perceptions that Tribal police are not trained to the same level as County, City, and State law enforcement to help drive better collaboration between all law enforcement agencies

- The speakers discussed the issue of Tribal police training and emphasized the need for better collaboration between Tribal police and other law enforcement agencies
- Improving collaboration between these agencies could help improve public safety and reduce crime rates in indigenous communities
- They noted that Tribal police officers are trained to the same level as county, city, and State law enforcement officers but face challenges in working together due to staffing issues
- Tribal police often face resource constraints that can limit their ability to carry out their duties effectively
- The speakers suggested that addressing underfunding for Tribal police could help improve public safety in indigenous communities and ensure that these officers have the resources they need to do their jobs effectively
- The value of Tribal police should be recognized and their efforts to keep indigenous communities safe should be supported
- The group highlighted the need to train County and State counterparts in the legal frameworks that Tribal Police operate within

> "I'm hearing that the Tribal officers are not being treated with equality, with respect. We are developing a Tribal curriculum that provides mandated training for early officers to understand laws, jurisdiction, how and what it's like to work in Indian country, and what case models look like. Their curriculum is now being developed. For those public officers who have already come out of the academy, they'll be required to take online courses. The thought here is if you as a non-native, non-Tribal police officer can clearly understand what the chief is having to go through every day and what jurisdiction laws are in Indian country, you'll gain the respect of what he has to face every day" – State Representative, 40th Legislative District
>
> "When we talk about partnerships, it's truly about sitting down and hammering out understandings that allow you to arrive at a commonplace where you can effectively support one another. In terms of the troops who-- if you run across a trooper with the holier than attitude, that's not a trooper. We don't allow that. In terms of somebody exercising saying they're not going to work with locals or not going to work with the tribe, that's totally unacceptable. We are a partnering agency, and if you run across something like that, any of you, I want to know about it" - Chief, Washington State Patrol

8. Support is needed in strengthening Tribal Drug Task Force to combat the cartel(s)

- The speakers noted that indigenous communities are often targeted by drug traffickers due to their remote locations and lack of resources

- They suggested that providing support to Tribal law enforcement agencies could help them better address drug-related issues and prevent cartel activity in their communities
- They also highlighted the importance of collaboration between Tribal and State law enforcement agencies to effectively combat drug trafficking in Washington State

> "Our task force has not had a state trooper assigned for over 16, 17 years. We have the same struggles of trying to find bodies, right? Just like every law enforcement agency out here, we're down three in my dispatch center, seven in patrol, and one detective. We struggle just like everybody else but I'm hoping that we can find that relationship between the Tribes and the State again and a partnership" - Detective Sergeant, Tulalip Police Department
>
> "We focus on mid to upper-level organizations that are trafficking drugs into our communities and essentially profiting off other people's addiction. And we work very closely with our State and federal partners to stem the flow of these dangerous drugs to our community." – Undersheriff, Whatcom County Sheriff's Office

9. There is a need to address the legislative veto due to the administrative burden

- The speakers mentioned that legislative veto can create an administrative burden for Tribal governments, as they must comply with both federal and Tribal laws
- Addressing this issue could help reduce the burden on Tribal governments and improve their ability to govern effectively
- They also emphasized the importance to recognize Tribal sovereignty and ensure that Tribal governments have the authority to make decisions that affect their communities without undue interference from outside entities

> "I think the message to our Governor is to, of course, support the Tribes. And with respect to their sovereignty, [but] working together because Yakama Nation, we have a very diverse community." – Law and Order Chair, Yakama Nation

10. Ensure that Tribal input is received for legislation that will impact indigenous communities prior to being introduced on the floor

- The speakers discussed the need for establishing Tribal-State partnerships to address opioid addiction and related issues, with collaboration when developing legislative solutions before introduction to the floor

- Such an approach to partnership ensures that indigenous communities are adequately represented in policy discussions, their unique needs are taken into account and trust is built

> "I can tell you [that] my leadership [has] government-to-government meetings. For example, they'll meet with Chief Batiste from the state patrol on an MOU; They met with our sheriff from the county; They met with our US attorney's office, the FBI. In return, that helps me do my job better because I have better communication with our partners. You just got to have those partnerships in law enforcement. We're fortunate up in Yakama that we get along with everybody we work with or just the ones I mentioned." – Tribal member, Confederated Tribes of The Yakama Nation
>
> "The question about getting warrants and tribal agencies having trouble getting warrants is interesting to me. The statute that allows local agencies to get information through search warrants from large companies like Google or Facebook or something else is a federal statute. And that means that if there are problems for the tribes getting this kind of information, it would be a federal fix. It would need to be some legislation through the federal government. "– Prosecutor, Whatcom County

11. Setting cameras on transportation routes could help track Missing and Murdered Indigenous Women (MMIW) victims

- The speakers discussed the issues of MMIW and suggested that setting up cameras on transportation routes could help track victims who go missing
- They noted that indigenous women are disproportionately affected by violence and often go missing without a trace
- The speakers suggested incorporating better tracking methods, such as cameras, to help law enforcement agencies locate missing persons more quickly and effectively
- This issue needs to be addressed to ensure justice for indigenous communities and prevent further violence against indigenous women

> "When the DOJ comes asking for Tribal input on VAWA, or MMIW, or fentanyl, staffing is incredibly important because we can't address these systemic problems without officers to run, to participate" – Chief of Police, Tulalip Tribal Police

Treatment, Recovery, and Prevention

Addiction is a chronic condition that harms individuals, families, and communities. Consequences from addiction impact a person's physical health and affect their social, psychological, physiological, spiritual, and cultural well-being. Addiction is associated with trauma and loss, and in Tribal communities the traumas are generational.

The impact of opioid/fentanyl addiction in Indian Country is at catastrophic proportions, and Tribal Leaders are worried about their people and their futures. Countless lives and families are falling victim to substance use and addiction and cannot access the treatment and recovery programs they seek.

The path to wellness is complex, and the needs of Tribal people can be addressed by unique approaches to healing and care. In this time of the fentanyl crisis, access to resources, funding, and diversification of our workforce and philosophies is critically important.

The breakout discussions focused on surfacing the differing cultural considerations that complement clinical and programmatic initiatives related to prevention, treatment, and recovery. The group aligned on goals that identify what Tribal communities want, clarify gaps and define how the State and Tribes can collectively promote healing.

The facilitators for the Treatment, Recovery, and Prevention breakout session were:

- Chairman Anthony Hillaire, Lummi Nation
- Dr. Charissa Fotinos, State Medicaid and Behavioral Health Medical Director, Health Care Authority
- Keri Waterland, Ph.D., State Behavioral Health Authority, Health Care Authority

Key takeaways

Near term priorities

1. Continue to meet and bring HCA, Tribes, and other State Agencies together to refine Treatment, Recovery, and Prevention planning

- The participants discussed the importance of having conversations between different providers, including Medicaid and private insurance providers, as these conversations improve healthcare service access and delivery for Native American communities, identify gaps in care, and support the development of evidence-based approaches that meet the individual needs of Tribes
- In addition, the group noted a need to better understand the unique needs of Native American communities when it comes to addiction treatment and mental health services

> "I hope that we can bring it to the audience here, the idea for this Summit was not for us to just report out on the work that we're doing as Tribes and as the State. But to talk about solutions. This is a time to talk about the gaps that we see, the issues that we're facing." – Chairman, Lummi Nation

> "We know that the Native Americans experience higher rates of health disparities, higher rates of substance misuse, mental health issues, [...], and it's related to historical and intergenerational trauma. When we increase our connection to culture, it acts as a buffer to mitigate the impacts of stress and trauma on health outcomes" – Behavioral Health Programs Director, Northwest Portland Area Indian Health Board

2. Develop an awareness campaign to raise the profile for fentanyl danger, particularly among youth

- Fentanyl is a highly potent synthetic opioid that is often mixed with other drugs, making it difficult to detect
- The participants discussed how an awareness campaign can help educate young people about the dangers of fentanyl and other opioids, as well as provide information on how to seek help if they or someone they know is struggling with addiction

"We need to have more education on what's happening with our youth and what's happening with our people in general. We need to have more education on what fentanyl is doing." – Director of Division of Behavioral Health and Recovery, HCA

"…And then the question about teen drug use and girls and boys and how that's changing with fentanyl… Now that fentanyl is here when you take pills, there is no opportunity for intervention. A lot of these cases, a lot of these kids die." – Health Officer, Whatcom County

3. Declare fentanyl and the opioids epidemic a public health emergency

- Tribes have already declared a public health emergency, and discussion among the group suggested the State also be more proactive about the crisis
- Declaring a public health emergency can help raise awareness about the severity of the crisis and mobilize resources to address it

"I think a commitment to this crisis is absolutely necessary. There's probably some validity to declaring a public health emergency. The Tribes are doing it. I think at the State level, you need to get ahead of this. The intensity of this crisis is coming for us, and we need to do something about it now. We need to be more proactive rather than reactive." – Tribal member, Confederated Tribes of the Colville Reservation

"We declared a state of emergency on fentanyl here in Lummi, and we started tackling these problems here at home. But the main thing we're running into is the funding part of it, getting funding to fund everything that we want to do. We have all these programs set up in Lummi here that will help." – Tribal member, Lummi Nation

4. Identify other avenues to leverage emergency authorities for HCA, DOH, and Executive Orders

- Declaring a public health emergency was also thought to enable access to funding and resources, but there may be other emergency authorities that can be explored as well such as addressing capacity issues faced by treatment facilities to improve access to care
- The group discussed the importance of collaboration between different providers, including Medicaid and private insurance providers, to get individuals access to the care they need

> "Back in 2017, I went and toured five different treatment facilities way down south. The biggest problem that we see is some of these – a lot of these places don't accept Medicaid. So, when they're not accepting Medicaid, but we have this humongous need, and everybody in the nation knows it, what do we do? It got to the point where we started paying for treatment." –Tribal member, Makah Tribe

5. Increase accessibility and capacity of treatment products and programs

- There are currently capacity issues faced by treatment facilities, which can result in individuals not receiving the care they need; increasing funding to expand capacity at treatment centers and supporting programs should be a priority
- The speakers also emphasized the importance of evidence-based approaches that meet the individual needs of Tribes, as well as better organization of care, research, and data to improve outcomes for those struggling with addiction

> "I was hoping we would be able to get some medical help and support from the healthcare authority or the Spokane Regional Health Department to help work with us and figure out what's really going on here because it's changed. The kids are more difficult to deal with. It takes them 30 days at a minimum to get through and start acting fairly decent, and we don't have a detox center." – Executive Director, The Healing Lodge of the Seven Nations
>
> "The capacity building that we're talking about for withdrawal management is an absolute need. The limitations that we're seeing on the funding, inability to build facilities, inability for some of the federal funding to be utilized for building facilities, is a real difficulty for many Tribes." – Tribal member, Confederated Tribes of the Colville Reservation

6. Conduct a landscape analysis of treatment and recovery services across the State to align capacity gaps, improve service coordination, and identify areas for investment/improvement

- The group noted a need to conduct a landscape analysis of treatment and recovery services across the State to align on capacity gaps, improve service coordination, and identify areas for investment/improvement
- One noted issue is a lack of coordination between different providers, which can result in individuals not receiving the care they need; the group suggested conducting a landscape analysis which would help identify gaps in capacity and areas for improvement, as well as improve coordination between different providers
- The speakers also emphasized the importance of evidence-based approaches that meet the individual needs of Tribes, better organization of care, additional research, and the use of Tribal-specific data to improve outcomes for those struggling with addiction

> "We need to, together as Tribal leaders, take a look at the landscape and see where we need the different types of facilities. Because the non-Tribal treatment centers out there and detox facilities, by and large, are not working for us because we can't get into them when we need to get into them… We need to look together about how maybe we pool some of these dollars into facilities in the right place." – Tribal member, Cowlitz Tribe

Medium-term priorities

1. Integrate culture into TRP programming given legacy and fit with the Tribal community to increase the success of treatment and recovery programs

- The speakers noted that incorporating cultural elements into treatment can help individuals feel more connected to their community and improve outcomes
- Working with Tribes to incorporate cultural elements into TRP programming can help improve the effectiveness of treatment and recovery programs

> "There's some that are still hanging in there. We have had a lot of success because it's focused on culture, and culture is the base of who we are, and we bring them back. They've fallen off being involved in culture for the time that they were on drugs and alcohol. And so then our treatment program brings them back into a cultural environment where they're receiving their treatment and part of their therapy is culture. And they're doing really well." – Executive Director, The Healing Lodge of the Seven Nations

2. Direct settlement funding to Tribes and support autonomy with decision-making for how and where to utilize funding

- The group identified a need for Tribes to operate autonomously with decision-making for how and where to utilize funding that is directed to them from the opioid settlements
- While funding resources are available for Tribes, there are often restrictions placed on how the funds can be used, which can limit their effectiveness
- Sovereignty and treaty rights are significant in decision-making processes related to funding allocation, including reporting on uses

> "There's so much restrictions on the funding we get from the State or the government. And it's so competitive to get funding through the grants and programs – now that we lose 40% of that to reporting and documenting stuff. The employees that are handed that funding out have to do so much reporting, and it's so competitive with other entities. That money could be going towards the youth." – Tribal member, Lummi Nation

3. Increase accessibility and capacity of treatment products and programs

- One of the noted constraints, highlighted through the shared experience of several breakout participants, is related to challenges for accessing treatment programs when someone is "ready to start their recovery"
- The challenges related to multiple factors include but are not limited to, long drives (lack of proximity), wait lists, payer coverage limitations, and lack of other supportive services that address the needs of the individual and family during the treatment and recovery journey
- This priority is linked to the landscape output, so Tribes and the State have appropriate data to direct investments to the areas of need without redundancy, misalignment, or waste of time, talent, and money

> "So we need to look at having a Tribal system across the State, take a landscape look, and see what we need. We all can't have 29 full-blown everything everywhere in our communities. But we need to take a look at what the landscape is." – Tribal member, Cowlitz Tribe
>
> "We talked about accessibility to treatment, recovery, sustainability, and support services. And with that, there are comments about our waiting time just to get people into treatment or into a bed for detoxing. But how do we measure that data, for one, and then also bring it into a way that we're going to address it so that we can set the goal." – Chairman, Lummi Nation

Long-term priorities

1. Advocate at the Federal-level for adjusting methadone loading dose; achieve regulatory and legislative update that refines clinical guidelines

- The group discussed how advocacy is required at the Federal level for adjusting methadone loading dose and achieving regulatory and legislative updates that refine clinical guidelines
- There are currently issues with methadone dosing, which can result in individuals not receiving the appropriate amount of medication at initiation which limits the success of treatment and recovery programs

> "One of the biggest barriers that I've heard from my colleagues who are working in opiate treatment programs is there is still a limit on the first daily dosing of methadone. 40 milligrams of methadone was a pretty high dose, and that helped a lot of people initially get through their symptoms. Now that's not adequate." – Medicaid and Behavioral Health Medical Director, HCA

2. Focus youth-oriented programming

- The speakers discussed how youth-oriented programming is important in addressing addiction and substance abuse issues
- Specifically, engaging youth in culturally relevant activities and programs can help prevent substance abuse and promote healthy behaviors
    - For example, the observations of programs in Iceland emphasize the need to build a healthy environment for youth through community-based efforts that influence youth health including peer groups, school wellbeing, extracurricular activities, and sports. Many tribal ancestral values could be seen in practice within the programing observed in Iceland
    - This model has been successful in reducing substance use among Icelandic youth and has been adapted for use in other countries through the Planet Youth approach
    - Canoe and other outdoor activities were highlighted as culturally connected youth programs that should be considered to support prevention initiatives
- Incorporating traditional practices and teachings into these programs strengthens cultural identity and resilience among youth
- The group also discussed involving youth in decision-making processes related to programming, as well as providing them with opportunities for leadership development, to bolster participation

> " I think it's an ounce of prevention is worth a pound of cure. Actually, that goes into the Iceland model. Creating a safe environment is really what's the core idea behind the Icelandic model. So, we have a culture room in our treatment program, and we know that works. It's easy for secular activities like sports and basketball, and football. For cultural activities, it's harder. We've had to create drug-free events to bring the kids together for sporting events.

> And other Tribes have done this because we've sent our kids to your Tribes – that's one of the struggles with prevention. If it's culturally based, it's great. We can do the canoe clubs. We can do the healing of the canoe. But then the flip side is a little bit harder." – Program Sponsor, Lummi Healing Spirit Clinic

3. Expand residential care infrastructure for treatment and recovery that accept families and not just individuals

- There are currently capacity issues faced by treatment facilities, which can result in individuals not receiving the care they need; participants also acknowledged the challenges faced by families while their loved ones are in a treatment and recovery program, and that co-location can support participation and increase the success
- Identifying opportunities for expanding residential care infrastructure to include families can help address this issue and provide a more supportive environment for those in recovery

> "The other is we need more adult inpatient treatment centers for our families. I think that would help if we had more because I think having more available at the Tribal level, that'll take that stigma out of going into inpatient treatment. They need it. The family needs to be well so that when the kids go home, they're coming to a well home." – Executive Director, The Healing Lodge of the Seven Nations

Housing and Homelessness

AI/AN communities are disproportionately impacted by housing issues with roughly 23 percent of existing homes in Tribal areas in need of repairs, upgrades, and reconstruction compared to 5 percent of all U.S. households. Homelessness, unstable housing, and overcrowded housing in Indian Country are strong determinants of health outcomes and contribute to ongoing and pervasive health provider shortages experienced across the Indian health system. The session will bring focus to the obstacles to long-term housing solutions for people with substance use disorder and their families under existing systems and seeks to identify how to provide State housing funding to Tribal governments and Tribal organizations. Session participants were asked to consider the following:

- The State is implementing focused technical assistance to help historically marginalized communities successfully compete for limited State capital funding to build housing. What is critical to make this new technical assistance successful for Tribal governments and Tribal organizations?
- How do we ensure there is an appropriate mix of accessible permanent supportive housing and sober housing?
- What changes are needed to increase the flexibility of State funding to house people with SUD?
- The Governor and State agencies regularly engage with the federal government regarding housing issues. What are the key messages and asks the State should communicate to the federal government regarding housing?
- How do we ensure there is an appropriate mix of accessible permanent supportive housing and sober housing?

The facilitators for the Housing and Homelessness breakout session were:

- Chairwoman Carol Evans, Spokane Tribe of Indians
- Tedd Kelleher, Housing Policy Director, Department of Commerce

Key takeaways

1. There is a lack of affordable and accessible housing

- The speakers discussed how there's not enough supply and access to different types of housing (e.g., emergency such as Oxford, transitional, sober housing) at different stages of SUD treatment and recovery
- Specifically, there's a lack of availability of transitional housing in the different Tribes
    - Existing units are overcrowded (2-3 bedroom houses with 8-10 people)
- The group pointed out that traditional HUD housing models may not be effective for all Tribal communities and alternative approaches should be considered
- Participants also brought up zoning rules and permitting as possible barriers to construction
    - The ask for the Governor's team is to explore mechanisms to potentially relax zoning rules to expedite housing construction

"For every two people that we have outside right now, we're only able to bring one inside… have and so we get into these horrible situations at the State and the community levels on how you decide who to bring inside…Even though we're doing better reaching out, it's just the shortage of resources for housing. There's not enough to go around." – Housing Policy Director, Washington State Department of Commerce

"We have all experienced multiple families living in the same homes. We have 2-3 bedrooms houses with 8-10 people living there at a time, which is really disturbing to see." – Chairman, Samish Tribe

2. Improve the transition from formal treatment into housing with supports such as medically assisted treatment (MAT)

- The participants discussed how housing paired with additional support services (such as MAT, and healthcare) are critical to sustained recovery
    - It is critically important that addiction treatment programs have culturally appropriate care
- Medication therapies for OUD (Opioid Use Disorder) are the most effective kinds of therapies and compliance with medication goes way up when people have a stable place to live
    - There is a need to think through how the healthcare services provided at the Tribes can be leveraged with the housing resources at the State
- People who are in active addiction or working to recover from opioid use disorder need an additional level of support in that housing to bring them indoors and to provide the healthcare services that we know they're going to need for a long time
    - The participates discussed how important is that admission is fast as people with active OUD can often die while waiting
- More broadly, participants discussed how not every Tribe even has access to clinics and needs support to increase the availability
    - There are several Tribes that have developed these centers and provide medical services that could be used as models
    - For example, the Quil Ceda Creek Counseling Company of the Tulalip Tribe provides SUD consultations and assessments, individual treatment planning, SUD outpatient groups, and referrals to other community resources.

"When we're talking about housing specifically for people with OUD, we have to think about that integration of healthcare and housing… The opioid settlement dollars are new resources for the State and the Tribes to try some new things. They must be focused on assisting people with opioid use disorder, but beyond that can be used for anything… so thinking about what are the right supports we can bring to people. What are those flexible kinds of needs that we can address that brings together healthcare and housing? – State representative, Seattle

"For us on the peninsula, it's tough enough getting guys into treatment. The wait could be 30 days or longer, and by that time you lose them. But you do get that special case where they do go to treatment. And when they get out, there's an expectation that they should be going to an Oxford home or a recovery home or a transitional house. That's even tougher to get into because they're always filled. It's tough just to get into treatment… it's hard to find a treatment facility that's going to treat the disease. And then once they finish, it's even harder to get them wrapped around services." – Tribal Council Member, Makah Tribe

3. Wraparound services are an essential component of addressing the opioid epidemic's impact on housing and homelessness

- The participants reinforced that housing alone is not enough; wrap-around services like transportation, child-care, workforce development, and counseling programs are needed especially in times of extreme vulnerability (e.g., transitioning between care setting and Oxford housing)
    - Jamestown Healing Clinic provides SUD counseling, behavioral health, child-watch, transportation, and individualized care coordination and helps folks succeed in these services also
- The participants discussed how services must be funded and provided in conjunction with stable housing to ensure the best outcomes for individuals experiencing substance use disorder or other mental health issues
- It is critically important to have outreach professionals to better understand what the community needs
    - Additionally, need to consider providing housing to the service providers as access to this staffing is often a challenge due to logistics
- The group emphasized that these wraparound services shouldn't have a "time-limit" as SUD is a lifetime disease
- Housing programs should prioritize rapid rehousing strategies that help individuals quickly transition into permanent housing

"I think what's important with Native Americans is that wherever they're coming from, especially when they're vulnerable, if they're coming from a place where they have received services for addiction, and they're moving somewhere else, they almost need a plan. They need someone there that's helping them identify where they need to go to be successful, to continue... Because some of them may not have driver's licenses. They may not have GEDs or diplomas. And they need those services that will help them grow so that they eventually can go out on their own" – Chairwoman, Spokane Tribe of Indians

"The money needs to go to help them learn life skills … some of these addictions are third generation…Transitional housing is an immediate need. Those in the first transitional housing and are in recovery get full wrap-around services (e.g., how to cook/clean, pay rent/manage money)… When they are coming out of treatment, incarceration, we built a new facility to help

them learn to become parents again." – Chairwoman, Lummi Grandparents Committee

"The [wraparound services] plan is not a short-term plan. You could say 3 months or even 2 years of support and that may not be so for some people because they haven't gotten their strength yet. So with family and their navigators and their connections, it is a lifetime plan for them and this still may not be enough." – Director of Indian Housing Authority, Spokane Tribe of Indians

4. There's a need for lower barrier or harm reduction housing solutions for homeless people still struggling with substance use disorder to receive support

- The speaker described how restrictive conditions that many houses and recovery programs have made it harder to achieve long-term recovery for those with substance use disorder, and one way to do this is to have lower-barrier housing
- There was discussion on the need to have a balance and it's important to not lose sight of the goal which should be to transition members into home ownership
    - As an example, the Muckleshoot Tribe shared that the results of the "path to ownership" program created $70m in wealth for members since they transition to home ownership
    - However, there need to be steps towards this and we need to think of ways to meet people where they are
- The participants also discussed how addiction treatment programs should be accessible to all individuals in need, regardless of their ability to pay

"There was a program in Canada where people who were still in addiction - and I believe that was for people in alcohol addiction - they would get a certain amount of alcohol a day. But they found that it reduced how much they would drink, but it kept a stable level and they had a place to live, but it wasn't where you had to be perfectly away from addiction. It wasn't like having your apartment type of thing, but I think harm reduction is something that could be looked at as well"– Tribal Member, Squaxin Island Tribe

5. Commerce should consider providing funding directly to Tribes (vs. passing through the county) and increase flexibility to use these funds

- The speaker explained how funds flow from the State to the county, and then they are supposed to go to the Tribes
- The ask from participants was to have the funding go straight to the Tribes and let the Tribes decide how money should be spent to aid their communities
- For example, it could be used to build transitional housing that provides culturally appropriate complementary services which is important in the healing process

"I would agree that the State funds are a little less restrictive than the federal funds, and we would be able to do some different things if we could tap into the more State funds. I know State funds channel through [non-profit] entities and most Tribes are just left with receiving block grants through federal funds. If we could open up more streams of funding from States to the Tribes, we could serve those vulnerable folks"– Okanogan County Community Action

6. Cap the increasing rental rates and increase access to housing vouchers for rental assistance

- In some Tribes, up to ~50% of members live outside of reservations where rental rates have increased significantly and there's a tremendous need to find affordable
- For example, a Tribal representative shared how her daughter pays $2k a month in rent, has car payments, and daycare, and has to live outside the reservation given that the Tribal housing listing is so long and getting in is unlikely
- The ask is to review possible ways to put a cap on these rental rate increases and increase housing vouchers for rental assistance

"As our people move from reservation to reservation or from the reservation to the cities, we need to work together even more than we have in the past because our people are moving all over. And so things like housing vouchers, we need more opportunities to provide housing vouchers for people because we can't go build homes for them where they are." – Chairwoman, Spokane Tribe of Indians

7. Include resources for Tribes to do environmental clean-up and to do home assessments in those where substances have been used

- We heard about two significant costs related keep houses clean/habitable
- There's first an assessment to understand if that house is habitable and second you have to do the clean-ups. This is being seen across the State and it is very costly to the Tribes
- Additionally, RVs are being used as temporary houses that stay in the reservation and to deal with contaminated ones, so it is a significant cost

"After someone moves out to test the home, the cost of that is large. It is important, though, because you could be putting other tenants or other people to move into those homes, and it's not a safe place" – Executive director, the American Indian Health Commission

"The removal of garbage that accumulates around RVs and to get rid of [the RV] when it's not habitable anymore is very, very expensive" - Unidentified summit attendee

8. Improve the Tribal-State partnership by establishing a consultation policy and moving towards government-to-government agreements

- This would include hosting listening sessions with the Tribes and include Tribal engagement guidance and internal education for State personnel
- We also discussed, moving towards a government-to-government agreement in which instead of legal agreements being structured towards county government and/or non-profit - they are focused on the Tribes

"Indian Nation agreements are a contract template that we have with the Tribes that were agreed upon through consultation to make sure that we had all the correct elements... With that, never having to waive Tribal sovereignty or anything like that throughout the contract ... That's one of the areas where I think that we can talk to all of our different sister agencies, to take out the troublesome language that you may have had" – Office of Tribal Affairs Administrator, HCA

Community and Family

The Community and Family session focused on the current negative impacts of the opioid/fentanyl epidemic, the disproportionate data for AI/ANs, statewide education campaign strategies, and "pain points" within the current tribal, state, and federal systems that cause barriers for individuals, families, and communities from seeking services.

The facilitators for the Community and Family breakout session were:

- Vice Chairwoman Loni Greninger, Jamestown S'Klallam Tribe
- Jilma Meneses, Secretary, Department of Social and Health Services
- Cheryl Strange, Secretary, Department of Corrections
- Ross Hunter, Secretary, Department of Children, Youth, & Families

Key takeaways

1. Educating the community about the risks of opioids is crucial in addressing the epidemic

- The group acknowledged the importance of education campaigns targeted to Government Leaders (Tribal, County, City, etc.), individuals who are at risk of an opioid use disorder, and also the community at large (e.g., in the case of inadvertent exposure)
    - One such campaign would be to educate youth on multiple themes, including identifying opioid use disorder, refusing opioid use, and recognizing symptoms of overdose
    - The campaign should be multi-channel across media platforms, including social media, to reach wider audiences who may not be watching traditional news channels
    - The goals are to raise awareness about the dangers of opioids and encourage people to seek help if they or someone they know is struggling with addiction, how to use Narcan, etc.
    - Awareness programs should be directed to both non-Tribal and Tribal populations; the group identified that minorities are often targeted as if they were the only ones with this problem, but opioids/fentanyl is affecting all races, ethnicities, and ages
- WA Secretary of Health stated education initiatives as a transformation effort (with information and resources) to build resilience to public health threats

> "One of the most important things that we can do is educate the community at large about this epidemic and the problems that you and others and I have in our communities as a result of fentanyl and other opioid risks." – Vice Chairwoman, Jamestown S'Klallam Tribe
>
> "We need a massive PR campaign about this, just like the AIDS campaign or give a hoot, don't pollute The just one pill will kill, something catchy, starting in the elementary school, when they're young" – Employee, Department of Health Services
>
> "We also talked about providing education in the schools and more media attention,

showing the impacts of drugs, just like they did with D.A.R.E. with the old campaigns, but really hit those social media platforms because that's what kids are looking at" – Secretary, Department of Social and Health Services

2. Improve communication between State and Tribal entities regarding treatment and support systems

- Establish treatment facilities on reservations and in communities so that people do not have to travel far away for treatment
- The goal is to ensure that there is a continuum of care and support for those struggling with addiction and that medications are available when needed. Currently, fentanyl pills are more accessible and cheaper than seeking treatment services
- The idea is to have open communication between State and Tribe, as well as between local governments, to ensure that everyone is on the same page when it comes to addressing the opioid epidemic
    - Continue to work on increasing the accuracy of data collection (qualitative, too)
- We need to evaluate the networking gaps between State and Tribal systems. We need to transition our people better from State services to Tribal and/or other community services
    - Warm handoffs were also discussed to prevent people from falling through the cracks
    - We need to evaluate where we can, and should, de-silo state and tribal services around OUD
- We need to cross-train state agencies between the tribal, county, and state, remove anti-tribal attitudes, and mandate communication with other local governments

"We could come together and do an inventory of capacity that each State agency has, each Tribe, look for gaps, and help together fill in those gaps" – Secretary, Department of Corrections

"We talked a lot about support for Tribal community resources and as well sort of opportunity to cross-train with State agencies between Tribal staff and agency staff and even local government staff to make sure there's more sort of shared meaning. The idea of warm handoffs so that folks don't fall through the cracks." –Unidentified summit attendee

3. Increase the focus on prevention

- Create low or no-barrier activities for kids and get them involved in healthy activities to prevent them from turning to drugs
    - It shouldn't be necessary for youth to pay hundreds of dollars to get into a sports or interest club
    - As mentioned in a previous section, the Icelandic Prevention Model emphasizes the need to build a healthy environment for youth through community-based efforts

- The group recognized that some issues, such as trauma and homelessness, are beyond one group's scope and require partnerships to address them effectively
- Increase focus on building both staff and service capacity on the state and tribal side for treatment and prevention services

> "Another area of concern is prevention for youth. So, we were talking about ideas on how we create low or no-barrier activities for kids. How do we get them busy with healthy activities? We shouldn't be having our youth pay hundreds of dollars to get into a sports or interest club." –Vice Chairwoman, Jamestown S'Klallam Tribal Council

4. Bring back community-based programs

- Programs need to be designed to be culturally specific and responsive, such as positive-Indian parenting
    - Culture and traditional healing are missing; many of the Tribal communities can relate to traditional healing (they are different across Tribes, but respected across all)
- Community-based programs like D.A.R.E. should be revived and families should be involved in them
- Take approaches to identify the "leaders" within smaller cohorts at the community level; inspire them to do the right thing, and it takes work and funding
    - Aunties can play a role also for outreach, but Tribes might consider expanding engagement with families and expanding the healing beyond just the individual
- Strengthening the family unit is discussed all the time, but want to ensure there are laws (and interpretations) for where children should be part of the purpose and meaning and identify and community; bring children "home"
- Build recovery capacity through developing job skills. We need to get those in recovery housed, employed, and their children back in their homes.
- The transition from DCYF JR or DOC or jails to reentry into tribal communities must be fixed

> "Bring back D.A.R.E. – bring back programs that are community-based and getting families involved. And then we had a pretty serious discussion on the root cause, trauma." – Representative, Washing State Department of Social and Health Services

> "We do not have access to treatment in a way that's effective for the families that we're working with. You heard that this morning. You all know this to be true. We do not have adequate access to substance abuse treatment. This is about one-quarter of all parents and caregivers had an indication of a substance use disorder, but only 39% got any treatment. And for kids where it was so dangerous that we had to remove the child, less than half of the

parents involved with us received any treatment." – Secretary, Department of Children, Youth, and Families

5. Wraparound services are essential for recovery, especially for those in/or leaving correctional institutions or drug treatment programs

- Wraparound services were discussed as critical for people leaving correctional institutions or drug treatment programs
    - A good example is the Jamestown Healing Clinic which provides holistic/integrated care (e.g., OTP, counseling, primary care) and wraparound services like childcare and transportation
- Also recognized that there is not enough support or structure for those addicted and no intervention in correctional facilities
    - The Blake Bill restored the misdemeanor penalty for drug possession and could help steer funding into assessing and treating those with substance use disorder who are arrested
    - Job training/greater access to employment for felons in recovery for drug-related offenses
- Many people who leave these programs are at high risk of relapse, and providing them with support and resources could help prevent this from happening
    - Focusing on jobs, housing, and transportation as barriers to recovery
    - Emphasized that these services should be provided holistically to treat the person's needs comprehensively
- People who are mostly affected by the opioid epidemic are at risk of poverty if they're not already in poverty. Therefore, providing wraparound services can help prevent them from falling into poverty and support their recovery

"When you leave the correctional institutions, or perhaps when you leave a drug treatment program, having a place to go to that has all of the wraparound services that include housing, health, psychological, mental health, that is, as well as physical health and oral health, education, and food security is critical, and housing." – Secretary, Department of Children, Youth and Families

"We have the challenges of trying to find qualified professional staff to come to work for us. Because we're so far away, they got to drive an hour to even come to our community. And then we have the city of Spokane that's an hour away, and we have several of our Tribal members who, when they do become homeless-- I mean, we're seeing homelessness on the reservation right now, which is something we just never thought we'd see. But then they go to the city of Spokane, and then they're on the streets of Spokane." – Tribal member, Spokane Tribe of Indians

6. Reduce the barriers to direct provider licensing requirements by declaring a Public Health Emergency

- A public health emergency can help mobilize resources and funding to address the crisis
- It is important to have a coordinated response across all levels of government
- A public health emergency can help reduce the stigma associated with addiction and encourage individuals to seek treatment
- Licensing requirements were mentioned as a significant barrier to operating an OTP; trying to get licenses sometimes takes years before professionals can operate
- Declare a Public Health Emergency to increase flexibility

> "When that public health emergency was declared, Tribes got a lot of flexibility, and it created a pretty great State Tribal relationship... So we don't want the rules to stop us from operating well. We don't want the rules to stop any OTP clinic, native and non-native, from opening in a timely manner. So for example, trying to get our licenses and such took us an extra year before we could operate. Licensing requirements for clinics need to be lowered"– Vice Chairwoman, Jamestown S'Klallam Tribal Council

7. Lower barriers to OTP intake

- The participants discussed the need to effectively triage "emergency" patients; often the hurdles to medical treatment involve hours upon hours of programs before treatment can continue
- Consider suspending or waiving the rules for Tribes in an OTP (often 4 hours are required under HASHSA/DEA rules and no guarantee of medication/methadone on the same day). Often people leave, don't receive treatment, and won't return
- There was discussion on how the length of time it takes to get treatment is a concern due to a lack of capacity
    - There is a need for services to be available so that people can access them the moment they say "yes" to getting help. They cannot wait hours, days, or weeks for intakes and beds
    - Greater investment in crisis stabilization services, detox, treatment
- Build both staff and building capacity for treatment/prevention services (e.g., incentivize folks to become providers, raise wages, offer debt repayment, Repurpose empty buildings
- Rural isolation best practice could be permanent authorization for telemedicine

> "Our number one concern that took a lot of our time is getting rid of the OTP rules because the rules as they right now cause barriers for getting people into treatment and accessing the medication on a quick time frame. For example, the intake process takes about four hours. Then you don't even know if you're getting medication -that's just the intake"– Vice Chairwoman, Jamestown S'Klallam Tribal Council

Day 2: Working Sessions with Governor Jay Inslee

On the second day of the Summit, Tribal and State officials came together in a roundtable setting to share experiences, learnings, and recommendations from the breakout sessions of (1) Housing and Homelessness, (2) Treatment, Recovery, and Prevention, and (3) Community and Family with Governor Jay Inslee and other state leaders. Each of the sessions' comments were shared by Tribal leader moderators, and other Tribal leaders in attendance followed by comments, thoughts, and lived experiences of their own to reinforce the urgency and need to address the opioids/fentanyl crisis in partnership with the State.

As Tribal leaders engaged in a bi-directional working session with the Governor to discuss tangible actions and solutions, multiple points of alignment were reached including acknowledgment of the Summit being a starting point for directed and targeted partnership efforts between Tribes and the State, actions for follow-up including exploration of cross-licensure and accelerating credentialing of health professionals to meet the demands for treatment, and education campaigns for all ages.

Tribal leaders shared powerful stories, reinforcing the takeaways and priorities developed during Day 1, and personalizing them for the Governor and other state agency partners. All leaders in attendance appreciated the urgency of the situation and the dire need to fundamentally action against the opioids/fentanyl crisis afflicting AI/AN peoples in Washington.

In addition to the main discussions, additional comments were provide provided and can be found in **Appendix C**.

Participants acknowledged that to successfully fight this epidemic the conversation cannot end after the Summit. This collaborative effort is just the first step in a long journey toward addressing the challenges posed by the opioid epidemic and it must continue beyond the lands of the Lummi Nation, into the communities, and be recognized as a leading effort nationally.

During the session, Governor Inslee and other state agency leaders committed to follow-ups regarding the cross-licensure challenge, credentialing, and identifying ways to address workforce issues impacting healthcare, especially behavioral health, and other sectors such as law enforcement. Additionally, Governor Inslee identified key state agency partners including Secretary Shah (Health), Secretary Meneses (Social & Health Services), and Director Birch (Healthcare Authority) and their deputies as key for continuing the foundational efforts set forth during the Summit.

The work done during these two days serves as a foundation for future actions and initiatives. The expectation is that organized Task Forces will drive initiatives and actions to fight the opioid/fentanyl crisis. Areas the Task Force will explore include:

- Assessing the landscape of services and areas of demand to align services across the state and tribal lands to expand access and capacity
- Developing a strategic plan to integrate the opportunities and resources along a timeline to address the crisis
- Explore the lessons learned from community wellness centers such as those from Didgwalich to understand opportunities to bring holistic approaches to other areas of the state and meet the cultural and clinical needs of people in treatment and recovery

- Identify opportunities for combining different funding sources to combat the opioids/fentanyl crisis including settlement dollars and other Federal grants (e.g., CDC, SAMHSA)
- Explore tools, platforms, and policies to address the administrative constraints posed by reporting requirements of the national settlements and other grants mechanisms

The priority areas will be actioned by Task Force leaders, comprised of Tribal and State partners, to more specifically define the opportunities for programmatic, operational, and legislative action at the local, State, Federal, and Tribal levels. The outcomes of the Summit will also serve as a starting point for the National Tribal Opioid Summit in Tulalip in August 2023, and all subsequent forums to continue the partnership between the Tribes and State to address this crisis.

Appendix A: Key priorities identified and related jurisdictions

Justice

Justice priorities	Tribe	Local	State	Federal	Timeline
There is a need for Tribal Warrants reciprocity that is recognized in other jurisdictions throughout the State					
Increase coordination with Tribal Diversion / Wellness Court for diversion with healing focus vs. State diversion process					
Tribal / State partnerships including legislation should be established before being introduced on the floor					
Support is needed in strengthening Tribal Drug Task Force to combat the Cartel(s)					
Setting cameras on transportation routes could help track Missing and Murdered Indigenous Persons (MMIP), victims					
There is a need to increase funding to support traditional judges and their culture and legacy					
Corrections facilities are insufficient for detoxification, and proper detox programs are needed					
It is important to have Tribal representatives on the Jail Standards Task Force					
There is a need to address the legislative veto due to the administrative burden					
Tribal police are trained to the same level as county, city, and State law enforcement but it is underfunded; need better collaboration between Tribal police and other law enforcement agencies					

Legend

Categories: Programmatic (P), Operational (O), Legislative (L)
Timeline: Near-term (ST), Medium-term (MT), Long-term (LT)
Categories and timelines to be identified by post summit workgroups.

Treatment and Recovery

Treatment and Recovery Priorities	Tribe	Local	State	Federal	Timeline
Bring love and community to those in treatment, reducing stigma and increasing support; acknowledge that recovery is lifelong					
Increase access to treatment as the window for engagement is very small					
Reduce the barriers to SUDP licensing / execute initiatives that expand counselor capacity					
Better align/integrate SUD and Behavioral Health efforts including services, enable care coordination					
Execute a campaign for the treatment of fentanyl addiction					
Conduct more research in Indian country to develop evidence-based approaches that meet the individual needs of the Tribes					
Reduce barriers to in-patient treatment (expand capacity and access)					
Build capacity including for detox, with considerations for extending/adjusting time limits for multiple aspects of the user experience to increase the success of treatment					
Transition to another opioid, extend timing for withdrawal management					
Explore providing other services to support treatment participation for women and families					
Transportation, childcare, food, housing					
Assess the preparedness of facilities to meet demand, confirm alignment of services across the State, identify gaps and areas of excess/misaligned service capacity					
Include an analysis of payer coverage for accessing treatment; expand Medicaid-eligible facilities					
Invest in recovery cafes as places of connection and community					

Legend

Categories: Programmatic (P), Operational (O), Legislative (L)

Timeline: Near-term (NT), Medium-term (MT), Long-term (LT)

Prevention

Prevention priorities	Tribe	Local	State	Federal	Timeline
Change prescription limits through policy adjustment					
Raise awareness of opioid abuse among dentists and surgeons, particularly for prescribing to youth					
Address the SDOH that impacts Tribal communities					
-Housing & homelessness					
-Food security					
-Children in poverty					
Expand youth prevention and substance use awareness, particularly for adolescents					
Declare the fentanyl crisis a PHE					

Legend

Categories: Programmatic (P), Operational (O), Legislative (L)

Timeline: Near-term (NT), Medium-term (MT), Long-term (LT)

Housing and Homelessness

Housing and Homelessness priorities	Tribe	Local	State	Federal	Timeline
There is a lack of affordable and accessible housing					
Improve the transition from formal treatment into housing with support such as medically assisted treatment (MAT)					
Wraparound services are an essential component of addressing the opioid epidemic's impact on housing and homelessness					
There's a need for lower barrier or harm reduction housing solutions for homeless people still struggling with substance use disorder to receive support					
Commerce should consider providing funding directly to tribes (vs. passing through the county) and increase flexibility to use these funds					
Cap the increasing rental rates and increase access to housing vouchers for rental assistance					
Include resources for tribes to do environmental clean-up and do home assessments in those where substances have been used					
Improve the Tribal-State partnership by establishing a consultation policy and moving towards government-to-government agreements					

Legend

Categories: Programmatic (P), Operational (O), Legislative (L)

Timeline: Near-term (NT), Medium-term (MT), Long-term (LT)

Community and Family

Community and Family Priorities	Tribe	Local	State	Federal	Timeline
Educating the community about the risks of opioids is crucial in addressing the epidemic					
Improve communication between State and Tribal entities regarding treatment and support systems					
Increased focus on prevention)					
Bring back community-based programs					
Wraparound services are essential for recovery, especially for those in/or leaving correctional institutions or drug treatment programs					
Reduce the barriers to direct provider licensing requirements					
Lower barriers to intake					
Lower barriers to healthy activities for youth and families					
Recognition of traditional practices as prevention services, and insurances allowing payment for services					

Legend

Categories: Programmatic (P), Operational (O), Legislative (L)

Timeline: Near-term (NT), Medium-term (MT), Long-term (LT)

Appendix B: Insights from the Icelandic Prevention Model

In May 2023, Tribal leaders visited Iceland and had the opportunity to learn more about the Icelandic Prevention model with the aim to obtain best practices that could be leveraged in the community to address and prevent opioid use disorder.

- Many values within Icelandic programming can be traced and/or translated from ancestral tribal values. The model was a confirmation that tribal values create successful and healthy communities
- The Icelandic Prevention Model is a comprehensive approach to preventing substance use among adolescents that was developed in Iceland in the 1990s
- The model is based on the idea that substance use is primarily a social and environmental problem, rather than an individual problem, and focuses on creating healthy environments for young people
- The focus of this prevention model is on impacting important risk and protective factors that influence youth health including peer group, family factors, school wellbeing, extracurricular activities, and sports.
- It involves a range of interventions across different domains of youth life, including family, school, peer group, and leisure time
- It also emphasizes the importance of community involvement and collaboration between different parties in implementing prevention strategies
- The Icelandic Prevention Model has been successful in reducing substance use among Icelandic youth and has been adapted for use in other countries through the Planet Youth approach
- The model is based on three pillars of success: evidence-based practice, community-based approach, and creating and maintaining a dialogue among research, policy, and practice

Planet Youth Community

- The Planet Youth Community approach is based on the Icelandic Prevention Model and focuses on four domains of youth life: family, peer group, school, and leisure time
- It was designed to support community-based efforts to reduce substance use and improve the health and well-being of young people by reducing the risk and protective factors that influence youth's health. The model has been shown to have significant positive effects on youth health.
- The program has been implemented in hundreds of communities around the world and has found that risk and protective factors of young people are largely the same across different locations
- The model is based on four principles: Society is the patient, Meaningful connection is a treatment, Sustained attention as a treatment, and Community-Specific and Institution-level Capacity

Appendix C: Additional Statements (as submitted)

1. **Vicki Lowe - Executive Director at American Indian Health Commission of Washington State**

Summit Final Report Page 14 – "The question about getting warrants and tribal agencies having trouble getting warrants is interesting to me. The statute that allows local agencies to get information through search warrants from large companies like Google or Facebook or something else is a federal statute. And that means that if there are problems for the tribes getting this kind of information, it would be a federal fix. It would need to be some legislation through the federal government. "– Prosecutor, Whatcom County

> I am concerned about the accuracy of this statement, the kick the can down the road attitude and that it is trauma triggering. Tribal members and Tribal community members are also Washingtonians. Dealers and fentanyl are not being air dropped onto reservations. This is a Washington State issue and needs to be addressed in a sovereign to sovereign manner between the state and the federally recognized Tribes in the state. This is not my area of expertise but from my attendance in the law and justice subcommittee of the MMIWP- I believe there are things that can be done at the state level. Law enforcement uses a guidance document from 2008 on jurisdiction on Tribal land. This document needs to be updated and Tribal Governments need to be included in the effort to update the document. The same can be said about the language in the MOU between WASPC and Tribal governments. The requirements are burdensome, and the document asks Tribes to compromise their federal trust responsibility by waiving sovereign immunity. It is abusive to ask vulnerable people to give up their protection in order to work together. I think it should be removed.

2. **Suquamish Tribe Wellness Center**

These comments stem from my experience in Tribal behavioral health and/or arose from discussions in the summit itself. I am very grateful to all involved and their interest in the experiences of Tribal communities.

1 – Ricky's Law. My experience has been that during the time that an individual would meet criteria for imminent danger/risk due to SUD, they are in the treatment of medical staff (usually post-overdose). By the time they can be seen by a DCR for ITA evaluation, they have stabilized and are no longer considered appropriate for involuntary care. ASK: Administrative, amend interpretation of imminent risk to "have exhibited such risk to self/others and/or grave disability in past 12 hours."

2 – 42 CFR Part II. Was amended to align with HIPAA for sharing information with other healthcare providers for the coordination of care in the 2021 CARES Act. [The] understanding is that it is still w/ DHHS, and that new guidance should be available "soon". Will allow sharing of SUD info for care coordination w/out Release of Information. ASK: State agencies providing behavioral health oversight proceed immediately with the new definition of 42 CFR (has been law since 2021), allowing SUD providers to be a part of the larger healthcare provider community and reduce barriers to care.

3 – Workforce Credentialing. $550 for initial SUDP application, several hundred dollars for annual renewal. This is much higher than other health professions. My understanding is that this is due to the higher cost of processing applications in our field. This is understandable, but is there any requirement that this be

revenue neutral? ASK: Given the emergent need for workers in the field, the State should be prepared to subsidize the costs of certification to reduce barriers to working.

4 – Workforce Credentialing. I have multiple colleagues who are credentialed in other States and have faced significant barriers in transferring their credentials to Washington. In these cases the standards in the State where they were licensed generally exceeded the requirements in Washington, but did not align in some of the details. Because of these minutiae well-qualified counselors have faced excessive wait times to achieve licensure in Washington. ASK: Streamline licensing processes & expand interState licensing agreements with States offering comparable levels of care to our own (Washington seems to rank in the bottom half of States by most measures, so it is difficult to argue that current standards are associated with better outcomes).

5 – Workforce Credentialing. Related to the previous item, Federal Law allows for out-of-State licensed providers to practice in Tribal programs. This was raised at the summit – 25 USC Ch 18 Subch. II Sec 1621t – Licensing: "Licensed health professionals employed by a Tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the Tribal health program performs the services described in the contract." ASK: Please offer clarification from the State as to how this relates to behavioral health providers, and [ensure] that all systems are in place for out-of-State licensed practitioners to be able to bill Medicaid in Washington State.

3. Colville Business Council

There is a need for a Tribal Youth and Adult Detox Center that is Tribally Operated with Cultural and Traditional practices. Also there is no Tribal Youth Treatment for Higher Risk Patients that uses Traditional and Cultural Practices! Tribes need Transitional Housing for Recovering Patients of Youth and Adults. There needs to be Prevention training all through K-12 and Parenting Training on Prevention. We need Prevention TV broadcasts that show all Races of Ethnicity on the Damages caused by Drug Use! Drug Dealers need to be treated like a person who murdered someone. They are Killing our People and get a slap on the hands. The State and the Counties need to Contract their share of Law Enforcement funding. We have Towns within the Boundaries of our Reservation that do not have funding to provide Law Enforcement. It is kind of like our School Districts. School Districts on or near Reservations receive Impact Aid to help offset Tax revenue. [Somehow] the State needs to make sure all the Citizens of the State have adequate Safety on Reservation Lands. We need help to fully Cover Law Enforcement as Tribes Law Enforcement is paid for by the Bureau of Indian Affairs at about 1/3 of the need. Their Budget is discretionary which is likely to be held to a possible 1% increase. Tribes can not keep Law Enforcement Officers at this rate.

4. Lummi Nation

Please find below additional comments from the Lummi Nation following the Washington State Tribal Opioid / Fentanyl Summit, held at the Lummi Nation on May 22nd – 23rd 2023. We have itemized these according to feedback from our Tribal leaders, approved attending health care and other Lummi Nation staff present to witness the event.

Recommendations:

A. Individuals who are incarcerated and have OUD

1. Require prisons and jails in Washington State to treat opioid use disorder (OUD) throughout the entire incarceration period and mobilize any available State resources to support this goal (including but not limited to the Reentry Section 1115 Demonstration Opportunity discussed at the Summit). Currently, people who are incarcerated are not consistently offered the medications needed to treat opioid use disorder. This practice is not consistent with what we know about opioid use disorder, especially when fentanyl is involved, which is a chronic disease that often requires long term treatment with medication. As a result of current practices, people who are incarcerated experience craving for opioids even after the withdrawal period ends, and they are at high risk for relapse and fatal overdose once they are released from prison/jail and have access to opioids. Internal data from the Lummi Tribal Health Clinic suggests that approximately 45% of overdose deaths in Tribal members occurred within 90 days of their release from prison.

2. Ideally, people who are incarcerated would be given the option to receive daily buprenorphine (suboxone or Subutex) OR to receive long-acting injectable buprenorphine (Sublocade) which is given once a month. Sublocade could be especially helpful to people if they received it immediately prior to being released from prison/jail. Another important step would be to confirm that people have a follow up appointment with their primary care clinic or other nearby buprenorphine provider to assure continuity of care after the person leaves prison/jail. We understand Dr. Fotinos and her team are working on expanding treatment to MOUD in prisons and jails, however we would ask if the State had the power; to require jails and prisons to provide this care.

3. There are trusted and leading medical journal editorials that [show] how MOUD in prisons decreased fatal overdoses of people who were incarcerated. We ask the State to conduct its own research and data analysis to justify MOUD in prisons. Additionally, the period after discharge from the hospital is also risky for people with OUD, and Medicaid coverage for Sublocade prior to hospital discharge would be another valuable intervention.

B. Inpatient, outpatient, and SWMS and data services

4. We ask the State to create a real-time dashboard of available beds/openings at inpatient and outpatient treatment programs for opioid use disorder and a coordination center to facilitate rapid placement of patients seeking treatment. A similar system was developed in Washington State to identify hospital beds that were available for patients with COVID, and it was highly successful. Given insurance barriers, it would be helpful to designate which programs in this system accept Medicaid/Apple Health.

5. Create State Dept. of Health guidelines for the treatment of opioid use disorder that acknowledge that fentanyl use often requires higher doses of medication (methadone and buprenorphine) than we are familiar with using for the treatment of OUD due to heroin and provide clear guidelines for prescribers of these medications so that they can safely and effectively treat OUD related to fentanyl. With the removal of the requirement for an X-waiver, many physicians will be newly prescribing buprenorphine

and having clear guidelines will benefit everyone.

6. Create a public health communications campaign educating the public that OUD is a chronic disease that is treatable with medication and explain how to access that treatment.

7. Give Tribal governments and their associated public health departments/health officers access to the same data that are accessed by county public health departments (LHJs) related to opioid use disorder and overdoses (and other public health threats). The NPAIHB Epi Center is helping our public health team access these data, but the process could be simplified.

8. SWMS (Secure Withdrawal Management and Stabilization) facility – Lummi Nation is much closer to its goal of having the necessary funding ($27 million) to build an urgently needed SWMS that would be readily and timely accessible by Tribal members. Most importantly, the facility will be designed to support and promote culturally attuned care essential for recovery needs. We still require approximately $11 million dollars.

C. Sovereignty Issues

9. We do not want to have to apply for and access social and health grants which are competitive to Tribes
and overly administrative, burdensome or are not attuned to our Tribal Sovereignty. Rather we would request monies from the State to Tribes have no burdensome reporting requirements attached to them so
that we can free up more time to work on specific activities to tackle the social and health related issues that can contribute to substance use. Through exercising our Sovereignty, we self-determine how best to use funds and not be limited by regulations or reporting requirements.

10. We are faced with critical shortages of providers and general health and social service workers. (Doctors, mid-levels, RNs, MH and SUDP counselors, and social workers, billing staff, health managers, health researchers, care coordinators and home care providers). National surveys show high rates of burnout after Covid or retirement age. We need a better bridge and education programs from high school to college and practical / assessment work-based learning opportunities to help fill the gaps.

11. We ask the Governor to use his unique powers to implement new rules and regulations on an emergency basis to address culturally attuned care and workforce shortages in our Tribal communities.

12. In alignment with our Sovereignty goals, the Lummi Nation would want to see opportunities developed for a Tribal specific practitioner's license* for either Master's or Bachelor's level graduates who seek work in Tribal behavioral health, substance use, youth, or housing programs. These individuals who hold Human Services, Social Work or Psychology Degrees should be able to practice in Tribal communities without having to go through the process of further examination and licensure. These individuals have been through college and been awarded a degree - proving they are competent in their field of learning. For the Tribal specific licensure, an individual could be employed and over the course of for example 90 days, complete any additional observed practice in real-time, whilst being supervised by a

primary licensed clinician or practice supervisor. The new hire would build upon any additional culturally attuned skills development needed for their position especially to cover

- Culturally competent practice specific to Tribe and customs
- Enhanced assessment, care planning and level of care determination
- Tribal Crisis Intervention
- Basic counseling modalities and applications within a Tribal context and setting
- *(additional time required) Advanced counseling modalities and applications within a Tribal context and setting

13. Allow for BILLING of these providers at the OMB rate - under a Tribal Nation Specific Practice License * from the get-go - this will help Tribes afford to increase capacity of their workforce quickly, teach and train providers in line with the cultural context of their community of employment, and will help Tribes pay for urgently needed providers from reimbursements. This will also help stabilize critical workforce shortages and help Tribes grow their own practitioners for behavioral health services.

14. We recommend increasing opportunities and variations for diverse types of housing, especially those that provide Habilitation Services, Transitional housing, Housing First, Oxford, Clean and sober living, and RS models (Relapse sensitive) to prevent ongoing harmful cycles of housing, evictions, and homelessness.

15. We want to see more investments into prevention funds to support both cultural activities and extracurricular activities to include sports, arts, STEM programs or any activities that a child would be interested in pursuing Statewide as a preventative against drug use and harm.

16. We recommend yearly or bi-annual educational summits and collaborations to learn about all resources available for mental health and substance use treatment for Tribal communities in Washington.

17. We recommend changing requirements so that recovered community members can have a better opportunity to find and keep employment - Expunge charges when possible (certain jobs have lived experience as a requirement, but criminal record affects getting licensure or makes more difficult as we heard testimony at the summit).

18. We would like to see a similar process set up to address fentanyl as was followed with Covid. We would like officials to get daily updates on OD's - fatal and non-fatal - and help aggregate data to identify targeted and real-time responses to critical incident areas (homeless camps - communities - rural and urban hotspots) in order to get public health and workers where they are urgently needed most.

19. We also recommend specific help to pregnant mothers and babies born affected – especially wrap-around care and to plan, design and provide targeted help and support to them. We need real time monitoring to get a better understanding of what's happening and what sorts of interventions we should target and what would be the most effective for our pregnant mothers and newborns.

20. We want to see assistance to police departments where there are shortages or limitations of police presence to ensure community safety in areas of concern - including outreach at the street level to homeless - vulnerable youth, women, and persons, and who would be able to provide brief interventions to help promote prevention and safety - facilitate transportation to treatment and SWMS or crisis centers. We are concerned about rising crime reports and the exploitation of vulnerable individuals who are

homeless.

Conclusion:

Thank you for receiving our additional comments. We look forward to receiving a copy of the final Summit Report on June 6th in respect of all recommendations provided by participants and attendees. Please contact us if you require additional information on the contents of this letter.

Additional comments from Lummi nation:

We need to educate family members, frontline workers, and Directors.

5. Chief Seattle Club

Treatment, Recovery, and Prevention

- Bring back ADATSA or similar type program that allows for quick referral to detox/treatment
- Increase funding and support for Tribal treatment/detox
- Increase funding and access to build sober living transitional house in urban centers
- More culturally grounded and responsive mental health / SUD
- Fewer barriers around intake eligibility for care - stop incentivizing the use of non-culturally responsive assessment tools to determine eligibility for care
- Create more [opportunities] for community based-supportive services to help maintain recovery or shorten relapse periods
- Understand and incorporate historical/intergenerational trauma and related mental health in funding plans for treatment (i.e., don't expect decades of harm and the symptoms that follow to be undone and healed in 30-90 days
- Long-term treatment with co-occurring diagnosis as well as cultural, physical, and spiritual care is most beneficial to Native people
- In urban centers, the majority of Native people are enrolled in out of State Tribes which means lower coverage by in-State IHS clinics and higher reliance on Medicaid
- Medicaid providers and funded services should be more culturally responsive and clear for Native people to navigate
- Certification or some other process that allows for traditional and spiritual care/support as supplement to treatment and recovery programs
- Prioritize voices - wisdom of Tribal elders - leaders in designing funding eligibility, certification processes, and allocation of funds for treatment and recovery programming or facilities
- Fund more day centers and community gathering places in urban centers for Native people to create the connection, community support, and position associated with Native identity to prevent cycles of addiction and homelessness
- Make opioid settlement dollars available to urban Native organizations who work in addiction, mental health, and homelessness (especially chronic homelessness)
- Treat the opioid/fentanyl crisis like a crisis, just like the pandemic or Hurricane Katrina

Housing and Homelessness

- Approximately 16% of unsheltered homeless in Seattle /King County are AI /AN

- Urban nature organizations are unable to access money for housing and services that are earmarked for Tribes, yet we serve Tribal people in culturally specific programs.
- Need more funds and advocacy for shelters / tiny homes/wages, transitional housing, permanent housing, high acuity facilities (mental health / SUD) & workforce housing.
- Fund organizations to bring services to the people, not the people to the services
- More money for family housing in cities in addition to single adult homeless community members
- More investment in culturally specific services across the board -> detox, treatment, sober transitional housing, etc., and including traditional/spiritual ways as treatment
- More funding for services within shelters, transitional housing & permanent supportive housing so that we can keep our people housed rather than in the revolving door of chronic homelessness
- More support/resources for opioid prevention (e.g., Narcan, culturally specific / based SUD support) within PSH sites

6. Spokane Tribal Business Council

I have a comment and a question. On State Housing Boards/committees/groups, what efforts were made to obtain Eastside Tribe's participation? Is it possible to still get some of the Eastside Tribes on some of the Committees/groups?

6. Lummi Health & Family Services Commission

I'm very glad this event took place at Lummi last week. I attended as a Lummi Elder, age 87, and a member of Lummi Health & Family Services Commission. I appreciate the many Washington Services Agencies that participated.

My main concern is connecting with our community people by providing them with good information, education on the dangerous Fentanyl crisis, and available resources. Most program services seem to leave this part out. We learned how effective culturally sensitive information is for both our Lummi People and non-Indian People when offering Services such as Medicaid Insurance.

Our outreach advocates were called "assisters" and were taught about Lummi Sovereignty and history. Their ability to talk with and listen to our Tribal Members was greatly increased. Building mutual trust and respect is key to succeeding. Our "grassroots" People working on the frontline [ensure] successful results.

We need facts from people we can trust. It was very wise to offer facts to Tribal Leaders who are basically inexperienced at dealing with the effects of Covid and Fentanyl at the same time. Our leaders need a quick course about facing the crisis and the solutions.

7. Jamestown S'Klallam Tribe & Family Services Commission

Recommendations to Improve Opiate Treatment Program (OTP) Service Delivery in the Era of Fentanyl

- Make OTP enrollment and engagement easier for the patient and the clinic

- Intakes take several hours; there are numerous state and federal guidelines that must be followed, but these are steeped in 30+ years of stigmatized beliefs and rather than unraveling these guidelines and starting fresh, more layers of regulation, addendums, etc get put on top and this leads to confusion and fear from patients and OTPs of being out of compliance.
- The extensive intake process leaves patients feeling vulnerable and exposed due to the nature of the questions that must be asked per the American Society of Addiction Medicine assessment standards.
- We would propose allowing up to 90 days for the ASAM assessment to be completed. The first few weeks at an OTP should be focused on medical stabilization and giving people hope that recovery is possible.
- We would like to see WA State put pressure on SAMHSA and the DEA to simplify the guidelines in order to allow for more autonomy of the tribes and OTPs to provide individualized care
- We also suggest that SAMHSA and the DEA publish joint OTP guidelines rather than their own separate guidelines (currently OTPs must follow both sets of guidelines, along with all Federal and WA State level laws, rules, and regulations)

- Simplify the process to open an OTP
  - It takes 12-18 months to open an OTP due to the number of inspections, reviews, policies, procedures, etc that must be in place first
  - Streamline the OTP opening process on the state level
  - Jamestown can offer detailed plan on how this could be done
  - This would save OTPs and WA State a significant amount of money that could instead be used to fight the fentanyl crisis
  - Tribes are paying large amounts of money to consultants to help them figure out the tedious and often contradictory guidelines, which makes opening an OTP even more costly
  - The solution that has been offered by WA State and SAMHSA before is for the possible creation of a navigator program to help clinics open, we feel this would add a level of complexity to an already onerous process. Instead, just make the process simpler

- Allow tribes to pick their own medical director based on who they think will best serve their patients
  - Per SAMHSA criteria, only MDs or DOs (ie, physicians) can be OTP medical directors, but there are numerous medically trained ARNPs or PA-Cs working for tribes who have the experience and knowledge to serve in this role
  - By limiting the credentials of who can be an OTP medical director, tribes are paying exorbitant salaries to people who may not be the best fit for the tribe's needs, just to satisfy these regulations
  - WA State should work with SAMHSA/SOTA to give WA State tribes a blanket exception to this rule; tribes should be able to pick who they feel is best to care for their people

8. <u>Community and Family Breakout Materials</u>

Major Themes for Focus Area 1: Identify tribal/IHCP areas of concern and change that can happen with current authority in our Governor's Cabinet system

- We need to reduce the amount of time it takes to get medication into people's hands. Need to evaluate the rules around the intake process. What can we shorten?
- Education for our youth and greater communities is imperative
    - Chair Evans: Tribal Leaders need education on fentanyl.
    - Youth/communities need to know how to identify opioids/fentanyl, the confidence to saying no, the symptoms of when someone has overdosed, and what to do next.
    - Bring back DARE (or similar) models to schools.
    - The education campaign should be like what we did for COVID-19 (hourly/daily
- information).
    - "Just Say No" isn't enough of a solution.
    - Address roots of fear/anxiety (aka "NIMBY") in the community for MH and SUD.
    - Overall, we need a huge education/PR campaign.
- We need to evaluate the networking gaps between state and tribal systems. We need to transition our people better from state services to tribal and/or other community services.
- We need to evaluate where we can, and should, de-silo state and tribal services around OUD.
- Continue to work on increasing the accuracy of data collection (qualitative, too!).
- Get Tribes and Secretaries together to assess roadblocks and find out who can fix them.
- We need to DO ACTION, stop just talking about it!!

Major Themes for Focus Area 2: Begin to formulate what a tribal-state partnership to combat the opioid/fentanyl crisis looks like

- Declare a public health emergency. Build on the success we had when we declared an emergency for the COVID-19 pandemic. Flexibility saved lives!
- Permanent authorization of telemedicine.
- Build both staff and building capacity for treatment/prevention services.
    - Tribes can pool certain funding sources together to build infrastructure.
    - Incentivize folks to become providers—let's get creative!
    - Raise wages. Offer debt repayment.
    - Repurpose empty buildings.
- Build recovery capacity through job skills. We need to get those in recovery housed, employed, and their children back in their homes. The transition from DCYF JR or DOC or jails to reentry into tribal communities must be fixed.
    - Could the state provide resources to tribes to build more housing for everyone, native and non-native?
- Build capacity for law enforcement for state, county, local, and tribal.
- Remove collaboration and communication barriers. What portions of 42 CFR cause barriers?
- Create more opportunities to come back together; keep your foot on the gas pedal! We must keep this ongoing!
    - Start thinking about parties we need to include, i.e., Office of Insurance Commissioner.
- We need to educate the community on the signs of OUD, overdose, how to use Narcan, etc.

Major Themes for Focus Area 3: Identify areas where legislative intervention is needed (because it falls outside of the purview of Gov and Secretaries)

- Create interstate compacts for treatment services available outside of the state.
- Reduce barriers in direct provider licensure.
- Assess which laws need to be strengthened or loosened depending on the barriers caused.
- Recognize that tribal cultural traditions bring about healing. Tribes need recognition and funds; the evaluation process to become an EBP is a barrier.
- Set the expectation that providers must treat the person holistically, and be trauma-informed.
- Greater investment in crisis stabilization services, outreach, detox, and treatment. We need services that people can access the moment they say "yes" to geţng help. We cannot wait hours, days, or weeks for intakes and beds.

Notes from Tribal Leaders during Community-Family Breakout Report Out

- Squaxin: State Leadership and staff are actively working with tribes for solutions. Thank you!!
- Tulalip: We need funding for outreach care teams. We need to make treatment easier to access than fentanyl pills. We also need more investment crisis stabilization centers. We use 988 and advertise it! We have Drug Court at Tulalip which gives a different path from the traditional Western court. It has helped make a difference in people's lives! Cash is a trigger for addiction and tribes publish when per caps are coming out and it attracts drug dealers to our reservations.
- Upper Skagit: Traditional healing is missing from the information we are promoƟng. We all have our spirituality and traditions. The importance of spirituality can be the first step toward a person's healing journey!
- Yakama: We need more investment in outreach/treatment/support groups for families. Awareness is good, but also share our knowledge about fentanyl and how powerful it is. "Just Say No" is not going to cut it. We need to get people through the whole treatment and help them stick with it.
- Nooksack: I see your group came up with a list of solutions. We struggle to find answers internally in our Tribe; I want to hear what others are doing. We need to make it more well-known for community members to become certified to become helpers for their families. We need to identify the safe people within our communities who people can call and just talk or pray with together. We need an "Auntie Hotline"! I remember attending girl's/women's conferences as a girl. We learned our traditional medicines, stories, how to act during ceremonies, etc. There were boys'/men's conferences, too. We should bring those back! Concern: At what age do we start talking to our children about this? That is sad! It does need to be at a young age, unfortunately.
- Lummi: We need to strengthen the family unit, which includes placing children in Lummi homes. We have children who have been placed on reservation and they are disconnected from us. We need to increase our recognition of those in recovery ("Silver Dances"); it was a celebration of sobriety. How young do we teach our youth? We are trying to put counselors back in our schools. We need to teach our people how to deal with anxiety healthily! Everything comes down to funding; it's always the first question. Some of the barriers we see are a lack of detox, loss of opportunities because it takes too long to get beds, lack of funding, and no home solutions for more aftercare (like low-barrier housing), when leaving incarceration we need better transition of the individual, communicate the available beds more readily!
- Chehalis: We need to get together more than once or twice a year; more like once a month!

- Muckleshoot: We must address the historical trauma that is recent, just one generation ago. And these traumas also greatly affect social determinants of health. It was a Western policy that got us here. We also need to acknowledge that addiction is a family/community issue, not an individual issue because it affects everyone.

Community and Family Materials as provided by Vice Chairwoman Loni Greninger.

Community-Family Breakout Synthesis Greninger Cawston

Community-Family Breakout_Major Themes Greninger Cawston

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UPDATED_WA Opioid Fentanyl Summit 2023_Family Community Breakout_Tribal Prgms Sheet

Fentanyl Summit Presentation 2023

Recommendations to Simplify OTP Processes

Community-Family Breakout_Major Themes w/ Tribal Leader Notes