Standing Advisory Committee

Opioid-Associated Prevention and Outreach Programs

December 4, 2020

10:00 AM – 12:00 PM

I. Welcome – Erin Russell, Center Chief
Standing Advisory Committee Roll Call

In attendance:

- Dr. Gregory Branch
- Dr. Gregory Burnett
- Katie Carroll
- Dr. Deanna Dunn
- Dr. Sarah Kattakuzhy
- Samantha Kerr
- Heather Kirby
- Zachary Kosinski
- Joshua McCauley
- Terry Prochnow
- Dr. Susan Sherman
- Harriet Smith

Introduction of Dr. Sohail Qarni and Dr. Peter DeMartino

Dr. Sohail M. Qarni, Medical Director of Prevention and Health Promotion Administration

I was present for the inception of the needle exchange in San Francisco in 1988 because of HIV among injection drug users. Thirty-two years later, the program has not changed in terms of what it is meant to do and hoped to do. It has expanded from preventing morbidity and mortality from injection drug use, and has incorporated STIs, Hepatitis A, B, C, linkage to care, vaccination, etc. Has moved a long way, but still true to mission. Public Health in my definition is anything we can do today that can protect a human life tomorrow. Going back to vaccination and linkage to care and treatment, putting out the idea to think about providing COVID testing, screening, and vaccine when it's appropriate to deliver to these individuals we serve under SSP.

Dr. Peter DeMartino, Director of Bureau of Infectious Disease Prevention and Health Services.

Hello and thank you for the opportunity to address the group. As we are thinking about closing another calendar year and planning for 2021, I wanted to share that we are at the end of our 5-year HIV integrated plan. Next year we will move into developing the next 5-year plan for 2022-2027. Wanted to address this group and say how critical a role this group will provide in that process. There is a key movement happening now as we address federal ending the HIV epidemic plan. For people living with HIV, the epidemic does not end for them. Thinking about what service delivery model looks like in a zero-transmission environment. Thinking about how SSPs integrate COVID services, we know the programs are a critical link to the population we have to work with if we are going to get zero transmission. As we think about the pandemic, I hope you all answer our call to help us take

best practices (which SSPs are) and help us replicate those programs. We know when a Marylander shows up to a service provider, the issue foremost in their mind is not singular, and we must address all their needs when we have them in front of us.

Meeting Agenda and Introduction of New Syringe Service Programs

Erin Russell, Chief of the Center for Harm Reduction Services

Dr. Chan could not be here with us today as she is leading efforts around COVID. The agenda today is a culmination of important topics this calendar year. First is engagement with law enforcement; that has been an ongoing challenge in some counties. We are looking at the resources we have available to support the SSPs in achieving effective partnerships with law enforcement. We have a panel to talk about LEAD and the harm reduction approach in Maryland. We will talk about how that's taking shape, status, and how SSPs are working with LEAD programs. We will talk again about COVID. We have a guidance document to review and an amazing video to show a clip of, a video of how programs are continuing services while wearing PPE and social distancing to show how guidelines are being put into practice.

Welcome Three New Syringe Service Programs: Calvert County Health Department, Health Care for the Homeless, and SPARC Women's Center

Anita Ray, Program Development Specialist (Calvert County Health Department)

We are utilizing partners in existing SSPs which have provided a lot of support. We have adopted Mark from Family & Medical Counseling Services, as a mentor since he is close to Calvert County. We are connecting with people doing outreach to begin a program that is entirely outreach. The Department of Behavioral Health System does outreach as well to, so we are connecting with them as well.

Andrea Shearer, Health Care for the Homeless

We will have a soft launch in January. We have policies and procedures in place, everyone is very excited. We work to prevent and end homelessness. Syringe services will be built in client-based services/setting. People can schedule with providers or walk-in and get safer use supplies. Staff are currently undergoing training.

Katie Evans, Outreach Coordinator at SPARC

Primary function prior to COVID was a drop-in center for people who identify as non-male; healthcare services, legal services, case management, etc, as well as supplemental outreach programs at night. Since COVID, we have a transformed the model significantly to become a delivery-based harm reduction model. Deliveries to 85 households. Have support of Baltimore City and relationship with BHRC. Initially offered services at the center, with BHRC staff on site. Now it looks very different, grown and changed a lot with COVID. Working out supply chain pieces, etc. to provide services in a consistent way and maintain relationships. Expanding health care services to make them as deliverable as possible, emphasizing meeting people where they're at. Offering testing and wound care through a nurse who works for city health department.

Erin Russell, CHRS

Theme through COVID has been partnership. Shoutout to BHRC who has been supporting other organizations to get SSPs started. Expanding the reach of this throughout the city and beyond. Shoutout to Charm City Care Connection as well who is identifying satellite sites.

Candy Kerr, BHRC

How many programs are in the works?

Erin Russell, CHRS

When a program applies to Maryland Department of Health, we receive it at CHRS and it goes to subcommittee of the advisory committee to review. We have charts and forms to cover and facilitate the review. If nonprofit, will go also to the health department in which jurisdiction the organization is seeking approval to operate. Then comes back to the department and we work with the program on any revisions—all has to happen within 60 days. We have one active application we received last week.

Tonya Green-Pyles, Baltimore County Health Department

Did SPARC launch services yet?

Katie Evans, SPARC

There has been a seamless transition from providing services in partnership with BHRC. When we had a physical space, BHRC could come and support clients directly. Since then, we are collaborating with BHRC and CCCC and navigating the pandemic. There has not been a gap in services, there isn't a new launch date. It is just a new participant ID card and new responsibilities for some of our staff and refreshing trainings. Service delivery itself looks the same for clients, most probably do not know about the transition behind the scenes.

II. Law Enforcement Engagement
LEAD Panel: Daniel Atzmon, Jessica Nesbitt, David Washington

Daniel Atzmon

Update about expansion of LEAD; great partnership with CHRS to help us grow police led diversion programs like LEAD. We have seen a lot of growth over the past year. In late 2019, our office was awarded COPE grant, which was renamed to COSAP in 2020. This year was the first year of the grant. Despite the pandemic and associated delays, local sites have been doing good work. There are four operating programs, the city is the most longstanding; Washington county was second. Over the summer, Westminster and Bel Air launched their programs. Harford County, City of Annapolis are making progress, Wicomico and Worcester and St. Mary's are doing well. Testament to the hard work on the ground, partnerships between law enforcement and public health. CHRS's Jess and Marie have developed an incredible curriculum for police training.

Jessica Nesbitt, CHRS

Provider partnership specialist at CHRS. Marie, Daniel, and I provide this training and technical assistance to partners across the state. Recommended training plan separated in three types: critical background information, interactive and virtual implementation training, and ongoing support and continuing education we provide. Critical background focuses on foundational public health and

behavioral health concepts to understand complexity of overdose crisis, address common misunderstandings related to drug use and provide overview of LEAD. LEAD supports people who use drugs rather than punishing them, it is a lot of work to unlearn negative things society teaches us. That is the Regrounding our Response portion. Then a two-hour training from the LEAD National Support Agency. That webinar reviews key roles and responsibilities and logistical information. Looks at stakeholder engagement, collaboration, and harm reduction principles. Implementation training is new to get people ready to launch and put skills into practice. In the third session, we will come together to talk about partnership, teamwork, community, and collaboration.

David Washington, Washington County Health Department

LEAD and SSP connect, with our correctional LEAD partnership, case management, and harm reduction program. Officers can let anyone they encounter know about the harm reduction program and syringe services access. Case managers (done through Potomac case management) provide transportation to the site. As a state agency, we are not allowed to bring participants onsite to get SSP. We work together with referrals, connect them with peers who connect to treatment or meet people where they are at for people who are not ready for treatment. LEAD is useful, connected us with people we did not have contact with and informed positive relationships with correctional staff.

Law Enforcement Engagement Document

Marie Stratton, CHRS

Thank you to everyone who helped develop this document. Brief outline of what is included in the document. Recommendations for building partnerships with local law enforcement. Education about the law is critical to reducing unnecessary arrests. The document is divided into four sections: first is “getting started: understanding the landscape, identifying and learning about complementary work, building and supporting your team, and gaining leadership support.” Section two is “Preparing for SSP implementation: Partnership building activities, understanding limitations of the law; developing a training plan.” Third section is “Operating an SSP and Ongoing Public Safety Collaboration: Preparing SSP participants for law enforcement interaction, ongoing public safety collaboration; problem solving.” Section four is “Additional Resources.”

Identifying and building key relationships, such as Crisis Intervention Teams and/or training (CIT); identifying officers involved in LEAD (can reach out to Daniel, Marie, or Jess to get in touch); other public safety overdose response programs. Finally, crime prevention or victim services partnerships.

Suggesting that law enforcement champions serve as your point of contact to schedule trainings, but to co-present at roll calls. Roll call trainings are very brief and we know we are not going to change perspectives in 20 minutes; having an internal partner helps make sure you have someone there who knows the benefits of SSP. Suggestion of leaning on partners and existing resources; Daniel Atzmon can be helpful in connecting you with partners, as well as Regrounding Our Response—we have 100 master presenters across the state, many who have existing relationships with law enforcement. Have a lot of template materials and compiled resources at the Center.

Lt. Joshua McCauley

Lieutenant with Washington County Sheriff’s Office, Law enforcement member of SSP SAC. My day job is managing a patrol shift. Manage the LEAD, mobile crisis, juvenile diversion—a lot of non-traditional law enforcement programs. Want to drive home the points that Marie made; the

importance of trying to establish internal champion within agencies as you are making relationships. We get a ton of training every year, sometime pre-scheduled months or years out. Many programs talk to us during roll calls. Having internal officer who is already on board really sets the training apart from a lot of the other trainings we get. Gives added credibility and understanding on part of officers that this can work. In personal experience, usually few questions that go into roll call trainings or conversation during training. Conversations and questions come later. After the team is gone and officers are discussing, great to have that person to champion the program, defend it, discuss it, answer questions. That is a very important part. As far as target audiences, we know about training the officers and deputies on patrol shifts—they are the main target audience. Important to remember first line supervisors; they get missed because they may not be at roll call. LE agencies still operate under quasi-military command structure. Officers on the street might get it, but if supervisor does not understand, might not get very far, restricted in actions they take. Include them, see if you can make a special training for first line supervisors or make sure they are invited to roll call trainings. As far as training, different levels; there's roll call (very brief, 15-30 minutes tops at beginning of patrol shift). In-service training is more in depth; if you can get on that schedule, you can probably get an hour or so; scheduled far out in advance. Academy training is wonderful; training recruits in police academy, get there early before they get out on the streets. All levels of training are important and ongoing training. If able to get roll call or in-service training early on, consider trying to schedule something on recurring basis. If can do roll call every 6 months or once a year to reinforce message, that's best possible training.

Benefits of ongoing public safety collaboration. Great to have someone to discuss issues with. If there is an issue with one of my deputies, I hope David knows he can call me and address something. Again, scheduling trainings—we were able to get roll call trainings. Great to have that relationship, benefits of having that person in the agency that you can connect with.

Panel Discussion

Update on SSP Statewide Participant Card, Erin Russell

We are continuing to work on draft participant ID card. The opportunity to talk with law enforcement has been a longer process, allowing it to be a longer process for those conversations to happen. Starting conversations with academy about incorporating SSP into initial trainings. Some preliminary conversations with Attorney General's office to discuss concerns regarding SSP law. Are we addressing concerns, and what else can we do?

Candy Kerr, BHRC

Can you clarify Daniel's title?

Daniel Atzmon

The name of the office changed to reflect new units added. LEAD is really for the adult population. Colleagues also provide support for juvenile diversion. I am happy to connect if jurisdictions want to explore new programming for youth as well.

Amy Hecht-Zizes

We heard a lot about police training options, can you go into more detail about "preparing participants for police interactions?"

David Washington, Washington County Health Department

For SSP participants, everyone who wants to join program (and get unique ID)—we talk to them about what unique ID is, intent of getting the card, if you encounter police, what to say. Officer will call and ask if number is associated with someone in the program. David can confirm that the person is engaged in the program. Officers have said "this card means nothing"—which speaks to the need for continued education. Tell people to think of it as a driver's license, think of not having it as driving without a license.

Harriet Smith, Baltimore Harm Reduction Coalition

If police call and say, "is this person a participant?" and you say, "Yes," what are you confirming? Guidance is clear on not cross-referencing the name with number. You are saying just that the number exists in the system?

David Washington, Washington County Health Department

Yes. If participant signs consent for release of information, we can give them a letter with name and unique ID. People have done this for court-related issues.

Harriet Smith, BHRC

Is this back-and-forth with police to verify prompting you to support decriminalization of paraphernalia. Are other panelists supportive of this?

David Washington, Washington County Health Department

(responding to question from chat box) If people with unstable housing lose cards, they can get a new card every time they come in. We have had issues where people are incarcerated and didn't have their card, so we've had to do some work—have a good relationship with Sheriff and Chief—talked to participants at jail to generate their number. It takes a lot of work to have a partnership allowing you to go into detention center and have conversation with someone who is already incarcerated.

Erin Russell, CHRS

The Center is working on a statewide card, template, and what will make it unique and state-certified—likely a watermark or raised seal. Taking extra time to run the card by law enforcement partners. Thank you to Lt. McCauley for feedback. Taking an opportunity to engage with law enforcement to get feedback on the card and make it acceptable to law enforcement once it's implemented.

Dr. Sarah Kattakushy

Is there any evidence or data that has been collected that having a card decreases the likelihood of arrest?

Erin Russell, CHRS

No data, just anecdotes from programs and experiences of participants.

Harriet Smith, BHRC

I'd love to follow up to hear where each of your agencies (represented on this panel) stand on the decriminalization of paraphernalia.

Lt. Joshua McCauley

I cannot speak on behalf of the agency to say a position on decriminalization; I do not have the authority. I would be happy to discuss on a private level about my personal thoughts. The way things are written, does also put LEO in sometimes a precarious situation; they are told they must make a determination about a person being in program, with not a whole lot to go off of. If left to judgment call, the right decision is not always made. That is why training is so important, to get in for roll call training, in-service, to lay groundwork in advance. In Washington County, we have the same problems and issues the rest of the state has, but the SSP has done such a good job training. I frequently hear about deputies making traffic stops and seeing clean needles but not taking them. Change in mindset and benefit of the work of SSP and training. I can't speak to the agency's position but do think where we are currently presents problems.

Katie Evans, SPARC

Could the language that is going to be used in the statewide card be released in advance to be used as a guide for existing cards?

Erin Russell, CHRS

Will follow up with language. Thank you to everyone for sharing their expertise.

III. Maryland Department of Health Updates

Introduction of new Center for Harm Reduction Staff
Latasha Brickhouse-Frazier
Talia Pettway
Chiwendu Mengarpuan

Syringe Service Program's Fiscal Year 2021, Quarter 1 Data Presentation
Allison Thomson, CHRS
Data Presentation from the first three months of the state fiscal year (July 1, 2020 – September 30, 2020)

Updates on MDH guidance for harm reduction programs during COVID-19
I want to share a few pieces of information about COVID-19. Most of our programs have continued to provide services. Not everyone has been able to do that for many reasons. CHRS drafted formal guidance for programs adapting what the CDC, National Harm Reduction Coalition, and Vital Strategies have put out into a Maryland-specific document. It continues to be a draft until committee gives us the sign-off, then we will share with programs. We hope to do that in the next week. This document is for all harm reduction, not just syringe services programs. We do want to encourage distribution of naloxone in counties where they might not have a syringe services program. It talks about importance of services. Harm reduction is considered an essential health service. Organizations and health departments should feel confident continuing services at this time. Recommendations are drawn from existing guidance. Committee has a draft version and will be publicly available soon after the committee approves it. Allison will share a video we filmed about how programs are providing services safely; hope this will be another resource and highlights the amazing work everyone is doing.

COVID-19 Video (first five minutes)
This was a sneak-peek, the video is not yet finalized but will be shared publicly once completed.

IV. Advisory Committee Actions

Erin Russell, CHRS
Can one of the committee members motion for the votes that need to take place to approve meeting minutes?
Candy Kerr, BHRC
Motion to approve meeting minutes.
Dr. Gregory Burnett
Second.
Erin Russell, CHRS
All meeting minutes are posted on the Center for Harm Reduction Services website.
Next item is discussing future meeting times. We have not yet scheduled the meetings for 2021. I wanted to poll committee members and get feedback from the public about whether we prefer to keep this Friday morning time or move these meetings to off-hours. Could do evenings, earlier in morning—want to get sense from committee whether meetings are accessible enough and how we could change timing to make them more accessible.
Candy Kerr, BHRC
Love this time of day, will come if I must after hours, but I have after-hours life stuff that is self-care to make sure I can come to these meetings on Fridays.
Dr. Sarah Kattakushy
Second that. Already so much bleeding of home and work life. Having it during the workday hours is great.
Dr. Deanna Dunn
Agree
Dr. Susan Sherman
Agreement
Harriet Smith, BHRC
I am here because of my work so 9-5 works for me. But there might be others who'd want to be here but work.
Erin Russell, CHRS
Reminder about sending the attendance report to secretary at this time of year; this meeting is mandated by legislation and subject to the Public Meetings Act. For those of you who have missed 50% of meetings, we will be following up with you. If you want to maintain position on committee, will need to write a letter explaining why you missed the meetings.

V. Public Comment

Candy Kerr, BHRC
MDH CHRS—can you write a bill or champion a bill about decriminalizing drugs? And if so, who do I talk to get that ball rolling?
Erin Russell, CHRS
Description of how MDH handles any piece of legislation: The Department can put forward a

Departmental bill. The bill that authorized SSPs was a departmental bill in 2016, MDH drafted it, it does not need legislative sponsor. Worked with advocates to move it through process. There is a precedent for that, it is something the department can do. There is an internal process at Department for parts to request that there be a Departmental bill. Decision made by secretary of health. Once session starts, decision of department which bills to support. There are channels for us in the department, we make use of them to make requests of legislation we think would be important to people we serve and programs we support. Whether or not they make it through the layers of approval and get endorsed by the Secretary is out of our hands.

Dr. Peter DeMartino, MDH

We are the executive branch; the legislative branch is a separate process. We have a role to play to crafting statute, but we primarily work with legislation once it has become statute. It is the way the government operates with the state legislature.

Candy Kerr, BHRC

How do we get in touch with the legislative branch?

Dr. Susan Sherman

I would suggest talking to Michael Collins, who represents an elected official.

Erin Russell, CHRS

(responding to a question from the chat box as to why Anne Arundel County was not represented in the SSP data presentation)

Clarification about Anne Arundel County data; they have become operational during the current quarter we are in. They will be represented in the next presentation in Q2.

Amy Hecht-Zizes

In future decriminalization, can Maryland envision SSPs without police involvement? What does this look like in the next 5 years?

Marie Stratton, CHRS

In terms of LEAD programs, significant amount of effort revolves around supporting services team. Officer training—talked about background information needed to increase buy-in. Process for officers is short, is a hand-off to services team. A lot of funding and training support goes to building services team, so we have an alternative 24/7 option for connection to services. Long-term for LEAD, those programs should not exist long term if we are effectively building up services capacity in counties.

Erin Russell, CHRS

Lt McCauley's example of pulling someone over with sterile syringes in the car and understanding the public health purpose and not hassling the person for it is the vision that would be achieved in a future where paraphernalia were not criminalized.

Lt. Joshua McCauley

The relationship now that exists is an unfortunate necessity. Because we deal with it, we must be aware of these programs. It is in our best interest to cooperate. In the future, for that relationship to not have to exist is where we all want to be. For SSPs to focus on services, and for us to focus on victim crimes where there is a true threat to public safety. Think it will be a natural progression. It is what we're all working towards.

VI. Closing

Erin Russell, CHRS

Thank you to everyone on the committee, thanks for your time and the work you do.