Multnomah County Public Health Advisory Board
Ethics Committee Minutes
August 2018

Date: Thursday, August 23, 2018
Time: 3:30 p.m. – 5:30 p.m.
Location: Multnomah Building, 501 SE Hawthorne, Room 126
Purpose: To advise the Public Health Division on several areas of work with a strong focus on ethics in public health practice and developing long-term public health approaches to address the leading causes of death and disability in Multnomah County.
Desired Outcomes:

1. Provide input on a Multnomah County shift from an opioid-specific substance-use focus to an all-substances prevention approach
2. Continually improve the Ethics Committee deliberation process

Members Present: Gerald Deloney, Tyra Black, Debbie McKissak, Chuck Tauman, Suzanne Hansche, Becca Brownlee, Alicia Junker, Cheryl Carter, Audrey DeCoursey, Bertha Ferran
Multnomah County staff: Jennifer Vines, Paul Lewis, Anthony Jordan, Charlene McGee, Aiesha Hasan, Christina Brown, Hilary U'Ren
External stakeholders: Jillene Joseph, Suzie Kuerschner, Andrea Cano

Item/Action	Process	Lead
Welcome, Introductions, & Minutes Review	• Welcome & introductions around the table (and on the phone) • Stakeholders/guests: Jillene Joseph & Suzie Kuerschner from Future Generations Collaborative (FGC); Paul Lewis, Anthony Jordan, Charlene McGee, and Aiesha Hasan from MCHD. • Reviewed agenda for August meeting. • Reviewed and unanimously approved May meeting minutes with no edits.	Tyra Black
Stage Setting	• Reviewed Ethics Committee process o Front-end use of the 5Ps in small groups o Return to large group for application of ethics deliberation questions o Sent background information to committee members for review and preparation in advance. o Have invited multiple stakeholders from inside Multnomah County organization and external organizations to participate and provide background context for discussion.	Tyra Black, Christina Brown
Background Review	Overall question for the committee: As we move into an all-substances prevention approach (and away from an opioids-only focus), what issues do we need to consider in our initial framing of this work? Background: • In 2012/2013, MCHD identified accidental death due to opioid overdose as an unexpectedly large figure and one that was contributing to the cause of years of life lost, which differentiates it from just being about death – it's about premature death. • Focus specifically on doctors prescribing opioids, though this is just a narrow slice of the problem • In the beginning there was a focus more generally on opioid treatment though it's become obvious that we're having a lot of deaths from multiple drugs, not just opioids. This year, we're seeing a lot of opiates and meth combinations. • Opiates have been focused on for several reasons, three of which are: o The misuse of prescribed opiates predominantly affects white, upper/middle-class people, while illicit opioid use impacts communities of colors. This partially contributes to why the "opioid epidemic" was only seen as a large-scale problem when it started impacting wealthy/white folks. o Opioid overdoses cause an unexpected, quick death, whereas many other types of substance abuse contribute to more long-term, slow, insidious health problems. For instance, alcohol can create many health problems over the course of years and can ultimately lead to death. People do not view that as being as visceral of a risk as a quick death from an opioid overdose.	Dr. Jennifer Vines, Dr. Paul Lewis, Anthony Jordan

	o From the medical perspective – there are a few options for medically treating opiate addiction that are not as available for other substance addictions. Doctors are drawn to being able to physically treat something – with opiates, you have Naloxone, which can resuscitate someone during an overdose, plus Methadone to help with recovery, etc. Medical people tend to think very short-term as opposed to long-term, preventative, upstream work that we're trying to do. Questions from MCPHAB: • What does it look like to shift our approach from opioid-centered to all-substances? How different are these two approaches? Are they largely similar, or would we need to implement new infrastructures, employees, programs, etc.? o Currently, many substance use disorder treatment programs focus on the development of the substance abuse later in life, when its root cause can often be traced back to early childhood trauma like racism, adverse childhood experiences, abuse, etc. Changing approaches would, in one regard, mean thinking more upstream and moving the focus to earlier prevention than most. o Rather than just treating one specific substance use type, this change would focus on treating the whole person. Often people start with prescription drugs and move on to heroin, or move on to other types of drugs altogether. This takes a holistic perspective, since just focusing on one may not necessarily prevent development of substance use of a different substance. The increase in cross-use of various drugs needs to be taken into account in treatment. • Do funding sources (federally, locally, etc.) change depending on whether we shift from opioid-centric work to an all-substances approach? Does that mean less money committed in one area and moved to another? • What count as opioids? (from graph used as supporting document) o Heroin o Methadone o Buprenophrine ▪ This study was from 2010, so now we have several more designer opiates like Fentanyl, as one example.	
5Ps Work – Ideas Carousel	Counted off into small groups to examine the 5Ps and implemented Jillene's "Idea Carousel" model – every three minutes, switched to the next P so that everyone got a chance to discuss each P before we came back together in the large group. • People o Be more inclusive o Take advantage of what we have (FGC) o Awareness of victim blaming/stigmatizing o Culture o Black (likely Native & Latino), immigrant & refugee communities o Trust deficit – avoiding seeking services & transparency o Don't have the access to services (private) as much as white dominant communities do o Poor people more likely to have access to health care that connects them to prescription pain medications than one that helps with substance abuse treatment and recovery o Not comfortable culturally w/services (e.g. not seeing someone that looks like you) o (Re) traumatization → POC incarceration o Onus on person to show burden o Who do we treat as deserving? o Medical implications o Poor people fall faster into more severe financially harmful situations which can follow families for generations o Poor people with fewer opportunities suffer more intractable losses than those with more wealth and social opportunities to recover o (Social) media portrayal o [Still] meet people where they are (on their healing path) o Learn **their** language	Small groups

- Response, responsibility, and resolution of this problem should be a shared responsibility among providers, health care administrators, population health advocates, and community leaders from all social locations and cultural backgrounds.

- Place
  - Targeted advertisements
  - Built environment
  - Criminal justice system
  - Schools
  - Social service delivery
  - Hospitals/CCO/Community clinics
  - Treatment facilities
  - Cycle of gentrification / displacement / housing insecurity (all works in refugee spaces/communities)
  - EEC
  - Equal access to nurturing environment
  - Inequality
  - Let's focus on individuals
  - Looking at treatment environments more holistically
  - Stabilize people in crisis
  - Create community (home, friends, food, etc.)
  - Inclusion in representation
  - Sterile environment
  - Marginally safe/or unsafe communities are fragile

- Process
  - Access to materials (education)
  - Better understanding systemic racism
  - Decolonization (white people healing from white superiority)
  - Healing is the answer to trauma, racism is trauma
  - Not having diverse providers & staff
  - Not having staff with lived experience
  - Persons impacted by substance abuse are rarely at the table to discuss how to address problems; when they speak their requests are easily dismissed/ignored
  - Treat patient or client where they are (in the stages along the healing process)
  - Not listening
  - Lack of culturally responsive communication and interaction
  - Policies are barriers most of the time
  - Can't treat every ethnic group & individual with the same model
  - Media
  - Which overdoses bring most blowback on the county?
  - Impact on decision-makers
  - Intersectionality of identities
  - Sentencing disparities (justice system)
  - Holistic approach that advocates for the dignity and well-being of the individual. In fact, since we have delved so profoundly into the social determinants of health, perhaps we could shift the narrative to the social determinants of well-being, which incorporates mind, body, heart, and spirit.

- Power
  - Barriers:
    - Money + Budget
    - Jurisdiction/locality
  - Benefits/Burdens
    - Resources/attention
    - Not inherently with the right direction
  - Accountability & decision structure
    - Who is at the table?
      - Medical community
      - Pharma/providers
    - Perception of "heart"

	o Accountability ▪ Who is actually accountable? o Holistic approach o Policy makers o Lack of political will to take responsibility for public health, to assign responsibility for cause and impact o Lack of investment in public health and preventative health care o Drugs are a business o Economic drivers targeting people o Not funneling funds into communities of color o Prejudices o Personal bias o Cycle keeps going o Decision-maker structure o Diverse policy makers (both lived experience and race/gender) o No common knowledge or understanding of racism (white superiority), power imbalances, systemic racism ▪ Systems designed for white people, sustained by white people o Broaden, be more inclusive o POC should not be responsible for ending racism o Prevention & treatment in a culturally specific lens o Trauma informed, culturally informed, healing o Directive rather than collaborative approach • Purpose o Ensuring promotion of racial equity o Effective Outreach o Minority input into politics & practices o 8th bullet – ensure diverse group of people (community) working with leader in various ways (e.g. work groups) o Change leadership if it doesn't reflect the community (race, gender, ethnicity, religion, etc.) & if they are not on board for change o Education – what are we doing and why o What does this look like actualized/operationally? ▪ Personnel, funding, "clients" served ▪ Proactive & upstream? ▪ Is this in our lane? ● Jurisdiction (dinosaur structures) o Equal rights to equal access o Meet people where they are and not where WE want them to be o Disperse fear o Find commonality o Inclusive – finding focus to all people o Decolonize o **Abundant thinking vs. deficit thinking** ***	
Large Group Discussion	Ethical Framework Questions for Consideration: 1. What are the public health goals? 2. Are the benefits and burdens distributed fairly? 3. Does the public health approach respect individual choices and interests? **1. What are the public health goals?** • Our goals should be equitable protection and service – in prevention, treatment, and mitigation of harm. • Want to avoid emanating an "all substances matter" message as we make this transition within the county. Emphasize that taking the focus off of opiates and moving to an all-substances approach is more racially equitable given the high priority that wealthy white folks tend to take in the public eye as related to opiate overdoses. By narrowing that focus, we're missing many people who need attention – when we broaden our scope, there's less chance of us missing the mark or failing to support our communities. • All substance use generates negative outcomes for families and children. Prevention & intervention are reciprocal and must be treated as such – putting those efforts into separate funding streams is a mistake. • We need to work to get at the root causes of substance use: social,	Dr. Jen Vines

economic, supply/demand, pain (physical & emotional), racism (how people are valued).
- Holistic approach and ability to respond – think long-term, what's next?
- Social acceptability of certain substance use of others (**alcohol**, specifically)
- **Data**

2. Are the benefits and burdens distributed fairly?
- What tools do we have for opiates vs. other drugs? What choices have to be made in terms of funding, staffing, clients? What are the tradeoffs? How might a shift potentially shortchange communities of color?
- Public Health tends not to do the direct service work. Mental Health and Addictions Services (Anthony Jordan's division) doesn't actually do direct service but does contract a lot of that. Tricky to do the cost shifting until we determine the conceptual shift.
- If we get resistance to the cost of prevention, one argument is the potential outcomes (long-term). This is part of the current vision problem – it costs us more in the end if we don't do early intervention & prevention as a joint effort.
- Debbie (board member) works in primary care and deals with the substance use population on a daily basis. Her workplace is currently in an all-substance model, rather than separating opiate from other addiction populations, and find it quite successful. It's the same group of practitioners regardless, and they collaborate to provide the best care for each patient.
- Can those <u>most</u> in need get what they need?

3. Does the public health approach respect individual choices and interests?
- Cultural responsiveness
- Trauma-informed
- Treat the <u>whole</u> person

<u>Themes</u>
- Cultural responsiveness
  - Meeting people where they are
- Holistic approach
- Diverse representation
  - Increased diversity/inclusivity
- Money
- Systemic racism / targeting populations & people
  - i.e., Rx/prescription substances target whites, illicit drugs target people of color
- Cultural specificity

<u>Questions/Further Discussion from MCPHAB:</u>
- Questions raised by Andrea (via email)
  - How do we draw and understand the correlations and gradients of symptom management and pain control among patients and consumers/users, and decriminalize the suffering?
  - What are the institutional responsibilities for response and action?
  - What are the individual communities responsibilities for the same (i.e. mine for example 'urban middle class Hispanic'), and who else should be engaged in this partnership (stakeholders in the community, churches, faith groups, schools, etc.)
  - How do we gauge benefit vs harm in our actions to resolve this critical problem?
  - What are the metrics we seek to signal we have been successful in our efforts
  - How best to create a new vocabulary, vernacular expressing sensitivity and grace as we discuss, deliberate, and decide, engage, educate, communicate, etc?
- What are the root causes for why people are choosing their drugs?
  - If we're really interested in doing this equitably, we need to address the economic factors involved in encouraging addiction to tobacco, opiates, other substances. Until we dig into that, we'll just be *responding* to the

	problems instead of preventing them. o One argument: purely economic - supply, demand, and availability is a root cause. o Counter: demand comes from trauma, comes from shared community knowledge about the drug and its effects, from peer network all using/chain reactions. Demand comes from depression, trauma, undertreatment of pain, etc. These are root causes. • The chart used as supporting documentation for this discussion doesn't adequately explain how they measured harm to society, which made it difficult to determine the relative harms of each of the drugs listed. o This is a good point. However, the takeaway of the chart, for the purpose of this conversation, is not about which substance causes the absolute most harm – it's about highlighting the fact that there are already so many substances available and in use actively harming people and society that we need to consider. No one substance is more or less important than any other, which supports our transition to an all-substances approach. • What's next for/from MCPHAB members for Multnomah County? o We will be revisiting this question in the future – it is long-term and open-ended, the county is just beginning our work on this transition. o <u>Summary from today's discussion</u>: ▪ Very strong message around respect for individuals and culture. ▪ Tension between notion of "all substances matter" and getting attention to those in need such that they get the necessary help. ▪ Emphasize root causes, prevention and intervention cannot and should not be separated. ▪ Data is important for PH approaches	
Wrap-up and meeting evaluation	• What worked about today's meeting? o Really enjoyed the idea carousel, would like to see that used again in the future. o Loved the guests/stakeholders – please return for future discussions on this topic. o Liked the dialogue & diversity at the table. o MCHD and PHD staff continue to do a good job of helping to bring the right people to do the table, which is very helpful for the conversation. o From a new/first-time member: loved the inclusivity of everyone's ideas and thought processes, felt heard. • What needed improvement about today's meeting? o Struggled with what we were being asked – didn't hear much of an argument against the proposal, so it was unclear what would be helpful to the County. If we're all on yes, what helps? o Ambiguity around who this is regarding – is it at the department or division level? If division, is it Public Health or Mental Health?	Tyra Black