8 Concerns with Dr. Unthank's presentation on September 24th 2019

On September 24, 2019, Dr Allyson Unthank, Clallam County Health Director presented a public information session about the opioid problem in Clallam County.(1, 2) She stated she has no conflict of interest in the proposed Regional MAT project, yet her medical practice is based in the Jamestown Family Practice Clinic in Sequim. It seems unlikely that her employer would tolerate any dissention on this matter since they are the primary developer on the proposed new facility

Dr Unthank presented some very good information about this problem, but there was much relevant information that was not included. (1, 2) Also, some information was presented in a leading manner as discussed below.

Public officials who have a financial interest in such projects should recuse from offering support (or otherwise) to specific projects. It is difficult to see how Dr. Unthank's position on this matter could be viewed as neutral.

Here is a list of the 8 issues of concern regarding Dr. Unthank's presentation.

1. Dr Unthank stressed the dire need for this proposed facility in Sequim. She failed to clearly reference existing or imminent care planned for Clallam County(3). The new Baymark facility, scheduled to open fall of 2019, would raise treatment capacity in Clallam County to 1:81 or 1.23%. The national opioid use disorder prevalence in 2018 is 0.6% (2million addicts/ 237 million population) or double the national figure.

How does our treatment density compare to other municipalities? Dr. Unthank stated that Seattle has a higher treatment capacity than our area. Our study of Pierce county (4) indicated a treatment density of 1:435 or 0.23%. We doubt that Seattle is that much different but have not seen Dr. Unthank's sources.

Should the proposed Jamestown facility open, our capacity in Clallam County would be 1:66 or 1.52% This reveals that Clallam County would have capacity to treat close to *three times* the OUD density of the US at large if EVERY addict wanted treatment (which they don't), and would have close to *seven times* the capacity of Pierce County following the opening of the Jamestown clinic.

We believe the lack of treatment in the metropolitan areas will drive this OUD population in our direction. And although some may initially be seeking treatment, the statistics show only 51% stay in treatment and of those, 45% continue to use drugs and 18% continue to use opioids. (5)

Our small town is not able to accommodate this influx. Furthermore, while we accept responsibility to help residents of Sequim who are seeking help for OUD, where does this responsibility end? Are we obligated to take on the challenge of treating addicts from across the state or even other states who travel to Sequim for services?

2. Dr Unthank stated OUD clients can't get treatment in 1 day. OPHS is only open 3 days per week. Our telephone survey revealed that this was due to lack of treatment applicants and not due to lack of capacity. (3)

3. Dr. Unthank showed a graph of Medicaid patients who had prior diagnoses of OUD and that only 45% of them had access to treatment. (6) She then stated that 70% wanted treatment according to the Syringe Exchange Program questionnaire. (7) The intent was to leave the impression that all of these people who desperately wanted or needed treatment were not being served in our county. This was a disingenuous representation for the following reasons:

- Medicaid OUD patients may not represent the population as a whole, but assuming it does -
- The 45% number reflects the percent who had actually *received* at least one treatment during the treatment year, not the % that wanted treatment. It is hard to say what that total is, Worth more discussion.
- The 70% number she referred to came from a syringe exchange questionnaire, also not exactly a group representative of the population as a whole, OR of OUD patients as a whole. Only represents IV - using addicts participating in the syringe exchange. (see below)
- The number 70% she uses is inaccurate according to 2 surveys I have seen (d) and has grouped together *both* the ones who said they were "very" interested in reducing or stopping use *along with* the ones who were "somewhat" interested.
- In both studies below, these are separated for clarity. I submit that the group who is "somewhat" interested are not really interested at all because getting clean is an all or nothing endeavor, not for the half-hearted. These people should not be lumped together with the very interested group without an explanation. They do not all have the same potential to benefit from treatment.
- A more accurate assessment would reveal the number of "very interested" in reducing use is somewhere between 43% and 55%. This is in the ballpark of the above Medicaid study. So going with the assumption that this represents the population as a whole, then the treatment penetration looks about the same as the Medicaid population

4. Abstinance vs Buprenorphine studies - Clinical trial study from 2003 showed 70% success rate, and 0% for abstinence.(8)

- Current data(5) shows this is actually only 51% with nuances to different surveyed sites, Grays Harbor being highest (60%), Seattle and Olympia being lowest (46%).
- By presenting the rate at 70% first, Dr. Unthank disingenuously orients public impression towards an unreasonably favorable impression rather than stating facts as they are. People will remember this FIRST number as a 70% success, rather than the 46% or 60% numbers buried in the presentation later.

- If the proposed Sequim facility has a success rate of 60% of 250 (the highest of the study results), this means 100 people did not remain in the program for 6 months.
- If the success rate was 46% as in the other 2 sites, then 135 people would remain in their addicted state.
- The study further shows that 48% were not stably housed. 13% were criminal justice involved (CJI). This number of CJI in itself (32) would be more than our entire police force of 20 including administrative staff. Neither of these numbers changed significantly over the course of treatment - only by a few percent.
- One problem with all of these studies is defining "success." The clinical trial study outlines the parameters as,

  "*successful outcome was defined as completing week 12 with self-reported opioid use on no more than 4 days in a month, absence of 2 consecutive opioid-positive urine test results, no additional substance use disorder treatment (other than self-help), and no more than 1 missing urine sample during the 12 weeks. "* (8)

- Basically this means the participant can use opioids on a weekly basis each month as long as they don't have 2 positive urine tests in a row. We were unable to ascertain how often urine was tested. Also, self-reporting relies on the honesty of the participant.
- The most current report (5) indicates that 45% of participants reported continued drug use at 6 month follow up, with 18% reporting opioid use. Granted these numbers are reduced, but still are problematic. (page 6)

5. Dr Unthank describes the opioid patient as people we know, grandmas and coworkers, moms and dads, people with jobs, even doctors! This is one face of the population. This is not the face of the people living in the camps of Port Angeles (9) or in the camp in Aberdeen (10) or streets of Seattle (11) and Pierce County. (12)

To focus on the population that is NOT troublesome as if it was representative of the whole gives an unreasonable, perhaps even negligent perception that we have nothing to worry about at all. Is this a responsible approach or is she persuading public opinion?

If Dr Unthank is concerned about the health of the county as a whole, why does she ignore the population that IS problematic? This approach suggests we won't experience any of the downsides at all. Our concern is not in helping the moms and doctors. Our concern is avoiding the burden of those who fall out of treatment, CJI, or bring communicable diseases, discarded needles, and trash to the community.

Dr. Unthank did not address the resurgence of medieval diseases like typhoid and bubonic plague, or shared diseases like tetanus, hepatitis and AIDS that are prevalent among this community. (12)

6. Dr Unthank stated that the medications used in MAT do not get you high. This is untrue. Methadone will get you high at higher doses (14, 15). Dr. Unthank repeatedly stated, "at therapeutic doses." She is minimizing the potential hazards of this drug, especially in the wrong hands. Drug addicts divert drugs often and are also prone to manipulate providers into increasing doses. Most will do what it takes to get high, including combining Xanax and meth amphetamines with methadone to get a similar effect as heroin. If they don't get you high, why are they diverted? Participants in programs continue to use illicit drugs at 45% rate and opioids at 18% rate.(5)

In addition, Methadone cam produce effects that place patients at risk for vehicular accidents. According to the NIH, among the drugs tested, methadone and Buprenorphine are both listed as a risk.

“Fifteen (28.3%) were associated with an increased risk of MVC. These included Buprenorphine, Codeine, Dihydrocodeine, Methadone, …” (16)

7. Comparison of OUD / SUD as a disease like any other such as Diabetes or Heart Disease is disingenuous and nonsensical. Its only purpose is to guide popular opinion towards a pre-determined conclusion that we have nothing to worry about.

While noncompliance may land heart patients or diabetics in the hospital or produce a litany of comorbidities, patients will not generally engage in robbery to get their doughnuts or break into the neighbor's house and lounge on the couch to avoid exercise. The addict however will engage in criminal behaviors to get money for their drugs. It is these problematic behaviors that concern us and all citizens who acknowledge the connection between drugs and crime. The evidence is ubiquitous that a connection exists between drug use and crime.

8. Methadone treatment is not available in this area. Dr. Unthank states her patients need to be bused OUT of the area to get Methadone. This amounts to less than 5 people. Should a $10 million regional facility be built to accommodate this small number? Furthermore, the imminent opening of the Baymark facility will address this problem. (17)

Also, we hope US Congress will consider changing the laws and allowing Methadone to be distributed at primary care locations. It would be worth addressing with our congressional representatives. (18)

Conclusion:
Sequim is an entirely inappropriate location for such a facility. The information provided at this public meeting avoided this issue entirely. If we are to solve the drug crisis then public officials must be committed to honesty. There IS a local impact with unintended consequences, and it is seen nationwide. Placing such a facility in an ill-equipped small town like Sequim is irresponsible. When these concerns are addressed honestly, we

can focus on how to do the right thing, instead of plowing forward with public pressure and half-truths designed to support the wrong ideas.

While it is not our organization's responsibility to find solutions for this problem, our members have suggested some possible solutions:

- Put the facility out of town at least 5 miles. The Didgiwalic facility in Anacortes has been cited as a model example to follow by the developers. Yet this facility is sited at a location approximately 5 miles away from the nearest town. While this approach may, for a time, reduce the impact, we also note that the facility has some concerns about homelessness and other related problems. (19) Still, the residents and visitors to Sequim would be spared some of the problems that can be anticipated by moving the proposed location.
- Consider offering treatment in primary care settings, treating SUD just like any other chronic disease. At the 3rd annual Opioid Response Summit a considerable amount of effort and time was focused on removing the stigma of drug addicts to make their healing more likely. Yet the entire system of SUD services involves segregating the addicts into designated treatment centers. This separate but not equal approach accomplishes exactly the opposite. It congregates users together where they remain in association with those just as unhealthy as they are. Let's get methadone available at local clinics (18)and stop this expensive and ineffective practice.

Sequim does not need a large regional drug treatment center. We need increased access to everyday health care rather than a facility that offers these needed services – but will only treat you if you are an opioid addict.

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