Regional Law Safety & Justice Committee

REGIONAL LAW SAFETY AND JUSTICE COMMITTEE

Thursday, March 31, 2016

7:30 – 9:00 A.M.

Seattle City Hall, Bertha Knight Landes Room

600 4th Ave., Seattle, WA 98104

Theme: Heroin and Opioids

Public Health Crisis – Dr. Caleb Banta-Green, University of Washington; Brad Finegood, King County Department of Community and Human Services

Dr. Banta-Green and Mr. Finegood provided a presentation from the public health perspective on Heroin & Opiate Trends and Interventions. Dr. Banta-Green has worked since 2001 tracking drug trends and is currently on the county Heroin Task Force. He is also an intervention researcher currently conducting an intervention at Harborview. Previously he worked directly with drug users.

Dr. Banta-Green presented King County statistics from four different sources (see slides):

- Police Evidence Testing: provides accurate information on drug type, but only includes drugs seized by law enforcement, so it captures trends in both drug supply and drug enforcement. Only heroin and methamphetamine are increasing.
- Treatment Admissions: admissions for publicly funded treatment. Most individuals use multiple drugs, so the data is simplified. Last year for the first time heroin exceeded alcohol as the primary drug.
- First treatment admission for Heroin by age: the data shows a dramatic increase for heroin treatment, primarily among young adults. Dr. Banta-Green emphasized the importance of this finding because opiate use leads to permanent brain changes, which means there is not quick fix and people may need treatment for 50-60 years, though it's a fixable problem with available tools.
- Drug Caused Death Counts and Rates: both the number and rate have increased by about 50%. Heroin and other opiates have an inverse relationship, with a dramatic increase in heroin

deaths after 2010. Eighty percent of deaths involve multiple drugs. Heroin is now frequently used together, which was not seen previously.

Dr. Banta-Green showed maps of the death data by place for the past few years, which show many deaths in Seattle, but also spread throughout the county. Most of the deaths on the East Side are young adults under age 30.

In 2015 a state-wide survey was conducted on drug injector heath, providing estimates on the number of drug users. In King County, seven million syringes were distributed and at a minimum, there are 25,000 active injectors throughout the state, though Dr. Banta-Green noted the actual numbers a likely double that.

Survey results show prescription opiates as the main drug can rarely be sustained. The typical way people begin using is prescription drugs, particularly for younger users. The survey asked people whether they would like to quit drug use, about 75% reported wanting treatment. If you had treatment on demand there are still 25% who are not ready for treatment , which leads to the question of what do you do to keep them alive?

Fentanyl, which is more potent than heroin and morphine is illicitly produced and there has been some distribution in this area, but much less so here than in other parts of the country .We're super vigilant to tack whether its occurring. We added a new category for not prescription and not heroin. These drugs are very hard to dose, which means they are more dangerous.

The Continuum of care for opioid misuse includes preventative activities, treatment, and harm reduction (see slide). Dr. Banta-Green encouraged the group to provide additions to the continuum of care.

Mr. Finegood provided more detail on the Heroin Task Force activities, which was convened a month ago by the County Executive and City Mayors. Many RLSJC members are participating in the task force and Mr. Finegood is encouraged to be sitting around a table with law enforcement and others working on new interventions. Subjects under consideration include safe injection sites, naloxone, and prescription drug collection (see slide). Mr. Finegood spoke in particular about the importance of getting naloxone to drug users. While medication assisted treatment such as methadone and bubrenorphine have expanded in recent years and a new center recently opened in Renton, there remain 150 people on waitlists and demand is not being met.

QUESTION – We can't or we won't build enough medication assisted sites?

There is stigma and public backlash. There are probably other just as effective ways without building methadone clinics. If my doctor is licensed, they can write prescriptions for suboxone. We're working with Harborview and other locations – when people come for help to be able to help them right then.

The Task Force is working on bth short and long term options. A safe consumption site in Vancouver BC recently did presentations in King County and the Task Force will make recommendations as to whether they support safe injection sites.

The task force met with US district attorney last week to discuss legality, but no clear direction was given, in part due to uncertainty around future direction in an election year. The Task Force doesn't want tot recommend safe injection sites if the DEA will shut them down.

QUESTION: with president Obama's approach is there a move to increase prescriptions for suboxone?

Made recommendations to double the number of patients per doctor. Mid-level providers cannot prescribe it, while they can prescribe opiates. Methadone treatment in jail is a possibility, but Medicaid doesn't cover it. It's good to raise the cap on prescription issuing, but it would be better if a regular doctor could prescribe it. We've done a lot of training, but doctors are rarely prescribing it afterwards. You can think about it not just as treatment, but also as preventing overdose. You can stabilize people. Medication assisted treatment is made difficult – methadone is well coordinated, but suboxone is not well coordinated. Unclear who's taking it and who's prescribing it. The Redmond fire department has it, but not police.

QUESTION – my understanding is these are evidence based with counseling treatment. What is the effort to build the counseling treatment?

We don't want to limit access that would keep people alive. It's not moving away from biosocial psycho, but it's stabilizing first. There's actually not evidence that counseling improves outcomes on average. There is a wide range of counseling quality and need. It is likely needed in some cases, but the barrier could be removed.

QUESTION: what about the beginning of the story? I was immediately prescribed opiates after a knee injury.

Doctors are prescribing medication just in case, which puts these drugs in homes. There is very little evidence that opiates help with long term pain beyond cancer treatment.

Legal and Law Enforcement Approach – Judge Cheryl Carey, King County Drug Court; Dan Satterberg, King County Prosecutor; Lisa Daugaard, Public Defenders Association; Captain Chris Fowler, Seattle Police Department

Captain Fowler began the panel presentation by addressing first responder access to suboxone. The map of deaths made it an easy conclusion to provide bike cops with the drug. It is a controlled substance, but law enforcement only needed four hours of training to begin carrying it. It's imperative for first responders to have a response. It gives officers another tool when responding to a crisis situation to someone who is near death. It's shocking in some respects to have such a fast acting tool where someone can just walk away. Captain Fowler reported that officers have only begun carrying suboxone in the last few weeks, so he can't report on effectiveness yet.

LEAD is another tool that is used in managing narcotics. Law enforcement also still sees cocaine and alcohol addiction. It allows law enforcement the opportunity to use an individual approach for people seen on a consistent and daily basis. The bike officers know the names and history of most of the individuals. LEAD has provided an opportunity beyond just funneling them to prosecutors. Society is

slowly realizing that this is a public health issue rather than a criminal justice issue. Captain Fowler emphasizes that arrests are still a tool, but there are now other options. LEAD has been in place for five years and its now being expanded to other areas.

Judge Carey then spoke about her experience as a Drug Court judge. She was the judge in the Kent Drug Court from 2012-2014, and became the King County Drug Court judge in 2015. The individuals in drug court have various charges including theft and identity theft and are addicted to drugs. The program continues to evolve as the science evolves. Judge Carey acknowledged that her expertise is in the criminal justice system, not public health and mental health. Judge Carey has worked in criminal justice for 27 years and her job entails speaking with Drug Court participants four days a week. She shared several examples of individuals who successfully completed Drug Court and resisted using even through traumatic experiences.

Judge Carey also described the Drug Court graduation ceremony, which happens the second Wednesday of every month to celebrate completion. Participants share their experiences and their families are there. Judge Carey sees lack of stable housing as a major barrier to success. She mentioned an example of a participant who was offered sober housing, but was unwilling to leave his wife to live there.

Next, King County Prosecutor Dan Satterberg spoke about the changes in prosecution over the last 30 years and the progress that has been made. In 1989 the passage of a tough drug law with mandatory minimums began sending many people to prison for a long time for selling very small amounts of drugs. Twenty-six percent of inmates were in prison for drugs. Now it's only seven percent, so strides have been made in recognizing that prison is not the solution. An array of other options is now available. Drug addiction is heartbreaking for users, families, communities and the impacts are far-reaching. Mr. Satterberg recently heard from people in South America about how drugs have impacted communities there. Today, rather crack downs and mandatory minimums, the conversation is about treatment. Drug Court started in 1994. It was very limited at that point and it has evolved over the years. LEAD is a newer strategy that focusses on harm reduction. Mr. Satterberg has heard from people who believe only abstinence works and those that provide evidence that medication assisted treatment is the only thing that works. He believes that an array of options should be offered. In learning about the science, Mr. Satterberg is rethinking every day what the role is of the CJ system, and he thinks Drug Court and LEAD are complementary approaches.

In suburban areas, the situation is different. LEAD participants are generally homeless and a teen in a suburban area has different needs than the current population served by LEAD, but both need options. The situation is in a transformational time – largely because prescription drugs are pushing people into heroin – are the roles in the system are being rethought. Mr. Satterberg believes that everything is on the table and if the Prosecuting Attorney's Office can help, they'll do so, and if they're hurting, they should get out of the way.

Lisa Daugaard, of the Public Defenders Association (PDA), spoke about the LEAD program. PDA organized LEAD when, after criticizing the current system, they were asked what should be done instead. Ms. Daugaard explained that LEAD uses case management to provide services rather than jail

time. LEAD case managers have the ability to purchase services for their clients, but not everything is included – most significantly not housing. LEAD is not a human services program, it's a public safety program. The goal is to reduce the criminal involvement and if done at scale, impact communities. The portal for access to the program is law enforcement. Originally, participants were enrolled when there was probable cause for an arrest. The person must agree that information can be shared as needed and they must agree to an intake assessment. It's not a get out of jail free card. Law enforcement still has option of arrest, but they also have other options. Early on it became clear that there should be a second portal. Officers know individuals who are candidates and it didn't make sense to wait until the law enforcement had probable cause for an arrest. Law enforcement can now be more responsive to community concerns. It also prevents delays for intervention and makes maximum use of limited resources.

When someone is in the program, LEAD coordinates all the touches of the CJ system. It sets up prosecutors to make discretionary decisions to have the maximum chance to change behavior. Sometimes that means file charges, but sometimes prosecutors are making release motions – which is surprising to many people. Prosecutors have information about housing appointments and other activities and can make decisions based on that. It is a harm reduction program and the goal is not sobriety. In a compliance based system, LEAD participants don't succeed. We have individuals who have been LEAD participants for 4 years who are just now getting into treatment.

Ms. Daugaard agrees with Mr. Satterberg that LEAD is a big deal. The program is being replicated around the country including in Baltimore and Atlanta. The program has been evaluated by the UW for outcomes, cost, and system impacts. A LEAD participant is 58% less likely to be arrested and it costs less than system as usual processing. Ms. Daugaard also emphasized that the program can work better. One way would be if participants had access to housing. There are also not options for people with extensive criminal history and current drug use.

The Prosecutor has dedicated an employee to LEAD and similar resources are needed in other prosecutor offices. LEAD is looking at that in Seattle and other municipalities where LEAD may operate. The role of community groups is also being explored. In the past, community groups mostly complained. Now they are a mechanism for referrals to the program. Finally, data sharing is improving. When MIDD II comes online, expanding the concept of LEAD across the county is being discussed. It was originally developed as a standalone diversion program, but LEAD currently in the process of rethinking care management from a broader perspective. If public health system changes what is provided, LEAD may be able to plug people into other existing systems that are robust and integrated. In 10 years, Ms. Daugaard anticipates that LEAD will primarily function as a valve to connect people to the services they need. Ms Daugaard ended the panel presentation by emphasizing that while there is obviously significant concern about deaths due to these drugs, interventions are really about the conditions of living.

The panel took a question about the differing conditions in the Eastside suburbs, where affluence and a puritanical approach prevents discussion of heroin. Panel members reflected on the importance of educating communities about good Samaritan laws, the options that don't include prosecution, reducing

stigma, and creating effective high school programs. As LEAD expands, it will look different in different communities.