Municipal Responses to the Opiate Epidemic

Materials


Speakers

**Brian Lowe** has served as the Chief of Staff for Mayor Miro Weinberger since July 2015 and supported the Mayor’s efforts to strengthen the City’s finances, modernize its operations, expand opportunities available for its residents, and reduce its environmental impact. He has been closely involved with the City’s efforts to address the opioid crisis through the Chittenden County Opioid Alliance and the City’s CommunityStat initiative. He worked previously at the U.S. Department of
the Treasury focused on terrorist financing and financial crimes and at the Council on Foreign Relations. His wife, Dr. Hillary Anderson, is a pediatric resident at the University of Vermont Medical Center and they live in Burlington with their young son Sawyer.

**Mayor Svante L. Myrick** was sworn into office and became the City of Ithaca’s youngest Mayor and first Mayor of color on January 1, 2012. After serving the 4th Ward of the city for 4 years on Common Council, Mayor Myrick brings several different perspectives to the office. Mayor Myrick has a deep understanding of the needs of the residents. "I am inspired by the sense of hope and willingness to get to work that is expressed repeatedly in my meetings with residents. I enjoy working with Common Council, city staff, and members of the community to find the innovative ideas that are often born during difficult economic times. My goal is for the City of Ithaca to become a model for other cities and I believe we are well on our way!" states Myrick.

As a passionate advocate for the youth in our community, Mayor Myrick chaired the committee that created the Ithaca Youth Council. He also chaired the Collegetown Vision Implementation Committee, which led to the creation and endorsement of a master plan for promoting development while still preserving neighborhoods in Collegetown. Raised by a single mother along with his 3 siblings, Mayor Myrick inherited his strong work ethic from his mom. A graduate of Cornell University, where he studied Communication, Mayor Myrick was a 3-year board member for REACH (Raising Education Attainment Challenge), and tutored under-served young people in Ithaca for 8 semesters. After graduating, he continued his work with local youth working as an apprenticeship coordinator with The Learning Web. Mayor Myrick also served as the Assistant Director of Student and Young Alumni Programs for Cornell University before resigning his position to run for mayor. In his spare time, the Mayor enjoys speaking to youth groups around the state about achievement, civic engagement, and community building.

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LEADING IN A CRISIS:  
RECOMMENDATIONS AT A GLANCE

City and county leaders must assume roles of leadership in local efforts to reverse the trends of the opioid crisis.

1. Set the tone in the local conversation on opioids.
2. Convene community leaders.
3. Foster regional cooperation.
4. Educate and advocate to state and federal partners.
5. Ensure progress for all in formulating responses to addiction.

Leading in a Crisis

In early 2016, the Massachusetts Municipal Association published a report for local leaders on the opioid crisis aptly titled “An Obligation to Lead.” The opioid epidemic, wrote the association, “presents more than an opportunity,” and is a “moral duty that all of us who are privileged to serve in local government must embrace fully.”

We wholeheartedly echo those sentiments and call on city and county leaders to assume leadership roles in local efforts to reverse the trends of the opioid epidemic. It has become apparent that this epidemic can ravage any community in the nation regardless of its size or composition. In the face of such a threat, which has taken far too many lives and torn apart countless families, local officials must lead with energy, urgency and compassion. There is much to be accomplished in reversing the opioid epidemic, and few are better positioned to carry out this work.
Recommendations

1 Set the tone in the local conversation on opioids.

As local government officials, we are privileged to speak to our constituents with the authority and legitimacy that comes with public office and the trust and empathy derived from living daily in the communities we serve. From this invaluable position, we must set the tone in conversations about opioids by breaking the silence and speaking candidly and compassionately about the crisis in our cities and counties. However, we must also highlight and uplift local efforts to prevent further abuse of opioids and the overdoses and deaths that result from such abuse. In short, we must define our local struggles with the opioid crisis so that those struggles do not define our cities and counties.

By setting a constructive and compassionate tone in conversations on opioid abuse, we can achieve the imperative of chipping away at the stigma of opioid addiction. Stigma can prevent parents and teachers from speaking with children about the dangers of opioids, prevent individuals struggling with opioid addiction from seeking the treatments they need and prevent cities and counties from providing these treatments. As local leaders, we must normalize conversations about addiction and its treatment to empower individuals, families and governments to take actions needed to address the opioid crisis, without fear of the stigma that such actions may bring.

2 Convene community leaders.

It is imperative that local government officials be in regular contact with community leaders who work with populations affected by the opioid crisis and who are thus well positioned to contribute to effective local responses. City and county leaders should form or join local task forces of leaders from various sectors of local government and across the community to assess the causes and impacts of opioid abuse and the solutions needed to decrease rates of abuse. Elected officials, health officials—including behavioral health and substance abuse directors—judges, prosecutors, public defenders and law enforcement officials, among others, should be involved in the task forces. Joining them should be education officials, representatives from local medical societies, directors of treatment facilities, parent advocates and faith leaders.

The Community Anti-Drug Coalitions of America (CADCA) helps to establish or strengthen local coalitions to create and maintain safe, healthy and drug-free communities. CADCA can point to community coalitions in an area or walk local government officials through the process of starting a coalition. The organization also offers a variety of resources for local coalitions, including technical assistance and training and media and marketing strategies.
3 Foster regional cooperation.

Just as it imperative that local government officials establish regular communication with leaders in the community, it is also vital to establish or strengthen lines of communication with neighboring governments. Although the causes and impacts of the opioid crisis may differ in neighboring communities, solutions are more effective when coordinated among the various governments within a region. Regional cooperation is perhaps most important in law enforcement, given that drug trafficking often cuts across local lines. In northern Kentucky, the counties of Boone, Campbell and Kenton and the city of Bellevue have formed a regional task force that enables their law enforcement departments to work cooperatively in drug enforcement. Whether through formal task forces like northern Kentucky’s or through less formal regular meetings, regional cooperation should not be overlooked.

4 Educate and advocate to state and federal partners.

Although we firmly believe that the opioid crisis must be confronted and addressed locally, we are also cognizant that many important decisions that affect this crisis are made at the state and federal levels. City and county officials should educate their state and federal counterparts on the effects of the opioid crisis on local communities and advocate for actions from those levels of governments that can help reverse trends of opioid misuse. State and national membership organizations, like the National League of Cities and the National Association of Counties and their sister organizations in states, are well positioned to assist local officials with state and federal advocacy.

See the section on “Recommendations for State and Federal Officials” for specific state and federal actions that can help local governments address the opioid crisis.

5 Ensure progress for all in formulating responses to addiction.

Communities of color continue to feel the detrimental effects of the criminalization of addiction, which today is being replaced by a new focus on harm reduction and improved public health. Moving forward, we must give ongoing attention and action to the racial disparities relevant to addiction and to its treatment. Both the National League of Cities and the National Association of Counties should continue programs of research, information sharing, educational programming, advocacy and technical assistance in the fields of addiction and addiction treatment beyond the duration of this task force.
In order to stem the tide of the opioid epidemic, local leaders must approach prevention and education efforts with the same urgency and determination with which we work to reverse overdoses and arrest drug traffickers.

1. Increase public awareness by all available means.
2. Reach children early, in and outside of schools.
3. Advocate for opioid training in higher education.
4. Embrace the power of data and technology.
5. Facilitate safe disposal sites and take-back days.

Focusing on Prevention and Education

It is said that an ounce of prevention is worth a pound of cure, and this certainly applies to our efforts to fight the opioid crisis. Given the staggering number of overdoses and deaths from the opioid crisis, a heavy focus is placed, with good reason, on treatment. But that focus and urgency should not diminish our determination to prevent others from becoming addicted in the first place. Preventing individuals from abusing and becoming dependent on opioids will save lives, preserve the health and vibrancy of our communities and result in significant fiscal savings for local governments, many of which are struggling to fund addiction treatments. By approaching prevention and education efforts with the same urgency and determination with which we work to reverse overdoses and arrest drug traffickers, we can begin to create the cultural transformation needed to free our communities from the grip of the opioid crisis.
Recommendations

1. **Increase public awareness by all available means.**

   As local elected leaders, we are uniquely positioned to spread information about the dangers of prescription painkillers and the lethality of heroin and other illicit opioids. From traditional forms of communication, like town hall meetings and pamphlets, to newer forms, like Facebook and Twitter, we have numerous platforms through which to communicate with our constituents. We must fully use these platforms to increase public awareness about the dangers of opioids, and we must be thoughtful and creative in crafting our messaging.

   Further, we must actively look for new opportunities to communicate with constituents, especially those who may be at greater risk of opioid abuse and addiction. The Ocean County, N.J., prosecutor’s office has done this through its “funeral cards,” which contain information about the dangers of prescription painkillers alongside instructions for proper disposal of remaining prescriptions. The prosecutor’s office gives these cards to funeral directors, who then hand them out to families of deceased individuals.

2. **Reach children early, in and outside of schools.**

   Children should be educated at the earliest possible age about the dangers of prescription painkillers and illicit opioids. Classrooms provide an excellent opportunity to do so. The
National Institute on Drug Abuse offers free resources for teachers, including lesson plans, activity finders and student-targeted pamphlets that answer questions like, How do opioids work? How do people get addicted to opioids? Out-of-school recreation programs also provide valuable opportunities to engage children and youth on these topics.

Local elected officials should also call on each parent in the community to speak regularly with their children about the dangers of prescription and illicit opioids. According to the Red Ribbon Campaign, an initiative of the National Family Partnership that asks parents to pledge to educate their children about drug abuse, children of parents who speak with their teens regularly about drugs are 42 percent less likely to use drugs than those whose parents do not, yet only one-fourth of teens report having these conversations.

3 Advocate for opioid training in higher education.

Students in health-related undergraduate and graduate programs, in addition to those in medical, pharmacy, nursing and dental schools, should receive appropriate training on pain management and substance use disorders. City and county leaders should assess the extent to which this training is provided in educational institutions within their jurisdiction and use their positions as elected leaders to advocate for greater training where needed.

Although the importance of opioid prescription training for medical and dental students is self-evident and overarching, local leaders should also advocate for drug abuse intervention
training for all students in health-related fields. The Screening, Brief Intervention and Referral to Treatment (SBIRT) program is an evidence-based approach endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). It promotes universal screening of all individuals to identify use, early risks and abuse in order to intervene appropriately. Basic SBIRT training is available via a free app developed at the Baylor College of Medicine.

4 Embrace the power of data and technology.

Local leaders must recognize the potential of data and technology to advance efforts in fighting the opioid crisis. When properly collected and analyzed, data can help cities and counties better understand the causes of opioid abuse in communities and fine-tune their responses. Data related to overdoses and deaths, for example, can help local leaders focus public awareness efforts on neighborhoods facing greater rates of opioid-related harm. City and county leaders should assess where data is being collected within local government and to what extent it is being shared between different departments and local, regional and state governments.

In addition, city and county leaders should advocate for greater data collection and use of data and technology. Coroners should list with specificity the drugs that caused opioid-related deaths so public health and law enforcement officials can adjust responses accordingly. Administration of the overdose antagonist naloxone should be tracked closely to better target overdose prevention and treatment efforts. Mapping technology can also provide information to individuals about resources such as safe disposal locations, pharmacies that dispense naloxone and facilities that offer treatment services.

5 Facilitate safe disposal sites and take-back days.

Cities and counties must ensure that there are a sufficient number of accessible, safe disposal sites within their jurisdiction so members of the community can dispose of unneeded opioids. Local pharmacies, physicians and law enforcement can serve as important partners in efforts to provide and promote safe and convenient disposal sites. Information about these sites should be widely shared through traditional and web-based forms of communication. Cities and counties should also host periodic drug take-back days so community members can dispose of unneeded opioids at a convenient location while also creating public awareness about the dangers of prescription drugs. The Drug Enforcement Administration (DEA) partners with local communities across the country to host national take-back days. On April 30, 2016, Franklin County, Ohio, collected 4,000 pounds of prescription drugs, and the DEA reported that 447 tons were collected overall throughout the country.
Expanding Treatment

As society has embraced the need to medically treat addiction rather than incarcerate those with a substance use disorder convicted of a crime, the need for treatment longer than 90 days has grown and overwhelmed city, county and state governments’ ability to respond. But we do know how to treat chronic illness. Nearly the same number need treatment for diabetes (29 million) as those needing treatment for substance use disorder (21 million). Yet roughly three of four diabetes patients receive treatment while only 12 percent of those with substance use disorder do, according to estimates from the Centers for Disease Control and Prevention. Society is in short supply of drug treatment specialists to carry out medication-assisted treatments and dispense methadone, buprenorphine and naltrexone. Training programs are necessary for health professionals, and more patients should be served by doctors in private practice. Arbitrary caps should be removed on the number of patients undergoing medication-assisted treatments, at least during the present epidemic.
Recommendations

1. **Make naloxone widely available.**

   Local leaders should work to ensure that naloxone, an overdose recovery medication, is made widely available in each community and provided to all city and county first responders. Nearly 40 states now grant some broad authority to pharmacists—such as through a standing prescription order from the state’s public health director or by a collaborative drug therapy agreement—to distribute naloxone not only to those with an opioid prescription but to those who support or act as caregivers to people suffering with addiction, and in some cases to the general public. This practice should be operational in all 50 states and territories. Bulk purchasing agreements by organizations such as the U.S. Communities Government Purchasing Alliance can make this life-saving drug available to cities and counties at a significant discount, easing the cost burden on local government.

   The administration of naloxone should be followed by medical holds, referrals or “warm handoffs” to counseling and treatment services that help individuals address the underlying drug abuse that led to their overdose. Without follow-up services, administering naloxone can amount to delaying a lethal overdose, rather than saving a life.

2. **Intervene to advance disease control by implementing a clean syringe program.**

   Safe disposal of unused prescription medications and needles contaminated with blood are important steps to protect against outbreaks of HIV and hepatitis. Establishing places or programs to deposit used syringes and needles not only helps with disposal, but also opens a path for individuals seeking substance use treatment.

   At a minimum, localities can provide information on hospitals, clinics or other health facilities and providers who will

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**TOOLS AND EXAMPLES**

**Recovery coaches in Ocean County, N.J.**

The Ocean County prosecutor’s office has launched the “Recovery Coach Program,” a voluntary program that connects individuals revived by naloxone with treatment options once they are stabilized in emergency rooms. Working with area hospitals, the program matches an overdose victim with a recovery coach, who, if the patient is willing, will work with the person for up to eight weeks and help steer him or her toward recovery. Free or subsidized treatment is available for willing participants. The coaches are typically in recovery themselves, which officials say provides a perspective that doctors and law enforcement officials cannot. Early in the program, up to 70 percent of overdose victims had agreed to participate in the program.
receive or exchange contaminated syringes and needles for new ones. One such program, The Point, developed by the Center for Health and Social Research at SUNY Buffalo in collaboration with the Erie County, N.Y., Department of Health, provides information on locations where an individual can access clean needles and syringes.

Increase availability of medication-assisted treatments.

A regimen of long-term (six months or more) medication exchange (such as methadone, buprenorphine or naltrexone replacing heroin), psychological counseling, peer-to-peer support networks and close patient monitoring is the evidence-based model to address addiction and co-occurring mental health problems. Such sophisticated medication-assisted treatment requires highly trained practitioners and access to often costly medication. At present there are too few drug treatment specialists to meet the growing demand. Progress can be made if more health professionals, such as licensed practical nurses, can undergo training to properly administer medications such as buprenorphine and naltrexone. Both the federal government and county governments (such as Erie County, N.Y.) have expanded the availability of such training programs.
Efforts are in place to make better use of community health centers to increase treatment services. Likewise, rules that limit the number of patients to whom any single physician can prescribe buprenorphine are barriers to increasing treatment. Instead of capping the level of physician treatment, doctors in private practice should be incentivized to treat more patients struggling with a substance use disorder.

Increasing the cooperation between city and county governments to enhance the number of beds for long-term medication-assisted treatment is critical to overcoming this health crisis.

4. **Expand insurance coverage of addiction treatments.**

Local leaders should advocate for including addiction treatments in all health insurance plans and removing limits on such treatments. In addition, city and county officials should work to ensure that the health plans of local government employees cover addiction treatments. Given that cities and counties together employ several million individuals, including addiction treatments in local government health plans represents a significant step toward enabling individuals to access affordable treatments for substance abuse.

5. **Employ telemedicine solutions.**

Although the nature of addiction treatment often requires in-person visits with medical professionals, telemedicine can enhance these treatments. Advances in technology have expanded access to health professionals and extended the capacity of each individual service provider to meet the growing needs of those with substance use disorders. For paramedics responding to calls, telemedicine can facilitate immediate support to patients. The technology is also useful in serving rural populations, where distance between first responders and patients is often a critical factor.

The U.S. Department of Agriculture has awarded Distance Learning and Telemedicine grants to establish telemedicine networks to provide treatment for medical conditions, including mental health and drug addiction treatment. These grants are also designed to expand and improve rural counseling centers with mental, behavioral and psychiatric care services and substance treatment services, and to support mobile health units providing onsite care and telemedicine video conferencing with doctors and specialists.
Local leaders should advocate for including addiction treatments in all health insurance plans and removing limits on such treatments.
Reassessing Public Safety and Law Enforcement Approaches

Cities and counties have been fighting the “war on drugs” for nearly five decades, and unlike many other wars, this war is waged on American soil. Because this war has largely failed to differentiate between individuals struggling with addiction and traffickers who profit from addiction, communities, and in particular communities of color, have suffered extensive casualties in the war. The end result of this criminalization of addiction has been a cycle of over-incarceration that fails to address the root causes of drug abuse in our communities and costs taxpayers trillions of dollars.

In recent years, and with the onset of the opioid epidemic, local governments are reassessing and shifting approaches to drug enforcement. Although law enforcement agencies continue to carry out the important task of aggressively pursuing the drug traffickers and cartels that are flooding our communities with illicit drugs such as heroin and fentanyl, they are placing a greater focus on alternatives to arrest for those whose low-level criminal behavior is rooted in addiction.
Good Samaritan laws that provide legal protection for individuals who report overdoses have also been widely embraced.

Local law enforcement and public safety officials must continue to work closely with health care providers, addiction treatment facilities, and drug courts to identify such alternatives. Equipped with the discretion to use these alternatives, local law enforcement officials can continue to play a crucial role in helping to break the cycle of addiction that, as past efforts to criminalize addiction have made clear, cannot be solved through arrest and incarceration.

**Recommendations**

1. **Reduce the illicit supply of opioids.**

   City and county leaders should facilitate partnerships between local law enforcement and their state and federal counterparts to identify the flow of illicit drugs into communities. They should use all available law enforcement resources to incarcerate drug traffickers. Local law enforcement agencies should work closely with DEA’s State and Local Task Force Program. The program’s ability to combine federal resources with state and local officers’ detailed knowledge of their jurisdictions leads to highly effective drug enforcement investigations.

   By targeting drug traffickers and the supply chain of drugs, local law enforcement can dramatically reduce the availability of drugs in communities. Reducing supply is especially important as drug dealers are increasingly lacing heroin with lethal drugs like carfentanil, which is used to sedate large animals. Drug users are typically unaware that the drugs they are purchasing are laced in this way, resulting in greater frequency of lethal overdoses. In August 2016, in a span of just two

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**TOOLS AND EXAMPLES**

**Drug Market Intervention in High Point, N.C.**

First piloted in 2004 in High Point, N.C., Drug Market Intervention (DMI) is a strategy for shutting down overt drug markets and improving life for residents in the surrounding communities. DMI identifies particular drug markets and street-level dealers, arrests violent offenders, creates “banked” cases—or suspends prosecution—for nonviolent dealers and brings together dealers, their families, law enforcement officials, service providers and community leaders for a call-in meeting that makes clear that selling drugs openly must stop. The strategy also includes a critical process of racial reconciliation to address historical conflict between law enforcement and communities of color.
days, Cincinnati’s emergency services responded to more than 60 heroin overdoses, many of which resulted from batches of heroin laced with carfentanil. Active and collaborative drug enforcement is key to preventing further tragedies.

2 Consider alternatives to arrest.

City and county leaders should empower local law enforcement officials to use alternatives to arrest for individuals who commit low-level crimes associated with drug abuse and often co-occurring mental health issues. Illicit drug use and low-level possession of drugs continue to be treated as criminal behavior throughout the country, leading to millions of arrests each year. However, many local law enforcement agencies have taken the position that arresting users for possession is not an effective way to change behavior. Instead of criminalizing drug addiction, communities are now addressing the problem as a treatable disease that requires intervention and treatment. The International Association of Chiefs of Police states that law enforcement leaders “should strive to create innovative partnerships with public health providers and rehabilitation experts to help line officers respond more effectively to substance abusers with an increased array of alternative solutions to incarceration.”

Local law enforcement officers are among a community’s best resources in the effort to identify individuals with who need treatment for a substance use disorder and divert those individuals to needed treatment services. As an alternative to arrest and incarceration, local law enforcement officers should be able to refer drug addicts to local, community-based drug treatment programs to break the cycle of drug use. Local governments should train local law enforcement officials on resources that are available for drug treatment programs and how individuals who need treatment can access these programs.
**Seattle/King County LEAD Program**

In 2011, Seattle and King County began piloting the Law Enforcement Assisted Diversion Program (LEAD) to address low-level drug and prostitution crimes in targeted city neighborhoods and parts of King County. The program's goals are to improve public safety and public order and to reduce the criminal behavior patterns of people who participate in the program. LEAD is a coalition of law enforcement, public health, city and county officials, community stakeholders and private-sector supporters.

LEAD is a pre-booking diversion program that empowers street-level public safety personnel to make decisions about arrests. Rather than moving persons with substance use disorder into the criminal justice system, LEAD participants begin working immediately with case managers and social workers. In the case of persons suffering from addiction, LEAD participants have access to trained clinicians who specialize in medication-assisted treatments and have been the key providers in the region for street-level outreach. Treatment services may include substance use disorder treatment, mental health support, housing and job training.

LEAD has been independently evaluated by researchers from the University of Washington. They find that the program reduces recidivism significantly among participants (both on a pre/post-participant-only analysis and when compared with a selected group of controls) and also reduces criminal justice spending.

### Divert from the criminal justice system.

City and county officials should advocate for diversion from incarceration for nonviolent individuals whose low-level criminal behavior stems from their drug addiction. Many communities throughout the country have established drug courts to help individuals struggling with addiction enter a substance abuse program instead of serving time in jail. Drug courts employ a program designed to reduce drug use relapse and criminal recidivism through risk and needs assessment, judicial interaction, monitoring and supervision, graduated sanctions and incentives, treatment and various rehabilitation services. A multidisciplinary team of judges, prosecutors, defense attorneys, community corrections, social workers and treatment service professionals often manages the courts and provides targeted treatment services to drug offenders.

Although drug courts have higher investment costs, especially in treatment services, many communities have experienced extensive savings associated with victim and criminal justice system costs because of fewer crimes, rearrests and incarcerations. On average, drug courts save an estimated $5,680 to $6,208 per offender.
Diversion courts have a particularly positive impact on our nation’s veterans. According to a 2011 study from the U.S. Department of Veterans Affairs (VA), veterans are nearly twice as likely to die from an accidental opioid overdose than their civilian counterparts. Veterans’ treatment courts offer an opportunity for those suffering with substance abuse or mental health issues to receive assistance in accessing their earned benefits, obtaining targeted treatment and connecting with a peer mentor who understands their challenges and pain. There are already over 200 such courts, and local jurisdictions can receive assistance in setting up their own veterans’ treatment court through the Justice for Vets initiative.

Facilitate treatment in jails.

Local leaders should work to ensure that inmates in local jails who struggle with addiction receive proper treatment for their illness, including medication-assisted treatments, with a special focus on pre-release treatment and service coordination. Treatment programs in jails offer an opportunity to break the cycle of drug abuse and criminal behavior that ensnares many individuals who come into contact with the criminal justice system. Jails can implement low-cost treatment programs to provide these individuals the treatment they need. Statistics demonstrate that incarcerated individuals who struggle with opioid addiction and receive little or no treatment are much more likely to relapse into drug use and criminal behavior on their release. These individuals also are more likely to suffer a lethal overdose shortly after being released. Treatment programs in jails have consistently been shown to reduce the costs associated with lost productivity, crime and incarceration caused by heroin use.

Providing treatment services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations. Drug treatment should address issues of motivation, problem solving and skill building for resisting drug use and criminal behavior. Treatment programs during incarceration should also facilitate the development of healthy interpersonal relationships and improve the participant’s ability to interact with family, peers and others in the community.
Support “Ban the Box” initiatives.

City and county officials should change hiring practices to prohibit questions regarding past criminal history on applications for local government jobs and hiring by vendors under government contract. Among the biggest challenges individuals convicted of drug offenses face is securing employment and housing after release from jail. The inability to find a job or a place to live leads many to return to their previous criminal activities and remain in the grip of opioid abuse and associated criminal behavior.

One program used in more than 100 cities and counties is the “Ban the Box” initiative. This initiative prevents prospective employers from asking about the criminal background history during the early stages of the application process. The goal of the initiative is to ensure employers first consider the job candidate’s qualifications without the stigma of a criminal record.

To support local efforts to enact “fair-chance” policies, the National Employment Law Project (NELP) has developed best practices and model policies for local governments. The NELP toolkit provides model administrative policies, sample resolutions, ordinances, state executive orders and model state legislation.

TOOLS AND EXAMPLES

Kenton County detention center treatment program

It is estimated that roughly 80 percent of those booked into the Kenton County detention center in northern Kentucky are incarcerated for charges that are either directly or indirectly related to substance abuse disorders. In 2015, jail directors dedicated a 70-bed dormitory in their facility to substance abuse treatment, adding to the 30 beds already designated for such treatment.

The voluntary, application-based six-month program provides inmates with cognitive-behavioral therapy, intensive counseling individually and in groups, spiritual programming and, prior to their release, a naltrexone injection to block the effects of opioids for 30 days after release. Inmates are also connected to community services before they are released, including organizations that help them attain health insurance. As of mid-2016, nearly 200 inmates had completed the program, and the recidivism rate was less than 10 percent.


TOOLS AND EXAMPLES

Tallahassee Ban the Box initiative

In January 2015, Tallahassee moved to adopt a new set of municipal hiring guidelines for criminal background checks. City officials recognized that in 2014, more than 1,700 formerly incarcerated individuals returned to Leon County, Fla., and almost 200,000 more are expected to be released in Florida during the next five years.

To help remove employment barriers for people with criminal convictions, the city manager can now inquire about criminal history and conduct background checks later in the interview process, rather than at the start.

Of the 816 criminal background screenings conducted in 2014, excluding those for public safety jobs, 15 percent had criminal histories. Of those 15 percent, 11 percent were hired and 4 percent were denied on the basis of their background as it applied to positions.
Law Enforcement Assisted Diversion (LEAD): Reducing the Role of Criminalization in Local Drug Control

February 2016

Many U.S. cities are taking steps to reduce the role of criminalization in their local drug policies. Seattle, Washington, has been at the forefront of this effort, pioneering a novel pre-booking diversion program for minor drug law violations and other low-level offenses known as Law Enforcement Assisted Diversion (LEAD). Santa Fe, New Mexico, Albany, New York, and several other cities have begun exploring LEAD as a promising new strategy to improve public safety and health.

What is LEAD?

In 2011, Seattle instituted a pilot program known as “Law Enforcement Assisted Diversion,” or LEAD. LEAD was the first pre-booking diversion program in the country. Instead of arresting and booking people for certain petty offenses, including low-level drug possession and sales (of seven grams or less), law enforcement in two Seattle-King County neighborhoods may immediately direct them to housing, treatment and other services.1

LEAD emerged after a growing realization that Seattle’s approach to drug law enforcement was both costly and unjust. A decade ago, Seattle had one of the worst racial disparities in drug arrests of any city in the country, propelling a multi-year lawsuit against the Seattle Police Department. In 2006, for example, black people were “more than 21 times more likely to be arrested for selling serious drugs than whites,” even though white people are the “majority of sellers and users” in Seattle.2 The litigation sparked an open dialogue between the Police Department and the community – which ultimately gave rise to LEAD.

LEAD is a collaborative effort among the King County Prosecuting Attorney, Seattle City Attorney, Seattle Police Department, King County Sheriff, King County Executive, Seattle Mayor, State Department of Corrections, Public Defender Association, ACLU of Washington and the community.

Harm Reduction: A Core Principle of LEAD

LEAD is based on a commitment to “a harm reduction framework for all service provision.”3 LEAD does not require abstinence, and clients cannot be sanctioned for drug use or relapse.

LEAD recognizes that drug misuse is a complex problem and people need to be reached where they currently are in their lives. LEAD incorporates measures like health, employment, social relationships and overall well-being – instead of abstinence – into the program’s goals and evaluation, so that participants are never punished for failing a drug test.4 The program emphasizes “individual and community wellness, rather than an exclusive focus on sobriety.”5 Former Interim Police Chief James Pugel explains that LEAD’s “over-all philosophy is harm reduction…we know there may be relapse and falls.”6

“Other programs want you to jump through so many hoops. But when a person got an addiction, you got to get them some help…a roof over their head…LEAD helped me get back to my true self.”

– LEAD Participant.7

LEAD has helped improve community-police relations8 and precipitated a fundamental policy shift in Seattle-King County, from an “enforcement-first” approach to a health-centered model – reinforced by specialized harm reduction training required of every officer.9 LEAD appears to be changing law enforcement culture about how to promote public safety.10
LEAD is a working example of how, even in the absence of state legislation, cities can craft policies that aim to bypass the criminal justice system – and that benefit public safety and health.

“Unlike drug court, LEAD does not require the presence of judges, court staff, prosecutors, or public defenders. The resources saved from keeping participants out of the criminal justice system are directed towards those individuals.”
– Lisa Daugaard, Defender Association, Seattle.

LEAD is a promising alternative to expensive court-based interventions. In the LEAD model, “the court is completely taken out of the equation.”12 Participants are given immediate access to services without displacing voluntary treatment candidates. LEAD seems to be reaching its target population, with reports indicating that a majority of clients are “referred on drug related offenses.”13 LEAD also accommodates “social contact” referrals – through which people in need can access services without getting arrested.

LEAD Has Been Rigorously Evaluated
To ensure LEAD is effective and replicable, it has undergone a rigorous, two-year evaluation by the University of Washington measuring a host of short- and long-term outcomes, including: reductions in drug-related harms, drug use and recidivism; improvements in health, psycho-social functioning, employment and family/community involvement; cost-savings; impacts on the community; and racial disparities in drug law enforcement.14

Responses to LEAD have been favorable, and initial indications are quite promising. The multi-year evaluation suggests that LEAD is reducing the number of people arrested, prosecuted, incarcerated and otherwise caught up in the criminal justice system. It is also achieving significant reductions in recidivism. The evaluation team found that LEAD participants were nearly 60 percent less likely to reoffend than a control group of non-LEAD participants.15 This result is particularly encouraging in light of the high re-arrest rate for this population under the traditional criminal justice model.

The evaluation team also conducted an analysis of LEAD’s effect on criminal justice costs, concluding: “Across nearly all outcomes, we observed statistically significant reductions for the LEAD group compared to the control group on average yearly criminal justice and legal system utilization and associated costs.”16

LEAD participants showed cost reductions, while non-LEAD controls showed cost increases. These significant cost decreases result from substantial reductions in time spent in jail, jail bookings per year, and probability of incarceration or felony charges among LEAD participants compared to “system-as-usual” controls.17

A prior evaluation report, published in 2014, found that LEAD improves coordination among multiple stakeholders who too often have worked at cross purposes. LEAD data strongly suggest improvements in the health and well-being of participants struggling at the intersection of poverty, drug misuse and mental health problems.18 LEAD is continuing a longer-term trend in Seattle of decreasing drug arrests and jail populations.19

“Treatment is expensive…but less expensive than booking people in jail. Jail is the most expensive and...least effective way to deal with drug crimes.”
– Dan Satterberg, King County Prosecuting Attorney.

Law Enforcement Supports LEAD
LEAD enjoys the enthusiastic support of local law enforcement. It allows law enforcement to focus on serious crime while playing a key role in linking people to services instead of funneling them into the justice system.21 According to officials, “Law enforcement is supportive of the program because it gives them additional tools to handle public safety issues.”22

““We’re out in the community, we know the offenders by name, know their situations…and we’re tired of the revolving door, too.”
– Sgt. Sean Whitcomb, Seattle Police Department.23

Scaling and Replicating the LEAD Model
LEAD operated in its first four years with private funding. Thereafter, the City of Seattle committed funds to help scale up locally.

In 2014, Santa Fe, New Mexico, became the second city in the U.S. to do so by unanimous city council vote. Santa Fe’s LEAD program was developed after nine months of study and community engagement and is tailored to the community’s needs: Unlike Seattle, Santa Fe’s main concerns are not drug markets, but rather opioid misuse, dependence and overdose, as well as rising rates of property crime.
Santa Fe’s experience demonstrates the flexibility of the LEAD model, and how different communities can adapt it to their particular local contexts and needs.

Eligibility for Santa Fe LEAD will be limited to those caught possessing or selling three grams or less of opioids. A cost-benefit analysis estimates that local and state government spends $1.5 million per year to criminalize people in the City for these offenses; LEAD could cut those costs in half.24

In June 2015, Albany, New York, became the third city in the United States — and the first in the Northeast — to adopt a LEAD program. After officials signed a memorandum of understanding, the program took effect immediately pursuant to Albany’s “community policing” philosophy.

Numerous other cities around the country — including Atlanta, Buffalo, Houston, Ithaca (NY), Los Angeles, New York City, Philadelphia, Portland (ME) and San Francisco — have expressed interest in replicating LEAD.

And in July 2015, in a remarkable indication of both the growing interest in LEAD as well as the rapid evolution of the Office of National Drug Control Policy (ONDCP), the White House held a national convening to discuss and promote LEAD, with the participation of representatives from over 30 cities, counties and states.25

4 Katherine Beckett, “Seattle’s Law Enforcement Assisted Diversion Program: Lessons Learned from the First Two Years,” (Ford Foundation, 2014)
6 The Defender Association, “L.E.A.D.: A Pre-Booking Diversion Model.”
7 James Pugel, “Law Enforcement Assisted Diversion” (presentation at the Smart Justice Symposium, Spokane, Washington, November 9 2012).
9 Beckett, “Seattle’s Law Enforcement Assisted Diversion Program: Lessons Learned from the First Two Years.”
10 Ibid.
17 Ibid.
18 Beckett, “Seattle’s Law Enforcement Assisted Diversion Program: Lessons Learned from the First Two Years.”
21 Maggie Clark, “Seattle Police.”
22 Dan Satterberg et al., “Seattle L.E.A.D.’s on Law Enforcement Diversion.”
23 Maggie Clark, “Seattle Police.”
24 LEAD Task Force City of Santa Fe, “Healthy Families, Safer Streets: City of Santa Fe’s Lead Task Force: Recommendations to the City Council” (2013).
Supervised Consumption Services

March 2017

Overview

Supervised consumption services (SCS) – also called safer injection facilities (SIFs), drug consumption rooms (DCRs) or safer drug use services (SDUS) – are legally sanctioned facilities designed to reduce the health and public order issues often associated with public injection. These facilities provide a space for people to consume pre-obtained drugs in controlled settings, under the supervision of trained staff, and with access to sterile injecting equipment. Participants can also receive health care, counseling, and referrals to health and social services, including drug treatment.

There are approximately 100 SCS currently operating in over 65 cities around the world in ten countries (Switzerland, Germany, the Netherlands, Norway, Luxembourg, Spain, Denmark, France, Australia, and Canada) – but none in the U.S. There are plans for the opening of SCS in Scotland, Ireland, major cities across Canada, and most recently in Seattle, WA.

SCS can play a vital role as part of a larger public health approach to drug policy. SCS are intended to complement – not replace – existing prevention, harm reduction and treatment interventions.

SCS Improve Safety and Health

Numerous evidence-based, peer-reviewed studies have proven the positive impacts of supervised injection services, including:

- Increasing use of substance use disorder treatment, especially among people who distrust the treatment system and are unlikely to seek treatment on their own;
- Reducing public disorder, reducing public injecting, and increasing public safety;
- Attracting and retaining a population of people who inject drugs and are at a high risk for infectious disease and overdose;
- Reducing HIV and hepatitis C risk behavior (i.e. syringe sharing, unsafe sex);
- Reducing the prevalence and harms of bacterial infections;
- Successfully managing hundreds of overdoses and reducing drug-related overdose death rates;
- Saving costs due to a reduction in disease, overdose deaths, and need for emergency medical services;
- Providing safer injection education, subsequently increasing safer injecting practices;
- Increasing the delivery of medical and social services.

In areas surrounding existing SCS, there has been no evidence of increased community drug use, initiation of injection drug use, or drug-related crime. A 2014 systematic review concluded: “All studies converged to find that SIFs were efficacious in attracting the most marginalized people who inject drugs, promoting safer injection conditions, enhancing access to primary health care, and reducing the overdose frequency. SIFs were not found to increase drug injecting, drug trafficking or crime in the surrounding environments. SIFs were found to be associated with reduced levels of public drug injections and dropped syringes.”

Vancouver’s InSite

Vancouver, Canada’s supervised injection facility, InSite, has been the most extensively studied SIF in the world, with over 60 peer-reviewed articles published examining its effects on a range of variables, from retention to treatment referrals to cost-effectiveness. These reports are in agreement with reviews of Australian and European SIFs, which show that these facilities have been successful in attracting at-risk populations, are associated with less risky
intervention. In January 2017, Seattle and the adopt proposal to study the feasibility of a safer DPA supports the efforts of local communities in the expand access to safer injection equipment to prevent deaths, increase access to health services and further staffed with trained professionals to reduce overdose state and national governments should explore the provided a societal benefit of more than $6 million per year.

“InSite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation.”

- Supreme Court of Canada, 2011. x

A survey of more than 1,000 people utilizing InSite found that 75 percent reported changing their injecting practices as a result of using the facility. Among these individuals, 80 percent indicated that the SIF had resulted in less rushed injecting, 71 percent indicated that the SIF had led to less outdoor injecting, and 56 percent reported less unsafe syringe disposal. xi InSite has produced a “large number of health and community benefits…and no indications of community or health-related harms.” xii

Recommendations

SCS are a vital part of a comprehensive public health approach to reducing the harms of drug misuse. Local, state and national governments should explore the implementation of legal SCS (at least at the pilot level) staffed with trained professionals to reduce overdose deaths, increase access to health services and further expand access to safer injection equipment to prevent the transmission of HIV and Hepatitis C.

DPA supports the efforts of local communities in the U.S. to pursue SCS programs. In 2012, New Mexico adopted a proposal to study the feasibility of a safer injection facility in the state – becoming the first state in the nation to consider this potentially life-saving intervention. xiii In January 2017, Seattle and the surrounding King County announced a plan to establish several SCS in the area as a pilot test to address overdose and drug use in the community. xiv Legislation has now been introduced in California, Maryland, New York, Vermont, and Massachusetts to allow SCS. Local efforts continue in cities such as Seattle, Ithaca, Boston, Baltimore, and San Francisco, where community stakeholders and people who inject drugs are similarly in favor of SCS as a step to reduce the harms of drug misuse.

Though SCS cannot prevent all risky drug use and related harms, evidence demonstrates that they can be remarkably effective and cost-effective at improving the lives of people who inject drugs as well as the public safety and health of their communities.

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xiii 50th Legislature, State of New Mexico, Senate Memorial 45 (2012) http://www.mlg.gov/Legislation/12%20Regular/memorials/senate/SM045.pdf


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iv Potier et al., “Supervised injection services: What has been demonstrated? A systematic literature review,” 48.


xiii 50th Legislature, State of New Mexico, Senate Memorial 45 (2012) http://www.mlg.gov/Legislation/12%20Regular/memorials/senate/SM045.pdf

The Ithaca Plan: A Public Health and Safety Approach to Drugs and Drug Policy
This report grows out of a recognition that the city of Ithaca, despite being a national leader in many ways, could do better in its response to drug use. As in many other parts of the country, interaction of policies and available services in Ithaca needs re-imagining to respond to past approaches that have failed. This report presents insights, findings, and recommendations that have emerged from a yearlong process of consultations with community members and stakeholders, policymakers, elected officials, experts, and service providers to inform Ithaca’s drug policies. Improving public health and safety are its guiding framework. As such, Ithaca stands poised to lead the nation in creating the first comprehensive municipal drug policy plan rooted in public health and harm reduction principles and grounded in the experiences and needs of the community.

The drug policies and services currently in place in the city of Ithaca reflect the broader policy dissonance of a shifting and bifurcated approach to drug use in New York state and nationally. While new practices are adopted to reduce the negative health and social consequences of drug use, older practices criminalizing drug use remain. The policy conflicts underlying these approaches are not new, but they create serious problems and inefficiencies when it comes to how drug use is addressed. Too often, our past approaches have failed to recognize that fundamentally, the community prevalence of health problems, such as problem drug use, and social problems, such as participation in the illegal drug economy, reflect deeper issues related to social and economic opportunity and racial inequality.

Over the past two decades, changes to drug policies and practices have been implemented in Ithaca with positive results. From the start of his tenure, Mayor Myrick recognized the need to build on these successes and develop an overall strategy to address the realities of drug use in our town.

In April 2014, Mayor Myrick convened a group of community experts and leaders, representing the various sectors involved with responding to drug use. This group came to be called the Municipal Drug Policy Community (MDPC). The MDPC was charged to identify and describe the drug-related problems we experience in Ithaca and to recommend policies and practices we could adopt to improve our local response to drug use and related policies. MDPC formed four teams to explore these questions: Prevention, Treatment, Harm Reduction, and Law Enforcement – four domains or “pillars” which reflect the ways our societal response to drug
use has been structured. The teams met several times to develop recommendations for new and reformed policies and practices, including reviews of the findings from community engagement activities designed to inform the process – a community convening with 200 Ithacans, eight focus groups involving nearly 100 participants, and dozens of one-on-one meetings with key stakeholders.

**Summary of Findings:**

**Prevention**
Finding 1: General programming for a substantial portion of young people is lacking and available programming is often inaccessible.

Finding 2: The drug trade is a symptom of widespread unemployment of young people and adults in Ithaca.

Finding 3: Geographic isolation, racism, and poverty contribute to hopelessness, which increases the likelihood of problematic drug use.

Finding 4: Drug education and prevention efforts should focus on both adults and young people and include information and skills about delaying the onset of use, preventing problem drug use, and reducing illness and death.

Finding 5: There is a lack of general awareness about drugs, how to navigate systems of care, and how to prevent drug-related deaths.

**Treatment**
Finding 1: Abstinence-based treatment programs predominate in Ithaca, and more varied treatment modalities are needed.

Finding 2: There are gaps in treatment accessibility due to limited capacity and affordability.

Finding 3: The lack of a detox center is putting an exorbitant amount of pressure on Cayuga Medical Center and costing hundreds of thousands of dollars to the tax payer.

Finding 4: Treatment programs may benefit from more cultural competency and sensitivity training.

Finding 5: Ithaca needs more medication assisted treatment options, including but not limited to, providing methadone in town and increasing the number of buprenorphine prescribers.

Finding 6: For some people, ancillary services such as mental health counseling, job training, and housing are necessary supportive services in addition to, or instead of, formal drug treatment.

**Harm Reduction**
Finding 1: More comprehensive training is needed on how to provide services to people at different points on the substance use continuum.

Finding 2: Harm Reduction is not widely understood, and few Ithacans know of the existing – and effective – local harm reduction programs already in operation.

Finding 3: Harm Reduction services need to be expanded.
Law Enforcement
Finding 1: Law Enforcement and community members alike do not believe that law enforcement personnel are best situated to deal with drug use.

Finding 2: Perceived experiences of racial profiling, difference in treatment, and racial disparities in arrests rates have created a perception that law enforcement targets communities of color and are less willing to connect them to services than white Ithacans.

Finding 3: Community opinion about drug courts is mixed. People like that drug courts connect those in need to resources, but most thought it would be more effective to make such resources available outside of the criminal justice system.

Finding 4: People fear calling law enforcement to help with drug-related issues because of the collateral consequences it can trigger.

Finding 5: While most community members and criminal justice system personnel recognize the good in diversion programs and treatment, more education about relapse and recovery are needed.

Recommendations were made across five categories and are summarized below.

Governance and Leadership
Goal: Create a mayoral-level office tasked to reduce the morbidity, mortality, cost, and inequities associated with illicit drugs and our current responses to them.

1. The mayor should open an Office of Drug Policy to orient the work of all city agencies towards reducing morbidity, mortality, crime and inequities stemming from drug use and our responses to it. This new approach recognizes that criminalizing people who use drugs has not been effective and anchors Ithaca’s policies in principles of harm reduction, public health, and public safety. It also recognizes that city agencies often work at cross purposes and provides a structure for coordinating their work with the simple aim of improving the health and safety of communities, families and individuals across the city.

a. The mayor should appoint a director to: run the office; advise the mayor and city agencies; implement the MDPC recommendations for how the city can improve its drug policies; coordinate the activities of various city agencies and departments; be a liaison between city, county, state and federal agencies; and act as a spokesperson for the city on drug policy matters.
**Education**

*Goal*: Key stakeholders and all Ithacans should have access to evidence-based practices and education around drugs, preventing problematic use, reducing harms associated with drug use, and helping oneself or others who have a drug use problem.

1. The Office of Drug Policy would coordinate with existing Ithaca organizations that provide services to the community (like Southern Tier AIDS Program) to host a series of community education events every year around drugs, policies associated with drugs, and general health within the community. The Office would also coordinate training modules for service providers to ensure they are informed with the most up to date treatment options, strategies, and resources. Where possible, these training programs should include people who are directly impacted by drugs or drug policies, be evidence-based, and be grounded in a harm reduction approach.

Office of Drug Policy public education responsibilities include, but are not limited to:

a. General community awareness events (around drugs/drug policies).

b. Education events for parents and loved ones of those struggling with addiction (topics could include: recovery is not linear, medication assisted treatment, syringe exchanges, relapse is a part of recovery, Ithaca resources).

c. Narcan and overdose response trainings for the public.

d. Education for law enforcement, healthcare providers, service providers and users on harm reduction models. Examples include a train the trainer curriculum based on the Enough Abuse structure that can be run by STAP.

e. Cultural competency and sensitivity trainings for treatment and medical professionals working with people in treatment and medical settings.

f. Training healthcare providers around opioid prescribing and patient education, such as a standard concise information sheet distributed by all providers when opioids are prescribed that would also include treatment resources and information for the Ithaca addiction hotline.

**Recovery-Oriented Treatment, Harm Reduction, and Ancillary Services**

*Goal*: Create a recovery-oriented treatment continuum that offers access to timely, individualized, and evidence-based, effective care, through services that are people-centered and able to meet the needs of individuals no matter their current relationship to drug use or recovery.

1. Add an on demand centralized treatment resource system to the existing Ithaca 211 directory:

a. Conduct short screenings over the phone to assess appropriate service referral.

b. Provide referrals for treatment centers in Ithaca with up to date inpatient bed numbers.

c. Create a parent/loved one hotline (based on the Partnership for Drug Free.org)

d. Connect people to a treatment navigator (based on the Affordable Care Act navigator) to help persons or families in trouble navigate the treatment and referral process, including after care assistance.
2. Open a freestanding 24-hour crisis center in Ithaca – medication assisted and supervised outpatient detox, with case management services available on-site.

**Activities:**

a. Law Enforcement and laypersons can voluntarily bring an intoxicated individual for safety and respite.

b. This center will include short-term temporary beds for persons waiting for enrollment in treatment centers.

c. The center will also include a “chill out” space for people who are under the influence to help assuage the proliferation of public intoxication. This is not the same service as detox; the purpose of this space is not primarily to help someone withdraw but to even out, provide them with health education, and potentially connect them to harm reduction services.

d. The crisis center would also be appropriate for parents or loved ones to send their loved one in distress voluntarily, instead of a PINS or person in need of supervision process, which involves putting the person through the court system and often leads to intense strain on familial relationships, usually during crucial intervention windows. Services would include support groups (abstinence based and non-abstinence), on-site counseling, case management, and family support services.

3. The Tompkins County Department of Health should be encouraged to continue implementing an aggressive public education campaign about harm reduction practices to reduce risks from underage drinking, tobacco use, and other illicit substances.

4. Increasing awareness around the New York State 911 Good Samaritan laws can also help make adults and young people aware of the resources and the legal protections afforded victims and people who call for help.

5. The city should partner with the Tompkins County Health Department and local medical providers to offer low cost or free Hepatitis A & B vaccinations and Hepatitis C treatment to people who actively inject drugs.

6. Implement a Housing First, basic, non-contingent needs model for Ithaca to increase access to housing, nutrition and health care services without requiring abstinence or participation in treatment.

**Activities:**

a. Maintaining the safety of themselves and those around them should be the criteria to receive services, which should not be dictated by whether or not a person is using a substance.

b. This model should include but not be limited to sober living facilities, low threshold housing, and housing options for people with families.

7. The city should work with relevant agencies to integrate mental health care options into substance use services, with an emphasis on providing more robust service options for people with dual diagnoses.
8. Increase the availability of medication assisted treatment in Ithaca, including opening a methadone clinic and increasing the number of office-based buprenorphine (i.e., Suboxone) prescribers.

9. Continue and expand proven harm reduction programs, including but not limited to, syringe exchange services, opioid overdose education/trainings, syringe disposal kiosks, and naloxone distribution.

10. Explore the operation of a supervised injection site staffed with medical personnel as a means to: prevent fatal and non-fatal overdose, infectious disease, and bacterial infections; reduce public drug use and discarded needles; and provide primary care and referrals to basic services, housing, and substance use services and treatment, including the integration a basic health care provider at harm reduction sites.1,2

11. The city of Ithaca should request the New York Academy of Medicine or another objective research institute to study the efficacy and feasibility of heroin maintenance therapy for people who do not respond effectively to other forms of opioid replacement therapies.3

Community and Economic Development
Goal: Support and expand existing efforts to improve youth and family development, economic opportunity, and public health of communities, targeting vulnerable communities as immediate beneficiaries and ensuring that all Ithacans have the same access to resources and investments.

1. Partner with alternative to incarceration programs that connect low level users and sellers to jobs programs (see LEAD recommendation); integrate a jobs training program as an ancillary service in treatment centers; and create an apprenticeship program in conjunction with the Downtown Ithaca Alliance and Tompkins County Chamber of Commerce and community outreach worker to encourage youth employment.

2. Pass Ban the Box legislation for private and public sector jobs and encourage Tompkins County to do the same in order to expand job opportunities for people returning from incarceration.

3. Develop a citywide training/education program on basic work skills that would be offered before the start of any potential job training course.

4. Lobby Tompkins County to create a dedicated case management program for the re-entry population.

5. Seek to reform zero tolerance programs in the school district to incorporate restorative justice systems in order to curb the rise of suspensions, expulsions, and dropout rates all of which contribute to a young person’s general community disengagement and raise the likelihood of unhealthy risk behaviors.

6. Integrate comprehensive services to reduce the risks associated with drug use or alcohol poisoning at local establishments frequented by residential college students such as, safe settings where patrons can sit and rest.
away from loud, crowded spaces; setting up syringe disposal containers in restrooms; and providing free and accessible water during school year weekends.

7. Establish a process through the Ithaca Office of Drug Policy to monitor, investigate, and address racial, gender, age, and geographic disparities in health and socio-economic outcomes across administrative and criminal systems. These efforts should include surveillance, research, and analysis of the different data systems (including desk appearance tickets, Unlawful Possession of Marijuana violation, treatment admissions/graduations, drug court enrollment, etc.). ODP should issue a findings report and make recommendations to reduce unwarranted disparities.

**Public Safety**

*Goal: Redirect law enforcement and community resources from criminalization to increasing access to services. Encourage a shared responsibility for community health and safety that extends beyond the Ithaca Police Department.*

1. Pilot a Law Enforcement Assisted Diversion program, modeled on the successful Seattle LEAD program (see alternatives to incarceration program).

2. Train Ithaca Police Department on the syringe exchange program annually. The trainings, conducted by Southern Tier AIDS Program, should include how to make sure officers are safe when interacting with people who inject drugs and collaboratively identifying public spaces to place syringe and medication disposal kiosks.

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BURLINGTON, Vt. — In this college town on the banks of Lake Champlain, Chief Brandon del Pozo has hired a plain-spoken social worker to oversee opioids policy and has begun mapping heroin deaths the way his former commanders in the New York Police Department track crime.

In New York City, detectives are investigating overdoses with the rigor of homicides even if murder charges are a long shot. They are plying the mobile phones of the dead for clues about suppliers and using telltale marks on heroin packages and pills to trace them back to dealers. And like their colleagues in Philadelphia and Ohio, they are racing to issue warnings about deadly strains of drugs when bodies fall, the way epidemiologists take on Zika.

The police in Arlington, Mass., intervene with vulnerable users. Officials in Everett, Wash., have sued a pharmaceutical firm that they say created a black market for addicts. Seattle’s officers give low-level drug and prostitution suspects a choice: treatment instead of arrest and jail.

They are assigning themselves a big role in reversing the problems. They are working with public health officials, and carrying more antidote for heroin and its synthetic cousin fentanyl.

Few see policing, by itself, as the answer to such a complex social problem, certainly not through enforcement alone. The law enforcement approach to the crack-cocaine scourge of the late 1980s filled jails and prisons, expanded government and did little to address the social issues driving that addiction crisis.

“The police can play a critical role in a very broadly based social and medical response,” said Samuel Walker, an emeritus professor of criminal justice at the University of Nebraska Omaha. “So if people think we are going to arrest our way out of the opioid crisis, they’re wrong.”

Governors like Andrew M. Cuomo of New York and Chris Christie of New Jersey, both former prosecutors, have adopted a notably compassionate tone in framing the crisis. In 2014, Gov. Peter Shumlin of Vermont used 34 minutes of his state-of-the-state speech to urge treatment
and support for addicts. As a candidate, President Trump vowed to solve America’s drug crisis, a pledge that resonated in impoverished, rural areas that have been ravaged in recent years by opioids.

Labeling it a health epidemic, not a war on drugs, marks a stark contrast with the criminal justice system’s approach to the crack-cocaine plague, which was met by mass arrests in mostly black and Hispanic communities.

Now, policing leaders claim to have learned from the past. But they also know how violent crime can flow from illegal drugs the way Anthony Riccio, a chief in the Chicago Police Department, says is happening in his city. A big fear among police chiefs is that increased demand for low-cost, high-potency opioids will lead to more shootings, and murders, as prices drop and drug traffickers organize.

In Mexico, where almost all of the heroin entering the United States is grown and cultivated, violence surrounding the drug trade is “horrific,” said Chuck Rosenberg, who runs the Drug Enforcement Administration.

But American cities are not immune.

“In almost all of our major seizures and arrests, we’re encountering weapons,” Mr. Rosenberg said. “And there’s only one reason to have those around.”

Increasingly, the police find themselves scrambling from call to call for reports of seemingly lifeless bodies. Death counts are rising. Nearly 1,400 people died of drug overdoses in New York City last year, the highest ever and up from 937 the previous year. In Philadelphia, the tally was 906. Nationally, there were 52,000 overdose deaths in 2015, Mr. Rosenberg said. And last year, the drug overdose death count likely exceeded 59,000, according to preliminary data compiled by The New York Times.

Despite the daily toll, no single loss has seemed to galvanize collective concern or outrage, and some fear that a kind of compassion fatigue is setting in.

“Where is the Len Bias moment?” asked Chuck Wexler, the executive director of the Police Executive Research Forum, referring to the college basketball star’s cocaine-overdose death in 1986, considered a starting point for a so-called national war on drugs.

“We’ve been at this for, now, four or five years, and the overdose numbers continue to go up,” he added. “What’s going to be the defining moment to move this in a different direction?”

To that end, Mr. Wexler brought scores of local law enforcement leaders together last month to confront a battle that J.Scott Thomson, the police chief in Camden, N.J., told them “we are still losing.” In an auditorium at 1 Police Plaza in Lower Manhattan, attendees spoke with prosecutors and public health officials of the new tactics and realignments the crisis has wrought.
They discussed the “good Samaritan” laws that grant overdose victims seeking medical help immunity from prosecution, and how sheriffs can get help for addicted inmates. But each idea seemed a friction point: How to tell a midlevel dealer from a user needing help? How to tie a specific drug to a death to bring a murder charge? How to choke off supply routes that begin beyond their borders? How to use more discretion on nonviolent drug violators when Attorney General Jeff Sessions is ordering the harshest possible charges in federal drug cases.

It is a complex crisis, with roots in years of overprescription and abuse of opioid pills, which hooked people around the nation, Mr. Rosenberg said. “Roughly four out of five new heroin users start out on prescription medication,” he said.

On the street, heroin can be one-fifth the price of opioid pills like hydrocodone and oxycodone. It is also a more plentiful substitute, Mr. Rosenberg said, and can be far more potent, particularly with the emergence of strains mixed with fentanyl and carfentanil.

In New York City, Robert K. Boyce, the chief of detectives, saw overdosed deaths hitting record highs in areas across the city. This as homicides dropped to 335 last year and traffic fatalities to 220. He created new teams of homicide and narcotics detectives to focus on how sales — usually of $10 bags or $100 bundles — occur via digital links, and “not on the street,” and added 84 investigators to the effort.

On the streets, 17,000 of the city’s 23,000 patrol officers have been trained in the use of naloxone, a drug that reverses opioid overdoses. And when people do die, patrol officers “freeze the scene like it’s a homicide case,” he said.

“Everything is data-driven,” the chief said. “Their last phone number is usually their provider. So now you see what else pops off that number. Now you have a nexus.”

There is no expectation of privacy for a dead person, so a warrant is not necessary, though the police often seek cooperation from relatives in seeking passwords. The investigators move quickly, even before a cause of death is officially determined. Details from one case can tie it to others.

In Vermont, a constant flow of illegal drugs arrives in cars driven from New York, Chief del Pozo and his investigators said. Couriers hide drugs in body cavities and alter their routes, coming up Interstate 91 or the New York State Thruway, veering east at Fort Ann, N.Y., and into Vermont’s southern region.

On a recent day, Lt. Michael Warren steered a police car along the tree-lined streets of the city’s Old North End, tracing a path of wreckage.

Here, on Ward Street, two brothers overdosed last June in chairs on their front porch. There, on Hyde Street, a genetics major at the University of Vermont was discovered dead. A sign for a corner store, at North and Rose Streets, marks the spot of a drive-by shooting over drugs two
summers ago. A block away, at North and LaFountain Streets, an open-air drug bazaar once reigned.

“It’s all around,” Lieutenant Warren said as a man who he said had overdosed several times bicycled by.

But the area has changed since the police started regular foot patrols, put 140-watt LED bulbs in the streetlights and encouraged merchants to do the same. Now drugs are not as visible, said Doug Olsaver, who has worked for 20 years as a manager at the Shopping Bag, a store at LaFountain and North Streets.

“An officer told me that his opinion of drug dealers were that they were like cockroaches,” Mr. Olsaver said. “They hate light.”

Photo
Brandon del Pozo, left, the police chief, and Jackie Corbally, center, from the Burlington Police Department, meeting with law enforcement officials and others in the neighboring town of Winooski. Credit Chang W. Lee/The New York Times

Earlier that day, Chief del Pozo took a seat with Jackie Corbally — whose title with the Burlington Police Department is opiate policy coordinator, but he calls her the drug czar — at a U-shaped set of tables at the Police Headquarters in the neighboring town of Winooski. The meeting, called SubStat, began convening regularly four months ago with the goal of tracking dozens of vulnerable users who have either been arrested or overdosed. It is based on New York’s computerized crime fighting system, CompStat, but broader, with those in corrections and parole, the prosecutor’s office and public health in on the talks with local police leaders.

“It’s all about shifting from addiction as a crime to addiction as a disease,” said Jane Helmstetter of the state’s human services agency, who was at the meeting.

One Burlington man, with a longtime addiction and a record of arrests, was struggling to believe the police could help him, he said, even after an officer revived him in April, after his second of three overdoses in 10 days. The officer followed him to a hospital emergency room and told him, “If you need help, we’ll drive you to treatment right now.”

Soon, the man met Ms. Corbally, and found himself face to face with Chief del Pozo, an unlikely ally. They helped get him into rehabilitation. The encounter was surprising, said the man and his mother, who have tried to keep their ordeal private and spoke on the condition that their names not be published.

“He wasn’t just treated as a drug addict and someone that wasn’t worthy of help,” his mother said. “Here you have a police chief sitting in the same room with a drug addict that knowingly uses illegal substances and he’s not going to handcuff him? It was unusual.”

A version of this article appears in print on June 13, 2017, on Page A20 of the New York edition with the headline: When Opioid Addicts Find an Ally in Blue.
Teamwork: Law enforcement, social workers join to combat opiate crisis
By Morgan True, Jun 20 2017

Members of a group known as SubStat discuss the most pressing opiate-related cases in the Burlington area. Photo by Morgan True/VTDigger

BURLINGTON — With Vermont on pace in 2017 to break last year’s record number of opiate overdose deaths, a group of police, social workers and others in Chittenden County is gathering to foster a more coordinated approach to the problem.

The effort comes as preliminary figures published this month by the state Health Department show that in the first quarter of 2017 Vermont averaged nearly 10 fatal opiate overdoses per month.

If that pace continues, there would be roughly 120 accidental opiate deaths this year, surpassing last year’s total of 106.

The numbers are said to be driven in part by the growing availability of cheap synthetic opiates like fentanyl and come despite greatly expanded drug treatment services and the growing availability of the anti-overdose drug naloxone.

Now police and prosecutors, social workers and others are having twice-monthly meetings that include a person-by-person inventory of many of the region’s toughest cases of addiction, crime, poverty and other social dysfunction.

That initiative grew out of larger stakeholder meetings modeled on CompStat — a data-intensive approach to law enforcement developed by the New York Police Department in the 1990s. Burlington Police Chief Brandon del Pozo spent two decades with the NYPD before taking his current job and has promoted using a similar technique to address Vermont’s opiate crisis.

Burlington Police Chief Brandon del Pozo. File photo by Morgan True/VTDigger

A smaller team within CompStat began meeting regularly with a more narrow focus. It’s called SubStat — for a subset of the CompStat effort — and it takes an approach more geared to improving the quality of individual lives and less on raw data.

The group has been meeting since February, with its members sharing information on drug users and low-level dealers causing problems in the region.
“It kind of took on a life of its own, because we realized it’s valuable not just for picking cases, but for kind of looking at the community as a whole,” del Pozo said.

How a SubStat meeting works

During SubStat meetings, representatives from police, probation and parole, social services and the state’s attorney’s office gathered around a table to discuss a dozen to two dozen cases.

Lt. Michael Cram, a 26-year veteran of the Winooski police, said the meetings foster conversations that weren’t taking place before.

“I get to know the people that I’ve heard the organizations but I’ve never dealt with them, so I just get to meet them face-to-face and work to get people help,” Cram said.

At a recent SubStat meeting in a conference room at the Burlington Police Department a spreadsheet listing cases was projected on a wall screen.

The case narratives are often bleak. A woman who has had her parental rights terminated is overdosing regularly, and those around the table fear that losing her children has left her nothing to live for.

A man struggling with depression told a social worker he’s no longer shooting up to get high, he’s shooting up to kill himself — saying he’s gone as far as filling a syringe with saline in the hopes of giving himself an aneurysm.

A young woman from a wealthy family is spiraling out of control while trying to hide her drug use from her parents. She’s overdosed three times since the year began and would likely have died during the last incident if emergency responders hadn’t intervened.

There was one uplifting report. A woman in equally dire straits just weeks before had secured a spot in drug treatment, found stable housing, and is now working to get her kids back.

As the group rattles through cases, members share how their latest interactions with the person played out, any past experiences with them, and what steps might be taken to intervene going forward.

In some cases, just locating the person is helpful for police. Is the person in jail or at least on supervision? Still living at the same place with the friends who are using drugs?

Winooski police responded to an overdose. The man had already been revived when they showed up, and after letting EMTs check him out, he declined a ride to the hospital where officers, medical staff or peer support workers may have tried to guide him into treatment.

Chittenden County State’s Attorney Sarah George. File photo by Elizabeth Hewitt/VTDigger

The man has a handful of pending charges and will soon be in court, Cram said. Turning to Chittenden County State’s Attorney Sarah George, he said, “He is not going to respond to us voluntarily getting him into treatment.” Cram urged the prosecutor to use the power of her office to add some pressure and get the man into treatment.

George said she would make a note for the assistant state’s attorney prosecuting the case, and the group moved on.

Experts recently completed a forensic evaluation of a woman in jail. They concluded her addiction is likely to kill her if she doesn’t get treatment in a secure facility.

Del Pozo said she fits the profile of an addict “who would do a stint in jail and get out and die a few days later.” The woman faces 18 to 36 months with credit for time served and will be sentenced in July.

That set off some give-and-take between Jackie Corbally, Burlington’s opioid policy manager, and Debbie Thibault, a regional manager for the Department of Corrections, on how best to use the woman’s jail time.
“If she’s got an 18-month minimum, as much as you want her to stay in there, the doors might open, and she might walk out. So just be aware of that,” Thibault said.

Corbally replied, “I think what the important piece for the (Department of Corrections) to hear is that she’s been sitting in jail for 11 weeks, and we have lost all that time that she could be getting treatment.”

Corbally asked if Corrections Commissioner Lisa Menard is still planning to attend a SubStat meeting. “I think Lisa needs to hear this conversation. … The question is, can we as a state system meet her needs or not.”

Legislation was introduced this year to increase access to drug treatment in Vermont prisons, but it stalled in committee. Currently treatment isn’t available to those who weren’t already in it before being locked up.

Special arrangements in the past have allowed some inmates to participate in out-of-state treatment programs in secure facilities, Corbally said. Could something similar be arranged for this woman?

George, the prosecutor, said that even if the SubStat team goes to great lengths and is able to get a spot for the woman in a secure out-of-state treatment facility, she might refuse to go, preferring instead to complete her sentence.

The chief asked whether the judge would be receptive if George pushed for a 36-month sentence. The prospect of a longer jail term could make treatment a more attractive option, he said.

**Criticisms of CompStat**

Part of CompStat’s appeal, and that of SubStat, is that they’re low-cost initiatives, requiring largely just the staff hours set aside for participants to be present.

There is the expense to Burlington for Corbally’s position, as well as a data analyst hired by the Chittenden County Opioid Alliance — the umbrella organization behind CompStat — which has sponsors in the United Way and the University of Vermont Medical Center.

Fentanyl powder. Photo from the Drug Enforcement Agency/Wikipedia

SubStat’s value is that it gets people talking who work the same cases from different angles, del Pozo said. “How could that not be better than just us being in our silos?” he asked.

Critics, who asked not to be identified in order to speak candidly about the initiative, said some of those interactions were already taking place, and they fear high expectations could lead to cherry-picking success stories in order to demonstrate results.

Del Pozo brushes off such criticism. “We recognize the power of narratives, but also their limits,” he said. Ultimately, CompStat and SubStat will be judged by the numbers, del Pozo added.

As to concerns that law enforcement data can be fudged, del Pozo said SubStat’s results would be measured by different agencies.

“The medical examiner is not going to alter a death certificate, and the hospital is not going to refuse somebody (who has overdosed) so the data looks better,” he said.

The chief acknowledged it may be difficult to tout results from the program when they could end up merely slowing a worsening trend of opiate abuse.

“That’s the worry, right? That we’re facing a tidal wave. That we’re on a rowboat facing a tidal wave, and we’re rowing as hard as we can, and then if the wave overtakes us we’ll say, ‘Oh, look, you didn’t row hard enough,’ or ‘You didn’t have the right boat,’” del Pozo said.

*Correction:* The New York Police Department’s CompStat model was implemented in the 1990s, not the 1980s as was stated in an earlier version of this story.
In addition to checking out and re-shelving books, San Francisco library staff may soon be trained to give lifesaving medication to reverse overdoses among the growing number of heroin users mixing in with the homeless in and around the Main Library.

“It does save lives,” City Librarian Luis Herrera said of the plan being floated to allow his staff to administer naloxone, also known by the brand name Narcan. The idea surfaced after an addict was found dead in one of the Civic Center library’s restrooms in early February.

Alarmed by the scope of the problem, the Department of Public Health assigned a couple of staffers to patrol the perimeter of the library last week in two shifts — one between 9 and 10 a.m. and the other between 5 and 6 p.m. — to talk with people who appear to be at risk and to administer the opioid-blocking drug when needed.

“San Francisco is a city with lots of drug use,” health department spokeswoman Rachael Kagan said, “and we consider people with drug-use issues part of the population we feel responsible for.”

She said the patrol hours were set “based on feedback and observations on when drug use is the heaviest among the people who gather there.”

The library also has a social worker and six formerly homeless health and safety associates who scour the Main Library and its 27 branches and provide outreach to those in need. Plus there are city police officers assigned to work overtime in and around the Main Library.

In a Feb. 28 email to his staff, Herrera cautioned that no decision about training librarians to treat overdoses with naloxone would be made “without fully exploring the matter.”

“Furthermore,” he added, “if we determine that library staff may use it, it will be on a strictly voluntary basis.”

Naloxone typically is administered by a nasal spray or leg injection — we’re told the library staff probably would be taught the spray method, with assistance from the Drug Overdose Prevention & Education Project. The group, which is funded by the Department of Public Health, already hands out naloxone to addicts through its needle access program.

San Francisco’s Main Library has become a magnet for the city’s exploding homeless population. Coincidentally or not, the neighborhood has seen epidemic numbers of users of heroin and prescription painkillers — opioids such as codeine, morphine and OxyContin.
Just around the corner, in fact, BART police arrested 27 suspected drug users last week during a three-day sweep of the Civic Center Station.

Library security guard Gloria Cowart has watched the passing show for years, as San Francisco police officers chase neighborhood drug dealers and addicts from one corner to the next — and back again. The addicts often wind up inside the library, shooting up in the stacks or restrooms.

“We might catch somebody (shooting up) once or twice a week,” Cowart said. “There is nowhere for them to go.”

In 2016, the Main Library tracked 689 instances of patron misbehavior, ranging from vandalism and altercations to verbal disturbances and drug use. Of those incidents, 72 were described as “severe violations” that merited the patron being suspended from the library for a year or longer.

Separately, records compiled by the San Francisco Department of Emergency Management show fire or ambulance crews were dispatched to the Main Library 138 times last year.

Fire Department spokesman Jonathan Baxter, who was assigned to a station in the Civic Center area for eight years, said the calls often involved homeless people who were intoxicated — though some were for injuries and ailments from living on the streets.

The health department’s most recently available estimates are from 2012 and put the number of addicts injecting drugs in San Francisco at between 15,000 and 22,000.

San Francisco has taken a compassionate approach when dealing with the problem, offering both free and unlimited access to syringes, plus methadone treatment on demand to help people better manage their addictions.

City police and emergency workers have long been trained how to administer naloxone, which has been in use for decades.

The overdose prevention project, operating on a $245,000 annual budget, not only hands out naloxone to addicts, but also trains welfare hotel staff and community service workers to identify signs of overdosing and how to dispense the lifesaving medication.

In 2014, there were 127 fatal opioid overdoses in San Francisco, the vast majority from prescription medicines, Kagan said. The same year, there were 365 overdose reversals with naloxone, she said. In 2016, the number of reversals more than doubled, to 877.

“When an overdose occurs in the library, we are the people most likely to be on the scene, not emergency responders,” librarian Kelley Trahan recently told colleagues at a staff meeting, urging that they get on board with the naloxone program.

“Drug use should not be punishable by death.”

San Francisco Chronicle columnists Phillip Matier and Andrew Ross appear Sundays, Mondays and Wednesdays. Matier can be seen on the KPIX TV morning and evening news. He can also be heard on KCBS radio Monday through Friday at 7:50 a.m. and 5:50 p.m. Got a tip? Call (415) 777-8815, or email matierandross@sfcchronicle.com. Twitter: @matierandross
City Council Passes Bill to Coordinate Drug Strategy Between Dozens of Departments and the Community

Emphasizes Research-based Approaches to Promote Public Health and Safety and Reduce Negative Impact of Past and Current Policies

Advocates Call for People Who Use Drugs and People in Recovery to be Immediately Involved in City’s Drug Strategy Coordination

New York, NY – The NYC Council recently passed legislation to create a coordinated municipal drug strategy, just as NYC experienced 9 overdoses in a 24-hour span, highlighting the urgent need for the City to face the opioid crisis with innovative approaches. The bill empowers the Mayor to designate a lead agency or office to convene stakeholders including city agencies, outside experts, and communities impacted by drug use to develop a city-wide, health-focused plan for a coordinated approach in addressing issues related to drug use.

Under current policies, city agencies often work at cross-purposes to address drug related issues, with conflicts arising between public health and law enforcement policies. Agencies also often miss opportunities to provide support to people in housing programs, the welfare system, family and homeless services, and the courts who have problematic drug use. Recognizing that, NYC Council Members Corey Johnson, Andrew Cohen, and Vanessa Gibson introduced municipal drug strategy legislation in April 2015.

The agency responsible for overseeing the municipal drug strategy, which is yet to be determined, would be responsible for convening multiple stakeholders – including community groups – to evaluate past and current drug strategies and develop a new, coordinated approach. By examining the harms caused by both drugs and our policy responses to drugs – like the drug war – NYC’s municipal drug strategy will reflect twenty-first century drug policy that enhances both health and safety.

Advocates expect the municipal drug strategy will engage with best practices and implementation for innovative improvements in individual and community health, including:

- Public education around fentanyl and other novel psychoactive substances
- Safer consumption spaces/supervised injection facilities
- Expanding access to harm reduction services, including syringe exchange and peer outreach
- Reducing contact between people who use drugs and law enforcement, especially for noncitizen immigrant populations that are vulnerable to mass deportation for minor drug infractions under Trump
- Ending marijuana prohibition
- Ensuring stable housing and access to social services, regardless of active use status
- Reducing stigma

Advocates say this level of coordination around a city’s drug policies could be a model for how American cities can begin to unwind devastating drug war policies. New York lags far behind dozens of other cities, notably in Europe and Canada, that began developing coordinated municipal drug strategies in the late 1980s. That approach has led to significantly lower rates of drug use, crime, and
public disorder and improved public health outcomes, such as reducing rates of HIV/AIDS and overdose deaths, compared to New York.

"I know firsthand why we need an Office of Drug Strategy, dedicated to creating alternatives to our city's failed drug policies," said Shantae Owens, a member of VOCAL New York. "When I was arrested for possessing a small amount of drugs, I was homeless and drug addicted, selling drugs just to support a habit. I was offered a prison sentence instead of treatment, which was a waste of my life and our tax dollars. New York City can and should be a national role model for how we can end drug war policies and replace them with policies of justice and equity, and politics of compassion and love."

After 40 years of the war on drugs, drugs are cheaper, more pure, and easier to obtain than ever, contributing to growing problems like mass incarceration and the increase in heroin overdose deaths in recent years—NYC experienced more than 10,000 unintentional drug poisoning deaths between 2003-2015. Meanwhile, current enforcement strategies have led to gross racial disparities and eroded the trust between communities and law enforcement.

"Too often city agencies have worked at cross purposes in their interactions with individuals and families affected by drug use," said Peter Schafer, Deputy Director for Family Health & Disparities, The New York Academy of Medicine. "We hope to see a more supportive and less punitive approach coordinated across city agencies so that people who use drugs are assisted in improving their health and well-being, rather than feeling forced to hide their drug use issues for fear of negative repercussions from various city agencies."

The de Blasio administration has already taken some important steps in the right direction, including reforms to low-level marijuana policing and the summons system, and initiatives to pilot criminal justice diversion for people with mental illness and other conditions. The creation of a municipal drug strategy is the next logical step in ensuring further coordination among city agencies and those directly impacted by the war on drugs.

"We’ve learned a lot about what works and what doesn’t during the past 40 years," said Alyssa Aguilera, co-executive director at VOCAL New York, a grassroots political group. "Innovation based on rigorous evaluation is already happening as cities recognize that an overwhelmingly law enforcement focused approach is only making drug related problems worse, but reform has been slow and piecemeal. A coordinated drug strategy in NYC will be a path toward long-lasting improvements in individual and community health, as well as smarter policing strategies."

The new municipal drug strategy guidelines reflect the need for innovation to tackle the current opioid overdose crisis and many years of calls from New Yorkers for a new approach. In 2013, the New York Academy of Medicine and the Drug Policy Alliance co-published a groundbreaking report, Blueprint for a Public Health and Safety Approach to Drug Policy, based on consultations with 500 New Yorkers, which called for a coordinated approach grounded in science. And in 2014, as part of the Talking Transition open tent process, VOCAL-NY and DPA led a town hall assembly about drugs with 200 New Yorkers, where a primary recommendation was an Office of Drug Strategy.

“This bill is an important step in adopting a more rational approach to drug policy in this City – one grounded in science, health, human rights, and principles of harm reduction,” said Kassandra Frederique, New York State Director at the Drug Policy Alliance. “We know the war on drugs has failed, and it’s time for a new plan. With a comprehensive and coordinated municipal drug strategy, NYC can lead the nation in improving public health and safety by reducing the morbidity, mortality, crime, and racial disparities stemming from failed practices.”
Cambridge may put anti-overdose drug in public boxes

By Steve Annear and Felice J. Freyer

GLOBE STAFF MAY 10, 2017

At least some firefighters and paramedics in communities in Massachusetts carry Narcan.

If someone suffers a heart attack in public, bystanders can grab an automated external defibrillator, or AED, if one is stationed nearby, and administer shocks to help reduce the risk of death until paramedics arrive.

Cambridge city officials don’t see why the same can’t be done in the event of an opioid overdose, using life-saving medicine.

With the state and much of the country in the grips of a devastating opioid epidemic, Cambridge officials say they’re intrigued by a new proposal that could make the drug naloxone, which reverses overdoses, readily available to the public.

The plan would involve placing lockboxes stocked with naloxone in parts of the city where drug use might occur. If passersby were to stumble upon someone who had overdosed, they could dial 911, get an access code to the box, and then follow instructions on how to administer the opioid blocker.

“If a Good Samaritan is willing to utilize a service like this, it could mean providing a faster response to an individual who has overdosed,” Cambridge Police Department spokesman Jeremy Warnick said in a statement. “And shortening that response time could mean the difference between life or death.”

The concept is still in development, so it’s too early to say if Cambridge will adopt the plan. But police got to see a prototype of the lockbox, created by the Boston startup GEMs, in action recently.

On April 28, as part of a study, Dr. Scott Goldberg, director of emergency medical services at Brigham & Women’s Hospital, and representatives of GEMs placed a mannequin on the sidewalk in Central Square and challenged passersby to intervene as though it were an opioid overdose victim.

The demonstration was a collaborative effort involving a number of agencies committed to fighting the opioid epidemic. The goal was to find out if people would jump into action to retrieve the naloxone from a lockbox, and use it correctly, if it was a matter of life or death.

“We know that bystanders can save lives,” said Goldberg, who is also an instructor of emergency medicine at Harvard Medical School. “We’d like to develop this concept, and see if it’s something worth trial-ing in real life and deploying in the community.”
Specialists in addiction reacted with enthusiasm when they heard about the proposal, which was first reported by The New York Times.

They welcomed it as another potential tool to use against the state’s opioid crisis, which claimed nearly 2,000 lives last year.

“It’s a smart idea,” said Dr. Barbara Herbert, president of the Massachusetts chapter of the American Society of Addiction Medicine. “It’s a good way to mobilize the community. It brings people together and makes everybody feel like you can be part of the answer.”

Herbert said that many people are trained to use naloxone but may not always carry it with them. Having the drug available in public places makes sense, she said.

If the lockbox project gets off the ground, it would add a new approach to a decade of efforts in Massachusetts to make naloxone widely available.

A state Department of Public Health program that started in 2007 offers instruction in recognizing and responding to opioid overdoses.

State grants have helped police and fire departments in 32 municipalities purchase naloxone. Since 2014, people who are at risk of overdosing, or know someone who is, can obtain naloxone kits at some 1,200 pharmacies without a prescription.

The Boston Public Health Commission trains more than 10,000 civilians a year to use naloxone, and health officials reach out to businesses in areas with high opioid use to offer training and naloxone kits, said Devin Larkin, director of the Bureau of Recovery Services at the commission.

“We’re always looking for new ways to get [the treatment] in the right place at the right time,” Larkin said. The lockbox project “could be an interesting avenue to explore.”

Goldberg said that during the demonstration in Cambridge, which involved about 50 people, some were hesitant at first.

“Some of the feedback before people actually started doing this was, ‘I don’t have medical training, and this isn’t something I am going to be able to do,’ ” he said.

Others said that if cities and towns adopt the idea and install lockboxes, it would give addicts a “free ticket to be able to use if they know they can be saved.”

But Mark Kennard, director of community services at Bridgewell, a Lynn addiction treatment provider, said some people wrongly believe naloxone encourages drug use. Kennard said that notion has been proven false.

“The more we involve the public in helping to solve it and help save lives,” he said, “the better off we’re going to be.”

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Fentanyl Is So Deadly That It's Changing How First Responders Do Their Jobs

The dangerous opioid is forcing police and forensic-lab workers to invent new ways to protect themselves.

As the number of fentanyl overdoses in America climbed last fall, the New Hampshire State Police Forensic Laboratory released a photo to highlight the drug’s particular dangers. The photo showed two vials. One showed how big a lethal dose of heroin might be: 30 milligrams, a small scoop. The second showed the equivalent for fentanyl: 3 milligrams, a bare sprinkle.

It was a warning to potential users, but also a visual reminder that fentanyl is so potent that it is dangerous even for people might accidentally touch or breathe a tiny amount of it. People like police, EMTs, forensic labs technicians, and even funeral directors. A puff of fentanyl from closing a plastic bag is enough to send a full-grown man to the emergency room, as a police officer from New Jersey described in a Drug Enforcement Agency video last fall. The DEA made the video as part of an official warning to law enforcement about the dangers of handling fentanyl.

The unprecedented rise of fentanyl has forced police and crime labs to change how they work. Police departments are using protective gear like Tyvek suits and respirators. Crime labs are looking for new ways to detect fentanyl without opening the bag. And both have stocked up on naloxone, the drug that reverses overdoses, for their employees.

Fentanyl first took off in North America in British Columbia, which declared the drug a public-health emergency in spring 2016. In response, the Justice Institute of British Columbia organized workshops for first responders and created a website: fentanylsafety.com. As fentanyl spread through the U.S., the website kept gaining relevance in new places. “The website has been accessed through all the world,” says Steve Schnitzer, director of the institute’s police academy. “We get inquiries from places all the time.”

Last fall, 11 SWAT officers in Hartford, CT, became ill after raiding a stash house. Their flash-bang grenade blasted heroin and fentanyl into air, and they came out dizzy and vomiting—symptoms of an overdose. Thomas Davoren, police chief in Groton, CT, says his
department now bring respirators, eye protection, and Tyvek suits to raids if they suspect fentanyl or other synthetic opioids.

Groton, like several other police departments since the DEA warning, has also stopped testing suspected opioids in the field. Officers used to do something called a colorimetric test: Scoop a bit of the suspected drug in plastic pouch with liquid reagents, and it would change color indicating this drug or that. That very act of scooping is now dangerous if it’s fentanyl. Since field tests are preliminary anyways, officers now just send it directly to a crime lab.

Some departments use a device called TruNarc, which shines a laser at a substance in a plastic bag. The problem with this approach, says Amber Burns, the forensic supervisor at the Maryland State Police, is that it doesn’t work well with heroin. Testing heroin with the device still requires a separate kit, in which a scoop of the drug has to be added to a vial of ethanol, in which case you have the danger of opening the bag again.

That’s why Burns and her lab are now in talks with the National Institute of Standards and Technology to test techniques that require only swiping the outside of a closed bag—similar to technology the TSA uses to look for traces of explosives. NIST scientists published a recent paper showing that two technologies, called IMS and DART-MS, can both be used to detect traces of fentanyl. That gets away from the problem of handling a “bulk amount of fentanyl,” says Ed Sisco, a research chemist at NIST. By bulk, he just means milligrams, essentially enough to be visible. IMS requires a $30,000 portable device about the size of a microwave that could be taken into the field; DART-MS is a little more sensitive, but also requires a bigger device, so it’s more suitable in a lab.

Burns says the techniques could also help in preliminary tests in the lab. If workers in forensics labs could rule out fentanyl or another synthetic opioid, they might not have to take extra precautions like working in a fume hood, which sucks any vapors or dust out of the room. She says it can take about an extra hour to set up to work in a hood. Her lab has also stockpiled naloxone. Timothy Pifer, director of the New Hampshire State Police Forensic Laboratory, says the same thing: His lab had added more doses of naloxone since fentanyl became common, one for every chemist station now.

Comparing the size of lethal doses of heroin, fentanyl, and carfentanil. The vials here contain an artificial sweetener for illustration. (New Hampshire State Police Forensic Laboratory)

The other advantage of the IMS and DART-MS systems is that they can detect other synthetic opioids. One of the particular challenges of the opioid crisis is that exact drugs keep changing. First it was heroin, then fentanyl. Now certain areas are seeing more overdoses of carfentanil, a drug originally used as an elephant tranquilizer that is an estimated 100 times even more potent than fentanyl. (It’s unclear though because it’s not really been tested in humans.) There are also reports of acrylfentanyl, which is resistant to naloxone. Who knows what’s next.

When I first contacted Pifer for this story, he mentioned they had updated their photo of lethal heroin and fentanyl doses with a vial representing carfentanil. “Hopefully we won’t have to update it again,” he says.
Philly plans 24-hour 'walk-in' center for drug users in crisis

Updated: MAY 2, 2017 — 5:59 PM EDT
by Don Sapatkin, STAFF WRITER

OxyContin is one of the opioid painkillers that may be legitimately prescribed, but then lead to addiction and even fatal overdoses, experts say.

The city plans to open an around-the-clock walk-in center in North Philadelphia over the summer where addicted drug users in crisis could be stabilized and perhaps begin medication as a bridge to treatment.

The center would go a step beyond the five behavioral health-crisis response centers in the city that can see and assess patients, but must refer them elsewhere for treatment — often to places with no space available.

Roland Lamb, deputy director of the city's Department of Behavioral Health and Intellectual disAbility Services, briefly mentioned the planned center during City Council testimony Tuesday on the Kenney administration's $1.6 billion budget request, more than 80 percent of which is federal and state reimbursement for Medicaid-funded behavioral health services.

He said later that the city had opened a temporary version of a walk-in center at North Philadelphia Health System a year and a half ago, but demand was so overwhelming that it ended up closing.

Lamb said details of the new center, including cost, location, capacity, and services, were still being worked out and would depend in large part on how providers respond to requests for proposals that his department expects to issue by June. He would say only that it would likely be able to handle "dozens" of clients and that he hoped some would be able to begin receiving buprenorphine, a medication that is used to assist in detox as well as a longer-term treatment for opioid addiction.

The center would not deal with overdoses, which can be fatal and are handled by hospital emergency departments.

More than 900 people died of drug overdoses in Philadelphia last year, over 25 percent more than in 2015; four-fifths of last year's deaths had opioids in their blood.
On Monday, the city announced a TV and social media campaign labeling prescription pain relievers "heroin in pill form," a recognition that most young heroin users today — and most people who die of any kind of opioid overdose — begin with prescription drugs, often prescribed legitimately for pain.

At the budget hearing, Councilman Allan Domb asked Lamb if the city could clean up a filthy area along the Conrail tracks in Kensington, known as El Campamento, within 30 days. Lamb said the cleanup would involve multiple agencies and he could not commit to a timeline.
COVINGTON, KY. — Not long ago, I visited a Narcotics Anonymous meeting where men with tattoos and short-cropped hair sat in a circle and talked out their errors. One had lived under an overpass, pimping his girlfriend’s daughter for cash to buy heroin. As the thought brought him to tears, his neighbor patted his shoulder. Others owned to stealing from grandparents, to losing jobs and children. Soon, most in the room — men with years of street addiction behind them — were wiping their eyes.

What made the meeting remarkable, however, was not the stories, but where it was taking place.

Unit 104 is a 70-man pod in Kenton County Detention Center in northern Kentucky, across the Ohio River from Cincinnati. The unit, and an equivalent one for women, is part of a new approach to jail made necessary by our nationwide epidemic of opiate addiction. Drug overdoses are now the leading cause of death among Americans under 50.

As the country has awakened to that epidemic, a new mantra has emerged: “We can’t arrest our way out of this,” accompanied by calls for more drug-addiction treatment. Yet the opiate epidemic has swamped our treatment-center infrastructure. Only one in 10 addicts get the treatment they need, according to a 2016 surgeon general’s report. New centers are costly to build, politically difficult to find real estate for and beyond the means of most uninsured street addicts, anyway.

So where can we quickly find cheap new capacity for drug treatment accessible to the street addict? Jail is one place few have thought to look.

Jails typically house inmates awaiting trial or serving up to a year for a misdemeanor crime. Many inmates are drug addicts. They vegetate for months, trading crime stories in an atmosphere of boredom and brutality. Any attempt at treatment is usually limited to a weekly visit by a pastor or an Alcoholics Anonymous volunteer. When inmates are released, they’re in the clothes they came in with, regardless of the weather, and have no assistance to re-enter the real world. This kind of jail has always been accepted as an unavoidable fixed cost of government.
But the sheer dimensions of the opiate-addiction epidemic are forcing new ideas. One of them, now being tried in Kentucky, is jail not as a cost but as an investment in recovery. Jails as full-time rehab centers — from lights on to lights out.

Jailing addicts is anathema to treatment advocates. However, as as any parent of an addict can tell you, opiates are mind-controlling beasts. A kid who complained about the least little household chore while sober will, as an addict, walk through five miles of snow, endure any hardship or humiliation, to get his dope.

Waiting for an addict to reach rock bottom and make a rational choice to seek treatment sounds nice in theory. But it ignores the nature of the drugs in question, while also assuming a private treatment bed is miraculously available at the moment the addict, who is usually without insurance, is willing and financially able to occupy it. The reality is that, unlike with other drugs, with opiates rock bottom is often death. (Drug overdose deaths last year most likely exceeded 59,000, the most ever in the United States, The Times found in an analysis of preliminary data this month, up about 19 percent over 2015.)

Jail can be a necessary, maybe the only, lever with which to encourage or force an addict who has been locked up to seek treatment before it’s too late. “People don’t go to treatment because they see the light,” said Kevin Pangburn, director of Substance Abuse Services for the Kentucky Department of Corrections. “They go to treatment because they feel the heat.”

Jail may in fact be the best place to initiate addict recovery. It’s in jail where addicts first come face-to-face with the criminal-justice system, long before they commit crimes that warrant a prison sentence. Once in custody and detoxed of the dope that has controlled their decisions, it’s in jail where addicts more clearly behold the wreckage of their lives. And it is at that moment of clarity and contrition when they are typically plunged into a jailhouse of extortion, violence and tedium.

“Imagine your most stressful day at work, multiply that by two or three, then imagine that every day,” a Kenton County inmate said. “Having to be on your guard. Always tense. Then you’re released from that. The first thing you’re going to take up is heroin” again.

In the red state of Kentucky, a relentless opiate-addiction epidemic is changing long-held dogma about how to deal with addicts. Families who once supported a “throw away the key” approach to addiction are thinking differently now that their loved ones are strung out. Kentucky is also the only state that elects its jailers. This gives them more autonomy than their counterparts elsewhere. It also inspires more budgetary accountability to voters, and thus an acute awareness of the costs of cycling inmates in and out and back in again.

Kenton County is among the latest of two dozen Kentucky county jails that have started full-time “therapeutic communities” aimed at rehabilitation within their walls, providing inmates the services that private treatment centers offer on the outside. Much of the impetus has come from the state’s Department of Corrections, which a decade ago began transitioning its prisons away from pure lockups to providing drug treatment.

With the state’s epidemic of addiction, and $3 million that state legislators approved for substance-abuse treatment in 2015, Kentucky has become a center of experimentation in a new way of doing jail.

Terry Carl, the Kenton County jailer, is a Vietnam veteran, Navy reservist, former operations manager for a local utility and a Republican — hardly a wild-eyed social experimenter.
But beginning several years ago, he watched pain pills and then heroin lead to the kind of low-level felonies that sent people in and out of his jail: needle possession, check forgery, possession of stolen property. The petty crimes of the common street addict almost never meant a lengthy prison sentence. To Mr. Carl, with outside treatment beds full, the question of what form jail took became paramount. So in 2015, with the support of the Kenton County commissioners, he took the unorthodox step of hiring a recovering addict named Jason Merrick to run Unit 104 with the explicit purpose of treating addicts. Mr. Merrick has a master’s degree in social work. He has been clean since 2009.

For its first three months, Unit 104 was not much different from others. Cliques formed. There were fights, thieving, yelling. Then Mr. Merrick and a few inmates serious about their recovery, following the program’s guidelines, wrote up “Cardinal Rules” governing behavior; those who couldn’t go along with them chose to leave. Eighteen months later, in 104 there’s none of the routine jail behavior that leaves inmates tense and isolated.

“Once people see that standard being met, then they abide by it,” said Jeremy Westerman, an inmate and recovering heroin addict who helped write those rules. “They live up to it, and it gets rid of all the other nonsense, and you’re free to work on your problems.”

Unit 104 offers G.E.D. classes, instruction on criminal-addictive thinking, 12-step meetings, overdose-resuscitation training, physical exercise, prayer and meditation, counseling, inmate self-governance and extensive writing assignments for those derelict in confronting the issues that landed them in custody. Classes begin at 8:30 a.m., with beds made military style.

The pod is open to anyone who volunteers for it, but it involves daily work, abiding by rules and cultivating an attitude of self-examination. Malingerers tend to shape up or wash out and be sent back to the general population. Inmates complete up to a six-month recovery regimen. Those who stay longer become peer mentors. Those leaving jail are offered help in re-entering society: a Vivitrol shot (which blocks the effects of opiates for one month and is associated with reduced cravings), connections to jobs, sober-living houses, 12-step meetings, recovering-addict mentors and more. And because Kentucky is one of 31 states that expanded Medicaid under Obamacare, some inmates would be eligible for addiction treatment once released.

After initial hiccups, Mr. Merrick and inmates told me, the culture in 104 evolved from predation to nurturing. I saw guys hugging, crying, admitting weakness, encouraging one another in public — behavior that is believed to be essential to recovery. One man even stood up at a pod gathering and read a poem he wrote.

“I’d never have done that in the other pods,” he told me on the day I visited.

“Here it’s structured and disciplined,” said another inmate, Dominique Evans. “That removes the tension and conflict. It’s a lot of caring here. We tell each other we love each other. Over there, in them other pods, you’d never hear that. You’d probably get jumped if you said that. Here, we hug, we pray in here, we work as a unit.”

In 104, inmate committees enforce the Cardinal Rules and maintain order. The pods don’t require paid janitors; inmates do the work themselves.

Perhaps the biggest departure from typical jail is that inmates call one another out for infractions or misbehavior. Many of them at first viewed that as snitching. But, inmates told me, snitching is telling on someone to benefit yourself; this is to help the other guy change — the
informant gets nothing out of it. Inmates will greet a new arrival with a day of grace to dispose of any drugs or weapons he has on him. If he’s found with them the next day, he’ll be ejected.

“It polices itself,” Mr. Pangburn of the state corrections department said. “It’s not perfect, but you find much fewer” fights and contraband. “You start finding that your security staff wants to work there.”

Inmates I spoke to said all this gives them hope they can leave readier for a clean life, even as, having failed before, they remain nervous about how they’ll do on the outside.

“I’m terrified,” Mr. Westerman told me.

In fact, some have gone back to using after leaving 104, as addicts have upon leaving private treatment centers. Addiction recovery is a messy thing. But a 2015 joint Kentucky Department of Corrections and University of Kentucky Center on Drug and Alcohol Research study of 339 inmates who left these programs statewide found fewer risk factors for recidivism 12 months after their release: 70 percent were not incarcerated; 68 percent were employed at least part-time; 86 percent were housed; 76 percent said they spent most of their time with family; and half reported a significant decrease in illicit drug use.

Unit 104 and the pods like it in jails across Kentucky don’t require more money to run; they do require political will, changing our long-held ideas regarding addiction and, above all, rethinking what jail can be. With state funds, Kenton County has expanded its counseling staff to seven, of whom five are recovering addicts — people whose backgrounds, it’s safe to say, would have kept them from finding work in any other jail.

It also matters who is hired to run these new jail pods. Mr. Merrick, for example, is highly regarded among Kenton County elected officials and judges for his passion for the job. It’s unclear whether others with less enthusiasm might have the energy for the experiment.

Nor are these pods some magical cure-all to our national affliction. There is no one solution to what our country faces. But what Kentucky jails are doing seems like a smarter use of public money than the counterproductive way so many jails across the country function today.

Amid this national epidemic of opiate addiction, rethinking jail, as Kentucky has, as a place of sanctuary and recovery for a population that has lost hope, might not just be advisable; it may be indispensable.