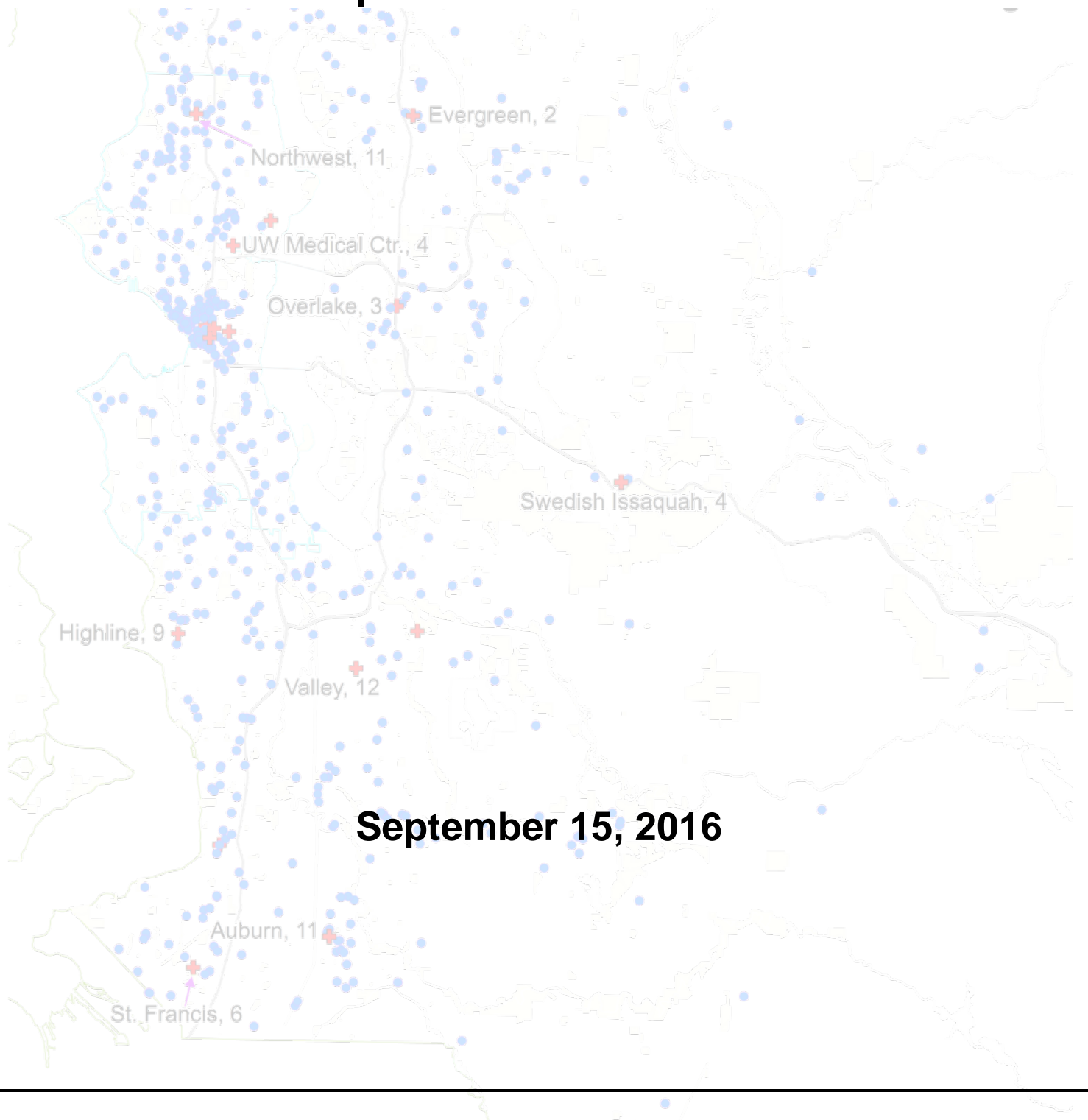


Heroin and Prescription Opiate Addiction Task Force

Final Report and Recommendations



September 15, 2016

Cover image: Deaths involving major drugs of abuse, King County, 2013-2015, from Caleb Banta-Green, University of Washington Alcohol and Drug Abuse Institute

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I. Executive Summary

Heroin and opioid use are at crisis levels in King County. In 2015, 229 individuals died from heroin and prescription opioid overdose in King County alone.¹ To confront this crisis, in March 2016, King County Executive Dow Constantine, Seattle Mayor Ed Murray, Renton Mayor Denis Law and Auburn Mayor Nancy Backus convened the Heroin and Prescription Opiate Addiction Task Force. The Task Force, co-chaired by the King County Department of Community and Human Services and Public Health – Seattle & King County, was charged with developing both short and long-term strategies to prevent opioid use disorder, prevent overdose, and improve access to treatment and other supportive services for individuals experiencing opioid use disorder.

Task Force participants included: All Home; American Civil Liberties Union; Auburn Police Department; City of Bellevue Fire Department; City of Seattle Mayor's Office; Department of Community and Human Services; Department of Social and Health Services, Children's Administration; Downtown Emergency Services Center; Evergreen Treatment Services; Harborview Medical Center; Hepatitis Education Project; Kelley-Ross Pharmacy; King County Adult Drug Diversion Court; King County Emergency Medical Services; King County Needle Exchange; Neighborcare Health; King County Prosecuting Attorney's Office; King County Sheriff's Office; Muckleshoot Tribe; People's Harm Reduction Alliance; Public Defender Association; Public Health – Seattle & King County; Puget Sound Educational Service District; Recovery Community; Renton Police Department; Seattle Children's; Seattle Fire Department; Seattle Human Services Department; Seattle Police Department; Seattle Public Schools; Swedish Hospital, Pregnant and Parenting Woman Program; Therapeutic Health Services; United States Attorney for Western Washington's Office; United States Department of Veterans Affairs, Veterans Health Administration; United States Substance Abuse and Mental Health Services Administration (SAMHSA); University of Washington Alcohol and Drug Abuse Institute (ADAI); Washington State Department of Social and Health Services, Behavioral Health Administration; and Washington State Health Care Authority.

The Heroin and Prescription Opiate Addiction Task Force met over a six month period from March to September 2016 to review 1) current local, state and federal initiatives and activities related to prevention, treatment and health services for individuals experiencing opioid use disorder; 2) promising strategies being developed and implemented in other communities; and 3) evidence-based practice in the areas of prevention, treatment and health services. The Task

¹ *2015 Drug Trends for King County, Washington, Caleb Banta-Green et al, Seattle: University of Washington Alcohol & Drug Abuse Institute, July 13, 2016. URL: <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>*

Force strived to avoid redundancy with other related activities and to leverage existing partnerships and activities where appropriate. Additionally, the Task Force applied an equity and social justice lens to the work to ensure that recommendations do not exacerbate, but rather lessen, inequities experienced by communities of color as a direct result of the “War on Drugs.”

This report provides a summary of the group’s recommendations to both prevent opioid addiction and improve opioid use disorder outcomes in King County.

Summary of the primary Task Force recommendations

Primary Prevention:

- Raise awareness and knowledge of the possible adverse effects of opioid use, including overdose and opioid use disorder;
- Promote safe storage and disposal of medications; and
- Leverage and augment existing screening practices in schools and health care settings to prevent and identify opioid use disorder.

Treatment Expansion and Enhancement:

- Create access to buprenorphine in low-barrier modalities close to where individuals live for all people in need of services;
- Develop treatment on demand for all modalities of substance use disorder treatment services; and
- Alleviate barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics.

User Health and Overdose Prevention:

- Expand distribution of naloxone in King County; and
- Establish, on a pilot program basis, at least two Community Health Engagement Locations* (CHEL sites) where supervised consumption occurs for adults with substance use disorders in the Seattle and King County region. Given the distribution of drug use across King County, one of the CHEL sites should be located outside of Seattle.

* The Task Force will refer to sites that provide harm reduction services where supervised consumption occurs as Community Health Engagement Locations for individuals with substance use disorders (CHEL sites). This terminology recognizes that the primary purpose of these sites is to engage individuals experiencing opioid use disorder using multiple strategies to reduce harm and promote health, including, but not limited to, overdose prevention through promoting safe consumption of substances and treatment of overdose. The Task Force’s equity and social justice (ESJ) charge emphasizes the importance of providing support and services to the most marginalized individuals experiencing substance use disorders in the County. The Task Force asserts that the designation CHEL sites is a non-stigmatizing term that recognizes that these sites provide multiple health interventions to decrease risks associated with substance use disorder and promote improved health outcomes.

II. Background

2016 Heroin and Prescription Opiate Addiction Task Force Formation: Partnership with King County and Cities of Seattle, Renton and Auburn

In March 2016, King County Executive Dow Constantine, Seattle Mayor Ed Murray, Renton Mayor Denis Law and Auburn Mayor Nancy Backus announced the formation of a Task Force of subject matter experts and stakeholders to confront the epidemics of heroin and prescription opioid addiction and overdose in King County.

Under the direction of the Executive and the Seattle, Renton and Auburn mayors, the Department of Community and Human Services (DCHS) partnered with Public Health – Seattle & King County to co-chair the Task Force. Task Force members represented multiple entities, including the University of Washington Alcohol and Drug Abuse Institute (ADAI), behavioral health services providers, hospitals, human service agencies, the recovery community, criminal justice partners, first responders, and others. Based on a review of evidence-based and evidence-informed practices and current strategies used in other communities, and building on recommendations established by Johns Hopkins Bloomberg School of Public Health² and the 2016 Washington State Interagency Opiate Plan³, the Task Force developed recommendations to both prevent opioid addiction and improve opioid use disorder outcomes in King County.

Statement of the Problem

Opioid prescribing has increased significantly since the mid-1990s and has been paralleled by increases in pharmaceutical opioid misuse and opioid use disorder, heroin use, and fatal overdoses.⁴ These increases in morbidity and mortality were seen among those who were prescribed opioids and those who were not. When opioid prescribing began decreasing between 2005-2010, the number of teens in Washington State reporting use of these medicines

² Alexander GC, Frattaroli S, Gielen AC, eds. *The Prescription Opiate Epidemic: An Evidence-Based Approach*. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2015

³ Department of Health. (2016). *Washington State Interagency Opiate Working Plan*. Retrieved from: http://stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

⁴ Jones, C. M., Mack, K. A. & Paulozzi, L. J. Pharmaceutical overdose deaths, United States, 2010. *JAMA* **309**, 657–9 (2013);

Paulozzi, L. J., Budnitz, D. S. & Xi, Y. Increasing deaths from opiate analgesics in the United States. *Pharmacoepidemiol. Drug Saf.* **15**, 618–27 (2006);

Paulozzi, L. J., Zhang, K., Jones, C. M. & Mack, K. A. Risk of adverse health outcomes with increasing duration and regularity of opiate therapy. *J. Am. Board Fam. Med.* **27**, 329–38 (2014); and Jones, C. M., Paulozzi, L. J. & Mack, K. A. Sources of prescription opiate pain relievers by frequency of past-year nonmedical use United States, 2008-2011. *JAMA Intern. Med.* **174**, 802–3 (2014).

to “get high” also decreased. As pharmaceutical opioids became less available, some people with opioid use disorder switched to heroin because of its greater availability and lower cost.⁵ Heroin, however, brings with it higher risks for overdose, infectious disease and, because it is illegal, incarceration.⁶

While these dynamics have affected individuals of all age groups, the impact is particularly striking for adolescents and young adults, with research indicating that youth ages 14-15 represent the peak time of initiation of opioid misuse.⁷ Since 2005, this young cohort has represented much of the increase in heroin-involved deaths and treatment admissions in King County and Washington State.⁸

In King County, heroin use continues to increase, resulting in a growing number of fatalities. In 2013, heroin overtook prescription opioids as the primary cause of opioid overdose deaths. By 2014, heroin-involved deaths in King County totaled 156, “their highest number since at least 1997 and a substantial increase since the lowest number recorded, 49, in 2009.”⁹ Increases in heroin deaths from 2013 to 2014 were seen in all four regions of the County, with a total increase from 99 to 156.¹⁰ Heroin-involved overdose deaths in King County remain high with 132 deaths in 2015.¹¹ (See Attachment A for Map of Overdose Deaths in King County, 2013-2015.) Although prescription opioid-involved deaths have been dropping since 2008, many individuals who use heroin, and the majority of young adults who use heroin, report being hooked on prescription-type opioids prior to using heroin.¹²

⁵ Jones, C. M., Logan, J., Gladden, R. M. & Bohm, M. K. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. *MMWR. Morb. Mortal. Wkly. Rep.* **64**, 719–25 (2015); and

Jones, C. M. Heroin use and heroin use risk behaviors among nonmedical users of prescription opiate pain relievers - United States, 2002-2004 and 2008-2010. *Drug Alcohol Depend.* **132**, 95–100 (2013).

⁶ Jenkins, L. M. *et al.* Risk Factors for Nonfatal Overdose at Seattle-Area Syringe Exchanges. *J. Urban Heal.* **88**, 118–128 (2011); and

Cedarbaum, E. R. & Banta-Green, C. J. Health behaviors of young adult heroin injectors in the Seattle area. *Drug Alcohol Depend.* (2015). doi:10.1016/j.drugalcdep.2015.11.011

⁷ McCabe, S. E., West, B. T., Teter, C. J. & Boyd, C. J. Medical and nonmedical use of prescription opiates among high school seniors in the United States. *Arch. Pediatr. Adolesc. Med.* **166**, 797–802 (2012); and

Meier, E. A. *et al.* Extramedical Use of Prescription Pain Relievers by Youth Aged 12 to 21 Years in the United States. *Arch. Pediatr. Adolesc. Med.* **166**, 803 (2012).

⁸ Banta-Green, Caleb J., Kingston, Susan, Ohta, John, Taylor, Mary, Sylla, Laurie, Tinsley, Joe, Smith, Robyn, Couper, Fiona, Harruff, Richard, Freng, Steve, Von Derau, K. *2015 Drug use trends in King County Washington* (2016) at <<http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>>

⁹ Drug Abuse Trends in the Seattle-King County Area: 2014. Banta-Green, C *et al.* Alcohol & Drug Abuse Institute, Univ. of Washington, June 17, 2015. adai.uw.edu/pubs/cewg/DrugTrends_2014_final.pdf

¹⁰ Drug Abuse Trends in the Seattle-King County Area: 2014. Banta-Green, C *et al.* Alcohol & Drug Abuse Institute, Univ. of Washington, June 17, 2015. adai.uw.edu/pubs/cewg/DrugTrends_2014_final.pdf

¹¹ Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C *et al.* Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

¹² Peavy KM, Banta-Green CJ, Kingston S, Hanrahan M, Merrill JO, Coffin PO. “Hooked on Prescription-Type Opiates Prior to Using Heroin: Results from a Survey of Syringe Exchange Clients,” *Journal of Psychoactive Drugs*, 2012;44(3):259-65, and Cedarbaum ER, Banta-Green CJ, “Health Behaviors of Young Adult Heroin Injectors in the Seattle Area,” *Drug Alcohol Depend* [Internet] 2015 [cited 2015 Dec 18]; available from <http://www.ncbi.nlm.nih.gov/pubmed/26651427>

According to the Centers for Disease Control and Prevention, more people die in the United States of drug-related overdose than from auto accidents, a difference that has been growing since 2008. In 2000, there were more than 40,000 traffic-related deaths and fewer than 20,000 from drug overdose; in 2013 there were 43,982 overdose-related deaths and 32,719 traffic fatalities.¹³

From 2010 to 2014 the number of people who entered the publicly funded treatment system for heroin use disorders annually in King County grew from 1,439 to 2,886. This increase occurred while the number of people receiving treatment for all other primary drugs of choice declined (except for people with methamphetamine use disorders).¹⁴ In fact, for the first time, heroin treatment admissions surpassed alcohol treatment admissions in 2015. The majority of those entering treatment for heroin for the first time were ages 18-29; among this age group, half reported injecting and half reported smoking heroin, a pattern that began slowly emerging in 2009.¹⁵ Heroin is also the most commonly mentioned drug among callers to the County Recovery Help Line, totaling 2,100 in 2015, almost double the number in 2012.¹⁶

Opioid treatment programs (OTP) that dispense methadone and buprenorphine in King County have been working to expand capacity, and the number of admissions to these programs increased from 696 in 2011 to 1,486 in 2014.¹⁷ As of October 1, 2015, there were 3,615 people currently maintained on methadone at an OTP in King County.¹⁸ Statutory capacity limitations have historically resulted in up to 150 people on a waitlist. Buprenorphine is another proven opioid use disorder medication that cuts the odds of dying in half compared to no treatment or counseling only.¹⁹ It can be provided at an OTP but, unlike methadone, it can also be prescribed by a physician in an office-based setting and obtained at a pharmacy. Requests for buprenorphine treatment by callers to the County Recovery Help Line have increased from 147 in 2013 to 363 in 2015.²⁰ Treatment capacity for buprenorphine is limited and far exceeded by demand.

¹³ Center for Disease Control. (2015, April 30). Injury Prevention & Control: Prescription Drug Overdose Retrieved from <http://www.cdc.gov/drugoverdose/data/overdose.html>

¹⁴ TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.

¹⁵ Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

¹⁶ Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

¹⁷ TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.

¹⁸ TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.

¹⁹ Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., and Millar, T. (2016) Impact of treatment for opiate dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction*, 111: 298–308.

²⁰ Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

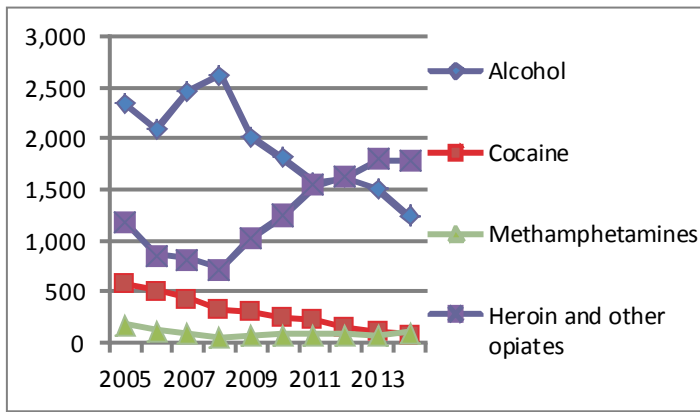


Figure 1: Heroin has Surpassed Alcohol as Primary Drug Reported on Admission to Detoxification Services in King County

In addition to being the leading reason for entering a drug treatment program, heroin is now also the primary drug used by people seeking withdrawal management (detoxification) in the King County publicly funded treatment system, surpassing alcohol.²¹ Also, people seeking opioid withdrawal management are younger than in

previous years. According to the King County Substance Abuse Prevention and Treatment Annual Report, “From

the first half of 2008 through the second half of 2011, there was a steady increase in the number and percentage of young adults under 30 years old entering detoxification services. The numbers and percentages of young adults leveled off during 2012, and have remained at higher levels. Among all individuals admitted in 2014, 85% of those younger than 30 years old indicated opioids are their primary drug used compared to 41% of those 30 years or older.”²²

Syringe exchange services remain a readily accessible effective health intervention and the demand for this service continues to grow. Close to six million clean syringes are handed out annually in King County.²³ In a recent Washington State survey of syringe exchange users, 75% were interested in getting help reducing or stopping their use, yet only 14% were enrolled in treatment.²⁴

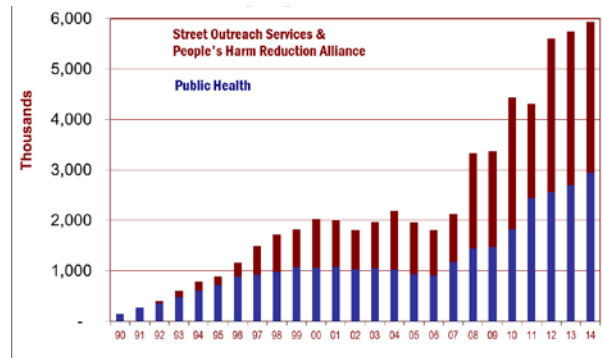


Figure 2 Syringe Exchange data 1989-2014, King County, WA

Homelessness is also a persistent problem in our community. The 2016 King County One Night Count found that 4,505 of our neighbors in King County were without shelter this year, a 19% increase over 2015. While the leading cause of death among homeless Americans used to be HIV, it is now drug overdose. A study in JAMA Internal Medicine found that overdoses, most of which involved opioids, are now responsible for the majority of deaths among individuals experiencing homelessness in the Boston area. The same trend is occurring locally, as documented in the death reports of individuals experiencing homelessness in King County.

²¹ TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.

²² King County Mental Health, Chemical Abuse and Dependency Services Division. Substance Abuse Prevention and Treatment Annual Report, 2014

²³ Drug Abuse Trends in the Seattle-King County Area: 2014. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, June 17, 2015. adai.uw.edu/pubs/cewg/DrugTrends_2014_final.pdf

²⁴ Results from the 2015 Washington State Drug Injector Health Survey, February 2016. Kingston, S. and Banta-Green, C. Alcohol and Drug Abuse Institute, Univ. of Washington. <http://adai.uw.edu/pubs/infobriefs/2015DrugInjectorHealthSurvey.pdf>

While the causes of homelessness are multi-faceted and complex, substance abuse is both a contributing cause and result of homelessness.

There is an urgent need for action. Fortunately, a variety of evidence-based interventions exist that have demonstrated effectiveness at helping individuals reduce opioid use and decrease related harms. Identifying creative ways to expand the use of, and access to, effective interventions is paramount to curbing the effects of heroin and other opioids in the community.

Building on History and Current Actions

From 1999 to 2001, then Seattle Mayor Paul Schell and King County Executive Ron Sims convened a multi-sector task force to address the rise in heroin use in the community. The group generated a set of recommendations to address the heroin epidemic. In 2007, the King County Board of Health adopted a Resolution on HIV / AIDS that endorsed a Public Health King County *Strategic and Operational Plan for HIV Prevention in King County*, which supported addressing harm from intravenous drug use through different health promotion and prevention activities.²⁵ In 2015, a Washington State Interagency Opiate Working Plan was drafted by a collaboration of the Department of Health, Division of Behavioral Health and Recovery and the University of Washington Alcohol and Drug Abuse Institute. Additionally, in 2015 a legislative workgroup was convened by state Representatives Brady Walkinshaw and Strom Peterson along with state Senator David Frockt to develop strategies to address the need to help people engage in opioid treatment and reduce overdose. This current Task Force drew from those initiatives and leveraged other activities and partnerships to develop a plan to respond to the region's growing heroin and opioid addiction problem.

III. 2016 Heroin and Prescription Opiate Addiction Task Force Charge

Responding to the direction of the sponsors of the 2016 Heroin and Prescription Opiate Addiction Task Force to confront the heroin and opioid epidemic with immediate action, the Task Force identified specific focus areas based on their potential to have the broadest and most meaningful public health impact on the region's heroin epidemic. The specific areas of focus are:

A. Primary Prevention (of opioid use disorders)

- Prescriber education
- Public education for adults and youth
- Prescription drug take-back (aka secure medication return)
- Enhancing screening for opioid misuse and opioid use disorder

B. Treatment Expansion and Enhancement

- Treatment on demand for all needed modalities of treatment
- Innovative buprenorphine prescribing practices

²⁵ Final Report and Recommendations: September 20, 2007. King County Board of Health HIV/AIDS Committee

C. User Health Services and Overdose Prevention

- Expansion of access to naloxone
- Community Health Engagement Locations for individuals with substance use disorders (CHEL sites) where supervised consumption occurs

Task Force members agreed that their work and recommendations must be directly influenced by equity and social justice considerations. The Task Force developed the following equity and social justice charge:

The Task Force will apply an Equity and Social Justice (ESJ) lens to all of its work. We acknowledge that the “War on Drugs” has disproportionately adversely impacted some communities of color, and it is important that supportive interventions recommended now not inadvertently replicate that pattern. Interventions to address the King County heroin and opioid problem will or could affect the health and safety of diverse communities, directly and indirectly (through re-allocation of resources). Measures recommended by the Task Force to enhance the health and well-being of heroin and opioid users or to prevent heroin and opioid addiction must be intentionally planned to ensure that they serve marginalized individuals and communities. At the same time, the response to heroin and opioid use must not exacerbate inequities in the care and response provided among users of various drugs. All recommendations by the Task Force will be reviewed using a racial impact statement framework. The Task Force will not seek to advance recommendations that can be expected to widen racial or ethnic disparities in health, healthcare, other services and support, income, or justice system involvement. Whenever possible, these concerns should lead to broadening the recommendations of the Task Force, rather than leaving behind interventions that are predicted to enhance the health and well-being of heroin and opioid users.

IV. SUMMARY OF TASK FORCE PROCESS

The Executive and mayors of Seattle, Renton and Auburn, in conjunction with the Departments of Community and Human Services and Public Health – Seattle & King County, appointed members to the Task Force from the following entities:

1. All Home
2. American Civil Liberties Union
3. Auburn Police Department
4. City of Bellevue Fire Department
5. City of Seattle Mayor’s Office
6. Department of Community and Human Services
7. Department of Social and Health Services, Children’s Administration
8. Downtown Emergency Services Center
9. Evergreen Treatment Services

10. Harborview Medical Center
11. Hepatitis Education Project
12. Kelley-Ross Pharmacy
13. King County Adult Drug Diversion Court
14. King County Emergency Medical Services
15. King County Needle Exchange
16. King County Prosecuting Attorney's Office
17. King County Sheriff's Office
18. Muckleshoot Tribe
19. Neighborcare Health
20. People's Harm Reduction Alliance
21. Public Defender Association
22. Public Health – Seattle & King County
23. Puget Sound Educational Service District
24. Recovery Community
25. Renton Police Department
26. Seattle Children's
27. Seattle Fire Department
28. Swedish Hospital, Pregnant and Parenting Woman Program
29. Seattle Human Services Department
30. Seattle Police Department
31. Seattle Public Schools
32. Therapeutic Health Services
33. United States Attorney for Western Washington's Office
34. United States Department of Veterans Affairs, Veterans Health Administration
35. United States Substance Abuse and Mental Health Services Administration (SAMHSA)
36. University of Washington Alcohol and Drug Abuse Institute (ADAI)
37. Washington State Department of Social and Health Services, Behavioral Health Administration
38. Washington State Health Care Authority

The Task Force met five times between March and September 2016 and was chaired by Brad Finegood, M.A. (Assistant Director of the King County Behavioral Health and Recovery Division, Department of Community and Human Services, DCHS) and Dr. Jeff Duchin, M.D. (Health Officer, Public Health – Seattle & King County, PHSKC). A list of the Task Force members is provided in Attachment B.

Three workgroups were initially formed to address the Task Force's three focus areas (opioid abuse prevention, treatment expansion and enhancement, and health services and overdose prevention). These workgroups were comprised of Task Force members with related subject matter expertise, and met between full Task Force meetings. The prevention workgroup was led by Dr. Caleb Banta-Green, Ph.D. (University of Washington), and met four times between April and August 2016. The treatment expansion and enhancement workgroup was led by Brad Finegood, M.A. and met eight times between April and August 2016. The workgroup addressing health services and overdose prevention of individuals using opioids was led by Dr. Jeff Duchin,

M.D., and met nine times between April and August 2016. DCHS and PHSKC staff members provided support to the workgroups.

A fourth workgroup was formed to address policy considerations associated with expanding the County's capacity for treatment, health services, and overdose prevention of individuals using opioids. This workgroup was led by Brad Finegood and was comprised of Task Force members and non-Task Force subject matter experts. The policy workgroup met four times between May and August 2016. A fifth workgroup was formed to plan for evaluation of recommendations implemented by the sponsors. This workgroup was led by Caleb Banta-Green and was also comprised of Task Force members and non-Task Force subject matter experts. A list of the five workgroups and their respective members is included in Attachment C.

During the course of the Task Force process, a series of community meetings was held in order to 1) provide public education about heroin and opioid addiction, treatment and health services, and/or 2) to obtain community input as the Task Force developed strategies and meaningful solutions to the problem of addiction and overdose in King County. Community meetings included the following:

- Presentation on the Heroin and Prescription Opiate Addiction Task Force to legislative staff, which was held at Sea Mar Community Health Center in Des Moines, Washington on August 16, 2016
- The Sound Cities Administration Meeting, which was held in Renton on July 5, 2016
- Presentation on Practical Implementation of an Agency Opiate Overdose Response Policy at the Washington State Behavioral Healthcare Conference in Yakima on June 23, 2016
- A Community Conversation about Addiction and Recovery, which was held at Thomas Jefferson High School in Auburn on June 9, 2016
- The Heroin Epidemic: A Community Conversation, which was held at the Museum of History and Industry in Seattle on June 6, 2016 (aired on public television on July 5, 2016)
- Community Conversation: Heroin and Prescription Opiate Overdose and Addiction, which was sponsored and facilitated by the Heroin and Prescription Opiate Addiction Task Force, and held at the Renton Community Center on May 31, 2016 (See Attachment D for Community Conversation [May 31, 2016]: Attendee Comments.)
- Presentation on the Heroin Epidemic and Local Efforts at a summit sponsored by the Seattle Municipal Court bench, held at the Seattle Municipal Court on May 20, 2016.
- Presentation on Medication-Assisted Treatment Services and the Opiate Epidemic at the Kent Municipal Court on May 13, 2016
- Presentation on the Heroin Epidemic at the Seattle University Symposium: Addressing Seattle's Urban Disorder with Collective Efficacy Principles on May 6, 2016
- The Recovery Café Community Conversation and Screening of Frontline Documentary Chasing Heroin, which was held at the Recovery Café in Seattle on May 2, 2016
- Presentation on Practical Implementation of an Agency Opiate Overdose Response Policy at the statewide Conference on Ending Homelessness in Spokane on May 11, 2016

- Presentation on the Heroin Epidemic and Local Efforts to the Ballard Community Taskforce on Homelessness and Hunger, which was held at the Nyer Urness House on April 28, 2016
- Presentation on Medication-Assisted Treatment Services at The Heroin Epidemic: New Challenges for the Courts, hosted by the Lake Forest Park Municipal Court on April 11, 2016
- Presentation on the Heroin Epidemic and Local Efforts to the King County Regional Law Safety and Justice Committee at Seattle City Hall on March 31, 2016
- Lessons from the North: Canada's Safe Consumption Space, Harm Reduction, and Seattle's Crisis, which was held at 12 Ave Arts of Capitol Hill Housing in Seattle on March 23, 2016
- Leading the Way: Public Health & Safety Approaches to Drug Policy Locally, Nationally, and Abroad, which was held at Seattle University on March 22, 2016
- Better is Better: Harm Reduction, Safe Consumption, and the Heroin Epidemic, which was held at the University of Washington on March 21, 2016
- Seattle City Council Lunch and Learn with Insite Co/Founders, which was held at Seattle City Hall on March 21, 2016

Task force members also utilized various media venues (including radio, television, print and social media) to discuss the heroin epidemic and efforts to address this issue.

V. Recommendations

Task Force recommendations were generated by the Primary Prevention workgroup, Treatment Expansion and Enhancement workgroup, and User Health Services and Overdose Prevention workgroup, in collaboration with Policy and Evaluation workgroups. Workgroup recommendations were presented to the full Task Force on two separate occasions for review, feedback and modification, culminating in a final vote on each recommendation. The Task Force Chairs determined that approval of recommendations would be based on achievement of a simple majority of voting members of the Task Force. Attachment B displays the voting members of the Task Force. City of Seattle and King County employees that report to the Task Force conveners did not vote on the final recommendations, although they participated in work group deliberations. Additionally, the U.S. Attorney for Western Washington, Annette Hayes, participated as a non-voting member. In total, seven recommendations were approved during a Task Force meeting and one recommendation was approved by e-mail vote. (See Attachment E for Summary of Recommendation Voting Tally.)

Primary Prevention Workgroup Recommendations

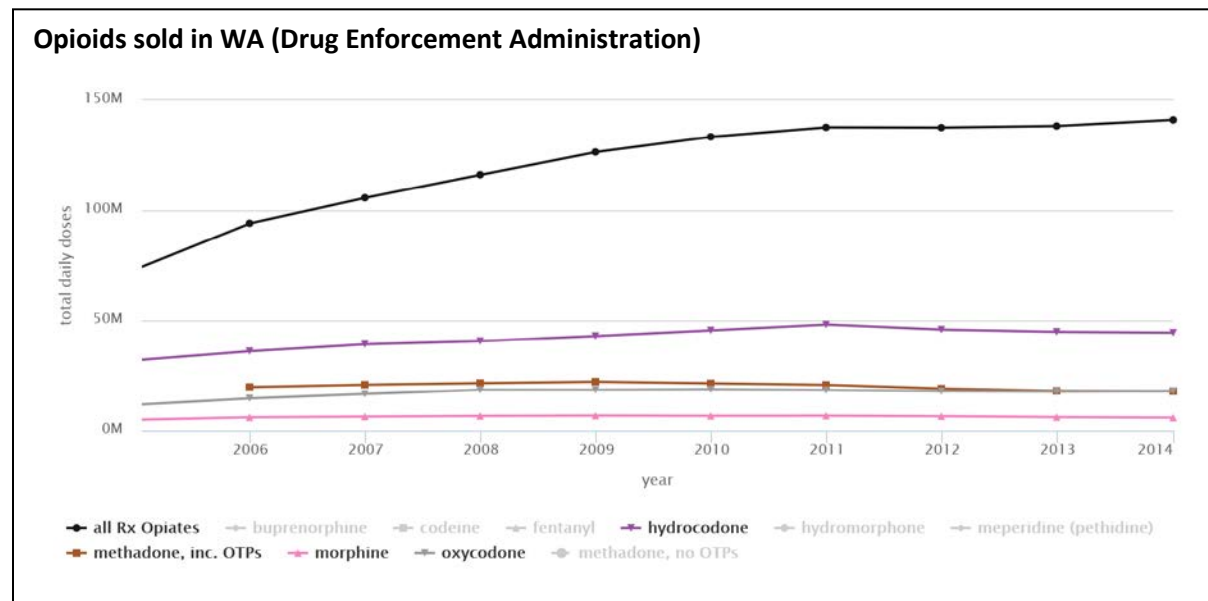
1. Raise awareness and knowledge of the possible adverse effects of opioid use, including overdose and opioid use disorder.

Goals:

- Opioid prescribing is appropriate in terms of who receives prescriptions, indications for treatment, and the type, amount and duration of opioid prescribed.
- Prescribers and those they serve will have sufficient understanding of evidence-based risks and benefits of opioids, other pain management strategies, and screening for opioid use disorder and overdose risks to make appropriate decisions regarding opioids.
- Parents of adolescents and children will receive information adequate to understand the risks and benefits of opioids for acute pain, other pain management strategies, as well as information on safe storage and disposal.

Rationale:

- Opioid prescribing has increased dramatically over the past 20 years. In recent years, the increase has plateaued in Washington State (see Figure below). However, the overall increase in prescribing of opioids over the last 20 years has contributed to increased misuse, opioid use disorder, and fatal overdoses among both those who were prescribed and not prescribed opioids.²⁶



²⁶ Jones, C. M., Mack, K. A. & Paulozzi, L. J. Pharmaceutical overdose deaths, United States, 2010. *JAMA* **309**, 657–9 (2013).

Paulozzi, L. J., Budnitz, D. S. & Xi, Y. Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiol. Drug Saf.* **15**, 618–27 (2006).

Paulozzi, L. J., Zhang, K., Jones, C. M. & Mack, K. A. Risk of adverse health outcomes with increasing duration and regularity of opioid therapy. *J. Am. Board Fam. Med.* **27**, 329–38 (2014).

Jones, C. M., Paulozzi, L. J. & Mack, K. A. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use United States, 2008-2011. *JAMA Intern. Med.* **174**, 802–3 (2014).

- Education and improved opioid prescribing may help reduce the risk of substance misuse while providing appropriate pain management.
- Providers who have registered for and use Washington’s Prescription Drug Monitoring Program (PDMP) will have an informed understanding of the individual’s prescription opioid use history and will be better able to assess risk for overdose and indications of possible misuse resulting in improved care. Washington regulations²⁷ state:

The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic non-cancer pain.

(2) The patient's health history should include:

(a) A review of any available prescription monitoring program or emergency department-based information exchange

- Education and support is critical to prevention and allows the individual seeking services to have an active role in their care and to recognize warning signs of opioid misuse.
- Impacting inappropriate opioid access requires behavior changes on the part of prescribers, patients, and family/household members. These same people should also be involved in addressing motivation to use opioids, including ways to think about and respond to physical and emotional pain as well as social pressures.
- Opioid misuse is currently an epidemic and prescribers and/or healthcare professionals across all settings play a key role in raising awareness. To reach all consumers, prevention practices should be implemented universally across settings and populations to address equity and social justice concerns.
- Concerns regarding opioids need to be balanced with the need for adequate pain control, especially in light of evidence of disparities in accessing opioid medication for pain, particularly for African Americans.

Approach:

- Coordinate with governmental agencies, professional organizations, medical/dental/nursing schools, health care training institutes, and health care systems to educate physicians on responsible opioid prescribing practices and pain management oversight.
- Create and distribute an educational flyer and counseling guide for use during opioid prescribing visits (medical /dental office or pharmacy) that addresses risk for overdose, addiction potential and other risk factors for those with pain conditions who are potential candidates for opioids. (See Attachment F for Implementation and Planning Details.)
- Encourage providers to register and use the PDMP. Increased outreach efforts will occur through King County Public Health and DCHS staff to professional organizations to inform them of the availability and utility of the PDMP and encourage utilization.

²⁷ <http://app.leg.wa.gov/wac/default.aspx?cite=246-919-853>

- Launch education campaign to reach broad audience including the general public, individuals using opioids, social networks, and professionals. (See Attachment F for Implementation and Planning Details.)
- Distribute counseling guidelines and other tools to pharmacists, behavioral health specialists, and other healthcare professionals and encourage them to provide education on prescription opioid safety (storage, disposal, overdose prevention, risk factors for addiction, and response to overdose).

2. Promote safe storage and disposal of medications.

Goals:

- Prevent access to and initiation of opioids by those not prescribed the medication.
- Prevent opioid overdoses.

Rationale:

- The number of non-medical users of opioid pain relievers (4.5 million in 2013 per the Substance Abuse and Mental Health Services Administration (SAMHSA) is high. Youth and adults access these medications through medicine cabinets, homes and sharing.
- Limiting access to opioids can potentially prevent misuse and inappropriate initiation among adolescents. The physical and mental health consequences of opioid misuse are significant, including fatal overdoses and opioid use disorder.
- Research indicates that the ages of 14-15 years represent the peak time of initiation of opioid misuse.²⁸ Adolescents who initiated misuse of opioids between 2005-2010 now represent many of the young adults dying from heroin involved overdoses or entering treatment across King County and Washington State.²⁹ Washington data indicate that 5% of 10th graders in 2014 reported using prescription-type opioids to get high in the past month and that there was a strong correlation with using heroin at some point in time (see figure on page 15). Note that in 2006 10% of 10th graders reported past month use and that the decline over time coincides closely with declines in prescribing of potent opioids in Washington state.
- A majority of individuals using heroin report initially using pharmaceutical opioids.
- Universal education should help de-stigmatize discussing opioid safety. Focusing educational messages on the inherent dangers of opioids may make individuals more receptive to messaging and more likely to change behaviors.
- Note there is no known published research on the effectiveness of interventions to specifically prevent abuse of pharmaceutical opioids or heroin.

²⁸ McCabe, S. E., West, B. T., Teter, C. J. & Boyd, C. J. Medical and nonmedical use of prescription opioids among high school seniors in the United States. *Arch. Pediatr. Adolesc. Med.* **166**, 797–802(2012); and

Meier, E. A. *et al.* Extramedical Use of Prescription Pain Relievers by Youth Aged 12 to 21 Years in the United States. *Arch. Pediatr. Adolesc. Med.* **166**, 803 (2012).

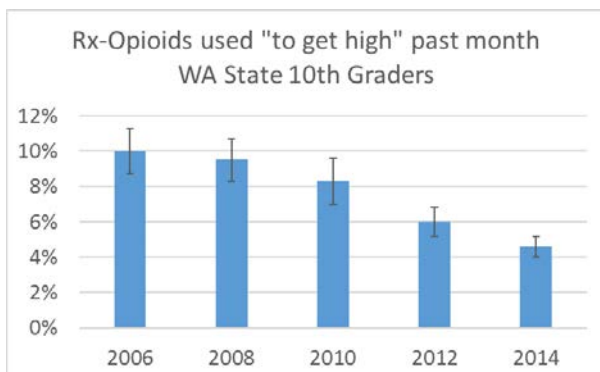
²⁹ Banta-Green, Caleb J., Kingston, Susan, Ohta, John, Taylor, Mary, Sylla, Laurie, Tinsley, Joe, Smith, Robyn, Couper, Fiona, Harruff, Richard, Freng, Steve, Von Derau, K. *2015 Drug use trends in King County Washington.* (2016). at <<http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>>

Approach:

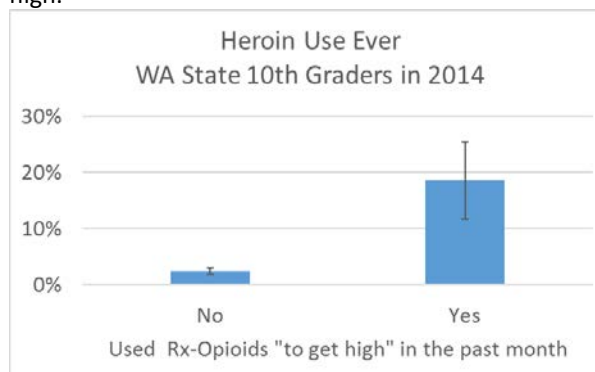
- Encourage pharmacies to provide counseling on safe storage and disposal of opioids and other controlled substances at the time of a first prescription in order to prevent unintended access to these medications. (See Attachment G for Implementation and Planning Details.)
- Increase pharmacy participation in promoting safe storage and medicine disposal to expand community awareness across all areas in the County.

Trends in the use of Rx-type opiates to “get high” among 10th graders and the association with heroin use

The proportion of 10th graders reporting using prescription-type opioids to get high in the past month declined significantly from 10% to 5% from 2006-2014



Among 10th graders those who reported they had used prescription-type opioids to get high in the past month 19% had ever used heroin, compared to 3% among those not using prescription-type-opioids to get high.



SOURCE: Healthy Youth Survey, analysis Alcohol and Drug Abuse Institute, University of Washington

- Expand access to prescription-take-back programs via King County Secure Medication Return locations and mail back envelopes. Coordinate and collaborate with the King County Secure Medication Return program to ensure population wide education and pharmacy based education. Incorporate consistent guidance on safe disposal methods for medications.
- In addition to providing education on the importance of disposal of unused and unwanted medication, engage local pharmacies to distribute mail-back envelopes with each opioid prescription dispensed.
- Use social media to promote safe storage and disposal of medications.
- Background Information
 - Sample education materials (to be amended with King County info) <http://here.doh.wa.gov/materials/safe-use-of-prescription-pain-medication>
 - Overview of trajectories of adolescent use and misuse of opioids <http://archpedi.jamanetwork.com/article.aspx?articleid=1149405>

3. Leverage and augment existing screening practices in schools and health care settings to prevent and identify opioid use disorder.

Goals:

- Identify youth who are at risk for developing opioid-related problems or who have developed opioid use disorder, using validated screening tools.
- Increase access to substance use disorder assessment and treatment, regardless of income, and provide appropriate services, brief interventions and referrals for them.

Rationale:

- Behavioral health agencies, primary care clinics, hospitals and other service organizations are currently providing screenings for substance use disorders.
- Non-medical use of opioids peaks between the ages of 14-16 indicating that screening needs to occur prior to and during adolescence
<http://www.ncbi.nlm.nih.gov/pubmed/22566514> .
- Treatment of substance use disorder is most effective when identification, referrals, and interventions are delivered during the early stages.
- Behavioral health agencies deliver school-based services in a number of middle schools and high schools in King County. Because opioids are so prevalent and initiation often happens among teens, it is important to identify, as early as possible, those who are at risk for or already misusing opioids. Providers delivering services in these settings are not always aware of opioid-related resources or equipped with tools to discuss opioid use.
- Behavioral health agencies can engage clients in a brief intervention and educational dialogue for those that screen positive for opioid misuse and/or related risk factors.
- Seattle Public Schools has social-emotional development curriculum for students that addresses holistic healthy development. There is opportunity to enhance this education and open dialogue in an existing practice within schools.
- Education and support is critical to prevention and allows individuals to have an active role in their care and recognize warning signs and risks of opioid misuse.
- Community education reduces stigma associated with use, promotes public health, helps individuals recognize the complexity of the issue, and empowers people to ask for help.
- To reach all consumers prevention practices should be universal to address equity and social justice concerns.

Approach:

- Expand existing school based screening, brief interventions and referrals for substance use, to include accurate and actionable information related to opioid misuse.
- Work with schools to have information available to students and families.
- Provide professionals with training on opioid use disorders, local resources, and interventions, including research-backed interventions for opioid use disorder.
- Explore opportunities to expand screening to other settings and populations.

- Work with the Department of Social and Health Services Children’s Administration on referral process for high risk youth for substance use disorder treatment.

Treatment Expansion and Enhancement Recommendations

1. Create access to buprenorphine for all people in need of services, in low-barrier modalities close to where individuals live.

Goal:

- Individuals experiencing opioid use disorder, who desire opioid agonist pharmacotherapy with buprenorphine, will have access to treatment on demand. Treatment on demand is defined as the individual meeting with a prescriber immediately, or on day one or day two, to initiate treatment.

Rationale:

- This recommendation would expand access to buprenorphine, an evidence-based treatment for opioid use disorder. Unlike methadone treatment, which is restricted to a limited supply of licensed programs, buprenorphine treatment can be prescribed by a general physician in an office-based setting.³⁰
- This recommendation would support treatment on demand by establishing access points for treatment induction, coordination and maintenance of care at behavioral health clinics, community health clinics, emergency rooms, and other sites already frequented by individuals with opioid use disorder seeking opioid agonist pharmacotherapy.
- This recommendation would address equity and social justice concerns, as evidence demonstrates racial/ethnic and socioeconomic disparities in use of buprenorphine for treatment of opioid use disorder.³¹ In particular, data suggest that individuals receiving buprenorphine for treatment of opioid use disorder are more likely to be white and have higher incomes than those receiving methadone. Expanding geographic access points to include health care providers that serve traditionally underserved people throughout King County would alleviate this disparity.
- This recommendation has the potential to reduce stigma associated with treatment of opioid use disorder, as individuals can obtain treatment outside of federally regulated methadone clinics if desired, and providers would obtain training on treatment of addiction that they could integrate into their general practice of medicine.
- This recommendation would support ongoing efforts in the community to achieve integrated and holistic care (mental health, substance use, and primary care treatment services) for persons with physical and behavioral health problems.

³⁰ Alexander GC, Frattaroli S, Gielen AC, eds. *The Prescription Opioid Epidemic: An Evidence-Based Approach*. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2015

³¹ Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City. *The Journal of Behavioral Health Services & Research*, 40(3): 367-377.

- This recommendation, which supports the creation of low-barrier treatment, has the potential to engage individuals in opioid use disorder treatment and other supportive services who may not engage in traditional substance use disorder treatment.
- This recommendation, which increases access to effective treatment, has the potential to reduce harm associated with untreated opioid addiction, including fatal overdose,³² infectious disease and other health complications, and incarceration.

Approach:

- Utilize multiple access points to facilitate buprenorphine induction and maintenance. This approach is informed by the San Francisco Integrated Buprenorphine Intervention Services (IBIS) program (see Attachment H for IBIS Process Protocol), adapted to meet the needs of our local communities. Level 1 facilities will focus on induction of buprenorphine for individuals experiencing opioid use disorder in a low-barrier modality. A Level 1 facility would provide frequent dosing of buprenorphine treatment until an individual has stabilized. Once stabilized on buprenorphine treatment, an individual may transfer their care to a Level 2 or Level 3 facility of their choice to continue buprenorphine services with a less frequent dosing regimen (referred to as buprenorphine maintenance services). Importantly, induction will not be restricted to Level 1 facilities; individuals may also access induction services at Level 2 and Level 3 facilities.
- Centralized client care coordination across the system will be necessary to ensure treatment on demand and successful transfer of buprenorphine services from a Level 1 facility to a Level 2 or 3 Facility. One current model that could be built upon is the Recovery Help Line. The Recovery Help Line offers 24-hour emotional support and referrals to local treatment services. (See Attachment I for Buprenorphine System of Care: Implementation and Planning Details associated with establishing buprenorphine services in Level 1 through Level 3 Facilities.)

Level 1 Facilities

- Downtown Public Health Needle Exchange Induction Site
- Emergency Department Induction Sites
- Recovery Center Valley Cities Detox and Residential Facility
- Mobile Medical Van
- King County Correctional Facilities

Level 2 Facilities

- Community Health Clinics (CHCs)

Level 3 Facilities

- Behavioral Health Clinics, including traditional medication-assisted treatment (MAT) facilities

³² Banta-Green, C. J., and Coffin, P. O. (2016) Commentary on Pierce et al. (2016): Raising the bar of addiction treatment—first do no harm. *Addiction*, 111: 309–310.

- A “**buprenorphine first**” model of care aims to use buprenorphine treatment induction and stabilization as the priority health intervention. A traditional approach to treatment has provided quality care to a subset of the overall population of individuals with opioid use disorder who are able to consistently and predictably engage in treatment and adhere to stringent treatment requirements (regular appointment attendance, urinalysis testing, etc.). However, individuals who 1) are experiencing homelessness, 2) have limited or no support systems, and/or 3) have complex medical and behavioral health needs may experience difficulty successfully engaging and receiving care at traditional opioid treatment programs. A “buprenorphine first” model of care is an alternative approach to opioid treatment that is client-centered, focused on harm reduction, and designed to engage a greater number of individuals experiencing opioid use disorder in effective opioid treatment.
- A **collaborative care** model, which utilizes nurses or other professionals in innovative care management models, has been successfully implemented in other communities to expand treatment access and is the preferred approach to support delivery of buprenorphine services (see Attachment J, Description of Collaborative Care/Nurse Care Manager Model).³³ The use of the collaborative care/nurse care manager (NCM) model addresses numerous major barriers to buprenorphine prescribing that prescribers face, including insufficient time and support to accomplish the necessary steps to initiate and maintain a client in treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided guidance on the specific role that nurse case managers can play in conducting screening, assessment, treatment monitoring, counseling, education, and other supportive services to facilitate office-based buprenorphine treatment of opioid use disorder.³⁴
- Healthcare facilities without on-site buprenorphine (waivered) prescribers could enter into agreements with waivered prescribers to provide buprenorphine services via telehealth technology. This would improve access to buprenorphine services for individuals experiencing opioid use disorder who reside in rural or underserved areas.

2. Develop Treatment on Demand for all Modalities of Substance Use Disorder Treatment Services

Goal:

- Individuals experiencing opioid use disorder who desire opioid treatment will have access to their treatment of choice on demand. Treatment on demand is defined as the individual meeting with a provider to initiate the treatment of choice on day one or day two of the request for treatment.

³³ LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2015). Office-based opioid treatment with buprenorphine (OBOT-B): Statewide implementation of the Massachusetts collaborative care model in community health centers. *Journal of Substance Abuse Treatment, 60*, 6-13.

³⁴ Substance Abuse and Mental Health Services Administration (2009). Buprenorphine: A guide for nurses. Technical Assistance Publication Series (TAP 30)

Rationale:

- There are a range of substance use disorder treatment modalities, including detoxification/withdrawal management, outpatient therapy, residential treatment, and opioid agonist pharmacotherapy (also referred to as medication-assisted treatment or MAT). Not every individual experiencing opioid use disorder is interested in treatment with opioid agonist pharmacotherapy or is an appropriate recipient of MAT. Providing individuals seeking treatment with multiple treatment options supports the many pathways of recovery and respects client choice and autonomy.
- Research demonstrates racial/ethnic and socioeconomic disparities in service delivery.³⁵ Providing individuals seeking treatment with a comprehensive menu of treatment services removes barriers to treatment and promotes equity and social justice.
- Delays to treatment access can be life threatening. Every day an individual is waiting for treatment access, they are at risk of continuing to use heroin and/or opioids. For many, especially those experiencing opioid dependence, this means risk of overdose and death. Creating a system of care where treatment can be accessed rapidly reduces harm and ultimately save lives.
- According to the National Council for Behavioral Health, shorter wait periods are associated with fewer missed appointments, and strategies to reduce waiting times reduce no-show rates for appointments. Providing treatment on demand or “open access” to a comprehensive array of treatment services increases the likelihood of treatment engagement. Careful “open access” model development may also help to increase provider revenue and reduce costs.

Approach:

- Develop a plan and protocol for all outpatient behavioral health providers in King County to provide “open access” to services. “Open access” may include same-day access, walk in hours or days, next-day appointments or a combination of client-driven scheduling options. “Open access” strategies should ensure that timely, meaningful follow-up is provided to individuals seen for “open access” services or on-demand assessments. (See Attachment K for Implementation and Planning Details.)
- Assess treatment network adequacy on an ongoing basis to ensure all treatment modalities (including residential and detox beds) are available to achieve treatment on demand for King County residents. The philosophy of “treatment on demand” maintains that treatment capacity must be flexible and able to meet the fluctuating demand for services. Individuals experiencing opioid use disorder, clients of opioid treatment services, and advocacy groups like the People’s Harm Reduction Alliance (PHRA) and Voices of Community Activists and Leaders (VOCAL) should be involved in identifying strategies for improving network adequacy and flexible access. (See Attachment K for Implementation and Planning Details.)

³⁵ Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City. *The Journal of Behavioral Health Services & Research*, 40(3): 367-377.

- Develop a plan to address the substance use disorder treatment workforce shortage and to support achievement of treatment on demand, timely and meaningful follow-up, and engagement of individuals seeking treatment. (See Attachment K for Implementation and Planning Details).
- Standardize and expand access to continuation of opioid treatment for incarcerated individuals in King County who are booked into jail and already stabilized on medication for treatment of opioid use disorder. Develop a plan to assist individuals incarcerated with untreated opioid use disorder, with direct referrals to a community-based MAT program upon release. (See Attachment K for Implementation and Planning Details).
- Develop and implement a plan for establishing and maintaining good neighbor relations. An example is provided of a neighbor relations plan that has been successfully implemented by a local opioid treatment program and has proven to be a very effective tool to fight stigma of clients served by opioid treatment programs and of treatment in general. (See Attachment L for Proposed Neighbor Relations Plan).

3. Alleviate barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics.

Goal:

- King County will be able to provide readily accessible treatment to meet the needs of the community and will be able to rapidly adjust treatment capacity to ensure demand for services is met.

Rationale:

- Opioid treatment programs offering medication-assisted treatment (MAT) have been in existence since the 1960s. While opioid treatment programs have historically offered methadone treatment, they have recently been authorized to dispense buprenorphine as well. Opioid treatment programs are sanctioned by the federal government and Washington State as an effective way to treat withdrawal symptoms and relieve drug cravings from heroin and prescription opioid medications.³⁶ Research shows additional benefits include patients reduced or stopped use of injection drugs, a reduced risk of overdose and of acquiring or transmitting diseases, reduced criminal activity, and improved family stability and employment potential.³⁷ These benefits have also been demonstrated in Washington where MAT participation results in “lower health care costs” and “reduces arrests and convictions” for participants.³⁸
- In 2014, opioid overdose deaths in King County were the highest ever recorded and remain high in 2015, with 229 opioid (heroin and/or pharmaceutical) overdose deaths

³⁶ University of Washington – Alcohol and Drug Abuse Institute – Medication Assisted Treatment for Opioid Use Disorders: Overview of the Evidence, June 2015, available at <http://adai.uw.edu/pubs/infobriefs/MAT.pdf>

³⁷ CDC – *Methadone Maintenance Treatment* – February 2002, available at

[http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20\(20\).pdf](http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20(20).pdf)

³⁸ DSHS Research and Data Analysis Division - *Methadone Treatment For Opiate Addiction Lowers HealthCare Costs And Reduces Arrests And Convictions* - June 2004 –

<https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-49.pdf>

documented.³⁹ Buprenorphine and methadone maintenance treatment are evidence-based treatments for opioid use disorder that reduce overdose mortality by 50% compared to no treatment or treatment with therapy only.⁴⁰ Efforts to reduce barriers to providing effective opioid treatment for all individuals in need save lives.

- Stigmatization of people suffering from substance use disorder can impact policy regarding treatment. Despite the overwhelming evidence that MAT works, MAT service providers regularly face obstacles when trying to open new facilities. These hurdles include placement of barriers to finding suitable locations that comply with zoning regulations and obtaining operating permits from local jurisdictions. Alleviating unnecessary barriers to opioid treatment contributes to destigmatizing substance use disorders and overcoming prejudice and discrimination against people seeking treatment for substance use disorders.
- Approximately 5,000 individuals in King County may be interested in treatment for opioid use disorder (Caleb Banta-Green, University of Washington Alcohol and Drug Abuse Institute, personal communication, August 15, 2016). Efforts to alleviate barriers placed upon opioid treatment programs can expand access to treatment and address equity and social justice concerns created due to stigmatization of issues related to opioid use disorder.

Approach:

- Work to eliminate the Washington State cap on the number of clients permitted to be served at opioid treatment programs. Currently, opioid treatment programs are capped at 350 clients receiving opioid agonist pharmacotherapy per dispensary location, unless the county of residence provides a waiver. In King County, the Department of Community and Human Services, Behavioral Health and Recovery Division is authorized to provide this waiver, renewable annually. In order to meet local demand and provide treatment to a greater number of individuals in need, opioid treatment programs could provide additional services with extended hours. The Task Force is recommending changes to RCW 71.24.590 (Recodified from 70.96A.410) (Opiate substitution treatment – Program certification by department, department duties – Definition of opiate substitution treatment) to reduce barriers to treating individuals with opioid use disorder and expanding treatment capacity.
- Support a call to action for community collaboration in establishing opioid treatment programs and associated supportive and/or complimentary services. State law is intended to allow for the operation of MAT facilities. One of the main obstacles to opening MAT facilities results from the actions of local governments, generally via permitting and zoning regulations. But they are counterproductive in combatting the opioid epidemic and generally grounded in a lack of knowledge about how these programs operate and how the facilities will impact the surrounding areas. To combat these misperceptions, there is a great need for sharing information about the vital

³⁹ Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

⁴⁰ Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., and Millar, T. (2016) Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction*, 111: 298–308.

importance of these facilities and their social and health benefits and to use evidence to address public safety concerns. A public education campaign and the support of elected officials could greatly expedite getting more MAT facilities up and running in a short amount of time. (See Attachment M for Implementation and Planning Details.)

- Work to amend RCW 71.24.585 (Recodified from 70.96A.400) (Opiate substitution treatment – Declaration of regulation by state) to reflect the potential need for long-term MAT as a current standard of care for effective treatment of opioid use disorder. Current language declares the primary goal of opioid substitution treatment is to “eliminate substance use, including opioid and opiate substitute addiction of program participants” and suggests a small percentage of persons who participate in opioid substitution treatment programs require treatment for an extended period of time. This is inconsistent with current evidence-based best practice guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA recommends a phased approach to treatment involving medication maintenance and consideration of individual need when determining whether to discontinue opioid agonist pharmacotherapy or pursue long-term maintenance.⁴¹ The Office of National Drug Control Policy suggests “ongoing MAT may be the safest and best approach for opiate rehabilitation” due to research demonstrating opiate agonist pharmacotherapy is associated with reduced risk of relapse and overdose relative to treatment with psychosocial services alone.⁴²

User Health Services and Overdose Prevention Recommendations

1. Expand distribution of naloxone in King County, Washington.

Goals:

- Reduce drug related overdose deaths by expanding the distribution of naloxone to individuals using heroin and pharmaceutical opioids, their social networks, and professionals who may administer naloxone through the course of their work.
- Educate service providers and the community about naloxone availability and access points, and inform the public about the Good Samaritan 911 Overdose Law.

Rationale:

- Naloxone is an opioid overdose antidote that may be safely used by health professionals and laypersons. When prioritizing interventions, the risks of the opioids being used, the likelihood of the naloxone recipient having or witnessing an overdose, and the overdose risks related to the location/timing of naloxone distribution should all be considered.

⁴¹ Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.) Available at <http://www.ncbi.nlm.nih.gov/books/NBK64164>

⁴² The White House, Office of National Drug Control Policy. (2012). *Medication-Assisted Treatment for Opioid Addiction* [Health Brief]. Retrieved from https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf

- Evidence exists for distributing naloxone to heroin users and their social networks at syringe exchanges. Adequate evidence does not currently exist for other means of distributing or administering naloxone. Given the limited financial resources, as well as the limited opportunities to work with stakeholders and the public on issues related to opioid use disorder and overdose, it is important to consider interventions that are most likely to have a public health impact by preventing and reversing the greatest number of overdoses. Outcomes may also be positively impacted by increasing awareness of overdose prevention, overdose recognition, and overdose response including rescue breathing and the Good Samaritan Overdose law. (See Attachment N for Naloxone Distribution and Administration Bibliography.)

Approach:

- Expand distribution of take-home naloxone to individuals using heroin and pharmaceutical opioids and their social networks.

Syringe exchanges

- Expand programs for take-home-naloxone at syringe exchanges so that it is free and available to all who want it.
- Consider dispensing more than one naloxone kit per client so that they can further distribute naloxone in their social networks.

Jail

- Expand naloxone distribution services to all correctional facilities in King County. Funding for staffing and other resources will need to be determined.

Pharmacies

- Request that insurers provide adequate reimbursement of take-home naloxone so that pharmacies will be willing to stock, prescribe and dispense naloxone.
- Advocate with insurers, as well as state regulators and policy makers as appropriate, for coverage/reimbursement of take-home-naloxone for persons not at risk for overdose but who are household members or other close contacts of persons who are at risk for opioid overdose.
- Incorporate education about naloxone availability at pharmacies in educational campaigns.
- Encourage pharmacies to educate individuals at risk for opioid overdose regarding overdose prevention and treatment and to consider obtaining take-home naloxone.

Prescribers

- Encourage prescribing of take-home naloxone to those at elevated risk for overdose due to their prescribed opioid use.. Targeting diverse care settings is appropriate, including emergency departments, primary care, specialty care, behavioral health, and withdrawal management facilities.

- Explore ways to more easily dispense naloxone directly to individuals in emergency departments, rather than requiring patients to take a prescription to a pharmacy.

Outreach workers

- Explore options for outreach workers to distribute take-home naloxone to those not accessing it through other services such as syringe exchange.
- Evaluate police/fire/Emergency Medical Services (EMS)/social/health services staff/schools having naloxone for administration in the course of their work.

Police and Fire

- Evaluate the utilization and health impacts of naloxone administered by police and emergency medical technicians.

Paramedics

- Develop and implement procedures to document opioid overdose occurrence.
- Develop and implement procedures to document bystander responses to opioid overdoses.

Social/Housing/Health Services staff

- Expand overdose education and naloxone availability for staff at facilities where opioid overdoses are likely to occur.
- Evaluate the utilization and health impacts of naloxone administered by social/housing/health services staff.
- Educate the public about opioid use disorder and the Good Samaritan 911 Overdose Law.
 - Incorporate education about the Good Samaritan overdose 911 law into public education about opioid use disorder and overdose.
 - Educate school staff about opioid use disorder and overdose risk as well as the Good Samaritan overdose law so they can provide appropriate education, referrals and interventions.
- Implement systematic and consistent ways to document naloxone distribution, utilization and disposition.
 - Encourage agencies and programs distributing and administering take-home-naloxone to collect standardized data at the time of distribution (E.g., demographics, motivation for obtaining naloxone, opioid use) and when obtaining a refill (disposition of the naloxone and health impacts of naloxone administration).
- Improve communication among stakeholders about practices and protocols related to naloxone distribution.

- Encourage stakeholders to meet to proactively discuss current naloxone distribution and administration practices and protocols to ensure coordination, consistency, clarity and good health outcomes.

2. Establish, on a pilot program basis, at least two Community Health Engagement Locations* (CHEL sites) where supervised consumption occurs for adults with substance use disorders in the Seattle and King County region. One site should be located outside of Seattle, reflecting the geographic distribution of drug use in other King County areas. The CHEL pilot program should have a provisional time limit of three years. Continuation of the program beyond that time should be based on evidence of positive outcomes.

* The Task Force will refer to sites that provide harm reduction services where supervised consumption occurs as Community Health Engagement Locations for individuals with substance use disorders (CHEL sites). This terminology recognizes that the primary purpose of these sites is to engage individuals experiencing opioid use disorder using multiple strategies to reduce harm and promote health, including, but not limited to, overdose prevention through promoting safe consumption of substances and treatment of overdose. The Task Force's equity and social justice (ESJ) charge emphasizes the importance of providing support and services to the most marginalized individuals in the County experiencing substance use disorders. The Task Force asserts that the designation CHEL sites is a non-stigmatizing term that recognizes that these sites provide multiple health interventions to decrease risks associated with substance use disorder and promote improved health outcomes.

Goals:

- Reduce drug-related health risks and harms including overdose death, transmission of HIV and hepatitis B and C viruses, and other drug-associated adverse health effects.
- Provide access to substance use disorder treatment and related health and social services, provide a safe and trusting environment where people who use drugs can engage with services to improve their health and reduce criminal justice system involvement and reduce emergency medical services utilization.
- Improve public safety and the community environment by reducing public drug use and discarding of drug using equipment.

Rationale:

- CHEL sites (aka supervised or safe consumption sites in other jurisdictions) offer a supervised place for hygienic consumption of drugs in a non-judgmental environment free from stigma, while providing low-barrier access to on-site health services and screenings, referrals, and linkages to behavioral health and other supportive services (for example, housing).
- Supervised consumption sites (SCS) have been operating in Europe since 1988. Sites in Sydney, Australia, and Vancouver, Canada, began operating in 2001 and 2003, respectively. As of 2014, there are 90 SCSs operating across the globe on three continents. (See Attachment O for Community Health Engagement Location [aka

Supervised Consumption Site] Bibliography, and see Attachment P for World Overview of Supervised Consumption Sites.)

- Published evaluations from existing SCSs show that SCSs can reduce overdose deaths and behaviors that cause HIV and hepatitis C infection (such as sharing of injection equipment and supplies), reduce unsafe injection practices, increase use of detox and substance use disorder treatment services, reduce public drug use and the amounts of publically discarded injection equipment; and, do not increase drug use, crime, or other negative impacts in the area of the SCS. SCSs can also be cost-effective. (See Attachment O for Community Health Engagement Location [aka Supervised Consumption Site] Bibliography.)
- SCSs are intended to engage individuals in substance use disorder treatment and other supportive services (physical and behavioral health care, housing, social services) who may not engage in traditional treatment related to substance use. The King County Board of Health previously endorsed and adopted the HIV/AIDS Committee's 2007 strategic and operational plan for HIV prevention in King County that included a recommendation to promote the use of a "safe injection site" within King County. (See Attachment O for Community Health Engagement Location [aka Supervised Consumption Site] Bibliography.)
- In July, 2016 the City Council of Toronto, Canada, approved the implementation of three SCSs for the downtown area of Toronto. In their decision making process, the City Council of Toronto considered data published in the 2012 Report of the Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA), funded by the Ontario HIV Treatment Network and the Canadian Institutes of Health Research, and the Supervised Injection Services Toolkit prepared by the Toronto Drug Strategy Implementation Panel in 2013. (See Attachment O for Community Health Engagement Location [aka Supervised Consumption Site] Bibliography.)
- Published studies support the effectiveness of the services provided at SCSs in reducing drug-related health risks and overdose mortality for individuals utilizing the SCSs. Research of established SCSs also did not reveal an increase in criminal activity or negative impacts on the communities following the implementation of SCSs in those areas.

Approach:

- Evaluation
The Taskforce recommends a rigorous evaluation process be integrated into the planning and design of the CHEL program. Outcomes should include fatal overdose prevention, other health outcomes, community and environmental indicators (impact on public drug use/injection, community impact including neighborhood perceptions and public safety experiences, OD-related first responder calls, 911 calls, etc.), and impact of linkage to services. Evaluation should be performed by public agencies (Public Health – Seattle & King County and King County Department of Community Health Services) and/or by third-party evaluators. Potential third party evaluators include the University of Washington School of Public Health, the Alcohol and Drug Abuse Institute (ADAI), the Harm Reduction Research and Treatment Center (HaRRT), Cardea, and Battelle. To the

extent feasible, selected indicators should be monitored in near real time in order to inform the need for any change in these recommendations during the pilot period.

- Planning and Implementation
 - Continue to engage members of the community (including civic and business stakeholders) and potential CHEL clients to inform the planning and implementation process and ensure the environment and services provided adequately and appropriately address the needs of the clients and the surrounding community.
 - Community partners and stakeholders (including persons who use drugs) should continue to be engaged in the CHEL planning and implementation process throughout the duration of the pilot program.
 - Conduct an Equity Impact Review in the planning process prior to implementation: http://www.kingcounty.gov/~media/elected/executive/equity-social-justice/2016/The_Equity_Impact_Review_checklist_Mar2016.ashx?la=en
- Sponsorship
 - Proposed CHEL program sponsorship options may include:
 - Public Health – Seattle & King County (PHSKC) in collaboration with King County Department of Community and Human Services (DCHS), or;
 - A public-private partnership between PHSKC/DCHS and other community-based service providers, or;
 - Another entity with oversight by PHSKC/DCHS.
 - See Attachment Q for Legal Framework Grid, and see Attachment R for Summary of Legal Considerations for CHEL sites in King County
- Siting
 - Consideration for siting CHELs should include the following priorities:
 - Geographic concentration of drug consumption and overdose.
 - Co-location with or in close geographic proximity to (if co-location not possible) existing services utilized by the target population.
 - Local governmental and community engagement.
 - Fixed locations are preferred over a mobile CHEL during the pilot period
 - Establish at least one site outside the city of Seattle.
 - Geographic areas that have been identified as drug use/OD “hotspots”, and that could potentially benefit from the services provided by a CHEL, should be prioritized for potential CHEL sites.
- Services Provided at a CHEL
 - The following services should be provided (essential services):
 - Hygienic space and sterile supplies
 - Overdose treatment: naloxone and oxygen administration
 - Overdose prevention: naloxone kit distribution
 - Syringe exchange services
 - Sexual health resources and supplies (including male and female condoms)
 - Drinking water; restrooms
 - Direct provision of (preferred), or linkage to, basic medical treatment (wound care), wraparound social services and case management
 - Peer support
 - Health education

- Rapid linkage to medication-assisted treatment, detox services and outpatient/inpatient treatment services
- Security and crisis response plan
- Post-consumption observation space
- Every effort is to be made to ensure that the provision of supplies and space for consuming illicit drugs (NOT tobacco-containing products or marijuana) via smoking (more precisely sublimation, meaning without combustion of the drug itself) and nasal inhalation be incorporated into the CHEL program design.
- The following services are highly desirable (but not essential):
 - On site medication-assisted treatment (MAT, for example, buprenorphine treatment)
 - On site drug and alcohol assessment
 - Basic medical treatment and screening services
 - Linkage to legal services
- Staffing
 - CHEL staffing should include at minimum: one (1) licensed healthcare professional (for example registered nurse) and appropriate support staff for the size of facility and scope of services provided, such as social workers, peer support workers, site manager(s) and/or security workers.
 - Medical supervision by a licensed healthcare professional should be provided on site during all hours of operation.
- Funding

No current dedicated resources have been identified to support CHEL implementation and evaluation. Possible public and private resources for this purpose should be explored during the recommendation implementation phase.
- Partner Service Providers
 - A CHEL should be an integrated part of the wide array of services and programs available to the target population. The pilot program should work in close cooperation with:
 - Drug treatment services
 - Medical and behavioral healthcare services including primary health care providers
 - Social services case management
 - Housing assistance
 - Employment assistance
 - Legal Services
 - EMS
 - Law enforcement

VI. Prioritization

The King County Heroin and Prescription Opiate Addiction Task Force proposes that its recommendations be considered and prioritized based on the following factors:

- Evidence base for effectiveness
- Population health/safety impact
- Community support
- Equity
- Complexity/Feasibility
- Legal considerations
- Cost
- Sustainability

Each of these factors is described in further detail below.

Evidence base for effectiveness: To what extent are there published studies or other data supporting the intervention for the population of interest? How rigorous was the research (for example, was there a comparison group? What conflicts of interest did the researchers have?). How big was the intervention effect compared to those who didn't receive the intervention? Is there statistical significance in the findings within relatively small confidence intervals (in other words, how likely is it that the results are the result of the intervention, and not chance)? Have the results been replicated? Do published studies include sub-group members that are demographically distinct by race, age, gender, etc.? What do experts in the field say about the intervention?

Population health/safety impact: How many people would potentially benefit from the intervention? What is the magnitude of the health impact for individuals? What results do we expect to see on specific groups of people in the target community or on the community as a whole? Populations may be geographic and/or identity driven. Examples include all the residents of King County, all 18-25 year olds, all individuals with an incarceration history, and all people living below 200% of the federal poverty level in south King County.

Community support: What is known about community support or opposition within the geographic area where the recommendation is likely to be implemented, or among the stakeholders that would be involved in the recommendation's implementation? Have community meetings been held and focus groups conducted? What kinds of statements for or against have appeared on print and social media sites? Are there any community-initiated initiatives occurring that support or oppose the intervention? Are there strategies to address community and stakeholder concern?

Equity: To what extent and in what ways will the proposed recommendation mitigate or exacerbate existing population inequities or create new ones? Who would be most affected by the change in equity?

Complexity/Feasibility: How difficult would it be to implement the recommendation? What is required for implementation? How long would it take to get the recommendation off the ground? How many entities need to be engaged and in agreement to implement?

Cost: What will it cost to implement the recommendation? What costs are absolute and what may be incremental? How will the intervention be funded? Are there alternatives to how a strategy might be implemented that would affect cost (for example, number of facilities, program size, staffing levels, size of target population, etc.)?

Legal considerations: Is the recommendation allowable under existing federal/state/local law? What dispensations, if any, are needed from law enforcement or other entities? What types and levels of difficulties and/or risk can be anticipated due to legal issues (for example, insurance purchase, client harassment, law enforcement action)? What legislative or regulatory change would be required, at what level of government?

Sustainability: What potential funding sources and mechanisms exist to support the recommended interventions in future years (if continuation is desired)? How likely are these sources to be obtained? What commitments have been secured to sustain recommendations?

The factors above should be considered when determining when and how to implement the recommendations developed by the Task Force. All recommendations developed by the Task Force are intended to significantly positively influence public health outcomes and community welfare.

VII. Draft Evaluation Plan

It is essential to understand what impact interventions implemented in accordance with the King County Heroin and Prescription Opiate Addiction Task Force recommendations have on the target population and the community. Evaluation results can be used to make policy and practice decisions about whether to modify or continue interventions. The initial draft evaluation plan maps each of the key outcomes of interest to one or more of the Task Force’s three areas of focus: primary prevention, treatment, and health services for individuals experiencing opioid use disorder. There are eight outcomes of interest and specific measures for each outcome:

Outcome of Interest	Outcome Measures
Survival	<ul style="list-style-type: none"> • Overdose mortality • Other drug-related mortality (acute and chronic)
Infectious Diseases	<ul style="list-style-type: none"> • HIV diagnoses, HIV transmission risk among HIV-infected PWID, hepatitis C diagnoses, hepatitis C treatment, hepatitis C cure
Health Indicators	<ul style="list-style-type: none"> • Non-fatal overdose, skin and soft tissue infections, cardiovascular outcomes, quality of life

Drug Use	<ul style="list-style-type: none"> • Prevalence of drug use and injection (by type of drug), syringe and other injection equipment sharing, unsafe injection practices, transition to safer injection and other use practices
Drug Treatment and Health Care	<ul style="list-style-type: none"> • Enrolled and maintained on buprenorphine treatment, enrolled and maintained on methadone treatment, EMS/ER use, enrollment in health insurance, has primary care provider
Community Impact and public safety	<ul style="list-style-type: none"> • Syringes and paraphernalia around CHEL, drug-related arrests, 911 calls - number and types, public injection, property values
Community Health Engagement Location (CHEL)	<ul style="list-style-type: none"> • Number of clients, number of encounters, overdoses on site, overdoses reversed on site, client satisfaction, feasibility and sustainability
Implementation of Prevention Efforts	<ul style="list-style-type: none"> • Education materials created and the number distributed, secure medication return implemented and accompanying messaging implemented, existing screening efforts augmented to include opioid misuse and opioid use disorder

The evaluation plan includes monitoring the impact of the intervention(s) at both the population and individual levels. In other words, these analyses would allow stakeholders to understand how interventions impact the general population (for example, did opioid overdose mortality rates in King County decline after an intervention was introduced?) as well as how interventions impact individual people (for example, is someone who gets maintained on buprenorphine less likely to have an opioid overdose?).

The evaluation plan proposes analyses of multiple existing data sources and the establishment of a cohort study that follows people who use drugs over time. Examples of existing data sources that will be queried include: vital statistics, administrative claims data, medical records, HIV and HCV surveillance data, needle exchange survey, and program utilization data. The cohort study will enroll individuals using drugs – some, but not all, of whom will seek services related to the new interventions – and collect baseline and follow-up data, which allow for service uptake patterns and rates to be measured and for the relationship between service uptake and health outcomes to be assessed. The cohort study design will capture outcomes that are most likely to be impacted by the proposed interventions but difficult to measure using existing data sources, including: syringe sharing, public injection, skin and soft tissue infections, and quality of life indicators.

Some of these secondary analyses are already being conducted within the University of Washington’s Alcohol and Drug Abuse Institute (ADAI) in collaboration with King County’s Departments of Community and Human Services and Public Health. However, the proposed evaluation would greatly exceed current FTE capacity and require additional funding, staffing, and new collaborations. Based on the evaluation plan described above, additional resources will require one full time employee (FTE) to lead the secondary data analyses, including analyses to establish baseline metrics for key outcomes.

VIII. Current Local and National Activities

In light of the increased prevalence of heroin as a drug of abuse and associated substantial morbidity and mortality, the Task Force was directed to confront the heroin and opioid addiction epidemic with immediate action in King County. To respond to this directive, whenever possible, the Task Force initiated immediate implementation of promising and/or evidence-based interventions rather than postponing implementation for presentation of the recommendations to the Task Force sponsors. Current status of local efforts to enhance primary prevention, opioid treatment and the health of individuals with opioid use disorder is described below. The Task Force also provided support to relevant state and federal initiatives and projects that would positively impact local efforts to address the opioid challenge. These state and federal initiatives are also described below.

Primary Prevention: Current Local Efforts

- The Task Force is partnering with organizations and entities developing countywide safe prescription drug disposal programs. The City of Seattle enacted a resolution expressing support for an effective, countywide disposal program for prescription drugs and controlled substances, and requesting local pharmacies and the Seattle Police Department install drug disposal drop-boxes across the city. Additionally, the King County Hazardous Waste Management Program is developing a safe disposal program (also known as a secure medicine return program) throughout the County; the Task Force will partner in this effort to publicize and promote the availability of secure medicine return sites. Finally, the Washington State Hospital Association has teamed up with a toxicology company to collect unused prescription drugs and safely dispose of them.
- The University of Washington Alcohol and Drug Abuse Institute (ADAI), represented on the Task Force, will host a state Department of Health nurse consultant to provide education and training, including tele-health sessions, on opioid addiction for professionals and community members.

Treatment Expansion and Enhancement: Current Local Efforts

- The Task Force is developing a strategy for expanding access to buprenorphine treatment by increasing the number of access points for receiving buprenorphine induction, stabilization and maintenance services in King County. The Downtown Public Health Needle Exchange and Public Health – Seattle & King County Mobile Medical Van are currently designing plans for low barrier implementation of buprenorphine services through pilot programs, effective in the fourth quarter of 2016. The pilot program at the needle exchange will pilot a “bupe first” model that focuses on medication stabilization as the primary goal of treatment. Other proposals for expanded access through community health clinics, emergency departments, behavioral health clinics (including traditional medication-assisted treatment [MAT] facilities), and local jails, have been developed and critical resource needs have been identified. The Department of Public Health – Seattle & King County Jail Health Services is currently evaluating the number of

individuals booked into the King County jail who are stable on buprenorphine to determine the feasibility of providing buprenorphine maintenance services during incarceration. The ultimate goal is to evaluate demand for both induction and maintenance services and devise a plan to provide these services to individuals with opioid use disorder who desire MAT.

- The Task Force conducted GIS mapping of current service sites (opioid treatment programs, behavioral health treatment agencies, needle exchange facilities, public health clinics, emergency departments, and hospitals) to evaluate network adequacy and geographic accessibility. The service map can be found at the following location: <http://kingcounty.maps.arcgis.com/apps/webappviewer/index.html?id=d9424b892f404c39a07cda52390ce627>. The Recovery Help Line is currently developing a plan for how King County could achieve centralized access and referral to treatment services in order to facilitate treatment on demand.
- In 2015, King County conducted a survey of behavioral health provider agencies to learn about recruitment and retention issues. Position vacancies were high and low wages relative to other professional opportunities significantly contributed to staff retention challenges. The King County Department of Community and Human Services, Behavioral Health and Recovery Division is designing a plan to address the workforce shortage in order to promote network adequacy and support achievement of treatment on demand.
- The Task Force has analyzed the challenge presented by local jurisdictions that make it difficult for opioid treatment providers to open treatment facilities. A legal analysis has been drafted describing the legality of MAT program facilities in Washington, common challenges in opening MAT facilities, and options to ease restrictions on opening MAT facilities. Additionally, the Task Force is drafting proposed amendments to state legislation that is inconsistent with the current standard of care for treatment of opioid use disorder and poses unnecessary barriers to treatment access (RCW 71.24.585 and RCW 71.24.590, respectively).
- The King County Department of Community and Human Services' Behavioral Health and Recovery Division, Washington State Health Care Authority (HCA) and Medicaid Managed Care Organizations (MCOs) convened in June and August 2016 to discuss the collaborative care/nurse care manager model as a means of supporting expansion of buprenorphine services for treatment of opioid use disorder. System barriers and funding challenges were identified. The group is currently working on developing a plan to support implementation of a collaborative care/nurse care manager model to facilitate buprenorphine services delivery in King County.

User Health and Overdose Prevention: Current Local Efforts

- Naloxone distribution is being expanded to ensure easy access to overdose prevention with distribution efforts that involve many providers, first responders and locations throughout the County. The County Department of Community and Human Services, Behavioral Health and Recovery Division is partnering with Kelley-Ross pharmacy to distribute naloxone to persons identified in the publicly funded treatment system. Additionally, naloxone is now being distributed through 18 homeless housing providers

for use in housing settings, and participating housing partners have documented two overdose reversals prior to the date of this report. DCHS has also distributed naloxone kits to local law enforcement including the Sheriff's Office and the Kent, Auburn and Redmond police departments and overdose reversals have also occurred as the result of this project. The Marah Project has collaborated with the Seattle Police Department and the UW Alcohol and Drug Abuse Institute (ADAI) to distribute naloxone to police officers on bicycles and evaluate implementation. As of August, 2016, 10 administrations of naloxone had been documented as a result of this collaboration. Finally, planning is underway for the King County Emergency Medical Services to develop an emergency medical technician naloxone program for County agencies; implementation of a pilot program is slated for the fall of 2016. All of the entities noted above (DCHS; pharmacy; housing providers; law enforcement; first responders; Marah Project; ADAI; city of Seattle; and Sound Cities Association) are represented on the Task Force. From the time the Task Force started until August 15, 2016 there have been at least 14 documented naloxone administrations to people in an overdose state as a result of the efforts from Task Force members.

State and Federal Initiatives

- The Comprehensive Addiction and Recovery Act (CARA) was approved by Congress and signed by the President on July 22, 2016. This legislation treats addiction as a disease and prioritizes prevention, treatment and recovery support services for those living with, and in recovery from, substance use disorders. The Act modifies the qualifications for providers who may prescribe buprenorphine to include nurse practitioners and/or physician assistants who meet specific licensing and training requirements. Additionally, it expands federal funding for opioid reversal medications and drug disposal sites, among other appropriations. (See Attachment S for Key Potential Opportunities for Washington and King County in CARA.)
- The Centers for Disease Control and Prevention issued Guidelines for Prescribing Opiates for Chronic Pain that provides recommendations for safer and more effective prescribing of opioids for adults in outpatient settings.
- In response to President Obama's call for the federal government to identify barriers to treatment for opioid use disorders, the Centers for Medicare and Medicaid Services (CMS) will require Medicare Part D formularies to allow access to medication-assisted treatment for these disorders.
- In the spring of 2016, the White House announced the final proposed Health and Human Services rules that mandated that doctor caps for prescribing buprenorphine were to be raised to 275 individuals per each Drug Addiction Treatment Act waived physician. The Task Force submitted comments urging the implementation of these rule changes which were promulgated in final form effective August 8, 2016.
- In 2013 the federal Substance Abuse and Mental Health Services Administration (SAMHSA) provided its final rule giving opioid treatment programs (OTPs) the flexibility to dispense buprenorphine take-homes, with no predetermined waiting period for individuals who are stable. In June of 2016 the State of Washington confirmed the use of

medications other than methadone that can be utilized in OTPs, including buprenorphine/naloxone (Suboxone®) and naloxone.

- In August, 2016 the U.S. Surgeon General, Dr. Vivek Murthy, announced his Turn the Tide Rx movement. Dr. Murthy is calling on health care professionals across the nation to take a pledge to educate themselves to treat pain safely and effectively, screen individuals for opioid use disorder and provide or connect individuals with evidence-based treatment, and talk about and treat addiction as a chronic illness, not a moral failing.
- The Department of Health, Washington State Department of Social and Health Services, Washington State Department of Labor and Industries, Washington State Health Care Authority, and University of Washington Alcohol and Drug Abuse Institute have created a statewide Interagency Opioid Working Plan that outlines a strategy for addressing the opioid abuse and overdose crisis. Priority goals include enhancing primary prevention; treatment of opioid use disorder, overdose prevention, and data collection (for the purposes of evaluating interventions, monitoring morbidity/mortality, and detecting misuse). Priority actions include improving prescribing practices, expanding treatment access, distributing naloxone to those using heroin, and optimizing and expanding data sources. Workgroups have been created to oversee implementation of strategies designed to address the four identified goals.

IX. Next Steps

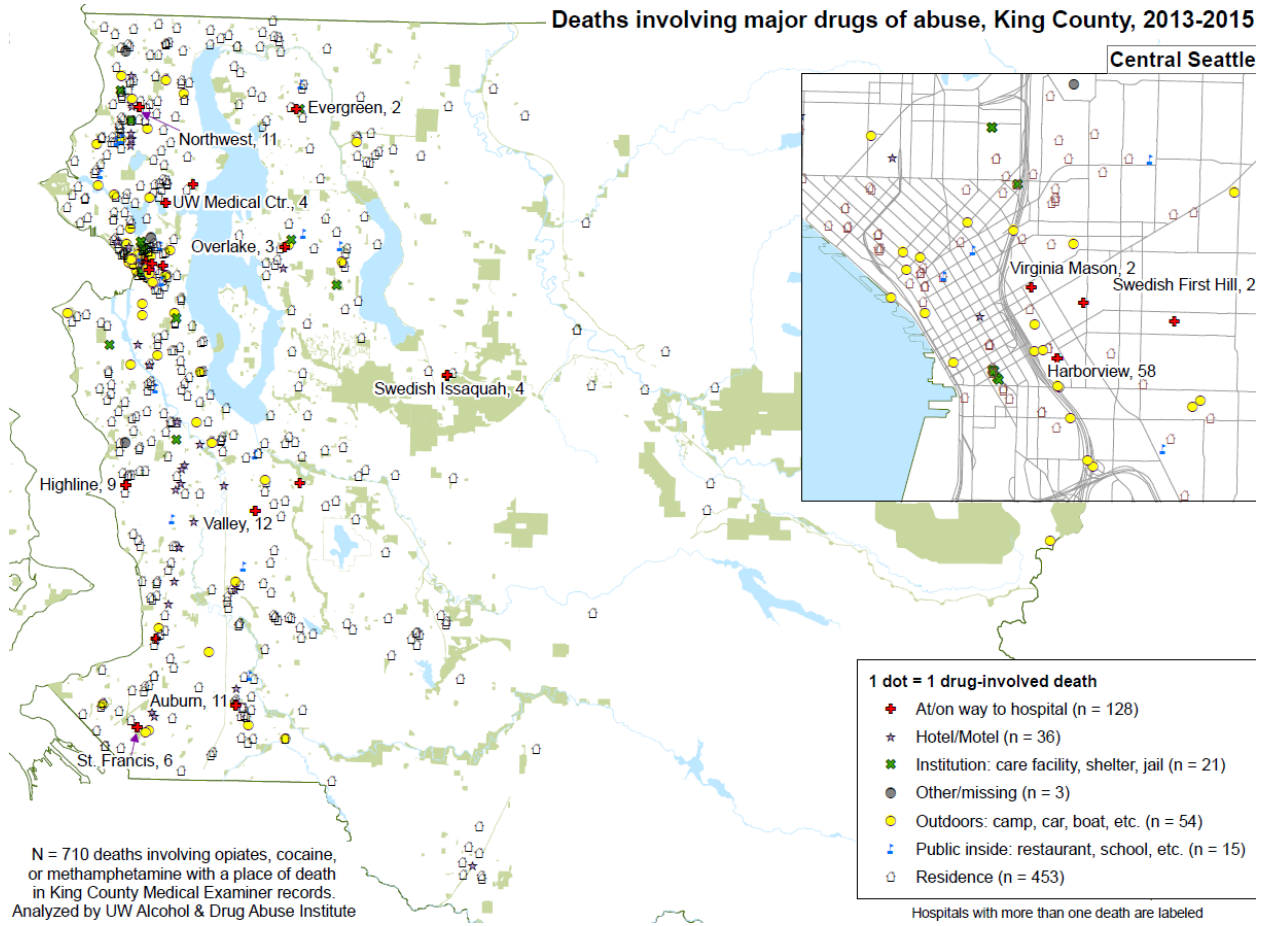
The Heroin and Prescription Opiate Addiction Task Force recommends that local government and other partners begin to implement the recommendations contained in the report as soon as possible. As previously noted, the Task Force has already begun to implement some recommendations with existing resources and the support of the County. Other recommendations have not yet been implemented.

The Task Force recommends that existing Task Force workgroups continue to convene, and that these can potentially transition to oversight groups to help guide implementation of the Task Force's recommendations.

After review of this report by the Task Force sponsors, implementation teams should be assembled corresponding to the various recommendations. It may also be useful to assemble special teams or work groups to help identify resources for implementation of the recommendations and to assist with public education and communication.

The Task Force requests that within 90 days of receipt of this report the sponsors provide a formal response to the recommendations in the report, and that the Task Force reconvene at that time to assess the response. The Task Force should also reconvene as needed to help facilitate and/or evaluate implementation of the recommendations, including at three to five years to review progress made and associated outcomes, and to recommend what, if any, further action should be taken to address the challenge of opioid abuse in King County.

Attachment A MAP OF OVERDOSE DEATHS IN KING COUNTY, 2013-2015



Attachment B
HEROIN AND PRESCRIPTION OPIATE ADDICTION TASK FORCE
MEMBERS

Task Force Member	Agency/Entity	Voting Member
Brad Finegood	King County Department of Community and Human Services	No
Jeff Duchin	Public Health - Seattle & King County	No
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute	Yes
Kate Joncas	City of Seattle Mayor's Office	No
Scott Lindsay	City of Seattle Mayor's Office	No
Jim Pugel	King County Sheriff's Office	Yes
Robert Merner	Seattle Police Department	No
Frank Chafee	Public Health - Seattle & King County	No
Karen Hartfield	Public Health - Seattle & King County	No
Reba Gonzales	Seattle Fire Department	No
Tom Rea	King County EMS	No
Catherine Lester	Seattle Human Services Department	No
Jeff Sakuma	Seattle Human Services Department	No
Darcy Jaffe	Harborview Medical Center	Yes
Mark Larson	King County Prosecuting Attorney's Office	Yes
Mark Cooke	American Civil Liberties Union (ACLU)	Yes
Steve Stocker	Auburn Police Department	Yes
Kevin Milosevich	Renton Police Department	Yes
Tim Bondurant	Veteran's Administration	Yes
Jim Walsh	Swedish Hospital, Pregnant and Parenting Women Program	Yes
Charissa Fotinos	Washington State Department of Social and Health Services, Behavioral Health Administration and Health Care Authority	Yes
Lisa Daugaard	Public Defender Association	Yes
Patricia Sully	Public Defender Association	Yes
Annette Hayes	U.S. Attorney for the Western District of Washington	No
Penny Legate	The Marah Project	Yes
Thea Oliphant-Wells	King County Needle Exchange	No
Mark Putnam	All Home	No

Task Force Member	Agency/Entity	Voting Member
Dan Cable	Muckleshoot Tribe	Yes
Molly Carney	Evergreen Treatment Services	Yes
Norm Johnson	Therapeutic Health Services	Yes
Michael Ninburg	Hepatitis Education Project	Yes
Andy Adolfson	City of Bellevue Fire Department	Yes
Pegi McEvoy	Seattle Public Schools	Yes
Shilo Murphy	People's Harm Reduction Alliance (PHRA)	Yes
David Dickinson	U.S. Substance Abuse and Mental Health Services Administration, Regional Office	Yes
Roger Dowdy	Neighborcare	Yes
Annie Hetzel	Puget Sound Educational Service District	Yes
Mary Taylor	King County Drug Court	Yes
Daniel Malone	Downtown Emergency Service Center	Yes
Ryan Oftebro	Kelley-Ross Pharmacy	Yes
Suzan Mazor	Seattle Children's	Yes
Milena Stott	Valley Cities Behavioral Health	Yes
Natalie Green	Department of Social and Health Services Children's Admin.	Yes

STAFF:

- Chelsea Baylen – King County Department of Community and Human Services
- Steve Gustaveson – King County Department of Community and Human Services
- Marcee Kerr – Public Health – Seattle & King County
- Milena Stott – Valley Cities Behavioral Health
- Erin James – King County Department of Community and Human Services

Attachment C
HEROIN AND OPIATE ADDICTION WORKGROUPS

Primary Prevention Workgroup

Member	Agency/Entity
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute
Pegi McEvoy	Seattle Public Schools
Suzan Mazor	Seattle Children's
Penny Legate	The Marah Project
Charissa Fotinos	Washington State Department of Social and Health Services, Behavioral Health Administration and Health Care Authority
Kevin Milosevich	Renton Police Department
Andy Adolfson	City of Bellevue Fire Department
Robert Merner	Seattle Police Department
David Dickinson	U.S. Substance Abuse and Mental Health Services Administration, Regional Office
Annie Hetzel	Puget Sound Educational Service District
Jeff Sakuma	Seattle Human Services Department
Natalie Green	Department of Social and Health Services Children's Administration
Milena Stott	Valley Cities Behavioral Health
Erin James	King County Department Community and Human Services

Treatment Expansion and Enhancement Workgroup

Member	Agency/Entity
Brad Finegood	King County Department Community and Human Services
Dan Cable	Muckleshoot Tribe
Molly Carney	Evergreen Treatment Services
Norm Johnson	Therapeutic Health Services
Daniel Malone	Downtown Emergency Service Center
Mary Taylor	King County Dept. of Judicial Administration
Roland Akers	Community Member
Roger Dowdy	Neighborcare
Darcy Jaffe	Harborview Medical Center
Tim Bondurant	US Veterans Administration
Tom Rea	King County Emergency Medical Services
Mark Larson	King County Prosecuting Attorneys' Office
Jim Walsh	Swedish Hospital, Pregnant and Parenting Women's Program
Lisa Daugaard	King County Public Defender Association
Jeff Sakuma	Seattle Human Services Department
Shilo Murphy	People's Harm Reduction Alliance
Laurie Sylla	King County Department Community and Human Services
Kris Nyrop	King County Public Defender Association
Cynthia Hobbs	Therapeutic Health Services
Milena Stott	Valley Cities
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute
Chelsea Baylen	King County Department Community and Human Services

User Health Services and Overdose Prevention Workgroup

Member	Agency/Entity
Jeff Duchin	Public Health - Seattle & King County
Mark Cooke	American Civil Liberties Union (ACLU)
Lisa Daugaard	Public Defender Association
Annie Hetzel	Puget Sound Educational Service District
Brad Finegood	King County Department of Community and Human Services
Shireesha Dhanireddy	University of Washington/Harborview Medical Center
Chloe Gale	REACH Program
Charissa Fotinos	Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR)
Reba Gonzales	Seattle Fire Department
Annette Hayes	U.S. Attorney for the Western District of Washington
Karen Hartfield	Public Health - Seattle & King County
Scott Lindsay	City of Seattle Mayor's Office
Joe Tinsley	King County Needle Exchange
Dan Otter	UW Public Health
Kris Nyrop	Public Defender Association
Patricia Sully	Public Defender Association
Mark Putnam	All Home
Michael Ninburg	Hepatitis Education Project
Ryan Oftebro	Kelley-Ross Pharmacy
Shilo Murphy	People's Harm Reduction Alliance (PHRA)
Steve Stocker	Auburn Police Department
Jim Pugel	King County Sheriff's Office
Thea Oliphant-Wells	King County Needle Exchange
Laurie Sylla	King County Department of Community and Human Services
Marcee Kerr	Public Health - Seattle & King County

Policy Workgroup

Member	Agency/Entity
Brad Finegood	Department of Community and Human Services
Scott Lindsay	City of Seattle Mayor's Office
Mark Larson	King County Prosecuting Attorney's Office
Mark Cooke	American Civil Liberties Union (ACLU)
Lisa Daugaard	King County Public Defender Association
Kris Nyrop	King County Public Defender Association
Patricia Sully	King County Public Defender Association
Shilo Murphy	People's Harm Reduction Alliance
Annette Hayes	U.S. Attorney for the Western District of Washington
Steve Gustaveson	Department of Community and Human Services
Chelsea Baylen	Department of Community and Human Services

Evaluation Workgroup

Member	Agency/Entity
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute
Sara Glick	Public Health – Seattle & King County
Julia Hood	Public Health – Seattle & King County
Laurie Sylla	Department of Community and Human Services

Attachment D

Community Conversation (May 31, 2016): Attendee Comments

Focus One: Primary Prevention

What is Working Well?

Adverse Childhood Experiences (ACES)

- The ACES work has also been extremely successful in identifying the key trauma areas and identifying that certain people just based on their childhood trauma may be more inclined.

Awareness, Social Norms, Education, and Training

- Education to the community has been good.
- ‘Providing Good Choices’ Parent program educates parents and gives them tools to get children to open up about issues. It works with different languages and faiths. Talking about issues allows more opportunities to address issues
- Altering points of view – debunking the illusion of ‘everybody else is using’. Show that drug use is not the social norm among the kids’ peers. This can lead to a positive ‘reverse peer pressure’.
- The community was working to relay ‘positive community norms’ through groups such as Youth Eastside Services (YES).
- These forums are working well they generate discussions, provide education, they are informative and bring community partners outside of the traditional; law enforcement, mental health, healthcare providers together. Adding all these other entities makes it much more educational.
- Awareness is growing. My daughter died four years ago and we were fighting hard to keep her alive and it was difficult. People are starting to understand it is a disease, the stigma is going away, there is a shift towards awareness and what addiction really is and what it does to someone. We still have a long way to go, but it’s getting better, for instance, there is a meeting tonight in Kirkland to discuss these issues.
- It is so amazing that it is being spoken about, it is out there and people are now talking about it openly.
- There is a lot more understanding and it has been great that people now understand that it is not just poor people that are impacted and there is also the issue that folks understand it is happening with younger and younger youth.
- In the past they did campaigns that I felt were effective; the faces of Meth, DARE and while I know many feel that was a bust, I still remember it and it was helpful to some.

- Awareness is big right now because unfortunately no community is untouched and it is becoming really frightening. Look at across the country it is a nationwide epidemic of Heroin and opiate use.
- It is good to see that people understand that this is not a socioeconomic issue, it is not a problem in only one area, it is a problem that is impacting everyone, and it is touching all spectrum of life.
- The discussion is becoming honest. There is no longer terror or the bogey man associated with the problem. People are having honest, clear discussions.
- The discussion has become honest and moved past the bumper sticker. It has become educational and part of a broader conversation about how to address the issue and how officials can tie down the problem to really help those that need the help.
- The media has done a good job, have learned a lot about from the news about the opiate crisis. It is a little late, but at least the story is being told now. I have been informative and it is really helpful to have them at the table. (Asked for examples)
- I am from Kentucky and would not associate the issue with them, but there are so many pill factories there and now look at the big Opiate/Heroin crisis going on there. The Frontline story was also good.
- Students/teachers/administrators know which substances are being used in the community and what local resources are available to assist with intervention efforts
- Training for administrators/teachers on warning signs of substance use so those interacting with school-age children can identify those at risk and can target prevention and intervention efforts accordingly
- Lots of people are here and it's because people are dying and it is starting to get people's attention.
- Many communities are "owning" the issue, realizing that this is a problem and it needs to be addressed. Though there are still some areas that are in denial.

Collaboration

- Various agencies are sharing information and training opportunities.

Continuum of Care – Comprehensive Strategies

- As I approached the table I thought the prevention meant to stop people from starting to use, but now I see it can mean several things, the prescribing habits, the reviving of people, getting people into effective treatment and other things to be done to prevent continued use.

Narcan/Naloxone

- The shift to harm reduction is great. Lots of attention on providing information to those in need and the efforts to address the overdose situation has been great. There are lots of efforts to get information out to first responders and provide the NARCAN kits. The "MARAH Project" has funded the Seattle Police Department with NARCAN kits and in 6

weeks has saved 6 lives – this was so encouraging and shows the importance of these kits and getting them out to first responders.

- A study at Evergreen Treatment Services regarding the distribution of NARCAN to users and how and if it is being used has been helpful. They are keeping stats on how often the NARCAN is being used and it has shown that it is not uncommon to have NARCAN used by someone more than once.

PDMP

- Prescription drug monitoring program and the take-back program were very positive and working well.
- Prescription monitoring programs are an effective tool for any prescriber who needs or wants to use it. But it is not being used by many. If they use it they can look at what folks are getting and prescribe smartly

Peers

- Using peers to engage other students in prevention education and identification of peer role models to assist with prevention and engagement efforts

Prevention Interventionists in Schools and Counselor Support

- The high schools have behavioral counselors who are termed ‘coaches’ but there is a need for more of them
- Engaging school-aged children through the school system (Boston model)
- Providing targeted prevention intervention for school-aged children who have family members with opiate use disorders or other substance use disorders
- Using prevention interventionists in schools (need more of these professionals)

Resources and Support

- Advocates being available for families have been really helpful. It has helped families to not be alone through the treatment process, and knowing where to go when they need help.
- Drug-free community grant
- Annual Prevention Conference in Kent (Kent Drug Free Coalition) and Peer to Peer Annual Education Conference
- CVS Pharmacy grant involving prescription take-back

Syringe Exchange

- Needle and syringe exchange programs have been helpful

Take-Back Boxes

- Talked about prescription take back boxes in all of their schools and that there is a great deal of buy in from the mayors, police chiefs, libraries and chambers of commerce in her

area. She states that there is a lot of sharing of information among these entities regarding 'the word on the street'.

- Prescription drop boxes in Police Departments are well received, but many may be intimidated by the location.

Youth Engagement

- Engaging students in the process of determining prevention content

What Needs to be Improved?

Adverse Childhood Experiences (ACES)

- ACES is a good start

Accessibility and Equity of Information

- Information needs to be in a broad spectrum of languages and written so that it is respectful of culture
- When family are immigrants the parents often do not speak English well/at all and are not culturally aware and so kids can take advantage of this.
- Need more culturally appropriate services (including services for those with English as a second language)

Addressing Mental Health and Co-Occurring Disorders

- Mental health treatment is a big issue. My daughter had several diagnoses and it made her anxious and unstable. She chose to self-medicate and even with all our efforts to help her, we could not get to her before she died.
- All agreed that Mental Health services in the county and state are lacking.

Alternative Pain and Traumatic Injury Treatments

- Alternative medication or treatments for pain from traumatic injuries

Attitudes

- 'If it makes you feel good, do it' attitude
- Past culture of opioid use – early medicines that were cure-alls, some Asian cultures where opium use was very acceptable at times in the past.

Beds and Housing

- Treatment facilities and after treatment housing needs to improve with more beds available.

Data to inform prevention efforts and policy

- Need access to community/neighborhood-centric data to impact and inform local prevention efforts and policy; also need education on where/how to access county-level and city-level data (some communities are currently utilizing national or state level data to inform local prevention efforts)
- Need access to data on young adults/transition aged-youth (18-25 year olds)

Diversions Programs

- Diversions opportunities need to be improved. There needs to be more opportunities for folks who are in a clean and sober situation to keep active whether it is a community project or just creative tasks for them to have an outlet.
- Expand the Law Enforcement Assisted Diversion (LEAD) program

Education – Information Dissemination

- Smoking heroin does not seem that bad to many , so informing early and informing accurately is important
- When we get funding we need to ensure education is a part of the requirement
- How are people teaching about it needs to be more than bumper sticker. Needs to be more than scare tactic and abstinence

Financial resources to target problem

- It feels like we are restricted in regards to how much we can do: Federal funding can be utilized, it feels like resources are there, the State is working with the Government for funding. The more we can get the better, because in the long run it will not only save lives, but money.
- Need more federal funding without strings: The problem with this is the restrictions around the funding that often hampers the ability of who you can help
- You have to wonder if the strings are meant to clutter the path for exclusionary reasons. One guess is that it is a manifestation of political fear - If one signs over funds to help people their constituents feel are not worthy, there may be fear the people who voted for you would vote you out.

Good SAM Law

- Broadcast ‘Good Samaritan Laws’ regarding calling 9-1-1 for overdoses – Police will not arrest person calling or victim, they just want people to get medical attention.

Legalization

- I think the best thing to do is to legalize everything – I know this is a controversial perspective, but what happens that right now we can’t safely engage the issue when we drive them deeper into hiding. We would get more momentum to the legalize trade than to treatment

Mental Health Screening

- Mental health screening is important – there needs to be a variety of education in this area.

- Maybe some kind of mental health screenings in schools, in adolescents or primary schools that would help identify the issues. A screening and brief intervention in the mental health setting would be great. There really need to be a lot more screening and intervention; more of a broad based screening, need more resources, it needs to be widespread, routine and it really needs to become common practice.

Narcan/Naloxone

- Regarding Narcan in Seattle: There are some politics around this especially with Fire – there is pushback. Medic-one carries the kits but Fire doesn't and wont – something to do with first on the scene. It took a year to get Seattle Police Department (SPD) to get on board. Approached the Mayor's Office but they just kind of gave the run around and no real assistance, made lots of efforts, but could not get them on board, we just heard, "okay, yeah, we'll look at it." It did not happen until we approached Chief O'Toole and it happened. She was extremely helpful and open to the idea. The project's goal is to save lives and it was so nice and interesting to see that it was successful and the results were seen so quickly.
- We want everyone in Seattle Police Department to carry the Narcan kit, we want to get parents to understand that buying a kit could save their child's life – recommend buy a kit, give it to them and teach them how to use it to save their child's life.

National support and promotion

- Educational information is good at the local level, but really needs to also be at the national level – forums like this one need to occur at a higher level. Public Service Announcements similar to the one Obama and Macklemore did was great.
- Look at the bill Obama did: one bill for the Opiate addiction and medication-assisted therapy.

Parent Education

- Need to train parents that prevention education will not encourage use

Patient Education

- My doctor and/or pharmacist did not tell me I could overdose

Prescription Drug Monitoring Program (PDMP)

- Prescription monitoring programs are an effective tool for any prescriber who needs or wants to use it. But it is not being used by many. If they use it they are can look at what folks are getting and prescribe smartly

Prescriber Education and Prescribing Practice

- Education and cooperation by prescribing doctors needs to be better.
- Supply is an issue, but informing youth early on so young people have time to make decisions about what they are going to do.

- You can't buy Opiate prescription now, it is all in the medicine cabinet – doctors are prescribing ridiculous amounts for benign things like. I had 30 for a hurt wrist and I have 30 for a pulled wisdom tooth and that is ridiculous
- Need more info on practitioners who over-prescribe

Reduce Access/Availability of Drugs

- Availability for people to get drugs

Resource Awareness for Law Enforcement/first responders

- Better educate law enforcement (first responders) about what prevention opportunities and resources are available so they can pass info on to folks they come across in the field.

Resource Awareness - Narcan/Naloxone and Take-Back Boxes/Events

- Provide better information on where to get Narcan
- Need more information about prescription take-back and prescription take-back events and permanent drop-boxes at appropriate/supervised locations

Safety

- There is no way to evaluate street drugs for safety

School Policy

- Kicking kids out of school for drug use enhances the problem – keep them in class and get them counseling.
- Random drug testing? – It is not allowed in schools; however, parents can have kids tested.

School and Youth Prevention Programming/Education, Intervention and Mentoring

- Improve education in the schools at all levels – drug abuse programs
- Informing young people about Methadone is key – we need to inform them. The thing is we focused on Crack, we focused on Meth and other types of drugs and maybe it made it look like Heroin may not be so bad, if they are focusing on the others. We need to make sure to inform youth better about heroin and opiates. People start using them and then it is on from there. They get that thing into their brain and then it is over – addiction.
- Need more prevention-interventionists in schools
- Need more healthy support networks and mentoring programs in our schools
- We need to provide alternatives to using drugs – keep the kids engaged.
- Empower children to make educated decision.

Social Norms and Media Messaging

- Social settings where drug use is the 'norm' and where drug use is being 'normalized' and where social media messaging promotes that drugs are 'fun'
- Movies and TV showing drugs as fun

- Needs to be more education to youth through TV, social media, other sources

Training – administrators, teachers, and parents

- Need to provide more training to school administrators, teachers, and parents on early identification of at-risk youth (what are the substances being used in the community? what are red flags to be looking for? what are local resources for intervention?)

What works? – Use research-based approach – Address issues to reduce risk

- In regards to homeless youth and the use – there are many that don't use, so what made the difference, was it early intervention?
- What works with kids not using?
 - Not being homeless – housing is a huge issue
 - Making kids excited about life
 - Employment programs
 - The availability of other options – healthy activities
 - Young people need really good non-scare tactic information
 - There needs to be engagement and the availability of all services – especially mental health

Focus Two: Treatment Expansion and Enhancement

What is Working Well?

Approach

- Shift in acceptance of Harm Reduction
 - Assigned police staff for community resource

Awareness, Attitudes, and Reduced Stigma

- More awareness and push to acknowledge the issue. The amount of discussion of problem
- A growing understanding that recovery is a process
- Society is coming to understand that opiate addiction is a disease, not a lifestyle
- Society is also seeing this current issue as a Public Health issue rather than a criminal justice issue.
- Shifting attitudes about medication for treatment
- Humanizing the problem
 - Schools are involved in the discussion
- Stigma is being addressed, compassion is happening
- Awareness and Education efforts are increasing.

Behavioral Health Integration and Language

- Merging of mental health and substance use treatment allows for better tracking of needs

- The County’s Department of Community and Human Services, Behavioral Health and Recovery Division (BHRD) name change shows emphasis on recovery and holistic wellness not “illness.”

Best Practices and Science

- Identifying ‘best practices’
- Emphasis on science instead of morals

Continuum of Care

- The focus on medication-assisted treatment is good, seeing it explored is a popular topic because abstinence does not work. It is good to see it being recognized more as a disease model. Telling people to say “no” and “why aren’t you strong enough to say no,” is the wrong message, because all it does is cause people to beat themselves up.

Media

- Media is presenting factual information as well as the grief in the community
 - Normalizing of the topic, bringing new voices to be heard

Narcan/Naloxone Access and Promotion

- The availability of Naloxone for users and family members
- Putting Narcan into treatment plans- for example, asking “who do you trust” to help you in an emergency and getting a plan in place just in case.

No wrong door approach

- Where it exists, the “no wrong door” approach is working.

Open Access

- Same day assessments and next day assessments are very helpful
- Next day appointments-treatment when you need it.

Opportunities and Solutions

- Feels like opportunities and new solutions are happening

Peer Support and Recovery Coaches

- Peer support, recovery support services exist, recovery houses
- Peer Bridger programs are very successful
- Recovery coaches are proving to be a promising practice
- Peer coaches seeing the community respond to peer coaches that are more client centered than sponsors “who tell you what to do instead of asking you what you’d like to work on”

Programs

- Innovation in the Law Enforcement Assisted Diversion (LEAD) program
 - Social services and law enforcement working together

Provider Communications

- Communication between providers

Treatment, Access, and Availability

- Increase in services available
- More treatment availability in pipeline
 - Greater access in areas that need it – that is, South King County
- More treatment options are serving more people
 - Suboxone providers/opiate treatment programs
- Methadone treatment is effective.
- New treatment options and drugs are coming on line.
- More treatment centers are opening in south King County
- Methadone and Suboxone treatment
- There is a demand for treatment (which is a good thing.)
- Small pilots for treatment on demand working well. Need to bring them to scale

What Needs to be Improved?

Attitudes, Stigma, Need for Education

- The negative stigma that impacts family members of users (lack of education)
- The assumption that users come from poor, broken families (education)

Community Concerns – Service Locations

- Community concerns over siting future clinics

Criminal Justice

- What is criminal justice doing?

Funding Needs

- Lack of funding

Housing

- Housing is a big one – various options are needed, it cannot be the same for everyone there needs to be different options. There are not enough treatment options that include housing.

Lack of Comprehensive Wraparound Systems

- Lack of a comprehensive wrap around system for users and recovering addicts. For example ongoing counseling, job opportunities, family support, and developing skills to transition to a drug-free lifestyle.
- 24 hour “wraparound services” in a shelter setting with a one-stop type of approach – for example, DSHS workers, housing workers, etc. – like the San Francisco “The Navigation Center” shelter and “radical hospitality” – and allows clients to bring with them the three Ps – pets partners and possessions (Seattle does this some places) since King County is more spread out that there may need to be more navigators (also Councilmember Bagshaw)

Libraries and Social Worker Support

- In Colorado, Denver employs social workers in the library or libraries to provide support, case management and this County should look at that option.
- Train librarians on options for people in need as well.

Low-Barrier Services and Shelter

- Develop a center like the Navigation Center in San Francisco that offers low barrier services and shelter. This center allows all genders, dogs, and a full array of services for people.

Meeting the needs of communities of color and priority populations

- What about communities of color in the data and media and workforce?
 - Family supports
 - Navigating the system for families and users in a culturally relevant way
 - A need for more trauma-focused care
 - Increased education across all demographics/211 system
 - Increased information about medications and side effects, esp. with various populations
 - Getting treatment to be outside of the agency - information
 - More/better relapse prevention strategies such as education and when relapse happens
 - More support services that are free; peers, youth
 - Inclusive models of care - both mental health and substance use and 1 degree care
 - Have treatment options in increased varied environments, greater access
 - Increased sober housing; integration of treatment w/ housing programs; more housing first programs
 - Efficient allocation of funds - more to treatment, less to admin
 - Lower income, working class need more funding
 - Single parents, pregnant women, LGBTQ, veterans, non-native English and non-English speaking individuals - targeted programs for groups with high barriers

Negative Impacts on Environment (places)

- The negative impacts on public spaces such as a library – presence of users, needles, etc.
- The feelings from librarians that they are being forced to become social workers to respond to users and patrons of the library system.

Open Access

- Increasing the numbers of substance use next day appointments that the Crisis Clinic has to offer. Immediate access to care was something that came up as key to individual's recovery. Once someone is open to detox, having quick access to a bed would not only provide treatment, but encouragement the person is making a healthy choice the community supports with resources.

Safe Injection and Consumption Sites – Equity Measures

- Need not only safe injection sites but safe consumption sites since this is equitable given that there are more white people injecting and more African-American people consuming (smoking) (From Sally Bagshaw, City of Seattle Council member)

Shortage of Treatment Professionals and Prescribing MDs

- Shortage of Chemical Dependency Professionals (CDP)
- Nursing shortage
- Lack of doctors prescribing--how do we incentivize them? Tuition forgiveness? Other options?

Transportation Access

- Lack of transportation options

Treatment Access, Approach, and Options

- Lack of available methadone treatment centers
- Poor accessibility of current methadone treatment centers
- Lack of services outside of Seattle
- No plan for early engagement for users who have just started
- Develop standard treatment guidelines for treatment providers around overdose prevention.
- More and expanded treatment on demand
- Less focus on abstinence based treatment more harm reduction focus

Focus Three: User Health and Overdose Prevention

What is Working Well?

Awareness, Attitudes, and Reducing Stigma

- Awareness (PBS Frontline, Vancouver's Insite visit and other events)
- Increasing public awareness
- Decreasing stigma
- Better attitudes of treatment whole person
- Becoming less judgment and more supportive

Behavioral Health Integration

- Behavioral Health Integration
- Behavioral Health Organizations (BHO)
 - Integration of primary care with Evergreen Treatment Services/Harborview
 - Physicians on staff @ methadone clinic

Community

- Community discussions
- Voices from community members most affected such as Voices of Community Activists and Leaders (VOCAL)

Decriminalization

- Movement toward decriminalization of drugs

Law Enforcement and First Responders

- Police/first responders

Naloxone Access and Promotion

- Getting Naloxone into schools
- Narcan in housing programs
- Naloxone
 - Police are carrying, using and reversing overdoses
 - Change in law in Washington is resulting in increased access to Naloxone
- Naloxone access

Needle Exchange

- Needle exchange
- Needle exchange

Parent Involvement in Programs

- Parental involvement in treatment programs (NAVOS)

Partnerships and Collaboration

- Partnerships, like between the King County Behavioral Health Organization, Kelley-Ross Pharmacy, and agencies like Community Psychiatric Clinic (CPC).

Peer Models

- Peer-based models such as People HR Alliance
- Peer-based support is effective

Programs

- The REACH Program of Evergreen Treatment Services
 - Outreach services to homeless
- Law Enforcement Assisted Diversion (LEAD) criminal justice diversion program

Race, Culture and Equity

- Better recognition of need to consider issue of race and culture

Resources

- Stopoverdose.org
- Connection to info about services

Treatment Expansion, Access, and Approach

- Methadone clinics expanding due to County and increased cap (Renton, Kent, eastside)
- Buprenorphine prescriptions by some docs
- Suboxone less difficult to kick than methadone
- Medical assisted treatment overall
- Harm reduction
- Medic One
- Increased treatment capacity (Renton Youth Treatment Services, Evergreen Treatment Services in Grays Harbor, etc.)
- Mobile Clinics (with limited primary care resources)
- Flexcare (Buprenorphine) medication-assisted treatment
- Access to methadone for pregnant women
- Access to methadone and Suboxone

User Education and Harm Reduction

- User education re-harm reduction

Wrap Around Services/Teams

- Wraparound services/teams

What Needs to be Improved?

Access to Services, Equity and Social Justice, and Increasing Providers/ Capacity

- Services needed in all cities
- Not enough access – geography, level of severity, treatment slots
- Limit on Buprenorphine prescriptions
- Mobile SCF to reach homeless people with others
- Expanded access to Suboxone
- More Suboxone prescribers

Best Practice

- Info about best practices

Care Model

- Providing comprehensive care

Education for Community/Public and Outreach

- More public education needed
- Community education to reduce “not in my back yard” responses and create “yes in my back yard” responses
- Utilize churches for outreach/education

Education for Youth

- Prevention education for kids

Education for MD Providers

- Education of next generation of doctors, those in med school
- Better education of medical professionals re: Suboxone

Equity and Social Justice, Sentencing Guidelines, medication-assisted treatment in Drug Court and Public Health Focus

- Only focused on heroin because it affects white middle class
- Revisit drug sentencing guidelines
- Acceptance of medication-assisted treatment for people in drug court – education of judges
- Less criminalization, more public health focus

Expand Peer Program Resources

- Expand information/tools/recovery resources for peers

Funding

- Maintain funding support for programs
- Flexible funds for people in recovery

Homeless Population Support and Access

- Valley Cities Counseling is teamed up with the King County Library System to assist with the homeless populations that are users within the downtown Renton branch with limited success.

Integration of Recovery Discussion

- Integrate people in recovery and discussion of drugs into other committees (housing, schools, etc.)

Mental Health and Co-Occurring Support

- Mental health support for those struggling with addiction issues
- More integration of primary care with behavioral health.

Narcan/Naloxone Access and Education

- More Narcan kits into hands of active users
 - Costs have risen, reducing number given to agencies
- After naloxone, then what?
 - Use media to help educate on what to do after someone is recued (next steps)

Narcan/Naloxone and medication-assisted treatment in Jail

- Jails should give naloxone and allow people to stay on medication-assisted treatment

Open Access

- Treatment on demand
- Need more treatment on demand
 - Utilize the Downtown Emergency Service Center (DESC) or other resources

Opportunities and Meeting Basic Needs

- Creating more opportunities for people in recovery (jobs, housing, education, etc.)
- Need more stable housing/affordable housing

Patient Education and Support

- Educate pharmacy on how to address addiction. How to talk to patients or doctors.

Reduce Access to Prescription Opioids

- Too easy to get prescription opiates

Reducing Stigma

- Stigma – must pay attention to use of language

Supervised Consumption Sites

- Supervised consumption sites
- Insite approach
- Safe consumption for all drugs
- Supervised consumption sites connect people to treatment
- Call it “supportive consumption facility”

Systems and Leadership

- Need to challenge prison and law enforcement systems
- More civic and law enforcement leadership
- Improve power sharing among decision makers

Attachment E
SUMMARY OF RECOMMENDATION VOTING TALLY

RECOMMENDATION	VOTING TALLY
PRIMARY PREVENTION REC#1	Y=24, N=0, A=2, S=4
PRIMARY PREVENTION REC#2	Y=25, N=0, A=1, S=4
PRIMARY PREVENTION REC#3	Y=25, N=0, A=1, S=4
TREATMENT EXPANSION & ENHANCEMENT REC#1	Y=25, N=0, A=1, S=4
TREATMENT EXPANSION & ENHANCEMENT REC#2	Y=26, N=0, A=1, S=3
TREATMENT EXPANSION & ENHANCEMENT REC#3	Y=26, N=0, A=1, S=3
HEALTH SERVICES & OVERDOSE PREVENTION REC#1	Y=23, N=1, A=1, S=5
HEALTH SERVICES & OVERDOSE PREVENTION REC#2	Y=23, N=3, A=1, S=3

Note: The Health Services and Overdose Prevention Workgroup Recommendation 1 was approved via an electronic voting process.

Y=YES N=NO A=ABSTAIN S=SILENT

Attachment F
IMPLEMENTATION AND PLANNING DETAILS
Primary Prevention Workgroup Recommendation 1

- Creation and Dissemination of Educational Flyer and Counseling Guide
Current implementation and planning: A new approach to education, potentially facilitated by an educational flier, could be implemented when considering opiates for a pain condition. The flyer is intended to help facilitate conversation about the risks and benefits of opiate drugs, including the risk for overdose, addiction potential and other risks associated with the medication and to provide information on non-opiate alternatives for treating pain. Dissemination of the educational approach/flier will be supported by King County agency staff, UW partners, local stakeholders and professional associations.

- Education Campaign
Current implementation and planning: An education campaign will be developed in partnership with local stakeholders, King County DCHS Prevention Staff, and Washington state workgroups to build capacity, partnership, and overall effectiveness in launching a comprehensive and unified educational campaign to reach a broad audience including the general public, opiate users, social networks, and professionals.

Attachment G
IMPLEMENTATION AND PLANNING DETAILS
Primary Prevention Workgroup Recommendation 2

- Encourage pharmacies to counsel all individuals on opiate use, storage and disposal
Current implementation and planning: King County pharmacies will be encouraged by King County Agency and involved community stakeholders to counsel all individuals at the time of first prescription regarding safe storage, disposal of opiates and other controlled substances to prevent unintended access to the medications by others, and how to prevent and recognize overdose.
- Increase pharmacy participation in promoting safe storage and medicine disposal
Current implementation and planning: King County pharmacies will be encouraged by local stakeholders and King County agency staff to promote safe storage and medicine disposal with each opiate prescription to expand community opiate prevention and awareness across all areas in the county.
- Expand access to and coordination with prescription-take-back programs
Current implementation and planning: Task Force members and King County prevention staff are currently partnering with King County Secure Medication Return to promote the expansion of their take-back locations and mail back program. Partnership includes unifying messaging and incorporating consistent guidance on disposal methods for medication types.
- Engage local pharmacies to distribute mail-back envelopes
Current implementation and planning: The Cordant pharmacy launched a program in July 2016 to provide free take-back envelopes to the public through partner agencies to collect and dispose of unwanted medications with the aim of contributing to a reduction in the opiate crisis. King County is ordering 5,000 Cordant mail back envelopes to begin piloting distribution of a postage paid take-back envelope to be paired with each opiate prescription dispensed in addition to related opiate prevention counsel by pharmacist.
- Use social media to promote safe storage and disposal of medications
Current implementation and planning: Task Force members and King County staff will outreach and partner with agencies, prevention coalitions, and pharmacies to promote safe storage and disposal.

Attachment H
SAN FRANCISCO INTEGRATED BUPRENORPHINE INTERVENTION SERVICES (IBIS)
PROCESS PROTOCOL



Brief Program Description

The IBIS Program represents a collaboration between the San Francisco Department of Public Health, Community Behavioral Health Services (CBHS) and the UCSF Department of Psychiatry at San Francisco General Hospital. The program identifies, evaluates and provides buprenorphine treatment to opiate dependent adults residing in San Francisco. Indigent, out-of-treatment, injection heroin users represent the primary patient population. IBIS is a maintenance (vs. detoxification) treatment program. Most IBIS patients begin buprenorphine treatment at the City's **Office-based Buprenorphine Induction Clinic (OBIC)**, and stabilize for a period time prior to transfer to a participating community-based IBIS provider. Community IBIS sites include a number of Primary Care and Mental Health clinics/programs. Indigent IBIS patients can receive Suboxone free-of-charge through the CBHS Pharmacy.

Program Eligibility

- Opiate Dependent San Francisco residents who are eligible for care in the SFDPH Community Oriented Primary Care Clinics (COPC). Must have Healthy San Francisco, S.F. Path, Healthy Families, Healthy Workers, San Francisco Health Plan, Medi-Cal or other coverage accepted by the COPC.
- Absence of benzodiazepine abuse or misuse
- Absence of current alcohol dependence or binge drinking
- 18 years or over or emancipated minor able to consent for medical and substance abuse treatment
- No medical or psychiatric contraindications for buprenorphine maintenance treatment (for example, unstable medical condition, active suicidal ideation, marked psychosis etc.) Any hepatic dysfunction must be in the mild-to-moderate range, with LFTs no greater than 5xs normal levels.

- Patients with acute or chronic pain syndrome requiring regular opioid analgesics should be carefully screened, as buprenorphine may provide less analgesia than a full opiate agonist, and will block (or partially block) other opiate agonists.
- Patients currently receiving more than 30mgs of methadone daily will likely be required to taper down to a dose \leq 30mgs prior to their first dose of buprenorphine.
- Women who are pregnant (or trying to become pregnant) should be evaluated on a case-by-case basis. Though methadone remains the standard of care for pregnant opioid dependent women, recent data support the safety and efficacy of buprenorphine in pregnancy.

Patient Identification, Referral, and Program Entry

To be eligible for treatment through IBIS, a patient must meet the above eligibility criteria and be able and willing to comply with program expectations, including compliance with counseling, medical, and pharmacy visits. Patients may be identified at, and referred to IBIS from, multiple sites/venues/providers across the City including, but not limited to, primary and mental health, social and outreach services (for example, Homeless Outreach Team, Project Homeless Connect and needle-exchange sites), and the Centralized Opiate Program Evaluation (COPE) Service. In certain circumstances patients may self-refer to OBIC/IBIS.

Potential IBIS patients must be discussed with medical staff at OBIC (552-6242) who will make a preliminary determination of appropriateness for buprenorphine treatment. Patients will typically be referred to OBIC for evaluation and medication induction. On occasion, induction can occur at the referring site.

OBIC Clinic Procedures

The Orientation Appointment

At the orientation appointment, patients meet with OBIC staff and review the OBIC/IBIS program, as well as potential benefits and side-effects/risks of buprenorphine. Typically at this visit, consent forms are reviewed and signed. If lab-work is indicated (for example, LFTs), the patient will be given a lab-slip to have their blood drawn at SFGH. Patients must have or obtain a CHN (Community Health Network) number in order to participate in IBIS. Induction procedures and expectations are reviewed, and after preliminary work is completed an induction appointment is scheduled. On rare occasions, the induction process may begin at the orientation appointment. Patients may be given adjunctive medications such as clonidine and trazadone at this appointment to help them prepare for the induction.

The Induction Appointment

At the induction appointment, preliminary labwork is reviewed, and a diagnosis of opiate dependence is confirmed. A point-of-service urine toxicology screen will be obtained. The patient receives a thorough medical, mental health, substance use and psychosocial assessment, and a physical examination is performed. If a recent physical exam, history, and/or

labwork have been conducted by the referring physician, a copy should be faxed to OBIC for review. **Patients must be in opiate withdrawal in order to be induced.** The only exception is a patient who has not used opiates for several days prior to the appointment. Patients who have recently ingested an opiate and do not appear to be in withdrawal may be asked to return at a later time. If deemed ready for induction, an initial dose of Suboxone will be administered. The patient is observed for 1-2 hours, and may receive additional Suboxone doses as determined by the OBIC physician. Adjunctive medication such as clonidine and trazadone may be dispensed to the patient to help them through the first days of the induction. Follow-up appointments to stabilize the dose are scheduled by OBIC staff.

Induction and Stabilization at OBIC

OBIC patients are generally seen daily during the first week of treatment (the induction period). The frequency of appointments typically decreases over the ensuing weeks. Most patients will reach a stable dose in less than 2 weeks, and typically progress to a weekly then bi-weekly dispensing schedule as determined by the IBIS physician. Buprenorphine is dispensed through the CBHS Pharmacy located 1 floor below OBIC at 1380 Howard Street.

Substance abuse counseling is required at OBIC during the induction and stabilization process. In addition, all OBIC/IBIS patients are encouraged to attend weekly group sessions with other patients in office-based opiate treatment. Urine toxicology screens are obtained at regular intervals while the patient is at OBIC. Communication with the referring site will occur while the patient is at OBIC.

For those patients who are not already engaged in Primary Care or Mental Health treatment at a participating community IBIS site, OBIC staff will review previous and current medical, mental health, substance use and psychosocial needs and work to match the patient to a community IBIS provider. Once an accepting community IBIS site is identified, OBIC staff will facilitate a transfer for ongoing care. Typically, patients spend 4 to 8 weeks at OBIC for stabilization and are then transferred to a community site; however, care at OBIC is based on individual needs and the treatment timeline will vary. In rare instances, if approved by the OBIC Director and Medical Director, a patient may remain at OBIC for ongoing treatment.

Transfer to Community IBIS

When the patient is clinically stable and has an appointment scheduled at an IBIS community site, OBIC will fax a treatment summary and any other requested information (for example, consents, H & P, etc.) to the referring/accepting community physician. The patient will receive buprenorphine at the CBHS Pharmacy. The OBIC physician will write the “transfer” prescription for Suboxone, and fax this to the pharmacy. This prescription will carry the patient through to their next community IBIS physician appointment. Patients with MediCal may have their Suboxone dispensed from a local community pharmacy other than the CBHS Pharmacy. All subsequent prescriptions will similarly be written by the IBIS community physician and faxed to the community pharmacy. The CBHS Pharmacy will accept only faxed and phoned prescriptions. **NO WRITTEN PRESCRIPTIONS SHOULD BE GIVEN TO PATIENTS.**

Maintenance Treatment Considerations

Clinic Visits

Some form of counseling is recommended for all IBIS patients. Physicians, nurses, social workers, behaviorists, and/or counselors can provide counseling. The prescribing physician may require the patient to attend support groups. Patients should meet with their prescribing physician regularly, with physician-determined visit frequency based on patient functionality, response to treatment, and adherence to the treatment plan.

Toxicology Screening

Toxicology screening is recommended for IBIS patients, particularly early in treatment, during periods of instability, and when indicated by patient history or appearance on examination.

Attachment I

BUPRENORPHINE SYSTEM OF CARE: IMPLEMENTATION AND PLANNING DETAILS

Treatment Workgroup Recommendation 1

Level 1 Facilities

- Downtown Public Health Needle Exchange Induction Site
Current implementation and planning: A design team has been established by Public Health-Seattle & King County to implement a centrally located, low-barrier buprenorphine induction site at the Downtown Public Health Needle Exchange. This facility has an on-site pharmacy and will provide individuals in need of buprenorphine treatment with treatment on demand utilizing a “Buprenorphine First” model of care and intensive oversight dosing. Similar to the San Francisco model, a Nurse Care Manager model will be utilized to support treatment on demand and address barriers to buprenorphine prescribing; additionally other supportive services will be available on site (see Attachment E for Description of Collaborative Care/Nurse Care Manager Model). A Collaborative Care/NCM model has also been successfully implemented in Massachusetts to expand treatment access.⁴³ Implementation of induction services is tentatively scheduled for end of September 2016.
- Emergency Department Induction Sites
Current implementation and planning: A subset of the Task Force is working on determining feasibility of buprenorphine induction in Emergency Departments (ED). Harborview Medical Center, represented on the Task Force, has drafted a proposal for induction of buprenorphine in their ED in conjunction with a brief intervention and referral for ongoing care, similar to the intervention ED staff use to treat other chronic and relapsing health conditions. Harborview Medical Center is considering leveraging an existing Substance Abuse Mental Health Service Administration (SAMHSA) grant to provide induction services, and will continue to identify and address barriers to implementation.
- Recovery Center Valley Cities Detox and Residential facility
Current implementation and planning: The Recovery Center will re-open by the second quarter of 2017. This facility (previously Recovery Center King County, RCKC), will provide approximately 30 to 35 detox beds and the same number of residential substance use disorder treatment beds. Valley Cities, represented on the Task Force, has drafted a proposal for inclusion of buprenorphine medication (induction and maintenance services) as part of the treatment resources offered to individuals seeking

⁴³ LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2015). Office-based opioid treatment with buprenorphine (OBOT-B): Statewide implementation of the Massachusetts collaborative care model in community health centers. *Journal of Substance Abuse Treatment, 60*, 6-13.

treatment at the Recovery Center. Valley Cities will work with the King County Behavioral Health Organization to address barriers to implementation.

- Mobile Medical Van

Current implementation and planning: As of July 2016, Public Health - Seattle & King County operate two Mobile Medical Vans (MMVs). These vans provide an array of health care services including basic medical care, behavioral health assessments and initial interventions, social service assistance, and referral to ongoing care. The MMV staff have the ability to prescribe buprenorphine, monitor the induction process, and provide brief intervention and referral for ongoing care. As such, the MMV offers a unique opportunity to reach individuals experiencing homelessness. Effective September 2016, Public Health-Seattle & King County, represented on the Task Force, will implement a pilot program to provide buprenorphine induction and maintenance through the South King County MMV to a small number of individuals that present with opioid use disorder. The pilot program will be evaluated to determine ongoing implementation and the possibility of program expansion.

- Jail

Current implementation and planning: A design team has been established by Public Health-Seattle & King County, Jail Health Services to determine feasibility of providing buprenorphine induction and maintenance services to individuals incarcerated in the King County jail. The first phase of implementation will focus on developing a plan to provide buprenorphine maintenance services to individuals that present to jail stable on buprenorphine. The second phase of implementation will focus on developing a plan to provide buprenorphine induction services to incarcerated individuals in need of opiate treatment. To inform implementation efforts, the design team is currently examining the number of individuals booked into the King County jail who are stable on buprenorphine treatment for opioid use disorder.

Level 2 Facilities

- Community Health Clinics (CHC)

Current implementation and planning: Primary care settings can provide a non-stigmatizing, low-barrier environment for the provision of medication-assisted treatment. Providing buprenorphine treatment of opioid use disorder through a primary care setting would also expand treatment availability to individuals who historically have not had equal access to buprenorphine services.⁴⁴ Neighborcare Health, represented on the Task Force, has drafted a proposal for implementation of buprenorphine induction and maintenance services within the King County network of CHCs. The proposal involves the identification of senior leaders and physician champions within each CHC to provide education to staff regarding community need for medication-assisted treatment. Each

⁴⁴ Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City. *The Journal of Behavioral Health Services & Research*, 40(3): 367-377.

CHC would identify prescribers to become waived to prescribe buprenorphine for treatment of opioid use disorder, and buprenorphine services would be offered utilizing a Nurse Care Manager model to support treatment on demand.

Level 3 Facilities

- Behavioral Health Clinics, including traditional Medication-Assisted Treatment (MAT) facilities

Current implementation and planning: There are 44 behavioral health providers in the King County network; as such, behavioral health clinics represent a unique opportunity to significantly expand access to buprenorphine treatment, a standard of care for treatment of opioid use disorder. As behavioral health clinics disproportionately serve individuals with limited income, and people of color are overrepresented among those with limited income, adding buprenorphine treatment to the array of services offered by behavioral health clinics improves access and equity. Downtown Emergency Services Center (DESC), represented on the Task Force, submitted a proposal for implementation of buprenorphine services in behavioral health clinics, and identified critical resource needs. DESC also highlighted opportunities to deliver buprenorphine services outside of the clinic in community settings (for example, supportive housing, homeless shelters, etc.), in order to engage individuals who are reluctant to present to a behavioral health clinic. Since the implementation of the Task Force, MAT facilities (which have traditionally provided methadone treatment for opioid use disorder) have received state approval to dispense buprenorphine, in addition to methadone. This liberalizing legislation provides an opportunity for conventional MAT facilities (which offer methadone treatment services) to also offer buprenorphine induction and stabilization services via an intensive oversight dosing program (in accordance with a Level 1 facility) and buprenorphine maintenance services. Evergreen Treatment Services (ETS), represented on the Task Force, submitted a proposal for implementation of buprenorphine services in MAT facilities, and highlighted opportunities for increased collaboration between opiate treatment programs (providing induction and stabilization services) and the greater medical community (providing maintenance services). Medical providers in the community may be less hesitant to offer buprenorphine services for treatment of opioid use disorder if more intensive oversight services and clinical backup will be available through MAT facilities when clinically indicated.

Attachment J

DESCRIPTION OF COLLABORATIVE CARE/NURSE CARE MANAGER MODEL

Judith Tsui MD, MPH

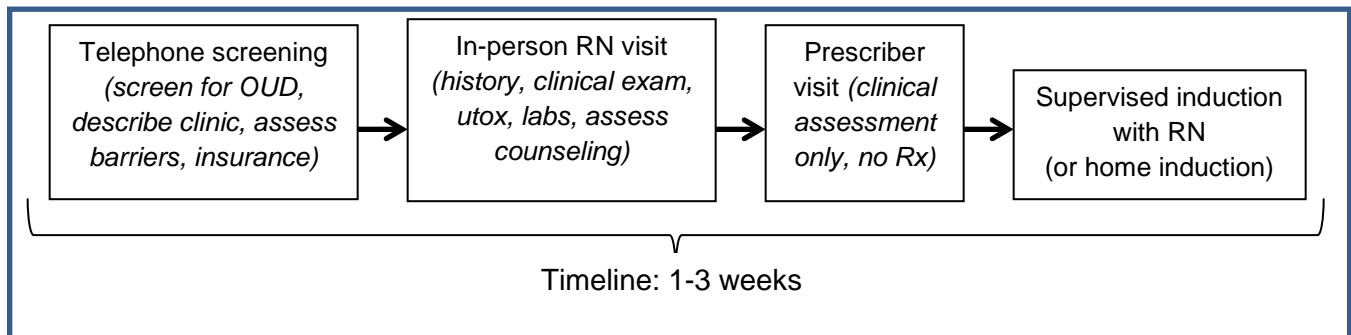
The Collaborative Care/Nurse Care Manager (NCM) model uses NCMs as the hub of the medical care team to coordinate and manage patients, supported by a program manager. The use of the NCM addresses major barriers to buprenorphine prescribing that physicians face, including insufficient time and support to accomplish the necessary steps to initiate and maintain a patient in treatment. Treatment for opioid use disorders with buprenorphine/naloxone (BUP/NX) is particularly time-intensive for the first 2-3 months. Clinical steps include: an initial screening for the appropriateness of BUP/NX; a comprehensive assessment of substance use and consequences, medical and mental health screening, and current barriers to and supports for recovery; medical review of assessment data and formal diagnosis of opioid use disorder and appropriateness for buprenorphine (that is, medication-assisted treatment, MAT); scheduling and monitoring of the induction (which typically takes place in clinic) and intensive monitoring thereafter, consisting of phone contacts and weekly visits, prescriptions, and urine drug testing for the first 1-2 months. It is unlikely that a typical prescriber could accomplish these steps within a real-world practice setting with time and scheduling constraints, yet these early steps are crucial to enhance patient engagement in care. In this model, the program manager and NCM, who are specifically trained to support office-based treatment for opioid use disorders, perform many of the initial activities, as well as the support with the induction, provision of prescriptions, and monitoring activities. This allows the prescriber time to be more efficiently concentrated on key clinical decisions (such as decisions to initiate; adjust dosage; taper; etc.). Weekly team meetings with the prescriber, NCM and program manager occur, during which team members can monitor progress and update treatment plans together.

The team roles are as follows:

- **Nurse Care Manager** is responsible for patient screening, assessment, education, care planning, medication induction, stabilization, and maintenance. Also, ongoing coordination of follow-up care, telephone monitoring when needed, relapse prevention, and support for patient self-management. Caseload capacity per nurse is 100 patients (with expected drop-out/new patients). The NCM will be available for patients during all open clinic hours, and will be a bridge to physicians, who typically have more restricted hours in clinic. The NCM may also serve as a consult/bridge to engage patients who are “non-treatment seeking” from other sites such as the emergency room or in-patient setting.
- **Prescribers** will maintain a federal waiver to prescribe OBOT medications, will conduct the medical intake to assure the patient’s diagnosis of opioid use disorder, appropriateness for MAT, determine induction setting (on-site vs at-home), write orders and prescriptions, supervise clinical services, and refer patients for counseling, psychosocial or primary care services. Prescribers at primary care clinics may provide primary care services directly to their patients, or may prescribe buprenorphine for patients who already have a primary provider in the practice.

- **Program Manager** will provide administrative support to the MAT team, conduct initial telephone screenings over the phone, help with insurance and prior authorization requirements, staffing and program issues, collaborate with referral sources, and seek referrals. He/she will also assist with assuring compliance with DEA and state licensure requirements and reporting activities.

The Collaborative Care/Nurse Care Manager Model allows patients to be more efficiently started on buprenorphine, with the process of intake as outlined below:



After enrollment, the NCM continues to see the patient weekly for the first 1-2 months, followed by every 2 week visits for 1-2 months. The prescriber sees the patient monthly or more frequently if desired at the beginning of treatment, then monthly or less frequently after the patient stabilizes. Such a schedule of visits is in compliance with the WA State Healthcare Authority's expectations for monitoring patients while on treatment with BUP/NX. The NCM can increase or decrease visit frequency depending on the stability of the patient, the mental health and substance use counseling frequency needed or desired, and the availability of the prescriber.

Attachment K
IMPLEMENTATION AND PLANNING DETAILS
Treatment Workgroup Recommendation 2

- Open Access

Current implementation and planning: The Task Force identified that central access and referral is an integral component to achieving treatment on demand. Central access and referral will provide a coordinated model for referral management across the behavioral health treatment system and will help individuals receive care as quickly as possible and in the most suitable location. One model that is currently available that could be built upon is the Recovery Help Line (RHL). The Washington RHL offers 24-hour emotional support and referrals to local treatment services. RHL staff are supervised by state-certified mental health and chemical dependency professionals who ensure callers receive the most effective response. There is current planning at the RHL to develop what a model for local implementation would look like.

- Ongoing Assessment of Network Adequacy

Current implementation and planning: The Task Force conducted GIS mapping of current service sites (opiate treatment programs, behavioral health treatment agencies, needle exchange facilities, public health clinics, emergency departments, and hospitals) to assess current network adequacy and geographic accessibility. This map can be accessed electronically at the following location: <http://kingcounty.maps.arcgis.com/apps/webappviewer/index.html?id=d9424b892f404c39a07cda52390ce627>. The Task Force also identified that the Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a list of physicians authorized to treat opioid use disorder with buprenorphine by state, city, and zip code. A review of the SAMHSA list suggests a slow steady growth of waived physicians.

- Workforce Shortage

Current implementation and planning: The King County Department of Community and Human Services (DCHS) surveyed behavioral health provider agencies in early fall 2015 about recruitment and retention issues. Of 29 responding agencies, 23 had vacant clinical positions, most often for four to seven weeks but some for 15 or more weeks. Most of the vacant positions were for psychiatrists, advanced registered nurse practitioners (ARNPs), or counseling staff. Over 80% of responding agencies reported that they lost employees to programs that offered better pay or benefits.⁴⁵ The King County Behavioral Health Organization is designing a plan to address the workforce shortage in order to achieve treatment on demand and maintain delivery of high quality services.

⁴⁵ Workforce Shortage Survey, King County Department of Community and Human Services, September 28 through November 2, 2015

- Opiate Treatment in Jail

Current Implementation and Planning: Currently, individuals stable on methadone for treatment of opioid use disorder, who are booked into a King County jail facility (King County Correctional Facility or Norm Maleng Regional Justice Center), are continued on methadone treatment during incarceration. However, this is not a policy practiced by municipal jails in King County (for example, Kent Jail; Issaquah Jail; Enumclaw Jail; Kirkland Jail; or South Correctional Entity, SCORE), and represents a significant equity issue. The Task Force has identified representatives to address this issue from a policy standpoint. Currently, individuals stabilized on buprenorphine treatment will not be continued on buprenorphine during incarceration at any of the jails in King County (county or municipal). A design team has been established by Public Health - Seattle & King County, Jail Health Services to determine feasibility of providing buprenorphine induction and maintenance services to individuals incarcerated in the King County jail. The first phase of implementation will focus on developing a plan to provide buprenorphine maintenance services to individuals that present to jail stable on buprenorphine. The second phase of implementation will focus on developing a plan to provide buprenorphine induction services to incarcerated individuals in need of opiate treatment. To inform implementation efforts, the design team is currently examining the number of individuals booked into the King County jail who are stable on buprenorphine treatment for opioid use disorder.

Attachment L
PROPOSED NEIGHBOR RELATIONS PLAN

Molly Carney, Executive Director at Evergreen Treatment Services

Opiate treatment programs and other locations providing care for individuals experiencing opioid use disorder (for example, syringe exchange programs, community health engagement locations for persons with substance use disorders) should consider the following practices to establish and maintain good neighbor relations.

Clearly articulated hours and rules of business: For facilities where medication is being dispensed, hours of dispensing should be publicly available and followed. Any terms that clients must abide by should be readily available to the neighbors and the public.

Public Safety staff: Public Safety staff should be employed by the facility who are to be active during the dispensing hours. These staff should be specially trained in how to work with individuals experiencing opioid use disorder, mental health issues, and trauma histories. These staff should also be specially trained to work with clientele varying in age, race, ethnicity, gender, sexual orientation, primary language, and cognitive ability.

Numbers: There should be sufficient Public Safety staff to lend order inside and outside of the facility to at least the organization's property line (where authority is explicit) or to nearby manageable landmarks (for example, an intersection). Inside, Public Safety will help the clinic staff maintain any Code of Conduct or admission criteria established by the business. Outside, the staff will be attending to issues of loitering, dealing, or behavior that interferes with the neighboring businesses (for example, shoplifting).

MOU: Businesses adjacent to the target business may be encouraged to enter into a Memorandum of Understanding (MOU) which is intended to help facilitate communication between the entities. This MOU may permit the target business to allow their Public Safety staff to patrol the business property. The MOU should be reviewed and renewed on an annual basis.

Monthly rounds to business neighbors: Public Safety staff should make rounds to business owners or their managers on at least a monthly basis. Inquiries should be made regarding what's working well, what could be improved and/or escalation information if necessary (for example, who to contact if a business manager desires to escalate a complaint upward). These staff shall summarize their monthly rounds in a written document that is to be circulated to the executives and operation managers of the target business and a review team member who is a client that represents the intervention population. This summary shall include recommendations for how to rectify any complaints or problems. The target business shall be expected to help the Public Safety staff address or resolve complaints or problems within one week of the original complaint and shall include either a written response to the business owner/manager or a return visit by the Public Safety staff with the proposed resolution. The target business may consider implementing a monthly newsletter to neighboring businesses, which summarizes clinical outcomes (for educational purposes) and the response to neighborhood issues.

Attachment M
IMPLEMENTATION AND PLANNING DETAILS
Treatment Workgroup Recommendation 3
Mark Cooke, Policy Director at American Civil Liberties Union

Members of the Task Force participating in the policy workgroup have analyzed the challenge presented by local jurisdictions that make it difficult for MAT service providers to open facilities. The following legal analysis describes the legality of MAT program facilities in the state of Washington, common challenges in opening MAT facilities, and options to ease restrictions on opening MAT facilities. The legal analysis primarily focuses on methadone clinics, but similar circumstances exist in the siting of mental health and chemical dependency treatment facilities generally, and facilities providing other supportive services (for example, needle exchange facilities, community health engagement locations for persons with substance use disorders, etc.).

The Legality of MAT Program Facilities in Washington State

MAT facilities like methadone clinics are regulated by the federal government (21 U.S.C. §823; 42 CFR Part 8) and by Washington state (RCW 71.24.585 et seq.; WAC 388-877 and 388-877B). Clinics are considered “essential public facilities” and cannot be banned outright (RCW 71.24.590 (1)(b), RCW 36.70A.200). The Department of Social and Health Services is also tasked with consulting with local jurisdictions where a MAT service provider hopes to locate and to consider the need of treatment in the area. Approximately 25 clinics currently operate in Washington.⁴⁶

Federal courts have ruled that clinic participants are legally designated as disabled and protected by the federal Americans with Disabilities Act, and that local governments cannot discriminate against clinics. *MX Group Inc. v. City of Covington*, 293 F.3d 326, (6th Cir. 2002); *Bay Area Addiction Research and Treatment v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999).

Common Challenges in Opening MAT Facilities

Despite the heavy regulation of MAT facilities and a state law that requires local jurisdictions to provide permitted locations for their operation, many facilities never open. Here is a common scenario:

⁴⁶ DSHS – Appendix Q - Opiate Substitution Treatment Programs in Washington State, available at page 244
<https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Cert%20%26%20Licensing/Directory%20of%20Certified%20CD%20Svcs.pdf>

A MAT service provider seeks to open a new facility in a local jurisdiction, identifies a suitable location (most frequently a building currently zoned for healthcare services), and the service provider seeks a permit from the jurisdiction to begin operations. During this process DSHS should be performing its duties to notify the local government about the facility and demonstrating the need for it (pursuant to RCW 71.24.590 (1)). The local jurisdiction objects to the opening of the MAT facility and utilizes various regulatory procedures to slow the process. These obstacles could come in the form of requiring conditional or special use permits (allowed under RCW 71.24.590 (1)(b)) or by issuing a moratorium on MAT facilities. This can significantly slow things down and ultimately force the MAT provider to stop pursuing the facility, especially if there are pending financial or real estate transactions contingent on obtaining permits in a timely fashion.

Media accounts illustrate this problem:

- Puyallup – *Tacoma News Tribune* – “Clinic hopes to offer methadone treatment in Puyallup; city not yet sure,” December 2016, available at <http://www.thenewstribune.com/news/local/article48078615.html>
- Bremerton – *Kitsap Sun* – “Bremerton council to consider moratorium on methadone treatment facilities,” July 2011, available at <http://www.kitsapsun.com/news/local/bremerton-council-to-consider-moratorium-on-methadone-treatment-facilities-ep-418347397-357153961.html>
- Lynnwood – *The Seattle Times* – “Methadone-treatment company sues Lynnwood over clinic plans,” February 2003, available at <http://community.seattletimes.nwsouce.com/archive/?date=20030212&slug=methadone12n0>

Options to Ease Restrictions on Opening MAT Facilities

Amend State Law

RCW 71.24.590 could be amended to make the siting of MAT facilities easier. Currently, DSHS make a determination of need and local jurisdictions can require onerous conditional or special use permits, as well as moratoriums. Due to the emergent nature of the opiate epidemic and statewide need for treatment, the DSHS need process may be unnecessary at this point. The legislature could also remove local jurisdictions’ ability to require special permits and require that MAT facilities be treated like any other healthcare facility.

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Attachment O
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Attachment P

WORLD OVERVIEW OF SUPERVISED CONSUMPTION SITES

World overview of drug consumption rooms

Country	DCR	Eligibility and services	Client profiles	Results
Australia	<p>Location 1 in Sydney</p> <p>Staff 1 in injecting room Training: At least 1 nurse, 3 officers with health training</p>	<p>Eligibility 18 years and over Already drug dependent Not pregnant nor with child Not intoxicated No dealing of drugs on premises</p> <p>Services Stage 1: Waiting room/assessment area Stage 2: Injecting room with 8 booths Stage 3: After care room Resuscitation room Links to health, legal, housing, welfare services</p>	<p>12,050 clients between May 2001 and April 2010 3 new clients a day on average 74% men / 26% women 33 years of age on average 13 years of average time injecting</p> <p>Principal substances used Drop in heroin use (40% in 2005) Increase in other opioid use (60% in 2012) Decline in cocaine use (15% in 2012) 10% methamphetamines 1-2% buprenorphine</p>	<p>Cost-effective Contacts vulnerable groups – 9,500 referrals to health and social welfare services 4,400 overdose interventions (no fatalities) Reduced risk of blood-borne virus transmission Reduced public injecting and injection-related litter No adverse impact on local community (e.g. increase in drug-related crime in area)</p>
Canada	<p>Location 1 in Vancouver called 'Insite'</p> <p>Staff 9 staff Training: nurses, programme workers (PHS), peer support workers</p>	<p>Eligibility No admission criteria</p> <p>Services Low-threshold, anonymous service with 12 drug consumption booths Supply of clean injection equipment and safer use counselling Primary healthcare services Voluntary detox (Onsite) Links to longer-term drug dependence treatment programmes Links to housing and community support</p>	<p>1.8 million visitors since 2003 Between 1st Jan 2010- 31st Dec 2010: 312,214 visits by 12,236 clients 855 average daily visits 587 average daily injections 74% men / 26% women 17% identified as Aboriginal</p> <p>Principal substances used 36% heroin 32% cocaine 12% morphine</p>	<p>221 overdose interventions (no fatalities) 3,383 clinical treatment interventions 5,268 referrals to other social and health services 458 admissions to Onsite detox programme (completion rate in 2010: 43%) Reduced risk of blood-borne virus transmission Reduced public injecting and injecting-related litter No adverse impact on local community</p>
Germany	<p>Location 26 in 17 cities country-wide</p> <p>Staff Number of staff variable according to size of DCR and financial constraints Training: Doctors, nurses, educators, qualified student assistants and freelancers</p>	<p>Eligibility Age eligibility varies according to state regulation Already drug dependent Not under OST (except in Hamburg) Not intoxicated</p> <p>Services DCRs integrated with harm reduction facilities Open between 3.5 and 12 hours a day 3 to 20 drug consumption booths Links to medical and social services</p>	<p>In Frankfurt⁹ from 2003 to 2009: Up to 4,700 visitors per year 26-35 years of age on average 85% men / 15% women</p> <p>Principal substances used 82% heroin 36% crack¹⁰</p>	<p>Since 1994, no drug-related deaths recorded in Germany Increased client awareness of safer use techniques Less drug-related health problems (e.g. fewer abscesses)</p> <p>Data from North Rhine Westphalia (2001-2009): 3,271 drug emergency cases 710 CPRs</p>
Luxembourg	<p>Location 1 in the City of Luxembourg called 'Abrigado'</p> <p>Staff 23 multilingual staff Training: Medical staff, psychologists social workers, educators, sociologists</p>	<p>Eligibility 18 years and over Already drug dependent Not under OST Not pregnant or with child Not intoxicated No dealing of drugs on premises Sign a 'terms of use' contract</p> <p>Services Integrated in low-threshold centre with 7 injection booths Pilot project 'Blow room' with 3 inhalation booths Open 6 days a week, 6h a day Night shelter (42 beds) and nursery Drop-in centre (Kontakt Café) with primary medical care On-site HIV/hepatitis C testing Needle exchange programme Safer use counselling</p>	<p>170,000 supervised drug consumptions (since 2005) 26,929 visits to DCR in 2011 207 average visitors per day (Kontakt Café) 96 average visitors per day (DCR) 25-34 years of age on average 80% men / 20% women</p> <p>Principal substances used 87% heroin 8% cocaine 5% mixtures</p>	<p>1,025 overdoses successfully managed (no fatalities) General decrease in overdose deaths and proportion of people who inject drugs in newly diagnosed HIV infection cases since the opening of the DCR Citizens hotline established to encourage public acceptance of DCR A few complaints from neighbouring communities recorded</p>

Country	DCR	Eligibility and services	Client profiles	Results
The Netherlands	<p>Location 37 in 25 cities country-wide</p> <p>Staff 3 staff members Training: Medical staff, social workers, former drug users, security staff</p>	<p>Eligibility Registered in city where DCR is located Sign a 'terms of use' contract No dealing of drugs on premises Different admission criteria according to each DCR</p> <p>Services 5 'stand-alone' DCRs, others are integrated within low-threshold services Separate rooms for injectors and smokers 15 booths for smokers, 5 for injectors Medical and safer use counselling</p>	<p>24 clients per day on average 90% clients are non-injectors 45 years of age on average¹¹ 90% men / 10% women¹²</p> <p>Principal Substances used¹³ Heroin Crack/coke base</p>	<p>Decrease in needle sharing Only 4% of new diagnoses of HIV, Hepatitis B and C among people who use drugs HIV incidence rates among people who inject drugs dropped from 8.6% in 1986 to 0% in 2000 94 acute drug-related deaths in 2010 with 20 non-municipal registered people Significant decrease in public disturbance High acceptance of DCRs (80%) by social/health providers, neighbourhoods and police</p>
Norway	<p>Location 1 in Oslo</p> <p>Staff Minimum of 5 staff on duty during opening hours, including at least 1 nurse. Training: Nurses, auxiliary nurses and social workers</p>	<p>Eligibility Heroin only substance allowed 18 years and over Sign a 'terms of use' contract Long term history of injecting heroin</p> <p>Services Limited to one dose of heroin per client per visit Integrated with harm reduction services Links with social and health services Links to drug dependence treatment programmes</p>	<p>2,480 registered clients since 2005 1,500 clients per year 109 clients per day on average (2011) 37 years of age on average 70% men / 30% women</p> <p>Principal substances used Heroin is the only substance allowed to be used in the DCR</p>	<p>Reduced perception of social exclusion among the user group Increased access to professional assistance in overdose situations Increased access to health and social services</p>
Spain	<p>Location 7 in 4 cities country-wide, including 1 mobile DCR</p> <p>Staff Number of staff variable according to each DCR Training: multidisciplinary, with at least 1 nurse</p>	<p>Eligibility 18 years and over Sign a 'terms of use' contract (in the Barcelona DCRs)</p> <p>Services 3 DCRs allow smoking Links to social and health services Links to drug dependence treatment programmes In Barcelona: HIV testing and counselling, health care and social, psychological and legal support</p>	<p>105,804 visits from 5,063 clients (2009) 34 years of age on average 80% men / 20% women</p> <p>Principal substances used Cocaine most popular (except in Bilbao and Sala Balaard in Barcelona, 2009) Heroin most popular (Barcelona, 2011) Speedball most popular (Madrid, 2011)</p>	<p>Decrease in overdose deaths from 1,833 in 1991 to 773 in 2008 Decrease in new HIV infections among clients from 19.9% in 2004 to 8.2% in 2008 High acceptance and demand for DCRs Reduced injection-related litter in public spaces Community awareness about DCRs as a public health strategy Development of common guidelines on harm reduction and DCRs</p>
Switzerland	<p>Location 13 in 8 cities country-wide</p> <p>Staff No country-wide data In Berne: Training: nurses and social workers.</p>	<p>Eligibility 18 years and over Already drug dependent Have official documentation No dealing of drugs on premises No consumption tolerated outside the DCR itself (e.g. cafeteria, toilets)</p> <p>Services Booths for intravenous use, smoking and sniffing (numbers vary according to the DCR) Cafeteria with food and non-alcoholic beverages Medical treatment Consultations for social problems Hygiene services (showers, provision of clothes) NSP Links to drug dependence treatment programmes and clinics</p>	<p>No country-wide data</p> <p>In Berne: 38 years of age on average 992 registered clients a year 200 clients a day 74.1% men / 25.9% women</p> <p>Principal Substances No country-wide data</p> <p>In Berne: Heroin Cocaine Benzodiazepines Cannabis Substitutes Alcohol</p>	<p>Decrease in drug-related deaths Increased client awareness of safer use techniques Reduces risk of blood-borne virus transmission</p>

Source: Schatz, E. and Nougier, M. IDPC Briefing Paper: Drug consumption rooms, evidence and practice (June 2012).

**Attachment Q
LEGAL FRAMEWORK GRID**

Mark Cooke, Policy Director at American Civil Liberties Union

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
<p>Public Health - Seattle & King County (PHSKC) in collaboration with King County Department of Community and Human Services (DCHS) governs and operates the CHEL site.</p>	<p>A CHEL site governed and operated by the public health authority would be in a strong legal position under state law, including protections against the prosecution of state criminal laws.</p> <p>No such protection would exist against the prosecution of federal criminal laws, but having a government run program would likely be a good political position to advocate against federal interference.</p>	<p>CHEL site would likely fall under King County’s self-insurance pool, which covers up to \$6.5million. Could also obtain a reinsurance policy on the private market for overages.</p>	<p>Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is technically more akin to “vaping” than “smoking.”</p>	<p>Government employees of a SCS would likely be insured to the same extent as the facility, up to \$6.5 million. The self-insurance also applies to professional licensing matters. Reinsurance for greater losses would be challenging to procure.</p>
<p>A public-private partnership between PHSKC/DCHS and other community-based service providers, in which PHSKC/DCHS authorizes the CHEL site and contracts with a service provider to operate it.</p>	<p>A CHEL site governed by the public health authority and operated by a community-based service provider via a contract would be in a strong legal position under state law, including protections against the prosecution of state criminal laws.</p>	<p>May fall under King County’s self-insurance pool, which covers up to \$6.5million, if an agency relationship between the county and provider is established. Could obtain coverage on the private secondary</p>	<p>Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is</p>	<p>Government “agents” would likely be insured to the same extent as the facility, including professional licensing matters. Otherwise, private insurance would be needed.</p>

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
	No such protection would exist against the prosecution of federal criminal laws, but having the program governed by public health authority would likely be a good political position to advocate against federal interference.	market (ex. Lloyds of London).	technically more akin to “vaping” than “smoking.”	
PHSKC/DCHS or local ordinance provides oversight of CHEL site via some sort of regulatory or permitting process, in which private community-based service providers determine independently whether to operate a CHEL site.	The strength of the CHEL site legal position under state law will depend on the nature of the government oversight of the CHEL site. If it’s the public health authority that creates and enforces the regulatory process for CHEL site permitting, then it’s possible that the legal protections for public health authorities could extend to the private community-based service providers. If the government oversight comes in the form of a local ordinance via a legislative body, not relying on public health authority, the legal protection would not be as	Could obtain coverage on the private secondary market (ex. Lloyds of London). Obtaining private insurance could also be a mandate of government regulation of a CHEL site.	Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is technically more akin to “vaping” than “smoking.”	Employees would need to find insurance via the secondary market.

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
	<p>robust. However, this is still a feasible option if local prosecutors decide to exercise discretion, allowing the CHEL site to operate, even if it's technically violating state criminal law.</p> <p>No protection would exist against the prosecution of federal criminal laws, but having some form of government oversight might help in making political arguments against federal interference.</p>			
<p>No changes to existing law, private community-based service providers start operating a CHEL site</p>	<p>Opening a private CHEL site under existing law would be in a relatively weak legal position. However, the community-based service provider could point to the 2007 King County Board of Health resolution that recommended the creation of a CHEL site as an indication that this type of program is a legitimate</p>	<p>Could obtain coverage on the private secondary market (ex. Lloyds of London).</p>	<p>Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is technically more akin to "vaping"</p>	<p>Employees would need to find insurance via the secondary market.</p>

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
	<p>public health intervention.⁴⁷</p> <p>Operating under the authority of public health or via local ordinance may also be unnecessary if local prosecutors decide to exercise discretion, allowing the CHEL site to operate, even if it's technically violating state criminal law.</p> <p>No protection would exist against the prosecution of federal criminal laws, but policy arguments could be made for why the federal government should not get involved in a local public health matter.</p>		than "smoking."	

⁴⁷BOH Resolution 07-07, adopting recommendations of the BOH HIV/AIDS Committee, September 20, 2007, available at <http://www.kingcounty.gov/depts/health/board-of-health/~media/depts/health/board-of-health/documents/resolutions/res0707.ashx>

Attachment R

SUMMARY OF LEGAL CONSIDERATIONS FOR COMMUNITY HEALTH ENGAGEMENT LOCATIONS FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS (CHEL sites) WHERE SUPERVISED CONSUMPTION OCCURS IN KING COUNTY

Mark Cooke, Policy Director at American Civil Liberties Union

The King County and Seattle Task Force on Heroin and Prescription Opiate Addiction is considering a recommendation to create Community Health Engagement Locations for individuals with substance use disorders (CHEL sites) where supervised consumption occurs (also known as Supervised Consumption Sites) in order to reduce drug-related health risks and harms, including overdose deaths, transmission of HIV and hepatitis B and C viruses, and drug-associated adverse health effects. These sites could also provide access to substance use disorder treatment and related health and social services; reduce impact of drug use in public spaces; provide a safe and trusting environment where individuals using drugs can engage with services to improve their health; and reduce participant engagement with the criminal justice system. Such a recommendation would not be unprecedented. In 2007, the Board of Health of King County adopted a resolution that recommended a CHEL site for purposes of HIV prevention.⁴⁸ Despite this formal acknowledgement that a CHEL site is a viable public health intervention, no such facility opened.

Due to the fact that most of the drugs consumed in a CHEL site will be obtained illicitly and are controlled substances, there are many questions about the legality of such facilities.⁴⁹ The following analysis provides background information on some of the legal issues that could arise in the creation and operation of a CHEL site.

A CHEL site Likely Fits Within the Legal Authority of a Local Board of Health and Local Health Officer

Under Washington State law, a local board of health is given broad authority to preserve “the life and health of people within its jurisdiction.”⁵⁰ This authority is derived from the state legislature and Washington Constitution.⁵¹ For purposes of a CHEL site, several of the local board of health’s affirmative responsibilities are relevant. These include the board’s duty to:

- Enact such local rules and regulations as are necessary in order to preserve, promote and improve the public health and provide for the enforcement thereof;

⁴⁸BOH Resolution 07-07, adopting recommendations of the BOH HIV/AIDS Committee, September 20, 2007, available at <http://www.kingcounty.gov/depts/health/board-of-health/~media/depts/health/board-of-health/documents/resolutions/res0707.ashx>

⁴⁹ For a more in depth analysis on the legality of SCS type facilities see – Beletsky, et al. The Law (and Politics) of Safe Injection Facilities in the United States, *American Journal of Public Health*, 2008 February; 98(2): 231-237, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2376869/>

⁵⁰ RCW 70.05.060, available at <http://app.leg.wa.gov/RCW/default.aspx?cite=70.05.060>

⁵¹ Washington Constitution, Article 11 Sec. 11 – “Any county, city, town or township may make and enforce within its limits all such local police, sanitary and other regulations as are not in conflict with general laws.”

- Provide for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department;
- Provide for the prevention, control and abatement of nuisances detrimental to the public health.⁵²

Similarly, a local health officer, under the direction of the local board of health, is given broad authority to enforce public health laws.⁵³ Several of the local health officer's responsibilities are relevant for purposes of creating and operating a CHEL site, including his or her duties to:

- Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;
- Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;
- Prevent, control or abate nuisances which are detrimental to the public health.⁵⁴

A CHEL site fulfills several of the public health aims listed above. By consuming drugs in a clean environment and providing individuals using drugs with sterile equipment, the spread of diseases such as HIV and hepatitis will be reduced. The board or health officer could also argue that a CHEL site is a method to control and prevent the "dangerous...disease" of severe substance use disorders and that a CHEL site is a gateway into treatment.⁵⁵ A CHEL site could also improve community public health by limiting the amount of public drug use and discarded drug equipment, which could be viewed as a form of nuisance abatement.

The legality of a CHEL site and the role of public health authority could also be impacted by the governing structure of the program. The task force has discussed three types of structures with varying degrees of Public Health – Seattle & King County (PHSKC)/Department of Community and Human Services (DCHS) involvement, and a fourth option is if a private CHEL site opens without any government oversight:

- A) Public Health - Seattle & King County (PHSKC) in collaboration with King County Department of Community and Human Services (DCHS), and/or;
- B) A public-private partnership between PHSKC/DCHS and other community-based service providers, and/or;
- C) Another entity with oversight by PHSKC/DCHS;
- D) Private entity opens CHEL site with no PHSKC/DCHS oversight.

Arguably, the public health authority described above would be applicable in the first three contexts, although it would be most straightforward if PHSKC/DCHS was in charge of governing

⁵² Id.

⁵³ RCW 70.05.070, available at <http://app.leg.wa.gov/RCW/default.aspx?cite=70.05.070>

⁵⁴ Id.

⁵⁵ See American Psychiatric Publishing – Substance-Related and Addictive Disorders, 2013, available at <http://www.dsm5.org/documents/substance%20use%20disorder%20fact%20sheet.pdf>

and operating the CHEL site (options A and B). This structure would make it quite obvious that public health authorizes the CHEL site for legitimate public health reasons. However, even if public health authorities plays more of an oversight role as in option C, it also seems like public health authority should be recognized and extend some protections to third party actors, since they are acting with the agencies' approval to advance public health.

Impact of State Criminal Drug Laws

Washington's Uniform Controlled Substances Act criminalizes the possession of many of the controlled substances that would be consumed in a CHEL site and could be applicable in other contexts such as paraphernalia, maintaining a building where people consume controlled substances, and civil asset forfeiture.⁵⁶ Although the Task Force can recommend that the state legislature make changes to these laws, they cannot change them on their own; therefore conflicting legal interests must be balanced. In this instance, how do state criminal laws interact with broad public health authority? Existing programs and laws already operating in Seattle and King County provide useful comparisons for legal frameworks.

Needle Exchange Programs

Washington and Seattle/King County have been national leaders in adopting needle exchange programs, which have proven to be an incredibly effective public health intervention for reducing the spread of infectious diseases.⁵⁷ When these programs originated in the late 1980's, legal questions were posed that are similar to those CHEL site's face currently. For example, some prosecutors argued that these programs illicitly distributed drug paraphernalia. In Washington State, this legal question was eventually answered in a state Supreme Court case – *Spokane County Health District v. Brockett* (1992).⁵⁸

In *Brockett*, the Spokane County Prosecutor, Spokane Sheriff, and State Attorney General challenged a Spokane County Health District Board of Health resolution, which directed the health officer to “to establish and implement a needle exchange program in Spokane as a part of an overall intervention to slow the spread of AIDS and other infectious diseases among IVDUs and those with whom they come into contact.” The recommendation to operate a needle exchange program was made after careful deliberation by the board of health about the need for the intervention. In ruling in favor of the needle exchange the court in *Brockett* stated that, “the broad powers given local health boards and officers under Const. art. 11, § 11 and RCW 70.05 authorize them to institute needle exchange programs in an effort to stop the spread of HIV and AIDS,” despite the fact that they were distributing drug paraphernalia.

⁵⁶ RCW 69.50 et seq., available at <http://app.leg.wa.gov/RCW/default.aspx?cite=69.50>

⁵⁷ See Public Health – Seattle & King County Needle Exchange Program, available at <http://www.kingcounty.gov/healthservices/health/communicable/hiv/resources/aboutnx.aspx>

⁵⁸ *Spokane County Health District v. Brockett*, 120 Wn.2d 140, P.2d 324, November 5, 1992, available at <http://courts.mrsc.org/supreme/120wn2d/120wn2d0140.htm>.

Just as Washington was facing an HIV/AIDS epidemic in the 1980's, we now face an opioid epidemic.⁵⁹ A decision by a board of health and/or local health officer to “establish and implement” a CHEL site in an effort to prevent overdoses and the spread of infectious diseases seems squarely within the public health authority at issue in the needle exchange context ruled on in *Brockett*.

Prosecutorial Discretion, LEAD Program, and Law Enforcement Prioritization

Another crucial component of a successful CHEL site will be to work with law enforcement in an honest and transparent manner. It will take discretion by police and prosecutors to not target the clients of CHEL sites for the intervention to succeed. Even if public health authority sanctions a CHEL site, that protection will not spread beyond the walls of the facility, so clients will need some assurances that they will not be targeted when coming and going. Fortunately, this type of law enforcement discretion and prioritization is not uncommon and Seattle/King County is again national leaders. For example, needle exchange programs would not have flourished here without tacit support by police and prosecutors. More recently, the Law Enforcement Assisted Diversion program (LEAD) began operating in Seattle and King County.⁶⁰ This program diverts low-level drug and prostitution cases to harm reduction focused case management services at the point of arrest, instead of a booking into jail and criminal charge. The legal basis for LEAD stems from the discretion of police who choose whether someone is eligible and from the prosecutor who chooses not to file a criminal case.

The law around this type of legal discretion is clear. For prosecutors, as stated by the U.S. Supreme Court, “the decision to file criminal charges, with the awesome consequences it entails, requires consideration of a wide range of factors ***in addition to the strength of the Government’s case***, in order to determine ***whether prosecution would be in the public interest. Prosecutors often need more information than proof of a suspect’s guilt***, therefore, before deciding whether to seek an indictment.”⁶¹ A strong case can be made that allowing a CHEL site to operate without interference from law enforcement is in the public interest.

Similarly, this type of discretion can be codified in the form of lowest law enforcement priority laws. Seattle passed such a law in 2003 in the marijuana context, which states that the “Seattle Police Department and City Attorney’s Office shall make the investigation, arrest and prosecution of marijuana offenses, where the marijuana was intended for adult personal use, the City’s lowest law enforcement priority.”⁶² Although this type of codified law is likely not necessary for a CHEL site to operate, it shows that discretion and prioritization are an everyday part of life for law enforcement.

⁵⁹ U.S. Department of Health & Human Services – About the Epidemic, available at <http://www.hhs.gov/opioids/about-the-epidemic/index.html>

⁶⁰ See – www.leadkingcounty.org

⁶¹ *United States v. Lovasco*, 431 U.S. 783

⁶² SMC 12A.20.060, available at https://www2.municode.com/library/wa/seattle/codes/municipal_code?nodeId=TIT12ACRCO_SUBTITLE_ICRCO_CH12A.20COSU_12A.20.060ENPRAR

911 Good Samaritan and Naloxone Laws

Two state laws that could potentially be helpful in the operation of a CHEL site are the 911 Good Samaritan and naloxone access laws.⁶³ Washington's Good Samaritan law, which passed in 2010, provides legal protection against drug possession charges for people who seek medical assistance during an overdose. This protection extends to the people who seek medical help as well as the person suffering from the overdose. The law also contains strong intent language – “the legislature intends to save lives by increasing timely medical attention to drug overdose victims through the establishment of limited immunity from prosecution for people who seek medical assistance in a drug overdose situation.”⁶⁴ Taken together, the legal protection could help insulate CHEL site employees and clients from drug possession charges in the event of an overdose at the facility and the intent language indicates that the state has an interest in preventing overdose deaths via means beyond the enforcement of criminal laws.

Similarly, Washington's naloxone access law, originally passed in 2010 with significant amendments in 2015, shows that public health approaches are welcomed by the state legislature. The intent of this law is “to increase access to opioid overdose medications...and to permit those individuals to possess and administer opioid overdose medications prescribed by an authorized health care provider.”⁶⁵ A CHEL site would be an ideal place to have naloxone on site and to distribute it to an at-risk population.

Impact of Federal Criminal Drug Laws

Similar to Washington State law, the federal government criminalizes activity that is likely to occur at a CHEL site, such as drug possession or maintaining a drug-involved premises, and the task force cannot change federal law.⁶⁶ Nonetheless, a strong case can be made that a CHEL site can lawfully exist parallel to federal prohibition, especially at a time when the federal government, like Seattle/King County, is trying to end the opiate epidemic.⁶⁷ However, it should be noted that it would ultimately be up to federal law enforcement to decide whether to enforce its own laws against a CHEL site. In examining this apparent conflict, other state/federal drug policy disconnects are worth considering.

An important consideration to keep in mind when looking at the intersection of federal and state drug policy is that the vast majority of drug law enforcement is conducted at the state and local level. In 2010, there were 27,200 federal drug arrests across the U.S, out of a total 1,638,846 drug arrests by all federal, state, and local agencies, which means over 98% of drug arrests are

⁶³ RCW 69.50.315, available at <http://app.leg.wa.gov/RCW/default.aspx?cite=69.50.315> and RCW 69.41.095, available at <http://app.leg.wa.gov/RCW/default.aspx?cite=69.41.095>

⁶⁴ RCW 69.50.315, available at <http://app.leg.wa.gov/RCW/default.aspx?cite=69.50.315>

⁶⁵ <http://app.leg.wa.gov/RCW/default.aspx?cite=69.41.095>

⁶⁶ 21 USC Secs. 844 and 856

⁶⁷ The White House – Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic, March 2016, available at <https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address>

conducted at the state and local level.⁶⁸ Federal law enforcement has also stated publicly that it must make choices about where to commit scarce resources, and that some low-level drug possession cases, such as for marijuana, are not worth pursuing, especially when state or local governments have strong and effective regulatory and enforcement systems in place.⁶⁹ This decision is obviously not the Task Force's to make, but it's apparent that just because an activity is illegal at the federal level doesn't mean that a state or local government must have an identical law. The clearest example of this is the fact that 24 states have medical marijuana laws and 4 states and Washington D.C. have marijuana legalization and regulation laws, despite continued federal prohibition of marijuana.⁷⁰ Needle exchanges are also not officially allowed by the federal government, yet they operate in 38 states, and the federal government's funding ban was recently eased.⁷¹

Similarly, arguments can be made that certain federal crimes are not intended to be applicable in the CHEL site context. For example, the actions that give rise to the "Maintaining drug-involved premises" crime may be technically present at a CHEL site, since individuals will be "using controlled substances" in a "place" managed or controlled by the CHEL site operators. But, this crime was intended to focus on illicit enterprises, while a CHEL site is a public health intervention aimed at saving lives and getting people into treatment. Ultimately, it would be up to federal prosecutors to make the decision of whether to bring charges for this type of crime, but they are not required to do so.

Some might also argue that a locally authorized CHEL site would be federally preempted. This specific legal question has not been answered in any U.S. court, but similar issues have been emerging in the marijuana context and the answer is by no means definitive that a more liberal drug policy at state or local level would be preempted by federal law.⁷² First, the federal government cannot force a state or local government to criminalize any type of drug activity.⁷³ Second, the Supreme Court has been very deferential to the traditional police powers of the states. In ruling in favor of the State of Oregon in the physician-assisted suicide context, the Court noted that the "structure and limitations of federalism ... allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons" (internal quotation omitted).⁷⁴ As noted above, local public health authority in Washington is derived from the state Constitution and the legislature, so it's likely this deference would also be extended to local authorities in the CHEL site context.

⁶⁸ See – US Census – Table 328 - <https://www.census.gov/prod/2011pubs/12statab/law.pdf> and FBI UCR 2010- <https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables/10tbl29.xls>

⁶⁹ See – Cole Memorandum, August 29, 2013 – Guidance Regarding Marijuana Enforcement – pg. 2, available at <https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>

⁷⁰ See – National Conference of State Legislatures – State Medical Marijuana Laws, available at <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>

⁷¹ Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016, available at <https://www.aids.gov/pdf/hhs-ssp-guidance.pdf>

⁷² *County of San Diego v. San Diego NORML*, 165 Cal. App. 4th 798, 81 Cal. Rptr. 3d 461 (2008)

⁷³ See – Chemerinsky – *LA Times*, "On pot laws, respect the states -

<http://articles.latimes.com/2013/mar/27/opinion/la-oe-chemerinsky-marijuana-legalization-20130327>

⁷⁴ *Gonzales v. Oregon*, 546 U.S. 243, 270, 126 S. Ct. 904, 163 L. Ed. 2d 748 (2006).

Conclusion

If the King County Board of Health and the local public health officer adopt resolutions to establish and implement a CHEL site, they would be in a strong legal position, despite existing state and federal criminal drug laws. It's also possible that these legal protections would exist if local legislative bodies set up a regulatory system that allows private actors to operate a CHEL site, but the outcome is less clear. Nonetheless, just as important as the legal considerations are political ones. For this reason the Task Force should continue to deliberate the need for a CHEL site in an open and collaborative manner.

Attachment S

Key Potential Opportunities for Washington and King County in S. 524, the Comprehensive Addiction and Recovery Act of 2016 (CARA)

Full text at: <https://www.congress.gov/114/bills/s524/BILLS-114s524enr.xml>

Chris Verschuyf, Department of Community and Human Services

*The grant programs described below, authorized by the CARA legislation, are subject to appropriation. As noted the President's July 22, 2016 [signing statement](#), **no funding had yet been appropriated at the time of this analysis**. This analysis also includes key policy changes that are not dependent on funding.*

Analysis of Key Sections of CARA⁷⁵

Implement Comprehensive Community-Wide Strategies (Section 103)

\$5M/year (\$25M total) Federal Fiscal Year (FFY) 2017-2021, if appropriated.

Grants to organizations funded under the Drug-Free Communities Act of 1997 (most often community coalitions), with documented sudden increases in opiate use or significantly higher rates of opiate use than the national average, to:

- Implement comprehensive community-wide strategies to address local drug crises.

Expand Access to Drugs or Devices for Opioid Overdose Reversal (Section 107)

\$5M total for FFY 2017-2021, if appropriated.

Grants to federally qualified health centers, opioid treatment programs, or any other entity deemed appropriate by HHS, to:

- establish a program for prescribing a drug or device for overdose reversal
- train and provide resources for health care providers and pharmacists regarding prescribing overdose reversal drugs and devices
- purchase overdose reversal drugs or devices
- establish protocols to connect patients who have experienced overdose with appropriate treatment

Opioid Overdose Reversal Medication Access and Education (Section 110)

\$5M total for FFY 2017-2019, if appropriated.

Grants to states that have authorized standing orders to be issued for overdose reversal drugs or devices,⁷⁶ in order to:

- implement strategies for pharmacists to dispense an opioid overdose reversal drug or device via standing orders

⁷⁵ See also a helpful section by section analysis of the entire CARA legislation, at <http://nasadad.org/wp-content/uploads/2016/07/CARA-Section-by-Section-July-2016.pdf>. The analysis in this document is informed by NASADAD's review, but focuses solely on programs, policies, and opportunities relevant to the state of Washington and King County. For example, most provisions relating to the Veterans Administration are excluded.

⁷⁶ In Washington, standing orders are explicitly permitted via [ESHB 1671](#), passed by the state legislature in 2015.

- encourage pharmacies to dispense opioid overdose reversal medication via standing orders
- develop or provide training materials on the administration of an opioid overdose reversal drug or device
- educate the public about the availability of opioid overdose reversal drugs or devices

Comprehensive Opioid Abuse Grant Program (Section 201)

\$103M/year (\$515M total) for FFY 2017-2021, if appropriated.

Grants of up to 4 years to states, local governments, and tribes (that may not supplant state, local, or tribal funds), to:

- develop, implement or expand any of the following:
 - treatment alternative to incarceration programs, which can include:
 - prebooking or postbooking components
 - training for criminal justice agencies regarding behavioral health conditions
 - mental health court, drug court, and/or veterans' treatment court
 - focus on parents whose incarceration could result in children entering the child welfare system, and
 - community-based substance use diversion program sponsored by a law enforcement agency⁷⁷
 - medication-assisted treatment (MAT)⁷⁸ programs used or operated by a criminal justice agency
 - prescription drug monitoring programs⁷⁹
 - the use of technology to provide a secure container for prescription drugs
 - integrated and comprehensive opioid abuse response programs
- enhance planning and collaboration between state criminal justice and state substance abuse agencies to address opioid abuse⁸⁰
- train first responders on carrying, administering, and purchasing opioid reversal drugs or devices
- locate or investigate illicit activities related to unlawful distribution of opioids

First Responder Training (Section 202)

\$12M/year (\$60M total) for FFY 2017-2021, if appropriated.

Grants to states, local governments, and tribes to allow first responders and other key community sectors to:

- administer an opioid overdose reversal drug or device
 - emphasis on evidence-based methodology, outcome evaluation, and broad replication

⁷⁷ This specific provision was added by Washington Rep. Suzan DelBene, who explicitly mentioned King County's Law Enforcement Assisted Diversion (LEAD) program as an example.

⁷⁸ In this legislation, MAT is defined as the use of FDA-approved medications in combination with counseling and behavioral therapies.

⁷⁹ This potential grant purpose would be available only to states, not local governments or tribes.

⁸⁰ This potential grant purpose would be available only to states, not local governments or tribes.

Expanded Disposal Sites for Unwanted Prescription Medications (Section 203)

No new funding authorization specific to this program.

Grants to state/local/tribal law enforcement agencies, prescription medication manufacturers or distributors, retail pharmacies, registered narcotic treatment programs, hospitals or clinics with onsite pharmacies, eligible long-term care facilities, or any other entity authorized by the DEA to dispose of prescription medications, to:

- expand or create disposal sites for unwanted prescription medications.

Evidence-based Prescription Opioid/Heroin Treatment and Interventions Demonstration (Section 301)

\$25M/year (\$125M total) for FFY 2017-2021, if appropriated.

Grants to state substance abuse agencies, units of local government, nonprofit organizations, and tribes that have a high rate or rapid increase in the use of opioids, to:

- expand the treatment of addiction, including expanding MAT,⁸¹ in specific geographic areas affected by the high rate or rapid increase in opioid use, including rural areas

Building Communities of Recovery via Recovery Community Organizations (Section 302)

\$1M/year (\$5M total) for FFY 2017-2021, if appropriated.

Grants to recovery community organizations,⁸² not to exceed half of program costs, to:

- develop, expand, and enhance recovery services, including recovery support services
- build connections with behavioral health and physical health care provider networks
- reduce stigma associated with substance use disorders (SUDs)
- conduct public education and outreach related to SUDs and recovery

Changes to Prescribing Rules for Buprenorphine (Section 303)

Makes certain revisions to the maximum number of patients per prescriber as follows:

- Maintains current maximum allowable caseload numbers (30 in first year and 100 thereafter), but permits HHS to change the maximum number by regulation
- Permits states to set lower maximum numbers, between 30 and the federally allowed maximum, or to add additional requirements for qualifying practitioners
- Excludes from any provider's maximum number any patients to whom buprenorphine is directly administered in the office setting

Changes the qualifications for providers who may prescribe buprenorphine, as follows:

- Includes nurse practitioners or physician assistants who:
 - are licensed to prescribe schedule III, IV, or V drugs for the treatment of pain;
 - have completed 24 hours of training in the treatment and management of opiate-dependent patients from national organizations deemed appropriate by HHS
 - are supervised by a qualifying physician

⁸¹ In this legislation, MAT is defined as the use of FDA-approved medications in combination with counseling and behavioral therapies.

⁸² Recovery community organizations are nonprofits that mobilize resources within and outside the recovery community to increase long-term recovery, and are principally governed by people in recovery who reflect the community served.

- Requires qualifying physicians to:
 - Hold a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties;
 - Hold an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine
 - Requires physicians' 8 hours of training from national organizations deemed appropriate by HHS to include:
 - opioid maintenance and detoxification
 - appropriate clinical use of all drugs approved by the FDA
 - initial and periodic patient assessments (including substance abuse monitoring)
 - individualized treatment planning, overdose reversal, and relapse prevention
 - counseling and recovery support services
 - staffing roles and considerations
 - diversion control
 - other best practices

Changes to Residential Treatment for Pregnant and Postpartum Women (PPW) (Section 501)

\$1M/year (\$5M total) increase for FFY 2017-2021 over \$15.9M/year FFY 2016 level, if appropriated. Up to 25% of the total authorized appropriation for PPW may be used for this pilot program (maximum of \$4.2M/year, \$21.1M total, if appropriated). However, the pilot program only moves forward if total PPW appropriation exceeds baseline level of \$15.9M/year.

Reauthorization of SAMHSA's PPW grants to state substance abuse agencies includes the following changes:

- Prioritizes grants to programs serving rural areas, health professional shortage areas, and areas with a shortage of family-based treatment options
- Enhances flexibility in the use of funds, to help state substance abuse agencies:
 - Address service gaps across the continuum of care, including in non-residential settings
 - Promote new approaches and evidence-based models of service delivery
 - Ensure delivery of certain minimum services, including but not limited to individual, group, and family counseling, as well as follow-up relapse prevention services⁸³

Attorney General Grants for Justice-Involved Veterans Services and Veterans Courts (Section 502)

No new funding authorization specific to this program.

Allows Attorney General, in consultation with the Secretary of Veterans Affairs, to make grants to establish or expand veterans treatment court programs; peer-to-peer services or programs for qualified veterans; practices that identify and provide treatment and other services to veterans who have been incarcerated; and training programs for criminal justice and behavioral health personnel in serving veterans.

⁸³ The legislation describes a wide range of potential additional minimum services specific to the needs of the target PPW population, to be determined by SAMSHA's Center for Substance Abuse Treatment (CSAT). See <http://nasadad.org/wp-content/uploads/2016/07/CARA-Section-by-Section-July-2016.pdf>, page 9, for details.

Plan of Safe Care for Infants (Section 503)

Requires state plans to ensure the safety and well-being of an infant identified as affected by maternal substance use to include addressing the health and substance use disorder treatment needs of the infant and the affected family member or caregiver.

State Demonstration Grants for Comprehensive Opioid Abuse Response (Section 601) *\$5M/year (\$25M total) for FFY 2017-2021, if appropriated.*

Grants to states and combinations of states to implement an integrated opioid abuse response initiative, including:

- Educational efforts
- Comprehensive prescription drug monitoring programs
- Expanding MAT
- Programs to treat and screen individuals in treatment for Hepatitis C and HIV
- Recovery support services in high schools and higher education institutions
- Programs to prevent opiate overdose death
- Raising public awareness of opioid use disorders

Partial Fills of Schedule II Controlled Substances (Section 702)

Allows prescriptions for Schedule II controlled substances to be partially filled, if:

- Not prohibited by state law
- Permitted under federal laws and regulations
- Partial fill is requested by patient or prescriber
- Total quantity dispensed does not exceed the total quantity prescribed

Promoting Abuse-Deterrent Formulations (Section 705)

Changes a definition to support the development and use of abuse-deterrent (including extended-release) formulations of drugs by excluding them from a Medicaid additional rebate requirement.

Pilot Program on Integration of Complementary and Integrative Health for Veterans (Section 933)

No new funding authorization specific to this program.

Requires HHS to establish a pilot program to:

- Assess the feasibility and advisability of using complementary and integrative health and wellness-based programs to complement the provision of pain management and other health care services to veterans.