



REDUCING THE SUPPLY OF ILLEGAL OPIOIDS IN WASHINGTON STATE



NOVEMBER
2017





Dear Washingtonians:

On average, two people die each day from opioid overdoses in our state. Tens of thousands of others struggle with addiction. Opioids are devastating Washington families, making our communities less safe, and overwhelming our safety nets.

We partnered to convene the Summit on Reducing the Supply of Illegal Opioids in Washington, bringing together law enforcement, public health experts, prosecutors, and medical professionals to identify next steps and solutions to this epidemic.

Based on information shared at the Summit, this report sets out decisive, evidence-based recommendations that policymakers should adopt to curb the tragic effects of this problem.

As public safety professionals, we recognize that response to the opioid epidemic must include prevention, treatment and enforcement. This is a public health crisis just as much as it is a public safety challenge. Opioid misuse and addiction are impacting our social service, health and criminal justice systems. Consequently, it is imperative that we foster strong partnerships across sectors and remove barriers to collecting and sharing information.

We look forward to working with the Legislature, the Governor, health professionals, tribal leaders, law enforcement and federal partners to carry forward these recommendations to reduce the supply of illegal opioids, prevent opioid addiction, and connect those suffering from addiction to treatment. Washington families and communities deserve nothing less.

Sincerely,

A handwritten signature in blue ink that reads "Bob Ferguson". The signature is fluid and cursive.

Bob Ferguson
Washington State Attorney General

A handwritten signature in blue ink that reads "John R. Batiste". The signature is cursive and somewhat stylized.

Chief John Batiste
Washington State Patrol

A handwritten signature in blue ink that reads "Rich Weyrich". The signature is very stylized and appears to be a large "R" followed by a horizontal line.

Skagit County Prosecuting Attorney Rich Weyrich
President, Washington Association of Prosecuting Attorneys

GOALS & RECOMMENDATIONS



ADDRESS SIGNIFICANT GAPS IN PUBLIC AWARENESS ABOUT THE DANGERS OF OPIOIDS, AS WELL AS LESS RISKY ALTERNATIVES AVAILABLE:

- Expand statewide, coordinated education and outreach efforts.



PREVENT ADDICTION BY CURTAILING OVERPRESCRIBING:

- Establish limits on the amount of opioids initially prescribed.
- Require patients to acknowledge that they have been informed about the dangers of opioids upon initial prescription.
- Support requirements or incentives for alternative pain management treatments.



REDUCE THE ILLICIT USE OF PRESCRIPTION OPIOIDS:

- Require providers to consult the Prescription Monitoring Program before prescribing certain controlled substances.
- Eliminate paper prescriptions.
- Create a statewide medicine take-back system.
- Enable investigators in Washington's Medicaid Fraud Control Unit to be appointed as limited authority peace officers for Medicaid fraud investigations.



DISRUPT AND DISMANTLE ORGANIZATIONS RESPONSIBLE FOR TRAFFICKING NARCOTICS:

- Restore resources for multi-jurisdictional drug-gang task forces.



PREVENT FURTHER INCREASES IN OVERDOSE DEATHS FROM FENTANYL:

- Adopt enhanced criminal penalties for trafficking of fentanyl and fentanyl analogues.



IMPROVE OVERDOSE REPORTING AND INFORMATION SHARING:

- Direct resources towards more timely analysis of samples at the Washington State Toxicology Laboratory.
- Require emergency medical service providers to report patient care information, including treatment of overdoses.
- Require law enforcement officers to report naloxone administrations.



EXPAND ACCESS TO ADDICTION TREATMENT:

- Support and expand statewide and local non-traditional law enforcement approaches, such as drug courts, Law Enforcement Assisted Diversion, and embedded social workers.

REDUCING THE SUPPLY OF ILLEGAL OPIOIDS IN WASHINGTON STATE

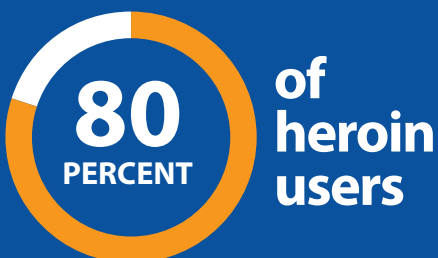


Attorney General Bob Ferguson provides introductory remarks at the Summit.

On June 15 and 16, 2017, the Attorney General’s Office (AGO), Washington State Patrol (WSP) and Washington Association of Prosecuting Attorneys (WAPA) convened more than 400 professionals to develop and recommend strategies to reduce the supply of illegal opioids in Washington. The attendees and presenters included law enforcement agencies, prosecutors, public health experts, policymakers, and medical professionals. The Summit was held in response to an Executive Order from Governor Inslee.

Solutions to the opioid crisis require removing barriers to information-sharing and establishing strong partnerships across sectors. Although Washington has taken steps to address opioid abuse, overdose deaths in our state continue to rise. Heroin deaths more than doubled between 2010 and 2015.¹ The majority of all drug overdose deaths in Washington —more than six out of ten— involve an opioid.²

Opioid misuse and addiction impose substantial economic and social costs on communities and families in Washington. As a result of this problem, significant public resources have been and will continue to be spent for emergency medical services, law enforcement, prisons and jails, diversion programs, prosecution, probation, treatment, and child welfare. Communities have to deal with the direct costs associated with opioid misuse, as well as the crimes people commit to support their addiction. In addition, increasing numbers of infants in our state are born addicted to opioids.³



To be more successful at reducing the supply of illegal opioids in our state, we must also address prescription opioids—often the source of initial exposure to opioids.⁴ As prescription opioids become expensive and difficult to obtain, dependent users often turn to heroin. According to WSP, drug cartels have fully exploited this market, more than doubling production of heroin since 2005. The high purity heroin being distributed in our region can be smoked and snorted, reducing the stigma associated with using needles.

Synthetic opioids, such as fentanyl, are an emerging contributor to

Opioid Overdose Deaths in Washington

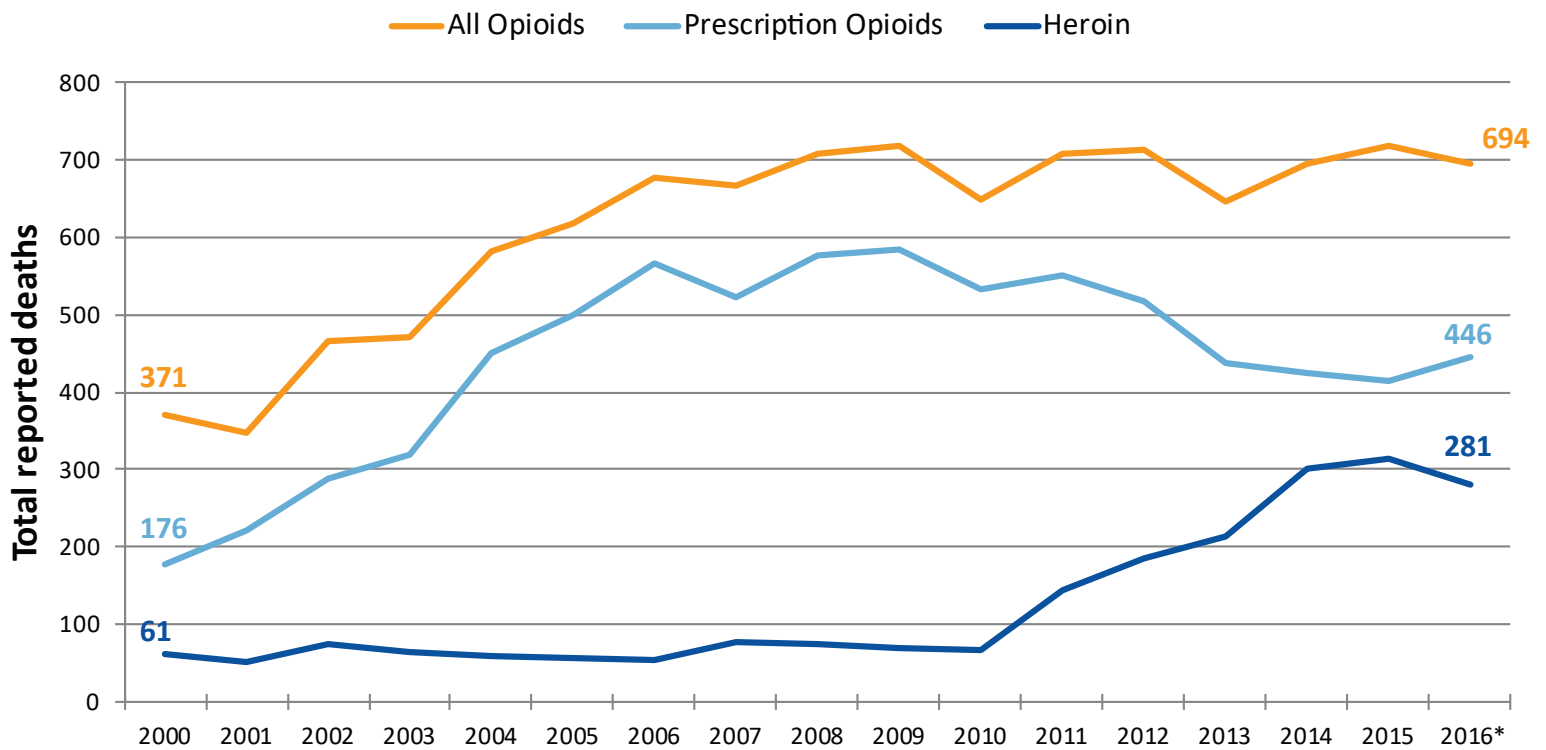


FIGURE A

SOURCE: WASHINGTON STATE DEPARTMENT OF HEALTH

NOTE: "ALL OPIOIDS" MAY NOT SUM WITH "PRESCRIPTION OPIOIDS" AND "HEROIN" AS IT INCLUDES ADDITIONAL CATEGORIES NOT DEPICTED (E.G, SYNTHETIC OPIOIDS) AND BECAUSE OVERDOSE DEATHS MAY INVOLVE MULTIPLE TYPES OF OPIOIDS.
*2016 DATA ARE PRELIMINARY.

Washington's opioid crisis. Fentanyl is 100 times more powerful than morphine and 50 times more potent than heroin⁵. A very small amount can be fatal. According to the Department of Health (DOH), our state experienced an 86 percent increase in fentanyl-related overdose deaths from 2015 to 2016.⁶

As demonstrated by the presenters and attendance at the June Summit, the opioid crisis is both a public safety and a public health crisis. Our government and communities cannot combat the ever-changing and growing supply of illegal opioids in isolation. Recognizing this fact, this report identifies seven overarching goals:

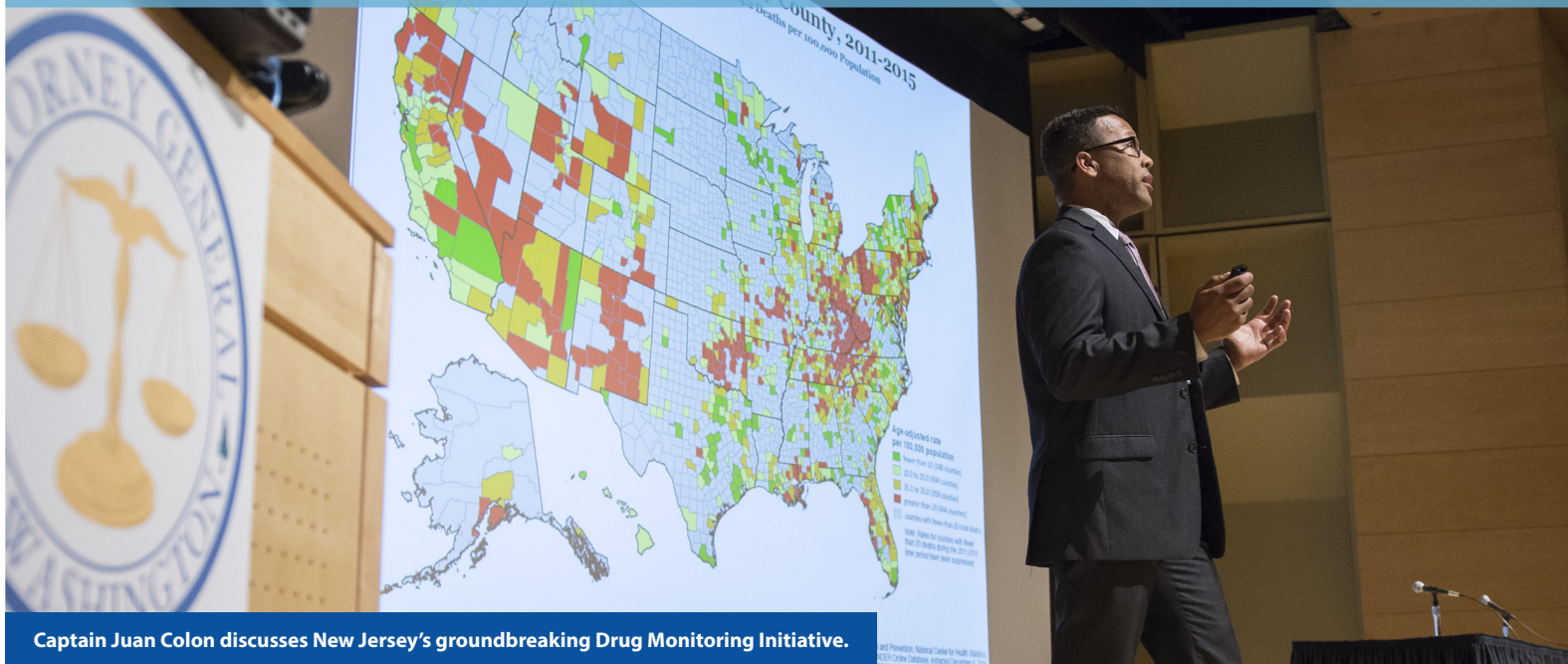
1. Address significant gaps in public awareness about the dangers of opioids, as well as less risky alternatives available.
2. Prevent addiction by curtailing overprescribing.
3. Reduce the illicit use of prescription opioids.
4. Disrupt and dismantle organizations responsible for trafficking narcotics.
5. Prevent further increases in overdose deaths from fentanyl.
6. Improve overdose reporting and information sharing.
7. Expand access to addiction treatment.

To work towards these goals, next steps are presented in the form of recommendations for policymakers to consider as Washington takes measures to address the devastating effects of the opioid crisis.



GOAL:

1 ADDRESS SIGNIFICANT GAPS IN PUBLIC AWARENESS ABOUT THE DANGERS OF OPIOIDS, AS WELL AS LESS RISKY ALTERNATIVES AVAILABLE



Captain Juan Colon discusses New Jersey’s groundbreaking Drug Monitoring Initiative.

RECOMMENDATION:

- Expand statewide, coordinated education and outreach efforts.

Youth and adults alike underestimate the risks associated with prescription opioids, highlighting a need for more robust efforts to educate the public about misuse—and the risks even when opioids are used as prescribed. A recent Partnership for Drug-Free Kids survey found that more than a quarter of teens believe that prescription drugs are safer than illegal drugs. One in five teens believe that painkillers are not addictive.⁷ Youth hold these views, in part, because prescription medications are provided by trusted health professionals. Washington’s 2016 Healthy Youth Survey reveals that a significant portion of Washington students misuse prescription drugs - about 4,500 12th graders use prescription opioids to get high in any given month, and about 3,600 have tried heroin at least once.⁸

The evidence confirms that even using opioids as prescribed can pose significant risk. Legitimate opioid use before high school graduation is associated with a 33 percent increase in the risk of future opioid misuse.⁹ The increased risk is not only seen—but concentrated—among youth who have little to no history of drug use and initially held strong views against illegal drug use.¹⁰ In addition, the Kaiser Family Foundation Health Tracking Poll found that, among a nationally representative sample of adults, about four in ten were not aware that 1) prescription opioid abuse makes a person more likely to use heroin, or 2) prescription opioids are about equally addictive as heroin.¹¹

1 in 4 teens believe there is

“LITTLE OR NO RISK”

in using prescription pain relievers without a prescription.

To begin to dispel such myths, Washington's Department of Social and Health Services (DSHS) is using one-time federal grant funds to conduct a statewide opioid misuse and overdose prevention public education campaign targeting teens, young adults, and parents, among other populations. The campaign objectives are to educate about the dangers of prescription drug misuse and increase awareness of appropriate opioid use, storage, and disposal, as well as how to respond to an overdose. Messages will be conveyed through paid and earned media, a campaign website, Facebook, and a toolkit for partner organizations. The major media buy will occur in early 2018 and will cover digital ads across the state, radio ads in most markets, television ads in Central and Eastern Washington, outdoor ads in Western Washington, and transit ads in Southwest Washington. To extend the reach of the campaign, the partner toolkit will be accessible online and will include materials that partner organizations can download, including posters, print ads, social media posts, and articles for blogs or newsletters. The toolkit will be launched in November 2017 with a webinar training for partner organizations.

Due to the limited budget available, the campaign will introduce target audiences to the campaign messages at a high level, but not with ideal reach and frequency (i.e., number of people exposed to the messages and the number of times they are exposed to each message). The deliverables include an evaluation report with recommendations for future campaigns. Based on the limitations already known, the campaign team has identified preliminary recommendations to build on the campaign going forward, such as tailoring outreach to additional target populations and using non-traditional advertising, including partnerships with pharmacies. If the DSHS campaign achieves the objectives described above, policymakers should consider providing support for ongoing efforts.

Other states have also carried out public education campaigns, portions of which Washington can adopt to complement DSHS's efforts. For example, in Utah the [Use Only As Directed](#) campaign targets patients with acute pain, urging them to talk to their doctor about alternatives to opioids. To prevent unnecessary prescriptions in the first place, the campaign suggests questions to start a conversation (e.g., "Will something else work?") and identifies less risky alternatives (e.g., acetaminophen, ibuprofen, physical therapy, and cognitive behavior therapy). Some messages were

placed directly in hospitals, priming patients moments before they interacted with their doctor. Within four months of launch, a survey found that 87 percent of patients seeing their doctors for pain reported that they talked to their doctors about opioid alternatives. Moreover, research found that there were one-third fewer opioid users since the campaign launch in 2010.

Another example of a statewide, multi-media campaign is Wisconsin's [Dose of Reality](#). This campaign also aims to reduce initial opioid usage by encouraging people to ask questions of their doctors and underscoring the serious health risks associated with opioid use, including addiction and death. It also highlights safe storage and disposal methods. The campaign includes radio and television commercials, digital online ads, print ads, and outdoor ads made available to organizations throughout the state at no charge. Community Outreach Kits targeted to different groups, including parents, coaches, and educators, provide information about how to spot prescription opioid abuse and help someone who is addicted. The kits include posters, fact sheets, talking points, PowerPoint presentations, social media content, and campaign logos. This campaign allows organizations to customize the toolkit materials with their own logos.

Since the campaign launch, the Wisconsin Department of Justice has documented significant increases in the amount of drugs collected during its biannual drug take-back days. Data gathered by DEA shows that during 2016's National Prescription Drug Take Back Days, Wisconsin trailed only Texas in the amount of drugs collected. The Wisconsin materials have been adapted for and adopted by several other states.¹² Maine, one of the states that adopted the *Dose of Reality* campaign, collected more than 56,000 pounds of unused medication during the 2016 National Prescription Drug Take Back Days. Washington, with a population more than five times greater than Maine, collected about 33,000 pounds of medication during this period.¹³



GOAL:

2 PREVENT ADDICTION BY ADDRESSING OVERPRESCRIBING



Drs. Amy Cook, Christopher Frank, and Sean Dobbin provide perspectives of dental, medical, and pharmacy providers.

RECOMMENDATIONS:

- Establish limits on the amount of opioids initially prescribed.
- Require patients to acknowledge that they have been informed about the dangers of opioids upon initial prescription.
- Support requirements or incentives for alternative pain management treatments.

It is well documented that overprescribing of opioids contributes to misuse, addiction, and overdose.¹⁴ By prescribing only the lowest effective dose of opioids and considering other types of pain treatment, medical and dental providers can help address this issue. According to DOH data, Washington dentists are —by far— the biggest prescribers of opioids to youth aged 14-19, prescribing more than 13,000 pills to youth in this age group in one six-month period in 2015. Emergency medicine providers, the second highest prescribers, issued prescriptions to this age group for approximately 2,500 pills in the same time frame. Some providers still follow the protocols they were taught in school – such as prescribing 30 narcotic pills for tooth extractions¹⁵ – even though research has found that, for most conditions, non-opioid pain treatment (e.g., acetaminophen and NSAIDs) is equally or more effective with significantly less risk than opioids¹⁶. This points to the need to change the protocols taught to medical and dental students, so that non-opioid treatments are the first-line pain treatment for many procedures and conditions.

Communities with higher rates of opioid prescribing generally have higher opioid overdose rates, as shown in Figures B and C. Recent research has found that prescribing more than a week's supply of opioids approximately doubles the chance that the person will still be using opioids one year later, as shown in Figure D.¹⁷ Prescribing less than a week of medication, ideally no more than three days, reduces the chance that any given patient will end up addicted. The CDC's 2016 *Guideline for Prescribing Opioids for Chronic Pain* notes that long-term opioid use often begins with the treatment of acute pain.¹⁸ Rather than routinely receiving lengthy prescriptions, patients should be given the lowest effective dose in no greater quantity than needed for the expected duration of pain severe enough to require opioids. In fact, according to CDC's Guideline, three days or less will often be sufficient; more than seven days will rarely be needed.

Looking to the CDC Guideline, at least fifteen states have adopted statutes or agency rules limiting the amount of opioids medical professionals may prescribe.¹⁹ The prescription limits are set at a daily supply or in morphine milligram equivalents. Most commonly, states have established a limit of no more than a seven-day supply, though

Rates of Opioids Prescribed, 2014

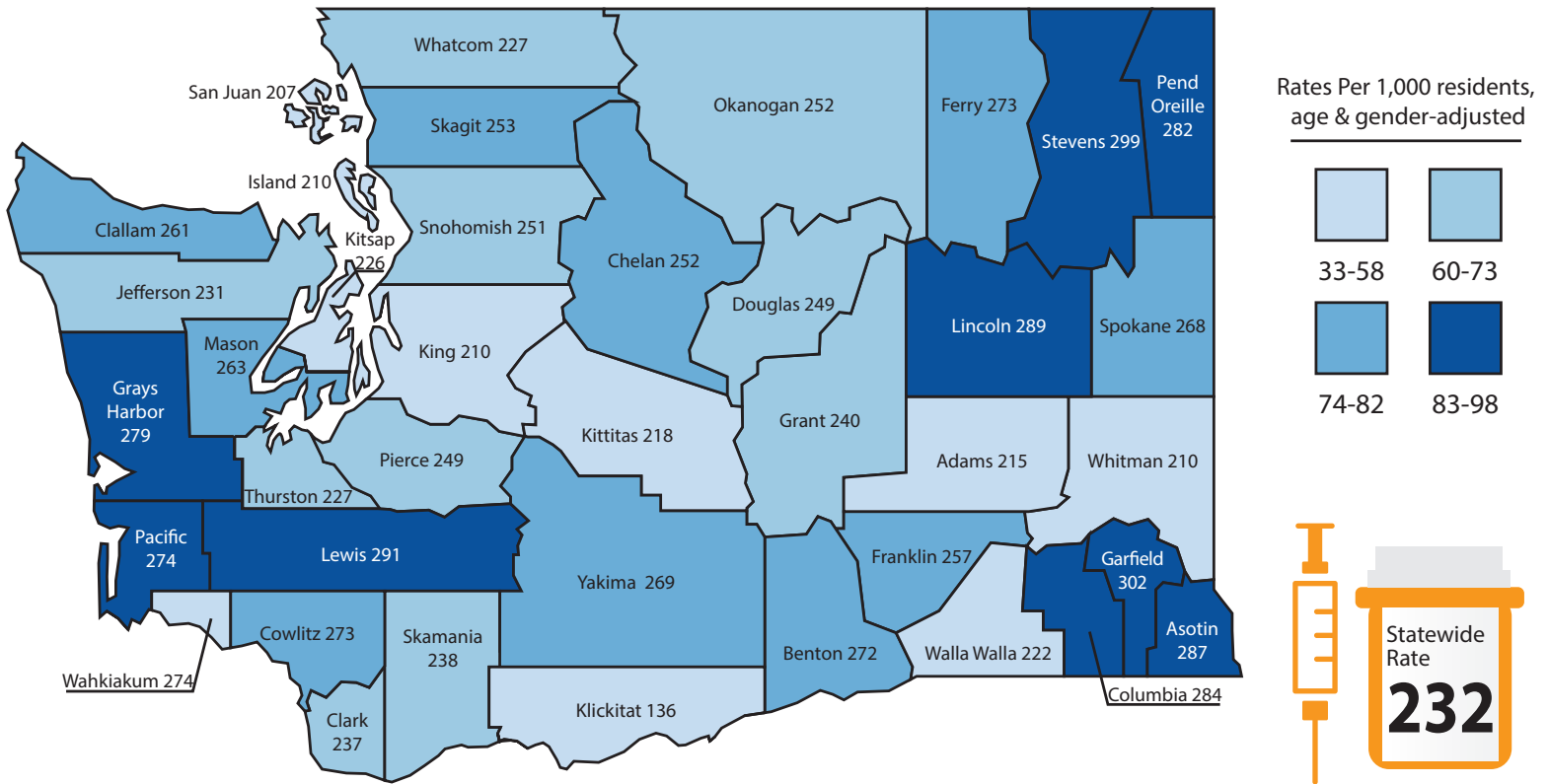


FIGURE B SOURCE: WASHINGTON STATE DEPARTMENT OF HEALTH

Rates of Opioid Overdose Deaths, 2011-2015

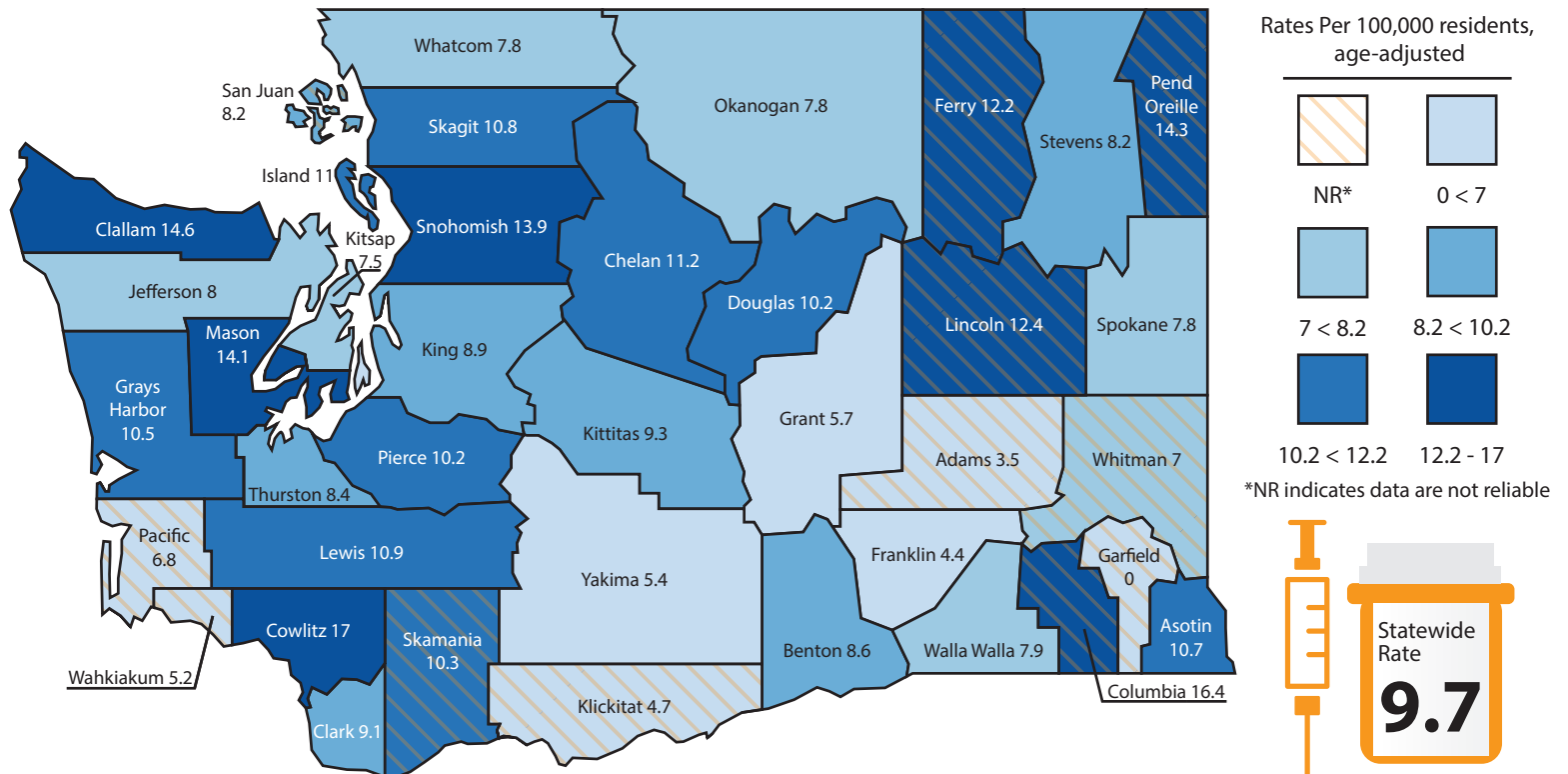


FIGURE C SOURCE: WASHINGTON STATE DEPARTMENT OF HEALTH

Risk of prolonged opioid use increases with each day of prescription after *just 3 days*

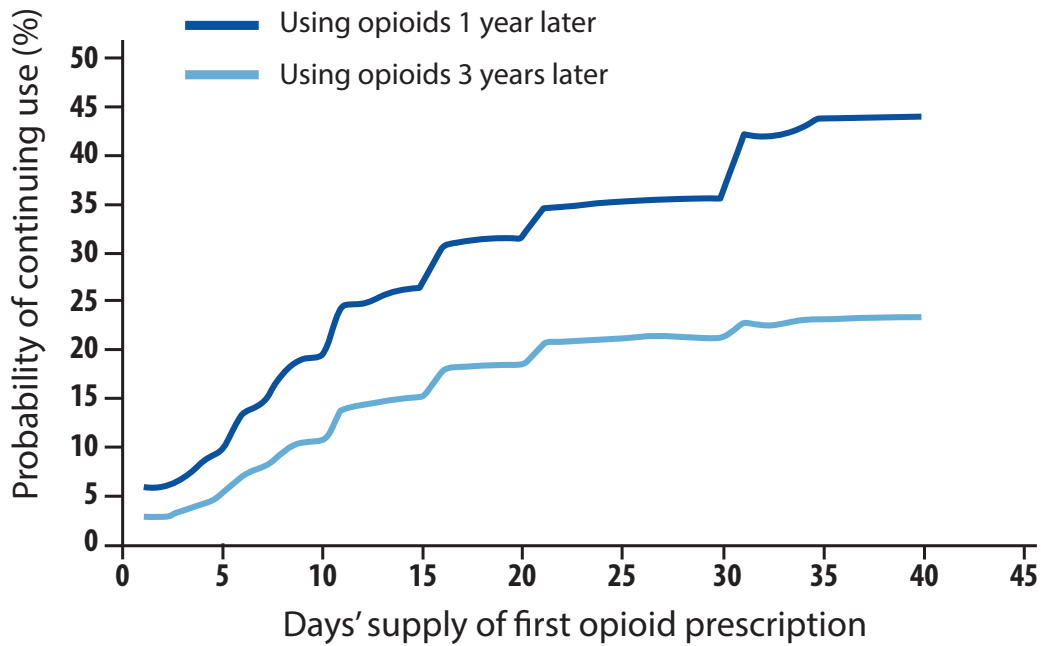
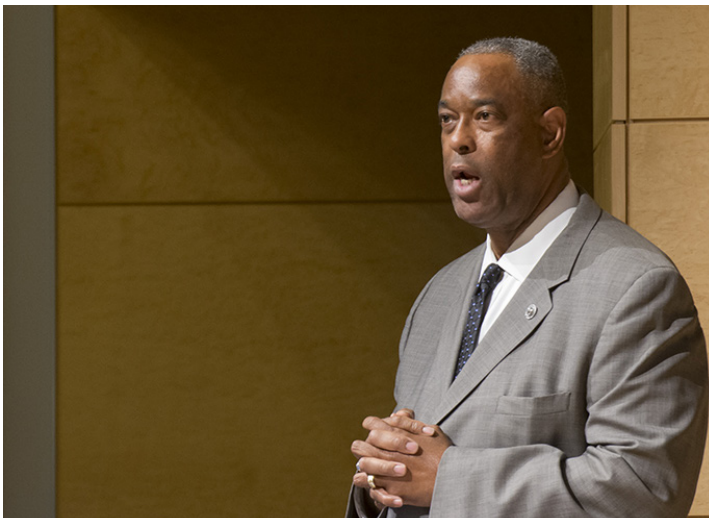


FIGURE D

SOURCE: SHAH ET AL. (2017)



Chief John Batiste highlights Washington State Patrol's role in combatting the opioid epidemic.



New Jersey and North Carolina recently set the limit at five days, Kentucky has a three-day limit, and Connecticut established a five-day limit on prescriptions for children.²⁰ The limits generally apply to an initial opioid prescription for acute pain, rather than chronic pain. Some states limit prescriptions for children at any time, rather than just the initial prescriptions. The laws often exempt cancer patients, residents of long-term care or nursing facilities, palliative care, and hospice care. In addition, exemptions are also often allowed when deemed appropriate by providers' professional medical judgment. Some states also require signed consent forms before opioid prescriptions can be issued. In Ohio and Pennsylvania, written informed consent is required to prescribe opioids to children, while in Delaware and Kentucky, it is required regardless of the age of the patient.²¹

The private sector has also imposed limits on opioid prescriptions. Two of the country's largest pharmacy benefits managers, Express Scripts and CVS Caremark, recently announced programs limiting initial opioid prescriptions to seven days for patients with acute conditions. Clients (e.g., health plans and employers) can opt out of these programs.

To date, Washington has not imposed daily or dosage limits on opioid prescriptions across-the-board. However, as of November 2017, new opioid prescriptions for acute pain



The audience engaged in a robust discussion with members of the Public Health and Medical Community Perspectives panel, moderated by Dr. Kathy Lofy.

are limited for Washington’s Medicaid clients—those under age 21 are limited to a three-day supply and clients age 21 and older are limited to a seven-day supply—unless providers document a medically necessary exemption.²² Beyond the Medicaid population, the Legislature has directed the various boards and commissions that regulate prescribing professionals to adopt rules by January 1, 2019 establishing requirements for all opioid prescribing with the goal of reducing the number of people who become addicted.²³ Though not required to do so, the rules could set limits on opioid prescriptions.²⁴

As patients and medical providers become educated on the dangers associated with opioids and as limits are placed on initial prescriptions, it is important that patients have access to other types of pain treatment. By law, health plans in Washington must cover certain non-opioid pain treatments, such as physical therapy and acupuncture.²⁵ However, according to the Office of the Insurance Commissioner (OIC), these services are often associated with high co-payments, which means that though they are covered, they may remain out of reach for some patients. The OIC is in the process of working with insurers to improve access to alternative pain treatment for patients. Though Medicaid cannot charge co-payments, the Health Care Authority also acknowledged that Medicaid patients face limitations when seeking non-opioid pain treatments, such as interventional therapies and cognitive behavior therapy. HCA is examining ways to improve access to alternatives for Medicaid patients, such as using care coordinators.





GOAL:

REDUCE ILLICIT USE OF PRESCRIPTION OPIOIDS



Snohomish County panelists Commander Patric Slack, Sheriff Ty Trenary, and Mr. Hil Kaman discuss innovative approaches underway in their community.

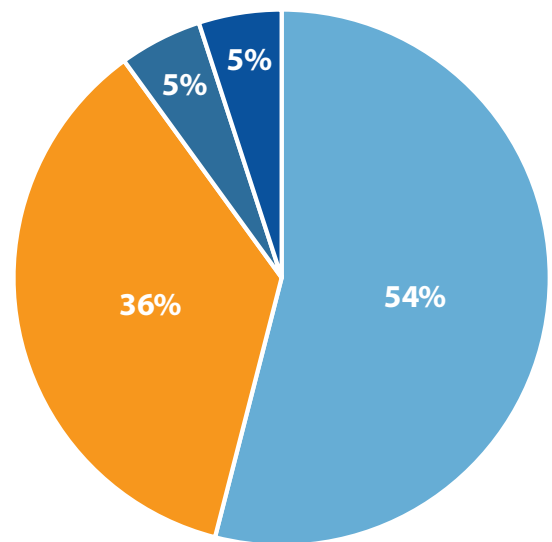
RECOMMENDATIONS:

- Require providers to consult the Prescription Monitoring Program before prescribing certain controlled substances.
- Eliminate paper prescriptions.
- Create a statewide medicine take-back system.
- Enable investigators in Washington’s Medicaid Fraud Control Unit to be appointed as limited authority peace officers for Medicaid fraud investigations.

PRESCRIPTION MONITORING PROGRAMS

According to the National Drug Threat Assessment, opioids are the most common controlled prescription drugs used for illicit purposes.²⁶ One way that people obtain increasing amounts of opioids to feed their own addiction or to sell for profit is to visit multiple providers (“doctor shopping”) or to fill prescriptions at multiple pharmacies. Because Prescription Monitoring Programs (PMP) effectively flag patterns of misuse and overprescribing, their use has been endorsed by the National Governors Association, the National Conference of State Legislatures, and the CDC. PMPs collect electronic records when certain controlled prescriptions are dispensed to patients, making this information available to medical providers to identify patients receiving too many opioids or dangerous combinations of medications. This gives providers an opportunity to refer patients suffering from addiction to treatment. In Washington, dispensers—generally pharmacists—must submit information to the PMP within one business day, including the patient’s name, address,

Source of Opioids Used Non-Medically



Legend: Friend/Family (light blue), Doctor (orange), Drug dealer/Stranger (dark blue), Other (medium blue)

FIGURE E SOURCE: NATIONAL SURVEY ON DRUG USE & HEALTH, 2015

and date of birth, pharmacy and prescriber information, and specific prescription information, such as the drug name and dosage, and the prescribing and dispensing dates.²⁷ Providers have access to a patient’s information; however, in our state they are not required to review this information before writing a prescription.²⁸

Until such time as all providers are required to use the system, Washington’s PMP will not effectively protect patients and expose potential illicit use of opioids. As it stands, the vast majority of Washington’s providers are issuing prescriptions for highly addictive substances without verifying whether the patient is also getting prescriptions from other providers.

Providers have expressed concern that the PMP is time-consuming and not user-friendly. However, according to DOH, since December 2015, Washington’s PMP data has been accessible to many Washington providers through one of the most commonly used electronic health record (EHR) systems, rather than a separate system. Despite the convenience this adds for providers and the fact that health systems using this EHR can access the PMP at no cost, beyond the emergency departments described below, only one health system has fully implemented this capability as of October 2017 – nearly two years after it became available. Three additional health systems are actively testing the technology. Beginning November 15, 2017, DOH is required to report annually to the Governor and the Legislature on the number of facilities, entities, and provider groups that have integrated their electronic health records with the PMP.²⁹

When most of the state’s emergency departments linked their electronic system with the PMP in 2015, there was a dramatic increase in PMP utilization, as shown in Table F.³⁰

Only about
30%
of Washington’s
MEDICAL & DENTAL PROVIDERS
who prescribe controlled substances have registered for the
Prescription Monitoring Program

With integration in the emergency department, providers no longer have to sign on to the PMP; instead PMP data is requested automatically when the patient registers in the emergency department. In addition to convenience, this eliminates bias, as providers do not have to make a determination about whether a patient is suspicious. Based on the results demonstrated in emergency departments, other healthcare settings using EHRs that are integrated with the PMP should fully implement this capability to enable their providers to more readily obtain patients’ prescription history before prescribing narcotics with high potential for abuse.

However, even when PMPs and EHRs are not integrated, checking the PMP can be routine. In New York checking the PMP is mandatory and many medical practices have made the checks a regular part of their morning organization as they prepare to see patients, similar to verifying patients’ insurance information. Providers do not have to spend time querying the PMP while they are with a patient. In Washington, providers

PMP Queries

	Emergency Departments	Prescribers in Other Medical Settings
2014	26,546	522,872
2015	2,222,446	958,246
2016	2,722,172	802,104

TABLE F

SOURCE: WASHINGTON STATE DEPARTMENT OF HEALTH

already have the ability to delegate PMP access to other licensed health care providers, such as medical assistants.³¹

The CDC Guideline states that prescribers should review PMP data before prescribing opioids.³² Accordingly, 30 states have enacted laws or regulations requiring prescribers to check the PMP before prescribing opioids and other controlled substances.³³ Kentucky became the first state to put such a requirement into effect in 2012.³⁴ New York's requirement went into effect a year later, and the impact can be seen in Figure G.³⁵ In both states, opioid prescribing decreased after the mandate went into effect and there was no indication that access was impacted for those with legitimate medical needs.³⁶ Moreover, Kentucky and New York have seen dramatic decreases in doctor shopping—at least 50 percent and 90 percent, respectively—since the requirements went into effect.³⁷

ELECTRONIC PRESCRIBING

Another way to reduce the potential for fraud or tampering is to require prescriptions to be transmitted electronically from medical providers to pharmacists. According to DOH's July 2017 *Rx Fraud Alert Report*, from April 2015 to early August 2017, healthcare providers reported 86 incidents of fraudulent opioid prescriptions or stolen pads to the Pharmacy Quality Assurance Commission.³⁸ Additional, unreported

incidents may have also occurred.

Four states—New York, Maine, Minnesota, and North Carolina—have passed e-prescribing laws.³⁹ According to a national review by the Office of the National Coordinator for Health Information Technology, nearly all community pharmacies across the country are enabled to accept e-prescriptions, though a smaller proportion of medical providers prescribe electronically. As of 2014, 72 percent of Washington physicians e-prescribe through an electronic health records system.⁴⁰

In addition to preventing fraud, e-prescribing has additional benefits for patients and medical providers. It reduces the risk of medication errors that can occur when relying on handwritten paper prescriptions. Most e-prescribing systems also automatically check for dangerous drug interactions and allergy concerns.

MEDICINE TAKE-BACK

Prescription opioids can become available for illicit use when they are left over after legitimate medical use. Patients prescribed a one-month supply of opioids following surgery, for example, may find that they only need to take the medication for a few days. The remaining pills are often kept in the house available for other household members, guests, or criminals to misuse. In fact, most misused medication comes from family or friends. More than half of teens say it is easy

Impact of Prescription Monitoring Program Mandate in New York

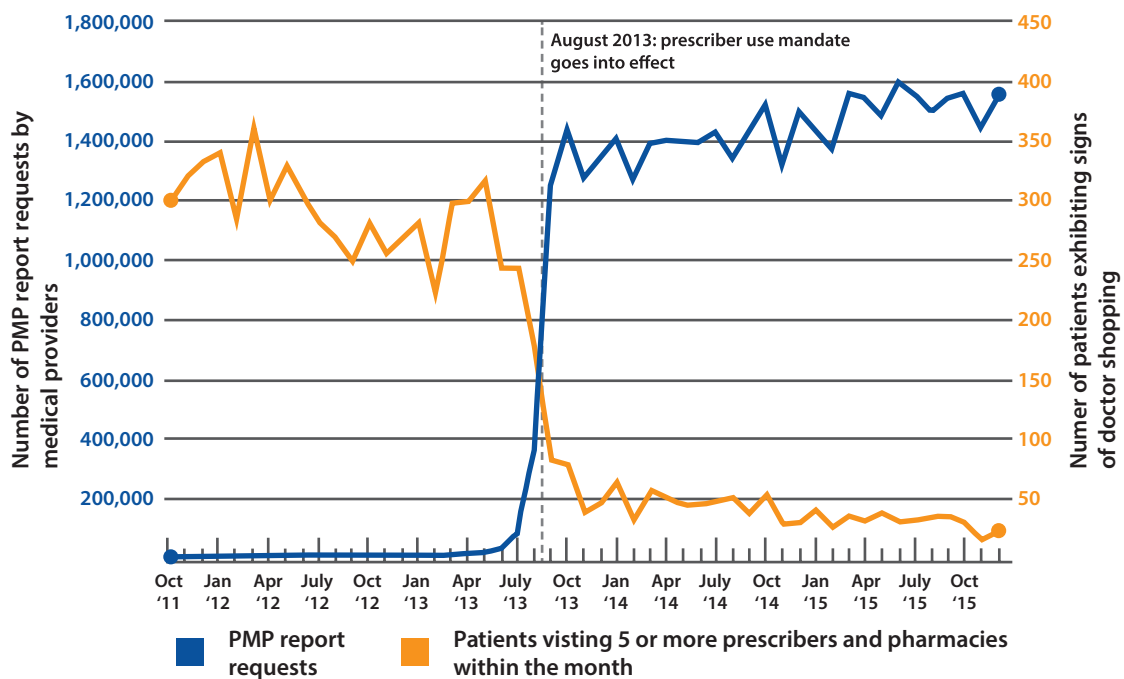


FIGURE G

SOURCE: THE PEW CHARITABLE TRUSTS

Snohomish County Law Enforcement Medicine Collection (pounds)

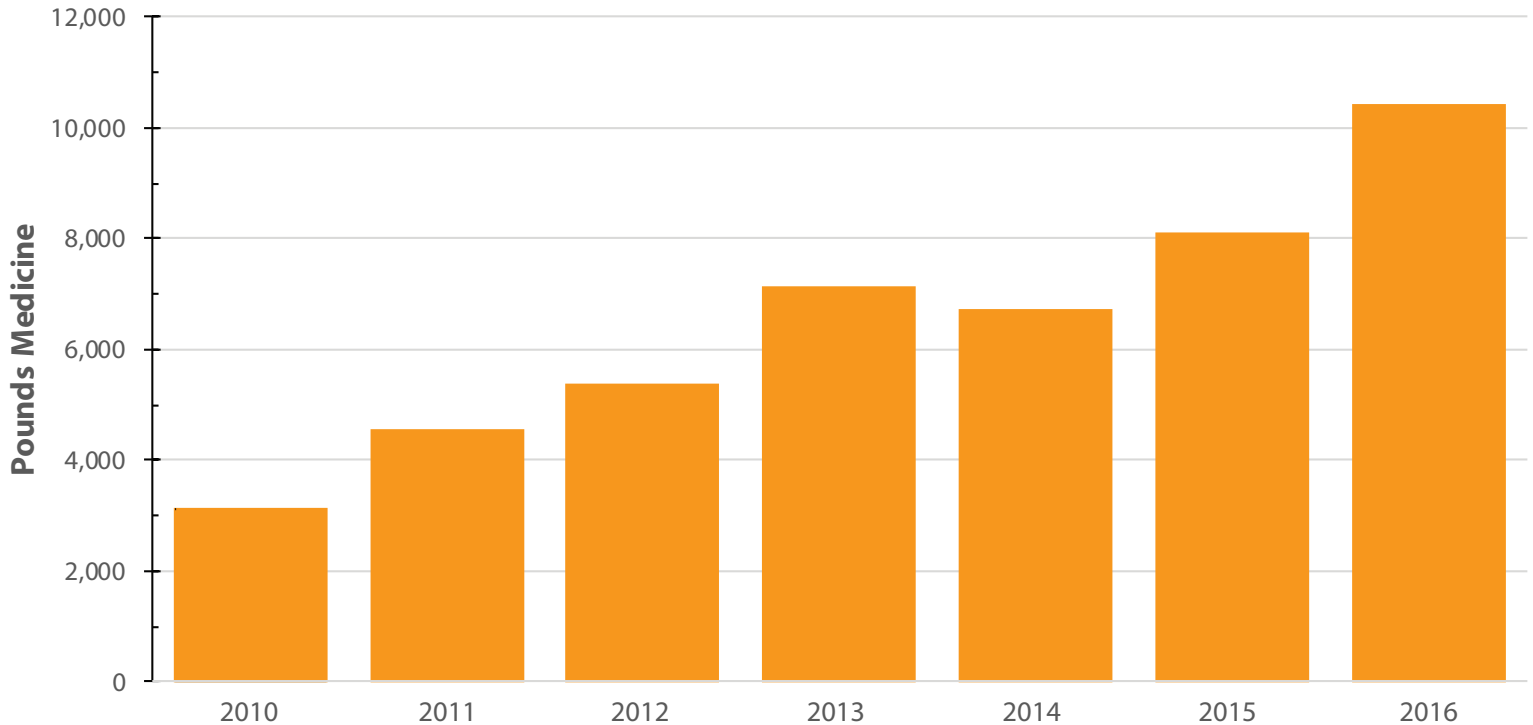


FIGURE H

SOURCE: THE SNOHOMISH COUNTY PARTNERSHIP FOR SECURE MEDICINE DISPOSAL

to get prescription drugs from their parents' medicine cabinets.⁴¹ A study exploring why parents of teens do not secure drugs found that parents did not think that their teens would be interested in their prescription drugs and did not believe that they could be used to get high.⁴² Another recent study found that less than 12 percent of parents with children ages 7 to 17 stored prescription opioids securely.⁴³ These conclusions support the need for additional education (see above), and safe medicine disposal options.

It can be difficult to determine how to properly dispose of prescription opioids. Throwing medication in the trash is not a secure option and flushing can be harmful to the environment and water system, as pharmaceuticals are not treated by septic or wastewater systems. Mixing medicines with undesirable substances, such as kitty litter or coffee grounds, before disposal does not meet DEA's standard, as it does not render the medicine unusable.⁴⁴

Since passing a pharmaceutical stewardship ordinance, the number of secure medicine drop boxes in

KING COUNTY

has increased from

10 to 99

with **80%**

now located at pharmacies.

Accordingly, drug take-back systems are the first choice for disposal per FDA, DEA, and EPA. Currently, the DEA coordinates two national drug take-back events each year, where people can bring their unused medications to a centralized site. According to DEA, from fall 2010 to spring 2017, more than 175,000 pounds of medicine were collected at these events in Washington. A study of medication returned to take-back events in six states from 2011 to 2015 found more than 60 percent of the opioids originally dispensed were unused.⁴⁵

Local law enforcement or pharmacies may also organize or operate other discrete or ongoing take back efforts. As shown in Figure H, the Snohomish County Partnership for Secure Medicine Disposal collected more than

45,000 pounds of medicine in seven years at drop boxes at police stations and sheriffs' offices with limited promotion of the program. However, drop boxes are not available in all communities. Walgreens, for example, has drop boxes at 10 out of 135 stores in Washington.⁴⁶ Though DEA issued a final rule in 2014 that permits retail pharmacies to maintain collection receptacles, it does not require them to do so, nor does it provide funding.⁴⁷ Funding is often an obstacle to expanding programs.

In an effort to make take-back programs more sustainable and convenient, some Washington counties have adopted pharmaceutical stewardship ordinances, including King, Snohomish, Kitsap, and Pierce Counties. These laws require drug manufacturers to provide secure medicine return systems, including a minimum number of secure drop boxes in each city or town, prepaid mailers for those who are homebound, and public education to promote the program. Alameda County, California passed the first pharmaceutical stewardship law in the country in 2012.⁴⁸ Three pharmaceutical associations filed a federal lawsuit against Alameda County to block the ordinance on the grounds that it interferes with interstate commerce. In 2013 and 2014, the U.S. Northern California District Court and the U.S. Ninth Circuit Court of Appeals rejected the industry's claims.⁴⁹ In 2015, the U.S. Supreme Court declined to review the Ninth Circuit ruling. King County faced a similar federal lawsuit; however, no hearings were held and the pharmaceutical associations ended this lawsuit after the Supreme Court declined Alameda County's petition.⁵⁰

There is an effort to create a statewide secure, convenient medicine take-back system modeled after the county programs. In the 2017 legislative session, Substitute House Bill 1047 passed the House Health Care and Wellness and the Appropriations Committees, but the bill did not receive a floor vote. The estimated cost to drug manufacturers is expected to be 0.1 percent of annual medicine sales. For example, in King County, annual medicine sales likely exceed \$1.8 billion and program cost estimates—from the county and industry—range from approximately \$1 million to \$2 million annually.⁵¹

In locations where stewardship programs are not available and take-back options are not within easy driving distance, drug deactivation and disposal pouches may be helpful.⁵² In 2017, Pennsylvania's Office

of the Attorney General began an initiative to offer 300,000 drug deactivation and disposal pouches to patients receiving a schedule II narcotic at participating pharmacies.⁵³ This initiative is funded by fines assessed for driving under the influence and drug offenses. Similarly, the Kentucky Office of the Attorney General recently began a pilot program to provide 50,000 drug deactivation pouches through the sheriffs' offices in four counties, as well as at local community centers and churches. This program is funded jointly by settlement funds and a nonprofit organization.⁵⁴ The effectiveness of these programs is not yet known.

MEDICAID FRAUD CONTROL

Designating investigators in the Attorney General's Medicaid Fraud Control Unit (MFCU) as limited authority peace officers will provide additional tools to crack down on opioid-related illicit activity. When providers and pharmacies in Washington's Medicaid program facilitate illicit use of prescription opioids, MFCU can conduct civil and criminal investigations and prosecutions. Law enforcement officers are instrumental in bringing cases of opioid-related illicit activity to the attention of the MFCU. For example, in one case, police officers, executing a routine stop for a traffic violation, noticed several pill bottles and blank prescription pads in the vehicle. They contacted the Pharmacy Board and Attorney General's Office. The ensuing investigation revealed that a pharmacy technician used his access to the pharmacy's computer systems to determine people's insurance benefits. Unbeknownst to these individuals, the perpetrator wrote and filled prescriptions in their names, obtaining access to opioids with a high street value paid for by the government.

In addition to identifying suspected illicit activity, Washington's MFCU also relies heavily on law enforcement to carry out key investigative tasks, as our state's MFCU investigators are not limited authority peace officers. This means that under Washington law, MFCU investigators cannot independently perform certain job functions, including issuing search warrants and making arrests. According to the National Association of Medicaid Fraud Control Units, the vast majority of MFCUs across the country have the authority to perform these duties. If investigators in Washington's Medicaid Fraud Control Unit were appointed as limited authority peace officers, their jurisdiction would be exclusively limited to Medicaid fraud investigations, as enumerated in 32 USC 1396(q).



Goal:

DISRUPT AND DISMANTLE DRUG TRAFFICKING ORGANIZATIONS RESPONSIBLE FOR BRINGING NARCOTICS INTO OUR STATE



Seizure by Grant County Taskforce - Oct. 2017

RECOMMENDATION:

- Restore resources for multi-jurisdictional drug-gang task forces.

As trafficking in heroin, fentanyl and other narcotics is on the rise in our state, Washington's multi-jurisdictional drug-gang task forces are well positioned to reduce the supply of drugs in communities by targeting mid- to upper-level drug traffickers. Drug trafficking organizations (DTOs) are often involved with other criminal enterprises as well, including human trafficking. Unfortunately, dramatic reductions in state and federal support for these efforts have reduced their presence at a time when the task forces are of critical need.

According to the Washington State Department of Commerce, the Edward Byrne Memorial Justice Assistance Grant (JAG) funded task forces disrupted or dismantled more than 150 DTOs with five or more members in 2014. This means that members were arrested on felony charges at the state or federal level. In 2016, the number of DTOs the task forces disrupted or dismantled dropped to 129.

Washington's drug task forces are primarily funded by the JAG program, the leading source of federal justice funding to state and local jurisdictions. JAG funding for Washington's drug-gang task forces averaged approximately \$5.5 million annually from 1990 to 2004. Subsequently, federal funding has significantly declined, averaging \$3.2 million per year. The State has also historically provided funding for the drug-gang task forces. From 2006 to 2010, state general funds for the task forces averaged approximately

Task Force Responsible for Largest Drug Seizure in Grant County's History

Acting on information the Moses Lake Police Department uncovered during a traffic stop, an investigation by Grant County's Interagency Narcotics Enforcement Team (INET) led to seven warrants served on homes and storage units throughout the county. In October 2017, seven pounds of heroin, 25 pounds of methamphetamine, and 40 pounds of marijuana—a total street value of \$1.2 million—were taken off the streets. To put this in perspective, seven pounds of heroin can supply more than 31,000 doses. INET also recovered nine guns, including two that were stolen, and ballistic body armor. INET members include detectives from the Grant County Sheriff's Office, Moses Lake Police Department, Ephrata Police Department, and WSP.

State Funding for Washington's Drug-Gang Task Forces

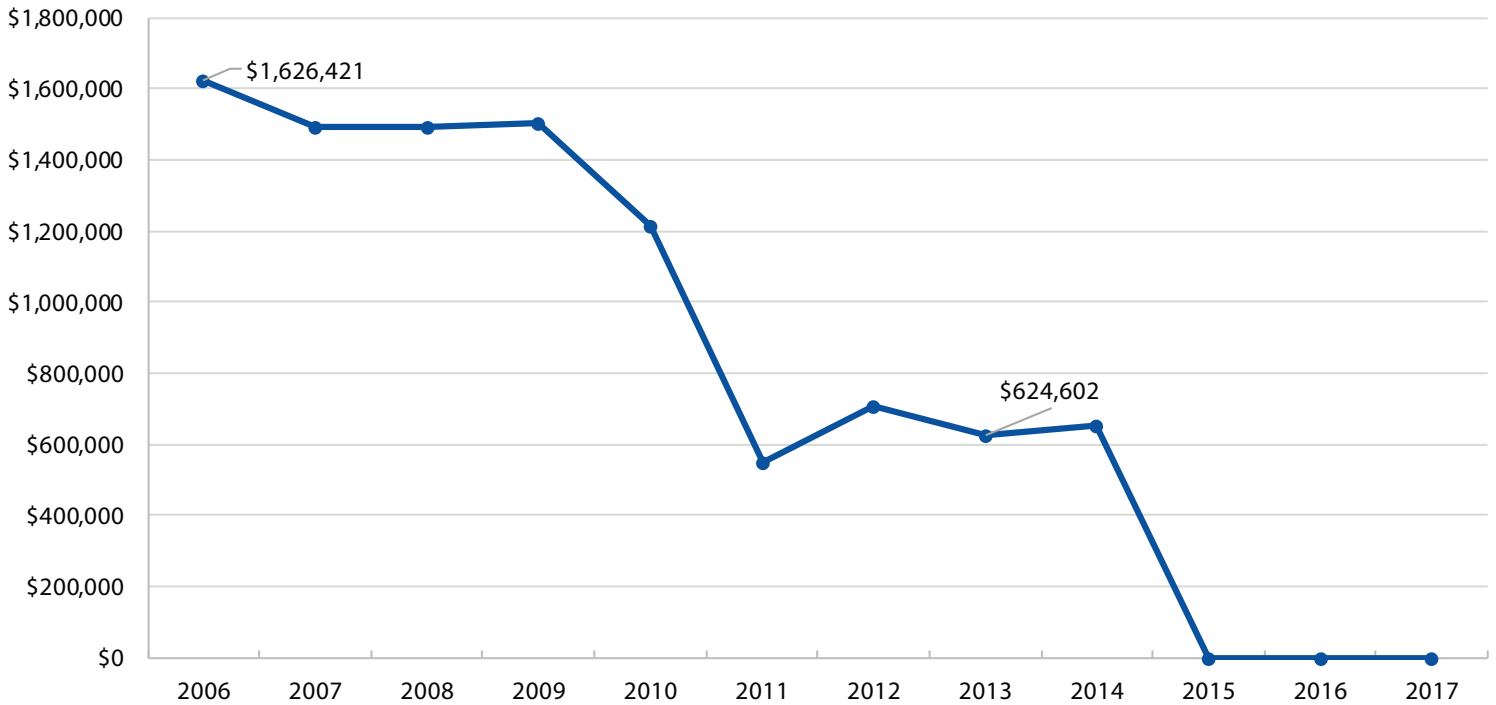


FIGURE I

SOURCE: WASHINGTON STATE DEPARTMENT OF COMMERCE

\$1.5 million annually. From 2011 to 2014, funding was cut by more than half to approximately \$634,000 per year, on average. Since 2015, the drug-gang task forces have received no state funding at all, as shown in Figure I. At the height, Washington had twenty JAG-funded task forces. Today, there are seventeen task forces. The decrease in funding has forced several task forces to disband, while others have limited the number of cases they pursue, as law enforcement agencies are faced with the choice of participation or fewer patrols in the communities the agencies are expected to protect. Funding moderates the impact on local law enforcement agencies, making it more feasible for them to assign a full-time detective to their local task force. Funding also allows for dedicated prosecutorial support, administrative support staff, and infrastructure, which sustain the operations and enhance the effectiveness of the task forces.

For decades, Washington's JAG-funded drug-gang task forces have leveraged the resources, personnel, and equipment of multiple law enforcement agencies and prosecutors' offices. Throughout most of Washington, these task forces provide the only investigative efforts dedicated to dismantling mid- to upper-level drug trafficking organizations, which are responsible for the vast majority of narcotics entering our state and are a major contributor to the opioid epidemic. The task forces play a particularly outsize role in less populated jurisdictions, where they also pursue more complex murder and human trafficking cases.

The task forces, predominantly led by county sheriffs' offices, include detectives from the sheriffs' offices and local police, who typically serve on the task forces for three to five year rotations. They often also include WSP detectives and detective sergeants, DEA agents, and prosecutors. Local law enforcement agencies

Grays Harbor Task Force Disrupts Vegas Pill Operation

A 2016 investigation by the Grays Harbor County Task Force, the smallest JAG-funded task force, disrupted a drug trafficking organization that was bringing prescription opioids into the county from Las Vegas. The suppliers worked out of a hotel in Aberdeen (a community of about 16,000 people), where approximately 30 people per day purchased pills in quantities ranging from 5 to 100. This investigation resulted in several successful prosecutions and the intelligence gained continues to inform the task force's work. The Grays Harbor County Task Force includes detectives from the Sheriff's Office, Aberdeen and Hoquiam Police Departments, along with a part-time prosecutor.

Federal JAG Funding for Washington's Drug-Gang Task Forces

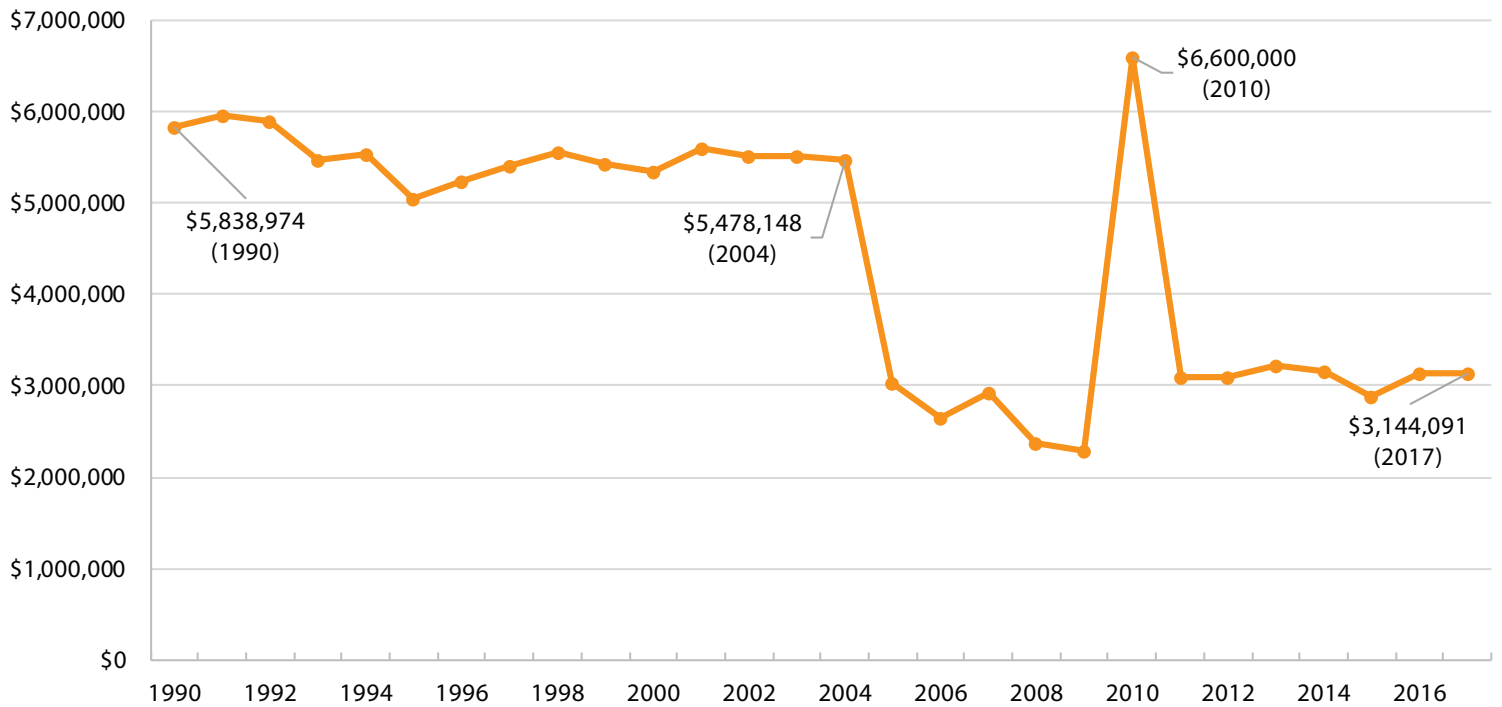


FIGURE J SOURCE: WASHINGTON STATE DEPARTMENT OF COMMERCE

NOTES: PRIOR TO 2005, FEDERAL FUNDS WERE PROVIDED BY THE EDWARD BYRNE MEMORIAL STATE AND LOCAL LAW ENFORCEMENT ASSISTANCE PROGRAM. 2009 DOES NOT INCLUDE ADDITIONAL FEDERAL FUNDING TO THE TASK FORCES PROVIDED BY THE AMERICAN RECOVERY AND REINVESTMENT ACT.

benefit from the skills that their officers develop while part of the task force, including specialized drug investigation training, best practices for conducting undercover operations, working with confidential informants, and engaging in deconfliction. When resource constraints limit local law enforcement agencies' ability to participate in the task forces, another consequence is that their jurisdictions are deprived of the specialized skills officers gain from the training and collaboration. WSP participation is also critical, as it can create stability and bring institutional knowledge. Currently, due to resource constraints, WSP participates in twelve of the task forces with a supervisory sergeant serving on only four task forces. Seventy percent of the funding for the WSP positions comes from the state's general fund.

The work of the task forces is subject to oversight by a number of entities. In Washington State, the Department of Commerce administers JAG awards and receives recommendations from the JAG Advisory Committee, comprised of criminal justice and victim advocacy professionals. Each JAG-funded task force is governed by an oversight board and subject to periodic audits and a peer review system to assess effectiveness.



GOAL:

5 PREVENT FURTHER INCREASES IN OVERDOSE DEATHS FROM FENTANYL

RECOMMENDATION:

- Adopt enhanced criminal penalties for trafficking of fentanyl and fentanyl analogues.

Fentanyl, a synthetic opioid, can be deadly even in small doses and is responsible for an increasing number of overdose deaths in our state.⁵⁵ A low-grade batch of heroin can be adulterated with fentanyl and sold as more potent to increase profits. There is no evidence that this is a common occurrence in Washington, as DOH has found that the majority of our state's fentanyl-related overdose deaths in 2016 did not involve heroin.⁵⁶ In contrast, according to the University of Washington's Alcohol and Drug Abuse Institute, WSP officers and medical providers in the Seattle area have reported that people have purchased fentanyl that was made to look like a prescription pill.⁵⁷ In such cases, buyers do not know how much fentanyl is in a drug and often do not know that the drug contains fentanyl at all. This can result in an overdose when they use the same amount they normally would.

Some states have sought to combat fentanyl by enhancing criminal penalties associated with distributing the drug. For example, in 2016, Massachusetts' Attorney General authored legislation to create the crime of trafficking in fentanyl for amounts greater than ten grams.⁵⁸ Those convicted of this crime now face up to twenty years in state prison. Previously, drug traffickers could only be charged with the lesser crimes of manufacturing, distributing or possessing fentanyl, regardless of the quantity of the drug. Similarly, in 2017, legislation requested by Rhode Island's Attorney General raised the penalties for possessing up to one kilogram of a mixture or substance containing fentanyl to up to fifty years in prison and \$500,000 in fines.⁵⁹

In Washington, those convicted of possessing up to two kilograms of a Schedule I or II narcotic, such as fentanyl, face up to ten years in prison, as well as fines up to \$25,000.⁶⁰ Washington law current identifies aggravating circumstances that can support a sentence above the standard range, including major violations of the Uniform



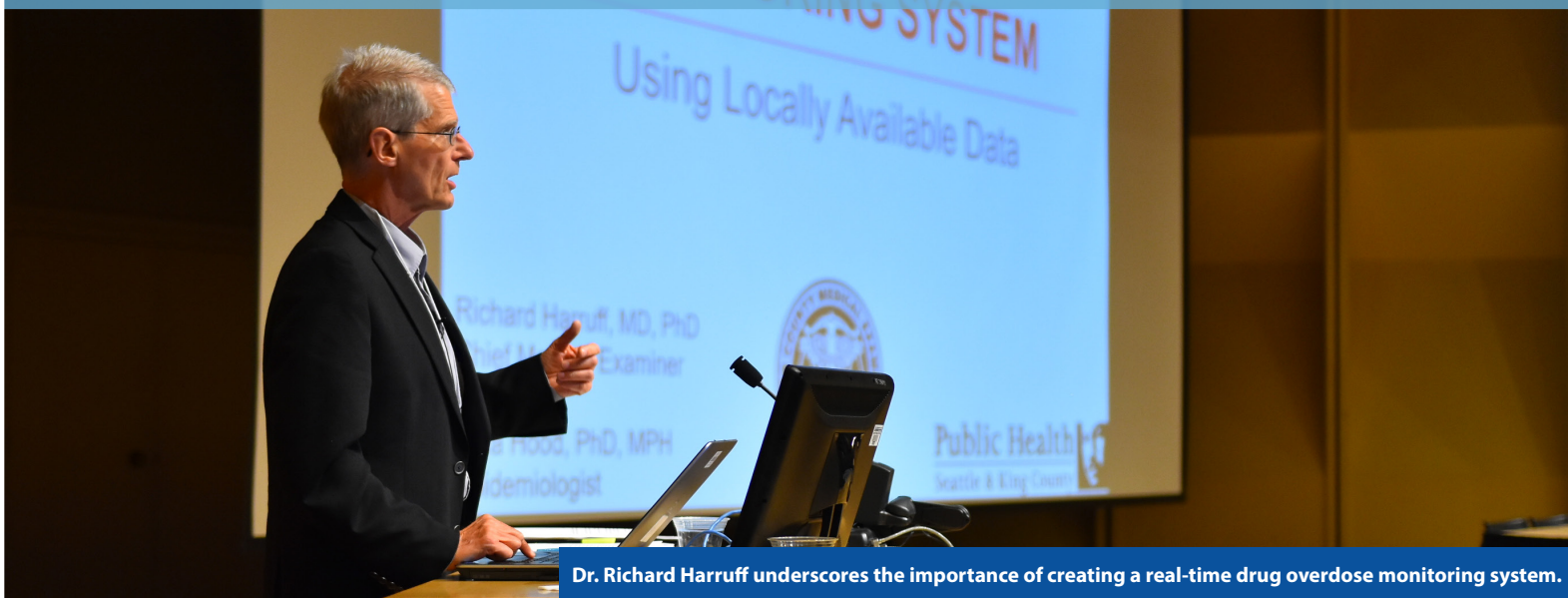
Controlled Substances Act related to trafficking in controlled substances.⁶¹ The lethality of fentanyl and fentanyl analogues warrants giving Washington prosecutors the option of an enhanced penalty when those substances are involved. This can be accomplished by adding a provision to RCW 9.94A.535(3) (e) identifying trafficking fentanyl or fentanyl analogues as an aggravating circumstance that can support a sentence above the standard range. Such a provision may prevent Washington from experiencing the explosion of fentanyl deaths experienced by states in other parts of the country.

Amount of fentanyl that can be deadly



GOAL:

6 IMPROVE OVERDOSE REPORTING AND INFORMATION SHARING



Dr. Richard Harruff underscores the importance of creating a real-time drug overdose monitoring system.

RECOMMENDATIONS:

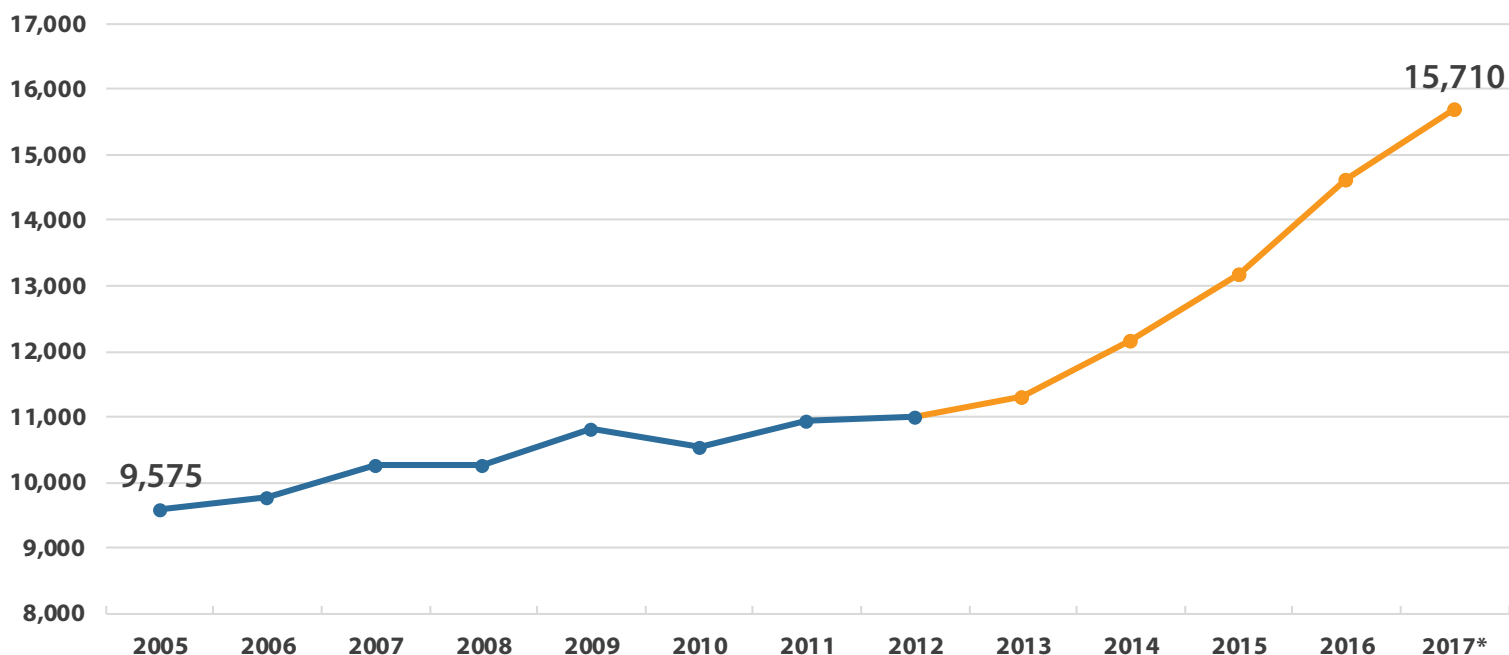
- Direct resources towards more timely analysis of samples at the Washington State Toxicology Laboratory.
- Require emergency medical service providers to report patient care information, including treatment of overdoses.
- Require law enforcement officers to report naloxone administrations.

Access to real-time overdose data can enhance the public health and public safety response to emergent threats and support more targeted intervention efforts. For example, if there is a significant increase in overdoses in a particular geographic area, officials can alert the public and first responders. With rapid analysis of drug evidence collected from overdoses, such alerts could specify that potent variants have been found in the community (e.g., heroin laced with fentanyl, or counterfeit pills). Real-time data can illuminate the magnitude of the problem in a particular area. For example, for one week, hospitals, police, and emergency medical service providers in Snohomish County reported real-time overdose information.⁶² This revealed that there were 37 overdoses, including three deaths in that brief period. Furthermore, many of the overdoses occurred in a single day, which could be due to the source of the drugs. Twenty-four people received the overdose antidote naloxone. In two-thirds of these cases, naloxone was administered by family or friends of the victim, demonstrating its penetration in the community.

Some states have data clearinghouses to collect and disseminate information to inform enforcement, treatment, and prevention responses to the opioid epidemic. For example, New Jersey's Drug Monitoring Initiative (DMI) expedites the chemical analysis of any drug evidence gathered whenever heroin is suspected in an overdose. According to New Jersey's Regional Operational Intelligence Center, results are quickly returned to the law enforcement agencies investigating the cases—within a day of submission to the lab, rather than the two months it took prior to initiative. The forensic data is analyzed in relation to other information on overdoses, including toxicology examinations, drug-related hospitalizations, naloxone deployments, PMP data, as well as crime data, such as shootings and gun recoveries. This provides a comprehensive picture of how drugs are being distributed and seized throughout the region and the impact on public health outcomes.

WSP Toxicology Lab

Number of case submissions per year



*2017 projected based on actual January-June 2017 submissions.

FIGURE K

SOURCE: WASHINGTON STATE TOXICOLOGY LABORATORY

In Washington, there are some efforts to improve the reporting of overdose-related data, but no centralized statewide system. The Washington State Toxicology Laboratory, housed within WSP, has had a significant increase in the number cases submitted for testing in recent years. As shown in Figure K, the number of total cases—primarily death investigations and impaired driving cases—has increased by more than 4,000 since 2013, approximately 1,000 cases each year. The Toxicology Lab’s increased caseload has not been accompanied by additional staffing, resulting in a backlog of untested samples. According to toxicology lab officials, it currently takes about four to five weeks to complete analyses. The State recently received one-time grant funding from CDC, which will be used to prioritize a portion of overdose cases for rapid analysis. This effort may demonstrate how quicker processing of overdose cases can help the state recognize and respond to emerging threats.

In contrast, the State is now receiving real-time information about overdoses when emergency departments are involved. Legislation effective July 2017 requires hospital emergency departments to provide automated, electronic patient care information to DOH.⁶³ Though this new mandate will provide vital information

and enhance response to public health threats, it does not capture overdoses not treated in the emergency department. Emergency medical service providers and law enforcement are not required to report when they respond to an overdose. Currently, there is erratic voluntary participation in Washington’s electronic data repository for patient care information provided by emergency medical services. However, DOH recently received a CDC grant to enhance overdose surveillance; these funds will be used, in part, to build the capacity of emergency medical service providers to report these data, including care provided to people who have overdosed. DOH will also use the grant funds to improve dissemination of both emergency medical service and emergency department data to key stakeholders working to prevent and respond to opioid overdoses. In contrast, the State does not have an electronic system for law enforcement officers to report when they respond to an overdose. The Overdose Detection Mapping Application Program (ODMAP), a mobile application that allows first responders to report their response to an overdose in real-time, is a tool that can facilitate this type of data reporting. Further, the program allows public safety and health officials to view reported overdoses on a map and receive alerts when a spike occurs in a defined geographic area.

Clallam County Community Opioid Report Card - 2016

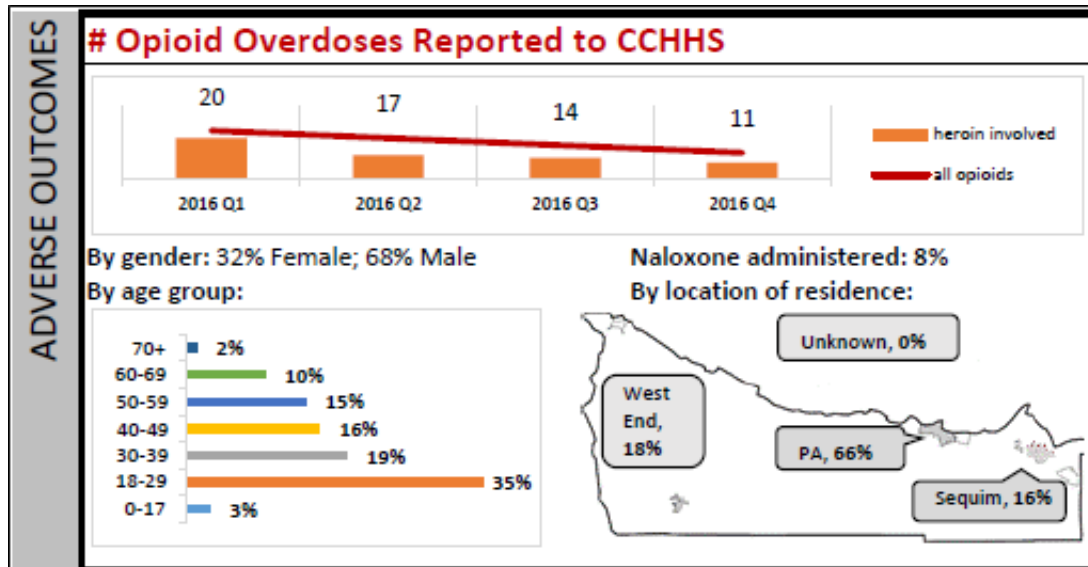


FIGURE L

SOURCE: CLALLAM COUNTY HEALTH AND HUMAN SERVICES

Several counties in Washington took actions to improve overdose reporting prior to the statewide emergency department mandate, illustrating how the response to the epidemic can be enhanced when data are collected. In 2016, Clallam County became the first county in Washington to mandate reporting of overdoses, both fatal and nonfatal.⁶⁴

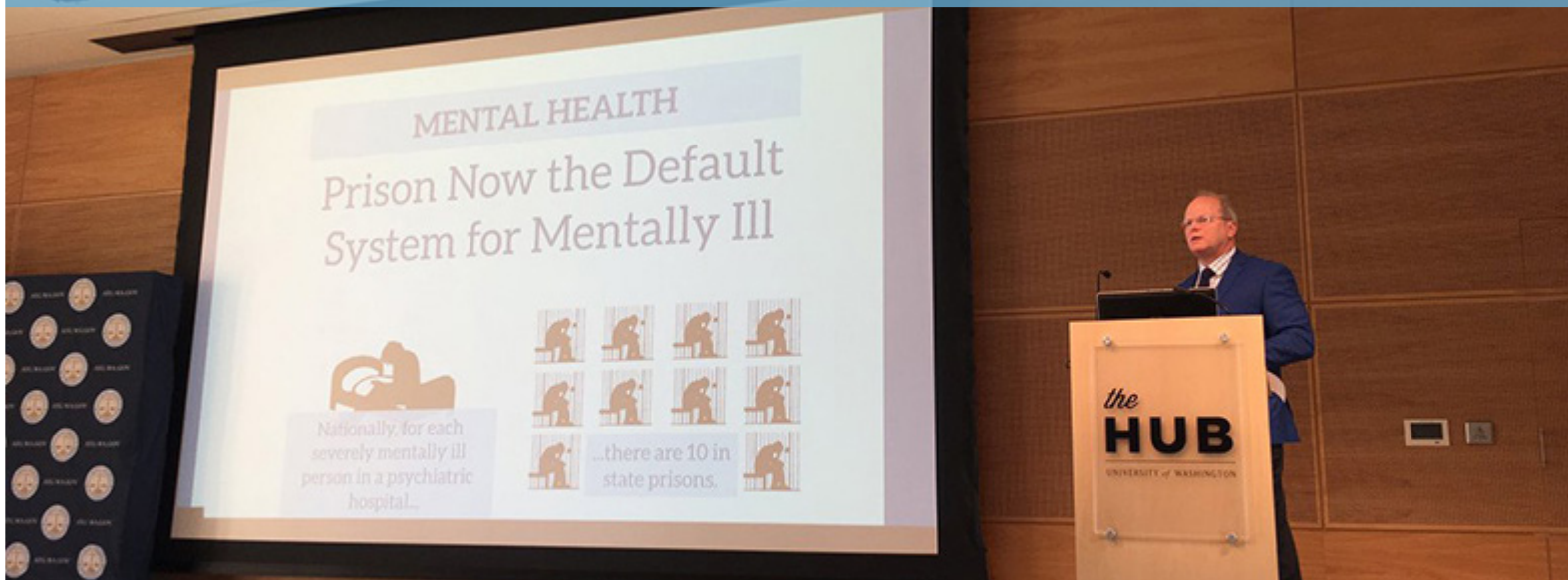
Emergency departments in the County provide near real-time overdose reporting to the public health department. This allows the public health department to follow-up with the person who overdosed to offer timely treatment and to notify the medical provider who prescribed the opioids to inform their prescribing practices. The reporting also allows the public health department to perform analyses and issue community opioid report cards to monitor progress, as shown in Figure L.

While Washington is working to improve the timeliness and comprehensiveness of data reporting, our state lacks a centralized clearinghouse for all overdose-related data to enable a more effective, unified public safety and public health response to emergent threats. In addition, as more data are collected, resources will also need to be devoted to ensure timely analysis, dissemination, and response.



GOAL:

7 EXPAND ACCESS TO TREATMENT



King County Prosecuting Attorney Dan Satterberg remarks on the changing role of a prosecutor's office in responding to the opioid epidemic.

RECOMMENDATION:

- Support and expand statewide and local non-traditional law enforcement approaches, such as drug courts, Law Enforcement Assisted Diversion, and embedded social workers.

Opioid addiction is a disease requiring treatment. In Washington, there is an urgent need for increased availability of treatment. The shortage includes services for those who are entering and leaving the criminal justice system, and aftercare services, such as connecting those in recovery to housing and employment. According to a 2016 report by the U.S. Surgeon General, nationally just ten percent of Americans facing drug addiction obtain treatment, in part due to limited availability and affordability of services.⁶⁵

The court system plays a role in treatment. Through the Administrative Office of the Courts (AOC) and DSHS's Division of Behavioral Health and Recovery, Washington operates a number of therapeutic courts, providing an alternative to the traditional criminal justice system for sentencing and supervision. Several types of these courts can involve people struggling with opioid addiction, including adult drug courts, juvenile drug courts, and family treatment courts. The principle behind these courts is that treating participants' underlying substance abuse disorder can lower recidivism. Each therapeutic court is unique in how it operates. Generally, non-violent offenders arrested for felony drug possession and addiction-driven property crime are eligible for supervised substance abuse treatment. If participants complete treatment, their charges can be dismissed or their sentences reduced. A study of Washington's drug courts found that participants were three times more likely to enter treatment within 90 days and four times more likely to be in treatment for at least 90 days, compared to a group of adults charged with similar felonies, who demonstrated a need for substance abuse treatment and were otherwise considered "statistically identical" to the drug court participants.⁶⁶

In part due to treatment costs, drug courts cost more to operate than traditional courts; however, a Washington State Institute for Public Policy's 2017 benefit-cost analysis found that overall, drug courts produce benefits of

\$9,002 per participant after accounting for the costs of the program.⁶⁷ To cover the costs to operate therapeutic courts, the State Legislature authorized jurisdictions to adopt an additional 0.1% sales tax.⁶⁸ According to AOC, 20 counties, as well as the City of Tacoma, have adopted this tax. The federal government has also recognized the value of these courts. The Substance Abuse and Mental Health Services Administration recently awarded a \$2.2 million grant to the Pierce County Family Recovery Court, which will enable it double the number of families it serves.

Law enforcement agencies and first responders also play a role in connecting people to treatment. For example, a King County program known as Law Enforcement Assisted Diversion (LEAD) has been operating for six years. LEAD diverts those arrested for low-level, nonviolent offenses (e.g., drug possession, minor property crime related to addiction, prostitution, etc.) into treatment and support services, rather than the criminal justice system. Under the program protocols, police officers have the discretion to refer a person to the program, rather than sending them to jail. They can also refer people known to them, but not necessarily involved in a potential crime at the time of the referral. In arrest diversion cases, prosecutors agree not to file charges if the participant completes an initial screening and intake assessment within thirty days. Participants engaged in services work with case workers to develop a plan to address issues that coincide with their addiction, such as medical needs, housing, and mental health treatment. According to the King County Prosecuting Attorney's Office, 439 individuals have participated in the LEAD program since October 2011. Research has found that the program costs \$2,100 less per year than housing a person in jail.⁶⁹ Program participants are 60 percent less likely to be re-arrested⁷⁰ and 87 percent less likely to go to prison than those who become involved in the traditional criminal justice system.⁷¹

Another local effort to connect people who come into contact with the criminal justice system with treatment and other resources began in Everett in 2015. The Everett Police Department and the Snohomish County Department of Human Services have partnered to hire embedded social workers, who accompany the Everett Police Community Outreach and Enforcement Team in the community. The purpose is to connect people on the streets—those facing chronic homelessness and mental illness—to treatment providers, housing, and

other resources. Many of these individuals also struggle with opioid addiction. According to the City of Everett's Police Department, from June 2016 to July 2017, the Community Outreach and Enforcement Team contacted 559 individuals on the street, nearly half with mental health and chemical dependency issues. Seventy-nine individuals were connected to treatment. The limited availability of treatment has presented a barrier to connecting even more people to treatment.

Finally, though another effort in King County does not expressly connect people to treatment, it does keep them out of jail for certain drug offenses. According to the King County Prosecuting Attorney's Office, drug possession cases have been treated as misdemeanors since 2008. Non-violent offenders, who meet certain criteria, including possessing seven grams or less of a controlled substance and showing no signs of dealing, are eligible to have their charges reduced to misdemeanors. Prosecuting attorneys in other counties have discretion to do the same.

NOTES

- ¹ Washington State Department of Health. (2017). *Opioid-related Deaths in Washington State, 2006-2016*. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/Pubs/346-083-SummaryOpioidOverdoseData.pdf>.
- ² According to the Washington Tracking Network, in 2015, for example, there were 1,145 drug overdose deaths, 718 of which involved an opioid. See: <https://fortress.wa.gov/doh/wtn/WTNPortal/>. The portion of Washington's overdose deaths that involve an opioid is consistent with the national average, as noted in Rudd, RA; Seth, P; David, F; Scholl, L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *Morbidity and Mortality Weekly Report*, 65:1445–1452. DOI: <http://dx.doi.org/10.15585/mmwr.mm655051e1>.
- ³ Ko, JY; Patrick, SW; Tong, VT; Patel, R; Lind, JN; Barfield, WD. (2016). Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. *Morbidity and Mortality Weekly Report*, 65:799–802. DOI: <http://dx.doi.org/10.15585/mmwr.mm6531a2>.
- ⁴ National Institute on Drug Abuse. (2015). *Prescription Opioids and Heroin*. Retrieved from <https://www.drugabuse.gov/publications/research-reports/prescription-opioids-heroin>.
- ⁵ Centers for Disease Control and Prevention. (2016). *Synthetic Opioid Data*. Retrieved from <https://www.cdc.gov/drugoverdose/data/fentanyl.html>.
- ⁶ Ndiaye, M (2017). *Fentanyl Overdose Deaths in Washington State*. Washington State Department of Health. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/1600/DOHFentanylReport2017Final.pdf>.
- ⁷ Partnership for Drug-Free Kids (formerly known as The Partnership at DrugFree.org). (2013). 2012 Partnership Attitude Tracking Study. Retrieved from: <https://drugfree.org/wp-content/uploads/2013/04/PATS-2012-FULL-REPORT2.pdf>.
- ⁸ 2016 Washington State Healthy Youth Survey. *Data Brief: Prescription Drugs and Opiates*. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/8350/160-NonDOH-DB-Opiates.pdf>.
- ⁹ Miech, R; Johnston, L; O'Malley, P; Keyes, K; Heard, K. (2015). Prescription Opioids in Adolescence and Future Opioid Misuse. *Pediatrics*, 136 (5) e1169-e1177.
- ¹⁰ Ibid.
- ¹¹ Kaiser Family Foundation Health Tracking Poll (conducted November 15-21, 2016).
- ¹² Maine, Minnesota, and Nebraska have adopted the *Dose of Reality* campaign.
- ¹³ National Prescription Drug Take Back Day Collection Results can be found online: https://www.deadiversion.usdoj.gov/drug_disposal/takeback/.
- ¹⁴ Dowell, D; Haegerich, TM; Chou, R. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *Morbidity and Mortality Weekly Report*;65 :1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>;
- Edlund, MJ; Martin, BC; Russo, JE; DeVries, A; Braden, JB; Sullivan, MD. (2014). The role of opioid prescription in incident opioid abuse and dependence among individuals with chronic noncancer pain: the role of opioid prescription. *Clinical Journal of Pain*, 30:557–64;

Zedler, B; Xie, L; Wang, L; et al. (2014). Risk factors for serious prescription opioid-related toxicity or overdose among Veterans Health Administration patients. *Pain Medicine*, 15:1911–29. DOI: <https://doi.org/10.1111/pme.12480>;

King, N. B., Fraser, V., Boikos, C., Richardson, R., & Harper, S. (2014). Determinants of Increased Opioid-Related Mortality in the United States and Canada, 1990–2013: A Systematic Review. *American Journal of Public Health*, 104, e32–e42, DOI: <http://doi.org/10.2105/AJPH.2014.301966>;

Bohnert, AS; Valenstein, M; Bair MJ, et al. (2011). Association between opioid prescribing patterns and opioid overdose-related deaths. *Journal of the American Medical Association*, 305:1315–21. DOI: <http://dx.doi.org/10.1001/jama.2011.370>;

CDC. (2011). Vital signs: overdoses of prescription opioid pain relievers— United States, 1999–2008. *Morbidity and Mortality Weekly Report*;60:1487–92.

¹⁵ DeRoss, S. (2016). Dentistry and the Opioid Epidemic. *Medscape*. Retrieved from <https://www.medscape.com/viewarticle/867751>;

Gordon, E. (2017). Dentists Work to Ease Patients’ Pain with Fewer Opioids. *NPR*. Retrieved from <http://www.npr.org/sections/health-shots/2017/02/26/513865623/dentists-work-to-ease-patients-pain-with-fewer-opioids>;

Moore, P.; Raymond, D.; Cooper, S.; Hersh, E. (2016). Why do we prescribe Vicodin? *Journal of the American Dental Association*, 7, 530-533. DOI: <http://dx.doi.org/10.1016/j.adaj.2016.05.005>.

¹⁶ Washington State Agency Medical Directors’ Group. (2015). *Interagency Guideline on Prescribing Opioids for Pain*. Retrieved from <http://www.agencymeddirectors.wa.gov/guidelines.asp>.

¹⁷ Shah, A; Hayes, CJ; Martin, BC. (2017). Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. *Morbidity and Mortality Weekly Report*, 66:265–269. DOI: <http://dx.doi.org/10.15585/mmwr.mm6610a1>.

¹⁸ Supra note 14, see Dowell et al. (2016).

¹⁹ As of October 2017, the following states have established statutory limitations on opioid prescriptions Connecticut, Indiana, Kentucky, Louisiana, Maine, Massachusetts, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, and Vermont. Delaware and New Hampshire have established limitations through agency rules. New Hampshire’s rule only applies to prescriptions provided by emergency departments, urgent care centers, and walk-in clinics.

²⁰ North Carolina’s five-day limit on opioid prescriptions does not apply to surgical procedures, for which there is a seven-day limit. Kentucky’s three-day limit on opioid prescriptions does not apply to major surgery or trauma.

²¹ Ohio’s form to obtain written informed consent to prescribe an opioid to a minor is available at: <http://ohioaap.org/wp-content/uploads/2014/08/Start-Talking-Model-Consent-Form-Med-Bd-August-2014.pdf>. Pennsylvania’s form to obtain written informed consent to prescribe an opioid to a minor is available at: <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/Act%20125-Consent%20to%20Prescribe%20Opioid%20Medication%20to%20Minor%2020170123.pdf>. Kentucky requires medical professionals to obtain written informed consent from all patients before issuing opioid prescriptions, but does not have standardized form. Delaware also does not have a standardized form, but provides a sample for medical professionals to obtain informed consent from patients before they receive subsequent opioid prescriptions beyond the initial prescription: <http://delaware.mystatedmed.org/DELAWARE/assets/files/opioid%20consent%20form.docx>.

²² Washington State Health Care Authority. *Opioid Clinical Policy—Medicaid*. Retrieved from <https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf>. These limits do not apply to the treatment of cancer, palliative care, hospice and end-of-life care. The number of dosages outlined in the policy is about a three-day supply for patients younger than 21 years of age, and a seven-day supply for patients 21 years of age and older, as noted in <https://www.hca.wa.gov/about-hca/hca-implement-opioid-clinical-policy-apple-health-medicaid-nov-1>.

²³ Engrossed Substitute House Bill 1427. Chapter 297, Laws of 2017.

²⁴ The boards and commissions previously passed rules for the management of chronic non-cancer pain, which established a mandatory consultation threshold – those prescribing opioids above the threshold are required to consult with a pain management specialist, unless certain exemptions are met.

²⁵ WAC 284-43-5640

²⁶ U.S. Drug Enforcement Administration. *2016 National Drug Threat Assessment Summary*. Retrieved from <https://www.dea.gov/resource-center/2016%20NTA%20Summary.pdf>.

²⁷ WAC 246-470-030

²⁸ WAC 246-470-050

²⁹ RCW 70.225.045

³⁰ The Emergency Department Information Exchange (EDIE) provides integrated PMP data to 87 of the 94 emergency departments in Washington.

³¹ WAC 246-470-050

³² Supra note 14, see Dowell et al. (2016).

³³ In some states, the mandate to check the PMP only applies under certain circumstances, such as when a certain amount of controlled substances are prescribed or when an initial prescription is issued and then periodically thereafter for ongoing treatment. The CDC states that, ideally, PMP data should be reviewed before every opioid prescription. For more information about PMP laws and regulations across the country, consult the Prescription Drug Monitoring Program Center of Excellence (COE) at Brandeis University. The May 2016 COE Briefing, *PDMP prescriber use mandates: characteristics, current status, and outcomes in selected states*, is available at: http://www.pdmpassist.org/pdf/Resources/Briefing_on_mandates_3rd_revision_A.pdf.

³⁴ Kentucky Revised Statutes 218A.172.

³⁵ 10 New York Code, Rules and Regulations §80.63 (c)(1).

³⁶ Freeman, P; Goodin, A; Troske, S; Talbert, J. (2015). *Kentucky House Bill 1 Impact Evaluation*. University of Kentucky College of Pharmacy. Retrieved from <http://www.khpi.org/downloads/2015/KentuckyHB1ImpactStudyReport03262015.pdf>.

The Pew Charitable Trusts (2016). *Prescription Drug Monitoring Programs*. Retrieved from http://www.pewtrusts.org/~media/assets/2016/12/prescription_drug_monitoring_programs.pdf.

³⁷ Ibid.

³⁸ The latest Rx Fraud Alert report is available online: <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/PharmacyCommission/RxFraudAlerts>.

³⁹ The e-prescribing component of North Carolina's law becomes effective January 2020. Though Minnesota's law is in effect, it lacks an enforcement mechanism.

⁴⁰ Gabriel, MH; Swain, M. (2014). E-Prescribing Trends in the United States. *ONC Data Brief, no.18*. Washington, DC: Office of the National Coordinator for Health Information Technology. Retrieved from <https://www.healthit.gov/sites/default/files/oncdatabriefe-prescribingincreases2014.pdf>.

⁴¹ Supra note 7.

⁴² Friese, B; Moore, R; Grube, J; Jennings, V. (2014). How Parents of Teens Store and Monitor Prescription Drugs in the Home. *Journal of Drug Education*, 43, 223 – 233. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4242095/>.

⁴³ McDonald, EM; Kennedy-Hendricks, A; McGinty, EE, et al. (2017). Safe Storage of Opioid Pain Relievers Among Adults Living in Households With Children. *Pediatrics*, 139: e20162161. Retrieved from <http://pediatrics.aappublications.org/content/pediatrics/139/3/e20162161.full.pdf>.

⁴⁴ Disposal of Controlled Substances, 21 C.F.R. § 1300.05 2014.

⁴⁵ Jaramillo-Stametz, J.; Stewart, H.; Ochs, L. and Payne, K. (2017). Multi-state medication take back initiative: Controlled substances collected from 2011 to 2015. *Journal of Substance Use*. DOI: <http://dx.doi.org/10.1080/14659891.2017.1337821>.

⁴⁶ For drop-box locations, refer to: <http://www.takebackyourmeds.org/search-by-list/>. For Walgreens store count by state, see <http://news.walgreens.com/fact-sheets/store-count-by-state.htm>.

⁴⁷ Disposal of Controlled Substances, 21 C.F.R. § 1317.40 2014.

⁴⁸ Safe Drug Disposal Ordinance. Alameda County, California Health and Safety Code § 6.53.

⁴⁹ Pharmaceutical Research and Manufacturers of America v. County of Alameda (9th Cir 2014).

⁵⁰ Pharmaceutical Research and Manufacturers of America v. King County, Washington. (W.D. Wash. 2013).

⁵¹ King County sales estimated on a per capita basis from Kaiser Family Foundation (2016). *State Health Facts: Total Retail Sales for Prescription Drugs Filled at Pharmacies*. Retrieved from <https://www.kff.org/health-costs/state-indicator/total-sales-for-retail-rx-drugs/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Program cost estimate derived from *King County Board of Health Staff Report* (June 20, 2013) R&R No. BOH 13-03 and industry cost estimate cited in *Pharmaceutical Research and Manufacturers of America v. County of Alameda* (N.D. California 2013), accounting for population differences between Alameda County and King County. Since the pharmaceutical stewardship programs in Washington counties have been operating for less than a year, actual costs are not yet available.

⁵² Executive Office of the President of the United States. (2016). *National Drug Control Strategy*. Retrieved from https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/2016_ndcs_final_report.pdf.

⁵³ Office of Attorney General Josh Shapiro, Commonwealth of Pennsylvania. (July 11, 2017). Press Release: *Attorney General Shapiro Unveils Major Initiative to Supply 300,000 Drug Deactivation Pouches in 12 Counties Hit Hardest by Opioid Epidemic*. Retrieved from https://www.attorneygeneral.gov/Media_and_Resources/Press_Releases/Press_Release/?pid=3700.

⁵⁴ Office of Kentucky Attorney General Andy Beshear. (August 22, 2017). Press Release: *Beshear, Partners Launch Kentucky Opioid Disposal Program to Fight State Drug Epidemic*. Retrieved from <http://kentucky.gov/Pages/Activity-stream.aspx?n=AttorneyGeneral&priId=383>.

⁵⁵ Supra note 6.

⁵⁶ Ibid.

⁵⁷ Banta-Green CJ. (2017). *Fentanyl Death Investigation in Four Washington State Counties*. Alcohol & Drug Abuse Institute, University of Washington. Retrieved from <http://adai.uw.edu/pubs/pdf/2017fentanyldeaths.pdf>

⁵⁸ M.G.L. ch.94C §32E (c1/2) (2015). See also: Office of the Attorney General of Massachusetts Maura Healey. (February 22, 2016). Press

Release: *Law Criminalizing Fentanyl Trafficking Takes Effect Tuesday*. Retrieved from <http://www.mass.gov/ago/news-and-updates/press-releases/2016/law-criminalizing-fentanyl-trafficking-takes-effect-tue.html>.

⁵⁹ Rhode Island H 5517 (2017). See also: Arditi, L. (March 6, 2017). AG Kilmartin advocates stiffer penalties for fentanyl possession. *Providence Journal*. Retrieved from <http://www.providencejournal.com/news/20170306/ag-kilmartin-advocates-stiffer-penalties-for-fentanyl-possession>.

⁶⁰ RCW 69.50.401 (2)(a).

⁶¹ RCW 9.94A.535 (3)(e).

⁶² The Herald Editorial Board. (August 14, 2017). Editorial: Facing 37 opioid overdoses in one week. *Everett Herald*. Retrieved from <http://www.heraldnet.com/opinion/editorial-facing-37-opioid-overdoses-in-one-week/>.

⁶³ Substitute Senate Bill 5514 (2017); RCW 43.70.057

⁶⁴ Under WAC 246-101-505(3), local health officers have the authority to require the notification of conditions of public health importance occurring within the jurisdiction of the local health officer.

⁶⁵ U.S. Department of Health and Human Services (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Retrieved from: <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>.

⁶⁶ Mayfield, J., Estee, S., Black, C., & Felver, B. (2013). *Drug court outcomes: Outcomes of adult defendants admitted to drug courts funded by the Washington State Criminal Justice Treatment Account*. Olympia, WA: Washington State Dept. of Social & Health Services, Research & Data Analysis Division. Retrieved from <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-89.pdf>.

⁶⁷ Washington State Institute for Public Policy (2017). *Benefit-Cost Results: Drug Courts. Adult Criminal Justice: Courts*. Retrieved from <http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/14/Drug-courts>.

⁶⁸ RCW 82.14.460.

⁶⁹ Collins, S; Lonczak, H; Clifasefi, S. (2015). *LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs*. University of Washington: Harm Reduction Research and Treatment Lab. Retrieved from <http://static1.1.sqspcdn.com/static/f/1185392/26401889/1437170937787/June+2015+LEAD-Program-Evaluation-Criminal-Justice-and-Legal-System-Utilization-and-Associated-Costs.pdf?token=heJMx7U8mOrfcQj84BG06VjddvY%3D>.

⁷⁰ Collins, S; Lonczak, H; Clifasefi, S. (2015). *LEAD Program Evaluation: Recidivism Report*. University of Washington: Harm Reduction Research and Treatment Lab. Retrieved from http://static1.1.sqspcdn.com/static/f/1185392/26121870/1428513375150/LEAD_EVALUATION_4-7-15.pdf?token=akhxusrZ2S22cBKDnoRFhjuc3nl%3D.

⁷¹ Supra note 69.