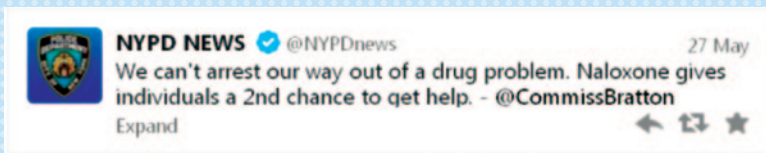
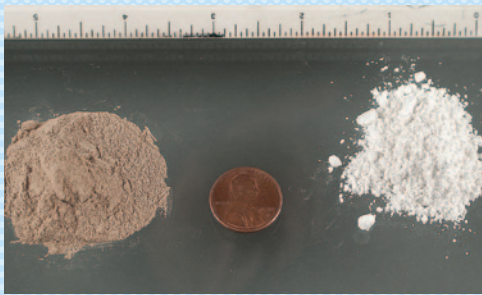


CRITICAL ISSUES IN POLICING SERIES

New Challenges for Police: A Heroin Epidemic and Changing Attitudes Toward Marijuana



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New Challenges for Police: A Heroin Epidemic and Changing Attitudes Toward Marijuana

August 2014



POLICE EXECUTIVE
RESEARCH FORUM

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Acknowledgments

PERF'S CRITICAL ISSUES IN POLICING SERIES IS designed to focus attention on emerging issues in policing. As we begin a Critical Issues project, we usually don't know the answers to most of the questions we are asking; the waters that we are sailing are uncharted. But by the time we finish the project and write a report like the one you are holding, we have conducted a good deal of research and have held a conference of specially chosen experts on the topic at hand. I'm proud that the Critical Issues reports help police executives to get a good start on these emerging issues.

This Critical Issues project had a two-fold nature, addressing two separate developments in the area of drug enforcement.

First, we were hearing about an epidemic of heroin abuse in many parts of the nation, resulting in hundreds of fatalities from overdoses. In many small and medium-size towns, heroin fatalities are outnumbering homicides.

Second, the marijuana legalization initiatives that are just beginning to take effect in Colorado and Washington State are going to fundamentally change how the nation looks at marijuana. Many jurisdictions have had medical marijuana for a long time, but legalization of recreational marijuana is raising many new issues.

So we looked at both of these topics, and I hope you will agree that this report sheds some light on what the field is doing, and what the remaining challenges are.

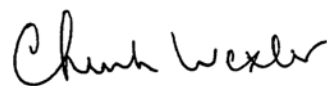
As always, I am deeply grateful to the Motorola Solutions Foundation for its sole sponsorship of the Critical Issues in Policing series. PERF has no other project quite like the Critical Issues series, because Motorola Solutions provides independence to PERF to jump on emerging issues as soon as they come to our attention.

Thanks go to Greg Brown, Chairman and CEO of Motorola Solutions; Mark Moon, Executive Vice President and President, Sales and Product Operations; Jack Molloy, Senior Vice President, North

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PERF is also grateful to all of the police executives, public health leaders, and federal officials who participated in our Summit in April 2014. Many police chiefs made time in their schedules to travel to Washington so they could tell us about their strategies on the heroin and marijuana legalization issues. We also are thankful to Attorney General Eric Holder, FBI Director James Comey, DEA Administrator Michele Leonhart, and ONDCP Acting Director Michael Botticelli for sharing their expertise at our meeting.

Finally, I'd like to thank all the people at PERF who contributed to this project. Chief of Staff Andrea Luna and Deputy Chief of Staff Shannon Branly skillfully oversaw this project. Research Assistant Chris Coghill performed background research, and Membership Coordinator Balinda Cockrell handled the complex arrangements for the Summit. Communications Director Craig Fischer and Communications Coordinator James McGinty wrote this publication, and James took the photographs. Craig and James deserve special recognition for pulling together this complex report and making sense of an issue that is fundamentally impacting the country. Our graphic designer, Dave Williams, brought his meticulous attention to detail to designing the final report.



Executive Director
Police Executive Research Forum
Washington, D.C.

Introduction

By Chuck Wexler

IS THE UNITED STATES FUNDAMENTALLY SHIFTING its approach to drugs?

That's a question underlying this report.

I think that in many ways, the nation still sees the harm that drugs cause to individual lives and to the fabric of our society. There is no question that drug abuse is a scourge and a tragedy. And the related issue of gang violence associated with drug trafficking is one of the biggest problems in many U.S. cities.

Still, around the edges, changes are noticeable. This report details two of those changes.

Surge in heroin abuse: First, we are experiencing a spreading epidemic of heroin abuse in many cities and towns across the nation. At the PERF Summit that is the center of this report, FBI Director James Comey told us he has been traveling the nation, and in every single FBI field office he has visited, people have been talking about heroin.

Today, the most common pathway to heroin addiction is through prescription pain-killer medications. People begin taking opioid medicine such as Oxycodone following an injury or surgery, and they become addicted to it. Their prescriptions run out, and they find that it's difficult and expensive to get the pills illegally on the street. But heroin, which has the same effect on the body, is cheap and plentiful. Over 80 percent of the people who have started using heroin in the last several years started with prescription drugs, according to DEA Administrator Michele Leonhart.

What's worse, today's heroin on the street is an order of magnitude more powerful than it was a

generation ago. Philadelphia Police Commissioner Chuck Ramsey recalled that in the 1970s, when he worked narcotics in Chicago, heroin was 2 or 3 percent purity. By contrast, in Philadelphia today, the purity is above 70 percent. So it's much more common for people to accidentally overdose and die.

Police departments have been sounding the alarm about this growing heroin epidemic. As Chauncey Parker of the New York County District Attorney's Office said,

The police, like other emergency responders, are on the front lines and see the consequences of drug abuse every day. At times it seems like they are like Cassandra standing outside the gates of Troy, yelling the warnings, but very few people are paying attention.

Here's the part that suggests a fundamental shift in attitude: While police are still focusing on the major drug dealers and traffickers of heroin for arrest and prosecution, what has changed is that they recognize that the users will continue using if they don't get treatment. Simply arresting them over and over again is not working. So police are now recognizing the public health issues associated with heroin addiction. In many locations, police are being outfitted with naloxone to save the lives of addicts who are overdosing before their eyes. And in places like Collier County, Florida and Prince William County, Virginia, police are separating the addicts from the dealers, and are directing the addicts to treatment centers.

There is a much different tone to the discussions about heroin today. At PERF's Summit, one police chief after another stood up to say that while

heroin use is a legal problem, it is primarily a medical problem that should be handled by public health officials.

After listening to this discussion for an hour, U.S. Capitol Police Chief Kim Dine marked the moment. “This is historic,” he said. “We are hearing police officials from across the country saying, ‘Heroin is a medical problem.’ That is not the way we have viewed this for the last 40 years.”

Even as police chiefs call for greater leadership by public health agencies, they recognize that most social problems inevitably end up at the door of the police. Unlike other organizations, police departments must answer the phone and respond to emergencies on a 24-7-365 basis.

So police already are taking the lead, and not merely in terms of rhetoric. They are developing their own initiatives to save heroin users’ lives and get them into treatment. As this report was being finalized, 10 weeks after our conference in Washington, we were checking with Captain Harold Minch of the Collier County, Florida Sheriff’s Office in Naples. And he gave us an update about his office’s program of bringing treatment providers along when police serve a warrant at a drug house. The idea is to offer treatment services to low-level offenders at a moment when they are “hitting bottom” and are most likely to be receptive. Listen to the tone of Captain Minch’s remarks to us:

Our program here continues to be a success and gain more community partners. I am very pleased at how well it has been received.

I have a success story from my first warrant. The gentleman not only calls me regularly to tell me he is still clean and trying very hard, but he has started to help others in the same circumstance. That’s what we really need. This initiative has given me a new look at a problem I have been trying to solve for almost 30 years.

Police chiefs and prosecutors tell us that big challenges remain in dealing with the heroin epidemic. One of the biggest problems is that the most recent national statistics about heroin addiction and overdoses deaths are from 2011 or 2012!

For police chiefs who have grown accustomed to working with monthly, weekly, and even daily crime statistics, it seems bizarre that public health officials are somehow trying to formulate responses to an epidemic without having any idea of the full extent of it. Chuck Ramsey put his finger on the problem, saying, “The part of this I don’t understand is why we are dealing with heroin overdose data that’s three years old. It takes me back to the pre-Compstat days in policing.”

We had a lively debate at our Summit about whether police should take the lead in responding to the heroin epidemic, or should defer to public health officials, since heroin abuse is a public health issue. I believe we reached a rough consensus that while public health agencies should take the lead, there are major roles for police chiefs to play in drawing attention to the issue, rallying public support, bringing all of the stakeholders together to formulate a comprehensive response, and pushing elected officials to get involved.

Marijuana legalization: The other major topic of this report—the legalization of recreational marijuana in Colorado and Washington State this year—is another issue where there has been a shift in attitude. Public opinion about marijuana obviously has been changing for some time. Nearly half of the 50 states have legalized medical marijuana, going back as far as 1996.

However, legalization of *recreational* marijuana feels like something much different, in the view of most of the police chiefs at our summit.

First, Denver Police Chief R.C. White told us that there wasn’t enough time in a two-hour session to discuss all of the challenges he has faced in dealing with Colorado’s medical marijuana law. So he ran through a list of a half-dozen issues that have been affecting his department on a daily basis. Chief White’s excellent summary can be found on page 36 of this report.

Later, we asked Chief John Jackson of Greenwood Village, CO what he would recommend to other states that are considering legalizing recreational marijuana. Chief Jackson has been active on this issue as Vice President of the Colorado

Association of Chiefs of Police. And here is what he said:

I would recommend that other states try to slow this down, and allow time for things like putting a comprehensive data collection system in place, coordinating with the federal government, and updating the banking laws to make this a non-cash only transaction.

I would also be stronger about putting limits on the amount of marijuana that someone can have. I would try to abolish home grows of any kind completely. I would try to move to one set of laws that govern both medical and recreational marijuana possession and use. I would advocate for strict regulations on edibles that contain THC. Finally, I would create a partnership with the State Department of Revenue to conduct systematic inspections of the sales locations.

So on the marijuana issue as well as heroin, police seem to be yelling warnings outside the gates

of Troy. I hope other states will take the Colorado chiefs' advice to heart if they are considering marijuana legalization. It is much too early to know how the introduction of legalized marijuana will impact these states, but there is a lot to learn from what is a major social experiment. What intended and unintended consequences will result from this major change in policy? What impact will it have on the underground market for drugs, on traffic safety, on crime, on overall social issues? We don't know the answer to these questions yet, but this much we do know: This trend is spreading as the public becomes more willing to experiment with legalizing or decriminalizing marijuana. Police agencies will again be on the front line of this movement, and their input will be important to policy makers across the country.

Like police agencies nationwide, PERF will continue to monitor developments on the implementation of marijuana legalization in Colorado and Washington State and the heroin issue nationwide.

Reports Detailing State Drug Legislation

The National Alliance for Model State Drug Laws (NAMSDL) has produced the following state-by-state summaries of legislation regarding heroin and marijuana issues. NAMSDL is a Congressionally funded resource that works in coordination with the Office of National Drug Control Policy to research and analyze state laws on drug and alcohol issues and draft model laws, policies, and regulations.

“Good Samaritan and Naloxone Bill Status Report.” (Research current through May 22, 2014.) <http://www.namsdl.org/library/4ECB3174-19B9-E1C5-3119EA3DF725DD85/>

“Naloxone Access Statutes.” (Current through June 19, 2014.) <http://www.namsdl.org/library/16CE4FDC-19B9-E1C5-3175B29881A03FBC/>

“Good Samaritan Overdose Prevention Statutes.” (Current through June 26, 2014.) <http://www.namsdl.org/library/16CF23D6-19B9-E1C5-31E4C6E7BAE2599E/>

“Marijuana Legalization Laws and Regulations: Colorado and Washington.” <http://www.namsdl.org/library/B2BFFCFC-65BE-F4BB-A8550E680B06E35B/>

Police Chiefs and Federal Leaders Focus on the Heroin Epidemic

PERF'S NATIONAL SUMMIT ON ILLEGAL DRUGS, held on April 16, 2014 in Washington, D.C., focused on two major issues: the growing epidemic of prescription opioid and heroin abuse, and the legalization of marijuana in Colorado and Washington State (as well as medical marijuana in many other jurisdictions).

This chapter summarizes the discussions regarding the heroin crisis. More than 200 police executives from across the nation joined Attorney General Eric Holder, FBI Director James Comey, DEA Administrator Michele M. Leonhart, and other federal officials who described the nature of the crisis as well as strategies for addressing it.

The following pages recount comments made by officials at the PERF Summit.

Heroin: The Nature and Extent of the Problem

Philadelphia Police Commissioner And PERF President Chuck Ramsey:

High Purity Levels Result in Overdoses

Philadelphia, like many other cities, has experienced a surge in heroin. We are considered a distribution point along the East Coast. The purity level of the heroin that we're seizing at the wholesale level is around 87 to 90 percent. Even at the street level, it's in the low 70s. It is a huge problem with more and more overdoses. About 30 percent of the drug-related deaths from overdoses in Philadelphia are heroin-related. We work very closely with the DEA,

and the Philadelphia-Camden High-Intensity Drug Trafficking Area is dealing with this issue. So this is very timely to have this discussion.

Chuck Wexler: Many of you who have been tracking drug issues for years know that 80 to 90 percent purity is a very high number. This is a significant factor in the staggering number of people who are dying of overdoses around the country.

Commissioner Ramsey: Yes, back in the 1970s when I was working narcotics in Chicago, the old "Mexican mud," as we called it, was 2 or 3 percent purity. DEA was actually seizing heroin as it was being sent back across the border *into* Mexico—loads that were rejected because the purity was so low. So this is a heck of an increase in purity that is resulting in a lot of problems. And heroin is cheaper than the opioid pills. The pills in Philadelphia have



Philadelphia Police Commissioner
And PERF President Chuck Ramsey

RIGHT:
Administrator
Michele M. Leonhart,
U.S. Drug
Enforcement
Administration



FAR RIGHT:
FBI Director
James B. Comey



gone up about 50 percent in price, while the price of heroin has gone down. Heroin is about \$57,000 a kilo in Philadelphia; it was \$100,000 in 2007.

There's also a change in who's using heroin. College kids are using it. They're snorting it primarily, and they don't think they're "junkies" because they're not mainlining. But they still get hooked on it and they overdose.

**Administrator Michele M. Leonhart,
U.S. Drug Enforcement Administration:**

*Young People Think Drug Abuse
Is Not Harmful*

What keeps me up at night is this changing perception that we see, especially among young people, that you can take drugs and it's not harmful. We know from every study that when kids and young adults start perceiving that there's no harm in taking drugs, we see drug abuse rates rise. And that's exactly what's happening now.

We have this exploding prescription drug and heroin problem. In the body and the brain, there's no difference between taking an opiate in pill form and shooting heroin. Either way, you become an opium addict. Over 80 percent of the people who have started using heroin in the last several years started with prescription drugs. And the reason you're seeing this on the streets in your communities

is that people switch to heroin because it is cheaper and more easily available than prescription opiates on the street.

In the 1970s and 1980s, the sources of opium were across the world, in Southeast and Southwest Asia. Today, the two primary sources are Colombia and Mexico. These poly-drug organizations—the same ones that brought meth, marijuana and cocaine to your communities—now are bringing heroin right to your town. Mexican trafficking organizations and the organizations that have roots and distribution centers all across our country now bring in about 50 percent of all the heroin on the street. It's grown in Mexico and trafficked by the Mexican traffickers.

Wexler: Why does it make a difference where it comes from?

Administrator Leonhart: Here's why: When we had heroin coming from Southeast and Southwest Asia, those trafficking organizations were limited to certain large cities in the United States. They didn't have distribution centers set up; they didn't have routes into rural America. The Mexican traffickers, on the other hand, have moved meth and coke and marijuana into these parts of the country, and now they are following the heroin market. They are exploiting the demand for heroin on the street.



FAR LEFT:
Geoffrey Laredo,
Senior Advisor
to the Director,
National Institute
on Drug Abuse

LEFT:
Lynn, MA Chief
Kevin Coppinger

FBI Director James B. Comey:

***Many FBI Field Offices
Are Seeing Heroin Problems***

In my seven months on the job as director, I've been to 25 of my field offices, and in every single place I've visited, whether it's Mississippi, California, or Ohio, I've heard about heroin.

Federal and state partners are saying the same thing: Heroin today is an urban thing and a suburban thing. It's a black and white thing, a rich and poor thing. It's everywhere and everybody.

I believe that the federal government must have a government-wide approach. We need to figure out how we can support all our state and local partners. It makes sense to me that the DEA takes the lead on this issue, and the FBI also has a role to play.

We can't arrest our way out of this problem, but arrests, especially when focused on international trafficking organizations, are a huge part of the solution. Arrests provide the pressure that makes all the other elements of our response to the heroin scourge more effective.

So the FBI is trying to figure out where we can make a hit that makes the most sense. I've asked each of my 56 Special Agents in Charge to talk to you and our other local partners in each of our field offices, to determine how the FBI can best assist your efforts. I don't think we have determined quite yet how exactly we want to have a government-wide approach federally, but we need to have one.

I'm very grateful to PERF for bringing this meeting together. This is the first time we've discussed this issue in this way, with all aspects of law enforcement coming together to share our stories and figuring out how we can respond together.

**Geoffrey Laredo, Senior Advisor to the Director,
National Institute on Drug Abuse:**

***There Were 207 Million Opiate
Prescriptions in 2013***

We've had a quadrupling of overdose deaths between 1999 and 2010, to approximately 16,000 a year.

Wexler: 2010? So we don't have current data. It has gotten worse since then, right?

Laredo: We think so. In 2013, there were 207 million prescriptions for opiates. That's a pretty damn big number when you think about the nation's population [of 314 million].

Lynn, MA Chief Kevin Coppinger:

***Some Addicts Begin Search
For Their Next High
Immediately After Narcan Saves Their Life***

We've been seeing problems with heroin for over 20 years. In the last couple years, it has skyrocketed. The City of Lynn is about eight miles north

continued on page 9

PERF Survey Confirms: Heroin Is an Increasing Concern in Many Locations

One of the findings at the PERF Summit was that official data from public health agencies about drug abuse is often extremely dated. The most recent nationwide statistics on many measures of drug abuse are two or even three years old.

To obtain more recent information, PERF conducted a survey of local law enforcement agencies in March 2014. The survey findings included the following:

- 81 percent of responding agencies said that drug-related problems and addiction issues have increased in their jurisdiction over the last five years. 79 percent said that drug overdoses have increased.
- When asked which drugs “are currently the most problematic in your jurisdiction,” 36 percent of agencies identified heroin as their top concern, followed by marijuana (23 percent), methamphetamine (20 percent), and prescription drugs (7 percent).
- Only 4 percent of agencies reported that their officers carry the medication naloxone to save the lives of persons who are overdosing on heroin. But of the agencies not currently using naloxone, 31 percent said they are considering it.
- In jurisdictions where the recreational use of marijuana continues to be a criminal offense, more than half of the agencies responding to the PERF survey said that the maximum penalty was a monetary fine, probation, diversion, or other sanctions other than jail time. Fewer than one-half reported that jail time was the maximum penalty.
- Three out of four agencies said that to some extent, they arrest offenders for possession of small amounts of marijuana.

Recent information also was obtained in a survey conducted by the National Association of State Alcohol and Drug Abuse Directors

(NASADAD) in March–April 2014.¹ State substance abuse agencies in 46 states and the District of Columbia responded. The findings included the following:

- A majority of states report that heroin use and heroin overdoses have been rising over the last two years.
- Of the 46 responding states plus the District of Columbia, 12 reported that prescription drug abuse is currently their most important issue, and 13 said that heroin is their most important issue. Large majorities of the 47 jurisdictions rated prescription drug abuse and heroin abuse either “most important” or “very important.”
- 37 of the 47 jurisdictions reported an increase in heroin treatment admissions over the last two years, and 27 reported an increase in heroin overdoses. Most of the other agencies reported being unsure.
- 20 of the 47 jurisdictions said they have engaged in new efforts to educate the public about heroin abuse, through printed materials, radio and television campaigns, and social media initiatives. And 21 jurisdictions have made special efforts to educate the public about the dangers of transitioning from prescription opioid medication to heroin.
- 29 of the 47 jurisdictions are considering or taking steps to expand the administration of naloxone by allowing additional groups of people, such as police officers, to administer the medication.
- Some states provided more detailed information. For example, Vermont reported that admissions to treatment for heroin and other opiates increased more than 900 percent from 2000 to 2013, and accounted for more than 40 percent of all drug treatment admissions in Vermont in 2013.

1. “State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Membership Inquiry.” May 20, 2014. <http://nasadad.org/nasadad-reports>

continued from page 7

of Boston. We have about 90,000 people and 193 police officers.

We investigate every overdose that we know of. But with HIPAA laws [the federal Health Insurance Portability and Accountability Act of 1996, which contains provisions to ensure privacy of medical data], we're not always notified. In 2012, we had 118 heroin-related overdoses that we know about, and 24 were fatal. Those numbers spiked to 188 total overdoses in 2013 with 19 deaths recorded to date. I suspect the number of fatalities will increase once final toxicology reports come back from the M.E.'s Office.

Wexler: How many homicides do you have in the City of Lynn?

Chief Coppinger: Last year we had two. This year, unfortunately, we've had three so far.

Wexler: So which is the bigger problem?

Chief Coppinger: The overdoses are the bigger problem obviously. And this affects all walks of life. It's not just people from blue-collar backgrounds. We have a methadone clinic in Lynn, and if you go down in the morning and watch, you see men in business suits, you see soccer moms, you see people from all walks of life. It's not just what you would consider the "street addicts." It's everybody.

Wexler: How are the bad guys finding Lynn, Massachusetts, population 90,000 people?



Taunton, MA Chief
Edward Walsh

Coppinger: Unfortunately, Lynn is known as a source city. You can buy heroin very cheaply. You can get a dosage unit for five or six dollars.

We have a lot of social service agencies in Lynn, and they provide good services to people with addiction problems. I've been told that the average success rate for a heroin-addicted person going into rehab is between 20 and 30 percent.

We don't issue Narcan to police officers, but we are looking into it. The Lynn Fire Department and the private ambulance services have Narcan, and if you haven't seen it, it's an amazing drug. You can have someone on the ground, unconscious, unresponsive, and you hit them with the Narcan and they get up.

And oftentimes they are mad as hell because you just ruined their high. They won't go to the hospital. Even though they almost died, they're determined to go find the money to get more heroin and get that high again.

One of the other problems we have is that some of the social service agencies give Narcan to street addicts and tell them that if they shoot up, they should "shoot up with a buddy." But it becomes a question of addicts taking a higher dose of heroin, knowing that the Narcan can save them if they overdose.

So are we enabling? Or are we trying to prevent drug abuse? The key to the solution, in my opinion, is prevention.

Taunton, MA Chief Edward Walsh:

My Town of 55,000 Has Had 9 Fatalities This Year

Taunton has a population of about 55,000, and I was shocked to find I've had more heroin overdose deaths this year than Washington, D.C. Taunton has had nine fatalities so far this year. My numbers are through the roof from last year.

We have transitioned from heroin being "street users" to "it's everybody and everywhere." Heroin is penetrating every social strata. And I can buy heroin cheaper than a Happy Meal at McDonald's.



Woburn, MA Chief Robert Ferullo:

We've Had 8 Deaths in 2 Months

Woburn has about 40,000 people. Through the end of February, we've had 23 overdoses resulting in 8 deaths. These aren't people on the street. We respond to office buildings. A senior executive overdosed in the bathroom at lunch time.

Police agencies in the region are working together closely as a group, with all the cities in a task force-like operation. But we've had more overdoses this year than we had all of last year.



Fall River, MA Police Chief Daniel Racine:

Overdose Deaths Are an Old Problem in Fall River

Fall River has about 90,000 people. It was once a textile magnet, but that has gone over to China, so we have a lot of poverty and a significant crime rate. We have about 385 overdose-related calls for service per year, with about 20 to 25 deaths. Heroin is second only to pills on overdose calls, and it's a close second. Heroin is \$5 a bag, very cheap.

Unfortunately, this is nothing new to Fall River. It has been going on since I was a kid. The numbers have been consistent over the last 20 years. This is not a spike in Fall River.



Vermont State Police Col. Thomas L'Esperance:

Our Governor Ripped the Lid Off the Heroin Issue

The governor of Vermont, as you know, spent his entire State of the State address this year talking about heroin. As I listened to the speech, I kept waiting for him to shift his discussion to jobs, the economy, health care, and other topics.

But he kept talking about heroin, and I realized that heroin impacts all of those other issues. Governor Shumlin's speech ripped the lid off of the heroin issue.²

TOP:
Woburn, MA Chief Robert Ferullo
MIDDLE:
Fall River, MA Police Chief Daniel Racine
BOTTOM:
Vermont State Police Col. Thomas L'Esperance

2. "Governor Peter Shumlin's 2014 State of the State Address." January 8, 2014. <http://governor.vermont.gov/newsroom-state-of-state-speech-2013>

Now doctors are being held accountable, as well as treatment facilities and prevention programs. And the discussion is turning to expanding the role of police in treatment. We are the Number 1 source of referrals to drug treatment.

We need to get more proactive in post-arrest interviews. When we arrest someone for a crime that is not going to send them to jail, if they have a drug addiction, we need to get them into treatment.

Burlington, VT Chief Michael Schirling:

Heroin Usually Begins with Prescription Pills

We are a small city of 40,000 people with 100 officers, but we have commensurate-size problems. Our federal prosecutions for heroin are up five-fold in the last two years. Ten years ago when we had what we considered a heroin “surge,” seizing 200 to 400 bags at a clip was a big deal. We’re now in the 10,000-bag-per-seizure arena. We’re hearing of kilo quantities coming into Vermont and being split, going south to Rutland and north to Burlington.

The price of heroin is much higher in Vermont than in Massachusetts. We’re in the \$20 per bag range or as high as \$30.

We hear very consistently from the addicts and families that prescription pills were the first foray into opiate use—for example, kids who had wisdom teeth taken out, took an opiate prescription, got hooked immediately as a result of their particular physiology, and then deteriorated.

And keeping up an opiate habit at \$80 a pill is too much, so they switch to the cheaper heroin.

Rutland, VT Chief James Baker:

1 Million Oxycodone Pills for 60,000 People

To put this in perspective, in 2011 in Rutland County, there were 1 million oxycodone tablets prescribed to a population of about 60,000.

As we talk to people who are coming into our facility under arrest, I have not talked to a parent or someone in custody related to heroin who does *not* start the story by saying, “It started with pills.” The parents of these young people are at their wits’ end.

Our primary source city is New York City. Young males buy heroin in New York for a couple dollars a bag, and they sell it on the streets of Rutland for \$15 to \$20 or more. So they can pick up 1,000 bags of heroin in New York for a \$2,000 investment and sell it for \$20,000.

The demand is so significant in Rutland. We just opened up a methadone clinic. It’s going to serve primarily the Rutland City and Rutland County area, and they’re geared up to take 400 clients.

Camden County, NJ Chief Scott Thomson:

Most Fatal ODs in Camden Are from Out of Town

Camden has 77,000 people, and in 9 square miles we have about 150 open-air drug markets. Over the last 24 months we have seen a transition in our open-air



FAR LEFT:
Burlington, VT Chief
Michael Schirling

LEFT:
Rutland, VT Chief
James Baker

Camden County, NJ
Chief Scott Thomson



drug markets to a predominance of heroin and pills. Our overdose rates have increased 91 percent over that same time frame. Because of the demand for heroin, many of the cocaine dealers are trying to broaden their own market to include heroin, which has spurred gang violence for us.

At the rate I am going this year, I will have more kids from suburbia die on my streets with a syringe in their arm than inner-city youths dying from gang violence.

In the first quarter of this year, I've had 16 overdose deaths, and 15 of them were not residents of Camden. I've had 120 overdoses, and 85 percent of them were not from my city. Camden is a retail *source* city for heroin.

**Executive Assistant DA Chauncey Parker,
NY County District Attorney's Office:**

We Try to Take a Compstat Approach

Wexler: Chauncey, you're head of the New York/New Jersey HIDTA. What's your take on the heroin problem?

Chauncey Parker: In New York City, we had over 730 people die of overdoses in 2012, compared to 419 who died of murder. In New York City, under



Executive Assistant DA Chauncey Parker,
NY County District Attorney's Office

the leadership of the Mayor and NYC Department of Health, we're asking, "Can we approach drug overdoses like Compstat, and try to reduce overdoses the way we try to reduce murders and other crimes?" We have about 20 public health and public safety agencies at the table each month, sharing data and ideas. We drill down and try to figure out what's causing those deaths and what kind of strategies we can develop.

Most of the strategies for reducing overdoses are going to be public health strategies, particularly treatment and prevention. It's not going to be primarily a law enforcement response. But police and prosecutors are at the table with everyone else, looking at the same data and trying to develop strategies to reduce the deaths.

But unlike Compstat, where we have daily or weekly crime reports, the drug overdose data is often too old—2011, 2012 at best. What could be more important than quickly tracking the number of people who die? **We need to get timely, accurate data to figure out exactly what's happening, just like law enforcement does with Compstat. If your data is two or three years old, you don't get a sense of urgency or the opportunity to implement timely and effective strategies to address the problem.**



Knoxville, TN Chief
David Rausch

**New York City Deputy Police Commissioner
Bill Andrews:**

*Staten Island Is Ground Zero
For Heroin in NYC*

Ground Zero for this problem in New York City is Staten Island. We've heard people say that heroin has become a problem for rural areas and suburbs, and Staten Island is like New York City's suburb. We have a much higher rate of opioid and heroin deaths in Staten Island than in the rest of the city.

Wexler: Does it surprise anyone that drug overdoses today outnumber murders or car accident fatalities?

Parker: I think the police know as well as anyone the scope and depth of this epidemic. The police, like other emergency responders, are on the front lines and see the consequences of drug abuse every day. At times it seems like they are like Cassandra standing outside the gates of Troy, yelling the warnings, but very few people are paying attention.

Albany, NY Chief Steven Krokoff:

Albany Is a Distribution Point for Heroin

Albany is mostly a distribution point. Our overdose numbers are difficult to quantify, because the police don't come into contact with many of the people who overdose; often they are dropped off at the hospital. We don't seem to have a tremendous increase in the numbers of overdoses in the city of Albany, but clearly we are fueling the overdoses in the outlying and suburban areas and going into places like Vermont.

Knoxville, TN Chief David Rausch:

Our Overdose Deaths Outnumber Homicides

What we're seeing is similar to what everyone else is seeing. Late last year is when we really started to see the impact of heroin and when we started making seizures of heroin. But the pill issue has been on the rise for the last couple years.

We had 50 deaths in 2012, and I found we weren't really investigating them. So I geared up a whole unit to investigate overdose deaths. Knoxville has about 180,000 people and a police department with 416 sworn officers. Our annual homicide rate is about 24, so we're seeing double the overdose



NYC Deputy Commissioner
Bill Andrews



Thomas Purtell, Chief,
NYPD Organized Crime Control Bureau

deaths compared to homicide deaths.

We've been making some strides in our legislature with the pills. Under state law, pain management clinics now have to register. Knoxville leads the state in these pain management clinics; we have 38 of them registered. Some of them are probably legitimate, but I would say that most probably are not.

**Thomas Purtell, Chief,
NYPD Organized Crime Control Bureau:**

NYC Is a Distribution Point for Heroin

Unfortunately, we have to acknowledge that New York City is the main distribution point. What we're seeing with the task forces and the DEA is that our seizures have increased two-fold, three-fold in the last couple years. We're getting kilos of heroin now where we hadn't gotten it before. Most of these people are setting up distribution out to the surrounding counties and up the Atlantic Coast. Each borough in New York City has its own narcotics unit. We're not seeing this increase in heroin on the street, so basically we feel that NY is more of a distribution point. I'm afraid that eventually this will tend to filter down and we'll see it become a drug of choice in the neighborhoods.

St. Paul, MN Chief
Thomas Smith

St. Paul, MN Chief Thomas Smith:

*Minnesota Has Heroin
That Is 97–98 Percent Pure*

The heroin in Minnesota is probably some of the purest in the United States—97 to 98 percent pure. We've had a lot of experience with heroin in Minneapolis and St. Paul and our two counties, which have a little more than 2 million people. When we look at deaths, in Hennepin County (Minneapolis) we had 84 deaths in 2012, and 69 deaths in the first six months of 2013. In Ramsey County (St. Paul), we had 45 deaths in 2012 and 22 for the first half of 2013. I believe we have cartel members who are pushing heroin out to the counties; this is truly a countywide issue. However, methamphetamine is the drug of choice in our city.

I want to say something positive about what we're doing about this with help from Jack Riley, the DEA Special Agent in Charge from the Chicago Field Office, and Dan Moren, who is a great Assistant Special Agent in Charge for us in Minnesota. We are taking down any heroin dealer we can; I don't care how big, how small. At the same time we are trying to get treatment for the users. And the biggest part of this that we haven't talked about yet is education. I think that ultimately the way to combat this problem is education.





FAR LEFT:
Executive Director
Thomas Carr,
Washington-
Baltimore HIDTA

LEFT:
Providence, RI Chief
Hugh T. Clements, Jr.

**Executive Director Thomas Carr,
Washington/Baltimore HIDTA:**

*Many HIDTAs Are Seeing
More Heroin Overdose Deaths*

We held a symposium in January in Annapolis in which we had HIDTAs from New England, New York/ New Jersey, Philadelphia/ Camden, and Appalachia to discuss their heroin issues. We're all confronting the same or similar issues. We're seeing increases in overdoses and increases in heroin-related deaths. We also brought in researchers from UCLA and the University of Maryland School of Social Work, who brought some demographics to light. We're seeing more white males and females from rural areas and people who are affluent who are involved in this. Heroin is seen as an alternative to prescription pain killers, because it is cheaper

and more available. But if people get an opportunity, they go right back to the pills.

It's terribly hard to get data on this. Medical examiners collect data for their own purposes, not to share with police. We have had to subpoena information from the Public Health Departments and from the Fire Departments.

Wexler: Why should you have to subpoena information?

Carr: They have all kinds of misunderstandings about what data should be available to us. All the HIDTAs that we spoke with have this problem.

Wexler: And what about the purity?

Carr: There's no comparison. It was 4 to 6 percent in Baltimore 20 years ago, and if you got 8 or 10 percent, they would OD on that. Now we're seeing it way above 50 percent, and up in the 80 to 90 percent range sometimes.

And in some cases people are not aware that it's laced with fentanyl, which is 100 times more powerful than heroin. And the really crazy thing is that sometimes people do know it has fentanyl, and that's the kind they want, *knowing that it might kill them.*



Anne Arundel County, MD
Chief Kevin Davis

Providence, RI Chief Hugh T. Clements, Jr.:

We Have Had Record Seizures of Heroin

Without question, Providence is a distribution point for New England. Our issue with the overdose epidemic is not in the city; it's been driven to the suburbs. We have a very robust narcotics unit, and we work closely with DEA, and normally when we hit an investigation right, we get between 5 and 7 kilos. Last summer we had a seizure of 19.5 kilos, which was a record in Providence and in New

England. Later that same day, Boston had a seizure of 21 kilos.

This is an East Coast phenomenon. The level of purity is extremely high. You can buy heroin as cheaply as \$5 a bag in Providence, sometimes as low as \$3 a bag. Some of our investigations have led to traces of fentanyl. Presently there are 79 deaths in the state of Rhode Island. There's only been a slight uptick in the city; it's the suburbs that have caused the stir.



Attorney General Eric Holder:

Thanks to PERF for Bringing Us Together To Address the Heroin Epidemic

Thank you, Chuck [Wexler], for your exemplary leadership over the past two decades as Executive Director of PERF. I also want to thank my good friend, Philadelphia Police Commissioner Chuck Ramsey, for his outstanding work as this organization's President.

Since its founding in 1976—the same year I reported for work as a line attorney in the Justice Department's Public Integrity Section—PERF has worked hard to strengthen community policing, to minimize the use of force, and to guide and inform our national debate about criminal justice issues. Your members and leaders have promoted the highest standards of integrity, professionalism, accountability, and ethics. And your consistent emphasis on proven, data-driven policing

strategies and practices has bolstered the efficiency and the effectiveness of departments throughout the nation.

That's why I'm so proud to stand with you today—as this Forum convenes once again to discuss one of the most urgent and complex challenges facing public safety professionals in this country: the question of how best to combat illegal drug use—and confront the stunning rise in heroin and prescription opiate overdose deaths that so many of you have witnessed in the jurisdictions you serve.

Especially over the last few years, we've come to understand that the cycle of heroin abuse all too often begins with prescription opiate abuse. From practitioners who illegally dispense prescriptions, to pharmacists who knowingly fill them, from notorious “pill

**Assistant Chief Peter Newsham,
Washington, DC Metropolitan Police Department:**

*We Are Not Capturing Data
On Nonfatal Overdoses*

Our fatal heroin overdoses ran about 44 last year, compared to 104 homicides. One thing that is not captured is the nonfatal overdoses.

The Fire Department in DC has been using Narcan for as long as I can remember, and they usually get there as quickly as our police officers do. They sent us a map indicating the number of

mills,” to unscrupulous distributors that send controlled substances downstream without due diligence, the Drug Enforcement Administration is standing vigilant against anyone who would divert prescription opiates from their legitimate use.

[M]y colleagues and I understand, as you do, that although vigorous enforcement will always be critical, enforcement on its own will never be enough. That’s why we’re partnering with leaders like you, and organizations like PERF, to increase our support for education, prevention, and treatment.

For example, in Ohio’s Northern District, our U.S. Attorney convened a summit at the Cleveland Clinic to bring together law enforcement and public health professionals to confront that area’s 400-percent rise in heroin-related deaths. Another U.S. Attorney’s Office, in Vermont, partnered with a family whose young son tragically lost his life to a heroin overdose. Together, they created an award-winning documentary, called “The Opiate Effect,” to raise awareness about the devastating consequences of opiate abuse. This powerful video has already reached more than 50,000 people.

But as law enforcement leaders, each of us has an obligation to do more. That’s why, today, I’m calling on all first responders—including state and local law enforcement agencies—to train and equip their men and women on the front lines to use the overdose-reversal drug known as naloxone.

When administered in a timely manner,

administrations of Narcan they have done. By the way, just because Narcan was administered doesn’t necessarily mean there was an overdose.

Anne Arundel County, MD Chief Kevin Davis:

*Our Fatal Heroin Overdoses Outnumber
Murders and Fatal Car Crashes Combined*

We’ve had success with our Fire Department in collectively gathering data about heroin overdoses, but we miss the emergency room drop-offs that the

naloxone can restore breathing to someone experiencing a heroin or opioid overdose. This critical tool can save lives. **To date, a total of 17 states and the District of Columbia have taken steps to increase access to naloxone, resulting in over 10,000 overdose reversals since 2001.** And I urge state policymakers and local leaders throughout the nation to take additional steps to increase the availability of naloxone among first responders.

After all, it’s only by working together—and adopting a holistic approach—that we can confront this crisis, strengthen our communities, and save lives. In every case and circumstance, our efforts will continue to be guided by the recognition that while smart law enforcement will always play a critical role in protecting communities from drug crime, we will never be able to arrest or incarcerate our way to becoming a safer nation.

We’ll keep relying on innovative leaders like you to apply 21st Century solutions to 21st Century problems. And we’ll never stop driving investments in the kinds of groundbreaking research and data-driven strategies that so many of you have long championed.

This afternoon, as we come together to discuss this work, I want you to know how proud, and humbled, I am to count you as colleagues and partners. I thank you and all of this Forum’s members once again for your service, your leadership, and your patriotism.

police and fire/EMS are not notified about. So our numbers of overdoses are very conservative.

In 2014, we've see 113 nonfatal heroin overdoses and 15 fatal heroin overdoses. By contrast, we've had 4 murders this year and 8 fatal car crashes. So heroin is a big issue.

Anne Arundel is a suburban area sandwiched between Washington, DC and Prince George's County, MD and Baltimore. The heroin overdoses are predominantly in the southern and central, less urban, parts of the county, and they're predominantly white males.

Strategies for Reducing Heroin Use and Overdoses

Norwood, MA Chief William Brooks:

We Have a Strategic Approach to Heroin

Opiate overdose fatalities not only outnumber homicides, they also outpace car fatalities. Massachusetts was the first state to have that situation, and now I think that's a national number. We've had a strong heroin influence in Massachusetts for many years.

We've spoken about the demand side, and there's also a supply side. When we started seeing heroin in Massachusetts suburbs in the 1990s, it was driven by foreign drug trafficking organizations

that had a profit motive. And that's happening again now. It's strong drug trafficking organizations from outside the country, with a profit to make and the ability to move drugs in. And the other side of that is pharmaceuticals. Most of our addicts started with prescription drugs and have moved over to heroin.

When I became chief of police a couple years ago, the heroin problem was in full swing. I wrote a 10-page strategy and issued a copy to everyone in the department.³ The strategy includes a variety of tactics. For example, most of our dealers live in rented property, so every time we arrest a dealer, we serve the landlord with paperwork about the fact that one of their tenants was arrested. We have information on our website under the Drug Control tab about how to evict a drug dealer, and we encourage the landlords to do that. Our goal is that by the time the arrest gets to trial, the arrestee will no longer live at the raid site. And on the night of a raid, our detectives go door to door afterwards to let the neighbors know what happened.

Furthermore, when we identify any drug buyers in an investigation, we approach them and their families with information about treatment. We provide a list of treatment providers and their telephone numbers on our website. And we proactively approach people who are addicted and try to get them into treatment. All of this is part of our strategic approach, and we have had some success with it.

RIGHT:
Norwood, MA Chief
William Brooks

FAR RIGHT:
Akron, OH Chief
James Nice



3. "Combating the Abuse of Heroin and Prescription Painkillers: A Strategy by the Norwood Police Department."
http://www.norwoodpolice.com/images/Drug_Strategy_-_Finished_Copy.docx

Akron Chief James Nice:

*I Respond to Overdose Incidents Myself
To Understand
What Is Happening On the Street*

Akron has a population of about 190,000 and we have about 430 police officers. It's a former "rubber" city—Goodyear, Firestone. Unfortunately, we have a demographic for a heroin problem—a lot of poverty and factory workers who no longer have work.

Every morning, I have a command staff meeting and we go over what happened the day before.

Out of nowhere, overdose deaths started popping up last year. It got on my radar, and I decided to pay close attention to it. I started going to the heroin overdoses myself, getting into the paramedic wagons and seeing exactly what happens on the scene. I have seen 15 or 20 people come back out of an overdose with Narcan. And I started interviewing the people myself.

The police don't carry Narcan in Akron, because in most cases the paramedics get there as fast as the police. Last year, the Akron Fire Department used Narcan 377 times. We probably had about

Police Officers Administering Medication That Stops Heroin Overdoses

A growing number of police agencies are training and equipping officers to administer naloxone—a life-saving medication that saves the lives of persons who have overdosed on heroin by quickly stopping the physiological effects of heroin on the brain.

The medication, also known by the trade name Narcan, can be administered as a nasal spray, so it is not difficult to learn how to use it.

The Quincy, Massachusetts Police Department is believed to be the first to have trained its officers to administer naloxone. Since its inception in 2010, Quincy's naloxone program has been credited with reversing more than 250 overdoses.

In the first year following the training of officers, 86 people in Quincy overdosed on opiates, but only 9 of them died. Of the 77 survivors, 45 had been revived by the police using naloxone. The others received medical care from EMTs or other persons, or were able to recover from the overdose without assistance.

By contrast, before the Quincy police began administering naloxone, Quincy had more than 90 overdose fatalities in an 18-month period.



From left to right, Quincy Police Chief Paul Keenan, Quincy Lt.-Detective Patrick Glynn, PERF Executive Director Chuck Wexler

In May 2014, Lieutenant-Detective Patrick Glynn of the Quincy Police Department was presented with PERF's Gary P. Hayes Award in recognition of his key role in equipping and training all Quincy police officers to administer naloxone to heroin overdose victims.

Lieutenant Glynn said, "We're in the business of saving lives. The individuals we treat through this program have a disease, and it is our place to treat them." Quincy Police Chief Paul Keenan said, "The program has saved lives and has been great for the city of Quincy. I would urge all chiefs to consider implementing it."

Dr. Roger A. Mitchell,
Chief Medical Examiner, Washington, DC



450 overdoses last year. We got to the point late last year where we were having about six overdoses a week and two deaths per week. We have 10 times the number of heroin fatalities as deaths from gun violence.

We've started doing quite a few things in Akron. I created new positions for heroin overdose investigations, so within Narcotics we now have people who only do overdose cases. They respond to the scene, collect phones, get search warrants if necessary, and interview the people if they come out through Narcan, before they leave for the hospital.

Dr. Roger A. Mitchell,
Chief Medical Examiner, Washington, DC:

In Washington, We Are Taking Down The Information Silos

Unfortunately, we often work in silos across different agencies. Even within our own agencies we don't always communicate properly. So it's important to break down these silos. We know that heroin use is not a purely law enforcement problem; it has public health ramifications, and it crosses lines into education and economics and housing.

In Washington, DC, we have data sharing agreements. We have to look at these problems in a multi-disciplinary way and build the bridges of communication. And those who aren't willing to share data need to be called on the carpet about it.

Wexler: Why should there have to be subpoenas for police to get information about a heroin overdose from a hospital? Why is it a legal issue?

Dr. Mitchell: Here in DC, it is not a barrier. There are legal ramifications in putting data outside

of your organization, but I'm working with my attorneys to develop MOUs between the Metropolitan Police Department and the Department of Health so that mortality data can be provided without a subpoena. There's a data-sharing agreement. You called me three days ago asking for data...

Wexler: And you provided it right away.

Dr. Mitchell: Yes, and it came through our Metropolitan Police Department partners. At the Medical Examiner's Office, use of timely, accurate data can inform policy and programs. Here in the District of Columbia, that's what we want to do.

**Geoffrey Laredo, Senior Advisor to the Director,
National Institute on Drug Abuse:**

Without Question, Police Should Administer Naloxone

Wexler: How does NIDA look at Narcan? Is administering Narcan a proper role for the police? How should police go about this?

Laredo: Just use it, period. I believe later today you will have Michael Botticelli here, the director of ONDCP, and he will deliver a full-throated endorsement of naloxone. On April 3 the FDA approved an additional tool to use it; it's an auto-injector like an EpiPen.⁴

4. "FDA approves new hand-held auto-injector to reverse opioid overdose." First naloxone treatment specifically designed to be given by family members or caregivers. Media release, April 3, 2014. <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm391465.htm>

Plain and simple, naloxone is a life-saving medication. Someone mentioned that ironically, if you “wake up” someone who’s overdosing, he or she might be angry with you because you’ve made them feel lousy. It’s absurd, because you’ve saved their life. As law enforcement officials, whatever your challenges and struggles are with these people—and I know they aren’t trivial—but saving lives is saving lives.

**Robert Childs, M.P.H., Executive Director,
North Carolina Harm Reduction Coalition:**

*Naloxone Is Safe, Inexpensive,
And Easy for Officers to Use*

The North Carolina Harm Reduction Coalition is North Carolina’s only comprehensive harm reduction program. NCHRC engages in grassroots advocacy, resource development, coalition building and direct services for law enforcement and those made

Holly Springs, GA Lieutenant Tanya Smith:

My Daughter Passed Away Last Year After Struggling with Heroin Addiction

I have a little bit more experience with the people that you all have been talking about today. My daughter passed away in August of 2013. She was a statistic of heroin addiction.

She grew up in a great home. She was very popular, and very loved. She was a high school cheerleader. She had it all. I had no idea that she had a pain pill addiction until she was arrested in September 2011 for possession of oxycodone that was not hers. She overdosed for the first time in February of 2012 from heroin, and that’s when I found out that she had a heroin problem.

She hid it very well. She didn’t live with me and stayed away from me as much as possible to hide her addiction. It was a little difficult for her to break into the drug world, because her mom was a cop. All of her friends knew that I was a cop. It made it a little hard for her, which you would think would be a benefit, but it wasn’t.

Narcan saved her life in 2012. Heroin is such a hard drug to break free from. I had no idea; I thought she’d go to rehab for 30 days



and would be fine. But 30 days was not enough. She struggled with the addiction for about another year, and a friend of hers convinced her that if she used methamphetamine, she would not crave heroin so badly. She was a lifelong sufferer from acute asthma, and when she ingested methamphetamine, she overdosed and died. She was with four people who were so terrified of being

arrested that their option was to put her in a bedroom away from them, allow her to die, and then take her to another jurisdiction and dump her body.

Since then, Georgia has enacted the Good Samaritan law, which is spreading around the country. Under these laws, if you’re using, abusing, and someone experiences a medical emergency, you can call 911 and you won’t be arrested. I spent a lot of time at the Georgia Capitol lobbying for this bill to be passed, and it was passed. The bill also authorized police officers to carry naloxone. My department will be the first in the state of Georgia to carry naloxone.

vulnerable by drug use, overdose, HIV and hepatitis. Harm reduction is a way of preventing disease and promoting health that “meets people where they are,” rather than making judgments about where they should be in terms of their personal health and lifestyle.

By accepting that not everyone is ready or able to stop risky or illegal behavior, harm reduction focuses on promoting scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors, including condom distribution, access to sterile syringes, and access to naloxone. We work with law enforcement, public health agencies, service providers and people who use illegal and prescription drugs.

Currently we’re working in Georgia and North Carolina to help law enforcement officers implement needlestick prevention measures and overdose prevention programs that equip officers with naloxone.

Naloxone is a relatively cheap medication. NCHRC passes out Intramuscular naloxone, which costs under \$12 per Overdose Prevention Kit. Intranasal naloxone works just as well and is used by the majority of the 68+ law enforcement departments that carry naloxone in the U.S. The intranasal form is a bit more expensive, but doesn’t cost more than \$60 for a two-dose naloxone kit. I am happy to assist any department to equip their officers with naloxone. Feel free to email me at robert.bb.childs@gmail.com or give me a call at 336-543-8050 and I can

assist with developing policies, trainings or ordering naloxone.

Both forms of naloxone work excellently and have been proven not to promote drug use. We’ve seen more people accessing drug treatment in cities that have a naloxone program, because people are given a second chance at life. Naloxone programs also mend and build community relationships, because community members start seeing law enforcement as lifesavers. A recent study showed that when a community invests in community-wide naloxone distribution, overdose mortality may decrease by up to 46 percent. Another benefit of naloxone is that it decreases PTSD among law enforcement officers. Equipping officers with naloxone allows them to reverse overdoses and prevent them from witnessing their community members dying in front of them.

Some states are going to need legal changes to run these programs. There are 24 states and DC that have good naloxone laws that take away civil and/or criminal liability for individuals who administer naloxone.

We’ve been polling officers on their attitudes toward carrying naloxone in NC, and have found that the vast majority want access to it ASAP. I’ve been dispensing naloxone to officers since August 2013, and after a training, we always have long lines of officers queuing to get it, because they want to be part of the solution. There isn’t any controversy among the officers about the life-saving benefits of naloxone.

Another good thing about naloxone is that it is incredibly durable. According to the 2008 study in the *American Journal of Emergency Medicine* called “Alteration in prehospital drug concentration after thermal exposure,” Naloxone can handle being in temperatures as low as 21 degrees and as high as 129 degrees for a 28-day period and keep a good concentration level of around 89%. We always recommend that you keep the medicine at room



Executive Director Robert Childs,
NC Harm Reduction Coalition



FAR LEFT:
U.S. Capitol Police
Chief Kim Dine

LEFT:
Charlotte-
Mecklenburg Capt.
Coerte Voorhees

temperature and out of sunlight, but naloxone is a burly medication that can handle limited exposure to the high heat and cold winter days that officers frequently deal with in the community.

**Capt. Coerte Voorhees,
Charlotte-Mecklenburg Police Department:**

We Would Like to See Additional Treatment Options for Juveniles

Wexler: Captain, I'm told that your department does some kind of debriefings in heroin cases, in order to gain information about the nature of the problem.

Captain Voorhees: Yes, with fatal overdoses, we try to collect information about the heroin supply chain that led to the fatality.

And we also interview people who have been caught with small amounts of heroin. These interviews aren't directed toward a criminal case; it's about their drug abuse background. We ask questions like, "When did you start using heroin? And how did it happen?"

We also try to educate school teachers, principals, parents—any time we have an opportunity to put law enforcement people in front of the community and teach them about this issue.

And we have put together some online training for our officers. We're seeing our arrest data double,

because officers are more aware and are recognizing what they need to look for in heroin cases.

One of the biggest problems we have is a lack of treatment facilities for juveniles. We have an issue with some high school kids using heroin, and we'd like to see better treatment options. So we're working with hospitals and treatment centers and looking to expand that.

U.S. Capitol Police Chief Kim Dine:

We Are Witnessing a Historic Change In Police Thinking About Drugs

This is historic. We are now hearing police officials from across the country saying "Heroin is a medical problem."

That is not the way we have viewed this for the last 40 years. Historically we generally viewed drug use and addiction as a criminal justice/police issue. We have put a lot of people in jail, and we have hurt police-community relations in a lot of ways by the way police agencies have historically approached the drug issue. And now we have the most enlightened police officials in the country saying this is a medical problem. It's historic that we now recognize that this is a medical issue as well as a police matter.

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Some Police and Sheriffs' Agencies Directly Offer Treatment to Low-Level Offenders

Seattle Interim Chief Jim Pugel:

Our LEAD Program Provides Real Help To Nonviolent Drug Users

Wexler: Jim, Seattle has a unique program called Law Enforcement Assisted Diversion (LEAD). Can you tell us about it?

Chief Pugel: Like other cities, Seattle has a problem with drugs, whether it's open-air street markets or drug abuse that's hidden behind walls. For the last 25 years, we were very much involved in the "war on drugs." We were going after the open-air drug markets, we were giving the prosecutors lots of suspects, they were prosecuting, the courts were convicting, and the jailers were jailing. We were doing it over and over again—with no results.

At the same time, legal actions were being brought against the Seattle Police Department and the King County prosecutor's office for disproportionality of arrests. People of color only made up 9 to 11 percent of the population of Seattle, but they were accounting for 70 to 75 percent of the people we were arresting in the open-air drug markets. So we were spending a lot of money on drug enforcement, and then spending even more money on outside attorneys to defend our practices.

At a meeting of the Police Department, prosecutors, and some of the people who were bringing litigation against the department, a precinct commander asked one of the litigants, "Tell me, what would you do if you were a precinct commander, and you kept getting calls from the downtown Seattle association and from the elected officials about all the disorder associated with this drug abuse? If we were to try a different approach, what would it be?"

And that prompted some serious discussions about how to design a new approach.

We knew that these drug users were not shooters; they were not carrying guns. These were low-level, nonviolent, subsistence-level users. If they were dealing at all, they were dealing only to maintain their habit. But there

was a lot of visible disorder that bothered people.

We ended up launching a major collaborative project with the ACLU, the University of Washington, the Racial Disparity Project, and with private funders, the Open Society Foundation and the Ford Foundation. It took us 18 months for everyone to come to the table and develop a new drug plan with public health and the elected officials.

LEAD is different from drug court, because it's a *pre-booking* diversion program. With LEADS, at point of *arrest*, before you're booked, before there's a picture taken, if you have less than a certain amount of drugs and are non-predatory and nonviolent, you are given the option to go to an initial assessment.

If you say yes to that offer, a social worker will immediately meet you at the precinct and take custody of you. We used money from Open Society and the Ford Foundation to hire more of these social workers and drug treatment providers.

The social worker gives you an initial assessment, and within 30 days you have to show up for a more thorough assessment, which takes about 4 hours. You are assessed for mental health, job training needs, job placement, addiction services, housing needs, transportation, child care—and our consortium will get you what you need.

And if you do all that within 30 days, the King County Prosecutor or the Seattle City Attorney will not file a charge against you.

In addition to the benefits for the drug users, there are benefits for the Police Department. At the point of arrest, the officer put the drugs into evidence, completes the paperwork, and he's done. The officers get back on the street sooner, because they don't have to bring the drug abusers to central booking. And this saves us money because we have to pay the county for every person we book.

We've been doing it now for about two years, and we have an initial assessment of the program that came out two weeks ago. (See page 26.)

It's not easy. It took a lot of breaking of the silos, and there's still a lot of work to be done, but it's one of the first of its kind in the world, and we believe it's working.

Albany, NY Chief Steven Krokoff:

The Seattle Model Avoids Low-Value Arrests

Wexler: Chief, you're also developing a pre-arresting diversion program, is that correct?

Chief Krokoff: Yes, Chief Pugel is coming to our city tomorrow to tell us about some of the things he has been able to accomplish in Seattle. We've dabbled in this for some time. What Chief Pugel described perfectly is our definition of a low-value arrest. We recognize that when we make these arrests of nonviolent and non-prolific offenders, either we get no net improvement or in some cases we do more harm than good.

So we're trying to get up into that upper quadrant of high-value arrests that have a large impact. But it creates a question—what are we going to do with the low-level offenders? We have tried this diversion concept with some of our street prostitutes, and we recognized that the biggest gap we had was getting them into treatment immediately. The service providers did not have the resources to take these people when we had them at the most critical time.

What the LEAD program does is bridge that gap; it starts providing service immediately. So we're very interested in seeing how we can adapt that to the City of Albany. It's an opportunity for us to save money by avoiding

these low-value arrests, and much more importantly, to actually do good for the people we serve. So we're excited about this opportunity but are just dipping our toe in the water right now.

Santa Fe Captain Jerome Sanchez:

Officers Can Make 'Social Referrals' To Drug Treatment and Other Assistance

Wexler: Captain Sanchez, you're also replicating the LEAD program in Santa Fe, is that right?

Captain Sanchez: Yes, we're launching pretty much the same thing as in Seattle. We're rolling it out next week. We are trying to keep people out of the criminal justice system so they don't catch the felonies that make it difficult for them to get a job and become productive members of society.

This is a perfect way to get people into treatment. Like Seattle, we will have something called social referral. In some programs, you have to have committed a crime to be referred. But with social referral, if our officers know about nonviolent people with drug problems, the officers can refer them to the program instead of arresting them.

Our criteria for drug diversion are much the same as in Seattle. The amount of drugs involved cannot exceed 3 grams, and they can't be involved in dealing above what we call subsistence dealing. The criteria are pretty

continued on page 26



FAR LEFT:
Albany, NY Chief
Steven Krokoff

LEFT:
Santa Fe Captain
Jerome Sanchez

strict. There can be no violent crime history whatsoever.

Seattle Interim Chief Jim Pugel:

Relapse Is Not Cause For Dismissal from Treatment

This is a harm reduction approach. I know the term “harm reduction” is controversial in many sectors, including policing. But if you look at the

way police have approached this issue of low-level drug users, we’ve been dealing with these same people on the same issue over and over again, and everything else we have tried has not worked. LEAD has empowered this group of officers to really take control of their beat. And with the social referral, you don’t even have to be arrested to get help.

These officers have known who the addicts are. They know who the low-level, nonviolent drug dealers are. And that’s why we allow this social referral process.

Harm Reduction Approach: LEAD Case Managers “Meet Their Clients Where They Are At”

Following is an excerpt from the two-year evaluation of Seattle’s LEAD program:⁵

LEAD stakeholders recognized the importance of hiring case managers who are accustomed to working in an intensive and “hands on” manner with their clients. **LEAD stakeholders refer to this orientation as the “guerilla approach” to social work,** highlighting case managers’ willingness to do everything from tracking down recalcitrant clients in dark alleys to accompanying them as they complete paperwork, keep appointments, and apply for services and housing.

LEAD stakeholders also sought case managers who are comfortable with a harm reduction philosophy. That is, LEAD case managers are trained to meet their clients “where they are at,” to help their clients identify their personal goals through motivational interviewing and other techniques, and to support their clients as they endeavor to achieve those goals. Abstinence may or may not be among their clients’ objectives, especially in the short term.

LEAD follows a harm reduction

approach, which, according to the LEAD protocol, means “a focus on individual and community wellness, rather than an exclusive focus on sobriety, by immediately addressing the participant’s drug activity and any other factors driving his/her problematic behavior, even if complete abstinence from drug use is not immediately achieved.”

That is, the harm reduction model assumes that overcoming drug addiction is a long and arduous process, that setbacks are to be expected, and that meaningful improvements may occur in the absence of abstinence. Moreover, the emphasis is on assisting clients in identifying their own goals and supporting them as they work to meet those goals.

Consistent with this harm reduction orientation, continued and ongoing participation in LEAD does not require abstinence. Rather, the hope is that by engaging clients, helping them to identify and articulate their own goals, and providing emotional, practical and financial support as clients work toward those goals, LEAD clients will cause less harm to themselves and to others than they would absent LEAD’s intervention.

5. Dr. Katherine Beckett, University of Washington. “Seattle’s Law Enforcement Assisted Diversion Program: Lessons Learned from the First Two Years.” <http://leadkingcounty.org/storage/2014-Lead-Process-Evaluation.pdf>

It should be noted that LEAD is not always about strict adherence to abstinence. Some of these people will relapse. But as long as they remain nonviolent and non-predatory, we'll allow them to remain in the program.

Collier County, FL.
Sheriff's Capt. Harold Minch

We Bring Drug Treatment People to Search Warrants, And Offer Services When Users Are at Their Low Point

Wexler: Captain, I'm told you have an innovative program for when you execute search warrants at drug houses.

Captain Minch: We've realized lately that when we serve warrants, mostly for heroin or crack cocaine, we arrest the people running the house, or the people we bought from if we did a reverse sting, but we always leave behind these groups of drug abusers who get no services.

These are typically the same group of individuals from house to house. They were being forgotten. I like the term "subsistence dealers" that Chief Pugel mentioned. There are gradations to drug law violations. Many of the people we encounter are very low-level offenders.

And they fall through the cracks, because our public health system in Collier County is not as robust as what some of you have. I don't have very many public health practitioners, so it falls to us in law enforcement.

We get some help from the David Lawrence Center, a mental health/drug abuse services facility based in Naples. They set aside beds for us. A David Lawrence intake staffer is with us when we do a search warrant at a drug house. And when we're finished conducting the search, if there are people who were at the house but who are not going to jail because they're such low-level offenders, we offer them services right then and there.

We tell these people, "I know you may not believe me, but we are here to help you. This is not a law enforcement thing. We are here to offer you services."

Keep in mind, what typically happens is that it's Zero Dark Thirty and these people have had

to sit on a couch for two hours tweaking while we search their underwear drawer. They are at their low point. If there is a bottom, they can see it. We have this period of about two hours of "captivity" while we do the search warrant, and we try very hard to get them to realize their circumstances during that conversation.

So the health care practitioner from the David Lawrence Center walks into the room, and we leave them alone if they like. These are not dangerous people. We've had them in custody for hours and have searched every inch of the room they're in. And we allow the David Lawrence people to offer them services, without judgment, without stigma, without shame.

If they don't get services that day, when we see them the next time—which we will—we get to offer them that again. And when they do take us up on it, we drive them right to the David Lawrence Center. We provide transportation for them.

So we try to make it as easy as possible for someone who is at that point in their life to accept this service. And many of them relapse. We don't count that against them. If you relapse, we're going to help you again. We value all human life. We're not going to stigmatize you because of something you may have done in your life. We're going to offer you the same respect we do anyone else.

I don't have any hard data yet, but we think this is working, and it's something we have to do. It's the human thing to do for us.



Collier County, FL Sheriff's Capt. Harold Minch

**Acting Director Michael Botticelli,
Office of National Drug Control Policy:**

Police Have Better Data Than Public Health Agencies

I think it's a significant advancement to hear some of the most influential law enforcement people in the country talking about opportunities to do both law enforcement work and public health work.

Our office has been promoting a balanced approach. Former ONDCP Director Gil Kerlikowske, who also served as police chief in Seattle, often said that we can't arrest our way out of the problem. We need to divert people away from the criminal justice system, especially those with

substance use disorders. We know that 95 percent of the people who are incarcerated sooner or later come back to the community, and many of them recidivate. That is particularly true for people with a substance use disorder. Putting them behind bars doesn't deal with the root cause of their issues.

For 20 years I worked in the Massachusetts Department of Public Health, and for the last nine of those years I was the director of the Bureau of Substance Abuse Services. We have always had a significant heroin problem in New England, certainly more so than in the rest of the country. Heroin has been an issue of particular interest to us in New England.

I've always felt that you all in law enforcement had better data than we did on the public health

Principles of Drug Abuse Treatment for Criminal Justice Populations

Source: National Institute on Drug Abuse. Full 36-page document available at <http://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations>

1. Drug addiction is a *brain disease* that affects behavior.
2. *Recovery* from drug addiction requires effective treatment, followed by management of the problem over time.
3. Treatment must last *long enough* to produce stable behavioral changes.
4. *Assessment* is the first step in treatment.
5. *Tailoring services* to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
6. *Drug use during treatment* should be carefully monitored.
7. Treatment should target factors that are associated with *criminal behavior*.
8. *Criminal justice supervision* should incorporate *treatment planning* for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
9. *Continuity of care* is essential for drug abusers re-entering the community.
10. A balance of *rewards and sanctions* encourages pro-social behavior and treatment participation.
11. Offenders with *co-occurring drug abuse and mental health problems* often require an integrated treatment approach.
12. *Medications* are an important part of treatment for many drug abusing offenders.
13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, *chronic medical conditions*, such as HIV/AIDS , hepatitis B and C , and tuberculosis.

Acting Director Michael Botticelli,
ONDCP



side. You were our early warning signal about what was happening on the street. If a spike occurred in certain communities, it was usually our law enforcement people and folks in the community who sounded the alarm first.

ONDCP has been promoting the use of naloxone by all first responders—police, fire departments, and emergency medical technicians. We’ve been working with the National Governors Association, the Association of State and Territorial Health Officials, and others to look for ways to expand naloxone access. We’ve been heartened by the number of states that have passed Good Samaritan laws and naloxone distribution laws.

Obviously the heroin issue has been significantly fueled by the prescription drug use issue, which has been a particular focus of our office. In 2010 we put forward a plan to reduce prescription drug use, and many components of that plan had to do with overprescribing.

Our office is also focused on enforcement. As you all know, lax legislation led to an increase in pill mills in some areas. I always use Broward County, Florida as an example of that. At one point, if you looked at the top 100 prescribers in the United States, I think 80 of them were from that one county in Florida. Closing down these pill mills is important.

Another part of our proposal is about disposal. We know that 70 percent of people who start using prescription pain medications get them free from their family or friends. It’s an epidemic that starts in the medicine cabinet. People should *not* save leftover prescription medications “for a rainy day.” Disposing of these medications in a safe, responsible way is important, so the DEA has been sponsoring drug takeback days. We have held six of them, and they have yielded 3.4 million pounds of medication.

We’ve also talked about treatment, which is an equally important issue. Only about one in nine

people who have a diagnosable substance use disorder get care and treatment. They end up on your police department door because they’re not getting care and treatment for their disorder. That’s why they’re overdosing and dying. It’s untreated addiction that kills people.

The Affordable Care Act mandates that treatment for substance use disorders is a benefit that must be offered by insurance. It also tells private insurance companies that they must offer drug treatment care on par with any other medical service they offer.

Our strategy has three main components. One, how do we divert people who don’t need to be engaged in the criminal justice system away from the system? I think we’ve heard many local law enforcement people say, “I’m arresting the same person over and over again, when I know they need care and treatment.” We have been promoting drug courts as a good alternative to accomplish these goals. We now have 2,700 drug courts in the United States that serve over 100,000 people a year.

Two, for offenders who do need to be incarcerated, how do we make sure that they are getting good treatment and care when they are behind the walls?

Three, how do we handle reentry? How do we make sure that people coming out of our criminal justice system and back into our communities



are being connected with the appropriate care and treatment organizations?

We can't stress enough the importance of a community-wide response. We need a partnership between public health and public safety. We've seen success on this in Massachusetts, and I think we're going to see success nationally.

Akron Chief Jim Nice:

We Warn People Who Are About to Leave Jail That Their Tolerances for Drugs May Have Decreased

Our coroner and I were able to determine that a number of the people in our jurisdiction who were dying of heroin overdoses had just gotten out of jail that day or the day before. It's really an unusually high percentage of the deaths. Their tolerances had changed while they were locked up.

So we've been working with the reentry program at our county jail to provide people with some education about this problem before they're released.

Geoffrey Laredo, Senior Advisor to the Director, National Institute on Drug Abuse:

Research Supports Providing Treatment To Prisoners About to Be Released

There's a lot of strong research to back up what Chief Nice is saying. Many of you may be pressured to start providing treatment, especially medication-assisted treatment, as prisoners are getting ready to be released. Research supports that. If that's something that you've been struggling with or haven't thought about, it's a topic worth considering.

We have a pretty robust criminal justice drug treatment research program at NIDA. When you go to our website, you'll find a couple documents about the principles of drug abuse treatment. One is specific to the criminal justice system. (See page 28.)

What we don't have yet is one that's specific to the juvenile system. That's desperately needed, and we're working on that right now.

Associate Professor Mary Beth Levin, Georgetown University School of Medicine:

"Needle Exchange" Programs Promote Drug Treatment

I'd like to talk for a minute about syringe services programs, also known as needle exchanges. Currently there are over 200 programs in 32 states, as well as the District of Columbia and Puerto Rico. You can't have a syringe services program without law enforcement support, but sometimes we see law enforcement is a little reluctant. I'd like to address some of the common misunderstandings.

One of the misperceptions about syringe services programs is that they increase drug use. We find that they actually decrease drug use. In New Jersey, 22 percent of clients at the state's five syringe services programs have entered treatment. The federal Substance Abuse and Mental Health Services Administration found that syringe services programs were 25 percent more successful than the other programs they funded at getting people into treatment.

Syringe services programs serve as a bridge to drug treatment, and do a better job of getting people



Howard County, MD Deputy Chief
Merritt Bender

Defining the Role Of Local Police in Responding to the Heroin Crisis

Philadelphia Police Commissioner
And PERF President Chuck Ramsey:

*We Don't Need
The Names of Overdose Victims,
We Just Need the Numbers*

Wexler: Commissioner Ramsey, is heroin a police problem? Is this a proper role for police officers? Or should this be a role for fire departments and EMS?

Commissioner Ramsey: I think it's a role for both police and fire/EMS. I think it's a question of whoever gets there first. In many cases, police get to the scene faster than the Fire Department, so I think it's appropriate that the police should carry Narcan, as well as the fire personnel. We carry tourniquets, and we've saved the lives of a lot of gunshot victims. Our job is to save lives, and that's what it boils down to.

The part of this I don't understand is why we are dealing with data that's three years old. It takes me back to the pre-Compstat days, when the data we got was very dated, and there was no way to make deployment decisions and other decisions to respond to crime with this old data.

We're talking about 2010–2011 data on heroin overdoses, and we all know that it's a lot worse now, but we don't have the details. It's the middle of April right now—we should have data up to the end of March.

We don't need to violate HIPAA. I'm not asking for the names of people who are overdosing; I just need the numbers, so I can target the areas of the city where the problem is most significant.

In a department my size, cost is an issue. These Narcan kits are not cheap, and it's a new issue, so we

into treatment, than other programs working in the same field.

Another misunderstanding is that they increase the number of used needles on the street. They actually decrease the number of needles. One of the services offered by syringe services programs is safe disposal of used syringes. When I worked in the county health department in Santa Cruz, California, we would receive a call at least once a week from a parent whose child had encountered a used syringe in a public space. Once we implemented a syringe services program, we stopped receiving those calls.

Law enforcement officers across the country have expressed concern about needle-stick injuries, which can often occur during pat-downs or searches. After implementing a syringe services program in Connecticut, we found that the number of needle stick injuries experienced by law enforcement in the program's jurisdiction decreased by two-thirds.

Syringe services programs prevent HIV and viral hepatitis, get people into drug treatment, and protect law enforcement and others who may encounter syringes on the street. In places that have implemented programs, we see law enforcement get behind it, because it protects them and protects their communities.



Chicago Police Superintendent
Garry McCarthy

haven't budgeted for it yet. So if I'm going to roll it out, I want to roll it out in the areas of the city that have the highest frequency of overdoses.

**Howard County, MD Deputy Chief
Merritt Bender:**

*We Are Missing the Data
On "Walk-Ins" at Hospitals*

Wexler: What exactly is the information we are missing about overdoses?

Chief Bender: We do real well working with our medical examiner, fire department and health department in getting information about overdoses they encounter. The information we are missing is the walk-ins to the hospitals. And the hospitals tell us that because of HIPAA, they cannot give us the information that we are looking for.

Chicago Police Superintendent Garry McCarthy:
*Police Cannot Solve
The Heroin Problem on Their Own*

Wexler: Who is going to lead this effort? Do public health officials have the same sense of urgency that police do about heroin?

Chauncey Parker: Public health has got to lead it. They lead RxStat in New York City. They

understand the urgency and they do an exceptional job leading our task force. Law enforcement is at the table and plays a key role sharing data, implementing enforcement initiatives, and, most recently, carrying naloxone. NYPD officers have had four reversals so far. But at the end of the day, this is a public health crisis. Law enforcement is a key partner, but public health must sit at the head of the table.

Superintendent McCarthy: I'm going to agree with Chauncey. This is a public health issue. We play a role in it, and as first responders, we have an obligation to do everything we can to save people's lives. But there is no way that law enforcement can fix this problem. I've had this view on narcotics enforcement for years. Our methods are not the right methods to make it happen. It has to be a multi-dimensional approach. The intersection of public health and public safety happens at a lot of different levels.

Wexler: Isn't the crux of this problem the fact that nobody "owns" it? Police are the canaries going into the mines and saying, "We've got a problem." And public health is supposed to be in charge, but they are telling us, "We can't give you that information."

Superintendent McCarthy: Yes. I'm big on staying in my lane, because we've already got a lot to do in policing. I'm looking at about 500 shooting victims in Chicago already this year, which is down a lot from where it was, but that is a big problem for us to handle. Our officers should carry tourniquets and should carry Narcan, no doubt about it. But in terms of owning this problem, it's not us. Public health is not going to solve it by themselves either. It takes a multi-dimensional approach.

And it takes elected officials to take the lead and provide the resources.

Virginia Beach, VA Chief James Cervera:

*Public Health Must Own the Problem,
But Police Can Create the Sense of Urgency*

I agree 100 percent with Garry that it's a public health issue, but there are a lot of Type A personalities in this room. If you compare police departments with other government agencies, police officials are the ones who identify a problem quickly and take the lead.

I think that public health will eventually own this problem, but I think it's incumbent upon police agencies across the country to bring it up and create the sense of urgency, and as Garry said, to get hold of the elected officials and bring them to the table.



Virginia Beach, VA Chief James Cervera

Marijuana Legalization in Colorado and Washington State, and the U.S. Justice Department's Response

Introduction

Colorado, which legalized medical marijuana in 2000, passed a Constitutional amendment in 2011 that permitted the sale of marijuana for recreational purposes beginning January 1, 2014.⁶ The state established a task force to design the implementation process of this Constitutional amendment. The task force released its report in March 2013.⁷

Under Colorado's regulations, retail marijuana stores can sell one ounce of marijuana to Colorado residents and a quarter-ounce to persons from out of state. Sales can be conducted between the hours of 8 a.m. and midnight. Retail marijuana stores are allowed to sell the marijuana plant or "edibles," such as baked goods or candy made with THC extract. In May 2014, the state legislature formed a committee to improve laws about the labeling and marketing of marijuana edibles after identifying problems with those products.⁸

Washington State legalized recreational marijuana through a ballot initiative in 2012.⁹ The measure permits individuals 21 years or older to possess

one ounce of marijuana and establishes a licensing process for business that wish to sell retail marijuana.¹⁰ The state expected to issue its first licenses in July 2014.¹¹

Conflicts with federal law: Because the sale and distribution of marijuana continues to be a federal crime, in August 2013 the Department of Justice released a memorandum outlining its priorities for marijuana enforcement in response to legalization of recreational or medical marijuana programs in the states.

The Justice Department indicated that conflicts between federal and state marijuana laws will be minimized if the state laws are written and enforced carefully to reduce risks to public safety and public health:

The Department's guidance in this memorandum rests on its expectation that states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety,

6. The text of the Constitutional amendment is available at <http://www.sos.state.co.us/pubs/elections/Initiatives/titleBoard/filings/2011-2012/30Final.pdf>

7. Task Force Report on the Implementation of Amendment 64: Regulation of Marijuana in Colorado. March 13, 2013. <http://www.colorado.gov/cms/forms/dor-tax/A64TaskForceFinalReport.pdf>

8. The legislation to create the committee is available at http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont3/4882145846DC62CE87257C98005D4C5D?Open&file=1366_enr.pdf

9. The text of the ballot initiative is available at http://sos.wa.gov/_assets/elections/initiatives/i502.pdf

10. Details about the licensing process are available at <http://apps.leg.wa.gov/wac/default.aspx?cite=314-55>

11. "Bumpy Road for Marijuana Legalization in Washington." The Associated Press, July 1, 2014. http://www.denverpost.com/marijuana/ci_26064762/bumpy-road-marijuana-legalization-washington

public health, and other law enforcement interests. A system adequate to that task must not only contain robust controls and procedures on paper; it must also be effective in practice. Jurisdictions that have implemented systems that provide for regulation of marijuana activity must provide the necessary resources and demonstrate the willingness to enforce their laws and regulations in a manner that ensures they do not undermine federal enforcement priorities.

In jurisdictions that have enacted laws legalizing marijuana in some form and that have also implemented strong and effective regulatory and enforcement systems to control the cultivation, distribution, sale, and possession of marijuana, conduct in compliance with those laws and regulations is less likely to threaten the federal priorities set forth [in this memorandum].¹²

The DOJ listed eight federal enforcement priorities in its memorandum:

1. Preventing the distribution of marijuana to minors;
2. Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
3. Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
4. Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
5. Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
6. Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
7. Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
8. Preventing marijuana possession or use on federal property.¹³

Marijuana businesses' access to banking services was identified as an issue in Colorado from the outset of legalization. Federally-insured banks are at risk of federal prosecution if they offer services to businesses that sell illegal drugs, so they have been reluctant to open accounts for marijuana businesses in Colorado. As a result, the industry remains largely cash-only. This raises public safety concerns because the large amounts of cash carried by business owners or kept in marijuana business establishments and business owners' homes present high-value targets for robbers and burglars.

In response to this concern, on February 14, 2014 the Department of Justice released a follow-up memo to provide guidance to banks regarding marijuana related financial crimes. The memo instructed prosecutors to focus resources on financial institutions in a manner consistent with the enforcement priorities listed in the August 29 memo. It also said that "if a financial institution or individual offers services to a marijuana-related business whose activities do not implicate any of the eight priority factors, prosecution for these offenses may not be appropriate."¹⁴

12. James M. Cole, Deputy Attorney General. "Memorandum for All United States Attorneys: Guidance Regarding Marijuana Enforcement." August 29, 2013. <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>

13. Ibid.

14. "James M. Cole, Deputy Attorney General. "Memorandum for All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes." February 14, 2014. [http://www.justice.gov/usao/waw/press/newsblog%20pdfs/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202%2014%2014%20\(2\).pdf](http://www.justice.gov/usao/waw/press/newsblog%20pdfs/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202%2014%2014%20(2).pdf)

Denver Chief R.C. White:

Marijuana Legalization Has Brought Many Issues For the Police to Handle

We don't have enough time to address all the challenges that the Denver Police Department has faced with the changes in marijuana laws. So I'll focus on a few issues that have impacted our everyday policing operations.

Medical Marijuana Dispensaries

The first issue I'd like to discuss is medical marijuana dispensaries. Many people don't realize that 22 states across the country have legalized medical marijuana dispensaries in one form or another. As of July 1, 2014, Denver has 190 marijuana dispensaries, which I believe is the second-highest total in the country behind Los Angeles.

The potency of the marijuana found at dispensaries in Colorado is approximately 25 to 30 percent, while the potency of marijuana that comes from Mexico is only approximately 3 to 4 percent. The quality of the product, along with the price and the convenience of getting it in country, has resulted in the state of Colorado becoming an exporter to many of the counties and cities in the United States.

A pound of marijuana in Denver sells for approximately \$2,200, but that exact same pound would sell for approximately \$5,500 in New York, so exporting it out of state is very profitable.

To legally use medical marijuana in Colorado, a person must go to a doctor and get a recommendation. The doctor will recommend a maximum number of plants. That person can take that recommendation to someone known as a caregiver, who is responsible for legally growing the plants on their behalf.

There are some limitations to the number of plants caregivers can grow. However, caregivers can legally grow the amount recommended to their clients which in some instances can mean hundreds of plants. Many caregivers are growing legally on behalf of people with recommendations, but we've found that some caregivers are also growing plants on the side that they sell to distribution networks, which export them out of state.



Legal Marijuana Dispensaries

Medical marijuana has been legal in Colorado for over a decade. As of January 2014, we have legalized recreational marijuana as well, which allows buyers without a doctor's recommendation to purchase marijuana. Any resident of Colorado can go to a dispensary and buy up to an ounce, and any out-of-state visitor can go to a dispensary and buy up to one-quarter of an ounce. Of our 190 medical marijuana dispensaries in Denver, 83 have the additional license that permits them to make recreational sales.

It is still illegal to consume marijuana in public. Even though it is a criminal violation under the Colorado State statute, the City of Denver has enacted an ordinance that allows officers to cite a civil violation for public consumption of marijuana.

Edibles

Marijuana edibles—cupcakes, cookies, suckers, and other foods—have also been a difficult issue. The THC content in edible marijuana is generally greater than what you find in a marijuana cigarette. We've had deaths that may have been directly related to edibles that contain marijuana. One concerned an individual from out of state who purchased a marijuana-infused cookie. The cookie was sectioned into six portions and meant for one portion per serving. This individual ultimately ate the entire cookie—six servings—and then jumped off of the fourth floor balcony of his hotel, resulting in his death. These edibles can be legally purchased by anyone, either from in-state or out-of-state. This is a significant concern for us.

Residential Marijuana Growing

I think residential marijuana growing operations are our greatest challenge. Live plants or seeds can be purchased from a dispensary, and Denver residents can take them home to grow up to 12 plants. Medical marijuana laws allow a resident to grow up to 6 plants, unless a doctor

has recommended more for a specific patient. Recreational marijuana laws also allow up to 6 plants to be grown. However, under the Denver zoning ordinance, a resident can only possess a maximum of 12 plants in their home.

We've seen a number of fires started by people who are improperly attempting to extract THC oil from the marijuana bud using butane. The lighting and wiring apparatuses necessary for growing marijuana are also a fire hazard.

We have 650,000 residents in hundreds of thousands of households, so it's virtually impossible to enforce every regulation in private residences. I see these residential growing operations as a greater problem than the licensed dispensaries.

Relationships with Federal Partners

As everyone knows, marijuana is still illegal federally. As a result of federal banking restrictions, most marijuana businesses operate on a cash-only basis. In February 2014, the Justice Department issued a memo that essentially gave banks permission to offer financial services to legal marijuana businesses. However, this memo also required them to submit Suspicious Activity Reports on these transactions and inserted specific language that provided guidance for banks to decide whether or not to provide services. With so much uncertainty about their potential liability associated with the record keeping, most banks are still unwilling to provide financial services to marijuana businesses. Between 2012-2013, marijuana-related burglaries totaled 3 percent of all burglaries committed in Denver—both commercial and residential. If you separate business burglaries, 13 percent of all business burglaries were marijuana-related. We've also had a number of robberies and a few homicides associated with marijuana operations.

In the last four to five months, the mayor of Denver and I have come to Washington, D.C. to meet with officials from the Treasury Department and Justice Department to discuss these banking challenges. We have made some progress, and there are certain banks that will accept money from marijuana businesses, but many banks in Denver are still reluctant to accept that money.

We have a lot of people walking around with large sums of cash, as they conduct their entire business in cash. The mayor and I are concerned

about public safety. It's critical from a public safety perspective to get the federal government on board with us to solve these banking issues. It remains pretty much a cash-only business.

Chuck Wexler: What kind of policy do you have in place if dispensaries would like to hire off-duty Denver police officers to provide security?

Chief White: We have a policy that officers cannot work off-duty in locations that sell marijuana. I don't want an officer working in one of these establishments when a federal agency or a task force that we're a part of raids the business.

Chuck Wexler: Has this changed any of your hiring standards?

Chief White: No, we still do not hire police officers with a history of drug use. Some of our employees have inquired, but our policy about that is still zero tolerance. I'm sure at some point that policy will face a legal challenge, but for now we're not hiring anyone with a recent history of drug use.

Chuck Wexler: How has this impacted DUI enforcement?

Chief White: There is a limit of 5 nanograms of THC per milliliter of blood, above which someone is considered to be under the influence. It has been and still is illegal to drive under the influence of anything that impairs driving, including prescription drugs. Many of our officers have been trained and certified as Drug Recognition Experts in order to recognize impaired driving, and the state has allocated money to expand that training.

Chuck Wexler: Why was the legalization measure passed?

Chief White: In Denver, 67 percent of the community voted to legalize marijuana. People think that smoking a joint is less dangerous than having a drink. People really aren't concerned with all the practical aspects of implementation that we've discussed today. Their mentality is that if people are able to drink a beer, they should be able to smoke a joint.

Colorado and Washington State Perspectives

**Greenwood Village, CO Chief
John Jackson, 1st Vice President,
Colorado Association of Chiefs of Police:**

Police Hiring Practices Will Have to Change

I was the lone law enforcement representative on the 24-member state task force that our Governor created to resolve the legal, policy, and procedural issues of Amendment 64.¹⁵ I didn't feel that they wanted to hear too much about law enforcement issues.

There's been a strong lobbying effort in favor of legalization. Advocates have been in force in Colorado, and the legalization measure was pushed through very quickly.

Medical marijuana was legalized in 2000, and then legalization of recreational marijuana was approved by voters in 2012 and took effect in 2013. These have been two sweeping law changes that present a number of challenges to our officers in the field.

One challenge is with handling property seizures of marijuana. It's not considered "personal property," so the jail won't take it. A court decision



Greenwood Village, CO Chief
John Jackson

has put a value of \$10,000 on each seized plant. I have argued that when we confiscate a plant from a grow house it's dead, and that we can't be expected to keep it alive when we seize it. But this court ruled that if law enforcement seize a plant that later must be returned to an individual, they must pay \$10,000 per plant if we are unable to return it alive.

The result is that law enforcement is just not seizing these plants anymore. We're walking away from them to avoid the risk that we'll face court judgments against us if we are expected to return these seized plants alive. The most that any department is doing that I know of is clipping a small piece of a plant or taking a picture of it.

As Chief White noted, the cash-only aspect of the business is also a big issue. The city manager in a mountain resort town recently had to meet with the owners of the dispensaries in that town to receive a large amount of cash in tax payments. Anyone would be nervous about walking around with that much money.

As for hiring, there is a specific clause written into the recreational marijuana legislation that says marijuana use will not affect hiring and personnel decisions, so I'm sure our hiring practices will be challenged, but they have not changed.

The butane hash oil explosions are one of the biggest concerns right now. The process involves filtering butane through marijuana to extract THC, then burning off that butane. There's a huge explosion risk if this process is done inside. We are losing two to three homes or hotel rooms per month in Colorado to these explosions.

Colombian drug cartels are certainly involved in this business. The DEA recently served a search warrant in an affluent community just south of Denver. They found a man living there with direct connections to the Colombian drug cartel, and six

15. See "Task Force Report on the Implementation of Amendment 64: Regulation of Marijuana in Colorado. March 13, 2013. <http://www.colorado.gov/cms/forms/dor-tax/A64TaskForceFinalReport.pdf>

dispensaries in Denver were closed down in relation to this investigation.

The Colorado Association of Chiefs of Police has made additional information about recreational marijuana legalization available on its website. It can be accessed by visiting www.coloradochiefs.org, clicking on the “Marijuana Information” tab on the left side of the website, and entering “Marijuana” in the User Name field and “mjudocs001” in the Password field.

Colorado Springs Deputy Chief Vincent Niski:

The Situation Is Full of Legal Contradictions

In 2013, the Colorado Springs City Council rejected a request to allow retail sales of marijuana in the City, but there is an expectation that this November or next April there will be a ballot initiative requesting the citizens to vote on the matter.

When medical marijuana dispensaries first started around 2008-2009, the Colorado Springs Police Department decided we would not seize plants above the legal limit for a caretaker/grower. Instead, we photographed the grow operation and took samplings for evidence. We would have the caretaker sign a document agreeing to maintain the plants until a decision was made on a potential prosecution. Often, within a couple days the caretaker would call and report their property had been burglarized and the plants in question were taken.

After this started occurring with some frequency, and after receiving a legal opinion from

our City Attorney’s Office, we started seizing plants from grow operations when those plants exceeded the legal limit under Amendment 20, the medical marijuana amendment. Some individuals were growing 300–400 plants above what they were authorized to have.

After the decision was made to seize plants, we had three cases where our detectives seized plants from the growers who were growing above their legal limit. The juries in those cases acquitted the defendants, and the Colorado Fourth Judicial District Court ordered us to return the plants to the owner. The Police Department had not maintained the plants, and our City Attorney and District Attorney argued that marijuana cultivation and possession was still against federal law. The Appellate Court ordered us to return the marijuana, which we did. We have asked the Colorado Supreme Court to hear one of these cases in order to get some direction from the Court.

The Colorado U. S. Attorney has sent a letter to one of the Colorado chiefs advising him that if his department returned seized marijuana, it would be breaking federal law by distributing marijuana.

We are caught in the middle of this marijuana battle. The Police Department receives a court order from our local district court to return marijuana from evidence, and the U. S. Attorney advises us we are in violation of federal law if we do. What are we supposed to do? This is one reason this is so frustrating.



FAR LEFT:
Colorado Springs
Deputy Chief
Vincent Niski

LEFT:
Lenexa, KS Chief
Thomas Hongslo

Lenexa, KS Chief Thomas Hongslo:

*We Are Seeing
Colorado's Marijuana in Kansas*

Lenexa is 400 miles from the Colorado border, and since marijuana was legalized in Colorado, we've seen an increase in the amount of the drug coming through the city. Our seizures have gone up. Investigations that track back to Colorado have gone up. We have a large UPS and FedEx hub, and those companies are seeing large amounts of marijuana going through there from Colorado. And the Kansas Highway Patrol has told our department that they're making many drug busts eastbound on Interstate 70, which comes out of Colorado.

We've also found that many people do not understand the limits of the Colorado law. People who we stop often tell us they thought it was okay to have marijuana in Kansas because they purchased it legally in Colorado.

Spokane, WA Assistant Chief Selby Smith:

*Washington Is Preparing to Handle
The Issues Colorado Is Facing Now*

Washington has also legalized marijuana, and is about 8 to 9 months behind Colorado in the implementation process. We know it's a cash business. We're preparing for a potential increase in robberies, burglaries, and home invasions based on the possible generation of cash.

We'll be reaching out to Colorado police departments for advice about the implementation of the Colorado law and how it changed policing in their cities.

Greenwood, CO Chief John Jackson:

*For Any States Considering Legalization,
Here's What I Would Do Differently*

I'm often asked what aspects of legalization I would change, and I think the primary thing I would do is slow the process down. We did this really quickly,

on a timetable set by those advocating legalization. I would recommend that other states try to slow this down, and allow time for things like putting a comprehensive data collection system in place, coordinating with the federal government, and updating the banking laws to make this a non-cash only transaction.

I would also be stronger about putting limits on the amount of marijuana that someone can have. I would try to abolish home grows of any kind completely. I would try to move to one set of laws that govern both medical and recreational marijuana possession and use. I would advocate for strict regulations on edibles that contain THC. Finally, I would create a partnership with the State Department of Revenue to conduct systematic inspections of the sales locations.

**Geoffrey Laredo, Senior Advisor to the Director,
National Institute on Drug Abuse:**

Marijuana Is Unhealthy, Especially for Kids

You frequently hear the term "medical marijuana" in the press without an explanation of what it actually means. That's because, as far as I can tell, it means different things to different people. We're talking about cannabinoids and cannabinoid extracts, such as THC and cannabidiol (CDB). Anecdotal evidence shows that high-CDB cannabis has therapeutic potential, but NIDA is not in a position to say that it definitely works. We're doing a lot of research to figure out whether or not it does work therapeutically.

For our research, we need to have marijuana that is high in CDB. We have a marijuana farm at



Spokane, WAS Asst. Chief
Selby Smith

Seattle Interim Chief Jim Pugel:

Our Legislature Is Watching the Issues We've Had With Medical Marijuana, and the Problems In Colorado

Washington has legalized marijuana for possession or use in private. The public use or display of marijuana is a civil infraction for an ounce or less and a criminal infraction for over an ounce. There is currently no way to lawfully buy or sell marijuana.

The Washington State Liquor Control Board was given the task of licensing a fixed number of marijuana producers, deliverers, and retailers. Those positions are not yet licensed.¹⁶

We've already seen the Eight Point Letter that the U.S. Justice Department published last year about how it is reconciling its enforcement activities with state and local laws allowing medical marijuana.¹⁷ The letter lists eight priorities for the DEA and U.S. Attorneys with regard to marijuana enforcement, including preventing the distribution of marijuana to minors, preventing marijuana revenue going to criminal enterprises, preventing the diversion of marijuana from states where it is legal under state law to other states, and preventing violence.

This means that if federal officers see that marijuana lawfully purchased in Washington is seeping into other states, it's going to be an issue. We are working closely with the DEA and HIDTA on large-scale marijuana issues.

The Washington State legislature has seen the conflict between medical marijuana, which has been legal since 2008, and the federal laws. Anyone in this room could qualify for medical marijuana and have a prescription

filled. Our local newspaper did an investigative report at Hempfest, a large hemp festival held in Seattle. Of more than 100 people who went into a "prescription tent," all but one came out with a prescription for medical marijuana. And all appeared able-bodied and lucid. The medical aspect of medical marijuana has never been anything but a farce.

Our state legislature, having seen issues we've had in Washington with medical marijuana and problems that have occurred in Colorado, is adding restrictions to the marijuana market. They aren't allowing medical marijuana home-growing operations. They're adding restrictions about the medical conditions that can justify marijuana prescriptions.

Recreational marijuana will be taxed 25% at production, 25% at distribution, and 25% at point of sale, so there will be a significant price difference between recreational and medical marijuana. For this reason, we expect people to try to avoid the recreational marijuana taxes by getting a medical prescription or just growing their own.

One of the arguments for legalizing marijuana was that it would free up law enforcement resources to handle more serious crimes. But there are still restrictions that need to be enforced to ensure marijuana is sold and taxed through the legal market, and those enforcement actions will require some law enforcement resources.



16. "Shortages, high prices expected for state's first pot stores." The Seattle Times, June 28, 2014. http://seattletimes.com/html/localnews/2023950199_potshortagexml.html

17. James M. Cole, Deputy Attorney General. "Memorandum for All United States Attorneys. Subject: Guidance Regarding Marijuana Enforcement." August 29, 2013. <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>

Los Angeles Lieutenant
Al Jackson



the University of Mississippi to supply our research needs. We're the U.S. government's sole provider of research-grade marijuana, which is possible because the United States has a treaty with the rest of the world enabling us to operate this farm. We're growing more high-CDB marijuana to do more research on this issue.

NIDA is also starting quite a bit of research in Colorado and Washington, because those states are a natural laboratory for research on marijuana use.

Marijuana is extremely unhealthy, especially for kids. My perception is that most of the public, no matter how they feel about the legalization of medical or recreational marijuana, agrees that kids shouldn't smoke marijuana. You've heard people today allude to long term addiction problems, respiratory problems, and lower brain function abilities. Regular marijuana use, starting in the mid-teens, has been shown to cause about an eight point decrease in IQ into the adult years. For many of those adults, those IQ points don't come back once they stop using.

Finally, I highly recommend that you or your staff take the time to visit our website at drugabuse.gov and familiarize yourself with our research. In particular, we have a series of publications called "Drug Facts" that lay out the current research about a wide range of drugs in several pages.

Los Angeles Lieutenant Al Jackson:

We Are Hearing that Mexican Cartels Are Switching from Marijuana to Heroin

About eight or 10 years ago, I spoke about medical marijuana clinics in Los Angeles at a national law enforcement conference, and only a couple of other people said they were seeing similar clinics in their jurisdictions. There were about a dozen in Los Angeles at the time. Now we have about 900.

What we're hearing anecdotally is that the cartels in Mexico are no longer harvesting marijuana

fields at the same rate. The wholesale price of marijuana in Mexico used to be about \$100 per kilo. Now, because of the legalization in Colorado and Washington, the wholesale price is down to about \$25 per kilo. So it's not as profitable for them to grow marijuana anymore.

In place of marijuana, they've started growing poppies, and are getting wholesale about \$1,500 per kilo. And we're seeing a trend with the heroin created from those poppies coming in through California and then heading east.

DEA Administrator Michele Leonhart:

Mexican Cartels Can Grow Marijuana in the U.S.

These cartels have been planning for years to move into states that legalize recreational or medicinal marijuana. We saw them in California when medical marijuana was legalized. The cartels don't see any reason to keep growing in Mexico when they can grow in the United States instead.

The cartels have also been increasing their poppy production for several years now, before the two states legalized marijuana.

Providence, RI Chief Hugh T. Clements, Jr.:

We Are Concerned that Rhode Island May Approve Legalization

We've seen a rise in home invasions since legalizing medicinal marijuana and have had at least



Asst. Chief Peter Newsham,
Washington, DC MPD

three homicides related to the medical marijuana business.

One of the homicides was on a Saturday morning. Two individuals were operating an authorized medical marijuana grow on the second floor of an apartment, but we didn't know about it because they are authorized by the Department of Health. We have no way of knowing who carries those cards. Two other people invaded the house for the marijuana. The 82-year-old landlord downstairs heard a ruckus and went upstairs to assist. They were pistol-whipping the two tenants, and when the landlord entered they did the same to him. He was in the hospital for three weeks and died.

There's a movement in our state legislature to legalize marijuana, and I think there's a very real possibility that it will pass. That really concerns us as law enforcement.

Our violent crime numbers are down in Providence, while drug issues have really become a primary concern.

Vermont State Police Colonel Tom L'Esperance:

Police Leaders Should Discuss Marijuana In an Up-to-Date Manner

We decriminalized marijuana, and I think that has freed up some of our troopers' time. I think public opinion is changing fast on this issue, and we should be trying to get our arms around it.

We should have a focus on the youth issues with marijuana, and treatment and diversion are an important piece of that. When a teenager is sent to treatment, the professionals they encounter may be

able to get to some of the root causes of drug use. These kids' parents generally aren't having that sort of a discussion with them, and the police don't have an opportunity to have that discussion with them until they're arrested.

I appreciate where NIDA and other research organizations are coming from, but I think sometimes when we come at people with all these statistics, it just reminds everyone of "Reefer Madness" all over again. We need a new approach to this issue, so the public doesn't think we have the same unchanged mindset from decades ago.

Denver Chief Robert C. White:

Yes, We Can Speak of Marijuana In a Measured Way

The world is not coming to an end, and I think it's important that we say that. We are facing a number of challenges, and I hope that those of you from states that may legalize marijuana in the future learn lessons from our experience.

A lot of our tax revenues from marijuana are going to the school system. So if you're looking for something positive in all this, I would say that's a positive thing.

Our state is being sued by Wyoming and other border states that want some of the revenue from our marijuana tax, to help offset the costs of their increased enforcement needs as a result of our legalization.

**Assistant Chief Peter Newsham,
Washington, DC**

Metropolitan Police Department:

DC May Be Moving Toward Legalization

Our chief's primary concern has been whether any measures would make marijuana more accessible to children.

I think there's a growing opinion that marijuana

will be legalized in the District of Columbia. The city is in the process of decriminalizing marijuana. We'll probably be inviting some of the folks from Colorado and Washington State to speak to our city council about some of these issues you've brought up today.

I think the best thing we can do is try to prepare for this. We need to speak to people who have been through this change, learn what the issues have been, and see if we can minimize the problems during the transition.

**Laurie Robinson,
George Mason University Professor
And Former Assistant Attorney General
For the Office of Justice Programs:**

*Marijuana Laws
Send Mixed Messages to Young People*

As I talk to my undergraduate students, they're very confused by the message that's coming across through the mix of laws that are now in place. They see the harm that's caused by heroin, meth, and cocaine, but they don't fully understand the issues with marijuana. Geoff Laredo of NIDA has come to George Mason at my request and has spoken to the students about the scientific research on marijuana. You police leaders are all so respected in your communities, so I think it's important for you to be spokespeople in your communities and nationally on these drug issues—because young people will listen.

Newport News Chief Rick Myers:
We Need to Be Aware of Public Opinion

When medical marijuana was starting to emerge, I think that we, as a profession, went a little overboard with digging our heels in against it. And polls show the public wasn't in the same place we were on the issue. As police professionals, we have a pretty

strong moral compass and we tend to look at this from the emotional and moral perspective.

There is also an economic perspective here. This is classic supply and demand. We've been focusing on the supply side for over 40 years, and we've made a little progress but look at how much money we've spent. If we had focused more on the demand side, I question whether we would have the need for this discussion today.

DEA Administrator Michele Leonhart:
*DEA Will Continue to Work
With Local Police
On Enforcement of Marijuana Laws*

I understand the challenges to policing that have come about because of the measures in Colorado and Washington State. All our DEA agents want to find a way to work together with you on this. When the Deputy Attorney General released his memo about the eight enforcement priorities, it didn't change anything for DEA and what we do, because we've always been going after the large-scale traffickers.

What we're most concerned about is that marijuana is still a very dangerous drug. We have heard the statistics from NIDA. We know that of people who start smoking marijuana as teens, one in six will become addicted. We know that more teens enter treatment for marijuana addiction than for alcohol and all other drugs combined. So when you just look at those facts, you have to wonder what



George Mason University
Prof. Laurie Robinson



Newport News, VA Chief
Rick Myers

good these legalization measures are doing for our young people.

We aren't shocked by what we've heard from officials from Colorado and Washington today. I'm sure there will be many more unintended consequences that will continue to come to light.

Marijuana use is still against federal law. This administration is against the legalization of any drug. The DEA will continue to do our work and partner with state and local agencies. We'll continue to go after large-scale drug traffickers. We'll keep working to dismantle the cartels and other organizations that are responsible for bringing these drugs to your community.

We're sympathetic to the law enforcement officers who have to deal with the dangers of this being a cash-only business. But I'm also worried that the crimes associated with this—burglaries and home invasions—are going after the product and not just money.

We've also done investigations that have shown that Colombian organizations and others are funneling their money through marijuana dispensaries. So there's reason to be concerned that foreign organizations are going to use this to put money into our banking system.

The DOJ has put out a memo to all U.S. Attorneys stating its eight priorities in enforcing marijuana laws in light of state medical marijuana or recreational marijuana laws, and another memo saying that they will use those eight priorities when dealing with the banks in marijuana-related cases.¹⁸ And FinCen at Treasury has put out guidance to the banks.¹⁹

I think these problems will continue to arise from legalization. I'm glad we have the opportunity to bring up these problems in forums like this, because I think some states are hearing about these issues and may be deciding they don't want to go in the direction of legalization.

As you can see, we have great challenges ahead of us. There's no easy answer to any of this. I think the drug strategy that's been put forward over the past five years is the best strategy I've seen in my 33 years with the DEA. The strategy is a balanced approach of prevention, treatment, and enforcement.

We need to partner with the treatment and prevention people. They need us and we need them.

I look forward to working more with all of you. Please let us know if there's something more the DEA can do, because we want to do it. I think we have a lot of work to do, but we'll do it together.

The mixed messages about some of these drugs concern me, but it makes a difference when law enforcement gives a clear message about them as a public safety problem.

18. James M. Cole, Deputy Attorney General. "Memorandum for All United States Attorneys. Subject: Guidance Regarding Marijuana Related Financial Crimes." February 14, 2014. [http://www.justice.gov/usao/waw/press/newsblog%20pdfs/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202014%2014%20\(2\).pdf](http://www.justice.gov/usao/waw/press/newsblog%20pdfs/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202014%2014%20(2).pdf)

19. "BSA Expectations Regarding Marijuana-Related Businesses." February 14, 2014. http://www.fincen.gov/statutes_regs/guidance/pdf/FIN-2014-G001.pdf

Conclusion

THIS REPORT SUMMARIZES THE INFORMATION and analyses of police leaders on two major developments on issues of drug enforcement: (1) the epidemic of prescription pain medicine and heroin abuse and related overdoses and fatalities, and (2) the increasing decriminalization of marijuana, legalization of medical marijuana, and in two states, legalization of recreational marijuana use.

Each development has required police agencies to change their policies, practices, and entire ways of thinking about drug enforcement issues. Following are some of the major points made by the police executives, federal officials, public health leaders, and others at PERF's Summit in Washington in April 2014:

Heroin Summary

Heroin is an epidemic: Jurisdictions across the nation, and especially in the Northeast states, are seeing an explosion of heroin abuse and overdose deaths. In many communities, heroin overdose deaths far outnumber homicides and deaths from motor vehicle accidents.

It often begins with prescription pain-killers: In most cases, heroin abuse today begins with use or abuse of prescription pain killers such as Oxycodone. These pain medications are often overprescribed by legitimate doctors as well as corrupt "pill mills," but states have been enacting laws and enforcement strategies to regulate the medications more tightly.

As a result, it can be difficult or impossible to obtain the pills illegally on the street, and street prices have increased sharply. By contrast, in many locations heroin is readily available and extremely cheap on the street. As a result, users switch from opioid painkiller pills to heroin. The drugs have the same effect on the brain.

High purity results in more fatal overdoses: Heroin overdoses are becoming more common, because the purity of today's heroin is often 70 percent or higher, compared to levels below 10 percent decades ago.

Detailed information is unavailable: Nationwide data on drug abuse is lacking. Many measures of drug abuse trends take years to compile, so the most recent data is often two to three years old. Police executives, many of whom began developing Compstat programs in the 1990s, have become accustomed to receiving monthly, weekly, and even daily data about crime patterns, and they are frustrated at the lack of comparable information in the field of public health.

Often, it is difficult even to obtain data within a local jurisdiction. Many police agencies keep records about heroin overdose calls to which they respond, so they can track trends over time and identify locations where overdoses are most frequent. But police officials report difficulty in obtaining information about overdose incidents in which they are not involved, such as cases in which an overdose victim is taken to a hospital by a family member or other person. Medical personnel often

claim they are unable to share such information because of medical privacy laws such as the federal Health Insurance Portability and Accountability Act (HIPAA).

Without current, accurate information about heroin abuse rates and patterns, it is difficult for the police to identify and implement countermeasures.

Police are saving lives with naloxone: An increasing number of police departments are training officers to administer naloxone, a medication that can quickly stop the effects of a heroin overdose and revive people who appear to be very near death. The drug, often referred to by the trade name Narcan, can be administered as a nasal spray. In Quincy, Massachusetts, officers have administered naloxone more than 250 times since 2010, when the Police Department trained all officers to use it.

Good Samaritan laws: At least 15 states plus the District of Columbia have enacted “Good Samaritan” laws, which create protections from arrest and criminal prosecution for persons who contact police to report a drug overdose. Such laws are designed to ensure that friends or acquaintances will not be afraid to call for help if they see another person who is overdosing.

Police are taking a new direction with respect to heroin users: In addition to administering naloxone, a number of police and sheriffs’ departments are undertaking innovative programs to get heroin users into treatment. Often this involves making arrangements to have treatment providers immediately available to users at the scene of a drug bust. Users who agree to undergo treatment may be given incentives, such as avoiding arrest or prosecution. Police executives are adopting new attitudes, such as accepting that users likely will relapse one or more times as they work to escape heroin addiction.

What is the proper role for police? The PERF Summit included a discussion of how local law enforcement agencies should define their role in responding to the heroin epidemic.

A number of police executives said that drug abuse, addiction, and overdoses are primarily

public health issues, and that public health agencies must step up and develop stronger responses to the heroin epidemic. One of the first steps should be devising ways to obtain current, accurate data on drug abuse patterns and trends, they noted, much as police departments have done with Compstat systems that collect detailed, up-to-the-minute data about crimes and criminal offenders.

It is difficult to develop solutions to a problem if the most recent information about the problem is two or three years old, the chiefs noted.

At the same time, police officials at PERF’s Summit noted that law enforcement agencies inevitably are involved in responding to drug abuse issues—if for no other reason than the fact that police departments provide services 24 hours a day, 365 days a year, so police officers handle the calls when other public and private organizations are unavailable.

In addition, most police chiefs have a highly visible place in their communities and enjoy public support, and they have important information and perspectives to share about local drug abuse issues and solutions.

So police officials at PERF’s Summit concluded that police chiefs can take an extremely important role in calling attention to the heroin epidemic, and in bringing together elected officials, public health officials, drug treatment agencies, community groups, and law enforcement agencies to discuss the local issues and options for solving problems.

Marijuana Summary

Legalizing recreational use of marijuana raises many new issues: State and local jurisdictions have been allowing residents to legally obtain marijuana to reduce pain or nausea or for other medical reasons for many years.

In some cases, depending on how strictly the laws are written and how tightly the medical marijuana industry is regulated, the medical justification is considered little more than a formality, and the “medical marijuana” system is seen as something approaching legalization of recreational use.

However, Colorado’s full legalization of recreational use, approved by voters in 2011, took effect

on January 1, 2014, and a number of officials consider Colorado's experience in implementing its law a cautionary tale for other states and localities that may be considering full legalization. Following are a number of issues that have emerged:

Preventing legally purchased marijuana from “leaking” into other states: Denver Police Chief R.C. White noted that marijuana purchased in Colorado can sell for more than twice as much in New York, so Colorado must take steps to avoid being a “source state” for illegal marijuana sales.

“Edibles” are poorly regulated: Colorado has experienced problems with selling of cupcakes, candy, and other food containing THC. In some cases, what appears to be a single serving—one brownie, or one cookie—may actually be meant to be shared by six or more people. As a result, there have been cases of extreme overdoses, and at least two fatalities have been attributed to this issue.

Residential growing of marijuana: Laws may allow residents to grow marijuana in their homes with certain limits, but it is unclear how the limits can be enforced.

Systems for DUI enforcement must be created: Over the years, legal standards and enforcement mechanisms have been developed to deter and investigate driving under the influence of alcohol. Similar rules and practices must be established for driving under the influence of marijuana.

Marijuana is being transported from Colorado to other states: In some cases, persons arrested with marijuana in other states apparently believe they were not breaking the law because they bought it legally in Colorado.

Details regarding taxation must be considered: In Washington State, recreational marijuana will be highly taxed, unlike medical marijuana. So officials expect some users to avoid the taxes by continuing to obtain medical marijuana.

Public health effects: Federal experts on drug treatment and research point to evidence that marijuana negatively impacts health and brain functioning, especially among young persons.

International cartels: Drug enforcement officials warn that international drug traffickers are aware of marijuana legalization in parts of the United States and are working to take advantage of these laws.

Police officials must be aware of public opinion: A number of officials cautioned against taking a knee-jerk reaction against any changes in marijuana laws. At the same time, police need to educate their communities about the potential consequences of marijuana legalization in terms of public safety and public health. The experiences of Colorado and Washington State can be instructive for other jurisdictions.

About the Police Executive Research Forum

THE POLICE EXECUTIVE RESEARCH FORUM (PERF) is an independent research organization that focuses on critical issues in policing. Since its founding in 1976, PERF has identified best practices on fundamental issues such as reducing police use of force; developing community policing and problem-oriented policing; using technologies to deliver police services to the community; and developing and assessing crime reduction strategies.

PERF strives to advance professionalism in policing and to improve the delivery of police services through the exercise of strong national leadership; public debate of police and criminal justice issues; and research and policy development.

The nature of PERF's work can be seen in the titles of a sample of PERF's reports over the last decade.

- *The Role of Local Law Enforcement Agencies in Preventing and Investigating Cybercrime* (2014)
- *The Police Response to Active Shooter Incidents* (2014)
- *Future Trends in Policing* (2014)
- *Legitimacy and Procedural Justice: A New Element of Police Leadership* (2014)
- *Social Media and Tactical Considerations for Law Enforcement* (2013)
- *Compstat: Its Origins, Evolution, and Future in Law Enforcement Agencies* (2013)
- *Civil Rights Investigations of Local Police: Lessons Learned* (2013)
- *A National Survey of Eyewitness Identification Procedures in Law Enforcement Agencies* (2013)
- *An Integrated Approach to De-Escalation and Minimizing Use of Force* (2012)
- *Improving the Police Response to Sexual Assault* (2012)
- *How Are Innovations in Technology Transforming Policing?* (2012)
- *Voices from Across the Country: Local Law Enforcement Officials Discuss the Challenges of Immigration Enforcement* (2012)
- *2011 Electronic Control Weapon Guidelines* (2011)
- *Managing Major Events: Best Practices from the Field* (2011)
- *It's More Complex than You Think: A Chief's Guide to DNA* (2010)
- *Guns and Crime: Breaking New Ground By Focusing on the Local Impact* (2010)
- *Gang Violence: The Police Role in Developing Community-Wide Solutions* (2010)
- *The Stop Snitching Phenomenon: Breaking the Code of Silence* (2009)
- *Violent Crime in America: What We Know About Hot Spots Enforcement* (2008)
- *Promoting Effective Homicide Investigations* (2007)
- "Good to Great" Policing: Application of Business Management Principles in the Public Sector (2007)
- *Police Management of Mass Demonstrations: Identifying Issues and Successful Approaches* (2006)
- *Strategies for Intervening with Officers through Early Intervention Systems: A Guide for Front-Line Supervisors* (2006)
- *Managing a Multi-Jurisdiction Case: Identifying Lessons Learned from the Sniper Investigation* (2004)

- *Community Policing: The Past, Present and Future (2004)*
- *Racially Biased Policing: A Principled Response (2001)*

In addition to conducting research and publishing reports on our findings, PERF conducts management studies of individual law enforcement agencies; educates hundreds of police officials each year in a three-week executive development program; and provides executive search services to governments that wish to conduct national searches for their next police chief.

All of PERF's work benefits from PERF's status as a membership organization of police officials,

who share information and open their agencies to research and study. PERF members also include academics, federal government leaders, and others with an interest in policing and criminal justice.

All PERF members must have a four-year college degree and must subscribe to a set of founding principles, emphasizing the importance of research and public debate in policing, adherence to the Constitution and the highest standards of ethics and integrity, and accountability to the communities that police agencies serve.

PERF is governed by a member-elected President and Board of Directors and a Board-appointed Executive Director.

To learn more about PERF, visit www.policeforum.org.

We provide progress in policing.



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Motorola Solutions serves both enterprise and government customers with core markets in public safety government agencies and commercial enterprises. Our leadership in these areas includes public safety communications from infrastructure to applications and devices such as radios as well as task specific mobile computing devices for enterprises. We produce advanced data capture devices such as barcode scanners and RFID (radio-frequency identification) products for business. We make professional and commercial two-way radios for a variety of markets, and we also bring unlicensed wireless broadband capabilities and wireless local area networks—or WLAN—to retail enterprises.

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For more information on Motorola Solutions Corporate and Foundation giving, visit www.motorolasolutions.com/giving.

For more information on Motorola Solutions, visit www.motorolasolutions.com.

APPENDIX
Participants at the PERF Summit
“New Challenges for Police:
A Heroin Epidemic and
Changing Attitudes Toward Marijuana”
April 16, 2014, Washington D.C.

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MINNEAPOLIS POLICE DEPARTMENT

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Titles reflect participants' positions at the time of the meeting in April 2014.

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