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2016 Symposium: Virginia's Opioid Epidemic: Treatment and Policy in the 21st Century

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2016 SYMPOSIUM PANEL DISCUSSION
VIRGINIA'S OPIOID EPIDEMIC: TREATMENT AND POLICY IN THE 21ST CENTURY

Moderator:
Professor Tara Casey, Carrico Center for Pro Bono and Public Service

Panelists:
Shannon Taylor, Commonwealth's Attorney for the County of Henrico
Brittany Anderson, Director of Legislative and Constituent Affairs for the Office of the Attorney General of Virginia
Timothy Coyne, Public Defender for the City of Winchester, Virginia

NOTE FROM THE EDITOR AND DISCLAIMER

The following is a minimally-edited transcript of the panel speakers from the 2016 Richmond Public Interest Law Review Symposium, Virginia's Opioid Epidemic: Treatment and Policy in the 21st Century, held on September 30, 2016. Short biographies of the speakers are included in the Introductory Remarks.

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2016 SYMPOSIUM PANEL DISCUSSION TRANSCRIPT

Tara Casey: Thank you so much Attorney General for sharing your words, especially taking what we see so often as a national issue and bringing it close to home. Knowing that this is an issue that is dominating headlines, it sometimes can take on that personal effect that it is dominating our communities as well so I appreciate you sharing that perspective with us. My name is Tara Casey and it is my pleasure to be the moderator for this afternoon's or late morning's panel discussion regarding the opioid epidemic in Virginia.

When I was approached to moderate this discussion, I'm on the faculty here at the University of Richmond School of Law, and I was touched to be asked to moderate because this is an issue that I feel many of us, we feel passionate about, but yet we also at the same time don't feel like we are the experts. And you start to fear that if you don't know enough, then how can I do enough about this issue? And what, in preparation for this, has shown me, is that you don't need to know every-

thing to do something. And I'm very appreciative of being given the opportunity to do something here today.

I would like to invite my fellow panelists up to the dais so that we may begin our program. We are going to be having this as a moderated panel discussion. We have areas that we're planning to cover today, but this is a discussion, and it is not just a discussion among ourselves up here; it is a discussion as much as we can have with all of you as well. So in that vein, I encourage you to think of questions and start to submit questions. We are taking advantage of social media to have this be a live question-and-answer session. On the back of your programs you'll find information on how you can participate during this presentation. You can either tweet questions during the presentation using the hashtag #PILRSymposium, that's P-I-L-R Symposium. So if you have your smartphone, which it seems many of us have attached to us, we have not got to the chip in the brain yet, you can tweet with the hashtag #PILRSymposium and one of our fabulous students, Kasey here, is going to be monitoring Twitter for those questions and share them with me as we go along. You can also email questions to pilrsymposium@richmond.edu. Again, that information is on the back of your program. We will have a question-and-answer session at the end of today's program. But in case there is something that you wanted to have one of the panelists address, sooner rather than later, and not towards the end, we are going to go ahead and have that option available to you as well.

And we have discussed what we are planning to cover today in our panel presentation, and in many ways I view myself as the Terry Gross of the morning because I am coming to this with interest and heart, but not necessarily expertise. So I am hoping to be able to listen and facilitate and guide discussion and we will have this be a fluid exchange and I, hopefully, will have a very soothing NPR voice as we move through the whole discussion.

So to get things started, I'd like to introduce to you our panelists, who will then also describe their roles in addressing the opioid epidemic in Virginia, and their offices' roles and their role in today's discussions.

The first person I would like to introduce is Shannon Taylor. Shannon Taylor is the Commonwealth's Attorney for the County of Henrico here in Virginia. She attended the University of Virginia, and after graduating she moved to Richmond where she joined the law firm of Hunton & Williams, and then decided to go to law school where she received her JD right here in these halls. After graduation, she went to work for the Richmond City Commonwealth's Attorney's office and then subsequently was a special assistant U.S. Attorney here in Richmond, where she handled gun cases arising from the Project Exile and Project Safe Neighborhoods programs. She was appointed Special Counsel for the Richmond Multijurisdictional Grand Jury from 2004 to 2008, prior to her service now as our Commonwealth Attorney in Henrico. Thank you so much, Shannon, for joining us.

To Shannon's right is Brittany Anderson. Brittany Anderson is the Director of Legislative and Constituent Affairs for the Office of the Attorney General. Ms. Anderson has spearheaded Attorney General Herring's efforts to combat the growing heroin and prescription drug epidemic here in Virginia. And she's helped develop and implement multi-faceted plans that include enforcement, legislation, education, and prevention. These components were the centerpiece in the forty minute documentary that Attorney General Herring referenced called *Heroin: the Hardest Hit*. Ms. Anderson is a proud graduate of Central Virginia Community College, Virginia Tech and the Sorensen Institute for Political Leadership. Thank you so much.

And last but not least, to my right is Timothy Coyne, who is the Public Defender for the City of Winchester, and the Counties of Clarke, Frederick, Page, Shenandoah, and Warren. You rack up a lot of mileage.

Timothy Coyne: I do, but not all by myself.

Casey: He has received his undergraduate degree from the University of Virginia as well, and graduated from our law school, University of Richmond, as well. He worked as a *pro se* law clerk for the U.S. District Court for the Eastern District of Virginia in Alexandria before becoming a litigation attorney with the Federal Trade Commission. Life brought him back to Winchester, Virginia, where he started his own private law practice and then soon becoming a part-time assistant public defender and then the Public Defender. He has also served on the Winchester City Council,

and he is currently vice-chairman of the Northern Shenandoah Valley Substance Abuse Coalition, which is a diverse, community-based organization, looking for ways to address the opioid epidemic that's affecting the Northern Shenandoah Valley. Thank you so much, Timothy.

So I would like to get started first with each of you describing your role individually and professionally and how we are addressing the opioid epidemic here in Virginia. And, Shannon, if you would like to kick things off.

Shannon Taylor: Alright, great. Good morning everyone. It is a pleasure to be here, and I am very thankful to be able to be part of the panel to talk about this issue that definitely is affecting not just public safety, but obviously public health. And I do want to recognize my colleague, Mike Herring, from the city who is here, as well as Stephen Miller, who is the managing assistant attorney in the Richmond U.S. Attorney's Office. Because not only does that demonstrate the kind of that teamwork aspect that Attorney General Herring referenced, but I know that Mike in the City of Richmond has the same issues, believe it or not, that the county of Henrico has.

And to talk about, you know, I can't believe I've been practicing over twenty years because I was at the U.S. Attorney's Office back in the late 90's and then the early 2000's. So when we had the idea of Project Exile, that was obviously when crack cocaine was very prevalent in the city of Richmond and we saw certain responses to that drug. And to quote the story that ran in the *Richmond Times-*

Dispatch regarding the young man Andrew Nelson, the one woman who was being interviewed said, "It's not that kids haven't been abusing drugs, they're just finally abusing a drug that's killing them."[1] And I think that's really been the wake-up call.

I first came to this idea of the heroin epidemic when I was doing defense work back in 2008 and was representing people who were being prosecuted for either thefts and/or maybe selling heroin and/or having the possession of heroin on them. And seeing the struggles that they were having in terms of trying to get into any type of programs, that's how I came to know John Shinholser at the McShin Foundation[2] and really since 2008 have developed that relationship with that recovery community. But as we saw over the years, 2008, we definitely saw that spike in terms of the overdose deaths happening recently. And so that's why I'm proud to say that in Henrico County, our county manager came to our different departments to say we need to come up with a plan, just like the Attorney General was talking about. So Henrico County has got a plan. It's not public yet, but I look forward to sharing some of the realizations that we have identified, recognizing this is a multi-agency, a multi-disciplinary problem to be addressed.

Casey: Thank you so much, Shannon. And now let's go to the other part of the state. Timo-

[1] Eric Kolenich, *No Life Worth Having Like This: A Former Mills Godwin High School Soccer Player's Story of Addiction, Desperation and Recovery*, RICHMOND TIMES-DISPATCH, Sept. 16, 2016, http://www.richmond.com/sports/high-school/schools/mills-godwin/article_03988b96-7b02-11e6-8c7a-9f50ff30a0b2.html.

[2] The McShin Foundation is a non-profit Recovery Community Organization aiding individuals and their families in the fight against substance use disorders. *See* McShin.org.

thy, can you please share with us some of your work and your office's experience?

Coyne: Thank you, as Tara said, my name is Tim Coyne. I'm the public defender for all of those localities in northwest Virginia. I don't know if anybody's been up there; it is a wide area and has a population of about 230,000 people. It doesn't seem like a whole lot compared to Henrico or Richmond or Tidewater or other areas of the state, but I think the problems that the Attorney General described are very much apparent in our area. In 2012, we had one death attributed to heroin or opioids in the area that's covered by those jurisdictions. We have a drug task force and they track those statistics. In 2013, the number went to twenty-one, in 2014 we had thirty-three, last year we were at thirty, and so far this year we have twenty-one deaths. We had eight overdoses, non-fatal, this week alone. Four were attributed to opioids or heroin. The other four, they're still working out, but they think several of those were synthetic drugs. This isn't something we've talked a whole lot about, but they're out there and present as well and contributing to this problem.

I've been doing criminal defense work since the early 90's, since 1991. Before I became a Public Defender I did federal court-appointed work, state court-appointed work – saw cocaine, methamphetamine, and more recently of course it came to heroin. I've stood next to people, represented people who got ten, twenty, thirty years of mandatory time in federal court because that was the reaction to the epidemic back in the early '90's – to in-

crease the mandatory minimums. What's significant, I think now, is that the response has been very different and encouraging, in that people are realizing that addiction is a disease, and we have to treat it as such.

In our community, it really started with law enforcement – our task force came forward and said we cannot arrest our way out of this problem. We have a problem, our deaths are rising, people are overdosing on our streets. We have to look about it and treat it differently. So with law enforcement, our public health system – we have one hospital that serves our area, our region, they contributed – we have the court system, commonwealth attorneys, defense attorneys, private community providers, our community service board, started meeting together to try and address it, which ultimately developed into the Northern Shenandoah Valley Substance Abuse Coalition. We were able to get some funding from the localities – Winchester City, Frederick County, Clark County, and Valley Health. It enabled us to start a drug treatment court, which our first docket was held August 16th. Drug courts aren't anything new. Shannon, I think you have had them in Henrico and in Richmond since the early 90's, but they were new to our area. And a lot of what we experienced was trying to change the mindset and peoples' approach in what they thought about addicts. It wasn't the junkie in the alley that it used to be. It was now fathers, sons, mothers, daughters, peoples' children. They could put a different face on it and that's really what has changed. And I think there are some positive changes. We have a lot of challenges ahead of us, but I think

there are some very good things that are coming together.

Casey: Thank you so much, Tim. Brittany, I'd like to turn to you now to provide the statewide perspective and what your role and your office's role has been doing at the 30,000-foot-level, especially.

Anderson: Sure, good morning everyone. First, thank you all for having us, and thank you for the *Public Interest Law Review* for making this the topic of your symposium. As you can tell, General Herring and our office feel very strongly about this, and we're very happy that you asked us to be here. General Herring sort of provided an overview of what our office has done and how this topic sort of came to be priority number one for our administration. When I accepted the position of Director of Legislative and Constituent Affairs for his administration, I did not expect that I would come into the office every day thinking about heroin and prescription drug abuse and what we could do to combat it. But that is what my role has morphed into along with some of my colleagues and we're really happy that it has.

When we first came into office, we were meeting with a number of our counterparts and partners in the criminal justice system and a U.S. Attorney in the Western District named Tim Heaphy came to meet with the Attorney General and handed him a report that his office had put together, titled, "Prescription Drug Abuse in Southwest Virginia." And, after Attorney General Herring read it, he handed it back to me, and said, "Hang onto this, I think we're gonna need it." Shortly after that, we

went on our public safety tour that you heard about where the majority of those localities talked to us about the need for something to be done about heroin and prescription drug overdoses. We were also approached by our colleagues in other Attorneys General offices, especially in the Northeast, that were really struggling with this problem, and they kept telling us, "You've got to get ahead of this because this is going to overrun your emergency departments, your courtrooms, and, if anybody is going to be a leader on this, please step up to the plate and do everything you can."

So we were able to pull some things from the playbooks of other people. Places like Winchester in the Northern Shenandoah Valley were doing really great work at the time to pull community leaders and partners together to try and come up with solutions that best fit their needs. So that's what we tried to do from a state perspective. We tried to pull in not just law enforcement and prosecutors. We tried to bring in doctors, physicians, law enforcement, and then a new team member in the recovery community. And we are very fortunate that we asked the recovery community to be a part of the solution because we went directly to the source. If you're going to make any kind of change, why not go directly to the people that understand the struggle and the problem of substance use disorder? And I can't tell you how fortunate we are to have their help because they've really helped us develop a roadmap for some of these solutions.

What we thought would be one initiative in 2014, we found some gaps in

> the system that could easily be filled. Things like passing Good Samaritan laws to encourage people to call 9-1-1. That was one of the things we sort of saw was missing was there were so many overdoses that were going unreported because we would talk to people in the community, and they would say, "Well, we don't want to call 9-1-1; we're scared of being penalized by law enforcement." So we tried to bring law enforcement to the table and get them to support legislation like this that would encourage reporting of overdoses and saving lives. And they did. We also saw that naloxone[3] was only restricted to first responders, which seemed silly because this is a non-addictive, non-harmful drug. Why not put it into the hands of anybody who wants it, or anybody who is trained to use it? We also saw there were prescription monitoring programs available in other states for doctors and pharmacists to report prescribing practices and dispensing. Why are there so many prescription drugs on the street? We need to understand why those are getting out of medicine cabinets and getting into the hands of people that don't need them.
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> So we saw that there were areas where we could be a leader. We thought we would sponsor some legislation. We thought we would host some forums, maybe a public awareness campaign. And two years and nine months later, we still feel like we haven't even moved the envelope as far as it needs to be. We're really proud of the work that we have done but so much more needs to be done.

[3] Naloxone is a drug used to block or reverse the effects of opioid medication and can be used to prevent deaths caused by overdose. *Naloxone*, DRUGS.COM, https://www.drugs.com/naloxone.html.

The last thing that I will say is that the biggest policy challenge that we have faced in all of this is not funding or partisanship. It has been getting people – even at the highest level of government – to believe that this cause was worthy, that the almost one thousand lives that were lost to heroin and prescription drugs in one year were worth something, and that those people did not write their own fates by making bad decisions and that they could have been saved. I can't tell you how many conversations that I've had with people who do not believe that somebody who is addicted to prescription drugs or heroin should not be locked away and that's the end of the conversation. That is the absolute worst thing that you can hear from somebody. That is not the pathway forward, but that has been the biggest challenge in this entire endeavor that we have faced. So I really ask that you keep that in mind during this discussion because if you take away anything from this, it's that anybody suffering from substance abuse disorder is just like us, and just like any disease, it can happen to anyone.

Casey: Thank you so much, Brittany, and I appreciate the perspectives that you all shared. Both on the local level with regional diversity as well as on the state level, and that leads me to my first question: What do you see as the role of the state and the locality in addressing the opioid epidemic? What is best left to localities to address? And what is best and what is more appropriate for a statewide response?

Taylor: Well, I think the biggest thing when you're talking about the localities is that each ju-

risdiction has their own issues. I attended the drug court conference a couple of weeks ago, down in Williamsburg, and one of the speakers there was the circuit court judge from Tazewell County which is, of course, down there, nicely tucked down in the nice corner of the southwest part of the state. And he showed a picture of the people who had been recently arrested for prescription drugs in his area. And it was prescription drugs. I mean it was all prescriptions. No heroin. So their issue to combat this problem may be different than Henrico's issue which is kind of a combination of both, and is also a situation where we have, we had this operation called Operation McNugguts. Because this is not, I'm not keeping anything private, there is a McDonald's on 360 that is on one side of the interstate and Wickham Court, that is on the other side of the interstate. And people drive from King William County, Hanover, down that 360 way and they go into Wickham Court, which Mike Herring is well aware of, and that's where they are buying the heroin, and so this is heroin – not prescription drugs – and they literally cannot go but as far as the parking lot of the McDonalds that is on the other side of the interstate in Henrico County, to use the heroin that they just purchased. So we know that when we talk about the local resources that we are dealing with, we are talking about helping people who may not necessarily be Henrico County citizens, which is often what you're thinking about with your locales is that the money you're spending is helping the citizens in your area.

So we look at it from that point of the people who are arresting, but then

again the people who will come through our court system, use the jail services that we have, be put on perhaps the drug court, again, resources that are being funded at the local level, and so we're mindful with trying to figure out how much money we are trying to put toward that system, recognizing of course that the General Assembly does not fund this and that it really is relying on state grants like the Attorney General talked about, getting money that way, because resources are the biggest problem and if you're fortunate like Henrico – that is, lucky to have good resources – we are trying to be mindful of how we can best use those resources.

Casey: And to follow up with Tim, can you address the regional differences that Shannon seemed to highlight, not only when places are abutting each other, county and city, but also just the regional geography to poverty and demographics?

Coyne: Sure, and it goes beyond just the Commonwealth of Virginia. I mean, our problem is primarily heroin. We're two hours away from Baltimore, less than two hours from D.C., 81 has been designated the heroin highway, down from basically down from Hagerstown, Maryland, all the way down as far as Roanoke. Roanoke in fact has received something called HIDA, designated High Intensity Drug Trafficking Area. It's a federal designation; they are part of the D.C., Baltimore HIDA. We're not yet. We've applied three times, hoping this will be the time we get it. That would open up some more resources at the federal level for not just law enforcement, intelligence gathering, that kind of thing, but

also prevention dollars from the DEA. So we get a lot of influx from out of state.

And I think there are differences between how the localities – we're not a very wealthy area. Winchester is an urban area but all the counties around us are rural. They don't have a lot of heavy tax base, not a lot of industry, so what monies we can get from localities we are very fortunate to get. Our community service board, which is our primary, frontline, mental health substance abuse treatment provider, was the lowest funded per capita in the state. So we have had to work through those challenges to try to get them to look at things differently to try to address the problem. I think all the localities do have different issues and have to come up with somewhat local solutions. It comes down to money. I mean that's the reality. We need money to do these things, whether it's operating a drug court but providing treatment for people. Treatment is not cheap. We estimated when we set up our court that it was going to cost at least five to seven thousand dollars per participant. And that's where we are putting most of the money that we've been able to scrape together. But a lot of localities have to look at what they have available in their communities to try to address the problem.

Casey: And Brittany, with this idea that the localities are experiencing similar but sometimes different manifestations of the opioid epidemic: Where is the state seeing the need for uniformity or consistency of practice and where is the state feeling like locality empowerment in response, that deference is needed?

Anderson: Well, I think it's the responsibility of the state to provide resources. Whether it be funding streams for treatment options or just reforming some of our codes to make it easier to support localities and other entities that want to be a part of the solution, like the example that Shannon gave about the McDonalds. There are nonprofits that exist right now that would like to purchase naloxone in bulk and go to these McDonalds and either wait there or give naloxone packs to the people that work there or to people that might hang out there. Because they know that's where people are using and that's where they are overdosing. But right now the law restricts them from doing that because the only person that can dispense naloxone is a pharmacist. So we should, if those people are out there and those non-profits exist and they want to do something like this, we should be getting naloxone to anybody who wants it as fast as we can because if we know where people are using we want to make sure the opportunity is there to save those lives. So that's just one example of something the state can do to support something like that.

Casey: And it also seems that something that you all three have touched upon is also the changing of minds; that part of addressing this issue is also addressing the stigma and the public perception of the issue. I think, Brittany, you even referenced in your opening comments about how you still are encountering people in your work who feel that the best solution is just imprisonment.

Anderson: Incarceration, mm-hmm.

Casey: Imprisonment and nothing further. How has this stigma influenced what you see as

being policy decisions coming both from the federal, state and local level moving forward?

Anderson: I think our office encounters that resistance more from the state level than we do from the local level; Tim can talk more about that and the federal level. Right now there is so much support coming from the White House and coming from ONDCP and the CDC to want to do everything they can, whether it be funding treatment or working with the Chinese government to restrict shipping of Fentanyl to the U.S. When we approach policymakers there is just this philosophical difference that something like the Good Samaritan law is the right thing to do. Some people see it as just a free pass for a drug user. Where we see naloxone as a life-saving drug, some people say they see it as a safety net for somebody just to use heroin until they get to the point of an overdose and that is just simply not true. So we have had to counter those arguments sometimes with statistics, sometimes with facts. We are really fortunate that the recovery community was there to talk through some of those misconceptions like about naloxone use and about calling 9-1-1. But then there are some things like drug courts we would love to have the state fund more drugs courts, we would love to open up the statute having to do with drugs courts, but there are some policymakers that just do not believe that drugs courts work. Even though there are so many studies that prove that they do – that if you get somebody treatment they are more likely to stay out of incarceration – they will never accept that. And Tim can probably speak to that a little bit more but some-

times you're just not going to break past those philosophical differences.

Casey: Right, and I want to go to the drug court issue because drug courts have been around now and we have the data that shows their success rates and Shannon, you referenced it in your comments and I believe we have a question from one of our attendees regarding the recent opening of a drug court in Winchester and whether that has helped with the issue as well. So Shannon and Tim, can you both address what it was like to launch a drug court, first of all the opposition and the now continuation in trying to show its worth?

Taylor: I regret the shortsightedness of lawmakers who don't see the utility of drug courts. I mean the one in Richmond has been there for twenty years. The one in Henrico we are almost fifteen years and the data has proven itself to be, you know, what's the proof in the pudding, so to speak. But I do think the issue regarding stigma and how that has affected drug courts and really impacted the judiciary is the concept behind an addict wanting to change and get better, this idea of relapse and, "Why can't you stop?" I am proud to say that, I think that in Henrico, all of our judges get it now, which is really, really great. And because they understand the idea that this addiction is just a little different than these other drugs in terms of the physical change of what happens to the cells in your body and those receptors and how they – because they are bombarded with such a potent drug – how the receptors die off and so that's why it's called "chasing the dragon" because that dulling effect on the brain is why they continue to want more, and

more, and more to get that first high that they'll never experience again. And so that stigma, we have finally educated our courts to understand, if they relapse, that's okay, that's an expectation in terms of treatment and recovery and the other component to that is what we talk about as first offender statutes that are currently on the books here for Virginia.

Regretfully, the idea was that if you were just a recreational user and you were caught with drugs that you could have your felony taken under advisement for twelve months, but you didn't use again, et cetera, et cetera. Well, I haven't met a recreational heroin user yet. So the idea that that statute was going to be utilized for the opioid user was just going to be disastrous. And so what we're doing in Henrico is we're modifying, again, taking what the legislators will not give us, but using the laws that are on the book to modify our approach on how we deal with heroin addicts and using general continuances and agreements of all parties with plans in place to show the courts that this young person is getting, is trying to accomplish this goal of recovery.

Casey: And I have a follow-up question and then Tim, I'd like to hear about the Winchester Drug Court. We have a question from one of our attendees regarding the use of medication-assisted treatment in the Henrico Drug Court. Can you describe to us, as we heard from Dr. May,[4] the benefits that can

[4] Dr. James C. May, Ph.D., is the Director of Planning, Development, Research, Evaluation and Substance use Disorders Services for the Richmond Behavioral Health Authority. Dr. May gave a presentation at the beginning of the symposium, introducing the topic of opioid addiction and treatment.

be seen from it? What is that role in drug courts?

Taylor: Well, there's a couple of things that are going on with what are called MATs. First, I'd like to say that, just like anything else, one program is not the panacea for all addicts. We have to be mindful of what works for one individual may not necessarily work for another individual. But like Attorney General Herring was saying, and like Dr. May was saying, when it came to the federally funded programs, they were not permitting any type of medical-assisted treatment. And so even though we were aware of certain drugs, like Vivitrol, that is a blocker and not a substitute, we couldn't have people use methadone, they couldn't use Suboxone, they couldn't use anything. But we now have it as such that our circuit court judges recognize, again, the benefit of medical-assisted treatment for people who need it, and we are continuing to work forward and probably Tim, with a brand new drug court, can even touch on that.

Casey: Yeah, and Tim, with the launching of the new drug court, I'd like to also go back to the stigma issue. I mean, many folks have seen the videos and Facebook posts of parents OD'ing in front of children and this is now the that stigma we're seeing because more often than not becomes a shaming, a public shaming example of addiction. What was the process for you, and putting forward the proposition of a drug court and its launch, in the midst of what is becoming a very social media-fueled stigmatization of this?

Coyne: I'll start with, I wish the law school had taught a course in how to start a drug court,

because it was about a year and a half of my life to try to get it done. It was a long process but we got it done.

Casey: I'll propose it to the curriculum commit tee.

Coyne: Thank you. I was ancient though, when I was here. We started back in 2014, again putting together this diverse group of people, from public health, law enforcement, the judicial system, both prosecution and defense, private treatment providers, and we tried to look around the country and we researched and looked at what best practices were out there. Drug courts was but one of the things that we found, they were right here in Virginia and they've been around since the '90s. In fact, a Chief Justice of the Virginia Supreme Court ran—started Richmond's drug court back in the 90's. So we realized we had to collect data if we were going to make the impact on the community, so we collected data from, not just the arrest and jail population and the cost that was having on the localities, but we had a real problem and have for a number of years with substance-exposed infants, which is sometimes kind of lost in this whole discussion, because I represent pregnant mothers all the time, and they don't stop their addiction because they're pregnant. They continue to use, and when they give birth those infants are sometimes addicted and have to go through painful to watch withdrawals in the hospital, so we collected data on the cost that was having in our NICU at Winchester Medical Center. The average stay for some of the most extreme cases was about a month, costing about $45,000 per infant, per stay. We collected data from social services showing

local cost going into treating parents whose children had been taken while they go through the process of getting their children back. That was a heavy cost, Frederick County was probably over a million dollars a year just for the treatment costs.

So we made an effort to collect all this data and then present it to the powers that be, the decision makers in our community. We had a summit late in 2014 where we called together boards of supervisors, city council members, school boards, anybody that we thought would have the power to affect this and we presented this data and that did in fact have a powerful impact. So, as a result, we followed up in a meeting with the chairman of the board of supervisors, the county administrator, president of the city council, and the city administrator and made a pitch: we need funding, we need some money. And they got behind the idea of establishing the drug treatment court and that's really where it started. And then we were able to get the local funding.

We also had community forums where we brought in and presented that same data. We brought in an ER doctor from UVA who talked about, your kids know more than you do, about all the drugs that are out there. We were getting a hundred to a hundred and fifty people at some of these forums and it was just a huge education effort and we're continuing with that as we go through it.

We did have to overcome some of the stigma, though. The first judge I approached about it, who came from the General Assembly, from the House Courts of Justice Committee – where things go to

die – told me he wouldn't get in the way, but he won't support it and he won't come to meetings. So I was fortunate to have two new judges come on the bench. One was a former Commonwealth Attorney who was supportive of it, and one defense attorney. And we now have two judges who are very invested and have gone through the training, and in our first month and a half, they both come to every docket, to sit in on the pre-docket meetings and they switch off who's actually going to preside while the other one sits in the jury box with a team. So it's been really good to see that and the mindset changing, but it's a huge education effort. You really need data and you have to put the human face on it, and some of the most powerful of those were the substance-exposed infants in the data that we presented to the decision makers.

Casey: I'd like to follow up on that because we received a question from one of our attendees regarding just that: the incidence of addiction that occurs when a woman is pregnant when she is also using drugs. An attendee was asking the same when there had been instances in which pregnant women suffering from opioid addiction are prosecuted, actually, under felony child abuse and child endangerment statutes for relapsing during, or in which she was denied bail in order to stop her from using opioids or drugs during her pregnancy. Is this something you, as you referenced earlier, this was data that was being used to show the effects on the child, is this possibly not only being used as a salve, but also a sword if it's used in this way?

Coyne: I haven't seen a child abuse prosecutions, but what I've seen though are pregnant

women charged with possession or other offenses. The judges know they're pregnant and will keep them in jail up until they go into labor, and then they'll release them at that point so that the jail won't incur the cost of labor and delivery, then allow them to be released at that time. So the judges are aware of it and they're taking what steps they can. It's unfortunate that we don't have any inpatient treatment or any other residential placement that we could possibly have pregnant women reside in while their cases are being prosecuted. I have seen that happen in our courts.

Taylor: And I'll add to that, being the prosecutor following through on all of this, you know the idea was that when this was being talked about so heavily, you know, two or three years ago, the recovery community was very anti-criminal justice. They definitely were like, "Why are you locking these people up?" you know, "They're sick," you know, "Why are we using the criminal justice system?" And my comeback has always been and continues to be, "We're using the court system as a tool to get them to the treatment that can be court ordered." Ultimately, at the end of the process, again, when you have people who are working together, it's not to give them that felony conviction that both Mike Herring and I feel very strongly about, you know, don't let that be the first time they're getting a felony conviction if you can help it working again within the parameters of what the law allows but when you're working together to use the court system as a tool to get them to that goal of treatment or recovery, that's what we're looking for. We're not doing it just because we're going to say, "Hey we got a notch and we got

another prosecution," for someone who's sick. That's not what we're doing. And I think that, again, the results of what we're doing in Henrico have demonstrated that.

Casey: Brittany, in your experience, have you seen this? You know we've talked about the data being an issue, and Tim was referring to data as being a driving force and Shannon was saying the data has shown the success. So being seen as the creator as well as the supporter, what data do you see we're still not getting in our overall response and understanding to opioid addiction?

Anderson: We're still trying to find data to support our efforts to get people to call 9-1-1. That's one of the really strong messages that we put out there is that you need – as soon as somebody starts overdosing it's just like a heart attack – you need to get them medical attention right away, you need to keep, start calling 9-1-1, and so trying to do our best to track non-fatal overdoses to see if those people showed up at the hospital because of a 9-1-1 call or if EMS or firefighters were dispatched because of that or if 9-1-1 calls have increased or hospital visits have increased because of those. That's one of the things that we're kind of lacking to at least support in some of the things we're doing and that was one of the struggles we saw trying to pass that Good Samaritan law was we didn't really have a lot of data to back that up. Washington State tried to study it but it was pretty inconclusive. Luckily the law passed without us having a lot of statistics to support it but that's an area where we're trying to gather more scientific support.

Taylor: What would also be helpful is, I think that we all agree that the overdose deaths are grossly unreported because there are plenty of people who are going to the hospital who are dying and the diagnosis is not heroin overdose, it is some other type of way, and that's in part of the task force in Henrico County, we have two major hospitals, we have Bon Secours and Henrico Doctors. And in speaking with them and trying to work with doctors and get around HIPAA issues, to get them to better report what brought the person in to the ER. And then the other part of that is to really recognize the significance of what drug addiction is doing in playing in criminal behavior. While an officer may arrest somebody on the street for the larceny that happened at the Wawa or Target or whatever, and they get booked under petty larceny or grand larceny or whatever, in Henrico, they come through and they go through the medical process before they ultimately get booked into the jail and part of that is a question about issues and addictions and are you currently under the influence of anything. So I know that my sheriff, Sheriff Mike Wade, can talk about how almost eighty percent of the population, and it's pretty high, my note's over the seventy mark, a very, very significant population of the people who are in the Henrico County jail have addiction issues. They might not be booked under a drug offense, but addiction is definitely a part of the problem.

Casey: In all of your responses when we were talking about the methodology of combating the epidemic it seems that we're talking, a couple of recurring themes come up: education, prevention, recovery. Those seem to be the recurring themes. But when

you think about what are the charges to law enforcement on the local and state level, it's not necessarily what your duties are as an office, it's not necessarily education, prevention, recovery, it's a whole host of other responsibilities. So it seems also that partnerships are key to addressing this problem and this issue. And with opioid addiction in particular, we've been hearing about the relationship with the medical community. I think Dr. May even referenced that the gateway often to heroin is the prescription painkiller. And there were articles recently about pharmaceutical companies and the lobbying power and how they're able to have the painkillers readily available. And we have a question from one of our attendees too: How do we preserve or restore appropriate acts as to opioid pain medication for the management of pain and work with the medical community while also at the same time exercising such increased scrutiny of the profession and of the pharmaceutical companies?

Coyne: To speak to what Valley Health, who is the only medical hospital system in our area did, and they became involved in our coalition early on and they undertook on their own a change in their prescribing habits of docs in their ER from just having somebody walk out with thirty or sixty pills to, you know, much shorter supply, seven, fourteen days, and then referring them back to their primary care physician. They really stepped up their use of the prescription monitoring program that required their doctors to check. It wasn't a requirement under certain circumstances, but now every time a prescription goes out, they're checking PMP, as well as their pharmacy and

that's only been a recent change where dispensers have had to now check, Valley Health undertook on their own. They do physician education programs, they've done a number of them where they get two hundred physicians in the room, they give them dinner, but they bring in the DEA and they educate them.

Casey: Right.

Coyne: And I was at one of the earlier ones and what was astounding is the doctors didn't even realize the nature and extent of the problem. They may be prescribing oxycodone, another doctor the patient's seeing may be prescribing a benzo[5] and what the effect of that is.

Casey: Mm-hmm.

Coyne: So it's a matter of reaching out to the medical community and that's what at least what our hospital system has done.

Casey: It's the medical community but it also sounds like it's the treatment and counseling recovery community as well.

Coyne: Well, yeah, I mean, treatment is, there are, what we're finding, at least in our area, is that we have a number of private providers, there are different philosophies for treatment, as far as what's worked and what's going to be effective. A doctor may, say, go through five, six times, before it becomes effective, and we have providers in our community that don't agree on particular modalities. Some may agree with,

[5] Short hand for benzodiazepines, a class of prescription drugs distinct from opioids but also prone to abuse. *Benzodiazepines*, DRUGS.COM, https://www.drugs.com/drug-class/benzodiazepines.html.

with MAT, some may not. And we're bringing those providers together to try to come up with something that everybody can agree on, but I would agree that the recovery community is absolutely key to the process. I mean we went down the McShin foundation and met with Mr. Shinholser or he's been up to Winchester. That's a critical element, one which we didn't realize at first, but we brought in now and they're very active in our coalition.

Casey: Mm-hmm.

Coyne: Because they have a whole different perspective. I mean, I can talk about it in a certain way the people I've represented, but someone with the addiction, the disease of addiction, is going to respond much different with somebody who's been through it, and been through the same trials and tribulations they have.

Casey: So you referenced one of what sounds like a challenge to the partnerships, being that there is still is not necessarily a uniform agreement as to the best response to it.

Coyne: Right.

Casey: Brittany, on to the statewide level, have you identified what are the distinct advantages and also what have become now pronounced challenges to this private-public sector partnership in response to the epidemic?

Anderson: One of the challenges that we first faced in 2014 was the medical community being very resistant to extra work and to being more regulated, so when we had this prescription monitoring program but it was

virtually useless because doctors weren't required to register, they weren't required to report, so we tried to enhance that a little bit more; make requirements on when they had to report, how quickly they needed to report, when they needed to be querying it. And they've started to slowly come around and recognize that they need to be a part of the solution and so we've been able to sort of pick at it that way. And more doctors are registered for the prescription monitoring program. If they're prescribing somebody a prescription painkiller for more than fourteen days, they need to be registering that. Pharmacists need to be checking it so we're seeing less doctor shopping, we're seeing less pills out on the streets and out of medicine cabinets.

But some things that other states have done that we haven't been as successful at is we're finding that physicians have gotten into the business, like, general practice physicians have gotten into the business of prescribing painkillers and benzos a lot when they don't really have any formal training on pain management or addiction. So some states have said, you know, if you're a physician, and the more than fifty percent of the medications that you prescribe are within a certain schedule, you need to be receiving continuing medical education credits and learning about addiction and learning about pain management so you know what you're getting into. Same goes for physicians that want to engage in prescribing medical assisted treatment. If they want to be prescribing methadone and suboxone they need to be trained on how to do that. And that's one of the things we have really tried to ask the medical community to come talk to us

about, about working into curriculums in medical schools more training on pain management and education and continuing that through residency. Depending on what your specialty is, before you're an MD, you might get eight hours of training in addiction, or you might get two months of it. But that's something that they have been a little more resistant on. And I think lawyers can maybe identify that and with that, be as you have CLE credits and you don't want to have more CLEs to do. But we're hoping that's something we can see in the near future because that's really part of the education and prevention piece. You know, Medicaid filled twenty-seven million dollars' worth of prescriptions last year in Virginia. Why are we paying for so many pills and where are those pills going? And if they're coming from a doctor's office and from a pharmacy, we need to get a better handle on prescribing practices.

[Question from the audience followed by laughter]

Casey: Can you just hold it for just a moment, because there's one other thing I wanted to follow up on because I want to be conscious of the time and it was an issue that we've gotten actually a couple of questions on from folks in attendance. It's about what's considered to be the equity in treatment and recovery and response to this issue. So there is the historical war on drugs that we've had in our country, but yet this one seems to be garnering much more sympathetic attention. The comments today were, "It's not a problem we are going to arrest our way out of." And the question is: Has the racial and socio-economic demographic of this epidemic affected our response to it?

Taylor: The real answer? Maybe, I mean, again this is something that Mike and I are very, very sensitive about. And I remember that when we were talking about this, about the changes we were making in Henrico, we have two judges who do drug court, and I went to one of the judges and I said, "You know, the idea of this responsive enforcement for law enforcement is that we want to give the addicts the, 'okay you're sick, let's give you the public health response.'" But then we want to give the dealers and, not to say this is not a heartbreaker, we want to lock them up, and you're putting the poison out there that's killing people.

What I did not want to see happen in Henrico County was that all my addicts were white and all my low corner sellers were all young African American males. I did not want to see that and I was incredibly sensitive to what was ultimately going to happen. And interestingly, when I told you that story earlier about the Circuit Court Judge in Tazewell and how he showed the fifty people who had just been locked up in Tazewell Circuit Court there were forty-nine white people and one African American. So, depending on your jurisdiction – and of course then Tim can also talk about how it is impacting up in the Shenandoah area, the demographics may be different, I'm not sure – but to understand that after we had just come off of this national platform regarding disenfranchisement, the crack epidemic, and Stephen Miller is painfully aware of what happened with the five grams and how we were locking up many, many more young African American males than whites when it came to the Federal prosecution with

these very harsh sentencing standards. I do think that we have to be very, very careful about that. That was something that was said at the state drug court conference regarding the people who were coming into the program and recognizing that transportation is a major issue.

The ability to find employment is a major issue. Understanding that a majority – if not almost ninety-nine percent of these people – come to drug court with trauma-based issues that need to be addressed first before they can realize what the addiction is and, again, making sure you have resources for all of your participants. Again, I'm proud to say in Henrico we've been very good in terms of recognizing the diversity of the applicants who come into our drug court, which is a show-cause based drug court, which is different than the city of Richmond, and recognizing that we work with people who might be on the lower part of the socioeconomic scale than with other people who have other resources available to them. But it is a real issue that we must all be cognizant about.

Casey: Tim, can I follow up with you because I am interested to know and Shannon raised this is: How is this different from the 90's epidemic of crack and how we're responding to it?

Coyne: Well, I think the main difference is in the 90's the federal response was to impose harsh mandatory minimum sentences, and Shannon referenced the five grams of crack, you know, there was a hundred to one difference between powder cocaine and crack cocaine. And I represented any number of people on crack cases really,

even in the western district of Virginia, mostly African Americans who were charged with those possession and distribution offenses. They got harsh punishments. Ten, twenty, thirty plus years. That was the response then and the federal prison population just went up five-fold in that time. So you can't deny or ignore the fact there is a racial reality out there in terms of what was happening then versus now.

Our court – we just received a federal grant – so obviously we are making every effort to not exclude anybody. We can't exclude people on MATs and we have to be cognizant and aware of what the racial makeup of what our court is. We're processing people as they come in. I see the main difference: the people are dying now. Not that people didn't die, Len Bias was the number one draft pick of the Boston Celtics back in 1986; he died. And that had an almost immediate response from congress, in terms of enacting crime legislation. We've had famous people die. You saw the pictures up there of Philip Seymour Hoffman and Prince. So with the famous people dying, I think it is a reality that simply saying, "Just say no," or, "We are going to arrest our way out of the problem," isn't working. It hasn't worked, and it won't work, and we just need a different approach.

Casey: Well I am glad that you say the, "Just say no," because that is a flashback to the war on drugs and the education efforts that I remember growing up with when Nancy Reagan appeared on Different Strokes – completely dating myself right now, but I remember that episode. And I heard Dr. May and Attorney General Herring both

refer to the "adult response" versus the "juvenile response" to this issue and what/where are there similarities and where are their differences? Brittany, can you tell us: Why is it different? And if it is, why does it have to be?

Anderson: I guess I can sort of talk about the way we approach this from our office because we made this prescription drug documentary, and we made that with the target audience being middle school and high school students. So what's depicted in that are stories of young people and very relatable stories of people who were injured during sports activities and were prescribed painkillers to what should have been therapeutic, turned to problematic. And the stories of parents not recognizing the signs of dependence. So we approached it with that way and sort of made it very real, very graphic. We approached it in a way that we wanted it to be relatable and help people understand that even just trying heroin once, trying prescription drugs once, can get you hooked and can lead to death. Our response – or I guess our efforts with adults – is very similar, but we also have a juvenile legal education program called "Virginia Rules" that the Attorney General did talk about. So we try to talk to middle school and high school age students in a way that they understand about the different parts of the laws that affect them as juveniles – whether it be prescription drugs, possession of drugs, and then other things like bullying and internet safety and things like that. So they can understand – better understand the law and how it can work for them and protect them. But also how, you know, when they get in trouble, and later

on as adults how they can be penalized for that.

Casey: And to go forward with that, and Shannon you talked about the use of drug courts in general, do we need a juvenile drug court? Because of the special population?

Taylor: Well we are starting one in Henrico. Richmond has had one for some time. And when we had our first meeting, and kind of like Tim, you know, it's been years in the making to finally get to the point to put in the application. But trying to determine what is your population for that. I mean, recognizing, as we all know here from law school, you know, juvenile court is first for rehabilitation. And then lastly, as you're working your way through the matrix of what the response is. And so we were struggling to kind of identify: What does a juvenile drug court look like in Henrico? I mean, who is it catering to? And the reality is that we could do a lot better identifying children's issues earlier on than I think we are doing right now. And that comes with the work of schools and teachers, people who have contact with these children in other environments, educating parents to see what they see are changes in their child's behavior, to recognize that something is going on. And that is a big hurdle. I mean, while we talk about having people come into our school formats – I mean, remember DARE, just so you know, doesn't work. Regretfully, some kid doesn't want to hear from me, you know, some almost fifty-year-old woman. They want to hear about it from someone who actually relates to them. Which is probably more like a twenty-year-old kid who said, you

know, "Just five years ago, I was in your shoes," or whatever.

And what was particularly startling is that when you're dealing with schools, you have to work through your administrative body to come into the schools and talk about this. And, again, referring to the article that was in the *Richmond Times-Dispatch* about the young man, Andrew Nelson, who went to Godwin High School, I mean, one of the guys in my office who does drug court, Mike Feinmel said, "Wow, that really made me sad to see that they call, you know, Godwin High School, you know 'Pillswin High School,'" because the pills, the benzo, and the prescription pills were just rampant there. And part of that story was a principal who had seen this going on in her school for year after year after year and not knowing, "What can I do to reach out to this population of young people that are coming to school high who are not obviously getting educated, and what can I do to help protect these kids who are under my watch when they walk in that door at, you know, eight o'clock in the morning?" And we saw, you know, we saw that they brought Chris Herren. I mean Godwin High School is very fortunate that they got this famous NBA player to come there and I was very fortunate that I got to see him speak to the children on Tuesday morning. They listened to him because he's a cool basketball player who has this incredible story.

But it's the idea of trying to figure out: What do we do then with the kids who are coming to school who are high? Again, what's going on with the home that the kids are using before they even walk in the

door that day? And Andrew was very up-front about talking about the struggles that started when his parents split up. When he was twelve years old he started smoking marijuana. And he was this huge soccer player, but how he started hanging out with the different type of people and how that progression of marijuana to other drugs led him to the place where he was when he was balled up on the floor crying and telling his sister, "I need help. I'm finally reaching out for help." So we recognize that we need to do, you know, it's not just a court response when it comes to juveniles. It, again, is every time, every person who can touch that child's life as they grow up, identifying the factors and, again, having appropriate resources to refer these children to the right providers.

Casey: And I think too, it touched upon a comment – that I believe was made by Dr. May also – is that kids have always done drugs, but now they're dying from it, and that is what's also affecting the response to it. Mike, I would like to go back to your question.

Michael Herring:[6] There's a definite disparity in the state's response to heroin and crack and other Schedule I's and II's. And everybody around the country acknowledges that. In conversations like this, though, we have to be careful that we don't try to illustrate or frame that disparity with anecdotes about dealers. Dealers and users, to me, are apples and oranges, and users typically don't get sentences of ten to thirty years. Dealers do. If a user gets a sentence like that, it's

[6] Michael N. Herring is the Commonwealth's Attorney for the City of Richmond. He attended the symposium as a member of the audience.

because he's a cat-one or cat-two offender, someone with a history of violence. But the real question that I have is: Do you think there is a role for higher-level state officials to play in encouraging jurisdictions like Henrico to do diversion, which is really what she's doing, off the books? There's no state funding and there's no authorization by statute to do what she's doing. Drug courts, we all get it. They're great. I like mine. But you can't take them to scale to be effective. The only way law enforcement is going to be effective through the state is using custody as leverage to compel treatment through a diversion trajectory. But that will require reallocation of resources from detention to diversion, which localities can't afford. So the question is: Is there a role for the state to play in changing that dynamic?

Taylor: I can tell you, again, because Mike is absolutely right. So part of the changing of our mentality in Henrico was that it was doing no addict any good to come in, make a fifteen hundred dollar bond and go right back out there on the street after having been in jail for a couple days while they're cleaning out. And we actually were, again, trying to work with our General District Court judges to have them recognize that with opioids, it's like twelve, fifteen days plus, for someone's brain to even get cleaned out that they can have a meaningful dialogue with their attorney to figure out how do they want to handle this case.

So we were finally getting people to not get bond for the sole purpose of saving their lives, getting them the resources that, again, Henrico County Jail, we're very lucky to have. And even Sheriff Wade came back with a new response, which is

"I'm going to come up with a system that keeps somebody in our jail for twelve months." He calls it the ORBIT. And it's Offender Rehabilitation By Intensive Treatment. And the idea is that someone goes through the RISE program, again, a very, very good program in Henrico County Jail. And they go through the phases of the RISE program where they learn the coping mechanisms, they understand the issues of addiction or dealing, the changing the people, place, and things and all that good stuff. And then they can get a job, and so they can get work release. And then that's successful, and then they get stepped down to home electronic monitoring. So it takes about twelve months and it is a step down process.

The only thing that is lacking from that procedure is what I call the "infrastructure upon release," which is where a lot of people get caught up in relapse because if they just simply come out of jail and they have nothing set up, no net, no safety net, no anything, the likelihood for relapse is significantly higher. And so we are working to see if we can try to tack on something to the end of that program, but again it's not on the books. It's because you've got players who want to be partners, and we are working together. Again, ultimately, when someone is coming through the criminal justice system for the first time, and maybe even the second time or third, I'm not sure, I don't want it to be used for the purposes of a conviction and saying, "I've got a new stat for Henrico County." But Mike is absolutely right that we need more ability and programs for the people who are addicted, which is the public health aspect of it.

Casey: And Brittany, I'd like to follow up because when we talk about resources it's also what resources are available to localities to bring us forward, and you often then look to the state and to the federal. But it seems that it would, as the attorney general has said, it's putting the focus on the demand side. You know, law enforcement work has been squarely focused, for a long time on the supply, now also putting a focus on the demand side. Do you see as what Mike has described as a furtherance of that focus on the demand side because the intent behind it is to alleviate the demand, or are we looking at this in too binary a fashion, that we have suppliers and we have users where there is a spectrum, potentially, in between?

Anderson: This sort of gives rise to the discussion that we sometimes have about how much money the state is actually spending on people who are incarcerated and of those people, who needs treatment, who can get treatment, who can benefit from reentry resources when they are released from incarceration so that they don't come back. And we've fought for many years to make that a priority for the state when it comes to budgetary resources – investing in our localities and investing in our regional, our local jails. Investing in these resources for the Department of Corrections has shown through many studies that it will reduce recidivism, that these people won't come back and it's going to save the state a ton of money so we've – for a long time – we've asked the General Assembly to prioritize that through the Department of Criminal Justice Services, to prioritize that for funding for localities specific to their

jails and funding to our regional jails as well.

Casey: We're going to be wrapping up shortly to allow you all to pose questions. Thank you so much for all the questions that have come in so far. I have not been able to get to all of them. I might not have named you by name, but I've been trying to weave the questions we've received through twitter and email into the conversation today. But I wanted to follow up on the state's response and the federal response to the supply-demand and how do we address the issue. One of the questions we did receive is that right now Virginia has a full ban on TANF for drug offenders. And so if there is a ban on the Temporary Assistance for Needy Families for drug offenders, how is that necessarily helping the user go through recovery? And Tim, I don't know if you, through your public defender work, if you've seen the implications of that with your clients.

Coyne: Sure. I mean my clients, they get locked up, lose their Medicaid during the time they are incarcerated. What that means is if they have a medical problem, the jail has to pay for their care, so it comes back onto the localities and the taxpayers, so it doesn't make a lot of sense. And that's something that we've, we've tried to meet with state officials, and try to affect the change, but cutting off TANF or limiting their housing options, they are also banned from Section 8 housing. In fact, if they had a family that didn't have a felony conviction and now they now have a felony conviction they can't even live with that family if they're getting subsidized housing. So a lot of things like that are maybe

longer-term goals to change that would certainly open up and help reentry options down the road for people getting out.

Casey: Thank you all so much. We'd like to open, I have questions here I could ask, but I also do want to give people who did not take advantage of smartphones the opportunity to ask questions, as well, of our panelists. Okay well I'm going to go ahead with some of the questions we have here. What has been referenced earlier was also the different drug schedules, as regarding sentencing. If anyone here has ever seen sentencing guidelines it is determined by the drug that is used; not all drugs are treated equally in our currently sentencing structure. Heroin and marijuana are Schedule I and they lead to higher sentences and thus a greater impact. How do you see our current sentencing system and categorization affecting a law enforcement response to the opioid epidemic?

Taylor: That's really more of a federal issue than it is a state issue, except for the sentencing guidelines were changed at some point to recognize what once was a state response to the five grams in federal court which I think was 26.25 was one of the designations but that again was dealing with crack. I am on the sentencing guideline commission and that is a question that was posed to this body, which is comprised of mostly judges but there is a prosecutor and there is a delegate and a state senator and a defense attorney and an advocate and then the Attorney General's Office has representation there too. And it is a data-driven commission. So the idea that do we need to look at heroin differently than we're looking at cocaine, which is Schedule II because it

does have a medical purpose but can be highly abused, is something where that the commission is not prepared to address yet because of, again, data. But I think that is really more along the lines of the idea of the federal system that does use weight designation to play a part in their sentencing guidelines recommendation.

Coyne: In state we don't. The state doesn't really make weight unless you get up over distribution offenses dealing with more than an ounce. But whether it's a tenth of a gram of heroin or you know, a full gram of cocaine, they're going to be treated the same with the guidelines in the state system.

Casey: I wanted to ask a follow-up question, too, regarding what you see as being the coordinated efforts among localities under the state umbrella involving the local behavioral authorities in the health communities there, too. For example, we have the Good Samaritan laws, are the people who are probably collecting the data to show efficacy of that that requires partnerships to move forward. The training of first responders with the drugs that are necessary to stop the effects of an overdose. That requires, again, more partnerships. At what point, who is then tasked with the management of what seems to be so many different partnerships to have this coordinated response and is the current structure we have for that working?

Coyne: At the state level?

Casey: State, local.

Coyne: I don't know that there is a state structure to do it other than the Attorney General

obviously is aware of whatever efforts are going on in Hampton Roads, Winchester, and Henrico, and other places. I don't think there is a formalized state structure.

Taylor: I made a recommendation one time that there should be some type of state agency that oversees all the CSB's in the Commonwealth but—

Anderson: The department of behavioral health sort of oversees the CSB's but—

Coyne: Not really.

Anderson: We wish they did. But as far as a local response – a local coordinated response – I don't think you can have a statewide umbrella that those fall under. I think those have to be what works best for that locality. So in northern Shenandoah Valley they all came together, pooled their funding, created a 501(c)(3), and hired an executive director and she is tasked with making sure that it runs smoothly. I don't know if that would work in other localities but our message when we travel to other localities whether we are showing a documentary or having these discussions is that everyone needs to be at that table. If you don't have the appropriate players from your community at that table being a part of the solution, then it's not going to work. But again, what works best in Winchester won't necessarily work best in Southwest Virginia just because it's two different landscapes, but I don't know if making a top-down approach would necessarily be the right approach.

Casey: So we're not going to see in Virginia a

drug czar any time soon?

Coyne: Unlikely.

Anderson: I don't think so. Yes, unlikely.

Casey: Well thank you so much. Again, I appreciate your participation in this panel. We are about out of time. I know that lunch is awaiting you out in the atrium and definitely I am half-Italian so it is sinful for me to come between you and food so I do not want to delay you at all.

Brittany, Shannon, and Tim, thank you so much. I have appreciated your time, your wisdom, and it is something that I plan to take with me. Thank you all so much for attending.