Milwaukee City County Heroin, Opioid and Cocaine Task Force -- Work Plan Draft (as of 11-29-17) with comments and suggestions added by Paul Mozina.

Please note, that all of the comments made by me have been inserted below the relevant highlighted text in the original document. My comments are italicized to help distinguish them.

161554 - Work Plan Draft (as of 11-29-17)

2018-2022 WORK PLAN

PENGAD 800-631-6989
EXHIBIT
161554

INTRODUCTION

Drug overdoses, driven largely by overdoses related to the use of opioids, are now the leading cause of unintentional injury deaths in the United States. In order to stem the tide and reverse the 15 year trend in increasing drug overdose deaths a coordinated multi-disciplinary community participatory multi-facetted approach is needed to address this unprecedented public health crisis. This work plan serves as the City and County of Milwaukee's initial strategic plan for action.

Overview of Opioids

Opioids are a class of drugs that act on the body's opioid receptors including natural, semi-synthetic and synthetic opioids. Natural opioids include drugs such as morphine, which are derived from the resin of the opium poppy, semi-synthetic opioids such as hydrocodone and oxycodone, and synthetic opioids such as fentanyl and methadone. Opioids are often used medically to relieve moderate to severe pain, but can also be used or other conditions -for example, to suppress cough, to treat diarrhea and even to treat opioid use disorder. Opioids are very effective for treating severe pain such as that associated with cancer, post-surgery, or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other desired and undesired effects. Since these pharmacologic effects focus on blocking pain, opioids have high potential for misuse. (Substance Abuse Research Alliance, 2017)

Opioid drugs mimic the body's natural response to pain by stimulating the body's opioid receptors, most prominently the Mu (μ) receptors. Mu receptors account for most of the effects of opioids and are primarily located in the brain, spinal cord, peripheral nervous system, and intestinal tract. By stimulating the Mu receptors, opioids reduce the perception of pain by slowing down and blocking pain signal transmission to the brain while also triggering the release of dopamine, a neurotransmitter used in the brain's pleasure or reward system. When activated, dopamine produces a pleasurable and often euphoric feeling. Use of opioids for more than a short period of time leads to tolerance and physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, opioid users must not stop taking these drugs abruptly, or they will experience withdrawal symptoms such as agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when the amount of opioids used decreases or stops. (Substance Abuse Research Alliance, 2017)

Overview of Cocaine

Cocaine is a powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. Although health care providers can use it for valid medical purposes, such as local anesthesia for some surgeries, cocaine is an illegal drug. (NIDA, Cocaine, 2017)
Cocaine can be found in a number of forms, including white powder, paste, or solidified and rock-like (the latter commonly referred to as "crack cocaine"). Whatever the form, cocaine acts as a strong stimulant substance that can:

- Provide a rapid-onset, rewarding high.
- Speeds up various physiologic processes via its central nervous system effects.
- Influence both short- and long-term mental health.

Street dealers often mix it with things like cornstarch, talcum powder, or flour to increase profits. They may also mix it with other drugs such as the stimulant amphetamine.

Dependent on the method with which it is used—e.g., smoked, snorted or injected—cocaine can be quite rapidly acting. One of cocaine's effects in the brain is to increase dopamine release. Dopamine is a neurotransmitter that plays a role in the brain registering positive feelings, and "rewarding" the behaviors that led to those feelings to begin with. This increase of dopamine is, in part, what leads to the subjective "high" of cocaine use and its addictive power.

Cocaine's effects appear almost immediately after a single dose and disappear within a few minutes to an hour. Small amounts of cocaine usually make the user feel euphoric, energetic, talkative, mentally alert, and hypersensitive to sight, sound, and touch. The drug can also temporarily decrease the need for food and sleep. Some users find that cocaine helps them perform simple physical and intellectual tasks more quickly, although others experience the opposite effect.

The duration of cocaine's euphoric effects depend upon the route of administration. The faster the drug is absorbed, the more intense the resulting high, but also the shorter its duration. Snorting cocaine produces a relatively slow onset of the high, but it may last from 15 to 30 minutes. In contrast, the high from smoking is more immediate but may last only 5 to 10 minutes.

Short-term physiological effects of cocaine use include constricted blood vessels; dilated pupils; and increased body temperature, heart rate, and blood pressure. Large amounts of cocaine may intensify the user's high but can also lead to bizarre, erratic, and violent behavior. Some cocaine users report feelings of restlessness, irritability, anxiety, panic, and paranoia. Users may also experience tremors, vertigo, and muscle twitches.

Severe medical complications can occur with cocaine use. Some of the most frequent are cardiovascular effects, including disturbances in heart rhythm and heart attacks; neurological effects, including headaches, seizures, strokes, and coma; and gastrointestinal complications, including abdominal pain and nausea. In rare instances, sudden death can occur on the first use of cocaine or unexpectedly thereafter. Cocaine-related deaths are often a result of cardiac arrest or seizures. Many cocaine users also use alcohol, and this combination can be particularly dangerous. The two substances react to produce cocaethylene, which may potentiate the toxic effects of cocaine and alcohol on the heart.

The combination of cocaine and heroin is also very dangerous. Users combine these drugs because the stimulating effects of cocaine are offset by the sedating effects of heroin; however, this can lead to taking a high dose of heroin without initially realizing it. Because cocaine's effects wear off sooner, this can lead to a heroin overdose, in which the user's respiration dangerously slows down or stops, possibly fatally.

Over time cocaine alters the chemical pathways in the brain. Users may develop tolerances leading to higher doses and binge using. Regularly snorting cocaine can lead to loss of sense of smell, nosebleeds, problems with swallowing, hoarseness, and an overall irritation of the nasal septum leading to a chronically inflamed, runny nose. Smoking crack cocaine damages the lungs and can worsen asthma. People who inject cocaine have puncture marks called tracks, most commonly in their forearms, and they are at risk of contracting infectious diseases like HIV and hepatitis C

Risk for HIV and Hepatitis C

Drug intoxication and addiction can compromise judgment and decision-making and potentially lead to risky sexual behavior, including trading sex for drugs, and needle sharing. This increases an opioid or cocaine user's risk for contracting infectious diseases such as HIV and hepatitis C (HCV).

Injection drug users (IDUs) are the highest-risk group for acquiring hepatitis C (HCV) infection and continue to drive the escalating HCV epidemic. Each IDU infected with HCV is likely to infect 20 other people. (NIDA, Heroin Users At Risk, 2017) The risk related to infectious disease doesn't stop with transmission. Substance abuse places cocaine and opioid abuses at increased risk of significant morbidity and mortality from the infectious disease.

Cocaine users with HIV often have advanced progression of the disease, with increased viral load and accelerated decreases in CD4+ cell counts. Infection with HIV increases risk for co-infection with HCV, a virus that affects the liver. Co-infection can lead to serious illnesses—including problems with the immune system and neurologic conditions. Liver complications are very common, with many co-infected individuals dying of chronic liver disease and cancer. (NIDA, Cocaine Users At Risk, 2017)

The interaction of substance use, HIV, and hepatitis may accelerate disease progression. For example, HIV speeds the course of HCV infection by accelerating the progression of hepatitis-associated liver disease. Research has linked HIV/HCV co-infection with increased mortality when compared to either infection alone. Substance use and co-infection likely negatively influence HIV disease progression and the ability of the body to marshal an immune response.

Substance abuse can lead to outbreaks of infectious disease. Such was the case in rural Indiana in 2015, when a state of emergency was declared when an outbreak resulted in nearly 225 cases of HIV being reported due to injection drug use. 400 cases of hep c

It is important to recognize that drug prohibition is the main reason that people inject heroin. Given the high cost and risk of getting it, users try to optimize the effect by injecting the substance.

"It is true that before the Harrison Act, when opiates were cheap and plentiful, they were very rarely injected. Moreover, injection is rare in those Asian countries where opiates are inexpensive and easily available. For instance, in Hong Kong until recently, heroin, though illegal, was cheap and relatively available, and the drug was inhaled in smoke rather than injected. In the last few years, however, law enforcement has been able to exert pressure on the supply of the drug, raising its price considerably and resulting in a significant increase in the use of injection."

The Hardest Drug: Heroin and Public Policy 1983 by John Kaplan p. 128 quoted by Randy Barnett on page 10 of his article: "The Harmful Side Effects of Drug Prohibition", https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1837&context=facpub

The HIV/HIC issues associated with intravenous drug use are mainly caused by the prohibition of the injected substances. I hope the Task Force will include this highly relevant fact in the description of the problem in the Work Plan.

Given the attention paid to this issue above, consider adding a goal and strategies to reduce this harm e.g.: Increasing the availability of clean needles; Providing anonymous testing services so people can find out if their "heroin" is laced with fentanyl and, if so, to what extent; or simply what is the purity of the heroin present in the substance and what else has been added.

See:

Johns Hopkins Magazine "Supervised drug injection sites cut down on overdoses, infections, and opioid-related costs", https://hub.jhu.edu/magazine/2017/fall/safe-effective-drug-injection-centers/

No such facility currently operates in the United States, but a new cost-benefit analysis conducted by the Bloomberg School of Public Health and published in the May 2017 issue of Harm Reduction Journal, suggests that a single safe consumption space in Baltimore would annually prevent 5 percent of overdose deaths and save $6 million in costs related to the opioid epidemic. Drug overdoses now account for more fatalities than gun homicides and car crashes, and the problem is getting worse. The number of overdose deaths has climbed because of cheap and increasingly available synthetic opioids such as fentanyl, which is 50 to 100 times more potent than heroin or morphine, says Susan Sherman, a professor in the Department of Health, Behavior and Society at the Bloomberg School and senior author of the study.

Safer Injection Facilities (SIFs) for Injection Drug Users (IDUs) in Canada
http://journal.cpha.ca/index.php/cjph/article/download/338/338

Does HIV Needle Exchange Work?
https://prevention.ucsf.edu/uploads/pubs/FS/NEPrev.php

New York Times: "Politics Are Tricky but Science Is Clear: Needle Exchanges Work"
https://www.nytimes.com/2016/09/05/upshot/politics-are-tricky-but-science-is-clear-needle-exchanges-work.html

Scope of the Public Health Crisis

Last year, roughly 64,000 people died from a drug overdose in the United States -- the largest annual increase in drug-related deaths ever recorded in our history. Overdoses are now the leading cause of death for Americans under the age of 50. The majority of drug overdose deaths (more than six out of ten) involve an opioid. (Rudd, Seth, Felicita, & Scholl, 2016) Since 1999, the number of overdose deaths involving opioids (including prescription opioids and heroin) quadrupled. (CDC, Understanding the Epidemic, 2017) From 2000 to 2015 more than half a million people died from drug overdoses. More than ninety Americans die every day from an opioid overdose. (CDC, Understanding the Epidemic, 2017)

We now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. The amount of prescription opioids sold to pharmacies, hospitals, and doctors' offices nearly quadrupled from 1999 to 2010, (US Department of Justice, 2011) (Paulozzi, Jones, Mack, & Rudd, 2011) yet there had not been an overall change in the amount of pain that Americans reported. (Chang H, Daubresse, KruszewskiSP, & Alexander, 2014) (Daubresse, Chang, Yu, & Viswanathan, 2013)

Please consider including in your description scope and causes of the problem the contributions (harms actually) of prohibition. If people who choose to consume a substance can acquire it from a trusted source, at a known and tested purity and concentration, then the incidence of overdose will be significantly reduced. Granted, some people would choose to abuse the substance to the point where they might overdose and die. This could be intentional or an accident. The point is, The State has accepted this risk in the case of alcohol and tobacco. It acknowledges that the harms caused by the abuse of these substances would be greatly increased if they were made illegal.

See "The Consumers Union Report on Licit and Illicit Drugs", published by the Schaffer Library of Drug Policy, Chapter 8. The Harrison Narcotic Act (1914) at http://www.druglibrary.org/schaffer/library/studies/cu/cu8.html.
Below are a couple examples of commentary made on the effects of this act (from 1936):

"Stringent laws, spectacular police drives, vigorous prosecution, and imprisonment of addicts and peddlers have proved not only useless and enormously expensive as means of correcting this evil, but they are also unjustifiably and unbelievably cruel in their application to the unfortunate drug victims. Repression has driven this vice underground and produced the narcotic smugglers and supply agents, who have grown wealthy out of this evil practice and who, by devious methods, have stimulated traffic in drugs. Finally, and not the least of the evils associated with repression, the helpless addict has been forced to resort to crime in order to get money for the drug which is absolutely indispensable for his comfortable existence..."

"Drug addiction, like prostitution and like liquor, is not a police problem; it never has been and never can be solved by policemen. It is first and last a medical problem, and if there is a solution it will be discovered not by policemen, but by scientific and competently trained medical experts whose sole objective will be the reduction and possible eradication of this devastating appetite. There should be intelligent treatment of the incurables in outpatient clinics, hospitalization of those not too far gone to respond to therapeutic measures, and application of the prophylactic principles which medicine applies to all scourges of mankind. "

I reminded the Task Force repeatedly about the testimony that Ms. Kathy Federico gave regarding the high number of cases the DEA Diversion Squad has of doctors who are illegally prescribing opioids. Has anything been done about this? Are you serious about reducing the amount of prescription drugs being diverted and sold on the streets thus helping to fuel the "Opioid Epidemic"? (NOTE verify if this is redundant)

Wisconsin has been deeply impacted by the opioid crisis. According to the Wisconsin Department of Health Services, in 2016, 827 people died in Wisconsin of opioid overdose deaths caused by heroin, or prescription drugs, or both. From 2000 to 2016, the number of deaths in Wisconsin due to prescription opioids increased 600 percent, from 81 to 568 in 2016. Heroin overdose deaths increased 12 times, from 28 deaths in 2000 to 371 deaths in 2016.

Given the overall Public Health and Safety goals of the Task Force, it would help to put these numbers in perspective vis-a-via Alcohol and Tobacco. A 600% (as well as the 495% mentioned below) increase sounds dramatic, but, given the low starting number, the total pales in comparison to alcohol and tobacco deaths. In Wisconsin we have areas suffering from Opioid abuse that are characterized at "Epidemic" proportions; and we have areas where death from the Alcohol or Tobacco abuse is "Endemic". Death from alcohol and tobacco is accepted in society, while the mere possession and use of opioids is criminalized.

Wisconsin Epidemiological Profile on Alcohol and Other Drugs, 2016 https://www.dhs.wisconsin.gov/publications/p4/p45718-16.pdf

> *"In 2015, alcohol was a factor in at least 2,008 deaths and 2,907 motor vehicle crash injuries in Wisconsin. In 2013, the economic burden resulting from excessive alcohol use totaled $6.8 billion dollars."*

The Burden of Tobacco in Wisconsin 2015 Edition http://uwm.edu/cuir/wp-content/uploads/sites/111/2015/04/Burden-of-Tobacco-2015.pdf

> *"During 2008-2012, an estimated 6,678 people died from illnesses directly related to smoking each year, constituting nearly 15% of all annual deaths in Wisconsin among persons aged 35 years and older. Another 678 people died from illnesses and fires indirectly related to smoking. Collectively, 7,356 Wisconsin deaths were associated with tobacco use each year. The annual economic toll of tobacco in Wisconsin was approximately $3.0 billion paid in direct health care costs and $1.6 billion in lost productivity."*

The total deaths spanning 2000 - 2016 from alcohol and tobacco dwarf those from opioids. I don't mean to suggest there isn't a problem with increasing opioid overdose, but including alcohol and tobacco numbers in the description of the problem would put the opioid "epidemic" in perspective.

Since 2005, Milwaukee County has seen a 495% increase in heroin related deaths. Over the last five years overdose deaths have consistently surpass homicides, motor vehicle accidents and suicides investigations completed by the Milwaukee County Medical Examiner office for non-natural death investigations. Yet, deaths only illustrate a small part of the effect the opioid epidemic has on the Milwaukee community. In fact, in 2015, for every death, there were more than 6 additional people who experienced an overdose that required naloxone, and multitudes more who were addicted but never overdosed. (Fumo, 2017)

Image the Milwaukee County Non-Natural Deaths chart below with bars for alcohol and tobacco deaths. I wondered why these deaths were not included. Maybe it's just me -- but I don't thing that poisoning oneself to death with alcohol or tobacco is "natural"; abused to this extreme, they are vices for sure ,but this is not a "natural" way to die.

I contacted Brian L. Peterson, M.D., Chief Medical Examiner -- Milwaukee County Medical Examiner's Office, to ask him why deaths from alcohol and tobacco were not included in the Milwaukee County non-natural deaths 2011-2017 chart and here is his reply:

"Thank you for your interest. As to alcohol-related deaths, those are accounted for in a number of ways. Internally, our death certification software allows us to check an "alcohol involved" box. Externally, on the state death certificate, same box, and additionally, "complications of chronic ethanol abuse" is used quite often. ***The way the state counts such things, though, those deaths are considered natural as to manner, probably because ethanol is legal, but that was a decision made long before my time.*** *The exception would be a true ethanol poisoning death - and those are recorded like any other drug overdose.*

With respect to tobacco, we have a similar box - "was tobacco involved." That can be a bit harder to answer scientifically, though. For example, we all understand that in population studies, cigarette use is associated with higher lung cancer rates. When it comes down to one individual, though, a person can be a non-smoker and still get lung cancer, and the opposite is also true, in that a smoker can live out his or her life and never develop lung cancer. So, for one individual who smoked and has lung cancer, we cannot scientifically say that one led to the other. For that reason, I have never in my career used "tobacco use" as the cause of death. Additionally, the statistics that I report to the task force are derived from the cases handled by my office; ***most death by, say, lung cancer, are not handled by our staff, but rather those deaths are certified by their own doctors."***

I am hoping the Task Force considers the points I make comparing and contrasting the legal status of alcohol and tobacco with the illegal status heroin, opioids and cocaine and includes them in its description of the scope and cause of the overdose problem -- to demonstrate and make explicit the impact of prohibition. Including deaths from alcohol and tobacco in the Milwaukee Non-Natural Deaths chart, would be an appropriate acknowledgement of impact of these substances on Public Health.

Consider the Public Safety implications of arbitrarily criminalizing opioid abuse while arbitrarily accepting alcohol and tobacco abuse. There is relatively little crime (violent or property) directly associated with the ***legal status*** *of alcohol and tobacco abuse while there is a great deal of crime and violence associated with the* ***illegal status*** *of controlled substances.*

From a Public Health and Safety perspective, The State has accepted the fact that it cannot, via criminal sanction, prevent people from harming themselves by abusing alcohol and tobacco. This attempt to legislate morality was tried with alcohol prohibition and the resulting crime, violence, poisoning, moral corruption and other harms too numerous to mention, were soon recognized and the attempt to impose an arbitrary morality was quickly abandoned.

The Task Force is accepting the "natural death" definition used in the narrow context of the Medical Examiner's office, instead of a commonly recognized definition of "natural death" that would acknowledge that deaths resulting from alcohol and/or tobacco abuse are not "natural". The Task Force should be including deaths from alcohol and tobacco abuse in this Work Plan to fairly and accurately report the reality of the impact of prohibition.
Obviously, there is nothing the Task Force can do in the short term about drug prohibition and the Controlled Substances Act. But the Task Force can -- and it is my hope -- will, include in its final report/plan recommendations to both the Common Council and County Board that they work through their respective Federal and State Government liaison offices to communicate the recognition by the Task Force of the role that prohibition plays in thn overdose deaths. I want the Task Force to recommend that the issue of drug prohibition be included in the discussions at the both the Federal and State levels when considering solutions to the overdose problem.

Both the City and County have some discretion in how they enforce the drug laws within their jurisdictions. The Task Force can recommend that they use this discretionary power to try to mitigate the harms caused by prohibition. This would require the creation of appropriate "File Numbers" for inclusion in their respective agendas so they can discuss the issue (these discussion may have to start in a Committee). My goal is to help everyone involved gain a deeper appreciate of the relationship of prohibition and overdose deaths -- it is ***the*** *primary cause of the problem.*

Chart 1: Milwaukee County Non-Natural Deaths 2011-2017

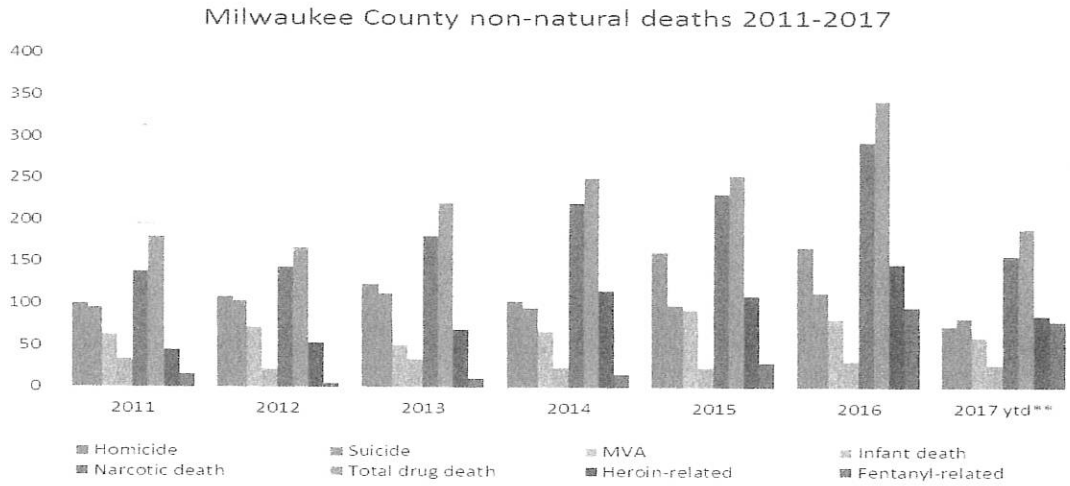


Chart 2: Opioid Related Overdose Deaths by Age Range for Years 2012-2016

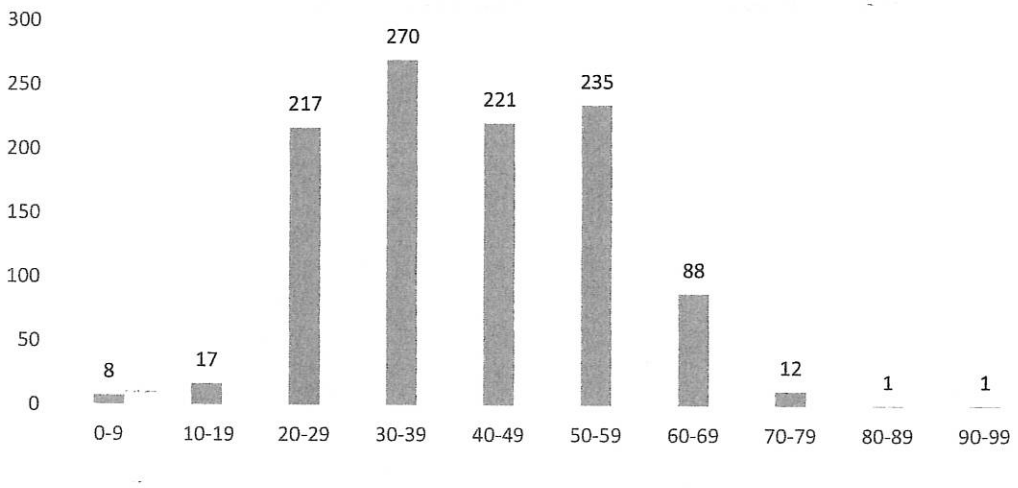


Chart 3: Opioid Related Overdose Deaths by Race / Ethnicity 2012-2016

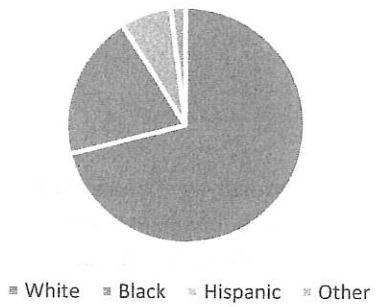


Chart 4: Opioid Related Overdose Deaths by Gender 2012-2016

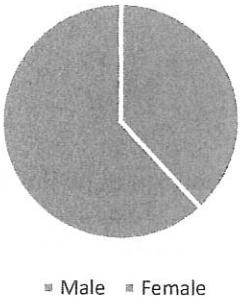
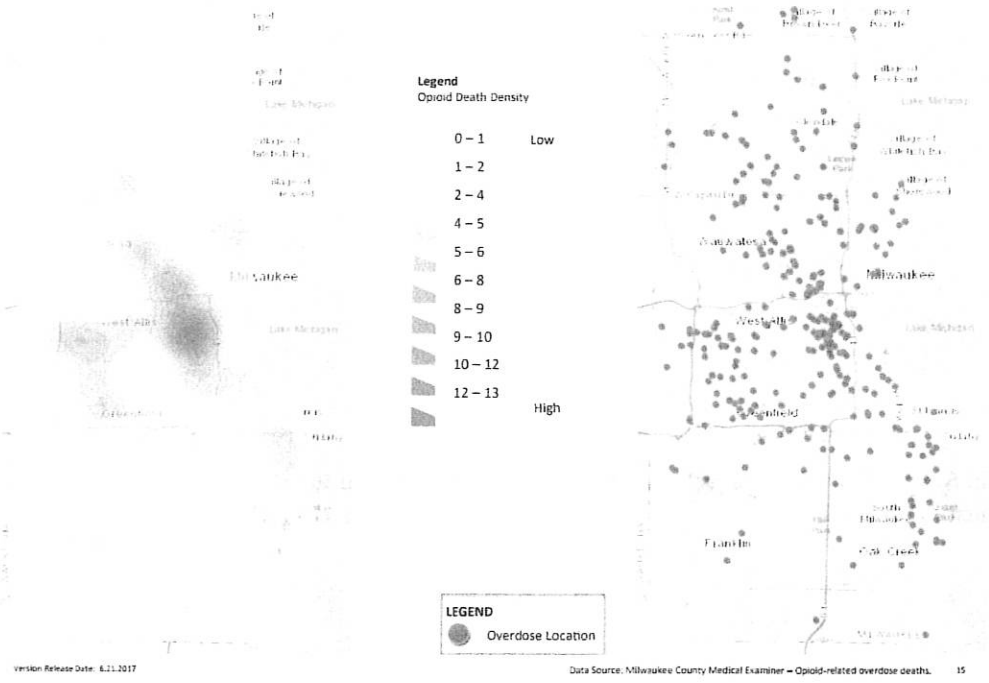


Figure x: Location of Opioid Related Overdose Deaths in Milwaukee County for Years 2013-2016

Figure: Overdose Location for Opioid-Related Deaths in Milwaukee County, 2016



While the charts and figures on the previous pages illustrate that fatal overdoses were more likely to occur in older white males, it also shows that no group nor no corner of the county has been spared from the opioid epidemic. Opioid, heroin, and synthetic analog and cocaine use, addiction, and overdose are

problems that affect an increasingly wide demographic of residents of the City of Milwaukee and Milwaukee County, including pregnant women and newborns

The majority of those who die from opioid overdoses are found to have ingested multiple drugs that contributed to their death. Further, there has been a steep rise in fentanyl-related overdose deaths. Alarmingly, among those who survived their overdose after receiving Naloxone, approximately one-quarter did not access the EMS system. Of those who died from an opioid overdose, the majority were not identified until after it was too late to attempt resuscitation or administer Naloxone either because the victim was alone or thought to be sleeping.

The White House says the true cost of the opioid drug epidemic in 2015 was $504 billion, or roughly half a trillion dollars

In 2007, the economic cost of illicit drug use totaled more than $193 billion in the United States. The estimated direct and indirect costs attributable to illicit drug use are in four principal areas: crime, health, medical care and productivity. Wisconsin's share of this cost is estimated to be at least $2 billion based upon admissions to substance use treatment facilities. A separate 2001 study estimated the economic cost of heroin use alone in the United States at $21.9 billion or about $220 million in Wisconsin3. The recent resurgence of opiate-related problems has increased emergency room visits, crime, homicides, high school drop-outs and loss of employment and has public health, criminal justice and public policy officials concerned.

The situation has reach the level that the Centers for Disease Control and Prevention has characterized prescription opioid use as a public health epidemic in the United States, and on October 26, 2017 the President officially declare the opioid crisis a public health emergency.

What is the source for the $504 billion number? What does it include? Can you find any more current data for the economic costs in Wisconsin?

Consider including the cost of the War On Drugs, which I am assuming are not included in the numbers you site above. See "AP IMPACT: After 40 years, $1 trillion, US War on Drugs has failed to meet any of its goals" http://www.foxnews.com/world/2010/05/13/ap-impact-years-trillion-war-drugs-failed-meet-goals.html, for just one example. It claims we have spent $1 trillion over the last 40 years.

It would help taxpayers understand both the scope and the costs of current efforts, here in Milwaukee, of the opioid epidemic/illicit drug use problem, if there was an enumeration or audit of all of the Departments, Programs, Initiatives, Grants etc..., in the City of Milwaukee City and Milwaukee County that are "drug related". This would also provide a benchmark for where we are now and facilitate a better understanding of how these various components might be integrated more efficiently. This would require a significant effort and could not be accomplished by the Task Force given its time is limited.

This would be another case where the Task Force, in its final Plan or recommendations, would ask the Common Council and County Board to perform the audits. The Work Plan could stipulate that the results be incorporated into strategies for Goal 6 (Enhance collaboration between community-based initiatives and government agencies)

For example:
How much is spent by law enforcement including: Police, Fire Department and EMS, The Court System (Judges, Sheriffs, Prosecutors, Public Defenders etc...), Jails, Prisons, Parole, Reintroduction Programs. What are the results?

How much has been spent on harm reduction including education, prevention and treatment, and what are the results?

What programs have worked and why or why not?

How effectively have the funds from the various DEA and SAMHSA grants that the City and County received been used? What results have accepting and implementing these grants achieved?

The City of Milwaukee received a $1 million dollar grant for the Office of Violence Prevention in 2017. What has been accomplished. Given the relevancy of this program to the Public Health and Safety goals of the Task Force, one would think that it would at least receive a mention in the Work Plan. I did contact former Task Force chairman Bevan Baker, and Reggie Moore, Director of the Office of Violence Prevention, in the Spring of 2017 asking that Mr. Moore make a presentation to the Task Force -- they chose not to.

What is the City of Milwaukee Health Department spending on this effort? There is no money allocated in the 2018 Budget for the City Health Department for any effort specific to substance abuse. There are no existing programs in the City of Milwaukee Health Department regarding drug, alcohol or tobacco abuse. I may be mistaken but I don't see anything relevant on the City's Health Department website http://city.milwaukee.gov/health/disease-Control-and-Environment#.WnyetIJG2As

Milwaukee County, on the other hand, has allocated money in its 2018 budget:

Community Services

- CCS Program Expansion
- Create three additional CART teams
- Expand all crisis resource centers to 24/7 operations
- Full year of Intensive Outpatient Program
- Increased TCM Capacity
- Increased AODA Capacity
- Enhanced Opioid Epidemic Strategies

An audit would help reveal gaps like this in the City of Milwaukee's Health Department.

The Milwaukee Community Opioid Prevention Effort (COPE) https://mkeopioidprevention.wordpress.com/ and more specifically https://mkeopioidprevention.wordpress.com/ has done an excellent job of gathering resources for prevention and treatment, but its efforts do not extend into the realms of City and County Government.

Getting audits of City and County Departments, Grants and Programs that play a role in prosecuting the War on Drugs (law enforcement, or in Harm Reduction (Education, Prevention, Treatment etc...) performed and holding these entities accountable for results, would be be a valuable contribution allocating scarce resources efficiently.

Selected Drug Use, Past Year Alcohol Use Disorder, and Past Year Mental Health Measures in *Wisconsin*, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2014-2015 NSDUHs

Measure[1]	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Year Marijuana Use	584	63	201	320	521
Past Month Marijuana Use	334	34	109	190	300
Past Year Cocaine Use	77	3	31	43	74
Past Year Heroin Use	15	1	6	9	15
First Use of Marijuana[2,3]	57	24	27	6	33
ALCOHOL					
Past Month Alcohol Use	2,923	50	414	2,459	2,872
Past Month Alcohol Use (Individuals Aged 12 to 20)	155[4]	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use[5]	1,228	36	226	967	1,193
Past Month Cigarette Use	998	26	182	789	971
PAST YEAR ALCOHOL USE DISORDER[6]					
Alcohol Dependence	140	4	35	100	135
Alcohol Use Disorder	355	14	91	250	341
PAST YEAR MENTAL HEALTH ISSUES					
Major Depressive Episode[3,7]	--	61	66	222	288
Serious Mental Illness[3,8]	--	--	33	142	175
Any Mental Illness[3,8]	--	--	140	684	824
Had Serious Thoughts of Suicide[9]	--	--	52	132	184

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

NOTE: Estimated numbers appearing as 0 in this table mean that the estimate is greater than 0 but less than 500 (because estimated numbers are shown in thousands).

[1] In 2015, a number of changes were made to the NSDUH questionnaire and data collection procedures resulting in the establishment of a new baseline for a number of measures. Therefore, estimates for several measures included in prior reports are not available. For details, see Section A of the "2014-2015 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at http://www.samhsa.gov/data/.

[2] *First use of marijuana* (or the average annual number of marijuana initiates) = $X_1 \div 2$, where X_1 is the number of marijuana initiates in the past 24 months.

[3] For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at http://www.samhsa.gov/data/.

[4] Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.

[5] Tobacco Products include cigarettes, smokeless tobacco (i.e., snuff, dip, chewing tobacco, or "snus"), cigars, or pipe tobacco.

[6] Alcohol Use Disorder is defined as meeting criteria for alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[7] Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.

[8] Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) *Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders* (MHSS-SCID), which is based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness (SMI). Any mental illness (AMI) includes individuals in any of the three categories.

[9] Respondents were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "Yes," they were categorized as having serious thoughts of suicide in the past year.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015.

Intersection of Substance Abuse and Public Safety

The use of alcohol and drugs can negatively affect all aspects of a person's life, impact their family, friends and community, and place an enormous burden on American society. One of the most significant areas of risk with the use of alcohol and drugs is the connection between alcohol, drugs and crime.

Alcohol and drugs are implicated in an estimated 80% of offenses leading to incarceration in the United States such as domestic violence, driving while intoxicated, property offenses, drug offenses, and public-order offenses.

Our nation's prison population has exploded beyond capacity and most inmates are in prison, in large part, because of substance abuse:

- 85% of offenders have substance abuse issues (9)
- Approximately 60% of individuals arrested for most types of crimes test positive for illegal drugs at arrest.
- Alcohol, alone or in combination with another substance, is involved in the incarceration of 57% of all prisoners

The Wisconsin Department of Corrections estimates that 70% of state prisoners have a substance abuse addiction. In comparison, the Wisconsin Department of Health Services estimates the rate of dependence or abuse of illicit drugs in the general population as 3%. Data specific to Milwaukee is not available?

According to an article in the Journal of the American Medical Association, 80% to 85% of prisoners who could benefit from substance abuse treatment in prisons do not receive it.[81] Despite the preponderance of evidence showing that treatment reduces drug use and drug-related crime, the U.S. Office of Justice Assistance notes that only 15% of state prisoners receive treatment while incarcerated.

According to the Federal Bureau of Justice Statistics, over half of the U.S. prison population has mental health issues8 and an estimated 85% have substance abuse issues.9

The National Center on Addiction and Substance Abuse at Columbia University estimates that while 65% of U The Bureau of Justice Statistics found that 56% of U.S. prisoners had substance use dependence or abuse in the month prior to entering prison, and 32% of state prisoners committed their offense under the influence of drugs.27 A 2006 study concluded that adults were 12 times more likely to be involved in the criminal justice system if they had substance abuse issues than if they did not.28

The relationship between drugs and crime is complex, and one question is whether drug use leads people into criminal activity or whether those who use drugs are already predisposed to such activity. Many illegal drug users commit no other kinds of crimes, and many persons who commit crimes never use illegal drugs. However, at the most intense levels of drug use, drugs and crime are directly and highly correlated and serious drug use can amplify and perpetuate preexisting criminal activity.

There are essentially three types of crimes related to drugs:

- Use-Related crime: These are crimes that result from or involve individuals who ingest drugs, and who commit crimes as a result of the effect the drug has on their thought processes and behavior.
- Economic-Related crime: These are crimes where an individual commits a crime in order to fund a drug habit. These include theft and prostitution.

*I tried to check the resources cited above on page 13 and could find no references to support them in the reference section -- I know, this **is** a draft. Hopefully all the percentages noted above will be fully referenced in the final version of the Work Plan.*

In the various percentages cited above, please distinguish between Federal Prisons, State Prisons and Local Jails (in some cases you do that already), and try to find more recent data.

Above the plan says: "Our nation's prison population has exploded beyond capacity and most inmates are in prison, in large part, because of substance abuse:". It would be relevant and appropriate to include a discussion of the role that drug prohibition and the "War On Drugs" has had on our prison population. Mandatory Minimum Sentencing laws (see Families Against Mandatory Minimums http://famm.org/) have resulted in a huge growth in prison populations .

The huge sentencing disparities between Crack and Power Cocaine. See "The Sentencing Project: Cracked Justice": https://www.sentencingproject.org/wp-content/uploads/2016/01/Cracked-Justice.pdf), somewhat mitigated, though not nearly enough, by the Fair Sentencing Act, https://en.wikipedia.org/wiki/FairSentencingAct, are just a couple of examples that could be included.

Not only have prison populations exploded, there is clearly a racial bias in the enforcement of the drug laws that results in a disproportionate number of Blacks and other minorities in our prison systems. See "Racial disparities Powder Cocaine and Crack Use in the United States: An Examination of Risk for Arrest and Socioeconomic Disparities in Use" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC533860/. And Wisconsin ranks #1! See "Wisconsin Prisons Incarcerate Most Black Men In U.S.": https://www.npr.org/sections/codeswitch/2013/10/03/228733846/wisconsin-prisons-incarcerate-most-black-men-in-u-s

Drug prohibition is root cause of the exploding prison population, not substance abuse.

Per the Bureau of Prisons https://www.bop.gov/about/statistics/statisticsinmateoffenses.jsp, 79,231 or 46% of the Federal Prison population is incarcerated because of a drug offense. It does not specifically distinguish whether or not the "offender" was abusing drugs.

The Plan says above: "Alcohol, alone or in combination with another substance, is involved in the incarceration of 57% of all prisoners" Here you have include the impact of alcohol, thus it would be appropriate and consistent to include it in the whole context of this Public Health and Safety discussion.

The comment highlighted above: "The relationship between drugs and crime is complex, and one question is whether drug use leads people into criminal activity or whether those who use drugs are already predisposed to such activity." -- ignores the real fundamental question: Who decides what is or is not a crime? Per The State, it is a crime to explore your own consciousness via the consumption of proscribed substances, but, per The State, it is OK to do the same with legal substances.

Lysander Spooner summarized the implications of these arbitrary policies succinctly in his essay "Vices Are Not Crimes":

"Unless this clear distinction between vices and crimes be made and recognized by the laws, there can be on earth no such thing as individual right, liberty, or property; no such things as the right of one man to the control of his own person and property, and the corresponding and co-equal rights of another man to the control of his own person and property."

Substitute drug abuse -- a crime, for drunkeness -- a vice, in the following excerpt from the same work by Mr. Spooner:

> *It seems to be much more consonant with the merciless character of these men to send an unfortunate man to prison for drunkenness, and thus crush, and degrade, and dishearten him, and ruin him for life, than it does for them to lift him out of the poverty and misery that caused him to become a drunkard.*

It is only those persons who have either little capacity, or little disposition, to enlighten, encourage, or aid mankind, that are possessed of this violent passion for governing, commanding, and punishing them. If, instead of standing by, and giving their consent and sanction to all the laws by which the weak man is first plundered, oppressed, and disheartened, and then punished as a criminal, they would turn their attention to the duty of defending his rights and improving his condition, and of thus strengthening him, and enabling him to stand on his own feet, and withstand the temptations that surround him, they would, I think, have little need to talk about laws and prisons for either rum-sellers or rum-drinkers, or even any other class of ordinary criminals. If, in short, these men, who are so anxious for the suppression of crime, would suspend, for a while, their calls upon the government for aid in suppressing the crimes of individuals, and would call upon the people for aid in suppressing the crimes of the government, they would show both their sincerity and good sense in a much stronger light than they do now. When the laws shall all be so just and equitable as to make it possible for all men and women to live honestly and virtuously, and to make themselves comfortable and happy, there will be much fewer occasions than now for charging them with living dishonestly and viciously.Regarding the correlation between drugs and crime noted above: Obviously this impacts Public Health and Safety. What specific goals or strategies is the Task Force recommending to break the connection between drugs and crime? Why is the Task Force not considering the relationship of prohibition to crime and considering strategies to reduce this harm?

From Randy E. Barnett's article "The Harmful Side Effects of Drug Prohibition": http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1837&context=facpub

"Illegalization makes the prices of drugs rise. By increasing scarcity, all else being equal, the confiscation and destruction of drugs causes the price of the prohibited good to rise. And by increasing the risk to those who manufacture and sell, drug laws raise the cost of production and distribution, necessitating higher prices that reflect a "risk premium."" "Higher prices require higher income by users. If users cannot earn enough by legal means to pay higher prices, then they may be induced to engage in illegal conduct—theft, burglary, robbery—in which they would not otherwise engage. The increased harm caused to the victims of these crimes will be discussed below as a cost inflicted by drug laws on the general public. Relevant here is the adverse effect drug laws have on the life of drug users. By raising the costs of drugs, drug laws breed criminality. They induce some drug users who would not otherwise have contemplated criminal conduct to develop into the kind of people who are willing to commit crimes against others."

"Prohibition automatically makes drug users into "criminals." While this point would seem too obvious to merit discussion, the effects of criminalization can be subtle and hidden. Criminalized drug users may not be able to obtain legitimate employment. This increases still further the likelihood that the artificially high prices of illicit drugs will lead drug users to engage in criminal conduct to obtain income. ***It is difficult to overestimate the harm caused by forcing drug users into a life of crime.*** *Once this threshold is crossed, there is often no return. Such a choice would not be nearly so compelling, nor as necessary, if prohibited substances were legally available and reasonably priced. Further, criminalization increases the hold that law enforcement agents have on drug users. This hold permits law enforcement agents to extort illegal payments from users or to coerce them into serving as informants who must necessarily engage in risky activity against others. Thus, prohibition both motivates and enables the police to inflict harm on drug users in ways that would be impossible in the absence of the legal leverage provided by drug laws."*

The plan cites a percentage: "...32% of state prisoners committed their offense under the influence of drugs." I hope you will provide a reference to support this. How likely is a person intoxicated with a systemic depressant like heroin to go out and commit crime?

- System-Related crime: These are crimes that result from the structure of the drug system. They include production, manufacture, transportation, and sale of drugs, as well as violence related to the production or sale of drugs, such as a turf war.

While the FBI does not report drug-related crimes, they do report arrests due to drug abuse violations. In 2009, about 18% of U.S. prisoners were sentenced for drug-related offenses,[160] and in 2010, 13% of total arrests were directly due to drug abuse violations.[161] In Wisconsin, an increase in drug offenders accounted for more than 20% of the growth in incarceration from 1996 to 2006, and OWI offenders were responsible for more than 60% of the growth from 2001 to 2006.162

Many people who commit non-violent crimes have substance abuse and mental health issues. By report of the Substance Abuse and Mental Health Services Commission we know that 60% and 50% of inmates have a substance abuse or mental health issue, respectively,164 and that 33% of all inmates have co-occurring disorders.165 Meanwhile, 72% of those with substance abuse issues166 and 39% of those with mental health issues 167 commit non-violent crimes

The U.S. Drug Enforcement Agency has announced that Milwaukee will be the second of four cities in the Midwest to take part in a pilot comprehensive diversion control law enforcement and prevention "360 Degree Strategy" to help cities dealing with the opioid misuse and heroin epidemic linked to violent crime. The City of Milwaukee recognizes a need for taking a proactive and prevention-oriented approach to the assurance of public health and safety of the community. Many residents of the City and County who misuse or suffer from addiction to opioids, heroin, and synthetic derivatives, and cocaine are stigmatized from seeking treatment from medical providers. It is against this backdrop that Ald. Michael Murphy, representing the 10th District, sponsored the resolution creating this Task Force to develop and recommend meaningful evidence-based solutions to the growing problem of heroin, opioid, and cocaine misuse, addiction, and overdose.

https://www.ncadd.org/about-addiction/alcohol-drugs-and-crime

City-County Heroin, Opioid, and Cocaine Task Force

Perhaps most surprising is an April 2016 Kaiser Health Tracking Poll that found most Americans believe the federal government is not doing enough to combat recent increases in the number of people who are addicted to prescription painkillers (66%) or heroin (62%). The poll found similar public views regarding state governments and doctors who prescribe painkillers.
In short, there is compelling evidence that prescription pain relief opioids are driving the overdose epidemic. The highly addictive nature of these drugs has also fueled the subsequent explosion in heroin and other synthetic opioid use and overdose. The epidemic has touched persons from every walk of life in families, workplaces, and within community social networks.

At the urging of other Common Council members, cocaine, including crack forms, was also added to the charge of this task force. There is long-standing historical trauma related to the way in which the cocaine epidemic of the 1980s and 90s was handled, with mass incarceration and little focus on treatment. Deaths due to cocaine overdose are much fewer than those of opioids or heroin. According to data from the Milwaukee County Medical Examiner's office, from 2011-16, there were 97 deaths due to cocaine

I could not find any sources to support the numbers cited above in the reference section at the end of the Work Plan. I hope this will be addressed in the final version.

Regarding "System-Related Crime": this is a euphemism for prohibition and its enforcement via the war on drugs and the Controlled Substances Act. These "crimes" exist only per the arbitrary prerogatives of The State. As I have mentioned many times in my feedback to the Task Force, this is the "neglected aspect" in the logic behind the Task Force's current recommendations. It is "The System" that is to blame per its malum prohibitum, rather than any natural law, or malum in se. These "System-Related Crimes" are manufactured by The State -- they do not derive from any authority granted to them by the people as "the people" cannot grant a right to their representatives or agents that none of them individually possess. None of us has the right to proscribe what another person can possess or consume, so how can that right be delegated to The State? It can't and therefore The State's usurpation of this right is illegitimate and so are all of it drug prohibition laws.

Regarding the State's lack of reporting of "drug-related crimes" please note the references I have made in this document to data from the Federal Bureau of Prisons.

How many incarcerated individuals become substance abusers ***<u>while in prison?</u>***

How many people who entered the prison system as non-violent drug law offenders emerge -- well trained -- as hardened criminals?

How many people released from prison or jail are so traumatized by the experience that they either immediately resume former substance abuse habits, or faced with the economic, familial, and social challenges and stigmatization resulting from prolonged incarceration succumb to hopelessness and substance abuse?

Regarding the DEA 360 program: Can you cite a single case where ***<u>any</u>*** *DEA program has been successful in any aspect of the war on drugs? What are the costs to the City and County of participating in this program? How will the results be measured?*

Regarding residents being stigmatized and thus less inclined to seek treatment: Please do note that the root of this stigmatization is the arbitrary criminalization of the use of certain substances by The State. Can you realistically address the stigmatization of substance abusers without addressing their criminalization? The scope and impact of the stigmatization of convicted drug law offenders goes way beyond them not seeking treatment: it includes inability to vote, difficulty getting employment, difficulty finding housing etc... This is a much more serious and multi-facetted problem than merely a disinclination to seek treatment. People who simply and inoffensively choose to possess and consume controlled substances are often stigmatized as if they were convicted criminals -- they just haven't been caught yet.

Abuse and diversion of prescription opioids are one of the factors "driving" overdoses but prohibition and the introduction of synthetic substances like fentanyl into the street market for heroin is the primordial and preeminent "driver" of overdose deaths.

intoxication. Despite this number appearing low, it may not be the best measure of the severity of the problem in the Milwaukee community. Many heroin and opioid overdose victims also have cocaine present in their systems at the time of death. And Impact, a Milwaukee County treatment access point, has stated that it is seeing a slight increase in the number of people seeking treatment who identify cocaine or crack as their primary drug of choice. While cocaine and heroin differ significantly in their chemical make-up and how they affect the body, many of the interventions that focus on treatment and destigmatization of substance use disorder are likely to be beneficial to people regardless of their specific primary drug of use.

The City-County Heroin, Opioid, and Cocaine Task Force (CCHOCTF) was established by Common Council File Number 161061 on January 18, 2017, to study the problem of rising prevalence of opioid, heroin, and synthetic analogs and cocaine (in both powder and crack form) misuse and addiction in Milwaukee, and to make evidence-based recommendations to reduce fatal and nonfatal overdose within the community.

The City-County Heroin, Opioid, and Cocaine Task Force is charged with investigating and making recommendations regarding ways to ensure long-term health and safety of City and County residents by reducing fatal and nonfatal overdose from misuse of opioids, heroin, and synthetic analogs, and cocaine (in both powder and crack form) through data-driven public health prevention approaches. (City of Milwaukee Resolution 161061).

The Milwaukee City-County Opioid, Heroin, and Cocaine Task Force Work Plan outlines the goals, strategies and actions that are being implemented by a number of stakeholders across diverse professional disciplines and communities. This working plan outlines both current efforts as well as new proposed actions to scale up response and will be regularly updated as the epidemic and response evolve over time.

PLAN OVERVIEW

The Milwaukee City-County Opioid, Heroin, and Cocaine Task Force Work Plan includes six priority goals:

1. Increase naloxone availability in the community
2. Enhance community-based options for easy, safe, and environmentally friendly medication disposal.
3. Promote community understanding of pain, pain management and substance abuse disorders to achieve a reduction in opioid exposure in order to reduce risk of individuals developing abuse of other medications including heroin and cocaine
4. Assure there is adequate access to timely, affordable, and quality services for substance use disorders.
5. Maintain and enhance availability and quality of timely data about heroine, opioids, and cocaine use, its outcomes and risk factors
6. Enhance collaboration between community-based initiatives and government agencies

Regarding goal 3 above: Strategy 3.1 says: "Immediately launch a community informed/engaged health promotion campaign focused on prevention and destigmatizing substance use disorder, and to promote seeking treatment."

There is no strategy listed to address the stigmas associated with being a convicted drug law felon or for being busted and diverted to drug court. The stigmas noted by me above that are created by prohibition should be considered and addressed for this Work Plan to be taken seriously in this regard.

Strategy 3.4: "Conduct outreach to healthcare providers regarding evidence-based pain management and substance-use disorder treatment."

Please consider also recommending the use of alternative "evidence-based" pain management such as Cannabis. There is no lethal dose of Cannabis and it has been shown to be effective in treating pain. See: "Is Cannabis Better for Chronic Pain Than Opioids?": https://www.leafly.com/news/health/cannabis-for-chronic-pain-vs-opioids

"Marijuana Relieves Chronic Pain, Research Shows": https://www.webmd.com/pain-management/news/20100830/marijuana-relieves-chronic-pain-research-show#1

The State even holds a patent on Cannabis:
"Patent No. 6,630,507: Why the U.S. government holds a patent on cannabis plant compounds': https://www.thecannabist.co/2016/08/22/marijuana-patents-6630507-research-dea-nih-fda-kannalife/61255/

The hypocrisy of The State holding a Patent for the medical use of Cannabis (U.S. Patent No. 6,630,507 covers the potential use of non-psychoactive cannabinoids — chemical compounds found within the plant species cannabis sativa — to protect the brain from damage or degeneration caused by certain diseases, such as cirrhosis.), while persisting in categorizing Cannabis as a Schedule 1 substance ("Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. ": https://www.dea.gov/druginfo/ds.shtml), is worse than shameful: It has prevented or severely hampered research into this amazing plant that could have huge benefits to the human species.

*I related my personal story of recently undergoing chemotherapy and radiation for throat cancer to the Task Force during a recent public comments session. I was given a prescription for oxycodone and told that if that wasn't strong enough, they would give me a fentanyl patch. I choose to forego the use of opioids and would have preferred a more gentle, non-addictive pain reliever like cannabis if it were legally available. I personally experienced how the medical establishment is pushing opioids. I asked the radiation oncologist who was treating me whether Ibuprofen might help and she said: **"We prefer opioids."***

I highlighted Goal #6 above just to call attention to the fact that Goal #7, discussed below, was not included in the list of priority goals. I hope it is not because Goal 7 is not a priority. The role of prohibition and its enforcement arm is of the utmost importance to consider for the accomplishment of the Public Health and Safety Goals of the Task force.

Towards the end of the document we see Goal 7: "Law enforcement and the criminal justice system is actively working to reduce the availability of addictive substances while treating addiction as a disease."

This is a draft document and this goal needs word-smithing to restate it in the form of a goal: it is an observation or opinion at this point. What is this goal really trying to accomplish? Do you want to increase the law enforcement effort to reduce the availability of illegal controlled substances in the City/County? How much additional money do you want to spend and where will it come from (2018 City Budget shows reduction in sworn officers).

Here are the strategies listed for this goal:

"7.1 Create a mechanism for the community to be able to anonymously report suspected drug trafficking / drug houses
7.2 Establish a collaborative information sharing environment across city/county law enforcement agencies.
7.3 Advocate for treatment alternatives to revocation for drug related offenses to probation violations.
7.4 Advocate for the expansion/adequate funding of treatment alternative diversion programs ("drug courts") as a cost effective alternative to incarceration"
7.5 Advocate that prisoners be adequately treated for SUD while incarcerated, including providing MAT when appropriate.

Strategy 7.1 includes: "See something say something campaign?" This approach is fraught with peril and could lead to corruption and abuse both by the "tipsters" and law enforcement. Considering the power of the current civil asset forfieture laws this policy could result expanding the application of this blatantly unfair practice.

Strategy 7.2 details includes : "Expand statutory tools for prosecuting major distributors. " What does this mean? What do you want? Tougher drug laws? Longer Mandatory Minimum Sentences? This goal also includes: "Expand law enforcement partnerships and data access to better target over-prescribers." Well, why don't you start in your own back yard and follow up with Ms. Kathy Federico, from the DEA Diversion Squad, about the testimony she gave to the Task Force on July 21, 2017:

"...And you did talk about some of the administrative proceedings that we can take against our physicians that are over prescribing and not prescribing in a legitimate manner, that puts oxycodone and hydrocodone on the street.

And we do have a lot of those.

And I mean the other issue we have is, is having ahh — prosecutions — of physicians that are pumping pills on the street without people having legitimate medical problems.

And that's an issue we address all the time because nobody wants to put a doctor behind — in jail."

I checked the Criminal Cases Against Doctors website at https://www.deadiversion.usdoj.gov/crim_admin_actions/index.html and found only 2 cases in the last 4 years reported in Wisconsin.

I filed a FOIA request with the DEA asking for information about any cases that had been opened regarding physicians illegally prescribing controlled substances, and was told that I needed the name, social security number and permission to release data, for any individual who might be involved. The DEA does not do research in response to FOIA requests. Please ask Ms. Federico how the many cases of doctors illegally prescribing controlled substances are handled. We know they are not criminally prosecuted because ... "nobody wants to put a doctor behind -- in jail."

Re: Strategy 7.3 Please consider advocating for better Re-Entry programs as a way to reduce probation and parole revocations and recidivism in general.

See: "The Challenges of Prisoner Re-Entry Into Society", https://socialwork.simmons.edu/blog/Prisoner-Reentry/

"Programs Keep Inmates From Returning To Prison", https://www.npr.org/2012/10/10/162652805/programs-keep-inmates-from-returning-to-prison

"Life after prison: re-entering society is no easy task", http://www.dw.com/en/life-after-prison-re-entering-society-is-no-easy-task/a-18051657

Re: Strategy 7.4 Did the Task Force interview any of Judges, Prosecutors or Public Defenders currently working in the existing drug courts here in Milwaukee? Did you interview any of the people who have gone through the diversion-treatment system?

*I spent 5-6 days observing the cases brought before Judge Carl Ashley (branch 33) and Judge Janet Protasiewicz (branch 24), who handle most of the "drug court" cases. I saw one pathetic case after another of mostly young, black men and women, who were frightened and intimidated. They are **required** to plead guilty to participate in the diversion/treatment program thus relieving The State of the burden of proving it's case. Watching the Judge, Prosecutor and, in most cases, Public Defender, negotiate guilty pleas from these defendants was painful.*

It seems like the main goal is reducing the cost of prosecuting these individuals because The State simply cannot afford to see these cases contested via a trial (cost of judges, baliffs, prosecutors, public defenders, jails, prisons, sheriff's deputies -- huge costs). Once they enter the diversion/treatment program every detail of their lives is closely monitored by The State. The key to successful completion of the program is the 100% unequivocal yielding of any personal freedom regarding the inherent and natural right to possess and consume any substance desired. The experience produces cowed, submissive, beaten-down people who don't seem to care or understand what they have lost -- they simply want to avoid being stigmatized as a felon.

My bias throughout has been clear, and my perceptions could be way off here. But, I suggest that due diligence by the Task Force requires a deeper investigation into all aspects of the drug court-drug treatment regime prior to the advocacy of it's expansion.

It was evident very early in the life of the Task Force that it was not going to seriously consider the impact of prohibition or the War on Drugs in its analysis. And it is way to late to investigate this and incorporate any new goals and strategies. So I make the following suggestions for Goals that woulda, coulda, shouda, been included. They could be added as an addendum to the Task Force's final Plan and recommendations.

A goal that acknowledges the need to address the many ways the current regime of prohibition and the drug war contributes to overdose deaths and endangers the Public Health and Safety of the City of Milwaukee and Milwaukee County. The investigation into appropriate strategies would include interviewing people currently incarcerated for a non-violent drug offense and their family members or friends as well.

See "Shattered Lives: Portraits from America's Drug War – December 1, 1998
by Mikki Norris (Author), Virginia Resner (Author), Chris Conrad (Author), R.U. Sirius (Author)

The War On Drugs creates many innocent victims, mostly in the families of those caught in its web. There have been and continue to be, generation after generation of children who grow up without one or both of their parents because of the harsh drug laws. These young people grow up under extremely stressful conditions including poverty, homelessness, loneliness, lack of guidance, mis-trust or outright hatred of what they accurately perceive to be an unjust system --- all leading to opportunities and inclination to try to escape their hopeless situations via the abuse of a substance.

The investigation would include an examination of the root causes of drug abuse that result in overdose deaths, which myself, and many others more knowledgeable than I, lay at the feet of prohibition and the War on Drugs. I refer you again to Randy E. Barnett's article "The Harmful Side Effects of Drug Prohibition": http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1837&context=facpub

"This Article will not attempt to identify and "weigh" the costs of drug use against the costs of drug laws. Instead, it will focus exclusively on identifying the harmful side effects of drug law enforcement and showing why these effects are unavoidable. So one-sided a treatment is justified for two reasons. First, a cost-benefit or cost-cost analysis may simply be impossible.5 Second, discussions by persons who support illegalizing drugs usually emphasize only the harmful effects of drug use while largely ignoring the serious costs of such policies.

By exclusively relating the other side of the story, this Article is intended to inject some balance into the normal debate. The harmful side-effects of drug laws have long been noted by a number of commentators, although among the general public the facts are not as well known as they should be.6 More importantly, even people who agree about the facts fail to grasp that it is the nature of the means—coercion—chosen to pursue the suppression of voluntary consumptive activity that makes these effects unavoidable. This vital and overlooked connection is the main subject of this Article."

One example of the harm wrought by the drug war is Fentanyl, which was introduced into the illegal market because of prohibition (see Mr. Barnett's article section "D. Drug Laws Induce the Invention of New Intoxicating Drugs". Fentanyl as quickly become the bête noire of society and its introduction is directly related to rapid increase in heroin overdose death.

The goal would include a strategy that acknowledges the hypocrisy of The State vis-a-via international drug trafficking and the drug war and might possibly include advocating for change via the City and County Government Liaison Offices. It might include taking making changes in the way the City and County enforce the drug laws in their jurisdictions. The U.S. government has a long history of using drugs as a political tool going back to the Vietnam War (where the CIA participated in heroin trafficking to gain support for their fight against the North Vietnamese), the Iran Contra Affair (where the CIA participated in the importation of cocaine into America to help fund the Contras leading to the "Crack Cocaine Crisis") and most recently in Afghanistan (where the CIA partnered with the drug lords in the Northern Alliance to gain their support in overthrowing the Taliban, and where U.S. troops currently help protect opium fields.).

Note that Afghanistan currently supplies 90% of the world's heroin and opium. See https://en.wikipedia.org/wiki/Opium_production_in_Afghanistan, https://www.voanews.com/a/afghanistan-opium-production/4083875.html, https://www.globalresearch.ca/drug-war-american-troops-are-protecting-afghan-opium-u-s-occupation-leads-to-all-time-high-heroin-production/5358053

The goal would include strategies to address the racial bias evident in the enforcement of the drug laws. See: "Race and the Drug War", http://www.drugpolicy.org/issues/race-and-drug-war . This leads to generation after generation of incarcerated individuals, broken homes, disenfranchisement and, ultimately, hopelessness, which feeds directly into drug abuse and overdose.

Strategies for this goal should challenge the City of Milwaukee City and Milwaukee County's current position of unquestioningly and uncritically participating in executing The State's failed drug war policies.

As mention previously, a strategy should be included to determine what departments and programs have "drug-related" components. It would try to determine how much more taxpayer money is Milwaukee willing to spend to continue implementing drug prohibition laws that -- to date -- have only resulted in more crime, violence, poverty, corruption, and which have not, after 40+ years resulted in any significant improvement.

The goals outlined thus far by the Task Force do not take the required step back to look at the big picture and causative factors factors that ultimately lead to drug abuse and overdose death. The Task Force is focused on the mitigating the harmful effects of the drug war at the tail end of the dismal process. This strategy will ***NEVER*** *work -- you cannot address only the effects of a problem, you must address the root causes.*

Last summer I distributed a copy of Lysander Spooner's Essasy: Vices Are Not Crimes. https://thebuckthornman.files.wordpress.com/2018/02/vices-are-not-crimes.pdf. I hope you will take the time to read it examine the underlying principles upon which we can clearly see that prohibition and the drug war are fundamentally attacks on basic human rights of liberty and freedom. They are doomed to fail because they will be eternally resisted by people asserting these fundamental rights.

> *"Unless this clear distinction between vices and crimes be made and recognized by the laws, there can be on earth no such thing as individual right, liberty, or property; no such things as the right of one man to the control of his own person and property, and the corresponding and co-equal rights of another man to the control of his own person and property." Lysander Spooner*

Returning finally to the Work Plan

Collectively, the goal, strategies and specific actions span across the social-ecological framework to target:

- Individuals: Those who use prescription opioids and/or heroin at any level of use or dependence ranging from the population as a whole to subset of the population such as adolescents or clients of syringe exchange programs. It also includes interventions targeting professionals such as healthcare care providers, pharmacists, first responders/law enforcement, social service providers and chemical dependency professionals.
- Neighborhood / Community such as schools, workplaces, organizations, peer support groups, and
- Society and Systems: Includes policies, financing structures, and information systems in medical, public health, criminal justice and other fields.

Proposed goals, activities and strategies under this work plan span the entire continuum of care to include:

- Prevention - Prevention, as defined by the SAMHSA Center for Substance Abuse Prevention (CSAP) is "A process that empowers individuals to meet the challenges of life by creating and reinforcing healthy behavior and lifestyles and by reducing the risks that contribute to alcohol, tobacco and other drug misuse and abuse.;
- Early Intervention - Early intervention aims to reduce the risk of harm and decrease problem behaviors that result from continued use of substances. The intent of the intervention is to take action that decreases risk factors related to substance use, abuse or dependency; enhance protective factors; and provide ongoing services, as appropriate; .
- Treatment – Treatment is intended to improve social functioning through complete abstinence from alcohol and drugs for individuals diagnosed with chemical dependency. Treatment is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual suffering from substance abuse/dependency and is designed to help that person achieve and maintain sobriety, physical and mental health and a maximum functional ability; and
- Recovery – Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential.

Prevention and early intervention measures may vary in their recommendation for application. In coordination with SAMSHA, Milwaukee utilizes a continuum of care description developed by the Institute of Medicine to describe and track interventions at different levels of risk for substance abuse and mental health disorders. This classification suggests that populations receiving prevention and early intervention services can be defined in universal, selective and indicated categories.

- Universal measures target the general public or an entire population group without regard to individual risk
- Selective measures target individuals or groups considered at risk for substance abuse through membership in a particular segment of the population. This may include children of adults addicted to alcohol, students failing academically or individuals residing in neighborhoods with a high incidence of drug abuse.
- Indicated measures are utilized to prevent the onset of substance abuse in persons who do not meet medical criteria for addiction, but are displaying early danger signs. These early signs may include some use of alcohol and/or marijuana. Prevention services may be provided in family settings, school settings or community settings.

Successful completion of this work plan would translate into the following outcomes:

- An **increase in community knowledge** about the risk of drug use, opioid use disorders, and how naloxone maybe used to reverse opioid overdoses as measured by the estimated number of individuals reached through media, messaging or outreach campaigns. Specific target objectives include:
  - By 2022 educating /training xxx individuals related to the risk of opioids and cocaine
  - By 2022 training xxx individuals on the administration of naloxone
  - By 2022, 100% of you youth attending high school in Milwaukee County receiving substance abuse education
  - By 2018, 100% of municipalities in Milwaukee County contributing to outreach and education regarding substance use disorders, especially heroin, opioids, and cocaine.
  - By 2022, increase the number of agencies and doses of naloxone administered.
- A **change in attitudes and beliefs around drug use, dependency, and treatment** as measured by the number of community education programs conducted to destigmatize opioid use disorder and its treatment. Additional performance targets include:
  - educational programs,
  - By 2022, community health workers, peer health educators with lived experiences educate the general public in order
- A reduction in the access to opioids as measured as
  - Increase in number of fixed site medication drop boxes.
  - Increase in distribution of drug take back envelopes
  - Increase in drug take back events
- Improved access to treatment and harm reduction
  - Increase in funding to the city and/or county to address substance use disorders, especially heroin, opioids, and cocaine. **5% increase by 2022**
  - Reduction in recidivism to drug treatment court, where cocaine or heroin/opiates are identified as their primary drug of use.
  - Increase in number of EDs providing a warm hand-off into treatment or detox for those with substance use disorder. **100% of Milwaukee Co. EDs by 2022**
  - Increase in drug treatment court capacity.

Please provide references to the SAMSHA and Institute of Medicine resources mentioned in paragraph 1 above. It may have been referring to this source "The Institute of Medicine Framework and its Implication for the Advancement of Prevention Policy, Programs and Practice", http://ca-sdfsc.org/docs/resources/ SDFSC_IOM_Policy.pdf

The definition of Universal preventitive interventions used in the Work Plan is not verbatim from the IOM document linked above -- Is the Task Force referencing a more recent IOM source that was not stamped "Draft"?

Universal preventive interventions:

IOM definition: Addresses general public or a segment of the entire population with average probability of developing a disorder, risk, or condition.

Work Plan definition: Universal measures target the general public or an entire population group without regard to individual risk

Selective measures:

IOM definition: Selective preventive interventions: Serves specific sub-populations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime.

Work Plan definition: Selective measures target individuals or groups considered at risk for substance abuse through membership in a particular segment of the population. This may include children of adults addicted to alcohol, students failing academically or individuals residing in neighborhoods with a high incidence of drug abuse.

Indicated preventive interventions:

IOM definition: Addresses identified individuals who have minimal but detectable signs or symptoms suggesting a disorder

WorkPlan defininition: Indicated measures are utilized to prevent the onset of substance abuse in persons who do not meet medical criteria for addiction, but are displaying early danger signs. These early signs may include some use of alcohol and/or marijuana. Prevention services may be provided in family settings, school settings or community settings.

*The IOM document does preface these definitions with: "The three categories are widely used to classify **target** populations, intervention strategies, and specific interventions."*

The word-smithing of the original definitions into those adopted in this Work Plan replacing "Address" and "Serve" in the IOM source with "Target" and "Prevent" in the Task Force Plan seems to me a significant change in tone. The content of the definitions has been altered to such an degree that I question whether they can be directly related to the Institute of Medicine as the Plan suggests: "In coordination with SAMSHA, Milwaukee utilizes a continuum of care description developed by the Institute of Medicine to describe and track interventions at different levels of risk for substance abuse and mental health disorders." Please consider clarifying the attribution of these measures.

The Work Plan defines prevention as "Prevention - Prevention, as defined by the SAMHSA Center for Substance Abuse Prevention (CSAP) is "A process that empowers individuals to meet the challenges of life by creating and reinforcing healthy behavior and lifestyles and by reducing the risks that contribute to alcohol, tobacco and other drug misuse and abuse."

What do you mean by "prevention"? Preventing controlled substances from existing? Preventing young people from being curious and desirous to explore alternative states of consciousness? Preventing young people from asserting their natural and inherent right to control their own bodies and any property the inoffensively choose to possess and consume?

There are numerous references in the Work Plan strategies aimed at targeting or predicting who might be likely to experiment with controlled substances. Please do document which sources in the reference section support the efficacy of this approach. There is danger in approaches like this for bias, coercion, and infringement of civil rights in their implementation. In fact the IOM document includes a table (shown on the following page) that mentions possible Iatrogenic effects. I confess I had to look that up. In the context used it cautions against unintended adverse side-effects resulting from some action.

I think the specific concern is that exposing very young people to discussions about drugs with the hope of educating them to avoid them, may, in fact, have the opposite effect sparking their curiosity to try them to see for themselves. This is a natural human tendency that cannot be legislated against or removed from the mind via some educational exercise. Please review this and carefully consider the strategies you have enumerated that "target" young people.

The targeted measures discussed in the continuum of care description sound like a propaganda strategy to me. The point seems to be that people, in general, cannot be trusted to use appropriate, "socially accepted" strategies to pursue their own happiness as they see fit: they must be guided and controlled and the earlier The State intervenes, the better the chances that their efforts will succeed in producing "useful members" of society.

My interpretation is subjective of course.

Is it realistic to think that you can implement some strategy that will suppress the natural human desire to explore alternative states of mind? Is it realistic to think you can implement a strategy that will completely extinguish the natural and inherent understanding that every human being possesses to think that they should have control over what they, without infringing on the rights of another, choose to possess and consume?

Is it realistic to think that through education and early intervention that you can teach generation after generation of young people that they should ignore their natural feelings and curiosity -- their liberty and freedom of choice -- in submission to the arbitrary prerogatives of The State (recall the points made above about the acknowledge and accepted harms caused by alcohol and tobacco)?

Is it wise, humane and in the interest of "Public Health and Safety " to continue to aid and abet The States' drug prohibition and war on drugs, despite its 40+ year history of failure, by simply focusing on mitigating some of the harmful effects rather that address the root causes?

Table 1:
Cautions in Applying Universal Policies, Programs and Practices

	Low Opportunity for Self-selection	High Opportunity for Self-selection
Control Behavior/ Opportunity for Risk	E.G., environmental policies such as price increases, marketing controls, school policies such as zero tolerance • *Potential for unintended consequences for low risk members* • *Low effectiveness for most relevant sub-population*	E.G., environmental policies such as use ordinances, nuisance location enforcement • *Limited scope of impact* • *Displacement rather than reduction of problem*
Promote Awareness of Risk	E.G., school-based education • *Iatrogenic effects* • *Potentially low behavioral impact* • *High opportunity cost*	E.G., media campaigns concerning health, legal, social risk • *Iatrogenic effects* • *Potentially low behavioral impact*
Promote Awareness of Protection	E.G., school-based social norms programs • *Potentially low behavioral impact*	E.G., media campaigns promoting positive actions such as designated drivers • *Potentially low behavioral impact*
Promote Protective Skills/ Protective Opportunities	E.G., full school reform programs, school-based behavioral skills programs, positive youth development programs	E.G., comprehensive community health and wellness programs, positive youth development • *Does not reach high risk/high need youth*

The top of this continuum references universal policies, programs and practices aimed at putting constraints on behavior, and that would be categorized as "environmental" in the current language of prevention. These policies, such as price increases, enforcement policies, public use ordinances, or zero tolerance policies in schools are designed to constrain access and increase sanctions to deter substance abuse. Most of these policies have low opportunities for self-selection by targeted populations, although some, such as campaigns to close or constrain nuisance bars or other locations, can be avoided by individual users. In selecting these policies when there is low opportunity for self-selection, there are important considerations that follow directly from the fact that universal populations are heterogeneous. These policies may have significant unintended consequences for low risk components of the population. For example, non-problem drinkers may be more sensitive to price than problem drinkers, and price increases may compel them to forego social drinking. Conversely, price increases may not impact use rates for dependent or high risk drinkers. Another area of concern with setting-based universal approaches that emphasize punitive control (e.g. zero tolerance school policies) is that they actually work counter to the school connectedness that has been shown to be a consistent positive contributor to reduced substance use and other positive youth outcomes (Drug Policy Alliance, 2005; Sambrano et al, 2005; Sale et al, 2002). Control-oriented environmental policy that can be avoided by problem users may result in the well known phenomenon of problem displacement rather than net reduction – problem users and their hot spots are simply moved from one location to another.

Universal programs aimed at increasing awareness of risk and awareness of protective skills or opportunities are in the center of the continuum in Table 1. These approaches are similar in assumptions about effects on behavior, but differ in encouraging avoidance or adoption. For example, a media program emphasizing legal consequences of drinking and driving increases awareness of risk, and a "designated driver" campaign emphasizes protective behavior. These approaches include programs such as school prevention curricula and public media campaigns. In simple application, they reflect a theory of change commonly summarized as the KAB theory, standing for knowledge-attitudes-behavior. It is assumed that improved knowledge will lead to changed attitudes and that this will lead to altered behavior.

- A reduction in the number of cocaine or opioid associated deaths as measured by the number of deaths recorded by the medical examiner's office. Specific target objectives include:
  - By 2022, stabilize or reduce the number of narcotic associated overdose deaths. By 2027 reduce the number associated overdose deaths by 50%.
  - By 2022, stabilize or reduce the number of drug involved homicides. By 2027 reduce the number drug involved homicides by 50%.
  - By 2027, decrease the need to administer naloxone. Decrease in the times naloxone is used by EMS, due to a lack of demand, not a lack of supply or availability.
  -

The bullet points listed above were highlighted in the original document and I want to address the following targets specifically:

o By 2022, stabilize or reduce the number of narcotic associated overdose deaths. By 2027 reduce the number associated overdose deaths by 50%.

o By 2022, stabilize or reduce the number of drug involved homicides. By 2027 reduce the number drug involved homicides by 50%.

Without analyzing and acknowledging the root causes of the crime, violence and overdoses directly associated with drug prohibition, how can you possibly hope to achieve these results?

What goal or strategy specifically enumerated by this Task Force will reduce "drug involved homicides".

So long as a market for "controlled substances" exists there will be people, who, at all risks and hazards, will be willing to supply that market and violently compete to control their share.

In the interest of keeping this document relatively small, I have deleted the pages that followed the enumeration of the desired outcomes that are in the original document.