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**Concurrent Session: "Using Public Health's Legal Authorities
to Address Health Disparities"**

4:15-5:45pm, June 28, 2001

**Moderator: David Harrowe, MD, JD, MPH, Public Health Officer, Gila River
Indian Community, Arizona**

**Panel: Case Presentation: "Legal Tools to Manage Non -Compliant
Tuberculosis Patients: New York City"**

**Benjamin Mojica, MD, MPH, Deputy Commissioner, Division
of Health, New York City Department of Health, New York**

**Wilfredo Lopez, JD, General Counsel, New York City
Department of Health, New York**

**Case Presentation: "Legal Tools to Reduce Retail Cigarette Sales to
Minors: Baltimore County, Maryland"**

**Michelle Leverett, MD, MPH, Health Officer, Baltimore
County Health Department, Maryland**

**John E. Beverungen, JD, Deputy County Attorney, Bal timore
County, Maryland**

**Case Presentation: "Legal Tools to Prevent Contamination of
Drinking Water and Commercial Fishing Waters: Kitsap County,
Washington"**

**Scott Daniels, MS, RS, Deputy Director, Bremerton -Kitsap
County Health District, Washington**

PROCEEDINGS

Dr. Harrowe, Moderator

Good afternoon and welcome to this session, "Using Public Health's Legal Authorities to Address Health Disparities." My name is David Harrowe, I am the medical officer for the Gila River Indian Community located about 40 miles south of Phoenix, Arizona.

During this afternoon's session, three panels of speakers will illustrate how public health law can improve and sustain community wellbeing, and also how government attorneys and public health officials can work together to achieve this goal. This session is being audiotaped, and handouts are on the back table.

The format for this session is that each of the three panels will have up to twenty minutes to give their presentation. After each presentation, we will have two questions from the floor directed to that panel, and then open it up for general discussion after the third presentation.

The topic for the first panel is "Managing Non-Compliant Individuals With Active Tuberculosis". The panelists consist of Dr. Benjamin Mojica, the Deputy Commissioner for the Division of Health, New York City Department of Health; and Mr. Wilfredo Lopez, General Counsel for the New York City Department of Health. Dr. Mojica joined the New York City Department of Health, Bureau of STD

Control and Prevention in 1993. He has been Deputy Commissioner of Health since February 1994, and served as acting Commissioner from 1997 to 1998. He received his BS and MD degrees from the University of The Philippines in Manila, and his MPH from Columbia University in New York City. As the Deputy Commissioner for Health, Dr. Mojica is responsible for the prevention and control of communicable diseases, regulatory and environmental health, and family and community health services. Mr. Lopez graduated from the City College of New York and from Brooklyn Law School. He became worked for Legal Aid Society, and as a Civil Court Law Clerk in Bronx County. Mr. Lopez joined the New York City Department of Health in 1979 as a staff attorney. He Deputy General Counsel in 1980, and was appointed General Counsel in 1992. He serves on the Executive Committee of the New York State Watershed Protection and Partnership Council. He is a Board Member of the Puerto Rican Bar Association and was recognized by the New York City Law Department as Agency Counsel of the Year for 1998.

Dr. Mojica

Good afternoon. I will speak first, and I will take about 10 minutes before I call on our legal counsel to explain the legal issues involved with our approach to managing non-compliant tuberculosis patients. On behalf of the New York City Department of Health, Mr. Lopez and I thank you for inviting us to participate in this meeting, and particularly in this panel discussion.

The City of New York saw an increasing trend in inactive cases of tuberculosis (TB) in

the early 1980s, and a sharp increase until it peaked in the 1992. [Slide 1] The number of cases has steadily decreased since then. The case rate in 1992 was 50.2 per 100,000 persons compared to 19.9 per 100,000 persons in 1999. There were 2,351 fewer cases in 1999 than in 1992. The 1,460 cases in 1999 is still higher than the all-time low of 1,307 cases in 1978. New York City accounted for 25.7% of the national decrease in TB between 1992 and 1999, although it comprised only about 2.7% of the total U.S. population. This recent epidemic of TB in New York City is coupled with increased cases of multidrug-resistant TB. [Slide 2] The number of multidrug-resistant TB (MDR TB) cases, however, has been declining, and decreased by 18% from 38 cases in 1998 to 31 in 1999. The number of MDR TB cases reported in 1999 decreased by 93% from the 441 cases reported in 1992 at the peak of this most recent epidemic. Non-Hispanic blacks and Hispanics constitute the majority of cases. [Slide 3] Recently, however, with the declining number of cases in non-Hispanic blacks, Hispanic and non-Hispanic whites, Asians are beginning to constitute a larger proportion of all the TB cases in the city. The trend in TB has been different among U.S. and foreign-born population. [Slide 4] The number of U.S.-born cases reached a peak in 1992, and has decreased 81% since 1992. The number of foreign-born cases peaked in 1995, and decreased only 17% from 1995 to 1999. In addition, the number of cases among the foreign-born has surpassed U.S.-born cases since 1997. So currently we're seeing more non-U.S.-born TB cases in the City of New York.

The New York City Department of Health's TB control program has established the

goal of preventing the spread of TB, and consequently eliminating TB as a public health problem. [Slides 5 & 6] To meet our goal, we operate a multi-faceted program that integrates surveillance and epidemiologic activities, clinical services, outreach education, and training. We strive to identify all suspected and confirmed cases of TB, ensure that treatment for TB meets acceptable standards, and monitor the care of every patient with TB in the city. We do this regardless of whether or not the patient receives treatment in the department's clinic, particularly for those with multi-drug resistant TB, to ensure completion of therapy.

The aggressive management of patients with TB inevitably meets with some resistance from patients who for numerous reasons may not be amenable to close supervision. To assist the department in these efforts, the department passed regulations to address the problems of non-adherence to treatment. (Rules of the City of New York, Title 24, Volume 8, Section 11.47) These regulations are used only in instances where all persuasive measures have failed, and where the patient continues to pose a risk for transmission of TB to others.

The first and least restrictive step is an order for reexamination. [Slide 7] This is issued when a patient who is very likely to have TB -- because of a history of signs and symptoms -- continues to refuse medical evaluation and remains in close physical contact with others. [Slide 8] The second step is an order to begin or to complete treatment, usually issued when a patient threatens to leave the hospital against medical advice, refuses treatment, fails to attend clinic, and stops medication prior

to laboratory confirmation of the absence of bacilli in sputum. [Slide 9] The third step is an order for directly observed therapy. This order is given to patients whose sputum is consistently positive for TB during the past year, who have not completed therapy, do not agree to voluntary directly observed therapy, are frequently difficult to locate and refuse treatment. [Slide 10] The fourth step is an order for isolation primarily for the patient who refuses hospitalization or threatens to leave the hospital against medical advice, and where the home situation does not allow separation from others at risk like children. [Slide 11] And the last and most restrictive step is an order of detention. This is reserved for patients who have shown no evidence of completing therapy, if possible to locate nonetheless failed to complete directly observed therapy, or who persistently refuse to accept the diagnosis of active TB.

From 1993 to 1995 the total number of TB cases in New York City was about 8,000, but only 150 were ordered for directly observed therapy, and only 139 for detention. [Slide 12] In 2000, when there were about 2,000 cases, only 30 were ordered for directly-observed therapy and only 24 were actually detained.

In summary, New York City witnessed a resurgence of TB beginning in the late 1980s and peaking in the early 1990s. In response, the city embarked on an aggressive TB control program, including the detention of patients who proved to be a continuing threat to public health. Amendments to the New York City Health Code were necessary to achieve some of these activities. The number of cases, in

which commissioner's orders were used to enforce compliance with TB management, was minimal however and continued to decline. We believe that these measures are necessary components of the TB program, and we continue to enforce it vigorously. Thank you very much.

Mr. Lopez

Good afternoon. I think I'll make some points that somewhat overlap with Dr. Mojica's presentation but present the same issues from a legal perspective. Since this session is, in part, about how lawyers assist the public health practitioners, let me just mention that I feel particularly fortunate -- and I think it's a good thing for the department -- that, in fact, we have a significant legal office within the Health Department. We do a number of things but within the legal division of the office of the General Counsel, there's myself, a Deputy General Counsel and ten lawyers. I realize that's a lot more than a lot of other practitioners have access to, but believe me, we're not underworked.

Back in 1992 when the TB epidemic was at its height, there was a pre-existing health code provision that allowed the Commissioner of Health to order individuals that presented a communicable disease risk to others, as a result of being a case carrier, that almost exclusively used in the context of TB. Typically, an infectious disease nurse from a hospital would call on a Friday afternoon saying "an infectious individual is about to leave the hospital against medical advice". We would send over a public health advisor who would look up the medical record and sometimes

we'd issue an order requiring the individual to be isolated. But, there was no real means to effectuate that.

At that time, Medicaid didn't pay for the posting of guards, for example, so the person would be in a room by themselves but not really guarded. There were no isolation rooms that had that negative air pressure in six exchanges of air per hour. Significantly, there was no real means for a detained person to access a lawyer which created some legal problems if they wanted to challenge the detention. There was a right to petition the Commissioner for release and of course, there was the concept of habeas corpus but, how you connect a detained person with a lawyer in this kind of setting was not part of the scheme at that time.

As Dr. Mojic pointed out, the disease and the epidemic were really quite extensive and when you think about potentially infectious individuals living in an AIDS facility with AIDS patients, there was a great risk to others. So we set about trying to look at the statute and create a new system that would work better. It took a lot of doing, there being many advocates and people concerned with civil rights in New York City. We had extensive meetings with not only medical professionals, but with the New York Civil Liberties Union, with the city's law department and that was really a conversation that was, I think, educational for both sides. There were a couple of issues that were of some contention. One was whether the Commissioner of Health should have the power to order somebody, without a court order, to be detained in a medical facility. On that issue, the practicalities really won the day.

Under the old health code, people would walk out of the hospital and there was no real way to keep them there and then we'd have to go looking for them and that's not so easy in New York City. So the practicalities of the situation really required that the Commissioner have the ability to order detention on a quick basis and not have to stop by a court to get a court order, even if it was an ex parte order, before detaining somebody when they're threatening to walk out of the hospital on Friday afternoon.

The other bone of contention was whether we should, in fact, detain people beyond their period of infectiousness. One of the considerations was the concept of the least restrictive alternative, that is if you're going to detain somebody they should present a clear and present danger to themselves or others. In the course of the conversation, I think what was enlightening to some was that public health really doesn't work that way. Public health is supposed to be preventive. If you think about the requirement for children to be immunized -- otherwise they get excluded from school even though the non-immunized child is not a present danger to others -- they present a danger when they contract a vaccine-preventable, communicable disease. Just by virtue of not being immunized, they don't present a danger and yet, it's well recognized and accepted that they can be excluded from school. Similarly, the problem we were seeing with drug-resistant TB was that people would start treatment, take their medication until they became non-infectious, leave the hospital, stop taking medication for all sorts of reasons that are really relevant to the main subject of this conference -- social

disparities, substandard housing, homelessness and related problems --difficulty with maintaining a regimen that could be quite complicated to taking their medication, and relapse. That's how the drug resistance developed. It was really important that the public health authority makes sure that they complete therapy and that was really your focus in looking at changes in the health code.

As a result of these conversations, the city's health code was amended in 1993. (There are copies of the provision in the back of the room that I would urge you to take a copy of.) I think, this provision can serve as a model for detention statutes because it did put in places significant due process protections and yet, was in fact, workable. To make it as brief as possible, the statute allows the Commissioner of Health to order somebody to be detained in a hospital. It allows the Commissioner to order all those pre-detention restrictions that Dr. Mojica mentioned such as ordering that they be examined, ordering that they complete treatment, ordering that they undergo a program of directly observed therapy, all of those are pre-detention. But the D4 and D5 provisions that Dr. Mojica mentioned, do allow for the detention of infectious individuals and non-infectious individuals. However, when a person is detained, either pursuant to D4 or D5, they are given all their rights. They're told that they can request that they be released and that they can request an attorney and one will be provided for them. That was a meaningful step to make this statute, this health code provision, pass judicial muster when it was challenged. Even if the individual does not request release after sixty days, the city has to go and get a court order to allow the individual to be detained for longer and

the order needs to be issued every ninety days thereafter. The city pays for outside counsel to represent individuals and a lawyer is connected with any individual who is suspected of having a mental disability, even without waiting for the individual to request release.

Significantly, as you'll see at the end of the provision, the Board of Health passed a resolution, and set forth at the end of section 11 .47 of the health code, that declared, non-compliant individuals constitute a public health risk. Let me just leave you with this particular quote: "The Board of Health finds that the potential reactivation of TB and the development and spread of drug -resistant TB caused by the failure of TB patients, whether or not infectious, to complete a course of anti -TB therapy, create a significant threat to the public health". And that finding was one that the courts relied on to sustain the provisions when challenged.

So just to conclude, I think this is an example of how law can benefit public health practice and in the course of revitalizing this statute, strengthen the public health infrastructure for the better. Thank you.

Dr. Harrowe

Thank you Dr. Mojica and Mr. Lopez. The topic of our next panel is going to be restricting access of under age youth to tobacco products. The panel will consist of Dr. Michelle Leverett and Mr. John Beverungen. Let me tell you a little bit about our next speakers. Dr. Leverett has been Health Officer and Director of the

Baltimore County Department of Health, for the past six years. She received her MD degree from the Johns Hopkins School of Medicine, then did a residency in pediatrics at Johns Hopkins and is board certified in pediatrics. Upon completing her specialty, she did private practice in Mississippi and in 1993, joined the Johns Hopkins Medical Services Corporation, Johnson Medical Center in Baltimore. She serves on numerous committees including the Health Advisory Committee for U.S. Congressman Ben Cardin, the Governor's Interagency Coordinating Counsel for Infants and Toddlers, the Johns Hopkins Community Health Workers Advisory Committee and the Marilyn Partland for Children, Youth and Families. Mr. Beverungen is the Deputy County Attorney for Baltimore County, Maryland and is a cum laude graduate of the University of Maryland, 1987, and a sum cum laude graduate of the University School of Law, 1991. He was admitted to the Maryland Bar in 1991. He is admitted to practice before the United States Court of Appeals 4th Circuit, and the U.S. District Court for the district of Maryland. Before joining Baltimore County as an Assistant County Attorney in 1994, Mr. Beverungen was an associate in the law firm of Miles and Stockbridge where he specialized in litigation.

Dr. Leverett

Thank you and good afternoon. [Slide 1]

It's a pleasure for us to be here today. We're going to be talking about using public health legal authorities to enforce tobacco sales restrictions. We certainly hope that

it is not a hazard to our health to talk about tobacco control in the state of North Carolina. [Slide 2]

Public health law is defined as the power and duty of the state to insure conditions for people to be healthy. State and/or local government has the authority to enact laws, enforce laws and promulgate regulations to protect the health, safety and welfare of the public. Often, in exercising our authority, personal and/or economic rights may be interfered with. We often seek a balance between our powers and the responsibility to protect the public's health, on one hand, and the right of individuals and businesses, on the other hand. John and I are going to use the example of Baltimore County's attempt to enforce Maryland's law that restricts the sale of tobacco products to minors to illustrate three pertinent questions regarding public health's legal authorities. Firstly, what powers does public health have as provided by law and what is our awareness of those powers? Secondly, how do we reconcile the fact that our powers to protect the public's health often conflict with individual and economic interests? And third, how do we use the law as a public health tool? John and I are going to tag-team this and so I'm going to call John up now to talk about some of the legal background.

Mr. Beverungen

Thank you. It's a pleasure to be here this afternoon. I want to start off with what I know best and that's the law governing some of the topics in this area. The first thing to note is that this is a very timely issue -- tobacco use among minors -- the

power that are shared between our federal, state and county levels of government and the cases or the case that we have here will really illustrate that. [Slide 3]

Less than a year ago, the Supreme Court decided the case of *FDA vs. Brown & Williamson* by a 5 to 4 decision which of course, you read about a lot and you know that they're very political decisions when they reach that level of divisiveness on the court. What the court held there was that the Food & Drug Administration could not regulate tobacco under the Food, Drug & Cosmetic Act. It was a very strange decision and it was a strange position that the government was left with arguing because the Food & Drug & Cosmetic Act allows the FDA to regulate drugs and devices and makes sure that those drugs and devices are safe and effective for their intended use. Now that's a very strange position to try to fit tobacco in because you almost need to say, "Yeah, tobacco does what it's supposed to do and that's get people sick". So that really was the fatal flaw in the case at least for the five -member majority that Justice O'Connor wrote the opinion for.

It's not all bad that the case went the way it did, because immediately thereafter Justice O'Connor in her closing remarks in the case -- and I would encourage you or the lawyers you work with to read the decision if you're going to examine these topics in your municipalities or your counties. She deemed under -ages smoking to be the number one public health threat facing America now. Right after the decision came down, I believe it was June 2000, Congress set forth a bipartisan bill, which is

pending now, known as the National Youth Smoking Reduction Act of 2001, which in essence caused the Supreme Court's opinion in picking out all the flaws as a road map for how Congress should delegate authority to the FDA to regulate tobacco as a drug or device, and enact into law much greater restrictions on children and minors use of and access to tobacco. One other development in the area that I did want to mention is that there is a Supreme Court case decided today, concerning the Federal Cigarette Labeling Act. The suit is Lorillard Tobacco Company vs. Thomas Riley, the Attorney General from Massachusetts. I don't know how the suit came out, but Massachusetts wanted to impose every strict restriction on tobacco advertising of any sort – near schools, outside of shops, on the sides of buses, things like that. So you can see, that it really is a timely issue. I had no idea how timely it was. [Slide 4]

The example I'll use in a second is the tobacco settlement we have in Maryland, which I will get to. The Department of Justice is also suing tobacco companies. I believe President Clinton was the one to kick off the lawsuit, and current articles in the paper now indicate that President Bush is instructing the Department of Justice to either dismiss the suit or enter into settlement discussions; which I think are taking place as we speak. So you can see how a shift in political power really changes what the government will do and how it will use its power against these corporations.

The second prong is that many states, if not all 50, have through their Attorneys General filed suit against tobacco companies, and at present are setting up

“restitution funds”. Dr. Leverett will speak about this. Maryland has been the beneficiary, I believe, of close to a billion dollars over ten years in what’s being called a “cigarette restitution fund”. This is also taking place in most states. I wish I could give you a state by state overview. I don’t know, obviously, where everybody hales from and where you practice, but it would behoove you to find out where the money is going and what it’s being spent on. In our county we’re hoping to use it for education and enforcement, which we will get into in a second. An interesting anecdote is that the owner of the Baltimore Orioles baseball team, Peter Angelos, is the lawyer that our Attorney General hired to sue the tobacco companies. It’s now in the papers in Maryland that he is seeking a legal fee of a billion dollars which is exactly how much Maryland’s going to get over ten years for this tobacco suit. Again, I guess lawyers come out better than anyone, really. I guess Michelle will take over at this point, and I believe I’ll be back when we get further along.

Dr. Leverett

Actually, Peter Angelos is seeking twenty-five percent of the total settlement which was \$4 billion for the state of Maryland. One billion was dedicated to the cigarette restitution fund over ten years; I’m not sure where the other three are going. [Slide 5] To give you an overview of the \$1 billion cigarette restitution fund, dedicated over ten years, a hundred and sixty-four million dollars was appropriated in fiscal year 2001 and sixty-three percent of that appropriation was to healthcare which we

consider a real victory and you can see bulleted below where the money was allocated. In fiscal year 2001, seven million dollars of the cigarette restitution fund actually went to Maryland's twenty-four local health departments in order to perform activities related to prevention, screening, treatment, and education around cancers that are tobacco related and also tobacco use prevention and cessation.

[Slide 6]

Just to give you an idea of the impact of tobacco use in Maryland, seventy-five hundred people die each year in Maryland from tobacco related illnesses. Sixty youths per day initiate tobacco use in Maryland and yearly healthcare costs for tobacco related diseases in Maryland are \$1.8 billion. For our tobacco use prevention and cessation programs, the law instructed that we focus on four areas: community based, school based, cessation, and enforcement.

Today I'm going to talk about enforcement. When we in the local health department began to look at the area of enforcement and our responsibilities, several questions came up. Three in particular which we posed to John, our Deputy County Attorney, are outlined here: 1) Can we issue citations to merchants who violate the law? 2) Can we carry out compliance checks? (We don't want to call them "stings".) 3) And can we use minors as agents in those compliance checks? And now John's going to come back up, and tell you what he told us. [Slide 7]

Mr. Beverungen

I think this is really the interesting part, assuming most of the audience here are health practitioners. Let me note that Baltimore County is a suburb of Baltimore City, with just under a million residents. Our legal department has twenty lawyers, and that covers the entire county, every agency in the county. So unlike my colleagues from New York, we don't have a lawyer solely representing the health department. One of my colleagues or I will be called with a question from the health department, and that's how we become involved in public health law issues. I suspect for smaller counties and states out there that's the way the relationship works. So hopefully if you can partner like that, and call and get some advice on topics, that's the ideal way to do it before you start doing things and find out there might be problems with it. [Slide 8]

When the issue of tobacco sales enforcement came up, as Dr. Leverett said, we had a meeting at the health department to discuss how we could use the restitution funds to prevent minors from using tobacco products. As Dr. Leverett said, the first question they asked us is "can the Health Department issue citations to merchants who sell tobacco products or minors who use tobacco products". And the answer to that is "no". All of this in Maryland is governed by state law, which makes selling tobacco to minors a criminal offense. The minor can be punished and the retail establishment can be punished, but the authority for doing that rests with the police, the state's attorney and the courts system. And that really brings up one of the big problems that I think faces public health: you need to get state or county legislature to authorize health officers to issue citations for these offenses, which

present larger public health concerns than criminal law concerns. Police are not going to issue citations for tobacco. They don't do it. It's just like all the other laws that are on the books, and it just doesn't happen. I cut this out of four Baltimore Sun which is our only daily newspaper. This was a week ago, and it says that "minors can buy cigarettes easily, state sting shows. In sting operation by the Maryland Attorney General's office, minors were able to buy cigarettes 62% of the time. Purchase attempts were made at stores in Baltimore City, Baltimore County and Prince George's County. Sales people often sold the cigarettes without asking for any identification, or even after asking for identification showing that the person was younger than 18." So this is the kind of thing that's just on the books, but the police department is not going to enforce them. Now part of it is they're going to say they're busy and, in fact they are really busy.

This is a public health matter. If your agency is the beneficiary of tobacco settlement funds, it would behoove you to try to seek greater legal authority. Again, I'm presenting the law in Maryland. I don't know what it would be for your locales but a very common problem is that criminal laws, of course, are historically administered through the state and then you have to rely on the police for enforcement. There is often a schism there and the police won't act as quickly as the Health Department would like them to.

The second question we faced was, can Baltimore County Health Department carry out sting

operations, and the answer to that is “yes, we can”. Again, we face some political pressures with our county executive not wanting to conduct these type operations. Some states that have laws like this, of course, want to make sure that the minor being employed in these operations is doing so willingly and that the parents are aware of how this is going to happen. But the answer is yes, we have authority in Maryland to carry it out. I have not seen a state that says “No, you don’t have the authority to employ minors in these type of operations”. And then of course, the third question would be subsumed within these second there.

The one thing I do want to mention before I stop is that I think the most effective target of a public health department’s enforcement efforts is at the retail establishment level. Congress does have laws now that would withhold federal block grant monies from states -- it’s known as the Sinar Amendment -- if states don’t enact laws prohibiting the sale of tobacco to minors. So the laws are there in pretty much every state. It’s just that no one’s going out and enforcing the laws. So, you really need to have the powers shifted to the health department to eradicate what is a public health threat more than a criminal threat. You need to also consider or seek advice from legal counsel on theories of revoking business and trade licenses.

That’s what will get retailers’ attention. You see on TV now that Phillip Morris is part of the settlement, and a commercial shows a guy at Seven Eleven who has a placard saying “We Card”. That’s not enough -- you need to have these places know that penalties will be enforced, whether it’s the ones that are on the books now by the police or the ones that you urge your legislature to put on the books, giving the

health department the power to seek creative ways to make the punishment more draconian. [Slide 9]

And finally, just to summarize and bring us back full circle to the larger picture, going back to the three questions that I delineated at the beginning of the presentation, what powers do we have as provided by law and what is our awareness of these powers? Using Baltimore County Health Department as an example, local health departments are often unaware of the extent of our legal authority until specific issues arise.

Dr. Leverett

How do we reconcile the fact that exercising our power to protect the public's health may conflict with individual or economic interests? You know, then the answer is that you try to protect both sets of rights but we all know that's a very delicate balance and often can be politically charged as John pointed out. And finally, how do we use the law as a public health tool? In this example, you know, what's our goal? Do we want to focus with regard to tobacco enforcement on law enforcement issuing citations, issuing sanctions, or do we want to educate the merchants and the cashiers regarding the law or do we want to do a combination of both? You know, which focus best accomplishes the advancement of the population's health and well-being with regard to tobacco enforcement? It's important to think about that beforehand and often when you're considering these types of issues.

Thank you Dr. Leverett, Mr. Beverungen. Are there any questions for our second panel?

Dr. Harrowe

Now we'll proceed to our next and final panel. Mr. Scott Daniels will talk about disposal of hazardous waste. Mr. Daniels is currently the Deputy Director for the Bremerton-Kitsap County Health District in Washington State. He received his Master of Science degree in Environmental Science in 1980 and his Bachelor of Arts degree in Geology in 1977 from Indiana University in Bloomington. He's been with the Health District in Bremerton for about ten years. Before being Deputy Director, he served as the Assistant Director for Environmental Health, managing regulatory programs in solid and hazardous waste, water quality and food and living environment programs. He played a key role in the creation of the Kitsap County Surface and Storm Water Management program and he is the winner of NACCHO's 1996 award for Excellence in Environmental Health.

Mr. Daniels

Thank you, David. When I put this slide presentation together last week, I simply called it "Enforcement Remedies in a Local Solid Waste Program", but it just didn't have anything to it so I put "Innovative Enforcement Remedies in a Local Solid Waste Program". [Slide 1] But I'm not really sure about that in the national perspective. You know, in Washington state, we do things a little differently in

Kitsap County than a lot of the other local health departments. But from a national perspective, it's really hard for me to say that we are truly innovative programs so I'll kind of let that sit for a little bit.

Kitsap County is the county directly west of Seattle. If you stand in the Pike's Place Market looking west across Puget Sound, you're looking at Kitsap County. We have 230,000 people and are the second most densely populated county in the state next to King County. Our population is growing rapidly so we have a lot of new people coming in. We also have a large U.S. Navy presence with a lot of transient people in the county. We have two hundred and twenty-eight miles of marine shoreline because we're a peninsula, so water quality's a big issue for us in Kitsap County. Our population is eighty-nine percent white. [Slide 2]

In terms of solid waste problems, which I'm going to talk about, we're like a lot of you folks that have environmental health departments: Garbage dumping, garbage burning, solid waste storage problems, abandoned vehicles, waste tires, medical waste, livestock waste, pet waste, a lot of different kinds of solid waste. We also have improper storage problems with hazardous waste. Methamphetamine labs are a big problem in western Washington. I hear earlier today there is also a problem in Salt Lake City, and I suspect that, they're probably a big problem all over the country these days. We've had exponential growth rates in the number of meth labs for the last four years in Kitsap County. They've doubled each year. [Slide 3]

Just to focus on what I'm going to talk about today, I'm only going to be talking about the health district's role in enforcement and about some of the enforcement tools we use as part of a comprehensive solid waste management response. Within that broad response, we do a lot of education work; we do television, radio, newspaper advertising along with our county Public Works Department. We offer a variety of other services, large-item pick-ups, amnesty days where you can dispose of waste tires, burn barrels, and those kind of things for free. We also have clean-up funds available for periodic community waste clean-ups. [Slides 4 & 5]

Let me give some background. In 1990, when I signed on to the Health District, we had no real significant legal tools for enforcement. We had an ordinance that didn't have any teeth, basically. And we really had very little interaction with our prosecuting attorney's office. We contracted with our county prosecuting attorney's office to help us do our legal work, probably like a lot of you folks out there. We also had low inspector morale because we had no real carrots and no real sticks available for inspectors to use. In 1991, we had an earnest conversation with our attorneys and asked them "How can we get the enforcement tools we need?" And as a result of that discussion, we were able to pass an ordinance that allowed us to write civil infraction notices. I think we were the first county in Washington state to do that. [Slide 6]

Our first cases were heard in 1991 in County District Court. In 1994, we implemented the Surface and Storm Water Management (SSWM) Program. That's

a joint program involving three different local agencies to address water quality problems in the county. We also have civil infraction authority in the SSWM program. We had our cleanup fund instituted in 1996, and in 1997 we started using injunctions for the first time to clean up these severely contaminated sites. These are the sites where you can write a ticket after a ticket and nothing basically happens on those sites so we went to the injunction process in 1997, and then in 2001, we started using health consultations to support our injunctions and I'll get into that a little bit later too.

This is what I found on the wall of an inspector's office when I started at the health district and I asked the inspector why he had his, since it seemed like kind of a negative thing to have up. "Meetings, the practical alternative to work" told me that he wasn't able to go out and enforce our laws. He felt like his job was to try to cajole people into compliance, basically to talk them into compliance -- which is still a good tool, obviously -- but he wasn't able to use any legal tools basically, to get the job done. [Slide 7]

But what we do today, with an array of new legal tools, is that we first write Notice and Order to violator telling them they need to clean up. They have the option to go to an administrative hearing if they'd like to do that. If all those processes fail to resolve the matter, we go to a civil infraction which basically is a ticket. It's like a speeding ticket. In Kitsap County, the violation fee is \$475 per infraction per day. Those cases are heard in District Court. If they choose to litigate or contest the

hearing, those go to District Court. No attorney is needed ninety-five percent of the time! It's like an advertisement for fabric softeners or breast enlargement supplements. But anyway, it's true, we needed a tool where we didn't have to use our attorneys to deal with every case and this is the tool that was able to get us there. Unless they bring an attorney into court, which happens very seldom in civil infractions, we don't need to use an attorney and we're very successful in court. Out of the hundreds of cases we've heard, I think we've not prevailed in less than five. So, it's a very effective tool. We also have injunction powers. We've decided to criminalize certain violations because we were not able in Washington State to get administrative search warrants. So for the more egregious types of violations, we have had to resort to criminalization. It's not a positive trend, for sure, but it gives us an additional tool if we need it. Just a brief note about the Washington State court system. It's probably similar to the other state court systems, but we hear all of our civil infraction cases in local district courts. The more serious injunction-type situations, where we have to file motions for injunction, are heard in superior court.

[Slide 8]

Let me give just a little more detail. In Washington State, our State Department of Ecology has a Criminal Task Force that works with the U.S. Environmental Protection Agency. They investigate environmental criminal cases, but our experience is they don't want to go after a lot of what they deem smaller, less important contamination cases. So those are the ones where we step in with our criminal authority and our new regulations to deal with the dumping of hazardous

waste and biomedical waste, solid waste facilities operating without a permit, or operating a facility after your permit has been revoked. Those are the types of criminal violations provided in our solid waste code. [Slides 9 & 10]

We're very serious about trying to keep our inspectors safe in the field. They're going out into dangerous situations sometimes involving dangerous people. In addition to basic training that we provide them on how to do the inspections, our prosecuting attorney's office gives them specific site entry and search training. So they are able to recognize what are the privacy areas on people's property and how to go onto a property without violating a constitutional requirement. They're also trained by our Humane Society in dealing with dogs and how to use pepper spray. All our inspectors carry pepper spray into the field, hopefully, just for the dogs. We've never had to use spray on a human, but it's there if they need it. They also have Hazwoper [spelling?] training and blood-borne pathogen training. The EPA had been providing a basic instructor training course, but now we're redoing that course ourselves. We also require inspectors to carry cell phones and to file trip itineraries before they go out so we know where they are in the field. [Slide 11]

This slide indicates the volume of complaints we have received. It's an indicator, really, of the solid waste problem we have in Kitsap County. As you see, in 1991, when we implemented the regulation, the number of complaints was a little over three hundred and fifty. From talking with community members at the time, they felt that, when they called the Health District, their complaint would not really be

responded to. And we really *didn't* respond effectively. So one of the things we saw after implementing the new legal tools, was a sky -rocketing in the number of complaints. We didn't expect that at first, but that's what actually happened. But, we sort of plateaued in 1997 and for the last three years it has dropped, and it's trending that way this year as well. [Slide 12]

Just to give you a sense of the number of court appearances vs. the number of complaints we receive, we're usually able to resolve ninety to ninety -five percent of all cases without going to court. Just having the tool is an effective deterrent for us, we've discovered.

Because the theme of this conference is health disparities, I wanted to look at a couple of those issues. We've found in Kitsap County, that the number of complaints by area is inversely proportional to the median income of the area, so the solid waste problems we have really reflect economic disparities as you would expect anywhere in the country. Bainbridge Island, with the highest median income area in the county, is also where we have the lowest number of complaints in the county. Suquamish and Bremerton are just the reverse. We also looked at the issue by race and ethnicity and it has a similar track. But I don't know if complaint numbers are really tied to ethnicity. I think it's really more tied to income levels. In the Silverdale area, we have a lesser number of complaints, more ethnically diverse. There's a more heavily Asian -American community in Silverdale. It's not really a good indicator as income is. [Slide 13]

In the state of Washington, forty-four percent of the local health departments have the ability to write tickets for environmental health violations, fifty-six percent don't. [Slide 14]

An injunction is really a court order prohibiting someone from doing some specified act or commanding someone to do something wrong or injury. What we've typically used these with businesses that are operating outside the bounds of the law, disposing hazardous waste on the ground, and ignoring civil infraction notices, and this has been a really effective tool as of late.

[Slide 15]

I just wanted to mention one case like this that we're recurrently working on. You may recognize something similar in your own community. Mr. Deno operates a radiator shop and heavy equipment repair shop. We got initial complaints about the business in 1993. We got involved and, along with our county land use agency, wrote \$30,000 worth of civil infraction notices against the business. The business never showed up in court and never responded to the collection agencies. So what do we do with a property like that? We still have a contamination issue there today with three residential rental properties on site and nearby public wells within a thousand feet of the business. The contaminants include heavy metals, semi-volatiles and total petroleum hydrocarbons. This Deno case is the first time we were able to use the health consultations I mentioned earlier. We've enlisted the support

of our Washington State Department of Health to evaluate the chemical releases at the Deno site to determine whether there's a high risk to public health and we're using their risk assessment data to support our case in court. We did that because the last time we went to court on an injunction, we got into a little bit of trouble demonstrating the actual human health risks side of our case, so we decided, in conversations with the state health department, to use some of their data for support. [Slide 16] [Slide 17]

Let me say a little bit about livestock waste enforcement. In Washington, we have inadequate state response on livestock waste – which is a big issue in Kitsap County – so we decided to use our new solid waste enforcement powers to respond. We also work with the Kitsap Conservation District to do that (to protect water quality) and with the unified county stormwater utility. [Slide 18]

This photo shows the typical problem we find in the field. We're a semi-rural county with a lot of hobby farms in the county. This shows a denuded pasture with too many horses or too many

[Slide 19] cattle on a small parcel of property. You can see how rain runs off the property, picking up manure and other waste with it, probably flowing into a roadside ditch which flows into a stream which flows into one of our marine embayments. Our marine embayments are highly productive shellfish resources and we have significant contamination threats. So, in that kind of scenario, we require landowners to work with our Conservation District, which is not a

regulatory agency, to develop farm plans. If they want to keep animals on the farm, they need to develop farm plans which include best management practices to address the contamination. If the landowners are uncooperative with the Conservation District, then we are able to step in and use the enforcement tools. In those cases, similar to the use of health consultations, we always bring in water quality monitoring data to demonstrate that actual water quality violations are present. We have several different groups in our health district that actually work on a case like this. [Slide 20]

The last thing to mention are our cleanup funds. We have a cleanup fund as an incentive program for landowners that have solid waste dumped on their property. We offer them money to clean up their property with their agreement that they will control access to prevent future dumping on their property. This has been quite effective in closing off some of the dumping areas in the county. We also have, as I mentioned, community cleanup funds as well. [Slide 21]

Dr. Harrowe

Thank you, Mr. Daniels. Are there any questions for our last speaker?

[Note: Audience questions were not recorded.]

Mr. Daniels

We got a grant of money from our county general fund several years ago to start the

program. We also supplement the program to some degree with our stormwater utility. In Kitsap County, we have a stormwater utility where people pay \$45 a year to the utility as part of their property tax bill and that revenue funds a bunch of different water quality programs including our program.

Dr. Harrowe

Okay, according to my watch, it is now almost twenty minutes before six o'clock and seeing as how we started a little bit late, perhaps the panelists would be agreeable to staying here until ten minutes before the hour and for the next ten or eleven minutes we can have just general discussion questions on public health law issues or maybe questions to any of our panels.

Mr. Daniels

From our perspective, having a civil infraction tool is really effective ninety to ninety-five percent of the time. So, in that respect, it's successful before we even write a ticket. It's also been an effective deterrent for the vast majority of cases. There are some, like the Deno situation where it (a civil infraction) doesn't work. You just have to accept that as part of the process, but it is effective for the portion that it works on. There's a smaller percentage where it's not effective. You have to use a broad array of tools to dress all the scenarios. I don't think a civil infraction will solve every situation.

Mr. Lopez

If I forgot to mention that, we actually built facilities to hold these individuals. There are two facilities and as the number of patients goes down, they're being utilized less but there was a ten-bed unit, locked unit established and built in Bellevue Hospital with that negative air pressure and six exchanges that in fact, hold the individuals. It's a locked ward. And then there's another locked ward in another hospital, Goldwater Hospital, that has a twenty-five bed capacity for the non-infectious detainees. So the way to enforce it is to have a locked ward.

Usually, the detention happens this way. On Friday afternoon, they're feeling better and announce they're going home. And we issue an order now, there is reimbursement available to, in fact, reimburse the hospital for posting the guard until we get there and then they are transferred as soon as possible to the locked ward. There have been a few occasions when we have had to remove somebody that's not in a hospital, other than their home setting which is a more difficult proposition. We have within the health department what we call the health police. They are, in fact, peace officers, they don't carry firearms but they go out with our public health advisors and with the police department kind of in the background to maintain the peace, but there have been a few instances where we've had to pick people up.

Dr. Mojica

Let me just be clear that regardless of what we do, sometimes the patients still do not cooperate even if they are detained. They may still refuse to take medications;

they may still refuse to do anything that will allow us to complete the regimen. We leave it to our physicians to cajole and to make these people cooperate. In Bellevue, of course, they are locked in wards or in rooms that they cannot really get out from. In Goldwater, for non-infectious cases we use a less restrictive environment where it's a locked facility but they can go outside of their rooms and have additional activities that allow them to be outside of their rooms so there are other activities they do day today. They can do their own laundry, they can cook their food, they can watch television, they can play pool, whatever it is that they may need to do to break the monotony of being in bed all day. But the real challenge I think is whether they cooperate in taking their medication when they are locked up. And that's not always the case. They still sometimes refuse to take the necessary medication, particularly for those who are extremely paranoid of the medications that are given.

Patient only remain in Bellevue if they are still infectious. We don't move them to Goldwater unless they are. In Bellevue they have private rooms and they don't ever leave that room. In Goldwater they can, as I mentioned, be placed in a less restrictive environment where they can really socialize with other patients and also with the personnel in that ward itself.

Mr. Lopez

When we've had to have court hearings for the infectious, they're held in the hospital as opposed to bringing the infectious to court. And at the beginning, there

were all sort of issues about putting them in one of these, what do you call those things, sputum chambers, something like that? So it can get a little weird.

Dr. Mojica

We work in the same department so it's impossible for the public health staff not to work with the lawyers. We employ the lawyers; the health department employs its own lawyer so there's no way for us not to work together. We in the programs develop what we think we need to pursue our public health activities. We have our own Board of Health that acts on this and put the public health in the books with the same strength of laws so we work together to be able to do that. Mr. Lopez requires us to read the codes. We work in the health departments so we have to learn about powers in the health department as health officials and what really are the legal underpinnings of our duties.

Mr. Lopez

But let me elaborate on that because I think it's an important point. For us, we do have the Board of Health that in fact, enacts the health code. And one of the things I try to emphasize to new people, high level managers that come into the department, is to really appreciate the fact that they have a board of health that they can go to and not have to go through legislature and a very political process. They can come up with solutions to problems, have the board of health codify them in a relatively quick period of time and what is reflected in the health code in law, is in fact, their epidemiologic choices and in that way, the health code can be viewed as

a collection of programmatic initiatives which, in fact, they are over time. So I'm talking to the director of four bureau of school health and point out "You have to read articles 45, 47, 48, 51" so that they understand how their program should work. I also tell them "If you change a program, don't forget to change the law". Otherwise, when the law and the program diverge, you may have lawsuits where you're not complying with mandates for example. But it helps when both sides keep an eye on program and law.

When there's any suspicion that an individual may have a mental disability or not understand what's going on, we always make sure that a lawyer is connected to that person so that you know whether they're expressing a desire, or are capable of expressing a request to be released, etc. It's interesting that the mental health system, I think, suffered from a lot of the same problems in that a person, who was a danger to themselves or others, would be involuntarily committed. They'd be given some psychotropic drugs and in seventy-two hours, when they were not acting out anymore, they'd be released, stop taking their medication and act out at their own risk or that of the public. And recent developments, I don't know if you've heard of Cadra's Law, etc., I think the mental health system is going toward the directly observed therapy, ordered medication and detention, so it's kind of like the mental health system going in the direction of the public health.

Mr. Beverungen

I don't really have any magic bullet at all. I think history was on our side in that the

health department does not employ attorneys. The county health department works with the county law office and in some cases, the state attorney general's office with regard to legal issues. But historically, I think the two agencies have worked very well and you know, that's continued. So it's really a nice fit to it all. We've been very fortunate in having that collaborative and cooperative relationship.

I think the only thing I would add to Dr. Leverett's comments is that we're like a law firm. My office is like a law firm for a county that has about 20 agencies. The downside of that is, that when they call and say there's someone who needs to be quarantined or can we issue tobacco citations to minors, or can we release these medical records? We need to kind of get on the case, and there's a slight learning curve each time. We don't have the luxury of having lawyers that devote their entire practice to public health law. But we have good lawyers, and we certainly employ lawyers that know this area.

Dr. Harrowe

From our perspective, we contract with our County Prosecuting Attorney's office, and we've found that we've had some good attorneys through the years and some not so good attorneys through the years. It's always been incumbent on us to make sure that we educate our attorneys so they understand what we do. It helps both of us really. We've also, on occasion, hired outside attorneys for special situations, and that's been effective for us as well. But it's really been who is our attorney at the time. That's usually a big determinant for us.

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