

The Unprecedented Opioid Epidemic:

AS OVERDOSES BECOME A LEADING CAUSE OF DEATH,
POLICE, SHERIFFS, AND HEALTH AGENCIES
MUST STEP UP THEIR RESPONSE

DEATHS IN THE UNITED STATES, PEAK YEAR

64,070 Drug Overdoses, 2016

54,589 Car Accidents, 1972

50,628 HIV/AIDS, 1995

44,193 Suicides, 2015

24,703 Homicides, 1991

16,899 Vietnam War, 1968



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ACKNOWLEDGMENTS

In PERF's 40-year history, we have taken on many difficult, sensitive issues: police use of force, racial bias, terrorism, active shooters, sexual assault, immigration issues, killings of police officers, riots and major demonstrations, the police response to natural disasters, and so many more.

But never has PERF worked on an issue more vexing and painful than the opioids crisis that the United States is now facing. In just one year, 2016, nearly as many people died from opioid overdoses as all U.S. fatalities during the entire course of the Vietnam War. And despite the huge amount of hard work and thoughtful strategies that police chiefs and sheriffs have thrown at this problem over the last few years, the crisis has not yet peaked. It is still getting worse, according to federal statistics.

This report is PERF's third major report on the opioids crisis. We keep coming back to this issue precisely because the fatalities continue to increase.

I am grateful to everyone who has contributed to helping PERF maintain its focus on this issue.

Many people deserve thanks for organizing and participating in the project that led to this report. I would like to begin by thanking the New York City Police Department for hosting our April 6, 2017 conference at their headquarters building in lower Manhattan. Commissioner James O'Neill could not have been more generous, in terms of providing much of the content for our meeting, as well as in flawlessly hosting a daylong event for more than 150 officials from across the country.

Commissioner O'Neill led off our meeting with a powerful summary of the opioids crisis and New York City's comprehensive initiatives that

are being undertaken to address the crisis with a Compstat-like approach. Deputy Commissioner Susan Herman, Chief of Crime Control Strategies Dermot Shea, Chief of Detectives Robert Boyce, Chief Edward Delatorre, Chief Kevin Ward, and many others from NYPD shared their expertise at our meeting and in interviews we conducted to prepare for the conference. Dr. Denise Paone of New York City's Department of Health and Mental Hygiene provided important information about public health perspectives. And Chauncey Parker of the New York County DA's Office, who played a key role in New York City's response to the opioid crisis, gave us the benefit of his expertise and insights from his remarkable career.

I also want to thank all of the police chiefs and other officials from across the country who came to New York to share their expertise with us. The opioids crisis is hitting cities and towns of all sizes across the nation, and this report provides a sense of how the situation is not the same in every jurisdiction, so there are some differences in how agencies are responding. I'm grateful to the public health and drug treatment professionals who participated, because there is universal agreement that the response must be a joint effort by many stakeholders. And DEA Acting Administrator Chuck Rosenberg and ONDCP Acting Director Richard Baum provided important federal perspectives.

Thanks also to all of the PERF members who completed our 2017 national survey about the opioids crisis. We conducted a similar survey on the opioids crisis back in 2014, and it's striking how many police agencies across the country have taken concrete actions to address the issue since



then. In 2014, only 4 percent of our survey respondents were equipping officers with naloxone; by 2017, that figure had risen to 63 percent.

I'm also deeply grateful to the Howard G. Buffett Foundation for supporting this project. Howard Buffett is a businessman, farmer, author, and philanthropist with an interest in a wide range of issues, including poverty and hunger, conservation and the environment, and law enforcement. Howard recently was named Sheriff of the Macon County, IL Sheriff's Office, after serving in a number of other positions in that department since 2012. He has seen the opioid problem first hand and taken a personal interest in this issue. I'm proud to call him my friend, and PERF is very grateful for his generous support.

Many PERF staffers worked together to organize this project. Assistant Communications Director James McGinty provided overall direction and used his excellent research skills to develop the agenda for our conference at NYPD. Research Assistant Allison Heider, Senior Research Assistants Sarah Mostyn and Matt Harman, and Research Associate Jason Cheney interviewed police executives and other experts to gather information about how police and other agencies are responding to the crisis. Senior Research Criminologist Sean Goodison conducted PERF's survey, with tenacious support from Research Assistant Nate Ballard. My executive assistant, Soline Simenauer, once again anticipated and managed 100 logistical issues, ensuring that everything went smoothly at the conference. Director of Applied Research Tom Wilson and Chief of Staff Andrea Luna provided guidance to the entire project. And lastly, I want to

thank Craig Fischer, our Communications Director, who spent considerable time reviewing transcripts of our meeting and drafting this well-organized and compelling report.

There is no more important issue in many cities and towns today than the opioids epidemic. Police and sheriffs' agencies across the country have undertaken brilliant new approaches to the crisis, in many cases taking on entirely new roles for law enforcement officers. Thousands of police officers are carrying naloxone and saving lives by the hour. Some officers are even knocking on the front doors of people who suffered a recent overdose, asking if they can help them get into treatment. Others are working with their forensics labs and medical examiners to analyze overdose cases as quickly as is humanly possible, in order to stop the deadly spikes in heroin or fentanyl overdoses.

Unfortunately, this epidemic is not yet showing signs of abating. So we must continue to expand the programs that we know are working, while reassessing our strategies and searching for new approaches.

PERF is grateful to the people who contributed to this report, who are at the front lines of this crisis every day.

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



More people are dying of opioid overdoses than are dying on our highways in motor vehicle accidents. In Camden, a city of 77,000, by the end of this month of April, we will exceed the number of fatal overdoses that we had all of last year. We've already eclipsed 30.

There are times when our ambulance crews can't even keep up with the overdose calls that are coming in.

And overall, we are still losing this battle.

We must not relent, because this is about preventing parents from having to bury their children, and there's nothing more significant than that.

—**Scott Thomson, Camden County, NJ Police Chief and PERF President**

Make no mistake about this: The opioid epidemic is a national crisis. Here in New York City, it's happening in all five of our boroughs. It's affecting people from all walks of life, of all races, ages, and financial backgrounds. No facet of our society is immune.

I'm confident that we can turn the tide on this. But it's going to take cooperation at every level of government, and working in public- and private-sector partnerships. That's our way forward.

—**James O'Neill, New York City Commissioner of Police**

We all remember that awful shooting in Orlando at the Pulse nightclub last year, in which 49 people were slaughtered by a madman. Imagine that happening three times a day, every day, for 365 days in a row. That's roughly what we're talking about with fatal drug overdoses.

So we truly have an epidemic; that's not hyperbole. This is unique and unprecedented.

—**DEA Acting Administrator Chuck Rosenberg**



TOP: Chief Scott Thomson, Commissioner James O'Neill.

ABOVE: DEA Acting Administrator Chuck Rosenberg.

SUMMARY:

POLICE AGENCIES ARE RUSHING TO SAVE LIVES, HELP ADDICTED PERSONS, AND REDUCE DRUG ABUSE

By Chuck Wexler

Consider the following pieces of information:

- In Philadelphia, 35 people died of heroin overdoses *in less than a week* last December.
 - In New York City, fatal drug overdoses, which numbered 1,374 in 2016, are four times more common than homicides. The police are moving mountains to analyze overdose cases quickly, in order to stop the fatalities when an extremely powerful batch of heroin or fentanyl hits the streets.
 - In Louisville, Kentucky, police had 52 overdose calls over a 32-hour period last February. On average, police save someone's life with naloxone about twice a day, and one person dies from an overdose every day.
 - In Cabell County, West Virginia, officials reported 26 drug overdoses in a five-hour period, due to a batch of heroin containing fentanyl. The county reported the highest overdose death rate in the state, with 132 deaths among a population of less than 100,000.
 - In Ohio, the state with the most overdose deaths, an average of 11 people died *every 24 hours* in 2016, and coroners report that the numbers for 2017 are even higher. In Akron, 16 drug dealers have been sentenced to long prison terms because their product was linked to fatal overdoses, but the police chief doesn't think those prosecutions have "sent a message" to other dealers or slowed down the heroin trafficking.
 - In Cook County, Illinois, where Chicago and some of its suburbs are located, fentanyl took hold with a vengeance in 2016, causing more than 560 fatal overdoses. When Chicago's opioid overdoses are laid out on a map of the city, it correlates closely with the locations of shootings, prompting one police official to note that "our violent crime problem is our drug problem."
 - In New Jersey, crime labs have backlogs, but they find a way to turn heroin analyses around in a matter of hours if fatalities are involved.
 - In Baltimore, where 694 people suffered fatal overdoses in 2016, the Health Department is very concerned about the high likelihood that prescription opioid pills will lead to more cases of heroin addiction. So it is taking action. The Health Department is asking doctors to provide a prescription for naloxone along with every prescription they write for opioid pain pills. The idea is that doctors will think twice about prescribing oxycodone if they have to tell their patients, "Here's a prescription for your shoulder pain. And this other prescription is in case you end up having a heroin overdose."
- These are a few of the stories that you will find in the report you are holding. This is PERF's third major report about the epidemic of overdoses by

persons addicted to opioid drugs.¹ In 2014 and again in 2016, we held national conferences and released reports about the crisis, focusing on what local police and other agencies were doing to reduce the carnage. This new report summarizes what we learned at a third national PERF conference, held at the New York City Police Department's headquarters in April 2017.

The reason PERF continues to focus on the opioids crisis is that despite the groundbreaking work that police and other agencies are doing, the epidemic is continuing to worsen.

The latest numbers, released by the Centers for Disease Control and Prevention (CDC) in August 2017, are horrible.

Drug overdose deaths in 2016 totaled 64,070, a 21-percent increase over the year before. And approximately three-fourths of all drug overdose deaths are caused by opioid drugs.²

Let's put those numbers in context:

- The 64,070 drug fatalities in 2016 outnumber the 35,092 motor vehicle fatalities in 2015.³
- Drug fatalities in 2016 outnumber American fatalities in the entire course of the Vietnam War, which totaled 58,200.⁴
- Drug fatalities in 2016 outnumber AIDS-related deaths in the worst year of the HIV epidemic, when 50,628 people died in 1995.⁵
- Drug fatalities in 2016 outnumber the peak year of homicides in the United States, when 24,703 people were murdered in 1991.⁶

- Drug fatalities in 2016 outnumber suicides, which have been increasing for nearly 30 years and which totaled 44,193 in 2015.⁷

Furthermore, the new CDC statistics confirm what police chiefs have been telling us—Fentanyl is driving the sharp increases in opioid-related fatalities.

CDC identified 15,466 fatalities in 2016 resulting from heroin overdoses, but 20,145 fatalities caused by fentanyl or other synthetic opioids.

So it is clear that police and other criminal justice agencies, along with public health departments, drug treatment and social service providers, elected officials, and others, must step up their efforts to prevent new cases of opioid addiction, while helping addicted persons through the long and difficult process of getting free of opioid drugs.

Following are several of the new concepts you will find in this report:

1. FENTANYL AND CARFENTANIL ARE DRIVING THE SPIKES IN FATAL OVERDOSES: As New York City saw its fatal drug overdoses rising from 937 in 2015 to an estimated 1,300 in 2016, officials knew that the sharp increase was due to the increasing phenomenon of dealers “boosting” relatively weak heroin with much stronger and cheaper fentanyl, as well as carfentanil, an elephant tranquilizer that is so dangerous that even a few grains of it can be fatal.

Many cities are reporting this phenomenon. Baltimore Police Commissioner Kevin Davis said that Baltimore police recently seized 15 kilograms of heroin bound for West Baltimore, along with 30

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1. See *Building Successful Partnerships between Law Enforcement and Public Health Agencies to Address Opioid Use* (2016) <http://ric-zai-inc.com/Publications/cops-p356-pub.pdf>. See also *New Challenges for Police: A Heroin Epidemic and Changing Attitudes Toward Marijuana* (2014) [http://www.policeforum.org/assets/docs/Critical_Issues_Series_2/a percent20heroin percent20epidemic percent20and percent20changing percent20attitudes percent20toward percent20marijuana.pdf](http://www.policeforum.org/assets/docs/Critical_Issues_Series_2/a%20percent20heroin%20epidemic%20and%20changing%20attitudes%20toward%20marijuana.pdf)
 2. “Provisional Counts of Drug Overdose Deaths, as of 8/6/2017.” Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf
 3. “Traffic Safety Facts 2015.” National Highway Traffic Safety Administration. Table 2, p. 18. <https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812384>
 4. “Statistical information about casualties of the Vietnam War.” The National Archives. <https://www.archives.gov/research/military/vietnam-war/casualty-statistics.html#date>
 5. “HIV Surveillance — United States, 1981–2008.” CDC Morbidity and Mortality Weekly Report, June 3, 2011. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6021a2.htm>
 6. “Homicide Trends in the United States, 1980-2008.” U.S. Dept. of Justice, Bureau of Justice Statistics. November 2011. Page 2. <https://www.bjs.gov/content/pub/pdf/htus8008.pdf>
 7. “Preventing Suicide,” CDC. <https://www.cdc.gov/features/preventingsuicide/index.html>

kilograms of the far more powerful and less expensive fentanyl.⁸

PERF's latest opioid survey revealed that 45 percent of responding agencies were seeing an increase in fatal overdoses involving fentanyl; only 3 percent reported a decrease in these deaths. And many chiefs noted at our meeting that carfentanil can be ordered inexpensively by email from China.

When overdoses occur, police and public health agencies are working to obtain laboratory test results as quickly as possible, in order to detect any spikes in overdoses caused by a batch of heroin that is mixed with fentanyl or carfentanil. Often, several people die in a matter of hours or days because they bought the same lethal mixture from a certain dealer. The idea is that if local officials can identify the spike quickly, they can issue a public warning.

However, police chiefs warned that perversely, some addicted persons are actually attracted to the news that an extremely strong mix of heroin and fentanyl is being sold in a certain location, and they may seek out that dealer to obtain the strong product.

Thus, some police departments are being careful about releasing such information. One approach is for police to advise local drug treatment providers, who "know their customers" and can spread the news judiciously, rather than making a general public announcement via news media and social media.

2. POLICE AND OTHER AGENCIES ARE SHARING INFORMATION TO DETECT AND STOP SPIKES IN FATAL OVERDOSES: In many cities and towns, there is a rush to obtain results of laboratory analysis of drugs found at overdose scenes, to determine whether a single source of heroin laced with fentanyl or carfentanil is causing a localized spike in overdoses. The laboratories provide the analysis of exactly what drugs are contained in a given sample, which can be used to determine whether multiple overdoses may be linked to the same dealer's drugs.

Police agencies and their partners are developing various ways to share information. In Ohio, for example, the Cincinnati Fusion Center shares overdose data on a weekly basis with every police officer in the southwest part of the state. In the

Maryland, Virginia, West Virginia, and DC area, the Washington/Baltimore has developed a smart-phone app that participating police, fire, and EMS agencies across the region use to share real-time data on fatal and nonfatal overdoses.

In Philadelphia, the Police Department is using its Real Time Crime Center as a portal for information about overdoses coming in from hospital emergency rooms and the Medical Examiner's Office.

New York City officials have developed one of the most sophisticated systems for sharing information, by taking their RxStat program to a new level. A new "RxStat Operations Group" of high-level officials from approximately 25 agencies, including police, probation, the health department, drug treatment providers, and others, meets quarterly, and focuses on identifying gaps in the city's response to the opioids crisis.

To date, the Operations Group has held three quarterly meetings, and has identified approximately 70 issues to solve. All 25 participating agencies agree that they are focused on one goal: reducing drug overdoses.

3. POLICE ARE DIRECTLY INTERVENING TO HELP OVERDOSE VICTIMS: An increasing number of police departments are directly intervening to help persons who experience a nonfatal opioid overdose. In Plymouth, MA, for example, Police Chief Michael Botieri said that police often are the first responders to an overdose incident, and they know that the first 12 to 24 hours following an overdose are a critical time for intervening. "So we got the idea of following up the next morning on every overdose that happened the night before," Chief Botieri said. Officers, along with public health clinicians, go to the overdose victim's home and offer resources to the victim and his or her family members or loved ones.

Botieri said police expected that perhaps half of the overdose victims would turn police away. "But no one turns us away. We've never been turned away," he said. This program has spread to all 27 police agencies in the county, he said.

8. "Baltimore to flood streets with police after rash of killings." Reuters, June 13, 2017. <https://www.reuters.com/article/us-maryland-crime/baltimore-to-flood-streets-with-police-after-rash-of-killings-idUSKBN1942VM>

In East Bridgewater, MA, city officials created a “Drop-In Center,” located in a church, where addicted persons can go to receive a range of services. All of the local drug treatment facilities participate. The center is marketed to active drug users and their family members.

And 264 police departments and 300 treatment centers have joined the Police Assisted Addiction and Recovery Initiative (PAARI), which is a nonprofit organization that helps police agencies adopt the “Gloucester Model” of encouraging addicted persons to come to the police for help in getting treatment services.

4. EXPONENTIAL GROWTH IN POLICE USE OF NALOXONE TO REVERSE OVERDOSES: PERF’s 2017 survey of its member police chiefs found that 63 percent of responding agencies have trained officers to carry and administer naloxone, the nasal spray medication that can reverse the effects of a heroin overdose, and save lives. (By contrast, a similar PERF survey conducted in 2014 found that only 4 percent of agencies were administering naloxone at that time.)

Police officers are saving thousands of lives with naloxone. The 164 agencies in PERF’s survey that provided data reported a total of more than 3,500 naloxone reversals in 2016. Seven agencies reported at least 100 naloxone saves each in 2016.

5. JAILS MAY BE AN UNDERUSED OPPORTUNITY FOR TREATMENT: Many police officials and other experts have noted that because opioids are extremely addictive, success in treatment can be very difficult to achieve. Addicted persons often drop out of treatment programs multiple times, and many die before they find success in treatment.

As a result, there is increasing discussion of how jails can take an important role in providing treatment services to inmates, including medication-assisted treatment such as Suboxone, which relieves withdrawal and cravings for opioids without causing the “high” of heroin or dangerous side effects. Because jail inmates are incapacitated for the time they are in jail, this can be an opportunity to help inmates undergo treatment without the temptations they might face if they were free.

The Essex County, MA Sheriff’s Department operates two 42-bed detox programs, which last 28 days. The programs are geared toward low-level offenders, such as prostitution offenses or larcenies, committed by persons to support their addictions. The Sheriff’s Department works closely with prosecutors, defense attorneys, and judges in order to provide this option to the best candidates for treatment. The department also is planning to create partnerships with aftercare programs, to help ensure that when offenders are released from the jail detox program, they have resources.

The New York Times featured a treatment program for jail inmates at the Kenton County, KY Detention Center. Inmates live in a special therapeutic-community “pod,” where they participate in a wide range of educational and counseling programs.⁹

6. POLICE AGENCIES RECOGNIZING THE IMPORTANCE OF FOCUSING ON AT-RISK YOUTHS: At PERF’s conference, police chiefs from West Virginia and New Jersey discussed programs they have established to provide services to youths who are at high risk for drug abuse. Research such as the Adverse Childhood Experiences Study (ACES) study has found that children who experience more traumatic events, such as physical or emotional abuse and neglect, are statistically more likely to engage in delinquent acts or drug abuse. A number of police departments are working with schools and others to make special efforts to help those youths avoid negative behavior.

7. A ROLE FOR POLICE IN EDUCATING THE PUBLIC ABOUT THE DANGERS OF PRESCRIPTION OPIOIDS: There is widespread agreement that because four out of five persons who are addicted to heroin began with prescription opioid drugs, such as oxycodone, any strategy for reducing the heroin crisis must include strong efforts to prevent additional people from becoming addicted to prescription opioids.

In fact, a growing number of jurisdictions, including Ohio, Mississippi, and counties and cities in California, Illinois, New York, and West Virginia, have been suing pharmaceutical companies,

9. “Addicts Need Help. Jails Could Have the Answer.” *New York Times*, June 16, 2017. https://www.nytimes.com/2017/06/16/opinion/sunday/opioid-epidemic-kentucky-jails.html?_r=0&mtref=undefined&gwh=CDCFC752C270F59C775FCB9E27689A89&gwt=pay&assetType=opinion

alleging that they bear responsibility for the heroin crisis because they engaged in deceptive marketing that minimized the addictiveness of prescription opioids.¹⁰

“We think that the manufacturers of opioid pills carry responsibility,” said Everett, WA Police Chief Dan Templeman at the PERF meeting in New York. “It’s a significant part of the equation when 80 percent of heroin addicts start on prescription medications.”

A number of police chiefs and other experts at PERF’s conference also said there is an important role for police chiefs to (1) educate the public about the risks of opioid medication, and (2) work to prevent the overprescribing of opioids by medical professionals.

The Centers for Disease Control and Prevention (CDC) have released a wide range of reports, fact sheets, brochures, posters, videos, and webinars that police chiefs can use to explain these risks. Some of the CDC documents are written for the general public, while others are intended mainly for medical practitioners.

For example, a CDC study found that when patients receive their first prescription for opioid pain relievers, there is a significant likelihood that they will still be using the medication a year later. Among persons who received an initial 12-day supply of opioid medication, 24 percent were still taking the drugs one year later. Even among persons who received only a *one-day supply*, 6 percent were still taking the drug a year later.

Many of today’s heroin addicts first became addicted to prescription opioid drugs, and changed to heroin when it became too difficult or expensive to obtain the prescription pills. In many places, heroin is more easily and cheaply available than opioid pills.

8. CHALLENGES TO PROSECUTION: Police chiefs and federal and local prosecutors addressed changes in their role regarding drug enforcement, and no simple answers emerged. One issue is that drugs are sold differently today. “These types of investigations are much more costly and complex than

in the past, because the dealing is happening on social media,” Middlesex County, MA District Attorney Marian Ryan said. “Today’s users are having heroin delivered to their house.”

Furthermore, opioid dealers increasingly obtain fentanyl and other synthetic opioids on the internet through the “dark web,” where transactions can be conducted anonymously.¹¹

Assistant U.S. Attorney John Gallagher from Philadelphia explained that federal prosecutions for heroin lag behind prosecutions for methamphetamine, cocaine, and marijuana, because the quantities needed to trigger mandatory minimum sentences for heroin are set higher than for other drugs.

One criterion would be to focus on prosecuting dealers who sold heroin to persons who suffered fatal overdoses. In the Akron, OH area, 16 drug dealers have already been sentenced to terms of approximately five to seven years for involuntary manslaughter after their product was linked to fatal overdoses.

That distinction may be less helpful in larger cities. NYPD Chief of Crime Control Strategies Dermot Shea said, “I don’t think this is the exception; this is the norm. Show me a drug dealer of heroin in New York City who *hasn’t* caused an overdose. This is what we are struggling with now.”

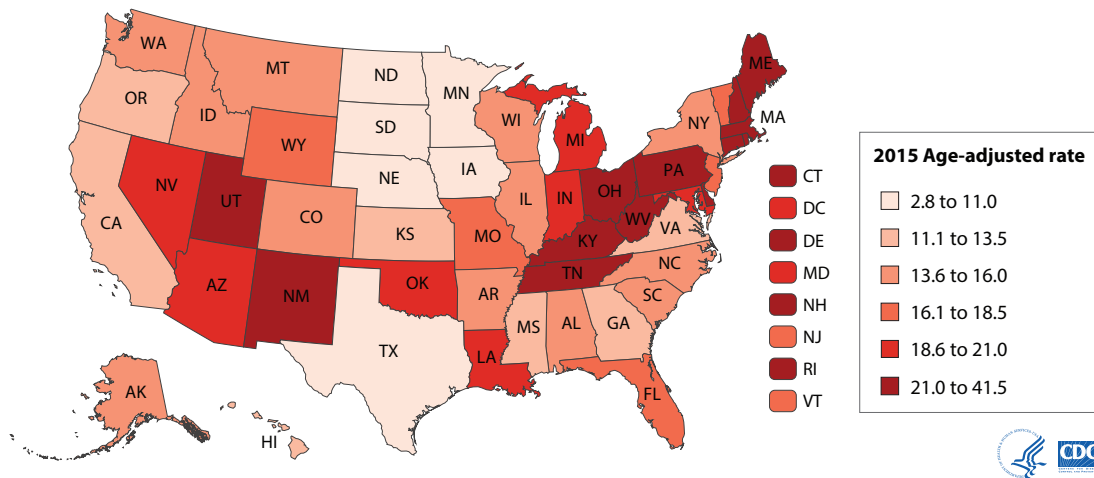
Akron Police Chief James Nice said he does not believe that the successful prosecutions of dealers linked to overdose deaths in his city have slowed down the heroin trafficking. “The overdoses didn’t go down as a result of that,” he said. “It’s just that some of these people are being held accountable for those deaths. Victims’ family members appreciate it, though, when the person who knowingly provided fentanyl or carfentanil to their loved one who died goes to jail for that.”

New York County Executive Assistant District Attorney Chauncey Parker said that his office is warning dealers not to sell heroin containing fentanyl or carfentanil, and advising them that federal law provides for 20-year mandatory minimum prison terms in cases where persons die.

10. “Ohio sues five drug companies over opioid crisis.” Reuters, May 31, 2017. <https://www.reuters.com/article/us-ohio-opioids-idUSKBN18R2BY>

11. “Opioid dealers embrace the dark web to send deadly drugs by mail.” *New York Times*, June 10, 2017. <https://www.nytimes.com/2017/06/10/business/dealbook/opioid-dark-web-drug-overdose.html>

Number and Age-Adjusted Rates of Drug Overdose Deaths by State, U.S. 2015



Source: CDC

The police chiefs of Delray Beach and Hollywood, FL, reported that when addicted persons complete residential treatment programs, they are targeted by dealers who frequent the areas near treatment centers. An addicted person who completes a 30-day program has a lower tolerance for heroin upon release, and is particularly vulnerable to overdosing on heroin that may be as much as 90-percent pure, or may be mixed with fentanyl or carfentanil.

There was general consensus at the PERF meeting that dealers who prey on vulnerable patients leaving treatment centers should face prosecution.

9. SOME STATES HAVE NOT YET EXPERIENCED THE FULL IMPACT OF THE OPIOIDS CRISIS: The opioids epidemic has caused tremendous hardship in many parts of the United States, especially New England and Appalachia. But upper-Midwest states, including the Dakotas, Minnesota, Nebraska, and Iowa, and the Western states of California and Oregon, have not yet felt the crisis to the same extent. Some states have fatality rates that are four or five times higher than other states'. **So this report should be seen as a wake-up call for the parts of the country that have yet to be hit hard by opioids. Those states would be well advised to study the patterns of the epidemic in other locations, and prepare so that they can quickly detect any increases**

in overdoses that may occur, and respond effectively with strategies that have already proved to be helpful.

10. THE IMMEDIATE PROGNOSIS IS STILL NEGATIVE: The opioids crisis is the most significant issue facing police chiefs in many parts of the United States. Police agencies and sherrifs' departments, working with public health agencies and others, described dozens of programs they have undertaken to reduce opioid deaths. To a large extent, Compstat principles that have proved successful in driving crime rates down may help reduce opioid deaths. And there is universal agreement that solutions lie in partnerships. When police and sheriffs work hand-in-glove with drug treatment and social service providers, hospitals, medical examiners' officers, prosecutors, courts, and others, solutions emerge.

However, the short-term prognosis is still not good. The opioid crisis came on too quickly, reaching the point of thousands of deaths per month. Police and other agencies have been scrambling to respond and have done tremendous work, but the problem is still getting worse.

PERF hopes that this report will help law enforcement agencies chart their course—particularly in locations where the opioid crisis is just beginning to manifest itself. The spread of the epidemic may be slowed if we can all benefit from strategies that have been tested in the cities and towns that felt the scourge first.

10 ACTIONS POLICE CHIEFS AND SHERIFFS CAN TAKE

Based on the discussions at the April 6 conference and PERF's research, PERF developed the following set of recommendations for all law enforcement agencies:

- 1. Naloxone:** Equip officers with naloxone. That single strategy has already saved 3,500 lives in the 276 police departments that responded to PERF's survey. Police chiefs and sheriffs also can use their positions of leadership in the community to call for widespread distribution of naloxone (and training of personnel to administer it) at drug treatment facilities, homeless shelters, and other locations where overdoses have occurred in each community.
- 2. Data collection:** It is important to promptly track the "who, how, when, and where" of fatal and nonfatal drug overdoses.
- 3. Early warning systems:** Use the data to develop systems for detecting the onset of an opioids crisis in your community, or for detecting overdose spikes caused by heroin that has been "boosted" with fentanyl or carfentanil.
- 4. Compstat:** Use Compstat principles as a methodology for addressing the opioid crisis. For example, New York City's RxStat system is based on: (1) the development and use of timely, accurate data; (2) developing strategies based on those data; and (3) rapid deployment of public health and public safety resources (4) to high-priority areas.
- 5. Get users into treatment:** Use your credibility in the community to take a leadership role in promoting drug treatment. Many police departments are taking proactive roles in getting addicted persons into treatment. For example, some police agencies send a team of an officer and a public health clinician to the home of a person who experienced an overdose, preferably the next day, and offer information, lists of resources, and assistance in placing the person in a treatment program.
- 6. Drug treatment in jails:** Many police chiefs said, "We cannot arrest our way out of the opioids crisis." However, to the extent that persons with an addiction are jailed for crimes other than drug possession, the period of incapacitation in jail can provide an opportunity to help addicted persons undergo treatment. Public health officials have recommended medication-assisted treatment, such as the use of Suboxone, which relieves withdrawal and cravings for opioids without causing the "high" of heroin or dangerous side effects. Sheriffs have a key role to play in providing detox and other treatment programs to jail inmates.
- 7. Strategic enforcement and prosecution:** Target opioid enforcement efforts strategically. There is widespread agreement that addicted persons should be offered treatment services rather than prosecution. It can be difficult to decide on criteria for prosecuting dealers. Federal laws are not well suited to targeting heroin dealers because the criteria for mandatory minimum sentences are set relatively high for heroin, compared to other drugs. One approach is to target prosecutions toward the goal of reducing overdose deaths, as opposed to traditional measures such as quantity of drugs seized. For example, police and prosecutors can focus enforcement on dealers who sell to persons near drug treatment facilities in order to thwart their efforts to stop using opioids.
- 8. Focus on prevention by educating the public about risks:** Take a leadership role in educating the public about the addiction risks of prescription opioid drugs. Four out of five heroin addicts began with prescription opioid drugs, and thousands of people overdose from prescription opioids. So a key element of any strategy for reducing opioid deaths must be reducing the number of people who become addicted to prescription opioids.
- 9. Work with partners:** Establish strong partnerships with public health agencies, social service providers, and treatment providers. Officials in New York City reported success with quarterly meetings in which officials from many agencies study recent case histories of overdoses, in order to identify opportunities that may have been missed to prevent the overdoses.
- 10. Encourage safety for officers:** Remember to protect your officers' well-being and safety. Establish strong protocols and train officers to use protective gear to protect themselves against exposure to fentanyl and carfentanil. And be aware that repeated exposure to overdose incidents can be traumatic for officers, particularly when children are present.

THE EXTENT AND NATURE OF THE OPIOID EPIDEMIC

Note: The bulk of this report consists of quotations from participants at PERF's conference at NYPD headquarters on April 6, 2017.

The comments below, and throughout this report, were made by the identified speakers. Participants were given an opportunity to edit their quotations, and to provide additional commentary if they wished.

Philadelphia Police Commissioner Richard Ross:

Heroin Is a Crisis in Philadelphia; We Had 35 People Die in One Week

This is a crisis. In Philadelphia, we have seen some of the most potent heroin in the nation, sometimes upwards of 90 percent purity. We had 35 people die in one week in December, and approximately 900 fatalities in all of 2016. We've had saves where the Fire Department and the police are both using naloxone to save two different people in the same car at the same time. Our fire department does many more saves than the police. The mayor

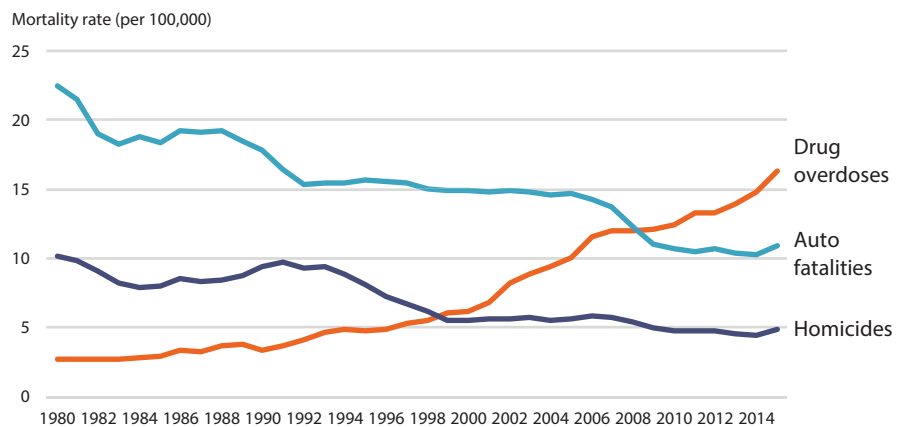
has created an opioids task force, and we have multiple agencies involved. We have developed a protocol for responding, but as of now, the crisis is continuing.

Akron, OH Police Chief James Nice:

Dealers Tell Us They Order Carfentanil by Email

In Akron we have a population of 190,000, and we had 1,400 overdoses in 2016, with 179 deaths. We track the toxicology on these, and when we started having problems with heroin, it was all heroin. But in mid-2016, it started to be heroin mixed

U.S. Mortality Rate



Sources: CDC, NHTSA, FBI



ROW 1: Philadelphia Police Commissioner Richard Ross; Akron, OH Police Chief James Nice; and Louisville, KY Assistant Chief of Police Greg Burns.

ROW 2: NYPD Chief of Detectives Robert Boyce; Hennepin County, MN Sheriff Richard Stanek; and Baltimore County Police Chief Terrence Sheridan.

with fentanyl. In July 2016, we became aware of carfentanil, and the deaths went out of this world. And now our toxicology comes back many times as fentanyl or carfentanil *only*.

The important thing is that people aren't even looking for heroin dealers; they're not having to make connections in back alleys with dealers from Mexico or Chicago. Some of the suspects we are arresting say they just send an email to China, with very little money, and they're getting 10,000 usages of carfentanil. The entire drug dealing business is easier.

Louisville, KY Assistant Chief of Police Greg Burns:

Dealers Tell Us that Heroin Is More Profitable than Other Drugs

We used 688 doses of Narcan in 2016, in incidents involving 480 patients. Sometimes a person needs more than one dosage to save their life. So far in 2017, we're at 268 doses that we've administered

to 189 patients. When we started to crack down on the prescription drug "pill mills," that's when we started to notice the heroin problems shoot up, because it was really cheap, and the pills are so expensive now.

When we interview the drug dealers, they say they give away the heroin. Dealers also tell us that the drug cartels will not give them any other drugs unless they also buy heroin, because heroin is where they make the most money. So if you want cocaine, you have to take heroin also. If you want marijuana, you have to take heroin also, whether or not you want to sell heroin. You have to take it.

NYPD Chief of Detectives Robert Boyce:

NYC Overdoses Deaths Are Four Times More Numerous than Homicides

We have an overdose rate that's four times the homicide rate here in New York City. We did a case in Brooklyn last week, Operation Hardball,

where we took down a Bloods gang selling heroin, and we found fentanyl packaged from China, bought on the Dark Web. That is particularly alarming. That heroin cocktail mix is what's driving our overdose numbers here in New York.

Hennepin County, MN Sheriff Richard Stanek:

We Are Starting to See Carfentanil Hit Our Community

In my county, we had a 39-percent increase in 2016 opioid-related deaths over the previous year- 110 to 153 deaths, which generally matches the national trend of opioid deaths being about three times the homicide rate. I hope at some point today we will see what ONDCP, DEA, and our other federal partners have in mind for a national strategy to help our communities and law enforcement deal with this crisis.

I was joined today by Mr. Nick Motu of the Hazelden-Betty Ford Foundation in Minnesota. They are key partners in our “#NOVerdose” awareness campaign. We know can't arrest our way out of this crisis- treatment, prevention and intervention are also a part of the solution. We've got to figure out what we can do better. I think the key question is, working with our community partners, how do we move forward?

We knew carfentanil was going to hit our community, and now we're seeing it. We have now had 11 carfentanil related deaths in Minnesota, all in this year, and nine have been in my county. It's going to hit us hard.

Baltimore County Police Chief Terrence Sheridan:

This Year We Have Had 13 Homicides, 16 Traffic Fatalities, and 86 Overdose Deaths

WEXLER: Terry, you were chief in Baltimore County many years ago, then you were head of the Maryland State Police, and now you're chief in Baltimore County again. The drug situation has changed a bit. Tell me what you're facing.

CHIEF SHERIDAN: As of this morning, we have had 13 criminal homicides in Baltimore County in 2017. We had 16 traffic fatalities. So far this year, we have had 86 overdose deaths.

We are trying to do many of the same things as other jurisdictions. We work with our Health Department and our Medical Examiner, trying to track the overdoses and the overdose deaths. Our information systems are disparate; we have silos. But we are trying to get everyone together so we can determine, where are these spots where the overdoses are occurring, how do we track them, and where's it coming from?

It's a tough problem. I go back a lot of years, and I remember the first heroin addict I locked up. He said, “There's no high like it.” And it's the same today. It's so addictive, and we're facing an addiction problem that is hard to describe, because the people who are using these drugs can't get out of it; they're overwhelmed by it. You can give people treatment when they are locked up, and you may get them over the hump, but it's hard to stay off the drug. We had a man who overdosed 20 times, and he died the 21st time. He received naloxone multiple times, but he would resist medics and police because he said they were “ruining his high.” That's what we're dealing with.

KEY POINTS ON THE NATURE AND EXTENT OF THE OPIOID EPIDEMIC

- **The opioids epidemic is a national crisis that continued to worsen dramatically in 2016.** The latest numbers from CDC reveal that drug overdose deaths in 2016 totaled 64,070, a 21-percent increase over 2015. While some of those deaths involve cocaine or other drugs, approximately three-fourths of the fatalities were caused by heroin, fentanyl, prescription opioid pills, or other opioid drugs.
- **Fentanyl is driving the sharp increases in opioid-related fatalities.** The new CDC study revealed that in 2016, fentanyl accounted for a much larger share of drug overdose deaths than in the past, even surpassing deaths attributed to heroin. Between 2015 and 2016, fentanyl-related deaths nationwide increased 103 percent, to a new total of 20,145. By contrast, heroin-related deaths increased 17 percent, to a total of 15,466.
- **Investigating opioids trafficking is more difficult than in the past.** Dealers are ordering carfentanil on the internet, and it is delivered from China by mail.
- **Opioids are more profitable to dealers than other drugs.**
- **Some states have not yet experienced the full impact of the opioids crisis.** The epidemic has caused tremendous hardship in many parts of the United States, especially New England and Appalachia. But upper-Midwest states and the Western states of California and Oregon have not yet felt the crisis to the same extent. However, some cities and towns that were not experiencing the crisis a year ago are seeing it now. States that have been relatively unscathed would be well advised to study the patterns of the epidemic in other locations, so they can prepare to detect any increases in overdoses and respond effectively.

PERF SURVEY SHOWS DRAMATIC SPIKE IN HEROIN AND FENTANYL DEATHS

In March–April 2017, PERF conducted a survey of its member police chiefs regarding the nature of the opioid crisis in their communities and their agencies’ responses. More than 275 chiefs completed the survey.

One major finding was that more than half of responding agencies reported an increase in fatal heroin overdoses in their jurisdiction in 2016, compared to 2015, and 45 percent reported an increase in fatal overdoses attributed to fentanyl. But only 23 percent reported an increase in fatal overdoses due to prescription opioid medications.

Those results are consistent with statements by police chiefs and other experts that many people who become addicted to prescription opioids begin using heroin instead, when it becomes too difficult or expensive to keep obtaining the prescription pills.

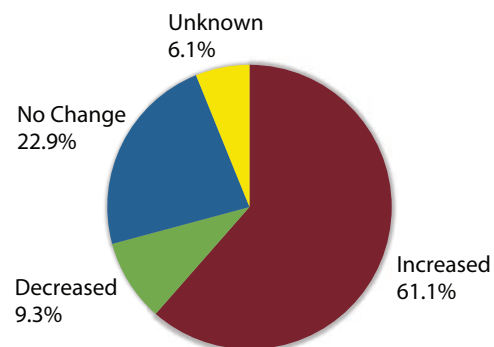
And PERF’s survey findings are consistent with what ONDCP’s Acting Director, Richard Baum, said at our conference:

“It does look like the increase in the nonmedical use of prescription drugs has begun to level off. But unfortunately, the fatalities haven’t leveled off because of the very pure heroin, the fentanyl, and the carfentanil that are killing so many people.”

Following are the questions and results from PERF’s 2017 survey:

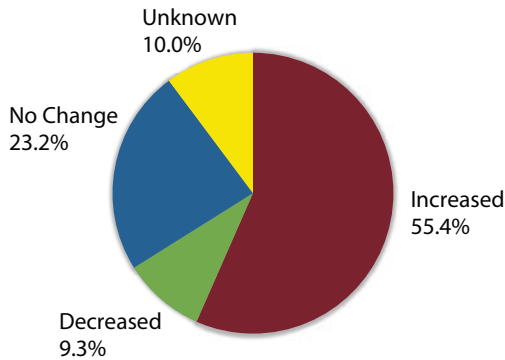
*In your best judgment, in 2016, compared to 2015, how did the **total number of fatal opioid overdoses** in your jurisdiction change, including heroin, fentanyl, and prescription opioid overdoses? (Percentages do not add to 100 percent because for each question, some respondents said they did not know or did not reply.)*

- 61.1 percent reported an increase.
- 9.3 percent reported a decrease.
- 22.9 percent reported no change.

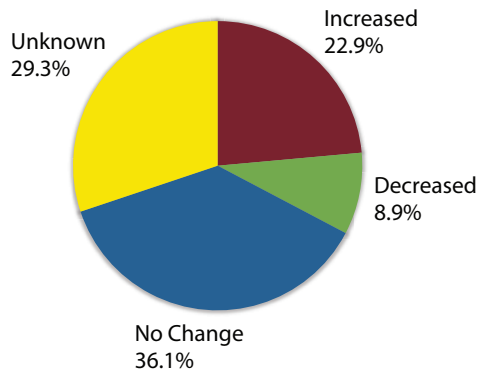


If possible, please provide the trend for each major type of opioid overdoses. (Because drug overdoses often involve multiple drugs, please provide your best estimates of the trends in each category according to the type of opioid drug that appeared to be the primary cause of an overdose.)

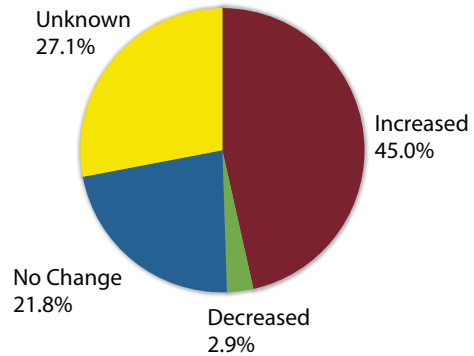
- Fatal **heroin** overdoses...
 - ▶ 55.4 percent reported an increase.
 - ▶ 9.3 percent reported a decrease.
 - ▶ 23.2 percent reported no change.



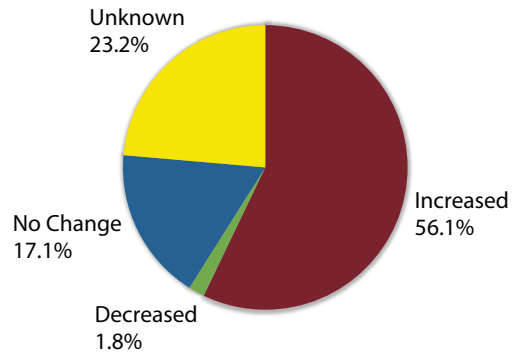
- Fatal **prescription opioid** overdoses...
 - ▶ 22.9 percent reported an increase.
 - ▶ 9 percent reported a decrease.
 - ▶ 36 percent reported no change.



- Fatal **fentanyl** overdoses...
 - ▶ 45.0 percent reported an increase.
 - ▶ 2.9 percent reported a decrease.
 - ▶ 21.8 percent reported no change.



- **Nonfatal** opioid overdoses...
 - ▶ 56 percent reported an increase.
 - ▶ 2 percent reported a decrease.
 - ▶ 17 percent reported no change.



Does your agency **track nonfatal overdoses**?

- 53 percent yes.
- 47 percent no.

If possible, please estimate the **ratio of nonfatal overdoses to fatal overdoses** in your jurisdiction.

- The most common responses were **3 to 5 nonfatal overdoses** for **each fatal overdose**.

Does your jurisdiction have a **“Good Samaritan” law** that provides immunity to those seeking medical assistance for an overdose?

- 69 percent yes.
- 31 percent no.

Does your agency **carry naloxone**? (PERF asked this question in a 2014 survey, and asked it again in our 2017 survey.)

- 2014 PERF Survey:
 - ▶ 4 percent of agencies reported that their officers were carrying naloxone.
 - ▶ 31 percent of agencies said they were considering it.
- 2017 PERF Survey:
 - ▶ 62.9 percent of agencies reported that their officers are carrying naloxone.

If you equip your officers with naloxone, approximately **how many overdose reversals** (lives saved) did your agency perform in 2016?

- 11 percent - 0 reversals
- 20 percent - 1 to 10 reversals
- 20 percent - More than 10 reversals
- 49 percent - No answer

Do you have a **diversion program such as “Law Enforcement Assisted Diversion”** (LEAD), in which some persons arrested for drug possession are allowed to avoid prosecution if they enter a treatment program or otherwise accept services from a case manager who works with the arrested person to create an intervention plan?

- 49 percent - Yes, we have such a program.

Do you have an **“ANGEL”** type program, in which police proactively help drug users to obtain treatment, independent of criminal justice system involvement?

- 23 percent - Yes, we have such a program.

Do you have a **comprehensive data-sharing program**, in which police, public health agencies, prosecutors, hospitals, drug treatment providers, probation/parole/corrections agencies, Medicaid fraud investigators, and others share information about opioid or other drug abuse patterns, and use that information to operationalize multi-agency strategies and close gaps in responses and services?

- 32 percent - Yes, we have such a program.

NEW YORK CITY OFFERS A MODEL FOR A DATA-DRIVEN, COLLABORATIVE RESPONSE

New York City, which experienced approximately 1,300 fatal drug overdoses in 2016, has launched a wide-ranging series of programs and protocols designed to reduce opioid fatalities. At PERF's conference, police, prosecutors, and public health officials described these initiatives, how they were created, how they are operating, and lessons that have been learned about multi-agency approaches.

First, NYPD Commissioner James O'Neill provided an overview of New York City's work to date.

Second, New York City officials from the police department and the health department described the city's RxStat program, which has quickly become a model for public health and law enforcement agencies that wish to operationalize shared data to reduce deaths.

Over the past year, RxStat shifted into high gear with a new RxStat Operations Group, a panel of high-ranking officials from approximately 25 agencies that meets quarterly to review overdose case histories and identify gaps in the city's response and new ideas for reducing fatalities.¹²

Finally, the NYC officials outlined a new citywide approach to reducing opioid deaths, with additional funding targeted to key areas, which was announced in March 2017 by NYC Mayor Bill de Blasio.¹³

12. Background information about RxStat is available in PERF's 2016 report, *Building Successful Partnerships between Law Enforcement and Public Health Agencies to Address Opioid Use*, pp. 66-69. <http://ric-zai-inc.com/Publications/cops-p356-pub.pdf>

13. *Healing NYC: Preventing Overdoses, Saving Lives*. The City of New York, Office of the Mayor. <http://www1.nyc.gov/assets/home/downloads/pdf/reports/2017/HealingNYC-Report.pdf>

NYPD Commissioner James O'Neill:

We Are Devoting Massive Resources To the Goal of Ending the Opioids Crisis

Make no mistake about this: the opioid epidemic is a national crisis. Here in New York City, it's happening in all five of our boroughs. It's affecting people from all walks of life, of all races, ages, and financial backgrounds. No facet of our society is immune.

What makes matters worse is that illegal drugs like heroin are increasingly being cut with fentanyl, a powerful synthetic opioid that is 50 to 100 times stronger than the pain killer morphine.

Last year, we had fatal 1,300 overdoses. 1,100 of them were opioid-related. To put that in perspective, New York City had 335 homicides and 220 traffic fatalities. So opioids are a crisis, and it's not going to go away on its own. That's why we at the NYPD are proactively facing it head-on.

This crisis is changing the way the men and women of this police department have to do their jobs. In 2013 the NYPD began a pilot program on Staten Island with our officers carrying naloxone. That program was expanded citywide in 2015. And now 17,000 of our officers are trained to use the naloxone kits deployed across our city. To date, the NYPD alone has recorded more than 140 saves, with 51 last year and about 20 already this year. And those numbers don't include hospitals and other places where people have been saved by EMTs or Good Samaritans.

84 NEW INVESTIGATORS TO FOCUS ON OPIOIDS: The NYPD will now investigate *all* cases of overdoses we're made aware of, both fatal and nonfatal. We investigated 381 of them last year. Going forward, this is going to be a massive manpower issue. In order to accomplish this, we are specifically assigning 84 NYPD investigators to tackle the problem. 64 of them will be assigned to our borough narcotics squads citywide, and the remaining 20 will be assigned to our Criminal Enterprise Division, where they



NYPD Commissioner James O'Neill

work with federal agents and handle longer, more complex cases.

We are handling this on the international, national, regional, and local levels. Every day we're partnering with New York's five district attorneys, the Office of the Special Narcotics Prosecutor,¹⁴ the FBI, the DEA, HIDTA, and the U.S. Attorneys' Offices for the Eastern and Southern Districts of New York. The goal of these partnerships is to keep dangerous opioids from entering New York City in the first place, and to dismantle the network of traffickers who support the market for illegal drugs. We're doing this at New York City airports, highways, and ports of entry, and our teams are working to identify major drug cartels, to gather intelligence, and to conduct surveillance to prosecute major drug suppliers.

50 NEW TECHNICIANS IN NYPD LAB TO TEST HEROIN: In addition, we're bringing in 50 new technicians to our NYPD lab, specifically to test the heroin we seize. Like many of you and your agencies, we used to test heroin in the field. But we found that the fentanyl it's being mixed with it is so potent, it is highly unsafe for our people to breathe the air in an uncontrolled area. And you're seeing that's the case all across the nation now.

14. The Office of the Special Narcotics Prosecutor for the City of New York, established in 1971, was given broad legal authority to prosecute sophisticated narcotics trafficking organizations, including those that cross state and national boundaries. <http://www.snpnyc.org/>

We're also studying the possible expansion of other initiatives already in place, including the HOPE program, an early diversion pre-arraignment effort on Staten Island for people charged with low-level drug offenses. New York City is also launching a campaign to raise public awareness about the state's 911 Good Samaritan law, which grants immunity from prosecution to those who call for help during an overdose and are in possession of small amounts of drugs or drug paraphernalia.

WE CAN TURN THE TIDE ON THIS: The bottom line is this: We can't arrest our way out of this problem. When our investigators interview those who have been lucky enough not to die after an overdose, we tell them we're not going to lock them up. We want to know how and where they got their drugs, and we want to move further up the food chain to cut off the supply. From 2011 to 2015, we saw a 57-percent increase in arrests for heroin sales here, and our efforts resulted in a 32-percent increase in heroin seizures from 2014 to 2015.

So that's our multi-pronged approach to this issue. Life-saving, administering aid out in the field, arrests of those manufacturing and distributing these drugs, and education. This is about teaching everyone, from school-age kids to adults with major substance abuse problems, to make good decisions, to resist peer pressure, and to live their lives in a positive, healthy, and productive way.

I'm confident that we can turn the tide on this. But it's going to take cooperation at every level of government, and working in public- and private-sector partnerships. That's our way forward.

Susan Herman, NYPD Deputy Commissioner of Collaborative Policing:

Our New RxStat Operations Group Analyzes Overdose Incidents and Identifies Gaps In the City's Response to the Opioids Crisis

The RxStat Operations Group is a group of about 25 agencies, including police, the city and state health departments, homeless services, corrections, probation, parole, DEA, the medical



Susan Herman, NYPD Deputy Commissioner of Collaborative Policing

examiner, and others. Everybody is at the table, and the table is still growing.

We meet quarterly as one large group. At each meeting, we review actual overdose cases, and surface issues that those cases raise. What did each agency do in each case? What more could have been done?

At the first meeting, we reviewed five cases of fatal overdoses, and identified about 40 issues from those cases. In our second meeting, we identified 20 issues, and in our third meeting, about 15 issues.

We don't try to fully address the issues at these meetings, because we have agreed that the purpose of the meetings is to raise the issues. At the large meetings, we want to take advantage of the diverse perspectives at the table to identify as many issues or problems as possible.

The best *resolutions* to the issues are typically going to come when smaller groups of people meet and have more time for creative problem-solving. Many of the problems will take more time and require more information, and sometimes different people, to solve them.

At our meetings, we look at the overdose cases and ask, "What happened? What happened next? How was your agency involved? What resource might be missing? What procedure could be tweaked? What policy is not as good as it might be?" After the Operations Group meeting, we find the key stakeholders for each

issue, and then hold smaller meetings to see how we can fill those gaps.

All of this is centered on the single goal of reducing overdoses.

The RxStat Operations Group isn't the only new initiative in New York to address the opioids epidemic. The Mayor recently announced a very comprehensive strategy called Healing NYC (see sidebar, page 32), which is going to support a range of public health and public safety efforts. For example, because of the Mayor's new strategy, we'll be able to hire 50 more lab technicians, so we can test drugs found at all fatal and nonfatal overdoses, and we'll understand much better what's on the street. The Operations Group, however, really highlighted the need for these technicians.

EXAMPLES OF GAPS THAT WERE IDENTIFIED: I'd like to give you some specific examples of how the case studies that we analyzed at our Operations meetings led to concrete changes:

- **More naloxone:** A few fatal overdose cases highlighted the fact that everybody in the NYPD is not equipped with naloxone. As a result, we decided to purchase supplies to equip every officer on patrol with a naloxone kit.
- **Notifying police of overdoses they otherwise would not know about:** The police aren't always called when an overdose occurs. So the Medical Examiner has agreed to give real-time notifications about overdoses to the Detective Bureau.
- **Homeless shelters:** Because of conversations that took place during an Operations Group meeting, our homeless shelters have gone from having naloxone at about 10 percent of their locations to more than 90 percent of their locations.
- **When people arrive at a hospital carrying drugs:** Our public hospitals are now working with us to develop a protocol for handling drugs found on patients who come in for treatment.
- **Keeping overdose victims in hospitals longer:** We're also working on a protocol for Emergency Departments to wait a more significant period of time before they release patients who have had an overdose reversed with naloxone. This idea came out of a conversation the Operations

Group had about one case where someone was reversed, left the hospital, and died a short time later.

- **Distributing naloxone at the jail:** Our correctional health colleagues are now distributing three times the amount of naloxone they used to distribute at our jail's visitor center. This change came out of a conversation about a person who had overdosed very shortly after leaving Rikers [the NYC jail]. Members of the Operations Group were asking, "Do released inmates get naloxone? Does anybody visiting them get naloxone? How many times a week do the jail administrators distribute naloxone? Can we ramp that up?"
- **Making sure people know about the Good Samaritan law:** To remove potential barriers to calling 911 during an overdose, we're launching a public awareness campaign about the New York State 911 Good Samaritan law. The law protects people who call for medical assistance for themselves or others—during an overdose—against the threat of arrest.

HOW TO MAKE A LARGE, MULTI-AGENCY COMMITTEE WORK:

We're still at the very early stages of this initiative, but we're all pretty optimistic about it. We've only had three quarterly meetings so far, but we've learned some lessons about how to make them work:

- It's good to remind ourselves that there's no mandate to meet. It's all voluntary. We are all aware that we must prepare enough for each meeting, so that no one around the table feels that their time is being wasted. Meetings have to be full of important work that we're all committed to doing.
- The initiative is led by three agencies: NYPD, the Health Department, and HIDTA. We have different missions, different resources, and different decision-making styles, but we meet because we share the important goal of reducing overdoses.
- We know that collaborating with each other takes patience and sometimes a willingness to just accept differences and move on. We model that for the rest of the working group.

- We've also learned to listen carefully and not make assumptions. For example, I had a conversation the other day with a colleague from the public health field, and I didn't understand for most of the conversation that when he was using the word "diversion," he wasn't talking about criminal justice diversion. He was talking about how to keep methadone from being diverted into the wrong hands. So we need to remember to keep asking questions because we come from different fields and speak different languages.
- This is particularly important for all of the law enforcement people in the room. Sometimes when we convene the follow-up meetings with other agencies to solve the problems we uncover, we encounter a certain amount of skepticism: "Why should I come to the Police Department to talk about this? I don't work for you." For example, why should officials from homeless shelters come talk to police officials about their naloxone procedures?

Of course, the NYPD doesn't have authority over other agencies, so we remind everyone that this is a voluntary initiative and that we all have agreed to work together to reduce overdoses. The NYPD, the Health Department, and HIDTA are just the conveners. We're asking questions and nudging people to think harder and do more. If there's a role that we all embrace, it's "to nudge."

- We know it's important to announce, at the beginning of each one of these large-group meetings, what specific progress we have made since the last meeting. How have procedures and policies changed? What resources have been added where? The whole group needs to know what's been accomplished, so they can see that this is worth their effort.

Moving forward, we'll face new challenges. As much as it's tempting to invite more and more people to join us, we need to not grow so big that we can't be productive. We also need to continue to put a premium on working together, no matter how much easier it is to retreat back into our silos. We'll need to push each other to stretch and be willing to experiment.

Finally, we need to remember, this is about saving lives, however we get there. As Chuck said at

the beginning of this conference, whatever we're all doing, it's not enough, because a lot of people are still dying.

Dr. Denise Paone,
Senior Director of Research and Surveillance
NYC Dept. of Health and Mental Hygiene:

RxStat, Like Compstat, Is About Using Data To Develop Strategies and Deploy Resources

RxStat is a public health/public safety partnership, and it's housed at the NYC Department of Health. The reason RxStat is located in the Health Department is to leverage our expertise with health data and content experts.

We started RxStat about seven years ago. A couple of us from the Health Department reached out to Public Safety, saying, "We have to form some relationships." We were led to Chauncey Parker early on, and that has been a wonderful relationship.

What is RxStat? It's a comprehensive surveillance system to monitor, in real time, opioids and other drugs and their associated consequences. And when I say real time, I mean it. We already have 2017 overdose data, and we have released the provisional 2016 data, which is why we're able to talk about the 1,300 overdose deaths confirmed by toxicology in New York City in 2016.

One of the critical pieces of RxStat, for anyone who's thinking of developing this type of partnership, and I credit Chauncey for this, is to develop a *central goal*. The goal of RxStat is to reduce overdose deaths. Having a central goal helped this partnership to develop, because we can all come around that essential purpose. And we have had some real successes.

We have basically four core goals or principles: (1) the development and use of timely, accurate data; (2) developing strategies based on those data; and (3) rapid deployment of public health and public safety resources, (4) to high-priority areas.

RESPONDING QUICKLY TO AN OVERDOSE SPIKE IN THE BRONX:

We have a capability we call the Rapid Assessment Response. Because we have timely data, we have



Dr. Denise Paone, Senior Director of Research and Surveillance, NYC Dept. of Health and Mental Hygiene

the responsibility to use it. We are able to identify, on a monthly basis, if there is an emerging drug issue, and we can deploy our Public Health staff immediately.

For example, in the north Bronx last summer, we saw rising overdose rates in neighborhoods where they historically haven't had high rates. So in the first two weeks of September, we sent a large number of staff to the Bronx, and we were able to reach 1,200 drug users and/or their families. We trained them on risk reduction as well as on naloxone. We distributed 1,200 naloxone kits in a two-week period.

In addition to mortality data, we get daily data from 52 hospital Emergency Departments in the city, so we're really able on a daily basis to monitor what's going on, and to respond and to share those data.

We respond rapidly to detecting outbreaks, even when they are very localized. While we understand what's going on in the whole city, we can also target a geographic area and deploy resources there more effectively.

VISITING 1,000 DOCTORS' OFFICES TO DISCUSS OPIOID

PRESCRIPTIONS: Another example was the work we did in Staten Island. Because we had the data early on, we realized that Staten Island had mortality rates that were four times higher than the rest of the city. And because the deaths were centered on the opioid analgesics, we went to more than 1,000 doctors' offices in Staten Island, to encourage them to practice judicious prescribing. And as a result of that, we saw a 27-percent decrease in opioid analgesic overdose deaths. So that was a very big success, and it was because we had the data.

POLICE AND PUBLIC HEALTH AGENCIES USE DIFFERENT TERMINOLOGY, BUT OUR WORK IS SIMILAR:

Having this common goal of reducing overdose deaths allows us to identify similar strategies. Police and public health agencies have different language that we use, but we're both committed to protecting the public, and we both investigate. Police talk about "gathering intelligence," and on the public health side we call it "quantitative and qualitative data-gathering."

Sometimes the changes we make by working together may seem incremental. But if we were not meeting with each other in the same room, we would not be having these conversations that lead to progress. For example, about five years ago, there were significant differences of opinion about the issue of medication-assisted treatment. Today I think there's much more common ground on that. Because we're using data, we're also using science, so if we're thinking about treatment for opioid use disorders, the science is going to lead us toward embracing methadone or Suboxone as an effective treatment.¹⁵

OUR WORK IN REDUCING OPIOID DEATHS IS LIKE COMPSTAT: In closing, I would emphasize the importance of the data in this public health-public safety partnership. We all can bring data to the table. We have a single goal. And we have indicators that can be measured. We're able to measure what we're doing with things like naloxone distributions, and we can measure

15. See, for example, "Extended Suboxone Treatment Substantially Improves Outcomes for Opioid-Addicted Young Adults." National Institutes of Health news release, Nov. 4, 2008. <https://www.nih.gov/news-events/news-releases/extended-suboxone-treatment-substantially-improves-outcomes-opioid-addicted-young-adults>

decreases or increases in overdoses at a geographic level, and we're tracking who's dying of overdoses and what drugs are involved in those overdoses, because we're able to link our data to medical examiner toxicology findings.

This is very much in the Compstat model.

Chauncey Parker, Executive Assistant District Attorney,
New York County District Attorney's Office and
Director, NY/NJ High-Intensity Drug Trafficking Area:

Together, We Will Reduce Overdoses – the Same Way the NYPD Reduced Crime by 90 Percent

I want to talk about the role of the HIDTA program and our partnerships to reduce opioid overdoses. HIDTA is a grant from the White House Office of National Drug Control Policy (ONDCP). HIDTA is not an agency, rather it is like an investment fund. And HIDTA “invests” in partnerships to build safe and healthy communities. Historically, we have invested in law enforcement partnerships, but now with the opioid epidemic, we are investing in public health partnerships, too.

As overdoses started to go through the roof over the last several years, one of the key goals of HIDTA program—our North Star—has become to reduce the number of people who die from a drug overdose. The tipping point for building a truly collaborative public health-public safety strategy was when the NYPD made reducing overdoses a CompStat performance measure, just like crime.

I am an enormous fan of the NYPD. I grew up in this city, so I know what it was like back in the '80s and early '90s, when we had 2,200 murders a year. I remember when people would put money in their pocket but also a little cash in their socks, so they would have some money to get home if they got robbed. And I saw first-hand what the NYPD did so successfully to fight that crime epidemic.

I think that NYPD's crime fighting strategy, CompStat, changed the world of policing. It certainly changed the world of New York City. CompStat's key idea is—“what gets measured, gets done.” You can measure all sorts of things, but if you don't have the right goal, you'll be measuring

the wrong things and you will have the wrong strategies.

So through CompStat the NYPD leadership said the goal of the police is not how many kilos we seize or how many people we arrest—the goal is to reduce crime and the performance measure is reported crime. And they said, very clearly and very publicly, that the NYPD is going to hold itself accountable for achieving this goal and that they will be successful. And that is why in New York City we are down from 2,200 murders in the early 1990s to about 300 murders a year today, why robberies are down 90 percent, why all crime is down dramatically across the board. It's because of this relentless, passionate focus by the NYPD and their partners on a clear, common goal—driving down crime. And crime continues to go down because the NYPD is never satisfied that crime is low enough. They keep pushing, innovating and collaborating with new partners.

I believe the new drug strategy today is to fight overdoses the same way the NYPD fights crime—with the same sense of focus and urgency and collaboration. To always remember that we're all in this together. And if the goal—the North Star—at this table, in this city, is to reduce the number of people who die from an overdose, I am optimistic that we will be successful. I don't have an ounce of pessimism. Yes, it's a huge challenge, with fentanyl and carfentanil and other poisons and doctors over-prescribing and all the other issues. But there is nothing that law enforcement hasn't accomplished when they set their sights on a specific goal.

So we have progressed from Version 1.0 of RxStat, which was public health on its own, trying to fight this opioid battle. Now we have law enforcement and particularly the NYPD joining this fight, together with over 20 different agencies. And this partnership has become very operational—all partners sitting at the same table, looking at the same map, at the same time, with the same goal. That is literally what happens in the RxStat Operations Group meetings where everyone is asking “what specific action steps can we take to reduce to these overdose deaths?”

I have no doubt that the overdoses will go down, because that's the story of what the NYPD



FAR LEFT: NYPD Chief of Crime Control Strategies Dermot Shea presents on the increase in drug overdose deaths in New York City.

LEFT: Chauncey Parker, Executive Assistant District Attorney, New York County District Attorney's Office and Director, NY/NJ High-Intensity Drug Trafficking Area.

ABOVE: NYPD Chief of Crime Control Strategies Dermot Shea.

has done, what police departments across the country have done with fighting crime. We have this feeling in our fingertips that we know we are all in this together—public safety and public health. And as we share information about what is causing overdoses in our communities, and with great partners like PERF we share ideas for best practices and stay focused on the goal of reducing these deaths, I have no doubt we're going to be successful.

NYPD Chief of Crime Control Strategies Dermot Shea:

Police, Public Health, and Others Are Using Case Studies to Find the Gaps We Need to Fill

In New York City, fatal overdoses were at a low point in 2010, but we began seeing double-digit percentage increases after that, and last year we saw a spike that we expect to crest over 1,300 in 2016. There's the impact of fentanyl right there. And now we're seeing jumps of 50 percent in first

two months of 2017. So the problem is not getting better.

But I am confident that there is a very solid base that is being laid. Within the NYPD, today there is a firm layer of procedures that have been rewritten. Years ago, we were not capturing the data we needed to even begin to fight this. Today we are getting the information.

When Denise spoke about the importance of communication with partner agencies, I couldn't underscore that more. All of us from many different agencies are in the same room, and we study actual cases of overdoses. It's "What do you see about this case that I don't know? What does your agency do? Here's what we do. You have this, I need that." And it really starts to come together.

We also have a solid plan now. A couple weeks ago, the mayor announced a plan with tremendous resources coming to the Police Department.¹⁶ It's not an arrest plan. There is an interdiction element, but it's diversion for low-level offenders. It's about data collection and analysis. It's ramping up the

16. "As Drug Deaths Soar, Mayor Offers Plan to Cut Toll." *The New York Times*, March 13, 2017. <https://www.nytimes.com/2017/03/13/nyregion/mayors-plan-to-fight-addiction-focuses-on-healing.html>

lab, which I think is a key point. You can't handle his problem if you don't have the resources in the lab. And it's about public awareness—going into the schools, going to community meetings.

Our Chief of Detectives, Bob Boyce, was ahead of the curve in many ways—assigning detectives from Narcotics to go to fatal overdoses, open an investigation, and treat it as a crime scene.

And we recently ramped up the RxStat meetings with a Compstat philosophy. Basically Susan Herman opened her Rolodex, and everyone was invited—corrections, prosecutors, health care providers, shelters, homeless police, many different units within the NYPD, you name it, they are at these meetings. And we run through these scenarios.

EXAMPLES OF OVERDOSE CASE STUDIES: To give you an idea of how this works, I'll tell you about a few of these cases. Unfortunately, they are all real cases, with just the names left out.

Overdose #1: June 16, 2016, 1:30 in the morning, at a large homeless shelter in Brooklyn, a call comes in to 911, somebody's overdosing. Someone tried to save the person's life with naloxone a couple times. Someone takes the person to the hospital, and he passes away.

The NYPD never responded to this call. Somebody overdosed and passed away, and the NYPD didn't know about it. Which means that we can't learn any lessons about this overdose, because we don't even know it happened.

When NYPD goes to an overdose scene, we do reports that we never did before. We're very confident about those. We collect a lot of information—naloxone used, drugs recovered, heroin stamps. But I don't know anything about the case where someone overdoses, a friend gives him a shot of naloxone, drives him to the hospital, and he dies in the hospital three days later.

So what did we do about this? We went down to the city's Medical Examiner's Office, because we figured if somebody dies and we don't know about it, they're eventually going to go to the morgue. So we went to the morgue and looked at what information comes in to the morgue. We wrote protocols to capture this information.

And we started categorizing the deceased people who came in to the morgue on a daily basis. We came up with a system that allows us, with probably 90 percent accuracy, to *tell us which people who are sent to the morgue died of an overdose*. For any given person, we'll know for sure months later, when the lab results come back, but we need to make assessments sooner than that.

The three top indicators of a drug overdose death that we decided on are:

- 1 The person died with a needle in his arm. Or he died and a person at the scene said he shot up or snorted drugs, and went into convulsions. Over 97 percent of the time, we think this scenario is going to be a drug overdose, and when the results come back, it is.
- 2 Somebody passes away, and there are illegal drugs at the scene.
- 3 The deceased person had a history of drug use.

So every day now, we get a report about these people who were sent to the morgue, and it's distributed. Why? Because we want Bob Boyce's detectives to be aware of incidents where police were not called to the scene, but there was an overdose. Maybe we find that there were two or three overdoses yesterday in a certain location.

It's important to get that timely information, so the detectives can get those phone records and talk to those witnesses. It doesn't help us to find out four months later that that was an overdose.

Overdose #2: Here's the next case example we studied. This one's in Brooklyn, about a month later, very near the homeless shelter where the first case happened. A 24-year-old male who passes away in his apartment and was discovered by his girlfriend. This one, NYPD responds. We recover heroin at the scene, we have a stamp collected showing the "brand" of the heroin.

Overdose #3: Later that same day, in a park about six blocks away, it looks like somebody overdosed, and somebody else put the body in the park. A woman is found in a sleeping bag, DOA. And the same heroin stamp is found in her pocket, Super 8.

KEY POINTS ON THE NEW YORK CITY MODEL

- **A Compstat-like approach can coordinate efforts to reduce overdose deaths.** Compstat, which emphasizes timely data and accountability, provides a good framework for identifying strategies for reducing overdose deaths and ensuring that the strategies are implemented.
- **Coordination between all stakeholders is critical.** New York City has brought together police, prosecutors, fire/EMS, public health, hospitals, and treatment providers to address this problem collectively.
- **Reducing opioid overdose deaths should be everyone's primary objective.** All relevant stakeholders must stay focused on the overarching goal: reducing the number of opioid overdose deaths. Differences in approach or ideology should be worked out by determining what best accomplishes that goal.
- **Track every overdose incident.** Examine factors and determine if an overdose death should be treated as a homicide.

Overdose #4: Another incident later that day, across the river on the Lower East Side of Manhattan, July 23, a Housing police officer comes across someone who's unconscious in a stairwell, starts CPR, calls EMS, but the end result was a fatal overdose. In this DOA's pocket is the ID from the girl in the sleeping bag in Brooklyn. Boyfriend-girlfriend.

So as we're going through this series of scenarios, we're turning to EMS, we're turning to the Fire Department, to the hospital. We've got public and private hospitals at this meeting. We're asking our detectives, what do you do with this? And each agency maybe knows a piece of his puzzle, but nobody has the entire puzzle. And we try to put it all together. Do we want to get to the dealer in this case who sold the drugs that caused people to pass away? Yes, we want to get to the dealer, but the main goal is to prevent future deaths. Do we have a toxic hit of carfentanil in a 10-block area of Brooklyn? How quickly can we get an awareness of that out to the community and try to do something about it?

What's the end result of all this? We are reorganizing how we look at data collection and analysis. We were having 700 to 800 overdoses a year, and we were not moving the needle. And we were not ready for that 38-percent increase in fatalities that we saw in 2016.

But we are miles away from where we were 12 months ago in terms of organizing our data, in terms of the information we're collecting, in terms of working with the lab, and getting the results we need. We're at the point now where we can map fentanyl recoveries in New York City; we can put alerts on individuals. Who's been arrested in the past for fentanyl? And the next time they're arrested, I'm going to want to talk to them. Who's selling fentanyl now on the street?

So instead of finding out that "Last year, we had a lot of overdoses," we now are anticipating how many overdoses we will have. We can redirect resources, whether it's the Detective Bureau or Narcotics, to hit certain areas. We can contact the Department of Health and say, "Do you have any information about this situation? We think we're seeing something."

We did a quick analysis of 500 overdose deaths last year, and we found that with almost 40 percent of them, we had had the people in our hands within the past 12 months—meaning we either arrested them or we responded to a case where they were on the scene.

We're also learning things that help us protect our officers. In reviewing cases, we came across incidents where undercover officers were buying what we believed was some pill, and in fact it was 100-percent fentanyl. That awareness can help us keep our people safe.

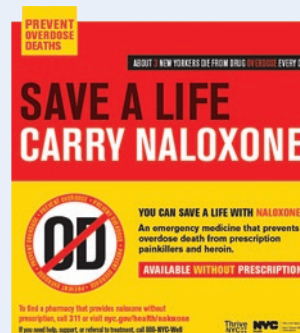
NEW YORK CITY MAYOR ANNOUNCES COMPREHENSIVE PLAN TO REDUCE OPIOID OVERDOSES

On March 13, 2017, New York City Mayor Bill de Blasio released “a new, comprehensive effort to disrupt a rising epidemic of deaths from opioid drug overdoses.”¹⁷

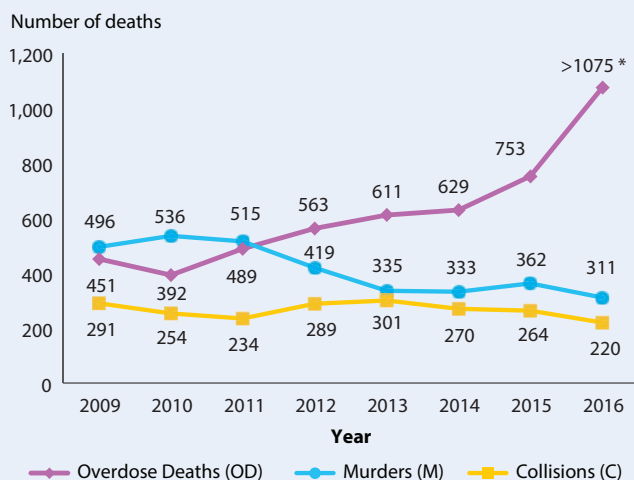
The plan, called “Healing NYC: Preventing Overdoses, Saving Lives,” calls for spending up to \$38 million annually toward the goal of reducing opioid overdose deaths by 35 percent within five years. More than one-fourth of that funding would go to purchasing naloxone. In 2016, the city Health Department distributed more than 15,000 naloxone kits to targeted programs and communities. The new plan will more than quadruple that figure. “The NYPD, often the first to arrive at the scene of an overdose, will equip all 23,000 of its patrol officers with naloxone,” the plan states. Naloxone also is available without a prescription in 750 pharmacies across the city.

In New York City, an estimated 1,300 people died from drug overdoses in 2016, the plan states, and approximately 1,075 of those deaths involved an opioid. “More New Yorkers died from opioid overdoses last year than from car accidents and homicides combined,” the report said.

Furthermore, fentanyl was involved in approximately half of the overdose deaths in NYC in the second half of 2016, the mayor’s report said, compared to fewer than 5 percent of overdose deaths in 2015.

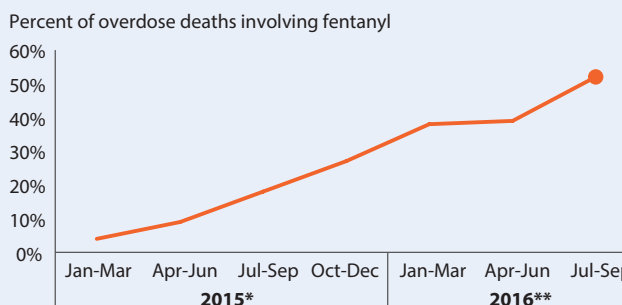


Opioid-Involved Overdose Deaths, Murders and Collision Deaths in NYC (2009-2016)



Source: NYC Office of the Chief Medical Examiner and NYC Health Dept.

An Increasing Proportion of NYC Overdose Deaths Involve Fentanyl (2015-2016)



17. *Healing NYC: Preventing Overdoses, Saving Lives*. The City of New York, Office of the Mayor. <http://www1.nyc.gov/assets/home/downloads/pdf/reports/2017/HealingNYC-Report.pdf>

HOW DO POLICE, PUBLIC HEALTH AGENCIES, AND OTHER ORGANIZATIONS SHARE INFORMATION ABOUT OVERDOSES?

New Jersey State Police Capt. Juan Colon:

We Can Analyze a Heroin Sample in Hours To Determine If We Have a Fentanyl Spike

WEXLER: Captain, New Jersey has one of the most sophisticated systems for gathering data. Can you tell us about it?

CAPTAIN COLON: We're collecting information on a daily basis from our nine Crime Forensic Labs that do analysis of this data on drug samples recovered by the police—for example, determining whether packets with heroin stamps just contain heroin, or if it's a combination of heroin and fentanyl. We geo-code this information, we map it, and we share the results with our law enforcement and public health partners in real time.

WEXLER: How long does it take to analyze a packet?

CAPTAIN COLON: We have nine different labs, and each one has a different level of backlogs. It can be a week, or some of them are as much as three months. But if a packet is involved in a fatal overdose and we need expedited analysis, they can turn it around in the same day.



New Jersey State Police Capt. Juan Colon

WEXLER: Wow, that's good, because when you have a rash of overdoses, it's important to get that information fast, right? How do you make the information actionable?

CAPTAIN COLON: We have historical data on thousands of heroin stamps. So for example, we will know that heroin with the "Batman" stamp name has been involved in many overdoses and arrests.¹⁸ So we take a specimen that was found

18. "Everything you need to know about 'Batman' heroin causing overdoses." *NJ.com*. August 30, 2016. http://www.nj.com/camden/index.ssf/2016/08/everything_you_need_to_know_about_batman_heroin_ca.html

at the scene of an overdose, and if it was branded with the Batman stamp, we will take that information, check it against our database, and map all of the prior arrests and overdoses. The goal is to see where the epicenter may be to help identify where the dealer (source) most likely could be.

So if it's down in the Camden area, we will call the Camden Police Department and tell them, "This is where the epicenter may be. You might want to go out there and make some 'controlled buys' and try to work your way back to who the dealer may be." That's on the law enforcement side.

On the public health side, we will call the EMS providers and the hospital systems in the affected area and let them know that there is an uptick in overdoses. And if it is just heroin, that's one thing, but if it's a strong version with fentanyl, we will tell them, "You're going to need additional doses of naloxone."

WEXLER: Thank you, that's very helpful. Let me go back to the Chief of Detectives in New York. What do you do with this kind of information in New York?

NYPD CHIEF OF DETECTIVES ROBERT BOYCE: We're using some of the same strategies that have been successful for us in the past in fighting crime, the pattern identification model. So I see three overdoses in Queens North, two in one precinct, and

I immediately call that chief there and tell him, "Get on this, tell me what this is about."

And we're hiring 50 more lab analysts. That's going to help us tremendously. They'll put out a daily report to me, so I can push that out to my folks as well.

WEXLER: I've got the commander of Staten Island here. Ed, how does this work on Staten Island?

CHIEF EDWARD DELATORRE: We have overdose response teams on Staten Island as well. As soon as we start to see a surge in overdoses—for instance, in the last seven days we had 11; two of them were fatal, and nine were saves—we're collecting that data and forwarding it to the Chief of Detectives, and at the same time we communicate directly with the commander of the lab as well. When the commander of the lab sees a surge, he's also dedicating a team of analysts to that surge, to try to get us some very quick results on *what's in those drugs*.

And at the same time, we transmit a communication over to Health. We say, "We see a surge; we don't know what it is yet, whether it's fentanyl or what. But as soon as we know, we'll let you know."

Nassau County Police Commissioner Thomas Krumpter:

We Can't Wait for Lab Tests or Toxicology Results, Because Spikes in Deaths Happen Quickly

In Nassau County, we focus on tracking all the heroin overdoses. Each and every one, we'll send out teams. Homicide detectives are assigned to every fatal overdose. And the focus really is on the front end, because it does take some time to get those lab results. It's about locating the source of where those overdoses are coming from.

So we're looking at the victims' cell phones, we're looking to get into the phones. More often than not, we can get access to the phones from family members or friends of the individuals who overdosed. About a year ago, we formed a Heroin Task Force, and we're seeing significant success in interrupting those overdoses. And usually, when we see spikes, we're seeing significant

“ We don't have time to wait for the drug results. If we wait for the toxicology results from the Medical Examiner, that's several weeks or sometimes months before we get those blood results back. And even if we get lab results on seized heroin within four or five days, if you have someone who's dealing hot heroin, you could have a number of fatalities in days. So we are trying to move faster with our investigations, and we have had a number of those cases where we were able to disrupt them quickly.”

—Nassau County Police Commissioner
Thomas Krumpter



LEFT TO RIGHT: East Bridgewater, MA Police Chief Scott Allen; Arlington, MA Police Chief Fred Ryan.

increases in fentanyl, and now we're seeing carfentanil starting to rise.

But it really comes down to the fact that we don't have time to wait for the drug results. If we wait for the toxicology results from the Medical Examiner, that's several weeks or sometimes months before we get those blood results back. And even if we get lab results on seized heroin within four or five days, if you have someone who's dealing hot heroin, you could have a number of fatalities in days. So we are trying to move faster with our investigations, and we have had a number of those cases where we were able to disrupt them quickly.

East Bridgewater, MA Police Chief Scott Allen:

27 Police Chiefs Are Working Together On Overdose Data In Plymouth County, MA

We're working together as a county. Chief Michael Botieri from Plymouth, MA and I have taken a key role in getting all 27 police chiefs in the county committed to sharing overdose information across the county in real time. We're actually sharing within law enforcement, the names of overdose victims, all the information, and the particulars for the sole purpose of ensuring that they are offered treatment resources and help if they don't accept treatment upon transport to a local hospital. If

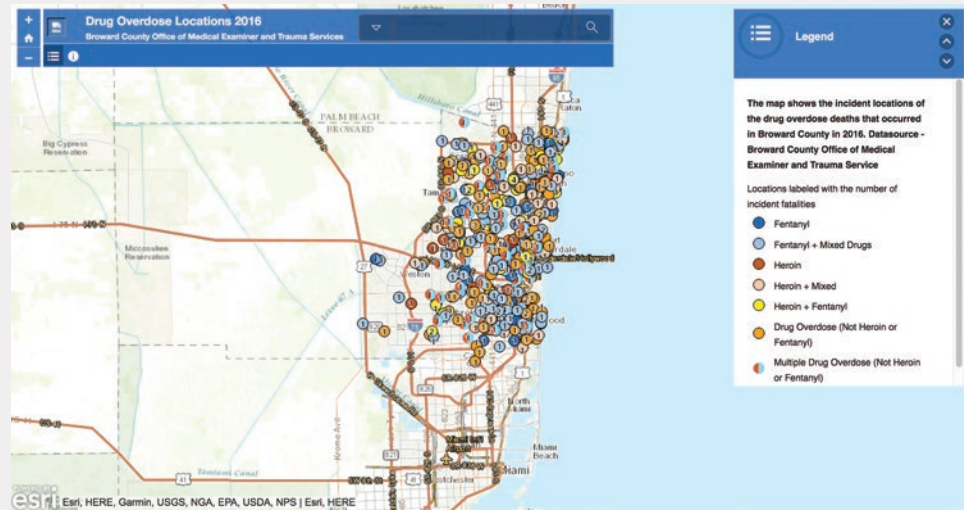
someone from my community overdoses in Chief Botieri's community, they get an alert, so that a victim of an overdose occurring in another town does not go unnoticed. And then we go knock on that victim's door and ask the victim of the Substance Abuse Disorder (SUD) if they need resources. We recommend sending plainclothes police officers with a recovery coach to knock on the door and ask, "How can we help you? We'll assist you in getting you into treatment." Chief Botieri started the 12-24 hour Overdose Follow-Up Visits in December 2015, and with our information sharing database now, we have a real-time true, accurate reflection on where the overdoses are occurring, and who they are, and then connecting them with our partners in other law enforcement agencies, and more importantly connecting them with the health care community.

Arlington, MA Police Chief Fred Ryan:

Realize that the Greatest Risk of Fatal Overdose Is Among People Who Have Overdosed Before, And Offer Services to Those People

Equally important to the fatal overdoses is the nonfatal overdoses. When Chief Kathy O'Toole coached me as a young police chief when I was in my 30s, she told me to peel the onion back on data. On heroin, for a while we had some

Locations of Drug Overdoses in Broward County, FL, 2016



Source: “GIS for Drug Overdose Mapping.” Broward County Office of Medical Examiner and Trauma Services. <http://bcgis.maps.arcgis.com/apps/View/index.html?appid=0471c198475844cb9e27002ab140c47c>

information but we didn’t realize what we knew. We had the names of the people at the highest risk of fatally overdosing, right in our database. Who’s at the highest risk of fatally overdosing? It’s the *people who have previously overdosed*. So in our 911 CAD system, we had the population of people in our jurisdiction at highest risk.

That was the population of people we targeted with an outreach coordinator, and we partnered with the Police Assisted Addiction and Recovery Initiative (PAARI). We had been experiencing about one fatal overdose per month, but in 2017, as of early April, we’ve had zero, from January to April this year.

I think this success is due to our outreach and relentless follow-up with those who are at highest risk of fatally overdosing.

Macon County, IL Undersheriff Howard Buffett:

These Are New Roles for Police Officers And Sheriffs’ Deputies to Take On

It’s important to think about these issues regionally. There’s a tendency for everyone to try to

do their own thing locally. If you can also think regionally, you’ll do better in the long run.

I think it also takes a shift in mindset to take someone who has been trained as a cop, trained to put criminals in jail, to think, “This is a health problem, and it’s my job to help this person.” Everyone in this room understands this new way of thinking, but we need to get that way of thinking down to all of the officers on the street. That’s something that has to be pushed down through lieutenants and sergeants to the patrol level.

Hollywood, FL Police Chief Tomas Sanchez:

Our Medical Examiner Helps Us Put All the Information on a Digital “Pin Map”

Everyone here knows how important it is to work with your partners. In Broward County, our medical examiner maintains an electronic “pin map” showing the locations of overdose deaths, and which drug or drugs each death is attributed to, whether it’s carfentanyl, fentanyl, heroin, or a mix. Yesterday this map was the subject of a top story in our Sun-Sentinel newspaper.¹⁹

19. “Interactive map pinpoints county’s 2016 drug overdoses.” *SunSentinel*, April 5, 2017. <http://www.sun-sentinel.com/local/broward/fort-lauderdale/fl-dff-overdosemap-0419-20170405-story.html>



LEFT TO RIGHT:
Macon County, IL
Undersheriff Howard
Buffett; Hollywood,
FL Police Chief Tomas
Sanchez.

On a daily basis, on our commander's log, all the overdoses are identified, with all the pertinent data. A fatal overdose is treated like a homicide, like in New York City. We also have our monthly Compstat meeting, where we analyze the Narcan deployments by the Fire Department. We compare all the data on our pin map—the locations of drug arrests and search warrants, where our rehab centers are located, and our overdose deaths and near-deaths.

Philadelphia Police Commissioner Richard Ross:

Many Overdose Victims in Philadelphia Are From Out of Town, Complicating Our Response

WEXLER: Rich, your department reported that Philadelphia had 900 drug overdose deaths in 2016, and half of them involved fentanyl. And you had a spike of 35 deaths in one week in December. You are dealing with a lot of challenges.

COMMISSIONER ROSS: It is a daunting task. We have two of our six police divisions that are really plagued with this. We have people from outside of Philadelphia who come in, because the heroin is so pure. Chief Ryan from Arlington was saying that many of the overdose victims in his community are people the police know, because they have overdosed before. But in Philadelphia, we have not dealt with some of these people before, because they're not from Philadelphia.

As we form our task force, we are still in the infancy stages compared to what New York City is doing, but we are developing all the things that they have talked about. We are using our Real Time Crime Center as the portal for all the information coming in from the Medical Examiner's Office and the hospital emergency rooms.

The high purity of the heroin in Philadelphia is a challenge, because it's what drives a lot of people to come to Philadelphia to get the heroin. We look at it from a criminal standpoint as well. We'll get heroin in the same area, within two or three blocks, with different packaging, that's from the same supplier. And so as we start to target some of these areas when we get these outbreaks, we may think we're on to one organization, but we've got two different drug organizations that are distributing the same drugs within the same four-block area. This makes it harder for us to pin down who's doing what. The heroin is so pervasive in some of these areas that it's ridiculous.

Burlington, VT Police Chief Brandon del Pozo:

Agencies Collect Data for Different Reasons, But We Can Pull Them Together For a Common Purpose

WEXLER: Brandon, your Governor in Vermont has declared a state of emergency about the opioids crisis. How do you get data about what's happening in your city?



LEFT TO RIGHT: Seattle Police Chief Kathleen O'Toole; Burlington, VT Police Chief Brandon del Pozo; and Hennepin County, MN Sheriff Richard Stanek.

CHIEF DEL POZO: When I arrived in Burlington and started looking around, I noticed there were a lot of silos. The Department of Health, the Police Department, the Department of Children and Families all have their own data systems, which were created for different purposes. But I've been telling people that I don't care if your data collection system was created to satisfy the requirements of a federal grant, or to comply with a law, or to help get a politician reelected. Our data collection systems might have been designed for different purposes, but we need to put them all together somehow in a pool that allows us to figure out what's going on with opioids. So we are trying to appropriate other data systems that were not designed to fight the opioids crisis.

To deal with our opioids crisis, I hired a very gifted analyst, Eric Fowler, who's here with me today, and we also used funding from the United Way to hire a specific opioids analyst. This is a big investment for a small department.

We also have an opioid policy coordinator. I've resisted calling her our Burlington "drug czar," but as a "cop," I needed an understanding of what the clinical responses were, what the mental health responses were, what the relevant data was and what the relevant measures were. I didn't have that.

For example, my instinct would be to think that if robberies and burglaries are going down, that must mean there are fewer desperate drug users around, stealing things to pay for their drugs. But I was wrong about that. There are other factors that I didn't understand.

By having an opioids policy person working directly in the Police Department, it gives us better credibility. We have been able to ask the relevant questions. So the public health people, instead of saying, "Brandon doesn't get it; he's a cop," realize I have an expert helping me to understand the issues. That helped us get legitimacy.

Seattle Police Chief Kathleen O'Toole:

We Encounter Many People in Crisis, And Most of Them Have Addiction Issues

In Seattle, we're doing great on crime; we continue to drive our crime numbers down. But our biggest challenge as a community and as a police department is the addiction issue. We never tracked these numbers until recently. About a year ago, we started using templates to track the people we are engaging with who are having mental health crises, and most of them have addiction issues. We determined that in less than a year, our officers responded to nearly 10,000 of these cases. I think Deputy



LEFT TO RIGHT:
Martinsburg, WV
Police Chief Maury
Richards; Springboro
OH Police Chief Jeffrey
Kruithoff.

Commissioner Herman makes a great point, that only a collaborative, multi-disciplinary approach will work to address this very complicated issue.

I think we're facing the same challenges on the West Coast that people are facing here on the East Coast. It certainly is a crisis, and we are making a huge investment in addressing it. Everyone has heard about the LEAD program, or Law Enforcement-Assisted Diversion, in which we have our officers making decisions, pre-booking, about whether to send people to jail or to treatment. And we estimate that our Community Policing Teams in our precincts, in every precinct now, are spending over 80 percent of their time dealing with people who are addicted, and many of them are homeless.

So there's no question that this is the most significant challenge we're facing in our community.

Hennepin County, MN Sheriff Richard Stanek:

There Is No "Typical" Opioid User

I've done more than 100 presentations to civic groups over the last several months, and I tell them there is no "typical" opioid user.

The opioid crisis is a great non-discriminator. Last year we had a 16-year-old female and a 98-year-old man die from opioid-related causes. We've had Caucasian, African-American, Hispanic, Asian, Somali, Kenyan, people in the inner city of Minneapolis with a population of 400,000, all the way to suburban areas like Rogers, MN, which has a population of about 12,000.

The prevalence of opioids across our country is tremendous, but there is no one common denominator. If you think it can't or won't affect you, you're wrong.

Martinsburg, WV Police Chief Maury Richards:

We Use a Phone App for Tracing Overdoses That Was Developed by Our HIDTA

In Martinsburg, we work very closely with EMS; they do the initial tracking. And we also work with the county. We're sharing our information with the Washington/Baltimore HIDTA; they have a phone app for tracing overdoses, which is promising in terms of sharing real-time information.²⁰

What makes this such a complex issue is that for the addicted heroin users, they are seeking out fentanyl. On one hand, you want

20. "The Overdose Detection Mapping Application Program (ODMAP) provides real-time overdose surveillance data across jurisdictions to support public safety and health efforts to mobilize an immediate response to an overdose spike," according to the Washington/Baltimore HIDTA. See <http://www.hidta.org/odmap/> and <https://ndews.umd.edu/sites/ndews.umd.edu/files/odmap-brochure-flyer.pdf>.



LEFT TO RIGHT: Macon County, IL Sheriff Thomas Schneider; Delray Beach, FL Police Chief Jeffrey Goldman.

to make a public service announcement saying, “Don’t go in this neighborhood, because they are selling fentanyl there and it can kill you.” But it’s going to be a wash, because some will heed the warning, but a lot of people will seek that out.

When you talk to some of these users, that’s what they’re looking for; they call it “fire” and say, “I want that fire.” They’re seeking that euphoric high that they can’t get any more from run-of-the-mill heroin. It’s a tough situation.

Springboro OH Police Chief Jeffrey Kruithoff:

Our Fusion Center Sends an Opioid Intelligence Bulletin To Every Police Officer in the Region, Every Week

I’m holding an Intelligence Bulletin that comes from the Cincinnati Fusion Center, which has been given the mission of dealing not only with issues of terrorism, but also opioid issues.

Every week, a report like this comes to every police officer in southwest Ohio. It includes the overdose data coming from a variety of sources, the age of the people taking heroin, the addresses where overdoses occurred. Because they are doing this on a weekly basis, it allows them to send out alerts.

This one I’m holding was just sent out because there was a spike of 36 overdoses over a 24-hour period. So it’s a warning to safety responders to carry more naloxone and other

equipment. It’s very similar to what I’ve heard that other agencies are doing on a monthly basis, but because they have formed the Heroin Task Force in Hamilton County, which is the greater Cincinnati area, they’re sending this out on a weekly basis, by email, to absolutely every police officer in the region.

Macon County, IL Sheriff Thomas Schneider:

We Also Get Opioid Reports Through our State Terrorism Intelligence Center

We’re similar to Ohio, in that we receive a lot of information through our State Terrorism Intelligence Center, and it goes to an individual who we’ve had trained in our department, and he disseminates it throughout our department.

Delray Beach, FL Police Chief Jeffrey Goldman:

We Share Information in Monthly Meetings With Public Health and Recovery Partners

Regarding educating the community, we have monthly meetings with law enforcement, public health, community members, and recovery community people. We tell them the trends in what we’re seeing, and we have seen successful arrests and shutdowns of sober homes, because of that back-and-forth communication and educating each other about what to look for. We’ve had a huge increase in heroin overdoses, and hopefully we will see these numbers go down in the near future.

KEY POINTS ON SHARING INFORMATION ABOUT OVERDOSES

- **Lives can be saved if police can quickly analyze drugs found at the scene of an overdose.** Forensic laboratories often have backlogs in their analysis of drug samples recovered by police. However, it is important to have systems for expediting certain samples when it appears that a packet of drugs may be causing fatal overdoses in a community because it is laced with fentanyl or carfentanil or is exceptionally high-purity. By speeding the analysis, police may be able to determine where the “epicenter” of the overdoses is located, who is dealing in the drug, and how to prevent further fatal overdoses.
- **Regional sharing of data can help prevent overdoses.** When multiple police agencies and partners contribute information to shared databases in real time, patterns in overdoses can become apparent more quickly.
- **New rules for police officers and sheriffs’ deputies:** Encourage line officers to think beyond enforcement and realize that their role is multi-faceted, and that drug users need to get into treatment.
- **Nonfatal overdose data is also important.** Generally speaking, the people at greatest risk of a fatal overdose are people who have previously experienced nonfatal overdoses. Because police respond to overdose scenes, they have information about the identity of overdose victims in CAD systems or other databases. These overdose victims can be prioritized for outreach.
- **The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) has developed a phone app for tracing overdoses.** This program provides real-time data collection to identify overdose spikes for a quick response.

WEXLER: Jeff, I know that in Delray Beach and also Hollywood, Florida, you have many drug treatment facilities and “sober homes,” etc. And it’s extremely challenging for you, because you have heroin dealers and other unscrupulous characters trying to take advantage of addicted persons, make them relapse, and use them for their health insurance benefits.

GOLDMAN: Yes, the majority of our people in recovery programs are not from our community. We have thousands of people in recovery in Delray Beach, a city of about 70,000. That results in a lot of manpower issues for us, homelessness issues, and crime, such as vehicle burglaries that have gone up exponentially. We’ve had a whole other issue with “patient brokering” and human trafficking, in addition to the opiate issues that everyone else is facing.

FEDERAL PERSPECTIVES FROM ONDCP AND DEA

ONDCP Acting Director Richard Baum

Police Deserve Credit for Taking Leadership And Partnering with Public Health Agencies

We are facing the worst drug epidemic in American history. We lost 52,000 people to overdoses in 2015, with 33,000 of those involving opioids—and the true number is likely higher. Too many families are burying sons, daughters, and parents, and too few people seek the treatment they need.

While the overprescribing of opioid pain medications is declining, fatalities are increasing because of synthetic opioids such as fentanyl, carfentanil, and other analogues.

But there is hope. Lives are being saved because families affected by this disease are speaking up, and our police are stepping up.

Addiction used to be hidden in the shadows, but families are breaking the stigma by acknowledging that their loved ones died of a drug overdose. They are turning their grief into action and helping change the conversation on addiction to prevent other families from going through what they went through.

This epidemic has increased the burden on our police, but they have stepped up by implementing naloxone programs that save lives every day. This is critically important and they deserve our thanks. We must go beyond reversing overdoses, however—we must help more people transition into treatment so they can get the help

they need and achieve recovery. That's why the public health-public safety partnerships being established across the country are so valuable—they help police and public health work together to address this complex problem. We must do everything we can to prevent people from dying from drug overdose, including preventing drug use in the first place.

The leadership of police has prevented our national nightmare from being much, much worse. The fact that so many police agencies around the country have taken on this mission and made it a priority is a mark of just how important they are to our communities. If we can continue to prevent drug use, reverse overdoses, and connect people to treatment, we will save countless lives and be closer to ending this epidemic.

DEA Acting Administrator Chuck Rosenberg:

Here Are 3 Ways DEA Can Help Local Police With Opioid Prevention and Education

It's difficult to digest these big numbers, like 52,000 fatal overdoses in 2015. So I break it down like this: We all remember that awful shooting in Orlando at the Pulse nightclub last year, in which 49 people were slaughtered by a madman. Imagine that happening three times a day, every day, for 365 days in a row. That's roughly what we're talking about with fatal drug overdoses. So we truly have



LEFT TO RIGHT: ONDCP Acting Director Richard Baum; DEA Acting Administrator Chuck Rosenberg.

THE DANGERS OF FENTANYL AND CARFENTENIL

EDITOR'S NOTE: In August 2017, CDC released new data indicating that in 2016, fentanyl accounted for a much larger share of drug overdose deaths than in the past, even surpassing deaths attributed to heroin. Between 2015 and 2016, fentanyl-related deaths nationwide increased 103 percent to 20,145, while heroin-related deaths increased 17 percent to 15,466. (https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf)

HOLLYWOOD, FL CHIEF TOM SANCHEZ: Mr. Rosenberg, the deaths in my county in Florida are directly related to fentanyl and carfentanil. Can you tell us about work that DEA is doing to stop the importation of fentanyl and carfentanil from China?

DEA ACTING ADMINISTRATOR CHUCK ROSENBERG: Fentanyl is up to 50 times more powerful than heroin, and carfentanil is up to 100 times more potent than fentanyl. We're getting flooded with this stuff. The profit margin on it is enormous. You don't have to grow it; you don't have to cultivate it. You order it over the internet, and it shows up either directly in the United States, or more typically, in Mexico, where the cartels bring it up through their more traditional routes.

I was in China in January, and we asked them very specifically to ban from export fentanyl and

three of its analogues. And they did that. They just announced in March that it is now prohibited in China to ship out fentanyl and the analogues.²¹

We're getting flooded, though, and simply banning it from export is not going to solve the problem. We are focused on this, because frankly, it scares the hell out of me.

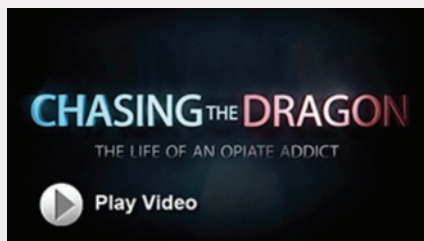
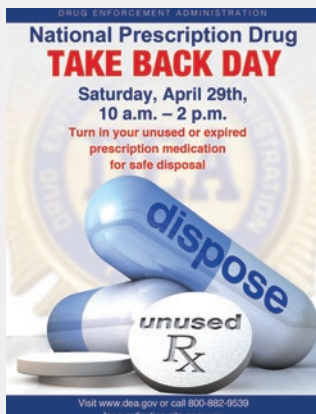
DEA wants to help get the word out to your officers and deputies that fentanyl and carfentanil can be lethal to the touch.²² We had a case where one of our agents did everything right; she had gloves and a mask on as she handled a substance which she believed to be heroin. It turned out to be fentanyl. She took her gloves off to handle the bad guy's phone, and trace amounts of fentanyl on the phone caused a very severe adverse reaction.

Fortunately, we had folks there who could help her, but we are trying to spread the word that "If you don't know what it is, don't touch it." Fentanyl is extraordinarily dangerous to touch. We're trying to get protocols out to make sure departments aren't doing field tests.

Not only do you not know what's in it, but I can tell you that most of the time, your users don't know what's in it, and your low-level suppliers may not know what's in it.

21. See "China's fentanyl ban a 'game-changer' for opioid epidemic, DEA officials say," *CNN*, February 16, 2017. <http://www.cnn.com/2017/02/16/health/fentanyl-china-ban-opioids/>

22. See "Fentanyl Crisis: DEA Issues Guideline for First Responders Dealing With Deadly Drug," *NBC News*, June 6, 2017. <http://www.nbcnews.com/storyline/americas-heroin-epidemic/fentanyl-crisis-dea-issues-guideline-first-responders-dealing-deadly-drug-n768901>



ROW ABOVE: National Take-Back Initiative poster, title screen of *Chasing the Dragon: The Life of an Opiate Addict* movie, and screenshot from the movie.

LEFT: Operation Prevention Web site.

an epidemic; that's not hyperbole. This is unique and unprecedented.

DEA has roughly 4,600 special agents and 9,000 people altogether. Many of you work with our DEA Task Force Officers (TFOs). We have about 2,600 TFOs. I hope you're getting a return on that investment; I can tell you it's vital to us.

I completely agree with Commissioner O'Neill and Chief Thomson and probably everyone in this room that we're not going to enforce or prosecute our way out of this mess. While the supply-side enforcement piece is absolutely vital, and I think we do it well, I want to talk a bit about what DEA does on the demand reduction side.

On the education side, there are three things we're doing, and we can use your help on all of them.

1. OUR NATIONAL TAKE-BACK INITIATIVE.²³ We do this twice a year. Please get the word out in your communities. In 2016, we took in 1.6 million

pounds of prescription drugs and disposed of them. Over the life of the program, DEA and our partners have collected 2,123 tons of unwanted, unused or expired medications.

Here's why we need to do this. People have a torn meniscus, they have their wisdom teeth removed, and they are sent home with 30 oxycodone pills. They don't need the pills, so they leave them in their medicine cabinet.

Four out of five heroin users started with prescription pills. We've got to get this garbage out of people's medicine cabinets; we've got to incinerate it. Go to our website²⁴ and enter your zip code, and we'll tell you where your local Take-Back sites are. If you want to register with us to host a site, we make it easy for you to do that. There are about 5,000 sites across the country. People can turn in these drugs to DEA anonymously and safely, and we take it away, no questions asked. Of those 1.6 million pounds collected last year, we think

23. DEA Diversion Control Division, "National Take-Back Initiative." https://www.deadiversion.usdoj.gov/drug_disposal/takeback/
For additional information and resources, see also DEA web page, "Drug Disposal Information." https://www.deadiversion.usdoj.gov/drug_disposal/index.html

24. https://www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html

KEY POINTS ON FEDERAL PERSPECTIVES

- **Opioid fatalities continue to increase sharply, mainly because of deaths caused by fentanyl and other synthetic opioids, which more than doubled from 2015 to 2016.** The prevalence of very pure heroin and the increases in heroin spiked with fentanyl or carfentanil are causing deaths to increase.
- **The Drug Enforcement Administration has demand reduction programs as well as its enforcement initiatives.** For example, DEA leads a national “Take-Back Initiative” that disposed of 1.6 million pounds of prescription drugs in 2016. DEA also produced a movie about the opioid epidemic that is useful for community meetings and high school presentations. DEA also has developed a STEM-based curriculum that teaches the science of opioid addiction to middle school and high-school students.
- **DEA also is working with the government of China to reduce fentanyl exports.**

that about 10 percent are opioids. That’s 160,000 pounds of opioids off the street.

2. DEA-FBI MOVIE – CHASING THE DRAGON: With the FBI, we produced a movie called *Chasing the Dragon*. It’s free. It’s available on YouTube, on FBI.gov, on DEA.gov.²⁵ I encourage everyone to download it and show it at your community meetings. We’ve used it many times to start conversations. We usually present a little introduction to the opioid problem, then we show the movie, and then we have a panel discussion. The panel may include a parent who lost a child, or a recovering addict, or treatment folks, or law enforcement folks, to talk about the opioid epidemic.

Hold one in your high school. (Watch the movie first; the language is a little rough).

3. EDUCATION: We have partnered with Discovery Education to build a STEM-based curriculum—Science, Technology, Engineering, and Math—available free of charge to high school and middle-school students around the country.²⁶ It’s for parents, for kids, for educators. It teaches the science of opioid addiction to kids. It’s something you can mention to the school superintendents in your communities. The program is named “Operation Prevention” and the material can be found on the web at www.operationprevention.com.

25. “DEA Videos.” Chasing the Dragon: The Life of an Opiate Addict. <https://www.dea.gov/media/chasing-dragon.shtml>

26. Operation Prevention. <https://www.operationprevention.com/>

POLICE ARE INCREASINGLY ACTIVE IN GETTING ADDICTED PERSONS INTO TREATMENT

Arlington, MA Police Chief Fred Ryan:

The Innovation Is That Police Now Do Outreach To Known Populations of Addicted Persons

I'm the Police Council Chair for an organization known as Police Assisted Addiction and Recovery Initiative (PAARI), which was born from the Gloucester ANGEL Program in northern Massachusetts.

In that program, the police department in the Gloucester fishing village welcomed people suffering from a substance abuse disorder *into the police department, as a point of access to treatment.*

Whoever would have thought that the lobby of a police station would become an access-to-treatment point? But that's what they did in Gloucester.

From that came what is known in Massachusetts as the Arlington Model, which a lot of organizations are implementing in the Commonwealth. What's different about Arlington's model and PAARI is that we do *outreach with a known population of people who are suffering from substance disorders.*

It's very simple. We've all been in Compstat meetings, where we find out what's happening and then use that information to solve problems. With regard to heroin, the epiphany for me was when I was at a Compstat-type meeting, and up on a TV screen I saw the name of a young lady who by all standards was a success story—a



Arlington, MA Police Chief Fred Ryan.

college graduate, her mom an educator and her dad a firefighter. Her name was on the screen as someone who had experienced an opioid overdose that was reversed, and she was transported to a Boston-area hospital.

Seven days later, same young woman, same thing—overdose reversed, transported to a Boston-area hospital. But seven *hours* later, overdose again, and this time she's dead.

This jumped out at me as an example of a situation that was totally predictable, and the system let this young lady down.

From that was born our outreach initiative. We see every nonfatal overdose as an opportunity to get access to the person in crisis, or their loved ones, and we try to work with them to build an



John Rosenthal, Co-Founder, Police Assisted Addiction and Recovery Initiative (PAARI).

intervention plan. When we get to the loved ones, we try to coach them up, and we tell them they need to have the mindset that helping an addicted person is no different than if you're helping a woman who is expecting a child. You create a plan. You know which hospital you'll take the woman to, you know what health insurance policy she'll be using, you know who the physician is going to be, she packs a bag, and you're ready.

With our intervention planning and our outreach social worker who's embedded in the Police Department, we develop these types of plans for opioid users, and we're driving down the fatalities in our jurisdiction.

With respect to the fatal overdoses, District Attorney Marian Ryan from Middlesex County is here, and she and her team do an outstanding job of investigating and following up on the leads from the fatalities. And Superintendent William Taylor from the Lowell Police Department is doing outreach as well.

We are also affiliated with Boston University as our research partner, and John Rosenthal

from PAARI will talk about an article published in the *New England Journal of Medicine* that substantiates the reality that addicted persons who seek treatment through law enforcement agencies are being placed into detox and rehab at a higher rate than those getting referrals from medical professionals, which is really an amazing statistic.

John Rosenthal, Co-Founder,
Police Assisted Addiction and Recovery Initiative (PAARI):²⁷

Police Departments Are Highly Effective In Getting Addicted Persons into Treatment

As devastating as this epidemic of opioid addiction is, I'm hoping that you leave here with a sense of hope, based on what you can do in your communities.

No one is born hoping to die with a needle in their arm. This is a chronic disease without a cure, like heart disease, cancer, or diabetes. We have to treat this chronic disease like every other chronic disease.

If you present to an emergency room with cancer, diabetes, or heart disease, you are treated for the rest of your life. But if you present to most emergency rooms with the disease of addiction, you're shamed, blamed, stigmatized, and sent back to the street to die. So the Gloucester, Massachusetts, Police Chief Leonard Campanello chose to do something very different. He said that starting on June 1, 2015, anyone with the disease of addiction could come into the Gloucester Police Department and they would not be arrested, they would not be judged. They *would* be helped into treatment.

Since June of 2015, 545 people have taken the Gloucester Police Department up on that offer, and all have been placed into treatment on the same day.

Today, PAARI has 300 treatment center partners, and 264 police department partners, and we're operating in 30 states now, just in the

27. The Police Assisted Addiction and Recovery Initiative. <http://paariusa.org/>



LEFT TO RIGHT: Executive Director Allie Hunter McDade, PAARI; Josh Rosenthal, Board Member, PAARI.

last 24 months. In addition to the 545 addicted persons we've placed through the Gloucester Police Department, we've surveyed the 264 police departments across the country, and we found that roughly 10,000 people have been placed into treatment *through our law enforcement-based treatment points* over the last 24 months.

As Chief Ryan mentioned, the New England Journal of Medicine published an account of a study²⁸ in which researchers surveyed and interviewed participants and found that 94.5 percent of the people who presented to the Police Department were placed into treatment, compared to 55 percent who received treatment through the health care system.

Talk about a broken system, where it is easier to get treatment through the police department than through the health care system!

And lo and behold—and this is no surprise to you police chiefs who are on the front lines, and thank you for your service—over the last 24 months, we've seen a 30-percent reduction in ancillary crimes usually associated with addiction in the community of Gloucester. That's 30 percent fewer smash-and-grabs, shoplifting incidents, breaking and entering.

And the level of trust that has developed in the community has been stratospheric. The Police Departments in Gloucester and in Arlington have become the rock stars for finally doing something about this disease of addiction. When a police officer calls a treatment center, there's a bed—unlike when a family member calls. So police are changing the entire national conversation, breaking down barriers to treatment, saving lives from preventable overdose deaths and building sorely needed trust in their communities.

Please join PAARI; we provide resources and start-up grants to law enforcement agencies and we are hearing from new big and small city chiefs every day.

Executive Director Allie Hunter McDade, PAARI:

Police Agencies Are in a Unique Position To Help People Gain Access to Care

The opioid epidemic hits at the intersection of public health and public safety, and police agencies are in a unique position to help people. One of the things that makes these programs special is that they are pre-arrest programs. They're not just for people who are in the criminal justice

28. "A Police-Led Addiction Treatment Referral Program in Massachusetts." The New England Journal of Medicine. Dec. 22, 2016. [https://www.fels.upenn.edu/sites/www.fels.upenn.edu/files/NE percent20Journal percent20of percent20Medicine-Gloucester percent20Police percent20Angel percent20Program.pdf](https://www.fels.upenn.edu/sites/www.fels.upenn.edu/files/NE%20percent20Journal%20of%20percent20Medicine-Gloucester%20Police%20Angel%20Program.pdf)

See also <http://paarius.org/2016/12/21/results-gloucester-angel-initiative-studied-new-england-journal-medicine-article/>

system but in fact divert people from entering the criminal justice system by preventing future crimes. With the complex disease of addiction and a health care system that is so difficult to navigate, these programs make it easier for people to access the care they need and deserve.

I encourage all law enforcement agencies to look at our PAARI website (www.paariususa.org), reach out by email (allie@paariususa.org), and consider if you'd like to adopt a pre-arrest program that creates a bridge to treatment for those in your community with substance use disorders. These programs save lives, reduce crime, save money, and build trust between police and community members. Police departments can follow the Gloucester Intake Model, the Arlington Outreach Model, or Plymouth County Drop In Model, or some combination or variation thereof. PAARI will provide the tools and resources to help you design and launch a program that suits your needs and helps your department better serve and protect your community.

We currently have 264 law enforcement partners in 30 states, with more joining every week, and there's a lot of wisdom and strength in this group. It is a group that learns from each other and works together across state lines to solve the most pressing issues that face our communities. It's an inspiring group of law enforcement leaders from around the country, and we encourage you to join us, and join them, in this important and life-saving work.

Josh Rosenthal, Board Member, PAARI:

This Is Not Just a Community Issue; It Is Saving One Life at a Time

I'd like to put a personal face on this. A year and a month ago, I lost my 35-year-old son, who was a stockbroker, to a fentanyl overdose. Had Narcan been easily available to the public at the time of his death in Calgary, Alberta; had there been police involvement where he could walk into a police station and get help; had his mother and his girlfriend been able to get him into treatment when there was no treatment for him, he would be alive today.

PAARI is more than helping the greater community; it's saving one life at a time. It's giving one person at a time an opportunity to succeed. It's essential. Being part of PAARI, and doing all these things like training fishermen how to administer Narcan, and having it available in first-aid kits... This is saving one life at a time.

Seattle Police Chief Kathleen O'Toole:

Law Enforcement Assisted Diversion (LEAD) Has Been Shown to Reduce Recidivism

The LEAD program, Law Enforcement Assisted Diversion, started in Seattle quite a few years ago, and we have reinvested in it and expanded the LEAD program in the last few years. It has been replicated in many other places.

LEAD gives police officers the discretion, at the time of arrest in certain cases, to make a determination about whether to book and prosecute that person, or whether to divert that person to services. It's working well; we've had the University of Washington as a research partner to determine its effectiveness, and we're showing a significant reduction in recidivism among those who participate in the LEAD program.

I wanted to make an important introduction today. I thought I knew quite a bit about the opioids issue; certainly it's the biggest challenge we are facing in Seattle right now at the intersection between public health and public safety. About a year ago, a member of my staff told me that Penny LeGate wanted to meet with me. Penny LeGate is a household name in Seattle. She is a journalist and TV personality who hosted an evening magazine show for many years. Of course I wanted to hear what she had to say, and I learned more about the opioids crisis in my first conversation with Penny than I ever imagined. She has been a great partner to the Police Department on this. I admire her courage and determination. This isn't just a police problem; this is a community challenge. We will only make progress if we work together on multi-disciplinary approaches with phenomenal partners like Penny.

Penny LeGate, The Marah Project:²⁹

Thank You for Your Compassion And Your Determination to Save Lives

I want to thank PERF and the NYPD for inviting me to this incredible gathering here today. I am completely overwhelmed, because I had no idea what to expect when Kathy invited me to come with her and attend this event. So I want to express to you how grateful I feel, as a parent of a child who died of an accidental heroin overdose, for your compassion and concern.

I have been talking with many law enforcement people on our countywide task force in Seattle, so I know they have come to the realization that incarceration and arresting people just doesn't work to solve this problem. I know that that shift has happened. But to see it here, with these numbers, from this many places in our country, and the fact that all of you are coming here with so much concern, it really means a lot to me.

I lost my daughter Marah at age 19. It will be five years this June. She was an extraordinary human being, probably the most intellectual and funniest person I've ever met in my life. She was fun, she was loving, she could tell jokes and make people laugh. But Marah had a lot of depression and anxiety. She had severe mental health issues that led to her drug use.

Marah came from a loving home and a very stable home; she was loved and supported. So you think, "Wow, what happens to a child like that, that goes so wrong?" And it has a lot to do with what we are learning now about the mental health challenges we have in our country that compound this drug problem. Although Marah had access to the best psychiatrists and received meds for her depression and ADHD, she continued to experiment with drugs. She said, "Mom, it's the only time I feel normal."

I ask for your compassion, because we have no idea of the internal demons that bring



Penny LeGate, The Marah Project.

someone to this drug and this disease. And it is a disease, and that's why incarceration doesn't work. We don't incarcerate people who have diabetes; we don't incarcerate people who have heart disease. Substance use addiction is the same thing; it's a chronic brain reward dysfunction. We know that; that's what the science tells us. So we have to treat it as such. We have to treat these people like any other person suffering from a chronic medical condition.

When I heard in 2014 that the NYPD had \$1.1 million to equip 20,000 officers with Narcan, I thought, "Wow, I wonder if we're doing that in Seattle." So I asked and was told, "No, we're not doing that, but we're thinking about it." Months went by and nothing happened, so I started going through all the channels of City Hall, and I got nowhere—until I got to Kathy's desk.

Once I got the attention of Kathy O'Toole, there was no more discussion, no more delays. She just said, "Yes, we'll do this. Why wouldn't we? Aren't we about saving lives?" So the Marah Project, which is a nonprofit founded in my daughter's name, basically took money that was donated for a memorial fund and bought kits for 70 police bicycle officers in the City of Seattle, so they could carry Narcan.³⁰

29. The Marah Project. <http://themarahproject.org/>

30. "Seattle bicycle cops to carry Narcan for heroin overdoses," The Seattle Times, March 15, 2016. <http://www.seattletimes.com/seattle-news/health/seattle-bicycle-cops-to-carry-narcan-for-heroin-overdoses/>



Former Albany, NY Police Chief Brendan Cox, LEAD National Support Bureau.

And you know what was really great about that? It's not just that the equipment saved 17 lives in one year. It was the attitude of the cops who carried it that really impressed me. I was able to speak to them during their first training, and I said, "Remember, all those people on the street, all the people who are dying in bathrooms, in people's living rooms, in the alleyways, that was somebody's child. That human being represents the lost dreams of a family that loved that person and still does."

I know that if Marah were here today, she would say, "God bless all you cops for being on our side." Thank you very much.

Former Albany, NY Police Chief Brendan Cox, LEAD National Support Bureau:³¹

LEAD Focuses on Addicted Persons' Needs, Because Not Everyone Is Ready to Embrace Treatment

I just retired from the Albany Police Department in January, and I took on a role with the LEAD Support Bureau so I can come around and help law enforcement agencies get LEAD off the ground.

If you follow the Seattle LEAD program, it did a great job of bringing us down the path and

giving us the support, so there's a way we can give that support back to help agencies that are looking for it. We can help you, whether it's just information you want about what we're doing, or help in actually implementing it. We've had a number of agencies kick off in the last couple months; Baltimore and Portland just came on board.

Chief O'Toole did a great job of explaining what LEAD is about. We look at it from a harm reduction perspective, recognizing that with the folks we are dealing with, not everyone is going to be ready to jump into treatment. Treatment is ultimately our goal; we want to get them well. But we know that not everyone is ready to accept treatment right now. So we try to *meet each person where they're at*, and meet what their basic needs are at that time with diversion, and then what other needs are complicating their lives.

So if it's housing, that's the first thing we need to deal with, get them housing or shelter. And if it's education, we help get them back to school. These things are ultimately going to help reduce that drug use, and start to heal them and hopefully get them on the path to recovery.

It's very focused on harm reduction, and it's very much about the individual—assessing what that individual is going through, what their needs are, and then helping to make them well.

Volusia County, FL Sheriff Mike Chitwood:

We Are Using Forfeiture Funds To Equip Officers with Naloxone

We are just starting to see heroin move into our county. In my 10 years in Daytona Beach, our biggest drug problems were with methamphetamine. With help from the feds and a countywide task force, we were able to shut that window, and now it's shut. But now we are seeing opioids. Two years ago, we had about 30 heroin deaths. Now we're at about 155.

We are just about to equip our deputies with Narcan, thanks to the help of our treatment

31. <https://www.leadbureau.org/>



LEFT TO RIGHT: Volusia County, FL Sheriff Mike Chitwood; Rhonda Harvey, Chief Operating Officer, Stewart-Marchman-Act Behavioral Healthcare; and Mark O'Brien, Director, Baltimore City Health Department.

provider, Stewart Marchman.³² Rhonda Harvey came with me today, she runs our rehab and mental health facility, and can tell you more....

RHONDA HARVEY, CHIEF OPERATING OFFICER, STEWART-MARCHMAN-ACT BEHAVIORAL HEALTHCARE: Yes, we have a really strong partnership with our law enforcement agencies. We receive forfeiture funds from the Sheriff's Department, and have for several years. And those funds are always targeted to prevention.

In the last year, we have noticed this opioid epidemic hitting us so hard, and so we decided that the best place for us to put those forfeiture funds is with our Sheriff's Department and our Police Department, to equip them with Narcan.

It feels a little odd to give money back to the same people who gave it to us for prevention. But it makes sense, because opioids are the biggest thing we are dealing with. They're a huge issue for us.

Director Pam Davis
Professional Development and Training Academy,
Baltimore Police Department:

We Recently Launched a LEAD Program

We just started our LEAD program about five weeks ago, and so far we have 14 active participants. We had 24 referrals, and 10 who didn't

qualify or declined the offer. Three of the participants were arrest diversions, and the other 11 were social referrals, where officers recognized that the person had a need. Maybe an officer ran into them a couple times, and referred them to a case worker after they had an overdose, to help them get services.

One of the first participants didn't have any official identification card like a driver's license. This is a common problem, because it's hard to get services for someone who doesn't have any ID card. So the first thing we did in that case was get him an ID.

LEAD is a harm reduction program that's been fantastic so far, because that's the only way we can really get people into treatment.

Now I'll let Mark talk about a Task Force that we have in which our department partners with the Mental Health Department.

Mark O'Brien, Director, Baltimore City Health Department:

Baltimore Has a Fentanyl Task Force That Is Bringing Real Organization To Our Response

In Baltimore, we've had a bad heroin problem for decades, and it's become dramatically worse over the last six years or so. Like a lot of places around

32. Stewart-Marchman-Act Behavioral Healthcare provides services to persons with mental illness and/or addiction. <http://www.smabehavioral.org/about-us/>

the country, we're seeing fentanyl driving the increases in our overdoses.

In 2012 we had 4 overdoses related to fentanyl, then 12 in 2013, 17 in 2014, 120 in 2015, and we had 267 in just the first nine months of 2016.

We recognized that we all need to be working together on this issue, and specifically focusing on what we can do about fentanyl.

So in Baltimore we have pulled together a Fentanyl Task Force with about 20 city and state agencies, the Health Department, the Fire Department, Police Department, and other agencies you would expect to be in a room like that. We also have our library, our convention center, our recreation and parks people who are involved in this.

And we ask everyone to come together on three key issues:

1. How can we disseminate more public health messages about these issues? How can we inform people about the risks, and the opportunities for treatment, and the importance of getting people trained on naloxone and prepared to save a life?

2. Who are the city's front-line people who are out in the community every day, but who are from agencies that you wouldn't expect to have a role in opioids prevention? And how can we get them be prepared to respond to an overdose with naloxone?

We have our police department training officers; they have reversed more than 100 overdoses in the last couple years. We've also trained our Department of Public Works and the staff members at our recreation centers, so when there's a spike of overdoses in a community, the Rec Center people can equip people with naloxone.

3. We've set up a system to recognize when there's an overdose spike, down to a census tract of a few square blocks in our city.

And when that happens, we alert our partners, our mental health and substance abuse disorder treatment providers. To know when a spike is happening, we get daily updates from our Fire Department, and we have epidemiologists who map out the nonfatal overdoses. (We track the nonfatals because we can get that information quickly; it takes longer to get confirmation of fatal overdoses.)

Across our city of 620,000 people, we have 15 to 30 nonfatal overdoses in an average day. But if we see 3 or 4 overdoses in a single day in a single census tract, our outreach teams tell people in the community what's happening. And we distribute naloxone, and we get the word out to our providers and our partners on the Task Force.

The question of "Are we sending people into harm's way by alerting them to the presence of high-purity heroin or fentanyl?" is a question that weighs heavily on us. We know that some users are attracted to the strongest, most dangerous drugs.

So we use the substance abuse and mental health care providers as a buffer for the information. They know their clients best, so we ask them to use their best judgment about sending the information to the people who they believe will be helped by the information, as opposed to people who will be sent into harm's way.

WEXLER: Mark, Baltimore has had a heroin problem for many years, hasn't it? Can you give us your perspective on how you see the current epidemic?

DIRECTOR O'BRIEN: Yes, we've had a problem for decades with heroin, and we have been a city that has been focused on harm reduction for decades. For example, in the early 1990s we implemented a needle exchange program in response to the HIV and hepatitis-C infections that we were seeing because of intravenous drug users who were using contaminated syringes. And because of the needle exchange program, those infections from contaminated syringes use have declined. They were about 70 percent of our new infections, and it's about 6 percent now.

We have strong relationships with drug users because of our needle exchange program: Our history of having a harm reduction approach is helping us now. Because we have the needle exchange, we have relationships with people who are using drugs in the city. And that was a natural resource for us when we needed to target our naloxone most effectively when we saw that overdoses were climbing. We have trained about 20,000 people in the city to administer naloxone. We collect reports back from

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CHECKLIST: ELEMENTS OF THE BALTIMORE POLICE DEPARTMENT'S RESPONSE TO OPIOID OVERDOSES

*By Director Pam Davis
Professional Development and Training Academy,
Baltimore Police Department*

Non-Fatal Overdoses

- Every incident is treated as a medical scene first.
- In cases of opioid overdose, officer administers Narcan if trained to do so.
- Locate all witnesses and a family member.
- Obtain information on the victim's history of addiction and locations where his or her drugs were purchased.
- Treat overdose scenes as potential crime scenes.
- Obtain cell phone/home phone numbers of the overdose victim. Try to gain consent to view the victim's cell phone for text messages and phone numbers of associates.
- Use body-worn cameras to record the gaining of consent and viewing the phone.
- Process the scene and submit evidence.
- Complete report, detailing the scene and all names of the victim, witnesses, and suspects.
- Include identifying marks/characteristics on paraphernalia (symbols, names/words, color).
- Complete and submit Heroin/Opioid Overdose Report to overdose@baltimorepolice.org.

Fatal Overdoses

- Homicide Section is notified.
- Seize all cell phones.
- Crime lab responds.



Director Pam Davis.

HIDTA and Cyber Crimes Unit

- Assist with downloading information from cell phones.
- Review/collect all overdose reporting.
- Analyze trends.

Changes to Response

- The Baltimore Police Department is creating a Opioid Response Team, made up of 1 sergeant and 4 officers housed in Homicide. Two officers will have Homicide experience and two will have street-level narcotics experience.
- The Opioid Response Team will respond to all fatal overdoses, and will review all overdose reports.
- The team will complete interviews with family members/witnesses.
- All reports will be sent to HIDTA to be put into their database to track all overdoses.

Drug Enforcement Administration (DEA) Assistance

- Will be working with Lt. Bryant Moore (HIDTA Task Force) to address all roll calls on the importance of investigating every overdose.
- DEA will analyze all data for commonalities (similar packaging, repeat numbers, etc.).
- DEA will assist with getting subpoenas for cell phone numbers that patrol officers are able to retrieve from overdose scenes. This can be obtained very quickly and will be used to find phone numbers that match other overdose incidents.

Access to Treatment:

LEAD – Law Enforcement Assisted Diversion

- Recently began a LEAD pilot program in Baltimore’s Central District.
- Harm Reduction approach: Improving public health and public safety by reducing future harm and criminal behavior caused by individuals engaged in minor drug offenses and prostitution.
- Diversion: The program diverts eligible individuals from prosecution and incarceration.
- Baltimore Police Department, Behavioral Health System Baltimore (BHSB), Office of State’s Attorney, Public Defender, Parole and Probation, and Baltimore City Health Department all partner in this program.
- Officers refer people who have committed low-level crimes to a LEAD coordinator, who invites

them to participate in a treatment program. A screening form is used to determine eligibility, and the individual must consent to participate.

- Offenders are not eligible if they have a history of drug distribution or violent crime, an open warrant, or are currently under supervision by Parole and Probation.
- Referrals can be “arrest-based” or “social-based.” Social-based referrals are for individuals perceived as having a high risk for future arrest for minor drug activity or prostitution.
- Once in the program, the individual is connected with a case manager, is given access to treatment, and is monitored. They will also be linked to other services, such as housing.
- Will continue pilot program for 18 months and expand from there.

Naloxone

The Baltimore Police Department has approximately 500 officers trained to administer naloxone. We have currently begun issuing a 4-milligram dose that does not require putting a kit together; it is used like a nasal spray. This larger 4 mg dose is a better response to fentanyl overdoses, because it takes more naloxone to reverse the effects of fentanyl.

So far the Baltimore Police Department has had approximately 102 administrations of naloxone, with 100 saves. We started the program in the fall of 2015 with grant funding. The program is being incorporated into the Baltimore Police Department’s budget and will continue to grow.

people in the community, so we know we've had 800 overdose reversals done by lay people out in the community.

And what we have found is that for all the naloxone kits we give out through needle exchange programs, about one in 11 of those naloxone kits is actually used to reverse an overdose. By contrast, for the naloxone kits we distribute to the community, only about one in 30 kits is actually used to reverse an overdose. And bear in mind that when we give out naloxone kits to the community, it's not done randomly, it's really "hot-spotted" into areas of the city where we have high overdose rates. But even with that kind of hot-spotting, we still see that the best bang for our buck in naloxone distribution is through our needle exchange program, putting it directly into the hands of people who we know are using drugs.

Burlington, VT Police Chief Brandon del Pozo:

Because Relapse Rates Are High, We Are Exploring Options Like Medication-Assisted Treatment in Jail

Our overdose rate in our city of 50,000 compares to the rate of NYC. But New York's overdoses are four times the homicide rate. In Burlington, we don't have many homicides, so the overdose rate is 18 to 20 times the homicide rate. And because Burlington is a close-knit community, the deaths are felt deeply. They really degrade the quality of life. It's a problem everywhere, but in Vermont it is really severe.

There's no shortage of compassionate thinking in Burlington, and we're all about providing treatment, and not trying to arrest our way out of the crisis. But we are finding that we have people who have absconded from voluntary treatment 10 times before they die. We have people who have been revived by naloxone five or six times before they die.

It can take 90 days for an addict to gain enough clarity to want to heal. A woman told us that the best thing that happened to her was getting an infection in her arm from injecting. It kept her in the hospital, incapacitated, for 90 days. And if it wasn't for that hospital stay, she's still be using.

So we're starting to explore whether we can exploit involuntary situations for treatment, such as providing medication-assisted treatment in jail. There may be opportunities for helping people stick with treatment, rather than just absconding from the same treatment facility 10 times.

Penny LeGate, The Marah Project:

Suboxone Can Stabilize People in Jail, And Reduce the Chance They Will Overdose After Release

University of Washington researchers tell us that half of the people who are currently incarcerated in our state are detoxing from heroin. And so there's a lot of interest in providing suboxone, which is a medication-assisted treatment for people on heroin, in the same class as methadone and buprenorphine. If you give people suboxone, it keeps them from detoxing, which is a cruel and inhumane thing to have to go through.

So you provide them with the drug while they are in jail, and it stabilizes them. They come out with a lower risk of overdosing and dying when they are released from jail.

Martinsburg, WV Police Chief Maury Richards:

Our Opioids Initiative Focuses on Youths, Their Families, and the Community

Listening to everyone here and trying to let all this information soak in, I'm confident and optimistic. I think we're all going to look back at this day and see it as a turning point in what we're doing in the war on opioids.

When Commissioner O'Neill kicked off this meeting, he said we cannot arrest our way out of this problem. I think we've all embraced a common wisdom that the only way we're going to win this is on three levels: enforcement; treatment and recovery; and prevention.

Enforcement will always be a part of our role; we're the police. Drug dealers and traffickers are going to get caught, and they're going to be sent where they belong, in jail.

Regarding treatment and recovery, we realize this is a disease of the brain, and this is a matter of public health. It is a public health crisis.

But when we talk about prevention, it often seems like it's something we just mention, but it never gets focused on in a big way. I think this is because prevention is so hard to do, and it takes time. And we're part of a police culture, part of an organization culture, where we want to see results. We want to see those stats right now, and we want to get things done.

But ultimately, it's prevention that's going to turn this situation around. Unless we reduce the demand for opioids, we will never effectively reduce the supply.

So that's what the Martinsburg initiative is all about. It's prevention. The Martinsburg Initiative is a partnership between the Police Department, the Berkeley County Schools, and Shepherd University.³³ It's focused on families, and it's focused on schools. It's based on the Adverse Childhood Experiences Study (ACES) study, which found that the more traumatic experiences a child goes through growing up, such as physical or emotional abuse and neglect, the more likely they're going to become delinquent, criminal, or a drug user.

So here's what we're doing. We're working with our schools, starting with two pilot schools. We're identifying the most extremely at-risk students, through the teachers, counselors, and social workers. We start working with those students, and we go much farther than that because we also reach out to the families, because that is where the key environment is. We can work with the kids, but unless we make a difference in the environment that that child has to go home to every day, we're going to have a very slow rate of success.

MAKING SCHOOLS THE LOCATION FOR POSITIVE EVENTS IN THE COMMUNITY: The final component is that we realize

that there's always been a unique and special relationship between schools, police, and families. So we're making the local neighborhood school the focal point of everything good that's happening in that community. If we're going to have a GED program, it's going to be in the school. Domestic violence counseling, in the school. Problem-solving meetings, in the school.

So not only are we going to make that family better, we're doing it in a way that will build up the community. Just as a child needs a positive *family* environment, a family needs a positive *community* environment. This will work not only to increase the drug resiliency and resistance with kids, but with families, and will empower the community as well.

Gloucester Township, NJ Police Chief Harry Earle

Our Project SAVE Focuses on Helping Children Who Are at High Risk for Addiction

Chief Earle discussed Project SAVE, a drug abuse prevention and intervention program. One of the most significant initiatives of Project SAVE provides for a state-certified drug and alcohol counselor to be present in municipal court. The counselor provides judges, prosecutors, defendants, and defendants' family members with information about available drug treatment programs, in order to provide options that go beyond prosecution and conviction.³⁴

I appreciate what Chief Richards was just saying about adverse childhood experiences being linked to addiction. With me is Casey Johnson, who is our SAVE advocate, who has been meeting with clients in our municipal courtroom since 2014. And last year we expanded that to call-ins at the time of arrest to help arrestees.

In Gloucester Township we have put quite a bit of commitment into the opioid issues that we are discussing today. We began carrying Narcan in

33. See "Police Chief: Martinsburg, WV offers model solution for opioid crisis." Herald-Mail Media, April 17, 2017. http://www.heraldmillmedia.com/news/tri_state/west_virginia/police-chief-martinsburg-offers-model-solution-for-opioid-crisis/article_7ca82261-9bde-5809-a066-ee464acc90fb.html

34. Gloucester Township Police webpage, "Project SAVE." <https://www.gtpolice.com/support-services-division/project-save/>

2014, and established the SAVE advocate, who was not initially targeted to drug offenders per se, but to crimes like metal theft and shoplifting that are linked to drug abuse. We were trying to get them help *before* they overdosed, very early on, in their first court appearances.

I'm not minimizing at all this issue of prescription opioids leading to heroin abuse. But I do get concerned at times that the narrative doesn't include enough about children of domestic violence, children who have run away from home, children who have ADHD, and other kids with these risk factors for drug abuse. I'm not sure that we're focusing enough attention on these kids.

In Gloucester Township we screen every one of those children—every child who runs away, every child who is living in the home where there is a domestic violence case, every child who is truant. And we have a social worker on staff, so there will be an action plan developed for each one of these children, and we provide things like free family counseling.

We are really trying to stop these children from becoming addicted later in life, because the data shows that they have a higher chance of becoming addicted. We are focusing on opioids right now, but we can't forget that kids will still huff gasoline and sniff aerosol cans. They're doing that for a reason. They have problems in their lives. And I think it's important that we focus on a program to address that.

Casey Johnson, Substance Abuse Advocate,
Genesis Counseling Centers:

We Help People with Substance Abuse Disorders Navigate the Health Care System To Get Treatment

It's extremely difficult in New Jersey to find treatment resources for individuals with substance use disorders. There's a wide array of different funding streams that people can access, but the people who come into court don't necessarily know what those funding streams are. So my job as a court advocate is to link them up with services they need and assist them in navigating through that web, through intensive case management services. I act

as a liaison between the courts, the clients, and the treatment providers.

We've been doing this for three years in Camden County, which has the highest rate of overdose deaths among all the counties in New Jersey. Since the implementation of this program, we have seen overdose deaths as well as crime decline in Gloucester Township, NJ. So we're very proud of Project SAVE's success and would like to see it implemented throughout New Jersey.

Anthony Riccio, Chief, Bureau of Organized Crime
Chicago Police Department:

Our Violent Crime Problem Is Our Drug Problem, So We Started a Diversion Program To Address Both

We looked at the locations where our shootings are, and also where our murders are, and developed a "heat map." It's primarily on the South and West Sides of our city. Then we did an overlay of where our fire department was doing runs for overdoses, and the two maps pretty much mirror each other.

So in Chicago, our violent crime is our drug problem, and our drug problem is our violent crime problem.

We also realize we can't arrest our way out of it, so we have developed a diversion program. We're off to kind of a slow start because we are limited by the availability of health care providers. We're working with a lot of people to try to expand our drug treatment options.

We have had some tremendous successes with the people who have been diverted, but unfortunately, our numbers are still small until we can expand the treatment services.

Our diversion program is strictly an arrest diversion, and we limited it to screen out people with violent backgrounds or weapons possession in their background. We had found that in a lot of the operations we were doing, we were scooping up addicts and putting them through the criminal justice system, and that wasn't accomplishing anything. So we are now able to divert some of the addicts who are picked up in our operations and send them in for treatment.



TOP TO BOTTOM: Gloucester Township, NJ Police Chief Harry Earle; Casey Johnson, Substance Abuse Advocate, Genesis Counseling Centers; and Anthony Riccio, Chief, Bureau of Organized Crime Chicago Police Department.

East Bridgewater, MA Police Chief Scott Allen:

**We Have a “Drop-In Center” to Provide Resources;
We Visit Overdose Victims at Their Homes;
And All 27 Police Chiefs Share Information**

We’re in a county with about 500,000 people, and our partner in the city of Brockton has approximately 100,000 of those residents. At EB HOPE and Plymouth Project Outreach, we were inspired by PAARI, and we talked to the police departments in Arlington and Gloucester in 2015 about their initiatives. We combined a little bit of their models into what we developed, our Drop-In Center model.

We created EB HOPE (East Bridgewater Help, Outreach, Prevention, and Education), which not only connects people with substance abuse disorders to professional resources, but also connects their family members and loved ones to resources as well. We created our Drop-In Center, inspired by Gloucester’s ANGEL initiative, which is run by EB HOPE (and now Plymouth Project Outreach) out of a church led by one of EB HOPE’s board members.

The Drop-In Center is an “open-house style,” bi-monthly open session attended by our region’s substance treatment and recovery organizations. We market it to the active drug-user community, and almost as importantly to their family members, because we feel it’s important to help the Moms and Dads to deal with their loved one’s disorder, as well as their own stresses. We have a clinician on-site who can vet an active user while also sitting with a family member to help develop an action plan for a Substance Use Disorder sufferer. The five major treatment facilities in our area are all represented at the Drop-In Center, and active users will go directly from the Drop-In Center into treatment or at a scheduled date arranged at the Drop-In Center.

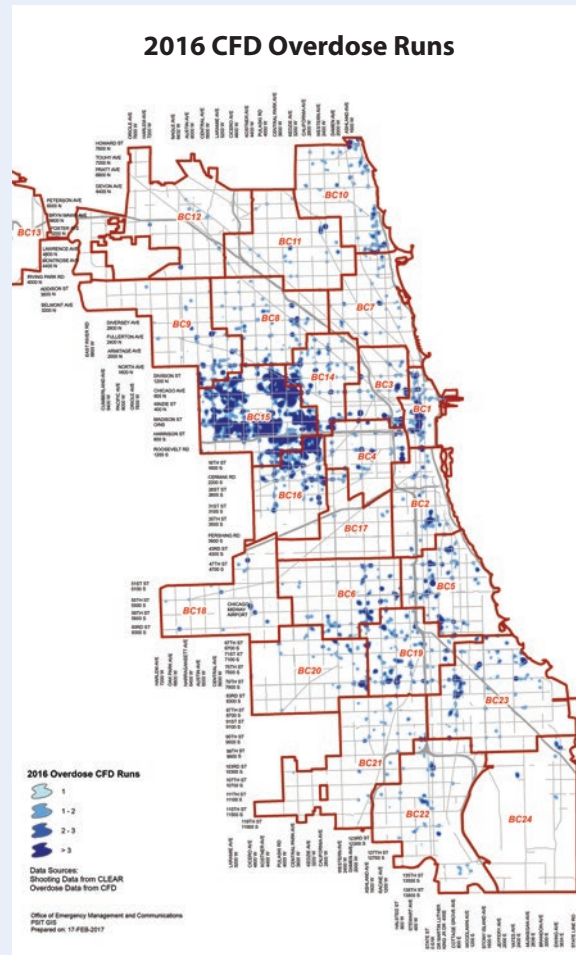
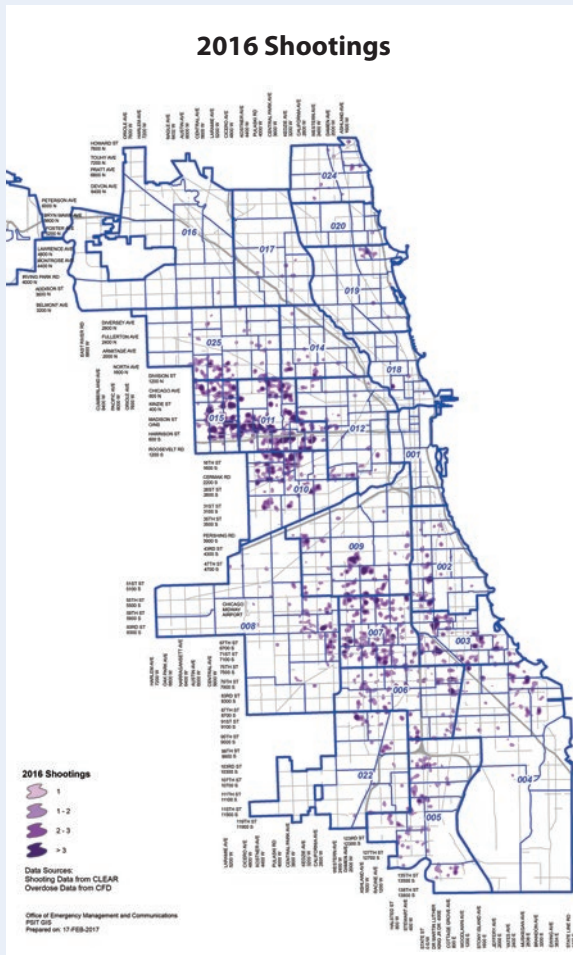
Over the past 18 months that we’ve hosted the Drop-In Center, we’ve had over 600 people come through the doors. About 200 are active drug users who were introduced to some level of treatment, while the rest are typically Moms and Dads who are looking for resources. Over

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CHICAGO POLICE DEPARTMENT MAPS SHOW OVERLAP OF HEROIN OVERDOSES AND SHOOTINGS

In March 2017, the Chicago Police Department released maps showing that shooting incidents and Fire Department ambulance responses to opioid overdoses on the West Side overlapped

very closely in 2016.³⁵ The mapping highlighted the connections between heroin overdoses and open-air drug markets, police officials said.



35. "On the West Side, maps show heroin ODs, shootings go hand in hand." *Chicago Sun-Times*, March 24, 2017. <http://chicago.suntimes.com/news/on-the-west-side-maps-show-heroin-ods-shootings-go-hand-in-hand/>

200 people attending the Drop-In Center have received Narcan and training in how to use it.

As our local models have evolved, we've partnered up. Plymouth's Police Chief, Michael Botieri, opened a drop-in center down his way. They were already doing some outreach visits. When they have an overdose, they go knock on the person's door within 12 to 24 hours. It can be a team of a police officer in plainclothes, a clinician, social worker, and we added a "recovery coach"—a peer, a mentor in recovery. So we go knock on the doors and ask them if they want help. We tell them about the Drop-In Center.

In August 2016, EB HOPE's sister Drop-In Center, the Plymouth Project Outreach Drop-In, opened its doors twice a month, ensuring that in the county there would be a Drop-In Center open each week of the month. The Plymouth Drop-In Center has had over 200 visitors since August of 2016.

In July 2017, the EB HOPE and Plymouth Project Outreach officially combined forces and formed one nonprofit coalition, with 17 executive board members to support both Drop-In Centers and coalition efforts.

We also have all 27 police chiefs in the county committed to sharing and doing the

same initiative county-wide. This was a credit to our initial partnership and collaboration. Chief Botieri, who has been around longer than I have and knows all the chiefs across the county, was instrumental in finalizing the county chiefs' commitment. We are tracking the overdoses in real time. So if someone overdoses in the city of Brockton but they're from East Bridgewater, we're getting an alert right away, so we know that we can go do the outreach and follow up.

On the investigations side, though this is not our program's intent, Moms and Dads are telling us, "Thank you for caring, and by the way, here's the name of Johnny's drug dealer." We're seeing some of these other issues coming up from these outreach visits.

Plymouth, MA Police Chief Michael Botieri:

When We Go to the Home of an Overdose Victim And Offer Help, We Are Never Turned Away

The Outreach Program began in December of 2015. Every community within Plymouth County was trying to create their own program to combat the Heroin epidemic. Our goal was to identify best practices and eventually include the entire 26 Towns and 1 city within Plymouth County.

We met with several stakeholders to include hospitals, drug court, police departments, probation, clinicians, medical service providers, treatment agencies, schools, clergy, and recovery coaches. Through our County Opiate Task Force we learned that the stigma of addiction was enormous and the intervention needed to be within the first 12-24 hours of an overdose. The stigma was stopping people from coming forward asking for help which in turn caused people to die.

The police department clearly has a front-row seat to the opiate epidemic and because of the stigma we knew that we needed to bring the treatment options to the subject who overdosed within that 12-to-24-hour period immediately after an overdose, which is a critical period, according to the subject matter experts in the medical field.

We began following up the next morning on every overdose that happened the day before,



LEFT TO RIGHT: Arlington, MA Police Chief Frederick Ryan; East Bridgewater, MA Police Chief Scott Allen; and Plymouth, MA Police Chief Michael Botieri.

providing prepared packets of resources for the subjects' family members and a packet for the addicts themselves. We also provide a packet for a family who has lost a loved one to an overdose, which we provide approximately one month after the loss.

This program quickly expanded to include the entire county. If you overdose in Plymouth County, you will receive a follow up the next day if you decided not to accept treatment at whichever hospital you were transported too. A plain clothes officer along with either a clinician or trained recovery coach will locate the subject who overdosed and offer assistance. We were prepared to be turned away at least half the time. However, because of the stigma and fear of reaching out for help—**No one turns us away. We've never been turned away.** We're taking away the stigma by offering resources in their homes where they are very comfortable to talk about the impact of addiction.

We have been funded by the Plymouth County District Attorney's Office to collect real time information in order to track the success of the Outreach Program. We're very proud of the program, and believe the model should be seen as a best practice.

Vancouver, BC Police Inspector Martin Bruce:

Since 2003 We Have Had a Safe Injection Site, Where There Has Never Been a Fatal Overdose

We have two safe injection sites in Vancouver and others coming online. The first one, which is called Insite, opened in 2003. Like other jurisdictions, we've had a problem with heroin that goes back to the 1970s, and when the heroin purity went up, we had overdoses. Since Insite opened in 2003, they've had 5,000 medical interventions on site, the vast majority of which were overdoses. But there have been no deaths.

WEXLER: Heroin is illegal in Canada, is that right? How can safe injection sites be allowed?

INSPECTOR BRUCE: Our injection sites received a medical exemption from Canada's Controlled Drugs and Substances Act. People bring the drugs

that they want to use and are allowed to do so under medical supervision.

WEXLER: So Vancouver has overdose deaths, but never at the safe injection site.

INSPECTOR BRUCE: Yes. Last year, we had 922 overdose fatalities in the entire province of British Columbia, which has a population of 4.6 million, and about 200 of those deaths were in the city of Vancouver. We have a downtown east side area where there is a concentration of drug users, so that's naturally where Insite was located. The idea was that if you build a facility that's far from where the addicted population are concentrated, they're not going to go to it. They'll die before they get there. So it has to be in the community or near a service that drug users are already utilizing. We also know that regular drug users with full time jobs, from across the city, are also going to our safe injection sites, because they're afraid of overdosing.

WEXLER: When people come to the sites and use heroin, how do you know their heroin doesn't have fentanyl in it?

INSPECTOR BRUCE: Typically it does. Fentanyl is in everything. It's in the cocaine, it's in the crystal methamphetamine. The huge profit potential that fentanyl offers is the driver.

WEXLER: Have crime rates been affected in the safe injection areas?

INSPECTOR BRUCE: Insite is in a downtown area where there's a high concentration of drug users, so property crime driven by addiction was already an issue. The users were already in the community where the harm reduction facility opened. So there's really no measurable impact on crime because of it. We have looked at it and there wasn't.

More recently, a secondary site has opened at a hospital. It's believed that the staff there were already providing the service prior to a license being granted as they'd identified the critical need to supervise drug use. Health Canada, the Federal Ministry that issues the licenses, is currently entertaining applications



LEFT TO RIGHT:
Vancouver, BC Police
Inspector Martin
Bruce; Essex County,
MA Sheriff Kevin
Coppinger.

from communities across the country that are now coming forward with a need. Canada’s fentanyl problem started in the West, in Vancouver, British Columbia, and Alberta, and it’s drifting east. The East is trying to get ahead of it; they’re noticing that fentanyl is starting to get into their drug supply, and they’re moving much more quickly toward harm reduction initiatives, such as getting these safe injection centers up and running before fentanyl really gets a foothold.

It’s important to know that Insite is all about treatment—addiction workers, mental health workers. So it’s not just a case of “Come in and use your drugs, and leave.” There are opportunities provided. Insite is a gateway to a range of services that promote recovery and that support those with mental health issues, housing issues and other needs.

Essex County, MA Sheriff Kevin Coppinger:

Detox Programs in Jails Are Very Expensive, But We Get the Funding Because It’s Important

WEXLER: Kevin, you used to be chief of police in Lynn, Massachusetts, and now you’re sheriff of Essex County. How is the heroin issue different for a sheriff, compared to a police chief?

SHERIFF COPPINGER: Well, the police can be seen as the feeder system as well as the end user for the jails run by the sheriffs. In most cases, you don’t go to jail unless you get arrested by the

police. And later, the police have to deal with the jail inmates again, when they return to their communities. The average stay in our facility is only 9 months.

If we can get people with addiction disorders into treatment before they get into the criminal justice system, that’s a win-win for all. However, we know that a lot of people get into the criminal justice system who are in need of drug treatment, and then the question is what do you do with these folks? One answer is a detox programs for inmates while they are in our custody.

We have two detox programs, one for men and one for women. There are 42 beds for each, and it’s a 28-day program. Detox programs are aimed at low-level offenses, such as prostitution offenses or larcenies, committed by individuals to fuel their addictions. And you can’t get into our treatment program if you’re a drug dealer or if you have committed serious crimes of violence.

The program is geared very closely with local law enforcement agencies, district attorneys, defense attorneys, and particularly the judges and the drug courts in Essex County. It gives the judges options, and it gives the inmates incentives. If you get arrested in Essex County, the judge looks at your record, and if you’re eligible for the program, they recommend it to the Sheriff’s Department, and 99 percent of the time, we will put the person into the detox program. Keep in mind, more than 90 percent of the inmates in our institutions have substance abuse addictions and/or mental health problems.



LEFT TO RIGHT: Macon County, IL Sheriff Thomas Schneider; Dr. Herbert D. Kleber, Columbia University.

WEXLER: How do you have the resources to do a detox program in your facility? This is expensive, isn't it?

SHERIFF COPPINGER: It is very expensive, but working with our state legislators and our Governor, they continue to fund it because of the need, and because we are trying to save lives.

It is in a dormitory-style setting, so the inmates are not going into individual cells or double-bunk cells. The treatment and the detox are provided by health care workers and substance abuse counselors. We do have correctional officers in the units, but they're at the soft approach, and they're there for the discipline and control. The care is administered by health care and substance abuse counselors.

WEXLER: People tell me that when people get out of jail or leave a residential treatment program, that's when they're most vulnerable to overdose, because they haven't been using for a while and their tolerance is low. Is that an issue you deal with?

SHERIFF COPPINGER: I've known the folks at PAARI for a long time, I've known Chief Ryan for many years, and we were talking during the lunch break about how they can work with the sheriffs' departments on the aftercare program, which everyone knows is very important. We need to make sure that when the people get out on their own, they have resources. We're going to partner up some more to provide that aftercare programming, so when these folks are out of custody and

back in the community, they have resources to use when they have those bad days.

Macon County, IL Sheriff Thomas Schneider:

Treatment Programs for Offenders And Naloxone Training Are Essential

We've started a program, and we have tried different strategies, everything from having a dedicated intervention officer for treatment, to training every officer to use Narcan. Getting addicts into treatment programs is going to be essential to us. Jails are critically important, and if we can spend more time identifying inmates who can benefit from these services, it will be good. There are a lot of things we have been learning about here today, that we can use as we fine-tune what we think is going to be a very good program.

Volusia County, FL Sheriff Mike Chitwood:

Sheriffs Should Use the Bully Pulpit, With Police Chiefs, To Build More Drug Treatment Capabilities

Dr. Rhonda Harvey and I were just at a symposium where more than 2,000 people demanded that I, as the chief law enforcement officer for Volusia County, coordinate with the other 12 law enforcement departments in the county and get Narcan rolled out into the community.

I don't run our jail; it is run separately from my department, and they did not budget separately

for drug rehab funding. So we constantly see the revolving door. You're in, you're out, and you're back on heroin or back on pills.

I think our job as sheriffs is to use the bully pulpit, and bring the police departments in the county along with us, on building drug treatment capabilities.

Dr. Herbert D. Kleber, Columbia University:

With Heroin, You Don't Complete Treatment, You Transition to Different Levels of Treatment

WEXLER: Dr. Kleber, you're one of the foremost treatment experts in the world. Tell us, what's the major difference between treatment for heroin addiction and treatment for other drugs, like crack cocaine?

DR. KLEBER: The difference is that you don't remain a crack addict for nearly as long as you do if you're a heroin addict. The stimulant drugs like cocaine tend to either kill you, or you stop using them. With the opiate-type drugs, you go on and on for years, unless you overdose because you get a batch with fentanyl or carfentanil, like the cases we're talking about today.

We're not doing enough with treatment, even though we know about treatment techniques that work. If you're a heroin addict and you're lucky, you should be in treatment for at least a decade. With heroin, you don't transition *out of treatment*; transition should be to a different level of treatment. Otherwise, you'll just keep relapsing and relapsing.

People should transition from using narcotics, to detox, to treatment. When you have someone who is a narcotic addict, you can't expect that they will stop being a narcotic addict, unless you do something different with treatment. The treatment will depend on the individual, but may include a narcotic antagonist,³⁶ like naltrexone,³⁷ or an agonist, like methadone or buprenorphine, in addition to psychosocial therapy.

NYPD Deputy Commissioner Susan Herman:

Police Should Defer to Drug Treatment Experts In Deciding Which Treatment Approaches to Take

One thing I've learned from collaborating with our public health community is that police officials and public health officials tend to talk about treatment very differently. As a general matter, police envision treatment as a 30-day residential program. By contrast, the health community talks about medication assisted treatment, methadone, buprenorphine, the drugs that Dr. Kleber mentioned, medications that can block the desire for heroin, and a range of other options. At least in New York, the health community does not go to "30-day residential treatment" as the first option.

So, I'm making a plea to other law enforcement professionals here—as we start to move into the business of helping people get treatment, we should not promote residential treatment as the best treatment for everyone. Let the health care professionals work with individuals to determine the most appropriate course of action for each person. It may be right for some, but not others.

Delray Beach, FL Police Chief Jeffrey Goldman:

Keep the Mental Health of Your Officers And Your Firefighters in Mind

Don't forget about your first responders. The amount of death that our officers and our firefighters are seeing is a lot more than most of us in this room saw in our careers. That is definitely having an effect on them. The empathy and compassion that you're asking your staff to have during this, the best thing to do is to educate them. So in Delray, we brought in a doctor to speak to the officers about their own wellness during this epidemic. Keep the mental health of your officers and firefighters in mind.

36. Narcotic antagonist medications block the euphoric and sedative effects of drugs such as heroin, and reduce the cravings for the drug.

37. See, for example, the "Naltrexone" web page of the Substance Abuse and Mental Health Services Administration: <https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone>

KEY POINTS ON THE EMERGING POLICE ROLE IN GETTING ADDICTED PERSONS INTO TREATMENT

- **Police agencies increasingly are actively working to get addicted persons into treatment.** Police stations have become a place where people can go to seek assistance in obtaining a placement in a treatment program. Police officers go to the homes of persons who experienced a nonfatal overdose the next morning to offer assistance. Police officers are partnering with social workers to conduct outreach. Police often are well positioned to take on this role because they respond to overdose scenes and become familiar with the addicted persons in their community.
- **Law Enforcement Assisted Diversion (LEAD) is a program used in many jurisdictions to divert addicted persons from the criminal justice system into drug treatment and other services.** LEAD focuses on “meeting each person where they’re at”—i.e., recognizing that an addicted person may not be psychologically ready to accept drug treatment, so the best approach is to help people with services they will accept, such as housing or educational services, and allow them to begin drug treatment when they are ready for it.
- **Baltimore’s systematic approach:** The Baltimore Police Department has developed a checklist of actions officers should take in responding to fatal and nonfatal overdose scenes, the role of HIDTA and the Cyber Crimes Unit in accessing information from overdose victims’ cell phones, officers’ use of naloxone, and the city’s LEAD program. The city’s Health Department also has demonstrated leadership, as part of a 20-agency Fentanyl Task Force, to educate the community about fentanyl and provide a quick response to overdose spikes.
- **East Bridgewater, MA created a “drop-in center” where addicted persons and their family members can obtain a wide range of services.** The major treatment facilities in the region are all represented at the drop-in center.
- **Plymouth, MA police bring resources to overdose victims’ homes.** The 12- to 24-hour period after a nonfatal overdose is a critical time, so Plymouth police officers and clinicians go to the home of an overdose victim the next day to offer services. Chief Michael Botieri said he expected that officers sometimes would be turned away, but that has never happened. Overdose victims and family members welcome the officers and clinicians into their homes.
- **Vancouver, BC has two “safe-injection” sites.** Drug users bring their drugs to these locations because they know they will be under supervision if they overdose. In 2016, Vancouver had approximately 200 overdose deaths, but none of the deaths occurred at a safe injection site. Drug addiction counselors and mental health workers are present at the site to offer treatment opportunities, and the sites also serve as a gateway for other services, such as housing assistance. It is important that safe-injection sites be located in areas where addicted persons live.
- **Police should trust drug treatment experts’ expertise.** Police tend to think about drug treatment as a 30-day residential program. But public health officials think of drug addiction as a long-term chronic condition, such as diabetes, that requires many years of treatment, particularly in the case of opioid addiction. Persons addicted to heroin do not transition out of treatment; they transition to different levels of treatment, which may include using a narcotic antagonist and other medical-assisted types of treatment.
- **Keep officers well protected.** The opioid epidemic can be stressful for officers, particularly when children witness overdoses by their parents.

TEACHING COMMUNITIES ABOUT THE ADDICTION RISKS OF OPIOID MEDICATION

Several participants at the PERF conference said there is an important role for police chiefs and other local officials in educating their communities about the addictiveness of heroin and prescription opioid medications. Because four out of five persons addicted to heroin began with prescription opioids, one of the best ways to reduce the heroin epidemic is to prevent additional people from becoming addicted, and that begins with avoiding use of opioid medications.

As Martinsburg, WV Police Chief Maury Richards said at the PERF conference, “Today, West Virginia has at least triple the national rate of heroin overdose deaths, and that’s because about five years ago we led the nation in overdose deaths from *prescription* drugs. People have made that transition to heroin.”

New York City’s comprehensive new opioid strategy summarizes the case that today’s heroin crisis began as a prescription opioid medication crisis:

Like so many communities across the nation, NYC has seen an epidemic of overdose deaths due to a toxic mix of illicit and legally prescribed opioids. This is a national issue

that was exacerbated throughout the 2000s by the overprescribing of prescription drugs, heavily marketed by pharmaceutical companies as non-addictive treatment for chronic pain.

Over time, as patients, doctors and government came to understand the dangers of these prescription drugs, efforts were made to reduce overprescribing and decrease the too-frequent use of opioids. But by that point, opioid misuse was already widespread, and people were increasingly turning to heroin, which was relatively cheaper and easier to obtain. The rate of overdose deaths involving heroin began to climb in 2011, and has continued to rise.³⁸

Officials in Ohio, California, Illinois, New York State, Mississippi, and West Virginia have filed lawsuits against pharmaceutical companies, alleging that the industry has misled the public about the risks of opioid-based medications.³⁹

At PERF’s conference, Everett, WA Police Chief Dan Templeman described a 2017 lawsuit filed by the City of Everett against Purdue Pharma “for allowing OxyContin to be funneled into the

38. *Healing NYC: Preventing Overdoses, Saving Lives*. The City of New York, Office of the Mayor. <http://www1.nyc.gov/assets/home/downloads/pdf/reports/2017/HealingNYC-Report.pdf>, page 9.

39. See, for example, “Ohio sues five drug companies over opioid crisis.” Reuters, May 31, 2107. <https://www.reuters.com/article/us-ohio-opioids-idUSKBN18R2BY>

black market, causing the current opioid crisis in Everett.”⁴⁰ Everett Mayor Ray Stephanson said that the lawsuit aims to hold the company responsible for “knowingly, recklessly, and/or negligently supplying OxyContin to obviously suspicious physicians and pharmacies and enabling the illegal diversion of OxyContin into the black market.”

Everett, WA Police Chief Dan Templeman:

We Believe the Oxycodone Manufacturer Is Responsible for This Epidemic

From our perspective in Everett, Washington, everything that has been said here today affects us as well. We filed a lawsuit in federal court against Purdue Pharma for what we truly believe was their reckless and negligent behavior, in terms of their lack of notification to law enforcement when their products were being illegally diverted to pill mills and were directly trafficked into our city. So we are seeing huge issues in Everett, and we are taking many of initiatives that have been discussed here today.

We have sent 15 of our people to PAARI; we have law-enforcement-embedded social workers working in our patrol division; every police officer carries naloxone, and we’ve reversed 45 overdoses in the last two years. So we are significantly impacted, and I believe that as the chief from Burlington mentioned, we think that the manufacturers of opioid pills carry responsibility. It’s significant when 80 percent of heroin addicts start on prescription medications.

WEXLER: What is the connection between the drug manufacturer and Everett?

CHIEF TEMPLEMAN: There was a drug dealer who was working out of the Los Angeles area who had ties directly to Everett, and who set up a bogus pharmacy and bogus doctor. And thousands and thousands of pills were being shipped from the manufacturer to this location. Purdue’s employees were aware of the fact that there was suspicious activity going on in terms of the volume of pills that were being diverted there, and this dealer was directly bringing them up into our community.



Everett, WA Police Chief Dan Templeman.

And so we believe that if Purdue had notified the DEA when they were supposed to when they had employees who recognized what was going on, they would have been able to take enforcement action and shut it down. Instead, it went on for years, and so these pills were being funneled into our community for years, and we are seeing devastating effects, with over 300 overdoses a year in Snohomish County.

Burlington, VT Police Chief Brandon del Pozo:

We Police Chiefs Should Use Our Bully Pulpit To Push Doctors to Reduce The Prescribing of Opioid Pills

DEA Administrator Chuck Rosenberg told us that four out of five heroin users started with pills. And as we look at cocaine and meth and heroin and opioids, only one of those drugs is something that you can get legally from hundreds of thousands of people who are licensed to give it to you in the United States, and that’s opioids.

So I think that as public leaders, we should do what we can to clean up the opioid pills part of the crisis, while we also work on the heroin part of it. We work with public health professionals in Vermont; we work with the hospital and the Department of Health. *And I will not meet with*

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40. “Everett files lawsuit against Purdue Pharma.” City of Everett News Release, January 19, 2017. <https://everettwa.gov/1681/Purdue-Lawsuit>

CDC FACT SHEETS DETAIL HIGH RISKS OF OPIOID MEDICATIONS

The Centers for Disease Control and Prevention (CDC) have produced a large number of reports, fact sheets, brochures, posters, videos, webinar trainings, and other resources to educate the public and medical care providers about the risks of opioid medications. These resources are available online at <https://www.cdc.gov/drugoverdose/prescribing/resources.html>.

For example, a CDC study found that when patients receive their first prescription for opioid pain relievers, there is a significant likelihood that they will still be using the medication a year later:

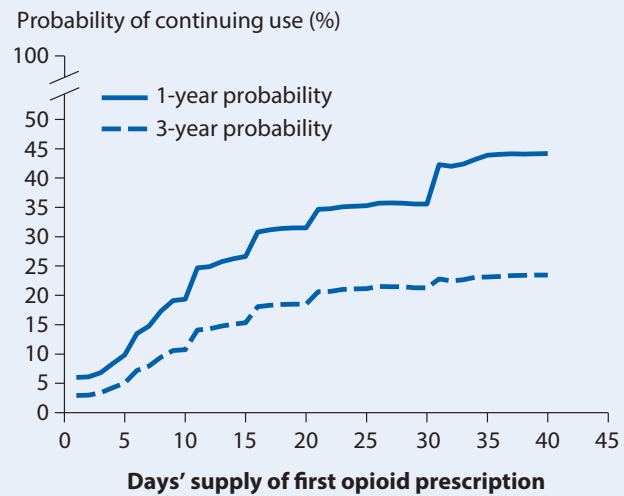
- Among persons who received an initial 12-day supply of opioid medication, 24 percent were still taking the drugs one year later.
- Even among persons who received only a *one-day supply*, 6 percent were still taking the drug a year later.⁴¹

Furthermore, the CDC has warned that the evidence is weak that opioid medications are very effective in reducing pain. In a checklist for physicians to use when they are considering prescribing an opioid medication, the CDC provided the following summary, and recommends that physicians consider other types of medication:

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*

Probability of Continued Use of Opioid Medication One or Three Years After Initial Prescription



Source: CDC. <https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm>

- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*⁴²

Similarly, in an infographic about the risks and benefits of opioid medications, CDC states the following:⁴³

MYTH	VS	TRUTH
1 Opioids are effective long-term treatments for chronic pain		While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
2 There is no unsafe dose of opioids as long as opioids are titrated slowly		Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.
3 The risk of addiction is minimal		Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

41. "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use—United States, 2006–2015." *CDC Morbidity and Mortality Weekly Report*, March 17, 2017. <https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm>

42. CDC, "Checklist for prescribing opioids for chronic pain." <https://stacks.cdc.gov/view/cdc/38025>

43. CDC, "Why Guidelines for Primary Care Providers?" https://www.cdc.gov/drugoverdose/pdf/guideline_infographic-a.pdf

these public health officials or have a conversation with them about what we can do together, unless that conversation starts with what they are doing to be transparent and accountable about doctors' prescribing practices.

I use my bully pulpit as a public leader to demand that. We have a 90-day commitment from our hospital to give a regime of transparency in doctor prescribing, to show that they are doing their job. When they say that this is a public health crisis, I reply, "Yes, so no conversation will happen between us unless you tell me what you're going to do to reduce the amount of pills that you're giving to people." We're beginning to make progress with that. We need to be relentless, because this is how the heroin crisis started: with pills.

Mark O'Brien, Director, Baltimore City Health Department:

We Are Urging Doctors to Prescribe Naloxone Every Time They Prescribe Oxycodone

The CDC guidelines that came out last spring suggest that physicians give a prescription for

naloxone with any prescription for opioids if the person has certain risk factors or if the doses are high. In Baltimore, we've asked our physicians to go beyond that, and provide a prescription for naloxone with every single opioid prescription.

We're saying that if oxycodone is prescribed, naloxone should be in the house, too.

Dr. Herbert D. Kleber, Columbia University:

Police Can Help Stop the Over-Prescribing That Results in Heroin Addictions

Police are in a good position to lean on physicians. Whenever I hear about doctors who prescribe a month's supply of Oxycontin following a medical procedure that should take three or four days to recover from, I report them to the medical society. They should be sanctioned and warned that if they continue doing it, they're going to lose their medical license.

KEY POINTS ON THE ROLE OF POLICE IN EDUCATING THEIR COMMUNITIES

- **Four out of five heroin addicts began with prescription opioid medication.** Thus, a key strategy for reducing the heroin epidemic is to prevent additional people from becoming addicted to opioid medications, and that begins with avoiding use of opioid medications.
- **A growing number of jurisdictions have filed lawsuits against pharmaceutical companies, alleging that they misled the public about the risks and addictiveness of opioid-based medications.** At least 25 states, cities, and counties have filed civil cases against various elements of the opioid industry, according to the Washington Post.⁴⁴
- **The Centers for Disease Control (CDC) have produced reports, fact sheets, brochures, posters, and other resources that police officials and partner organizations can use to educate the public about the risks of opioid medications.** For example, a CDC study found that among persons who received an initial 12-day supply of opioid medication, 24 percent were still taking the drugs one year later.
- **Police and their partners can help stop the over-prescribing of opioid medication.** The risk of addiction is so high that the Baltimore City Health Department is asking physicians to issue a prescription for naloxone every time they issue a prescription for opioid medication.

44. "Drugmakers and distributors face barrage of lawsuits over opioid epidemic." *The Washington Post*, July 4, 2017. https://www.washingtonpost.com/investigations/drugmakers-and-distributors-face-barrage-of-lawsuits-over-opioid-epidemic/2017/07/04/3fc33c64-5794-11e7-b38e-35fd8e0c288f_story.html?utm_term=.42ef908e78fc

PROSECUTORS FACE DIFFICULT QUESTIONS ABOUT THEIR ROLE IN REDUCING OVERDOSE DEATHS

At PERF's conference, federal and local prosecutors and police chiefs discussed a number of challenges they face in defining the role of prosecutions in the area of opioid addiction and fatal overdoses. Many people agree that the United States "can't arrest its way out of the opioid crisis," but it is a more difficult question to decide what police and prosecutors **should do.**

The discussion began with one particular situation where enforcement is clearly warranted: "patient brokering" operations in Florida that victimize addicts by taking their health insurance benefits while doing little to provide effective treatment services.

Delray Beach, FL Police Chief Jeff Goldman:

We Have Problems With Unregulated "Sober Homes" Where Addicted Persons Are Victimized

WEXLER: Chief Goldman, I know that Delray Beach, and also Hollywood, Florida, have a lot of drug treatment facilities. People from up north come down to your city for treatment, and there are dealers who try to get them using drugs again,

and people who victimize them for their insurance benefits. I think these people should be prosecuted. Do you think that's right?

CHIEF GOLDMAN: Yes, down in South Florida, we have large recovery communities, and we also have a lot of related issues. We have what's called "patient brokering,"⁴⁵ we have human trafficking, we have people committing insurance fraud in ways that are compounding our opioids problem.

The State's Attorney's Office in Palm Beach County was recently awarded money to start a sober homes task force, because south Florida is inundated with sober homes, and the quality of communities has deteriorated because there are so many sober homes in one area. Until recently there's been no regulation of this.

What happened to us was that, in the beginning, we were not getting any help from prosecutors on the fraud cases. This compounded the sales and created more and more vulnerable populations. We have just started to see some progress and successful case conclusions of patient brokering and insurance fraud investigations.

45. "Patient brokering" is the illegal payment of commissions for the referral of patients to drug treatment facilities or other health care providers, particularly patients who have health insurance or who can otherwise pay for treatment services. See, e.g., "Patient brokering: A festering wound for recovery community." Palm Beach Post, October 29, 2016. <http://www.mypalmbeachpost.com/news/local/patient-brokering-festering-wound-for-recovery-community/hTzetVZpPd2Lud2kV4evoM/>

See also "Exploiting addiction: Recovery industry faces crackdown for patient brokering." Sun Sentinel, October 31, 2016. <http://www.sun-sentinel.com/local/palm-beach/fl-sober-living-patient-brokering-20161031-story.html>



Delray Beach, FL Police Chief Jeff Goldman.

WEXLER: You were telling me you see instances where dealers are waiting around treatment facilities, and they give people free heroin to get them using again.

CHIEF GOLDMAN: Yes, and the days of the open-air drug markets, where the user would go to the street corner and buy crack or buy marijuana, have changed. Now the dealers are driving around and actually stopping people and saying, “Do you want to buy heroin?” or “Here’s some free heroin,” to get them hooked again. Which restarts the cycle of getting them “dirty” again, so they can do the patient brokering and milk them for their insurance. And the cycle starts over again.

This is what we are dealing with, and it’s a big-money game when it comes to insurance. To give you a quick idea, you can take someone on the street, you give them heroin and get them dirty, and they send them into a recovery community home, where they recruit other people. They might get paid \$3,000 a person, so that individual can take 10 people and make \$30,000, for example. It’s very lucrative, and it’s been going on for a long time.

The biggest issue we have is the transient aspect of it. Everyone comes to south Florida, to Delray, for the beautiful beach, the great downtown, the nightlife. And the bad operators promote it up here in the Northeast, and bring people down to Delray or Hollywood, without educating the parents or family members about what the issues are. So the addicted persons end up falling out of

recovery, and they don’t want to go back home, because they’re afraid to tell the family. You have to get to the family involved to solve these problems.

Also, you’ve got to make sure that the treatment facility people are doing it for the right reasons. The whole business has been unregulated, and we are working with our city officials, legislators and federal partners on that. Because it involves housing, the Department of Housing and Urban Development gets involved; it’s multi-faceted.

So I implore everyone to be aware of these issues, or they’ll creep up on you. Some of our recovery community are becoming productive citizens, but others are not. And those are the ones who are doing your vehicle burglaries and causing other issues. So stay educated about your population. Are you getting treatment centers? Are you getting halfway homes and recovery homes popping up? And do you have regulations or strategies in place to keep bad operators out?

Hollywood, FL Police Chief Tomas Sanchez:

We Produced a List Of Reputable Treatment Providers, To Direct People Away from the Fraudulent Ones

Broward County, where we are located, was the epicenter of the pill mill industry a decade ago. We were successful in shutting down over 40 pill mills in our city alone. Broward had been responsible for 80 percent of the Oxycontin going out across the country. With the prescription pills restricted, that left a void, and now a segment of our population is addicts. We have 27 drug rehab facilities last time I counted, in a 28-square mile area. We see street-level drug dealers targeting these rehabilitation locations. Just last week, we shut down two storefronts that were drug dealing hotspots (one operated as a convenience store and the other as a barber shop).

When you put it on a map and do data analysis like we do with any other crime, and you plot rehab centers, overdose deaths, and narcotics search warrants, you have a hot spot, clear as day.

So what are we doing? We want to address these treatment centers. As Jeff (Delray Beach Police Chief Jeffrey Goldman) said, yes, you want



LEFT TO RIGHT: Hollywood, FL Police Chief Tomas Sanchez (SHOWN SITTING, FAR LEFT); Joshua Scott, Guardian Recovery Network.

to get people into treatment, but it has to be the right kind of treatment centers. Like any other businesses in our city, some have poor business plans, and you have the treatment centers that are getting the kickbacks, the criminal element.

We have to problem-solve and we have to crack down on the bad ones with nuisance abatement and other tactics. To direct people to the legitimate treatment facilities, we put together a coalition of the hospital, community, and faith-based organizations and produced a brochure listing the reputable treatment providers.⁴⁶ This information is on our website (<http://www.hollywoodfl.org>) and given to our first responders.

Joshua Scott, Guardian Recovery Network

Watch Out for Fraudulent Treatment Providers, And Get Help from Florida Police and Prosecutors

In South Florida we have a bit of a unique environment with treatment providers. As fraudulent treatment providers are getting pushed out of our community—we’ve made 20 arrests in Palm Beach County for kickbacks and patient brokering—some of these providers are leaving the county before they can be arrested, and they are going to other states. We are aware that some of these providers

are already moving into Ohio, North Carolina, and Texas.

In areas that don’t have fraudulent providers running rampant, you may see that in the future. This is a trend that we unfortunately expect. If any of you start to see things that look like what we have experienced, you can certainly reach out to our Delray Beach and Palm Beach County community leaders, to our chiefs and our state attorneys, because we are prosecuting a brand of fraud that was unknown to us five years ago. When we weren’t aware of what was happening, we got behind the eight ball.

Looking back at our work on the opioids crisis, we’ve been proactive in some things and reactive in others. The areas where we have been proactive have worked better, and these fraudulent treatment providers are an issue that everyone should be aware of.

Assistant U.S. Attorney John Gallagher:

Federal Drug Sentencing Laws Are Not Calibrated to Solve the Heroin Crisis

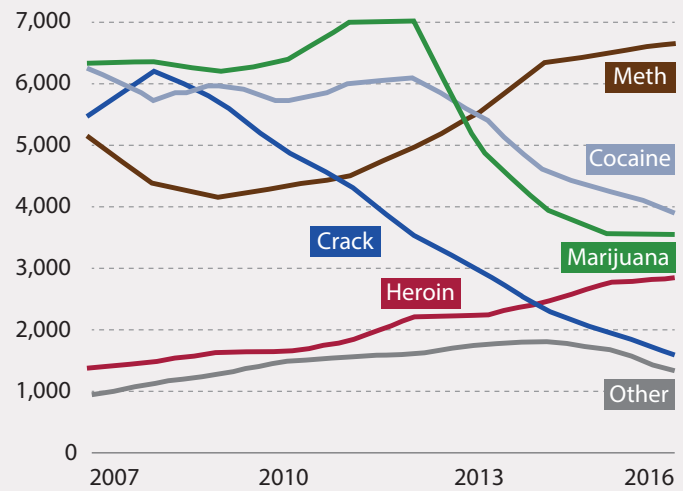
WEXLER: John, in this chart showing the numbers of federal prosecutions for various types of drug offenses, why is heroin down near the bottom?

46. “Substance Abuse Resource Guide: There Is Help for You.” <http://www.hollywoodfl.org/DocumentCenter/View/11708>



Assistant U.S. Attorney John Gallagher.

Number of people sentenced for federal drug crimes



Source: U.S. Sentencing Commission.

MR. GALLAGHER: First, Chuck, let me say that I’ll just share my experience from being a front-line federal prosecutor for a number of years. What I’ll say isn’t necessarily the position of the Department of Justice.

We all know that when it comes to drug prosecutions, the feds look for the most serious cases. What does that mean? It means the cases that carry the largest federal sentences, so that means the cases with the highest weight, the most kilos, the most bricks.

Under current federal laws, to get some teeth, to get a mandatory minimum sentence, you need 100 grams of heroin. That’s way too high. That’s a mid-level wholesale amount. The amount of drugs you need for a mandatory sentence is almost four times higher for heroin than it is for crack. The amount of heroin needed to get a mandatory sentence is 20 times higher than it is for meth.

In other words, depending on the purity of what’s being sold, 100 grams of heroin—the amount you need for a mandatory minimum sentence—is 3,000 to 5,000 “dime” bags or \$10 bags.

Each one of those 3,000 to 5,000 glassines is another bullet in the game of Russian Roulette for heroin users. If you’re dealing that much poison,

you need to be prosecuted, and the feds should have a role in that.

Because the mandatory minimums are skewed against heroin enforcement, I don’t think that the federal law enforcement world is well situated to deal with this current crisis. We cannot arrest our way out of this problem, but arrest has to be part of the solution here. But we don’t have a good “fit” under current federal laws.

We’ve heard a lot of talk that “the prisons are full of drug users.” But at the federal level, I always say, “Show me one.” People are not going to federal prison for using drugs. Essentially, drug distribution is treated like a nonviolent offense. I think that’s a fallacy; it’s a violent crime. The people who are profiting from this, we need to treat them more seriously. But the federal system’s just not built that way. At the federal level, the lowest threshold for us to consider a heroin case serious is much too high, in my opinion.

That’s not to say we aren’t doing anything. The DEA and FBI and ATF do a fantastic job. We prosecute loads of interdiction cases and loads of distribution gangs. We prosecute these pill mills, these “dirty doctors.”

But the deaths in this opioid crisis are happening at the lowest level, the street level, and the federal government doesn’t



LEFT TO RIGHT: Middlesex County, MA District Attorney Marian Ryan; Helen Morgan, Chief Deputy District Attorney, Denver District Attorney's Office.

have the tools or the laws to address that. The closer you get to the street, the less likely you are to find a “federal-worthy” defendant. So we need to make some changes.

Middlesex County, MA District Attorney Marian Ryan:

Heroin Dealing Today Is Done on Social Media, Not on Street Corners

WEXLER: Ms. Ryan, how do DAs in Massachusetts think about heroin prosecutions? What are your priorities?

DISTRICT ATTORNEY RYAN: In terms of prosecutions, we've really been focused on the big investigations. We're usually looking to get a fair amount of product off the street. These types of investigations are much more costly and complex than in the past, because the dealing is happening on social media. It isn't as simple as "Put a cruiser on the corner and arrest people." Today's users are having heroin delivered to their house.

So we are doing a lot of big, long-term investigations in trying to move up the food chain. We're aiming for the investigations that can get us 20 or 30 kilos, or can get us a lot of money. For example, we've intercepted a lot of operations where people are mailing money somewhere else and having the product sent back.

We're working hard on the overdoses, taking the phones and pulling the information we can get off the phones, both to get people into treatment and to figure out where the product is coming from.

Helen Morgan, Chief Deputy District Attorney, Denver District Attorney's Office:

We Can Seek Long Sentences For Serious Offenders, While Also Diverting Users Out of the System

I've been with Denver District Attorney's Office for 23 years. A multi-pronged approach is the only way we are going to adequately respond to this crisis. For example, our narcotics and homicide detectives participated in a cross-training this week with federal officials. They were educated about a federal statute that imposes a potential federal prison sentence of 20 years if an offender sells narcotics that directly result in a fatal overdose. While we recognize we can't treat every overdose death as a homicide, we had two last week alone, in cases where we can quickly identify a single narcotics supplier to an overdose victim. Our narcotics detectives will work those cases and present them to federal authorities for possible charging.

On the other end of the spectrum we are actively working on implementing Law



Chauncey Parker, Executive Assistant District Attorney, New York County District Attorney's Office.

Enforcement Assisted Diversion for offenders in need of treatment. My unit, the Behavioral Health Unit, will be staffing 1st and 2nd advisements to vigorously exercise our role as gatekeepers and keep people out of the criminal justice system who do not need to be involved.

As local DAs we have a responsibility to work with the entire community to tap into expertise. We will never arrest our way out of this crisis, but you also have to go after the bad guys.

Chauncey Parker, Executive Assistant District Attorney, New York County District Attorney's Office:

We Are Defining Our Goals And Choosing Prosecutions to Meet the Goals

WEXLER: Chauncey, with 1,300 fatal overdoses in NYC last year, how do you decide which of the drug dealers associated with those deaths need to go to jail?

CHAUNCEY PARKER: I've been a prosecutor for 30 years—local, federal, and state. And there's one conversation I always remember: Several years ago a very experienced supervising prosecutor said to me, "We're all so busy. I know that my prosecutors are so busy. I don't think they could work any harder than they're working. *But I'm just not sure we're working on the most important cases.*"

I work for Manhattan District Attorney Cy Vance. He came into the job and asked, "What's our goal?" He said our goal is not convictions; it's not

sentence length. That might be part of the strategy, but it's not the goal. *The goal of the Manhattan DA's Office is for Manhattan to be as safe as possible and not use one more day of jail than is necessary.*

As a prosecutor, having these twin goals—less crime, less jail—changes the way you think about your job. The first thing that District Attorney Vance did was create a Crime Strategies Unit. This is intelligence-driven prosecution, just like CompStat is intelligence-driven policing. DA Vance said, "If the goal is to reduce crime and to reduce *violent* crime first and foremost, let's start with looking precinct by precinct in Manhattan, and, together with our partners in the NYPD and the community, *let's identify the handful of people in each community who drive the violence.*"

And so we put together a list of about 400 people who, according to the NYPD and various other partners, are the most responsible for the violent crime in Manhattan.

Next, we took a look to see if any of those 400 people had an open felony in our office, and 30 percent of them did. Then the question was, what plea offer did we give them? And the answer was—"Well, this guy's a drug dealer, and this is what normally happens to drug dealers" or "This is the second arrest on a gun, and this is what happens in that kind of case." Our plea policy was based solely on the facts on that case, and not on achieving our goal of crime reduction.

What we're trying to do now in the DA's Office as part of RxStat is "*intelligence-driven drug prosecution.*" If the NYPD's goal is to reduce overdoses and violence that's related to drug trafficking, then those goals become our goals.

So in answer to your question about how to best prosecute overdose cases, let me give you an example of one specific project we're doing as it relates to fentanyl and fentanyl-related overdoses.

When someone gets arrested and it turns out that the heroin he sold had fentanyl in it, we're going to go to court and tell this dealer on the record—"The heroin you sold came back from the lab and it has fentanyl in it. Fentanyl is a lethal drug. Under federal law, there's strict liability if you sell drugs and it kills somebody. It's a mandatory minimum of 20 years in federal prison.

Message received? Don't ever say you didn't know."

And we're hoping that some of these drug dealers will be rational and will decide not to sell heroin with fentanyl, just like drug dealers who have made the rational decision that violent crime is bad for business because we will very aggressively prosecute in particular any drug dealer who commits a violent crime.

This new drug strategy is focused on a common goal. It's not just answering a "911 call for prosecutors"—someone gets arrested and we prosecute the case, or someone wants a search warrant so we write it up.

Rather, we are working very collaboratively with the NYPD to ask, "Will this particular strategy reduce violence or reduce overdose deaths?" And if prosecuting people for murder will not only bring justice in that particular case, but also may deter other people from selling the most lethal drugs in the first place, then it is part of a goal-driven, CompStat model, I believe.

WEXLER: Chauncey, what happens when you have an outbreak of deaths? Suddenly you have 25 overdoses, 10 of them fatal. You trace it all back to one dealer. That's their heroin that was laced with fentanyl and caused all those deaths. Should that person be charged, even if they're not a high-level dealer, because they created an outbreak of death?

CHAUNCEY PARKER: I think the federal prosecutor's hammer of a 20-year mandatory minimum for a drug dealer who sells drugs and kills someone is important—but it should be used very carefully and selectively.

JOHN GALLAGHER: We have had a number of these cases in my office, and they're very tricky. You have to establish that it was this specific drug that caused a death. So you look at the toxicology reports of the people who died, and they show cocaine, they show heroin, they show fentanyl, they show codeine. And you have to show that but for taking that hit of heroin that contained fentanyl, they would be alive. It's a difficult case to make, but in my opinion, I think we should prosecute more of those cases.



NYPD Chief Ed Delatorre.

NYPD CHIEF OF CRIME CONTROL STRATEGIES DERMOT SHEA:

I think it's going to get more difficult, because in addition to this question of whether a case merits a federal prosecution, we're in an era of moving away from mass incarceration. We had a case this week with a fatal overdose, and the drug dealer's phone come back, and when we did our analysis of the phone numbers in that dealer's phone, a very quick computer search of NYPD records showed six other overdoses in his contacts.

I don't think this is the exception; this is the norm. Show me a drug dealer of heroin in New York City who *hasn't* caused an overdose. So I think law enforcement agencies and prosecutors are going to have to come together and face these tough decisions. As we get better in gathering data, we're going to have evidence staring us in the face. The cartels clearly have liability, but the ground-level dealers are what we are faced with right now, and we don't know what the best answer to that is. This is what we are struggling with now.

NYPD Chief Ed Delatorre:

It Is Possible to Get Evidence That Dealers Know They Are Causing Deaths

We have several cases on Staten Island that we're working, and we're meeting regularly with the Staten Island DA, with the federal prosecutors for the Eastern District of New York and the Southern District, and also the Special Narcotics Prosecutor at times. We're looking at several statutes, and we



LEFT TO RIGHT: Akron, OH Police Chief Jim Nice; Lynn, MA Police Captain Mark O'Toole; and Stephen McConachie, Chief CBP Officer, U.S. Customs and Border Protection.

thought the burden would be great, because we have to be able to prove somehow that the dealer had some sense that he or she was causing those deaths. But when you're working a major case, you often start picking up the evidence you need. It's labor-intensive, but you do start picking up the conversations, the conversations with undercovers, where you get the admissions that they know it.

And the other thing we are finding that the U.S. Attorneys want to look at is a case enhancement. Once you get your conviction on a sale, you then go in with the enhancement, which can add 10 or 15 years to the sentence. So that's the other part of it that we are looking at with our federal partners. And we have a great DA in Staten Island who's willing to do anything that has to be done with the case in order to get the right outcome.

Akron, OH Police Chief Jim Nice:

We Have Already Had 16 Sentencings Of Dealers for Involuntary Manslaughter

We started out with a heroin overdose death investigation team and I put four officers working on that when the problem got bad, and we opened a death investigation on all 179 fatal overdoses last year. And we've had a very aggressive county prosecutor's office. We've had 16 sentencings already; people are getting five to seven years for involuntary manslaughter.

But the one drawback we've had when we start prosecuting the first-line dealers for

homicide is that they start dumping bodies. We have folks who are not as aware of the Good Samaritan law, so now we have bodies that are left in cars that are set on fire, because of the homicide prosecutions.

WEXLER: How long have these prosecutions been going on, Jim?

CHIEF NICE: A couple years.

WEXLER: Have you seen any change, with dealers being afraid to come to Akron because of the prosecutions and going to Cincinnati or some other city instead?

CHIEF NICE: I wish that I could say that, but I don't honestly think that it has slowed down the drug trafficking. The overdoses didn't go down as a result of that. It's just that some of these people are being held accountable for those deaths.

Victims' families members appreciate it, though, when the person who knowingly provided fentanyl or carfentanil to their loved one who died goes to jail for that.

Lynn, MA Police Captain Mark O'Toole:

We Have Endless Supplies Of Street-Level Dealers; There's No Risk in Selling Heroin

We're a city of about 93,000 that's seven miles north of Boston. We've had significant heroin issues for decades. Massachusetts changed its

legislation several years ago. We used to have mandatory sentences for distributing drugs within 1,000 feet of a school; that was reduced to 300 feet. And all of our trafficking amounts were increased for triggering mandatory minimum sentences. So today, there's no risk in selling heroin. Heroin dealers used to be stigmatized; if you suggested someone was a heroin dealer, they'd deny it. Not anymore. We seem to have an endless supply of people willing to sell heroin.

In a typical case, our drug unit will arrest the buyer, arrest the seller, and the seller has 10 bags of heroin, a bunch of cash, and a couple cell phones. The typical investigative technique would be to try to work them up to their dealer. But we find that they never cooperate. They know they aren't going to jail, because they aren't going to jail; they may get probation.

So until we get serious at that level, it's not going to change. We have endless supplies of

street-level dealers, and they insulate the mid-level dealers, because they're not cooperating. There's no risk in dealing heroin at the street level.

Stephen McConachie, Chief CBP Officer,
U.S. Customs and Border Protection:

Share Your Information with CBP About How Heroin Is Getting to Your City

It's not enough to collect data; you need to share it with the right people. The vast majority of drugs that are responsible for this misery are produced outside the United States. Help us figure out how it got here, so that we can target those who are responsible, and close gaps in border security. HIDTAs, in particular, are a model for getting that information from local agencies to those of us in Customs and Border Protection.

KEY POINTS ON PROSECUTORS' ROLE IN REDUCING OVERDOSE DEATHS

- **Many people agree that the United States “can’t arrest its way out of the opioid crisis,” but there is a role for targeted prosecutions in certain cases.** The question is what prosecutors *should* do with regard to opioids.
- **One area where prosecution is clearly warranted is unregulated “sober homes” in Florida.** Insurance fraud and “patient brokering” schemes at such facilities victimize addicted persons for their insurance benefits.
- **Another area where prosecution is warranted is dealers who target patients as they come out of treatment facilities.** Dealers sometimes target addicted persons, giving them free heroin to get them “dirty” again and restart the cycle of addiction. In addition to criminal prosecutions, injunctions to require drug dealers to keep away from treatment facilities should be considered.
- **Federal drug sentencing laws are not calibrated to focus on heroin.** The amount of drugs needed to trigger a mandatory minimum sentence is four times higher for heroin than it is for crack cocaine.
- **However, the threat of federal prosecutions for fatal overdoses may be credible.** Federal law provides for mandatory minimum sentences of 20 years in prison for selling drugs that result in death. Such cases can be difficult to prove beyond a reasonable doubt, but dealers should be told about such laws to deter them from selling heroin, especially heroin mixed with fentanyl or carfentanil that is likely to cause fatal overdoses.
- **Investigations are more difficult today than in the past.** Drug dealing today is often conducted behind closed doors through email or social media, rather than on street corners.
- **State laws in some jurisdictions provide significant sentences for involuntary manslaughter as a result of selling heroin.**

CONCLUSION:

A WORSENING NATIONAL CRISIS REQUIRES A STRONGER RESPONSE

The United States' opioids crisis is continuing to worsen, killing tens of thousands of people. The latest numbers from CDC reveal that drug overdose deaths in 2016 totaled 64,070, a 21-percent increase over 2015. While some of those deaths involve cocaine or other drugs, approximately three-fourths of the fatalities were caused by heroin, fentanyl, prescription opioid pills, or other opioid drugs.⁴⁷

Furthermore, the new CDC statistics confirm what police chiefs have been telling us: Fentanyl is driving the sharp increases in opioid-related fatalities. In 2016, fentanyl accounted for a much larger share of drug overdose deaths than in the past, even surpassing deaths attributed to heroin. Between 2015 and 2016, fentanyl-related deaths nationwide increased 103 percent, to a new total of 20,145. By contrast, heroin-related deaths increased 17 percent, to a total of 15,466.

To a large extent, the opioids crisis began several years ago in the eastern half of the United States. More recently, it has been spreading to all parts of the nation. This crisis is the most significant issue facing many police chiefs and sheriffs today. Some agencies already have spent years gearing up their response to

the crisis, working with public health agencies, hospitals, drug treatment providers, and others to develop comprehensive strategies for saving lives and helping addicted persons get into treatment. The cities, towns, and counties that are just beginning to experience the full force of the opioids epidemic can learn from these agencies that have greater experience with it.

At PERF's third national conference on the opioids epidemic, held in April 2017 at New York City Police Department headquarters, experienced police chiefs, sheriffs, public health officials, drug treatment experts, prosecutors, and federal officials discussed the programs and strategies they have undertaken to address the epidemic. The key points that emerged from this PERF meeting are summarized below:

The Nature and Extent Of the Opioid Epidemic

- **The opioids epidemic is a national crisis that continued to worsen in 2016.** According to new CDC data, drug overdose deaths in 2016 totaled 64,070, a 21-percent increase over 2015. While some of those deaths involve cocaine or other drugs,

47. "Provisional Counts of Drug Overdose Deaths, as of 8/6/2017," CDC National Center for Health Statistics. https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf.

approximately three-fourths of the fatalities were caused by opioids.

- **Fentanyl is driving the sharp increases in opioid-related fatalities.** Between 2015 and 2016, fentanyl-related deaths nationwide increased 103 percent, to a new total of 20,145. By contrast, heroin-related deaths increased 17 percent, to a total of 15,466.
- **Investigating opioids trafficking is more difficult than in the past.** Dealers are ordering carfentanil on the internet, and it is delivered from China by mail.
- **Opioids are more profitable to dealers than other drugs.**
- **Some states have not yet experienced the full impact of the opioids crisis.** The epidemic has caused tremendous hardship in many parts of the United States, especially New England and Appalachia. But upper-Midwest states and the Western states of California and Oregon have not yet felt the crisis to the same extent. However, some cities and towns that were not experiencing the crisis a year ago are seeing it now. **States that have been relatively unscathed would be well advised to study the patterns of the epidemic in other locations, so they can prepare to detect any increases in overdoses and respond effectively.**

The New York City Model

- **A Compstat-like approach can coordinate efforts to reduce overdose deaths.** Compstat, which emphasizes timely data and accountability, provides a good framework for identifying strategies for reducing overdose deaths and ensuring that the strategies are implemented.
- **Coordination between all stakeholders is critical.** New York City has brought together police, prosecutors, fire/EMS, public health, hospitals, and treatment providers to address this problem collectively.
- **Reducing opioid overdose deaths should be everyone's primary objective.** All relevant stakeholders must stay focused on the overarching goal: reducing the number of opioid overdose deaths.

Sharing Information About Overdoses

- **Lives can be saved if police can quickly analyze drugs found at the scene of an overdose.** Forensic laboratories often have backlogs in their analysis of drug samples recovered by police. However, lives can be saved if police have systems for expediting certain samples when it appears that a packet of drugs may be causing fatal overdoses in a community because it is laced with fentanyl or carfentanil or is exceptionally high-purity. By speeding the analysis, police may be able to determine where the “epicenter” of the overdoses is located, and who is dealing in the drug.
- **Regional sharing of data can help prevent overdoses.** When multiple police agencies and partners contribute information to shared databases in real time, patterns in overdoses can become apparent more quickly.
- **Nonfatal overdose data is also important.** Generally speaking, the people at greatest risk of a fatal overdose are people who have previously experienced nonfatal overdoses.

Federal Perspectives

- **Opioid fatalities continue to skyrocket, mainly because of deaths caused by fentanyl and other synthetic opioids, which more than doubled from 2015 to 2016.**
- **The Drug Enforcement Administration has demand reduction programs as well as its enforcement initiatives.** For example, DEA leads a national “Take-Back Initiative” that disposed of 1.6 million pounds of prescription drugs in 2016. DEA also produced a movie about the opioid epidemic that is useful for community meetings and high school presentations.
- **DEA also is working with the government of China to reduce fentanyl exports.**

The Police Role in Getting Addicted Persons Into Treatment

- **Police agencies increasingly are actively working to get addicted persons into treatment.** Police stations have become a place where people can go to seek assistance in obtaining a placement in a treatment program. Police officers go to the homes of persons who experienced a nonfatal overdose the next morning to offer assistance.
- **Law Enforcement Assisted Diversion (LEAD) is a program used in many jurisdictions to divert addicted persons from the criminal justice system into drug treatment and other services.** LEAD focuses on “meeting each person where they’re at”—i.e., recognizing that an addicted person may not be psychologically ready to accept drug treatment, so the best approach is to help people with services they will accept, and allow them to begin drug treatment when they are ready for it.
- **Baltimore’s systematic approach:** The Baltimore Police Department has developed a checklist of actions officers should take in responding to fatal and nonfatal overdose scenes, the role of HIDTA and the Cyber Crimes Unit in accessing information from overdose victims’ cell phones, officers’ use of naloxone, and the city’s LEAD program.
- **East Bridgewater, MA created a “drop-in center” where addicted persons and their family members can obtain a wide range of services.** The major treatment facilities in the region are all represented at the drop-in center.
- **Plymouth, MA police bring resources to overdose victims’ homes.** The 12- to 24-hour period after a nonfatal overdose is a critical time, so Plymouth police officers and clinicians go to the home of an overdose victim the next day to offer services.
- **Vancouver, BC has two “safe-injection” sites.** Drug users bring their drugs to these locations because they know they will be under supervision if they overdose. Drug addiction counselors and mental health workers are present at the site to offer treatment opportunities,

and the sites also serve as a gateway for other services, such as housing assistance.

- **Police should trust drug treatment experts’ expertise.** Police tend to think about drug treatment as a 30-day residential program. But public health officials think of drug addiction as a long-term chronic condition, such as diabetes, that requires many years of treatment, particularly in the case of opioid addiction. Different levels of treatment may include using a narcotic antagonist and other medical-assisted types of treatment.
- **Keep the wellness of your officers in mind.** The opioid epidemic can be stressful for officers, particularly when children witness overdoses by their parents.

The Role of Police In Educating Their Communities

- **Four out of five heroin addicts began with prescription opioid medication.** Thus, a key strategy for reducing the heroin epidemic is to prevent additional people from becoming addicted to opioid medications, and that begins with avoiding use of opioid medications.
- **A growing number of jurisdictions have filed lawsuits against pharmaceutical companies,** alleging that they misled the public about the risks and addictiveness of opioid-based medications.
- **The Centers for Disease Control (CDC) have produced reports, fact sheets, brochures, posters, and other resources that police officials and partner organizations can use to educate the public about the risks of opioid medications.**
- **Police and their partners can help stop the over-prescribing of opioid medication.** The risk of addiction is so high that the Baltimore City Health Department is asking physicians to issue a prescription for naloxone every time they issue a prescription for opioid medication.

Prosecutors' Role In Reducing Overdose Deaths

- **Many people agree that the United States “can’t arrest its way out of the opioid crisis,” but there is a role for targeted prosecutions in certain cases.** The question is what prosecutors *should* do with regard to opioids.
- **One area where prosecution is clearly warranted is unregulated “sober homes” in Florida.** Insurance fraud and “patient brokering” schemes at such facilities victimize addicted persons for their insurance benefits.
- **Another area where prosecution is warranted is dealers who target patients as they come out of treatment facilities.** Dealers sometimes target addicted persons, giving them free heroin to get them “dirty” again and restart the cycle of addiction. In addition to criminal prosecutions, injunctions to require drug dealers to keep away from treatment facilities should be considered.
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- **Investigations are more difficult today than in the past.** Drug dealing today is often conducted behind closed doors through social media, rather than on street corners.
- **State laws in some jurisdictions provide significant sentences for involuntary manslaughter as a result of selling heroin.**

PARTICIPANTS

“RESPONDING TO THE OPIOIDS EPIDEMIC” CONFERENCE

APRIL 6, 2017, NEW YORK, NY

Participants are listed alphabetically by the name of their department or agency. Titles reflect participants' positions at the time of the conference.

Chief Jim Nice

Akron (OH) Police Department

Chief Clarence Tucker

Akron (OH) Fire Department

John Barrett

An Garda Síochána

Owen McEvoy

Heroin Task Force Chairman
Anne Arundel County (MD)
Government

Chief Timothy Altomare

Anne Arundel County (MD)
Police Department

Deputy Chief Micky Hatmaker

Appalachia HIDTA

Chief Fred Ryan

Arlington (MA) Police Department

Director Mark O'Brien

Baltimore City Health Department

Maisha Wise

Baltimore City Public Schools

Monique Lyle

Public Information Officer
Baltimore County Department of
Health and Human Services

Captain Wes Fischer

Baltimore County Police Department

Chief Terrence Sheridan

Baltimore County Police Department

Lieutenant David Trivett

Baltimore County Police Department

Director Pamela Davis

Professional Development and
Training Academy
Baltimore Police Department

**Deputy Superintendent
Winifred Cotter**

Boston Police Department

Chief Brandon del Pozo

Burlington (VT) Police Department

Jackie Corbally

Citywide Opioid Policy Coordinator
Burlington, VT

Eric Fowler

Analyst
Burlington (VT) Police Department

Terry Chwanec

Vice President, National Security
Operations
Cadillac Fairview Corp. Ltd.

Patty DiRenzo

Advocate
Camden County (NJ) Addiction
Awareness Taskforce

Chief Scott Thomson

Camden County (NJ)
Police Department

Chief Anthony Riccio
Chicago Police Department

Daliah Heller
Clinical Professor
City University of New York /
Graduate School of Public Health
and Health Policy

Kristin Huisenga
Executive Director
Clinton (IA) Substance Abuse Council

Zubin Jelveh
Research Director
Crime Lab New York

Chief Jeffrey Goldman
Delray Beach (FL) Police Department

Regi Huerter
Office of Behavioral Health Strategies
Denver City and County

Ryan Brackley
Assistant District Attorney
Denver District Attorney's Office

Helen Morgan
Chief Deputy District Attorney
Denver District Attorney's Office

Deputy Chief David Quinones
Denver Police Department

Chuck Rosenberg
Acting Administrator
Drug Enforcement Administration

Chief Scott Allen
East Bridgewater (MA)
Police Department

Sheriff Kevin Coppinger
Essex County (MA)
Sheriff's Department

Chief Dan Templeman
Everett (WA) Police Department

Lauren Hahn
Fairfax County (VA) Commonwealth's
Attorney's Office

**Second Lieutenant
James Cox III**
Fairfax County (VA) Police Department

Captain Jack Hardin
Fairfax County (VA) Police Department

Lyn Tomlinson
Assistant Deputy Director
Fairfax Falls Church (VA)
Community Services Board

Casey Johnson
Substance Abuse Advocate
Genesis Counseling Centers
(Camden, NJ)

Chief William Earle
Gloucester Township (NJ)
Police Department

Rick Neal
Government Strategies Advisory Group

Deputy Chief Daniel Savage
Grand Rapids (MI) Police Department

Jenny Caviness
Community Engagement
Greensboro (NC) Police Department

Lieutenant Dan Moore
Greensboro (NC) Police Department

Chief Wayne Scott
Greensboro (NC) Police Department

Joshua Scott
Guardian Recovery Network

Sheriff Richard Stanek
Hennepin County (MN) Sheriff's Office

Joan Hamilton
Contractor
Howard G. Buffett Foundation

Mark Rigel
Manager, Field Operations
Howard G. Buffett Foundation

Interim Chief Bruce Jolley
Irving (TX) Police Department

Chief Michael Yankowski
Lansing (MI) Police Department

Brendan Cox
LEAD National Support Bureau

Commander Stuart Cundy
London Metropolitan Police Service

Commander Todd Chamberlain
Los Angeles Police Department

Assistant Chief Gregory Burns Jr.
Louisville Metro Police Department

Superintendent William Taylor
Lowell (MA) Police Department

Chief Raul Diaz
Lynchburg (VA) Police Department

Captain Mark O'Toole
Lynn (MA) Police Department

Undersheriff Howard Buffett
Macon County (IL) Sheriff's Office

Detective Dale Pope
Macon County (IL) Sheriff's Office

Sheriff Thomas Schneider
Macon County (IL) Sheriff's Office

Penny LeGate
Marah Project (WA)

Chief Maury Richards
Martinsburg (WV) Police Department

Chief Sean Dunn
Martinsville (VA) Police Department

Captain Robert Fincher
Martinsville (VA) Police Department

Captain Daniel Morgalo
Miami Beach (FL) Police Department

District Attorney Marian Ryan
Middlesex County (MA)
District Attorney's Office

Dr. Gayane Hovhannisyan
Middlesex-London (Ontario)
Health Unit

Commander Erick Fors
Minneapolis Police Department

Captain Paul Liquorie
Montgomery County (MD)
Police Department

Alejandra Munoz
Case Worker
Montgomery County (MD)
Police Department

Tracy Kimbo
Director, Public Safety Marketing
Motorola Solutions

Commissioner Thomas Krumpter
Nassau County (NY) Police Department

Anthony Ambrose
Director of Public Safety
Newark, NJ

Captain Juan Colon
New Jersey State Police

Superintendent Rick Fuentes
New Jersey State Police

**Lieutenant Colonel
Albert Ponenti**
New Jersey State Police

Detective Raymond Andolina
New Rochelle (NY) Police Department

Commissioner Patrick Carroll
New Rochelle (NY) Police Department

Captain Robert Gazzola
New Rochelle (NY) Police Department

Lieutenant Edward Hayes
New Rochelle (NY) Police Department

Captain Adrian Navarrete
New Rochelle (NY) Police Department

Lieutenant Gary Robinson
New Rochelle (NY) Police Department

Chief David MacDonald
Newton (MA) Police Department

Hannah Johnson
Policy Analyst
NY/NJ HIDTA

Pamela Lum
NY/NJ HIDTA

Margaret Moore
NY/NJ HIDTA

Chauncey Parker
Executive Assistant District Attorney,
New York County
District Attorney's Office and
Director, NY/NJ High-Intensity Drug
Trafficking Area

Grace Zimmerly
NY/NJ HIDTA

Dr. Denise Paone
NYC Department
of Health & Mental Hygiene

Lieutenant Arthur Beal
NYPD

Chief of Detectives Robert Boyce
NYPD

**Deputy Commissioner
Stephen P. Davis**
NYPD

Chief Edward Delatorre
NYPD

**Assistant Commissioner
J. Peter Donald**
NYPD

Sergeant John Flynn
NYPD

Deputy Inspector Matt Galvin
NYPD

Chief of Department**Carlos Gomez**

NYPD

Deputy Commissioner**Susan Herman**

NYPD

Debra Morgan

NYPD

Chief of Patrol Terence Monahan

NYPD

Commissioner James O'Neill

NYPD

Detective Jose Otero

NYPD

Lieutenant Sean Patterson

NYPD

Dermot Shea

Chief of Crime Control Strategies

NYPD

Detective Jim Shields

NYPD

Detective Steve Stefanakos

NYPD

Benjamin Tucker

First Deputy Commissioner

NYPD

Kevin Ward

Chief of Management Analysis
and Planning

NYPD

Detective Robert Zajac

NYPD

Chief Owen Monaghan

Metropolitan Transportation Authority

Police Department

New York, NY

Kaitrin Robert

Assistant District Attorney

New York County, NY

Richard Baum

Acting Director

Office of National Drug Control Policy

Jacqueline Hackett

Deputy Director

for Policy-External Affairs

Office of National Drug Control Policy

Mario Moreno

Press Secretary

Office of National Drug Control Policy

Taylor Weyeneth

White House Liaison

Office of National Drug Control Policy

John Sullivan

Chief Superintendent

Ontario Provincial Police

Commissioner Richard Ross

Philadelphia Police Department

Daniel Panusky

Investigative Support Center Manager

Philadelphia/Camden HIDTA

Chief Christopher Winters

Pine Hill (NJ) Police Department

Sheriff Robert Gualtieri

Pinellas County (FL) Sheriff's Office

Chief Michael Botieri

Plymouth (MA) Police Department

Allie Hunter McDade

Police Assisted Addiction & Recovery

Initiative (PAARI)

John Rosenthal

Co-Founder

Police Assisted Addiction & Recovery

Initiative (PAARI)

Josh Rosenthal

Board Member

Police Assisted Addiction & Recovery

Initiative (PAARI)

Nancy Hans

Prevention Council

of Roanoke County (VA)

Assistant Chief Hector Velez

Prince George's County (MD)

Police Department

Major Kevin Hughart

Prince William County (VA)

Police Department

Chief Allwyn Brown

Richmond (CA) Police Department

District Attorney**Michael McMahon**

Richmond County (NY)

District Attorney's Office

Chief Howard Hall

Roanoke County (VA)

Police Department

Chelsey Clarke

Strategic Intelligence Unit Supervisor

Rocky Mountain HIDTA

Christopher Fisher

Chief Strategic Advisor

Seattle Police Department

Chief Kathleen O’Toole

Seattle Police Department

Sergeant Kurt Zempel

Sheboygan (WI) Police Department

Rhonda Harvey

Chief Operating Officer

SMA Behavioral Healthcare (FL)

Chief Jeffrey Kruthoff

Springboro (OH) Police Department

Lieutenant Michael Mueller

St. Louis Metropolitan

Police Department

Chief Todd Axtell

St. Paul (MN) Police Department

Senior Commander

Robert Thomasser

St. Paul (MN) Police Department

Patrick Harrington

County Prosecutor

Tippecanoe County (IN)

Prosecutor’s Office

Rodney Washburn

Associate Chief

U.S. Border Patrol

Leon Hayward

Acting Director Field Operations

U.S. Customs and Border Protection

Stephen McConachie

Chief CBP Officer

U.S. Customs and Border Protection

Frank Russo

Port Director - JFK Airport

U.S. Customs and Border Protection

John Gallagher

Assistant U.S. Attorney

U.S. Department of Justice

Julia Quinn

Associate Director

University of Chicago Crime Lab

Inspector Martin Bruce

Vancouver Police Department

Superintendent Mike Porteous

Vancouver Police Department

Commissioner Thomas Anderson

Vermont Department of Public Safety

Colonel Matthew Birmingham

Vermont State Police

Sheriff Michael Chitwood

Volusia County (FL) Sheriff’s Office

Chief Richard Smith

Wakefield (MA) Police Department

Catherine Dhingra

Wakefield (MA) Unified Prevention

Coalition

Assistant Chief Robert Alder

Washington, DC Metropolitan

Police Department

Rachel Schaerr

Public Affairs Specialist

Washington, DC Metropolitan

Police Department

Lieutenant Andrew Struhar

Washington, DC Metropolitan

Police Department

Chief Jason Dombkowski

West Lafayette (IN) Police Department

Chief Robert Ferullo, Jr.

Woburn (MA) Police Department

Stephen Wood

Woburn (MA) Police Department /

Winchester Hospital



POLICE EXECUTIVE
RESEARCH FORUM

Police Executive Research Forum
1120 Connecticut Avenue, NW, Suite 930
Washington, DC 20036
202-466-7820
www.PoliceForum.org

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