Public Health / Public Safety Collaborations

Voiceover

00:00

This is *The Beat*—a podcast series that keeps you in the know about the latest community policing topics facing our nation.

Nazmia Comrie

00:08

Hello and welcome. My name is Nazmia Comrie, and on behalf of the COPS Office, I would like to continue the discussion with Acting Director of National Drug Control Policy Michael Botticelli and Vermont State Police Colonel Tom L'Esperance on public health/public safety collaborations and law enforcement use of naloxone in part two of this podcast series.

Acting Director Botticelli, in many instances nationwide, we have heard that implementing a naloxone program into law enforcement agencies has enhanced collaborative partnerships between public safety, community organizations, and residents to enhance solutions to the problems and increase trust. Is that the norm? In addition, Colonel L'Esperance, what impact has your naloxone program had in this regard?

Acting Director Michael Botticelli

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I think, fortunately, this concept of inclusiveness at the community level and collaboration among a wide number of stakeholders—local law enforcement, youth serving agencies, residents and families, who are impacted, health and human service agencies—I think people have understood that this is where the solutions are, that each of the community stakeholders has a role to play in dealing with this epidemic that we have here. And again, I think while people have come together over looking at overdose prevention and naloxone distribution, I think the kind of fortunate consequence and fortunate by-product of that is that it really has fostered better and enhanced communication, really looking at a holistic and comprehensive response to this issue.

Colonel Tom L'Esperance

01:40

And I would follow up that my goal is to have people call 911. And I don't want people, individuals, or groups to be afraid to call 911 anticipating they may get arrested for something that involves an overdose or potential overdose. So by having troopers carry naloxone, if that's what it takes for someone to pick up the phone and make that call immediately—because time is of the essence to get that trooper there and have them respond and, potentially, take someone out from the grips of death—that's going to in and of itself bolster a relationship in communities that we don't necessarily have a partnership with. Already we've seen some changes. We're now on a first name basis with treatment folks. I'm a true believer that law enforcement is the number one ticket to drug rehab. An arrest sometimes has to be made to get someone in there. I think if you speak to people who have been in the

program before, a lot of times that is what it takes, to hit rock bottom. So if we're there, we're trusted, we can get there and help with that level, then this program will be successful.

Botticelli

02:42

I think Colonel L'Esperance just perfectly articulated what's happening across this country and that law enforcement is seen as part of the solution to the problem. I have my own history with substance use issues and law enforcement. It took me a long time not to be afraid of the police. And I think now what we're seeing and what he just articulated was how law enforcement is part of the problem and communities are seeing law enforcement as really the ticket to treatment and quite honestly, the ticket to saving their lives.

Comrie

03:16

Thank you. Colonel L'Esperance, some agencies may be concerned about what barriers they may face in implementing a naloxone program. Did you experience any resistance from officers, executive staff, community, or policy makers, any legal barriers, and how did you respond? In addition, Acting Director Botticelli, what have you seen on the national level?

L'Esperance

03:38

Well, the training that we received initially was brought up by the Albany Medical Center and a particular doctor here in northern Vermont, Dr. Roberts. And I made it a point that I attend this training with a number of other troopers. I needed them to see and understand that this was coming from the top. I was passionate about this. Not only were we just looking into but it was going to take place; it was just a matter of how and when. But as I watched this training unfold, as I was watching the instructors, I was also watching the reaction of the troopers to kind of gauge what their thought process may be. Again, I've been on the state police for 28 years. There were troopers in there with five and 10 years, and in law enforcement, you can become cynical relatively quickly, and I just wanted to see the reaction of the troopers and how this program could roll out or how would it roll out.

Some of the materials that we used, I keyed right in on; they had a couple of addicts from Maine that were on a video discussing how they were brought out of an overdose state three and four and five times and kind of laughing amongst themselves about how insignificant it was—maybe it was significant at the time but look how we made it. And that's not the message that I really wanted going out to the troopers, because immediately, it puts them on the defensive as, "They don't even care about their own lives, so why should we care?" So I started to formulate some thoughts during the training to see if I could counter that a bit. And then I opened it right up to, you could be a first responder where you arrive at a child's house with a three year old who got into a grandparent's medicine cabinet. Would you not want to have this at your fingertips to save that child? Or if there was a homeless person, for instance, that you came upon and you're looking at this person and you're thinking, looks homeless,

doesn't care about their own life. However, they just got back from Afghanistan, from a second or third tour and developed a habit and now they're in an overdose state.

We would be jumping over each other's shoulders to save that person. Then there's everybody in between. Everybody's got a mother, a brother, a father, a cousin that loves them. Our job as first responders is first and foremost to save someone's life. I don't care if they're in a burning car after stealing or robbing a bank or if they're in fact, in an overdose state from shooting and injecting heroin into their arms. Anybody that comes on the state police or any police officer in their right mind wants to save someone's life. So I did everything I could to kind of change the conversation to the point where this is much bigger than just the everyday addict that you encounter. I don't care if it takes three or four or five times to get this person into treatment. But if we're there, we administer the naloxone. EMS then takes them to the hospital. That may be their first introduction to public—to health care. Otherwise they may never get there.

So there were some barriers. I worked with the union president very quickly. I had a conversation with Mike O'Neil, our union president. In about 20 seconds, we both agreed this is not only the right thing to do but it has to be done. Across the conversations that I've had since then, these same questions come up as most recently as Sunday afternoon. There were some chiefs, internal, that had the same questions. And I think after we opened the discussion up, to not just the addicts but—there are other potential officer safety issues related to Fentanyl. If an officer roadside is searching a vehicle and opens up a package that contains Fentanyl and gets exposed to it, the officer could or would go immediately into an overdose state, another reason to carry this. But I don't want to lose sight of the reason we carry it, which is because there is an opiate problem here in our state and we are first responders. We have an obligation to respond, to be equipped, and save that person's life.

Botticelli

07:22

I think what the colonel just articulated we hear nationally, that sometimes law enforcement agencies have some—and it's usually pretty minor—issues with it, that having this direct law enforcement to law enforcement conversation really, really helps. I actually just attended training in New York City for New York City police officers where they had videos of officer testimonials who had administered naloxone and you could see the reaction in the people who were being trained and you could see, actually, the emotion in the officers who had reversed someone and what it meant to them about saving someone's life. Lieutenant Glenn in Quincy tells this story now that a badge of honor for Quincy officers is now to talk about how many lives that they've been able to save. The colonel raised an interesting issue that merits some discussion: one of the hallmarks of some people with addiction is that they relapse, and sometimes we do have to reverse people. I don't want officers to see that as a sign that we're just perpetuating substance use by saving someone's life. And, as he articulated, this is someone's son, this is someone's daughter, someone's brother, and every life is worth saving. Our ultimate goal is to get people into treatment and recovery but we have to keep them alive to do it.

Comrie

08:48

Thank you. For law enforcement agencies interested in implementing a naloxone program, what steps did you take to implement your program and what should they know before starting the process?

L'Esperance

08:58

Well, I would recommend that they go to the tool kit right away because I think looking that over, all of the questions that were asked and raised and most of the discussions that I've had are in fact, articulated in the tool kit. So take a look at that and that will help you pave the way. For those states that have strong union representation, I would suggest you bring union representatives right into the conversation at the outset. Partner with your department of health to see what role they can play, because they are probably the most important partner to us right now. They provided the funding, the training, did some training with us where we train the trainer and have troopers in each barracks that can then do the practical piece of the training. And again, I can't emphasize this enough, it has to be emphasized from the top down. I think if you're a chief or a sheriff or colonel, you need to—not sell the program, because I don't think that does it justice—you have to push this program out with conviction and as the Acting Director mentioned again, everybody's family; there are families in law enforcement. I asked recently, I didn't need anyone to raise their hands, but if anybody in this room—and there people from all over the country—do you have someone in your family that has an addiction problem. I didn't need anyone to raise their hand, but I would suggest that 90 percent of the people in that room did, or they don't know that they do but they will find out soon enough. So this affects all walks of life, so that message from the top down and having those conversations with our partner law enforcement agencies helps, helped me anyhow, to develop the program and implement that program.

Comrie

10:34

And what type of training do you provide your officers? How often and how are you funding the training and the naloxone purchases?

L'Esperance

10:40

We have an e-learning program that troopers go online so they don't have to go to a central location to get the initial training which kind of spells out what naloxone is, the upside of naloxone, and how it can be administered. It takes about 30 to 45 minutes to go through that training. There's then a practical that we have, as I mentioned earlier, the train-the-trainer program. We have a trooper in each barracks that's been trained by our department of health to put this on, and that's about a 30-minute training, and each barracks and every trooper in the state has had that training. I think the way we're going to continue to roll out the program is implement this program with our CPR and first aid training. Honestly, I think that—you can back it up with numbers if I had done the research—that more often than not, officers across the country will save a life using naloxone as opposed to CPR. I think they're more likely to come upon someone in an overdose state than cardiac arrest. I think that answers that.

Comrie

11:39

Acting Director Botticelli and Colonel L'Esperance, with overdose being a public health concern, what would be your recommendations to other agencies on public health collaboration?

Botticelli

11:49

First and foremost, I think what has really been underscored by this conversation is two things. One, leadership, finding leaders both within your public health agencies and your public safety agencies. Get to know one another. Really focus on how do we get to know each other's issues and responsibilities and how can we present a united front here. I think that's where we've seen and you heard the colonel talk about just how impactful one dedicated leadership can be. But also the integral role that—public safety in partnership with public health really can play a strong role here. I think that these are examples of how we can make sure that we have good leadership, both at the federal level, but also at the state and local level and really what we can do and put forward with these kinds of collaborations.

L'Esperance

12:42

And I agree, Acting Director. I think some of the relationships that were developed as a result of the heroin epidemic and naloxone program have helped us in our conversations related to Ebola. The people that we're working with are the same individuals, the same groups that we worked with, for the heroin and opiate problem. So those relationships started then; they continue now and will only continue to grow. Any time where public health bisects with public safety, we have a core group of leadership that will be able to address any problem and any issue we are confronted with as a result of this program and as a result of relationships.

Comrie

13:22

Colonel L'Esperance, how do you all work with your treatment providers?

L'Esperance

13:26

In a lot of respects, we're on a first name basis now and we've brought their programs to the streets if you will. Some of our largest sweeps are arrest sweeps. We now look at those individuals that are more likely selling to provide their own habit of working with their own addiction. Those individuals that are arrested, the last person they should see in a state police barracks would be someone from the treatment side of the house. At least have a quick conversation with them, maybe provide them with some literature, that type of thing, before they go off to see a judge and/or go to jail. However, I can't lose sight of those individuals with mid-level bails or high-level bails that are either bringing heroin and other drugs into our state or are already here up and running. Those individuals are in fact going to jail. We've been able to take a look through a different lens of those who are supporting their own habits and those who are committing felonies beyond just distribution but are robbing stores and banks and

things like that. There's a different approach to those individuals, which I think is very healthy when we look at the approach to those problems as a whole. So those relationships have helped us and I hope that they will continue to grow.

Botticelli

14:38

The colonel just articulated what our national drug control policy looks like as it relates to dealing with the intersection of public health and public safety. We want to make sure that we're diverting people who come into contact with the criminal justice system largely as a function of their own addiction away. And I think we've all learned together that kind of arrest and incarcerating those folks are not only expensive but really ineffective. But what we do know is that some people, particularly traffickers, dealers, violent offenders, do need to be in jail. And so we really want to make sure that we are preserving our law enforcement resources both at the federal and state level and the local level for those folks that do need to be incarcerated and making sure that we're giving other people good care and good treatment.

Comrie

15:22

Thank you. Finally, Acting Director Botticelli and Colonel L'Esperance, what other ways can agencies engage in public health and public safety collaborations?

Botticelli

15:31

I go back to what the colonel just talked about. And I think that overdose prevention and naloxone distribution programs have spurred broader conversation about diverting people away from the criminal justice system. And we all have finite resources on the public health side and the public safety side. And so we want to make sure that we're using those resources for those folks who need it and really looking at things like diversionary opportunities to make sure that we are not just saving someone's life again, but how are we making sure that we're getting them good care and good treatment. Interaction with law enforcement can be a really powerful motivator for someone to seek care. And so they play a really critical role in the community and in someone's life in terms of strongly suggesting that someone get care and treatment. And so I think that the overdose prevention has spurred ongoing collaboration between—a continued response to not only the opioid epidemic but substance use in general by making sure that we are each using our limited resources to the best and most effective way possible.

L'Esperance

16:39

And I would follow up with the Director by saying one of the greatest advancements in law enforcement since 9/11 was the building of our fusion centers. Our fusion centers—each state has a fusion center; some have more—of gathering information and intelligence and sharing that with other law enforcement agencies. New Jersey State Police have developed a program called the Drug Monitoring

Initiative. Within that program, they're bringing together many partners from outside law enforcement to share information, not necessarily about individuals, but about the overdose deaths, tracking overdose deaths, tracking the heroin that is traveling up and down the east coast, and at fusion centers from across the country—I know DEA is involved now—sharing that type of information across the country and trying to get our arms around—say if someone overdoses in a more urban area yet they're from a rural section of the state. It may indicate that, if we have a few overdose deaths, individuals from rural sections of that state that that area of the state might need to change their prevention techniques or their treatment programs and things like that. But having all these partners enter into an agreement to share information that they can bring to the table, it doesn't violate any HIPAA rules or anything like that. I think collectively, this partnership that developed at this level with leadership in each of those entities—prevention, treatment, and law enforcement—we'll be able to share information and hopefully get a better grasp on how we can approach this issue.

Comrie

18:04

Thank you Acting Director Botticelli and Colonel L'Esperance for providing us with your expertise and time today.

Botticelli

18:09

Thank you.

L'Esperance

18:10

My pleasure. Thank you very much.

Voiceover: *The Beat* Exit

18:12

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Voiceover: Disclaimer

18:29

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