# Building Successful Partnerships between Law Enforcement and Public Health Agencies to Address Opioid Use

COPS
Community Oriented Policing Services
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# Letter from the Director of the COPS Office

Dear Colleagues,

The growing opioid and heroin epidemic is literally killing tens of thousands of Americans each year and destroying countless numbers of families across the country. To effectively respond to this challenge, law enforcement leaders must recognize and embrace two key facts—(1) addiction is a disease, and (2) any response to this challenge must be in strong partnership with the public health sector.

To learn how law enforcement agencies across the country are combating this epidemic through comprehensive approaches focused on prevention and treatment, the Office of Community Oriented Policing Services (COPS Office) hosted a forum with the White House Office of National Drug Control Policy (ONDCP) and the Police Executive Research Forum (PERF) last spring.

The following report, *Law Enforcement and Public Health: Successful Partnerships in Addressing Opioid Use*, documents the forum's discussions. It highlights new programs that bring police together with community volunteers, public defenders, health providers, and others to divert addicted individuals away from the criminal justice system and toward treatment. These programs represent a significant change from the law enforcement activities of the past, which focused almost exclusively on response to the "supply" side of the drug markets; and as the report demonstrates, they are showing great promise.

Practices such as training officers to administer life-saving naloxone to individuals who have overdosed on heroin and helping addicts get transportation to treatment centers are saving lives as well as building positive relationships between police and their communities.

On behalf of the COPS Office, I thank the ONDCP and PERF for helping to organize and host this forum. In doing so, they have generated much-needed debate on and insightful examination of the challenges surrounding prescription drug addiction while also providing practical ideas for addressing them. The interviews with public health providers, law enforcement professionals, and other forum participants are inspiring, and the innovative programs in which they are involved can serve as models for replication in other agencies.

The number of overdose deaths from opioids—including both heroin and painkillers—has approximately quadrupled since 1999, and we have to take action now to fight it. To that end, President Barack Obama proclaimed September 18–24 Prescription Opioid and Heroin Epidemic Awareness Week, and Attorney General Loretta E. Lynch has spoken at events that included a youth town hall and a meeting with parents of children who have died of overdoses. As she has said, "The heroin and opioid epidemic is one of the most urgent law enforcement and public health challenges facing our country."

I urge all law enforcement, health, education, government, and public safety leaders to read this report and share it with their colleagues. Together, we can and must make progress in combating this deadly epidemic.

Sincerely,

Ronald L. Davis
Director
Office of Community Oriented Policing Services

# Letter from the Director of the ONDCP

Dear colleagues,

We are in the midst of a national opioid epidemic. Since 1999, overdose deaths involving opioids have tripled with an average of 78 people per day dying opioid-involved overdose deaths. This is a national crisis made worse by the fact that we have a significant gap between the number of people who want treatment and our country's capacity to treat them.

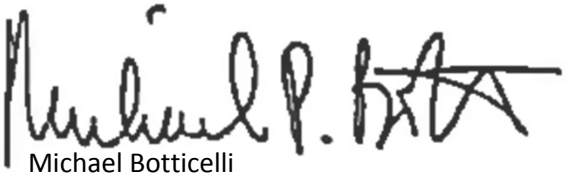
The symptoms of this national epidemic are seen on the local level, whether in the community or in the emergency room. Law enforcement officers and other first responders have a front-row seat to this crisis and are often the first to be called in the case of an overdose. Law enforcement officers are saving lives on a daily basis—and are doing it by working in partnership with public health.

Continuing law enforcement strategies to reduce the flow of drugs in our communities remain important. But everywhere I go, I hear law enforcement officials say that the solution to this crisis isn't more officers or more jails—it's more treatment. The president recognizes that we can't arrest our way out of this crisis. That's why the administration is working to expand access to treatment so people can get the care they need, reach recovery, and live healthy and productive lives.

Police departments across the country—many of which are members of PERF—are joining with public health to implement innovative solutions to help turn the tide of this epidemic in their communities by equipping and training officers to use naloxone, linking overdose victims with treatment and recovery services, supporting syringe service programs, and implementing drug take-back initiatives.

This is exactly the kind of community-driven leadership we need, and it was inspiring to be a part of the PERF symposium. Ending this crisis will take everyone working together, from the Federal Government to the local city council, from law enforcement to public health, and from parents to teachers and others in the community. We need an all-hands-on-deck approach to prevention, treatment, and law enforcement, and partnerships between public health and public safety are essential.

Thank you for all you do to serve and protect our communities. With your help, we will move our country from crisis to recovery.



Michael Botticelli
Director
Office of National Drug Control Policy

# Letter from the Executive Director of PERF

Dear colleagues,

It is no exaggeration to say that communities across the nation are in a state of crisis as we face one of the worst drug epidemics in history. Millions of Americans are struggling with opioid addictions, and the harm caused by these drugs—including heroin, prescription painkillers, and synthetic opioids such as fentanyl—is devastating. Opioid-related overdose deaths have skyrocketed to record levels. Nonfatal overdoses are also on the rise, as are infectious diseases associated with intravenous drug use, such as hepatitis and HIV. The reach of the opioid epidemic knows no bounds, and many families are losing their loved ones to death and addiction.

The most recent data from the Centers for Disease Control and Prevention (CDC) include the following:[1]

- More than 28,000 people died from opioid overdoses in 2014, which is nearly the number of people who were killed in motor vehicle crashes during that year.[2]
- In 2014 there were nearly 19,000 deaths involving prescription opioids—about 52 deaths per day. This is an increase from approximately 16,000 in 2013.
- Overdose deaths involving prescription opioids have quadrupled since 1999.
- In 2014, almost 2 million Americans abused or were dependent on prescription opioids.
- Heroin-related overdose deaths have more than tripled since 2010.

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[1] "Injury Prevention & Control: Opioid Overdose," Centers for Disease Control and Prevention, last modified March 16, 2016, http://www.cdc.gov/drugoverdose/index.html; "Opioid Data Analysis," Centers for Disease Control and Prevention, last modified March 14, 2016, http://www.cdc.gov/drugoverdose/data/analysis.html; "Prescription Opioid Overdose Data," Centers for Disease Control and Prevention, last modified June 21, 2016, http://www.cdc.gov/drugoverdose/data/overdose.html; "Heroin Overdose Data," Centers for Disease Control and Prevention, last modified March 14, 2016, http://www.cdc.gov/drugoverdose/data/heroin.html.

[2] The number of fatalities from motor vehicle crashes in 2014 was 32,675. Derrell Lyles, "Traffic Fatalities Fall in 2014, But Early Estimates Show 2015 Trending Higher," National Highway Traffic Safety Administration, last modified November 24, 2015, http://www.nhtsa.gov/About+NHTSA/Press+Releases/2015/2014-traffic-deaths-drop-but-2015-trending-higher.

Fortunately, state and local law enforcement agencies, public health departments, drug treatment providers, community groups, and a wide range of other organizations across the nation have been responding to this crisis. In an unprecedented way, all of these groups are joining forces and are working together to implement solutions. This report documents these efforts.

On April 27, 2016, the Police Executive Research Forum (PERF)—working with the U.S. Department of Justice's Office of Community Oriented Policing Services (COPS Office) and at the request of the White House Office of National Drug Control Policy (ONDCP)—held a national conference to explore how officials from many professions are collaborating to address the opioid crisis.

At our conference, we heard how there has been an evolution in the policing philosophy regarding addiction and drug enforcement. As more is known about the nature of addiction, many police officials are embracing a public health approach that emphasizes drug treatment for people struggling with addiction. Many police agencies are taking the lead in these efforts as they redefine what it means to protect and serve their communities. Although drug enforcement continues to play an important role in reducing supplies of drugs, the current thinking is that the real solution to drug addiction lies mainly in prevention and treatment and in support services for people who are struggling to overcome addictions.

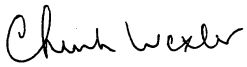
As you read this publication, which documents the discussions from the forum and interviews with forum participants, you will learn about exciting public safety-public health partnerships that are being created in many cities and towns. In Gloucester, Massachusetts, the ANGEL Program has helped facilitate treatment for hundreds of people. In Seattle, Washington, the LEAD program has brought together a broad coalition of police, prosecutors, public defenders, treatment providers, civil rights groups, and community groups to divert people away from the criminal justice system and towards the services they need.

In these and many other locations, police are administering the life-saving medicine naloxone to reverse the effects of an opioid overdose. Police chiefs report that their officers are thrilled to be saving people's lives, and these efforts have the additional benefit of helping to build trust between police agencies and the communities they serve.

Our goal in developing this publication is to assist law enforcement agencies, public health organizations, and other stakeholders as they seek to collaborate with one another to develop their own programs to address the opioid epidemic. This report provides guidance to police, public health officials, and other professionals as well as community leaders who wish to learn from the experience of those who already have built successful programs.

By coming together and sharing our experiences, expertise, and resources, we can address the opioid epidemic and strengthen our communities.

Sincerely,



Chuck Wexler
Executive Director
Police Executive Research Forum

# Acknowledgments

PERF would like to extend our appreciation to the COPS Office for supporting this effort to bring together law enforcement executives and public health experts to share strategies for responding to the opioid epidemic. We are especially grateful to COPS Office Director Ronald L. Davis for his continued leadership and guidance on critical issues in policing. We would also like to thank Helene Bushwick and Jessica Mansourian at the COPS Office, who offered support and assistance in coordinating this work.

This project was launched at the suggestion of the ONDCP, and we would like to pay special recognition to ONDCP Director Michael Botticelli for his tireless commitment to building strong partnerships between the public health and public safety sectors as we work toward common goals. We are also grateful to Mary Lou Leary and Darren Neely at the ONDCP for their leadership on this project.

Most of all, PERF would like to thank the law enforcement executives, public health experts, federal officials, prosecutors, and other experts who participated in our April 2016 forum. These leaders' candid discussions, both at the forum and during interviews with PERF staff members, are the substance of this report.

Finally, credit is due to PERF staff members who coordinated the forum, conducted interviews, and helped write and edit this publication, including Jessica Toliver, Adam Kemerer, Allison Heider, and Craig Fischer. Lindsay Miller Goodison took the lead in pulling this comprehensive report together.

# Introduction

In 2014, deaths caused by opioids—including prescription drugs, heroin, and synthetic opioids such as fentanyl—reached record-breaking levels in the United States.[3] With an estimated 78 Americans dying from opioid overdoses each day,[4] opioid abuse has emerged as a public health crisis that crosses geographic, racial, gender, and socioeconomic boundaries.

In many places, the opioid epidemic has contributed to a shift in how law enforcement agencies fight opioid abuse in their communities. Historically, many of the law enforcement efforts to curb opioid abuse have focused on using enforcement actions (including arrests and incarceration) to target drug use and distribution. However, as opioid-related deaths continue to rise and as more is understood about the nature of opioid addiction, many law enforcement officials are realizing that a more comprehensive approach is needed.

"Targeting the 'supply' side of the drug markets, which is what we've been doing for the last 50 or 60 years, is important work," said Leonard Campanello, Chief of Police for the Gloucester (Massachusetts) Police Department. "But this approach alone hasn't solved the problem. We still have more people addicted. We have more people dying. As police, we need to start looking at the problem from a public health perspective. When our communities are suffering such great losses, it is critical that we find new ways to help."

For decades, many law enforcement agencies have supported comprehensive approaches in which police provide enforcement while public health agencies, educational organizations, court systems, and others provide drug treatment and drug abuse prevention work. What is new is the extent to which the opioid epidemic has caused many law enforcement agencies to increase their own involvement in "demand-side" efforts. Today, police officers in many agencies are themselves administering naloxone to save the lives of opioid users who are in an overdose crisis and connecting people to treatment services. And some law enforcement agencies are facilitating "syringe services" programs and other

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[3] Lenny Bernstein, "Deaths from Opioid Overdoses Set a Record in 2014," *Washington Post*, December 18, 2015, https://www.washingtonpost.com/news/to-your-health/wp/2015/12/11/deaths-from-heroin-overdoses-surged-in-2014.

[4] "Understanding the Epidemic," Centers for Disease Control and Prevention, last modified June 21, 2016, https://www.cdc.gov/drugoverdose/epidemic/index.html.

harm reduction efforts and using public health data to drive policy decisions.[5] These strategies, which focus on reducing opioid-related deaths and mitigating the harms caused by opioid abuse, rely on building strong—and often unprecedented—partnerships between the public health and public safety sectors.

"If we've learned any lesson over the past 30 years, it is that there is no silver bullet solution to the opioid problem. It requires a comprehensive response, and it requires that the public health and public safety sectors work together."
– Michael Botticelli, Director, Office of National Drug Control Policy

"We cannot fix this problem with a pair of handcuffs," said Chief Scott Thomson of the Camden County (New Jersey) Police Department. "It has to be a collective effort between public health providers and law enforcement agencies. We have a shared responsibility to save lives, and by learning from each other and working together, we are moving in the right direction."

**Director Michael Botticelli,** Office of National Drug Control Policy (L)
and **Director Ronald L. Davis,** Office of Community Oriented Policing Services (R)

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[5] Treatment approaches also are being advanced by policymakers at the state and national levels. For example, in 2016 President Obama and the U.S. Congress called for broader access to opioid treatment services, and in 2015 nearly every state enacted legislation to address opioid use that included expanded treatment and services. See "Fact Sheet: President Obama Proposes $1.1 Billion in New Funding to Address the Prescription Opioid Abuse and Heroin Use Epidemic," The White House, February 2, 2016, https://www.whitehouse.gov/the-press-office/2016/02/02/president-obama-proposes-11-billion-new-funding-address-prescription; Sarah Ferris, "Congress Sends First Major Opioid Bill to Obama's Desk," *The Hill*, July 13, 2016, http://thehill.com/policy/healthcare/287656-congresss-first-major-opioids-bill-heads-to-obamas-desk; "Drug Overdose Immunity and Good Samaritan Laws," National Conference of State Legislatures, last modified August 1, 2016, http://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx.

## Project overview

On April 27, 2016, the Police Executive Research Forum (PERF), the White House Office of National Drug Control Policy (ONDCP), and the U.S. Department of Justice's Office of Community Oriented Policing Services (COPS Office) convened a forum to explore how the public health and public safety sectors can better collaborate to address the opioid epidemic. At the forum, nearly 100 law enforcement officials, public health providers, prosecutors, researchers, federal officials, and other experts discussed strategies for building partnerships and shared promising programs from the field.[6]

"Law enforcement's response to the opioid epidemic highlights how we are redefining policing for the 21st Century. Thirty years ago, we never would have been talking about taking a public health approach to drug use. Instead, we viewed this issue in very simplistic terms—if you used drugs, you went to jail. But fortunately we've evolved from that way of thinking. We now understand that to truly address this crisis, we must take a community policing approach that integrates sound public health strategies. As a result, we are now seeing law enforcement agencies leading the way in adopting innovative strategies and working with public health partners. We are now training our officers to understand things like mental health issues and addiction. This represents a profound shift in the culture of policing."
– Ronald L. Davis, Director, Office of Community Oriented Policing Services

This publication documents the discussions that occurred at the April 27 meeting as well as information gathered from individual interviews of forum participants. Each chapter includes an in-depth description of an innovative program that features collaboration between the public health and public safety sectors. The goal of this publication is to highlight these promising models and to provide guidance to other jurisdictions on how to develop and implement their own programs.

Chapter 1 of this publication discusses how law enforcement agencies, public health providers, prosecutors, and others are partnering to connect people to treatment and recovery services. The programs highlighted in this chapter, such as the ANGEL Program in Gloucester, Massachusetts, and the LEAD program in Seattle, Washington, represent innovative approaches that are being adopted throughout the country.

[6] A complete list of forum participants is included in the appendix of this publication. The titles used for participants throughout this document generally reflect their positions at the time of the April 27, 2016, forum.

Chapter 2 focuses on the use of naloxone by law enforcement agencies to reverse the effects of opioid overdoses. This chapter discusses the benefits of naloxone programs and shares strategies for addressing the issues raised by naloxone deployment such as liability concerns and how to fund these programs.

> "As a sheriff, I see first-hand the toll that addiction has taken on my community. In 2015, we had 65 people lose their lives as a result of an opioid overdose. This epidemic is not just a public health issue or a public safety issue—it is both. We must do everything we can to address this crisis, just as we would if we had 65 people dying of gunfire last year."
> – David Mahoney, Sheriff, Dane County (Wisconsin) Sheriff's Office

Chapter 3 discusses programs aimed at reducing the rise of HIV, hepatitis C, and other infectious diseases that are spread when people share contaminated needles and syringes. This chapter explores the benefits and challenges of implementing syringe services programs and examines the role that law enforcement agencies can play in these efforts. Programs such as the Cabell-Huntington Harm Reduction Program in West Virginia are highlighted as models for how to develop and implement these types of initiatives.

Chapter 4 looks at how law enforcement agencies and public health organizations can use public health data to develop policies and programs aimed at addressing opioid abuse. The issues explored in this chapter include the barriers to collecting and accessing data, and strategies for improving information-sharing between partners. The initiatives examined in this chapter, such as the RxStat Program in New York City, show how the public health and public safety sectors are effectively sharing and using data to save lives and reduce drug abuse.

> "The public health and public safety sectors often see the opioid issue from different sides, so we can learn a lot from each other if we truly listen to one another and respect these different perspectives. That is the key to building better partnerships and working together to address this problem."
> – Lisa Roberts, RN, Portsmouth City Health Department, Ohio

### Building Effective Public Safety-Public Health Partnerships

At the April 2016 forum, participants shared some of the principles they have found useful for building better partnerships between law enforcement agencies, public health organizations, treatment providers, and other stakeholders.

1. Find common ground and work toward shared goals.

*"Before even talking about what strategies to implement, we first have to ask ourselves, what are we trying to accomplish? What is our primary goal? Once we've reached agreement on that, then we can use that goal as the North Star to guide all of our efforts and to hold ourselves accountable for how we're doing."*
*– Chauncey Parker, Executive Assistant District Attorney and Special Policy Advisor, New York County District Attorney's Office and Director, New York-New Jersey High Intensity Drug Trafficking Area*

*"Sometimes we come at these issues from different perspectives, so it can be easy to think that we're at odds. But in reality, the law enforcement side and the public health side usually have the same goals. So find common ground, and use that to get over the wall of disagreement."*
*– Katherine Bryant, Assistant Chief of Police, Fayetteville (North Carolina) Police Department*

*"There is a need to get everyone on the same page, because we aren't always speaking the same language. But public safety and public health can mean the same thing in some situations, especially when we talk about the impact of opioids. So we need to find those commonalities and remember that, at the root of it all, we all want the same thing: to have fewer people becoming addicted to opioids, fewer people dying, and fewer people committing crimes."*
*– Caleb Banta-Green, Senior Research Scientist, University of Washington Alcohol and Drug Abuse Institute*

*"Find areas where people agree, then try not to let the areas where they disagree derail the entire project."*
*– Corey Davis, Deputy Director, Network for Public Health Law*

*"Partnership and engagement begins with meeting on neutral ground. Then it's moving forward with joint action that everyone can agree to. Even if people are on different ends of the spectrum, you can always find something in the middle."*
*– Robert Childs, Executive Director, North Carolina Harm Reduction Coalition*

2. Respect and learn from one another's positions and perspectives.

*"The key is to respect each other and try to understand where the other side is coming from. We can really expose each other to different facets of this epidemic, which is so important if we're going to truly understand it and figure out how to address it. Here is an example. The Huntington [West Virginia] Police Department sent some veteran officers to Portsmouth to learn about our syringe exchange. These officers had never been exposed to some of the concepts of addiction and harm reduction, but as we shared stories and told them about our experiences, they really began to understand and see the value of the program. You need to keep these lines of communication open, even when there are differences."*
*– Lisa Roberts, RN, Portsmouth City Health Department, Ohio*

*"Make sure you can have an open and honest dialogue. Have the hard conversations and hear the other side's frustrations."*
*– Paul Liquorie, Captain, Montgomery County (Maryland) Police Department*

*"A multidisciplinary approach is the strongest. As law enforcement began to recognize that we can't arrest our way out of this problem, we have begun to work with organizations we had not considered partnering with before. This approach allows us to attack the problem from multiple angles."*
*– Christina McNichol, Special Agent in Charge, Wisconsin Department of Justice*

*"When we work with police agencies, we try to frame our trainings from the police standpoint, rather than just talking about public health. We want to speak the language of police. Often people on the public health side don't do that, but it is so important because police have different incentives and metrics than we do. And by talking about the issues in a way that resonates with police, it helps us find common ground."*
*– Leo Beletsky, Associate Professor, the Northeastern School of Law and Bouvé College of Health Sciences, Massachusetts*

3. Involve people from all levels within an organization.

*"People will be much more excited about a project if they have a chance to take ownership over it. Don't just go in and demand information – be able to give them something back! Plus, bringing in people from all levels, and from a variety of disciplines, can give projects more depth and relevance."*
*– Juan Colon, Captain, New Jersey State Police and Bureau Chief, Information & Intelligence Support Bureau*

*"It is sometimes easier to create real, lasting relationships when you build coalitions that include the people who are on the ground—people like the officers who are out in the field, the social workers who are working with clients. They are the ones who have a first-hand understanding of what challenges exist in the community and what help is needed. When you bring these front-line people to the table, it can lead to concrete progress and relationships that are institutionalized throughout an entire organization."*
*– Michael Baier, Overdose Prevention Director, Maryland Department of Health and Mental Hygiene*

4. Be open to expanding your perspective and accepting new roles.

*"Learn what is going on in the community and what other local agencies are doing. Ask if you or someone else could be doing something different, and then be a problem solver! And be open to the suggestions that others give you. This isn't a health problem, and it isn't a police problem. It is everyone's problem. Once you break down those barriers and others can look past your uniform and see that you are there to help, you can build bridges and strengthen trust."*
*– Paul Kifer, Captain, Hagerstown (Maryland) Police Department*

*"As police, we need to get out of our lane sometimes and recognize that we are not just law enforcement—we are a resource to the community, and we have a responsibility to strengthen communities just like the schools, human services departments, parks departments, and other local agencies. We need to engage people in positive activities that are safe and productive so that they don't end up in engaged in criminal or drug-related activities. And the police need to be a part of that effort."*
*– William Dean, Deputy Chief, Virginia Beach (Virginia) Police Department*

5. Maintain a community focus.

*"We all need to remember that the ultimate goal of these programs is to help our communities. So we need to keep an eye towards the community at all times. Our responses need to be defined by the community—not in the privacy of the police station or a health department. We need to ask people throughout the community for feedback and ideas. Not only will this lead to more effective programs, but it will also help build trust."*
*– Frederick Ryan, Chief of Police, Arlington (Massachuetts) Police Department*

# 1. Partnering to Provide Access to Treatment and Recovery Services

With the rise of the opioid epidemic, law enforcement agencies have played an increasing role in connecting people to drug treatment and recovery services. For example, a number of police agencies are now acting as the primary access point within the community for people seeking treatment for opioid addictions. In other places, police agencies are proactively conducting outreach to identify people struggling with opioid use and to offer assistance with treatment and other services. Some police agencies are also partnering with prosecutors to divert nonviolent drug offenders into treatment rather than placing them in the criminal justice system.

These types of initiatives require strong collaboration between the public health and public safety sectors, because the responsibility of connecting people to treatment—which has traditionally fallen primarily on social service and health providers—is one that many law enforcement officials never expected to take on.

> "Data have shown that the best use of police resources is to help people struggling with opioid addictions get into evidence-based treatment, rather than putting them into jail. This is true from a public health standpoint as well as a public safety standpoint. If the goal is to reduce opioid-related deaths, then treatment is the best option. If the goal is to reduce the number of people breaking the law because they're dealing with an addiction, then treatment is also the best option. There is a lot of rhetoric around the idea of not being able to arrest our way out of this problem, and ensuring access to appropriate treatment is a way to operationalize this rhetoric. It truly benefits everyone."
> – Corey Davis, Deputy Director, Network for Public Health Law

Several factors have contributed to this shifting role for law enforcement. First, a lack of resources for social services has created a gap in services and treatment—a gap that local police agencies have increasingly been asked to fill. "As police, we are often the most visible face of local government," said Camden County (New Jersey) Police Chief Scott Thomson. "And in the midst of this opioid crisis, people

in the community are asking us for help in part because they don't know where else to turn. Even though this isn't a role we are used to playing, it is important that we step up and take on this responsibility, that we be champions for our communities."

Second, an approach centered on treatment reflects the growing body of research on the nature of drug addiction, which demonstrates the benefits of emphasizing treatment over arrest. For example, the National Institute on Drug Abuse (NIDA) found that "according to conservative estimates, every dollar invested in drug addiction treatment programs yields a return of between four and seven dollars in reduced drug-related crime, criminal justice costs, and theft."[7] When factoring in additional savings related to health care costs, the total savings of treatment programs exceed their costs by 12 to 1.[8]

Third, this approach reflects a better understanding of the unintended consequences of enforcement actions that are not accompanied by a treatment component. "One thing we have seen is that when you simply constrict the supply of one type of drug, such as prescription opioids, it can cause people to just shift to another type of drug, such as heroin," said Leo Beletsky, an associate professor at the Northeastern School of Law and Bouvé College of Health Sciences.

"When we are out there arresting drug traffickers and dealers, we have to remember that we are taking drugs away from people who are addicted," said Chief Fred Ryan of the Arlington (Massachusetts) Police Department. "What are we doing to ensure that they are getting the treatment they need so they don't get sick or seek out even more dangerous drugs? If the answer is nothing, then we are missing out on a critical opportunity."

"The drug policies and programs we are seeing now reflect science much more than they did in the past," said Mary Lou Leary, Deputy Director of the Office of Policy, Research, and Budget at the ONDCP. "We now understand that addiction is a chronic disease, much like diabetes or heart conditions, and so while we still must focus efforts to reduce the supply of drugs, we must also incorporate strategies like treatment that lift up and support people struggling with addiction."

**Mary Lou Leary,** Office of National Drug Control Policy

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[7] *Principles of Drug Addiction Treatment: A Research-Based Guide*, third edition (Washington, DC: National Institute on Drug Abuse, 2012), 13, https://www.drugabuse.gov/sites/default/files/podat_1.pdf.

[8] Ibid.

## Challenges with connecting people to treatment and recovery services

Although many law enforcement officials and public health experts agree that connecting people with drug addictions to treatment services is a growing function of law enforcement agencies, this approach can raise many challenges.

First, many law enforcement agencies do not have the resources or expertise to act as the primary access point to treatment and recovery services. This is why police agencies should partner with public health organizations and other service providers when undertaking these types of efforts. "It isn't realistic to expect law enforcement officials to be experts in public health. People in the public health and harm reduction communities need to step in and help fill some of these gaps," said Daniel Raymond, policy director of the Harm Reduction Coalition.

"Law enforcement agencies have done a good job of stepping in and taking on the role normally played by social service providers. They have been innovating from the grass roots level to address the problem that they're seeing in their communities, and it has really been inspiring. In many cases they have had to do this, because social services were underresourced and police couldn't just stand by and see their communities suffer. But connecting people to treatment isn't traditionally a law enforcement function, so they can't—and shouldn't—do it alone. We are in crisis mode, and the bottom line is that we need more resources for treatment and social services if we are going to solve this problem."
– Leo Beletsky, Associate Professor, the Northeastern School of Law and Bouvé College of Health Sciences, Massachusetts

Second, in many places there is a significant lack of treatment resources. "The biggest problem in our area is a lack of treatment capacity," said Captain Paul Kifer of the Hagerstown (Maryland) Police Department. "It is so frustrating to encounter someone who wants help and not be able to give it to them. We've had situations in which a person sought help on a Friday, but a treatment spot wasn't open until Monday. That's too long for people to wait. They are often using again by Saturday."

In many other locations, backlogs for various types of drug treatment can result in waiting lists lasting weeks or months. "As I talk to local law enforcement officials about what they need from the Federal Government to fight this opioid epidemic, I'm hearing more and more requests for treatment resources.

Not more officers, or stricter penalties, but funding for treatment. This represents a significant change in how law enforcement thinks about addressing drug abuse, and it is a request we should pay attention to," said ONDCP Director Michael Botticelli.

Finally, it can sometimes be difficult to secure support for programs that shift a police department's focus away from traditional drug enforcement and towards connecting people to treatment. Some officers may feel that it is not their responsibility to act as social service providers, and some members of the public may fear that de-emphasizing arrest will lead to an increase in crime. In addition, some prosecutors may feel uncomfortable with the amount of discretion these programs afford to police officers when it comes to deciding whom to arrest and whom to divert to treatment.

"A lot of police officials across the country are going out on a limb and taking a leadership role in adopting innovative treatment-based approaches," said James Baker, Director of the Advocacy Team for the International Association of Chiefs of Police (IACP) and former chief of police for the Rutland (Vermont) Police Department. "But they are also getting some pushback from the public, from prosecutors, and from local officials about whether this is the right approach to take. We have to recognize the risks that these police officials are taking and find ways to demonstrate why the treatment-based approach, combined with targeted enforcement against traffickers, is important."

**Tisha Wiley**
National Institute
on Drug Abuse

Tisha Wiley, Health Scientist Administrator with NIDA, said, "In terms of implementing interventions in places or organizations where there might be ideological resistance, it is often helpful to use research and data to demonstrate the intervention's effectiveness. We see this with things like medication-assisted treatment [MAT], which is sometimes hard for people to embrace. But if you show people the research around MAT, and how effective it can be at treating addiction, it can help people understand why it is an important treatment option. This can be particularly powerful if you help an organization use their own data to track outcomes. The attitudes aren't necessarily easy to change, but showing that something works can usually help especially when it is combined with other supports that help an organization figure out how MAT can fit with their existing practices."

"We're seeing a lot of police chiefs and sheriffs stepping up and taking the lead on this issue, and I think people are beginning to understand that we're not looking to arrest our way out of it. However, it may be challenging for law enforcement officials to implement some of the new programs discussed due to the lack of familiarity by their constituents. That is why it is critical to educate people about what we're doing and why it is important."
– Dwayne Crawford, Executive Director, National Organization of Black Law Enforcement Executives

As the programs highlighted in this chapter will demonstrate, the benefits that come with connecting people to treatment can help address these concerns and create support for these initiatives within the community. And for many police officials, prosecutors, and public health experts, any risks that come with implementing a treatment-based approach are far outweighed by the urgent need to take action.

"I'm an elected official, and I know I'm taking a political risk by supporting some of these more innovative drug diversion programs," said Michael McMahon, the District Attorney for Richmond County, New York. "But the stakes are too high to keep on doing the same things that we've always done. This opioid epidemic has reached a critical mass, and so we have to be willing to take these risks and do what we think is right."

The remainder of this chapter highlights four programs that involve partnerships between law enforcement agencies, public health agencies, service providers, and other stakeholders to connect people with opioid addictions to treatment rather than placing them in the criminal justice system. These programs illustrate the benefits and challenges associated with this approach. By examining how these programs were developed and implemented, officials in other jurisdictions can consider similar strategies to help address the opioid crisis in their communities.

## The ANGEL Program, Gloucester, Massachusetts

**Leonard Campanello**
Gloucester (MA)
Chief of Police

In 2015, Leonard Campanello, Chief of Police of the Gloucester (Massachusetts) Police Department, was disheartened by the toll he saw opioids taking on his community. "We were seeing overdose deaths climb each year, and there was so much loss and suffering. We were on track for our 2015 overdose rates to double our losses from 2014, and it just wasn't acceptable," Campanello said.

Recognizing that traditional enforcement tactics were not doing enough to halt the epidemic, Campanello began exploring creative solutions. Part of that process involved listening to what the community wanted. "We listened to people in our community, and they were clear that they did not want people with addictions to have their problems exacerbated by being put in the criminal justice system. They wanted us to be proactive and address the problem before it comes to an arrest," he said.

Although the police department still devotes resources to addressing the supply of opioids through enforcement, Campanello decided that a comprehensive approach required a similar focus on reducing the demand for opioids. Campanello worked to identify and remove the barriers to people seeking treatment, and the result was the development of the ANGEL Program, an innovative partnership between public health and public safety that places the police department front and center in the efforts to connect people to treatment. The ANGEL Program started in Gloucester, and more than 140 police agencies in 25 states have since adopted all or part of the program.

"With the ANGEL Program, we have created a compassionate entry point for anyone seeking treatment. And the fact that law enforcement took the lead on this was a game changer. When a police department says, 'We are here to help you, not to arrest you,' it legitimizes the idea that people who are struggling with addiction need treatment, not jail. It has helped change the national conversation around addiction and the need for long-term treatment, just like any chronic disease."
– John Rosenthal, Co-Founder and Chairman, Police Assisted Addiction and Recovery Initiative

### *How the Gloucester Police ANGEL Program works*

Through the ANGEL Program, which started on June 1, 2015, people seeking help for an opioid addiction are invited to contact or present to the Gloucester Police Department, which will connect them directly to treatment services. Those requesting help through the program are not charged with a criminal offense even if they are in possession of drugs or drug paraphernalia. Under this model, the police department acts as a direct entry point to the treatment process.

"In the beginning, we went out into the community and invited people to come down to the police station if they needed help," Campanello said. "We assured them that we would not arrest them unless they had an outstanding warrant—that we were there to help them, not judge them." Gloucester patrol officers can also use their discretion to identify candidates for the program while they are interacting with people in the field. If an officer thinks a person is a good fit for a treatment program, the officer can encourage the person to go to the station and get help.

Before long, the Gloucester Police Department was assisting 20 to 30 people per week as part of the program. Following is the general process that occurs when a person requests help through the ANGEL Program in Gloucester:

- **The person goes to the police station to request assistance.** People may turn drugs and drug paraphernalia in at the police station and not face criminal charges.
- **The watch commander conducts intake.** The watch commander works with the person to fill out an intake form (which is about four pages long) and assigns an officer to remain with the person until a volunteer "angel" arrives. The ANGEL Program policy states that "all officers having contact with anyone requesting help with their addiction will be professional, compassionate, and understanding at all times."[9] Officers who are participating in the program receive training on the policy and on how to complete the intake forms.
- **A volunteer "angel" arrives to assist the person seeking help.** Angels are volunteers from the community who are called in by the watch commander to sit with the person and provide comfort, conversation, food and drinks, and other assistance. There are approximately 60 angels in Gloucester who provide support during the intake process at the police station. Angels receive an orientation, but they are not necessarily trained recovery coaches or advocates. "The main thing we want in an angel is someone who can be a comforting presence and hold a person's hand in a crisis," Campanello said.

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[9] *Gloucester Police Department: Volunteer ANGEL Program* (Gloucester, MA: Gloucester Police Department, n.d.), http://paariusa.org/wp-content/uploads/sites/46/2015/08/Angel-program-policy-Aug-7-2015.pdf.

- **The watch commander coordinates placement at a partner treatment center.** As the angel sits with the person requesting help, the watch commander contacts partner treatment facilities to find an open space. When an open treatment spot is identified, the space is reserved and admission to the facility is coordinated over the telephone.
- **Transportation to take the person to the treatment center is arranged.** The police department partners with ambulance companies, taxi services, and car sharing programs to provide discounted transportation services.

The only people who are not eligible to receive assistance through the program are those who have an outstanding arrest warrant, are younger than 18 and do not have consent from their parent(s) or guardian, pose a potential danger to the angel volunteer, or have three or more drug-related arrests on their criminal record (a single arrest is disqualifying if it resulted in a conviction for possession with intent to distribute, trafficking, or drug violation in a school zone).

The ANGEL Program also works to re-place people who have previously participated in the program but have relapsed.

### *ANGEL Program partnerships*

The Gloucester Police Department now partners with 250 treatment providers in 28 states, including 35 facilities in Massachusetts. Each of these treatment centers is willing to accept referrals from police departments participating in the ANGEL Program, and each has provided a minimum of two scholarships to help people who may not have insurance.[10]

When a patient arrives at a treatment center, a clinician conducts an assessment to determine which type of treatment is appropriate. “People need to remember that there are a lot of different types of treatment out there,” said Donna Pellegrino, a vice president with Spectrum Health Systems, Inc., which is a partner in the ANGEL Program. “The range of options may include short-term detox, residential treatment, medication-assisted therapy, outpatient programs, or long-term recovery support programs. For us, it is about taking the time to work with the patient so that we can understand what they need, and they can understand what kind of help is available,” Pellegrino said.

Spectrum Health Systems, which is based in Massachusetts, works with nearly half of Gloucester’s ANGEL Program participants. “We work very closely with the Gloucester Police Department. I will sometimes get calls from the police station at 3:00 in the morning, asking if we have space available to help someone. We make sure to get that person into the appropriate level of care, whether it is detox or outpatient services,” said Pellegrino.

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[10] Treatment for Massachusetts residents is covered by state health insurance programs.

In addition to treatment centers, the Gloucester Police Department partners with many local businesses that support the ANGEL Program. For example, many pharmacies in Gloucester offer discounted naloxone, which reverses the effects of opioid overdoses. Campanello said that one of the key partnerships is with the local transportation companies. “An ambulance company approached us and said that one of the primary barriers to people seeking treatment is that they can’t afford to pay for a ride to the treatment center. So they offered to take ANGEL Program participants to any facility in Massachusetts for just $75.00, which is a huge discount,” Campanello said. “We have taxi companies that have offered to take people to a treatment facility or airport anywhere in the state for free. We’re working with car service companies to work out similar partnerships, including possibly installing buttons for naloxone and training drivers how to use it.

“The ANGEL Program is all about saying to people struggling with addiction, ‘Here is a point person. Here is someone you can call.’ It’s about personal, direct relationships between people in the police department and people in the community. It’s about relationships between public safety, local government, and treatment providers. And it’s about changing the conversation about how we deal with addiction.”
– Donna Pellegrino, Vice President of Business Development, Spectrum Health Systems, Inc.

“We haven’t really had any trouble finding partners,” Campanello noted. “These partnerships have developed very organically for us. We’ve found that when a law enforcement agency announces an initiative to address the demand side of the issue, we have people reach out to us. It has been pretty incredible to see how much people want to help.”

### *Changing the policing philosophy*

To make an initiative like the ANGEL Program work, there needs to be support for the program throughout all levels of the police department. Some law enforcement personnel may be initially hesitant to embrace a program that makes a police department the entry point for drug treatment.

“There is a mindset that can permeate a department,” Campanello said, “where people think, ‘This isn’t the job of the police—what are we doing, getting involved with getting people into treatment?’ But then we look at the lives we’re saving, and the help that we’re giving to people in our community, and we realize that we have no choice but to step in. Law enforcement has never been so poised to make a big impact as it is right now.”

Campanello noted that implementing the ANGEL Program required everyone in the police department to change how they view addiction. “We have outlawed the word ‘junkie’ within the department,” he said. “We are reinforcing to officers that they must treat everyone with respect, dignity, and compassion.”

### *ANGEL Program outcomes*

Although the ANGEL Program is still relatively new, Campanello is encouraged by the program’s preliminary outcomes. He said the police department has seen tangible benefits such as a reduction in overdose deaths and crimes usually associated with addiction as well as intangible benefits including improved pride, trust, and relationships between the police department and the community.

#### Accomplishments in the Gloucester ANGEL Program’s First Year

Between June 2015 and June 2016, the Gloucester ANGEL Program accomplished the following:

- The program facilitated treatment for more than 450 people from around the country, approximately 40 percent of whom were from the Gloucester area. All were placed into treatment. The Gloucester Police Department receives an average of four to five people per week.
- Gloucester reduced overdose deaths from five during the first six months of 2015 to one overdose death during the whole first year of the ANGEL Program.
- There was a 31 percent reduction in crimes usually associated with addiction such as shoplifting and breaking and entering.
- Compared to making arrests, the Gloucester Police Department saves money by facilitating people’s entry into treatment rather than into the criminal justice system. According to Chief Campanello, it costs an average of $55 to help get one person into treatment compared to $220 to arrest, process, and hold one person for just a single day.

According to people involved with the ANGEL Program in Gloucester, the program has had a positive impact on the way that the public views addiction and treatment as well as their police department. "Through the ANGEL Program, the Gloucester Police Department has changed the conversation around addiction," Pellegrino said. "When a law enforcement agency publicly agrees with the medical community that that addiction is a disease, it reduces the stigma and shame involved with seeking treatment."

John Rosenthal, the co-founder and chairman of the Police Assisted Addiction and Recovery Initiative (PAARI), a nonprofit organization created to sustain and expand the ANGEL Program throughout the country, said that the ANGEL Program has helped strengthen police-community relationships in Gloucester. "People in Gloucester love the fact that the police department recognizes that people need treatment, not jail. They have a renewed trust in their police. This program has saved lives and been a game changer in the national conversation about the need for long-term treatment for the growing number of people suffering from the disease of addiction," Rosenthal said.

Researchers at the Boston University School of Public Health are currently studying the ANGEL Program to better understand the program's long-term impact on relapse and recovery. Although the study is ongoing, preliminary results have been encouraging. "So far we are seeing that program participants have lower relapse rates than average," Rosenthal said. "It is still early, but we are excited at the difference that the ANGEL Program is making."

> "We've seen some really promising outcomes with the ANGEL Program. Not only has it helped improve trust between our police department and the community, but we've had fewer overdose deaths and a drop in ancillary crimes tied to drug addiction. We're also finding that it is cost effective. It just demonstrates how if we are going to recognize that addiction is a disease, it won't work to arrest our way out of it. We've learned that by listening to people struggling with addiction, listening to their families. It requires us to make a philosophical change, but we can't argue with the logic anymore."
> – Leonard Campanello, Chief of Police, Gloucester (Massachusetts) Police Department

### *Expanding the ANGEL Program: The Police Assisted Addiction Recovery Initiative*

As the ANGEL Program grew in Gloucester—and as the program's benefits became evident—Campanello began exploring ways to sustain the program and to potentially replicate it in other cities. He reached out to Rosenthal, a local business person with a history of involvement in public safety and justice issues and gun control efforts, and together they founded PAARI, a nonprofit organization dedicated to sustaining, expanding, and replicating the ANGEL Program by raising money to help fund treatment, transportation, and startup costs for police departments interested in creating a similar program in their communities.

As of August 2016, PAARI has helped 140 law enforcement agencies in 25 states adopt some or all elements of the ANGEL Program. Rosenthal, who chairs PAARI, said that the organization is working with more than 100 additional agencies that have inquired about the program. "I've been amazed at how quickly people have embraced changing the conversation around law enforcement's response to addiction," he said. "People are coming to understand that this is a disease that knows no bounds, and that treatment—not jail—is what is needed. Until the health care system stops discriminating against people with the disease of addiction versus how they treat people with every other chronic illness, police have once again helped to fill this huge void like so many others. Long term, the health care systems will have to step up and create long-term care for this disease just like it has for cancer, heart disease, and diabetes."

Campanello recognizes that what has worked in Gloucester may not work in every community. However, he said that this should not stop law enforcement agencies in other places from exploring programs to help connect people to treatment. "There is no single law enforcement-initiated program that will fit everywhere. But there isn't a law enforcement agency in the country that can't do something to attack the demand side of this issue, whatever that program looks like," Campanello said.

## The LEAD program, Seattle, Washington

The Law Enforcement Assisted Diversion (LEAD) program, which started in Seattle, Washington, in 2011 and is expanding throughout the country, demonstrates the progress that can be made when unlikely partners come together to solve problems within their community.

The LEAD program involves the pre-arrest diversion of low-level drug offenders into treatment and support services rather than into the criminal justice system. It began after years of legal challenges brought by the American Civil Liberties Union (ACLU) and the Public Defender Association (PDA) alleging racial disparity in the Seattle Police Department's drug enforcement operations, according to Lisa Daugaard, Policy Director for the PDA's Racial Disparity Project and a co-founder of the LEAD program. "After eight years of fighting one another on this issue, we realized that we weren't getting anywhere," Daugaard said. "We eventually sat down with the police department, and they asked, 'What do you want us to do to solve this problem?' And we realized that we had no idea. We were very good at criticizing the police, but we weren't offering any useful alternatives."

"We were all frustrated by the years of fruitless litigation," said Dan Satterberg, the King County, Washington, Prosecuting Attorney. "So we all came together and had a frank conversation about how we could solve this problem. We knew weren't going to litigate our way out of it. We had to find a better option."

What emerged from this conversation was a coalition of law enforcement agencies, prosecutors, elected officials, civil rights organizations, and community groups whose focus was to find solutions to the negative impact that traditional drug enforcement policies had on people in the community. "Unlike a lot of programs, the LEAD program didn't arise just as a response to the opioid epidemic or overdose deaths. It arose as a response to the way that lives were being affected by being put into the criminal justice system, especially for low-level drug offenses," said Daugaard.

"The big question that we are asking is, 'If we are no longer fighting the war on drugs, then what are we doing? What comes next?' The LEAD program is a big piece of the emerging set of answers to that question. This program is about more than just addressing the current opioid crisis or the stigma of incarceration and punishment. It is also about reducing disparities in policing. In that sense, the LEAD program gets at what it really means to implement the President's [Task Force on] 21st Century [Policing] recommendations."
– Lisa Daugaard, Policy Director, Public Defender Association's Racial Disparity Project, Washington

### *Developing the LEAD program*

The first step in developing the LEAD program was to gain an understanding of what people in the community wanted with respect to how law enforcement agencies responded to drug use. Members of the ACLU and PDA conducted informal focus groups with community organizations, particularly in communities of color, and incorporated the feedback as they explored policy options.

"Initially, our thought was that police should not be involved with drug users at all—that there should be a complete moratorium on low-level drug sting operations. But then we talked to leaders in communities of color and found that this wasn't necessarily what they wanted," Daugaard said. "They wanted what other communities offered for people with addictions—not neglect but treatment. They didn't want people in their communities thrown in jail for using drugs, but they didn't want them to be ignored. They called instead for a supportive framework that treats drug addiction as a health condition and that provides services and help for people before they get entangled in the criminal justice system. That is where the idea for the LEAD program was born," she said.

As the focus of the LEAD program took shape, Daugaard and others set about securing support from a wide range of community partners. They developed a policy coordinating group that included the Seattle Mayor's Office, the King County Executive's Office, the Seattle City Attorney, the King County Prosecutor, the King County Sheriff's Office, the Seattle Police Department, the Seattle City Council, the King County Council, the PDA, and the ACLU of Washington. "Never before had there been this kind of 360-degree rallying around an alternative paradigm. We built up support based on what we found in the focus groups, and we had the momentum to really get things started," said Daugaard.

### *How the LEAD program works*

The LEAD program focuses on diverting low-level drug and prostitution offenders into community-based treatment and support services, rather than into the criminal justice system at the time of arrest. Services are not limited to drug treatment; they can also include assistance with housing, health care, job training, and mental health support. The program requires strong communication and coordination between law enforcement agencies, prosecutors, and service providers.

The LEAD program generally involves the following components:

- **The initial contact and decision to divert.** Upon encountering someone who would typically be arrested for a nonviolent, nonfelony offense such as drug possession, prostitution, or a minor property crime related to addiction, a law enforcement officer uses discretion to determine whether the person would be a good candidate for diversion. This decision is based on the officer's engagement with the person and the person's willingness to participate in the program. King County Prosecuting Attorney Satterberg said that his office has no legal concerns about giving this discretion to officers. "Police have always had discretion when it comes to arrest decisions, so this is really nothing new," he said. "It's better to use discretion in this way." Daugaard said that the discretion is

guided by a well-defined operational protocol that officers must follow. Officers may also consult with prosecutors or a program case manager (or both) to determine if a person is a good fit for the program.

- **Coordination with prosecutors.** When someone is selected for diversion, the officer follows the initial arrest protocols (e.g., placing the person under arrest, writing a case report, collecting evidence), makes the arrest, and writes a case report according to usual protocol. However, the officer then flags the case as a LEAD case and immediately contacts the prosecutor, who agrees not to file charges as long as the person enters a treatment program or participates in services within 30 days. Daugaard notes that prosecutorial discretion is one of the keys to the LEAD program. "The prosecutor's role is one of the program's core features. You need to have them at the table to make it all work," she said.

- **Coordination with case managers.** After making the arrest, the officer also contacts one of the program case managers, who are available 24/7. The case manager meets with the person to develop an individualized intervention plan, which seeks to address the root problems underlying the person's addictions or criminal behavior. "We don't frame this to people as just getting drug treatment, because a lot of the people we encounter may not yet be at the point where they accept that they need treatment. Instead, we ask people to identify the need that is driving the crisis they are in, which may be unemployment, homelessness, or family problems. By developing a plan to address those problems, we find that people are ultimately willing to engage in drug treatment, even if it wasn't their self-identified goal at the outset," Daugaard said.

- **Case follow-up.** The King County Prosecutor's Office, which has one full-time deputy prosecutor and one part-time legal assistant dedicated to the program, tracks the progress of program participants. If a participant enters treatment within 30 days of the arrest, prosecutors agree never to file charges on that arrest. If a participant has a new arrest for a low-level offense while in the program, prosecutors use discretion to decide whether to file charges on the new arrest. "This is a harm-reduction program, and the focus is on long-term changes to a person's behavior—not necessarily abstinence. If we think charging someone with a new arrest will derail the person's treatment, we won't file charges," said Satterberg.

"From the criminal justice perspective, we all had to wrap our heads around the idea of a harm-reduction model rather than a zero-tolerance, abstinence model. But we've seen that it works. People who are participating in the program are getting services that they may not have gotten otherwise. Police officers, prosecutors, and case managers are consulting with each other for the first time. And people throughout the community are supportive of these efforts."
– Dan Satterberg, Prosecuting Attorney, King County Prosecuting Attorney's Office, Washington

### *LEAD program partnerships*

Collaboration between law enforcement agencies, prosecutors, and case managers is at the center of the LEAD program. Each of these groups plays a critical role in the program's success, and according to Satterberg the partnerships they have forged have been effective. "We have law enforcement agencies acting as the gatekeepers, prosecutors who are dedicated to the program, and case managers who are experts at navigating the system and facilitating support services. Everyone has bought into the mission of reducing harm to the community," he said. The LEAD program also involves partnerships with local community organizations including local business groups, residential public safety groups, and civil rights organizations.

"Today we are sitting here at the table together—public defender, prosecutor, and police—and we are on the same page about what needs to be done. That sort of partnership didn't happen for us until the LEAD Program came along. It has brought us together in a way that nothing else had."
– John Urquhart, Sheriff, King County Sheriff's Office, Washington

Several key partners have also been instrumental in providing the resources to develop and sustain the LEAD program. The program was initially funded under a four-year grant from the Ford Foundation, and Daugaard credits this assistance, as well as that from the Open Society Foundations and other private groups, for getting the program off the ground. "When we started the LEAD program, it was in the middle of the recession, and so local public funding options were limited," Daugaard said. "These private foundations took an amazing leap of faith with us, but I think they saw an opportunity for this program to make real change to the status quo."

Daugaard said that the support of local elected officials has also been critical. The City of Seattle and King County have stepped in to provide funds to double the size of the program, and Daugaard said that government partners regularly reach out to find ways to get involved.

"The LEAD program is based on a relationship-building model. You must have robust partnerships for this to work. It is also about sharing responsibility. We share the credit when things are going well, and the blame when they aren't," said Daugaard.

### *Changing the policing philosophy*

Support from law enforcement officers, who act as the initial point of contact for LEAD program participants, is necessary for the program to be effective. King County Sheriff John Urquhart's experiences are similar to those of police officials in other agencies that have adopted initiatives like the LEAD program. "As with any new program, some of our deputies were on board right away, and others needed convincing," he said. "But now the deputies who work in the areas where the LEAD program has been implemented are fully on board and excited about participating."

Urquhart said that one of the keys to getting support within the department was the fact that deputies have discretion regarding whether to divert someone from prosecution to the program. "Deputies like that they have the ability to make these decisions. They like being able to engage with people and decide on their own whether the person needs assistance, rather than having it dictated to them by a supervisor or an outside group," he said.

Daugaard agreed and said that soliciting input from officers during the program development phase was also critical in securing their support. In Seattle, planners held focus groups with sergeants and line officers to gather feedback about the initial program design and protocols. "What officers shared during the focus groups was so critical," said Daugaard. "They told us that they are rarely consulted when reform efforts are being made, which is one reason they are so skeptical of change. They were enthusiastic about the idea behind the LEAD program—getting assistance to people who need it—but they wanted to be part of the planning process. They wanted their voices to be heard about what would and wouldn't actually work in the field."

The officers' feedback was incorporated into the LEAD program operational protocols, and the officers were shown the changes that were made based on their input. Daugaard said, "Suddenly, people who had initially written the program off started discussing how they could make it work. They said this was the first time they had been asked to contribute their experiences and knowledge to a reform initiative."

Daugaard said that the focus groups taught her the importance of giving ownership to officers when implementing programs like the LEAD program. "It honestly changed everything that I used to think about police reform. I used to believe that changes had to come from up above or from an outside force like a court order. Now I understand that police involvement at all ranks is important. Moving forward without the support of rank-and-file officers is impossible. You have to honor and credit their role and what they bring to the table."

This experience has led other cities implementing the LEAD program to emphasize officer input in the implementation process. For example, the Albany (New York) Police Department created a cross-agency team to develop program protocols and the officer training curriculum. “The training program in Albany was co-produced and is co-taught by law enforcement and human services providers. That partnership is crucial, because if it doesn’t come from within the police department, it won’t have the same ability to transform all aspects of departmental operations,” Daugaard said.

Urquhart said that it has also been helpful for his deputies to see the benefits of participating in the LEAD program. “They see it working, and they hear stories from their peers, and it really helps get them on board.”

### *LEAD program outcomes*

As of April 2016, more than 350 people were participating in Seattle’s LEAD program. The first two years of the program are currently being evaluated by a team of researchers supported by the Arnold Foundation. So far, the evaluation has found that the LEAD program is associated with several positive outcomes for participants, including a reduction in the chances of being rearrested, and improved income and housing prospects. The evaluation also found that the cost of diverting people into the LEAD program is less than placing them into the criminal justice system.

**Findings from the Evaluation of the LEAD Program in Seattle**

Preliminary findings from the Arnold Foundation evaluation of Seattle’s pilot program include the following:

- Program participants were 58 percent less likely to be arrested than members of a control group.
- Connecting people with services through the LEAD program costs less than placing them into the criminal justice system.
- The program was associated with a positive effect on participants’ income and housing prospects.

Daugaard said that these positive outcomes could be even greater if there were better resources for treatment, housing, employment, and other services. However, she noted that despite a lack of resources, the outcomes from the LEAD program demonstrate its value. “There is a sad reality knowing that we could accomplish more if we had additional resources. But what we’ve shown in Seattle is that even without having a systematic plan to provide treatment on demand, this approach is still so much better than the alternative.”

In addition to these tangible benefits, LEAD program partners said that the program has been instrumental in improving relationships between those involved. “One surprise benefit of the LEAD program is that it has opened up a whole new relationship between police, prosecutors, and public defenders. We are sitting down at the table together now in a way that we weren’t before,” said Urquhart.

### *The future of the LEAD program*

The LEAD program is continuously being expanded in King County, and more than 40 jurisdictions across the country have also studied Seattle’s approach. Many cities have adopted or are planning to adopt a version of the program.

The PDA has launched a LEAD national support bureau to provide technical assistance and support to places looking to adopt the program.[11] “We’ve recently put together a set of core principles for police, prosecutors, community safety partners, and case managers so that this program can be replicated elsewhere,” Daugaard said. “These principles are based on what we know works, both for law enforcement and for the community, which is important if these types of programs are going to be effective.”

[11] “Our Mission,” The LEAD National Support Bureau, accessed August 2, 2016, http://www.leadbureau.org/.

## The Arlington Opiate Outreach Initiative, Arlington, Massachusetts

In 2015, Arlington (Massachusetts) Police Department Chief Fred Ryan sat in a briefing about a local drug dealer who had been connected to at least two overdose deaths. After hearing investigators and prosecutors detail the tactical plan to apprehend and arrest the suspected dealer, Ryan came to an important realization. “I learned that although we knew the identities of the people who were purchasing drugs from this dealer, nothing was being done to get them connected to services. I realized that this was a missed opportunity,” Ryan said. “Opioids have had a terrible impact on our community, and here we had an identifiable population of people we knew were at risk, but we weren’t doing anything to help them.”

Ryan decided to seize this opportunity and declared that any tactical drug enforcement operation conducted by his office had to have a parallel public health plan in place. “Enforcement actions can have unintended consequences. People can get sick when their drugs are taken away, or they can turn to other sources for their drugs. We wanted to take a step towards preventing a further public health crisis that might unintentionally result from our enforcement actions,” Ryan said.

Ryan convened an internal group that included members of his command staff, investigators, and a clinician embedded within the department, and they began developing what emerged as the Arlington Opiate Outreach Initiative.

### *How the Arlington Opiate Outreach Initiative works*

Through the Arlington Opiate Outreach Initiative, the police department works with health professionals, service providers, and other community partners to proactively identify and engage people who have substance use issues with the goal of helping them obtain treatment and other services.

With its focus on outreach, one defining feature of the initiative is that it takes a proactive approach to providing people with assistance. Mike Duggan is the founder of Wicked Sober LLC, an organization that links clients to treatment services and is a key partner in the Arlington initiative. He said that the proactive approach is critical to the success of the initiative. “If someone has an opioid addiction, usually the only thing that will stop them from using drugs is being arrested, overdosing, or receiving the appropriate intervention. We don’t want to wait for an arrest or overdose to occur before we step in. We want to be preventative,” Duggan said.

The Arlington initiative involves the following general steps:

- **Identifying potential candidates for outreach.** The Arlington Police Department uses a variety of means to identify people in the community who are struggling with substance use issues. In many cases, officers become aware of potential outreach candidates through their community policing efforts. "Our officers know the neighborhoods where they work. They know who is using, who might be amenable to seeking treatment, the families that are suffering," Ryan said. The police department also identifies potential candidates by examining 911 call data for nonfatal overdoses and through routine field operations conducted by drug control officers.

- **Conducting outreach.** Once the police department identifies potential outreach candidates, their names are provided to Rebecca Wolfe, a clinician who is embedded within the department. Wolfe's position is funded through a grant from the Massachusetts Department of Mental Health, and she is involved in the police response in all cases involving mental health or substance use issues. For the Arlington Opiate Outreach Initiative, Wolfe's role is to coordinate and conduct outreach and intervention efforts.

  Upon receiving the name of an outreach candidate, Wolfe first attempts to contact the person by telephone. If she is unsuccessful, she may also attempt to contact the person's family members, friends, or caregivers. When she finds someone who is receptive to learning more about the program, Wolfe arranges to meet at the person's home or other location in which the person feels comfortable. During the meetings, which are typically also attended by a police officer, Wolfe shares information about available services and offers to help connect the person to treatment options. She also leaves behind a naloxone kit and shows the person (or the family members, or both) how to use it.

"I find that giving people naloxone is a particularly important piece to our outreach efforts, because it shows that we are here to help them, not to judge or arrest them. Sometimes all they want is the naloxone at first, but then a few days later they call and say they do want help with getting treatment. In that way, we consider naloxone to be like a handshake—it introduces us to the person and opens the door for a future relationship."
– Rebecca Wolfe, MEd, Clinical Responder for the Arlington (Massachusetts) Police Department

- **Connecting people to treatment and services.** As she works with people in the program, Wolfe develops intervention plans and connects people to Duggan at Wicked Sober. Duggan's organization provides people with information on treatment options, searches for open treatment spots, and helps people enroll in and find scholarships for treatment programs.

### *Arlington Opiate Outreach Initiative partnerships*

Although the initiative is led by the Arlington Police Department, it involves collaboration with a number of partners. One of these partners is Wolfe, whose role is central to the success of the program.

Because Wolfe's position was created through a state mental health grant, she is not officially employed by the police department. However, she is fully embedded within the department and co-responds to all calls for service involving people with mental health and/or substance use problems. Wolfe, whose background is as a long-term crisis counselor, also conducts follow-up on these calls to provide continued assistance to people who need it. "Having a clinician in the police department has been critical," Duggan said. "She acts as the liaison between the police department and the treatment providers, as well as the point person for people in the community who are getting help through this program. The person in this position has to be able to work well with police and the treatment partners, and has to be impactful in terms of delivering services and reaching out to people in a way that will be well-received," he said.

Duggan and Wicked Sober are also key partners in the Arlington initiative. Wicked Sober assists clients from throughout the state in the process of seeking treatment for substance abuse issues. The organization maintains a support hotline for people to call and request assistance, and it works with clients to develop treatment plans, provide information on treatment options, provide certified interventionist services, and enroll drug users with numerous treatment provider partners.

"My advice is to build a response to the opioid crisis that is defined by the community, not the police department. Ask people in the public health community for feedback and ideas. Reach out and engage people to see what they need. Ask others for help. And don't be afraid to take action, even if you think you might make some mistakes along the way. In times like this, you can't just sit around and wait for more deaths to occur."
– Frederick Ryan, Chief of Police, Arlington (Massachusetts) Police Department

Duggan, a certified intervention professional who was brought into the Arlington initiative through Wolfe, has a special connection to the people he helps through the program. "I'm a long-time Arlington resident, and I'm also in long-term recovery myself from a substance use disorder," he said. "My history is what put me on the path towards helping others who are struggling. I started Wicked Sober as a direct result of the cracks in the system that my family and I fell through when we were trying to access services."

In addition to Wicked Sober, the Arlington Police Department partners with inpatient treatment facilities, hospitals, outpatient treatment programs, and clinics that provide medication-assisted therapy. Ryan said that most of these partnerships were initiated by the police department, largely through Wolfe.

Informal partnerships with local organizations, especially in the faith community, have also been important to the Arlington initiative. “Local faith groups have been very supportive,” Wolfe said. “They let us use their buildings for community meetings, they help us campaign against the stigma of addiction, and they are really on board with what we’re doing.”

### *Community outreach and naloxone deployment*

Community outreach is a significant component of the Arlington Opiate Outreach Initiative. At the outset, Ryan recorded a message about the initiative and why it is important for addressing the opioid epidemic. He distributed the message to approximately 21,000 people via a reverse-911 call through the town-wide community notification system.

The police department also works with its partners to coordinate and participate in community meetings as part of the Arlington Acts program. The goal of these meetings, which are held once or twice per month, is to conduct outreach and provide information on addiction and treatment resources. Duggan and Wolfe lead the meetings, and they typically feature presentations from clinicians, service providers, police department personnel, and people recovering from addictions.

The meetings also include training on how to use naloxone, and naloxone kits are distributed directly to community members who may need them for themselves or their family members. Naloxone training and deployment are central not just to these meetings but also to the police department’s greater community outreach efforts. “We were the first police department in Massachusetts to dispense naloxone directly to people in the community. We’ve done a widespread campaign to make sure that naloxone was in the hands of people who need it,” Ryan said.

In addition to dispensing naloxone at the community meetings, Wolfe also does naloxone training and deployment one-on-one with people with addictions as well as their friends and family members. To help keep deployment under control, Wolfe is generally the only person involved who is authorized to dispense naloxone directly to community members. Recipients are also required to sign a waiver, which was developed by the police department’s attorney.

All Arlington Police Department officers as well as the local firefighters and emergency medical services (EMS) personnel, carry naloxone. Wolfe conducts the mandatory naloxone training for the police department. She also trains officers on mental health and substance use issues both at the police academy and during ongoing roll call presentations.

"I've been so impressed with the officers I've worked with," Wolfe said. "Throughout the years I've done training on so many different issues, like addiction, autism, mental health, dementia, and hoarding. Officers have been incredibly receptive, and they are really out there engaging people in the community on these issues."

"When we first engage with someone, they may not even be ready to get help. They may not know how sick they are. I know that when I was struggling with addiction, I personally didn't understand how much I needed help until I'd been in a treatment program long enough to come to a point of clarity. And that is what this initiative is all about—assisting people in the process of reaching that point of clarity, by whatever means possible, and by working with people all throughout the community to do so. We are there to navigate people through the system so that they don't fall through the cracks."
– Mike Duggan, Certified Intervention Professional and founder of Wicked Sober LLC

Duggan stressed the importance of having the police department and the community on board with programs like the Arlington initiative. "I'm a big fan of the idea that problems in the community need to have solutions that come from the community," he said. "That is exactly what this program is all about. We have a police chief who is a true leader and who wasn't afraid to be a voice for change regardless of the potential pushback. This is my hometown, and it has been amazing to see the kind support we've gotten from all sides."

### *Arlington Opiate Outreach Initiative outcomes*

Ryan said the evaluation component of the initiative is basic by design. The police department tracks outcomes such as the number of interventions conducted, the number of overdoses in the community, activities such as community meetings, and naloxone deployments. The police department has also begun working with researchers from the Boston University School of Social Work to improve data tracking and analysis. Though the initiative is still new, Ryan said it has already had a positive impact. "Before we started the program, we were averaging one fatal overdose per month. During the first eight months of the program, we had one overdose death," he said.

Ryan said that one of the most surprising outcomes has been the positive impact that the initiative has had on the police department's relationship with the community. "The community's trust in the police department has skyrocketed," Ryan said. "People know now that we aren't going to arrest them or their loved ones for drugs, so they are calling us to get help. People are saying, 'Finally, the police understand us.'"

Wolfe has presented the Arlington initiative to more than 70 police departments, and she has developed a how-to guide to help others interested in starting a law enforcement-based program.[12] Duggan is also looking at how to expand the program beyond Arlington. He said it is important to be creative when it comes to building partnerships, and one of his goals is to identify additional private funding streams so anyone who needs help can obtain it for free. Duggan would also like to see other police departments use clinicians like Wolfe and said he is looking into ways to fund those positions in other places.

Ryan tells a story that underscores the importance of programs like the Arlington Opiate Outreach Initiative. "A woman in our community had a son who she knew was doing heroin. She didn't want him arrested, but she wanted him to get help. She called the police department, and we went out to meet with her. Rebecca [Wolfe] coached her on how to use naloxone and how to manage the situation, and she worked to get the son placed into treatment within 48 hours. The woman never would have called us if she thought we were going to just come out and arrest her son. This is all possible because we changed our approach to how we respond to people who need help."

**Director Ronald L. Davis,** Office of Community Oriented Policing Services

[12] Rebecca Wolfe, *Doing a Lot with a Little: How to Start a Police Department-Based Opiate Outreach Program* (Arlington, MA: Arlington Police Department, n.d.), http://www.arlingtonma.gov/home/showdocument?id=29978.

## Conversations for Change, Dayton, Ohio

Conversations for Change is an example of how strong existing relationships between law enforcement agencies and community partners can help these groups tackle new problems that arise.

When fatal opioid overdoses began to rise in Dayton, the Dayton Police Department joined forces with one of its longstanding partners, East End Community Services, or East End, to explore ways to address the problem. East End is a nonprofit organization that works to promote community development and advocacy, with a general focus in areas such as housing, education, and after-school programs.

"We never intended to be in the business of programming to address opioid abuse, but that's where we are needed," said Jan Lepore-Jentleson, East End's executive director. "When we started looking at crime hot spots in our community, we found that more than 90 percent of property crimes were committed by people who were using heroin or other drugs. Crime rates have a destabilizing and stressful impact on the families and kids we work with, which is one reason we knew we had to get involved," she said.

Working together, officials from East End and the Dayton Police Department explored ways to encourage people in the community to seek treatment for opioid addictions. They looked at programs such as Operation Ceasefire and wondered whether the same principles that those programs use to reduce gun violence—targeted specific deterrence, direct interventions, etc.—could also be applied to address opioid abuse. They incorporated many of these principles as they developed the Conversations for Change program, which had its first event in May 2014.

### *How Conversations for Change works*

Conversations for Change centers around meetings that are held every few months for the purpose of providing information to people in the community about addiction, treatment options, and support services. The Dayton Police Department and East End work together to identify people with substance abuse problems to invite to the meetings.

"The people we initially invited were recent survivors of overdoses, as we thought they might be the most open to treatment," Dayton Police Chief Richard Biehl said. They also worked with parole and probation officials to identify and invite people struggling with addictions, invited women involved in prostitution, worked with local agencies that had connections to people with drug problems, and even used the news media for outreach efforts. For at least one of the meetings, a major from the police department brought in a busload of participants from around the community. To help incentivize people to attend, the organizers offered $10 gift cards to Kroger, a grocery store chain.

At the meetings, participants are asked whether they are interested in having a conversation and are then paired with trained motivational interviewers from the Dayton Mediation Center. Mediators engage participants in a one-on-one conversation about their needs, challenges, and willingness to explore treatment options.

The meetings feature presentations from nurses about addiction including how opiates affect the body and why chemical dependency is so difficult to overcome. Peer supporters also share their own journeys with addiction. Participants are trained on how to administer naloxone, and each person leaves the meeting with a naloxone kit. Treatment providers are also on site representing a variety of treatment options that range from faith-based and abstinence-based treatment to medication-assisted therapy treatment providers. Participants can connect with treatment providers and make appointments on the spot.

Lepore-Jentleson said the meetings are very informal and one of their goals is to make participants feel comfortable. "We want it to be a relaxed, welcoming atmosphere. For example, we provide food for everyone—we order pizza, and the district commander from the police department always provides cookies," she said.

"We first thought that people were coming to Conversations for Change events primarily to get naloxone. But then we did a survey that asked people why they attended, and almost every answer was focused on recovery. Only one-fifth of respondents even mentioned naloxone. That shows us where we need to focus our energy—getting people into treatment."
– Richard Biehl, Chief of Police, Dayton (Ohio) Police Department

### *Naloxone deployment*

Conversations for Change is one piece of a larger strategy to address opioid abuse in Dayton. In addition to a needle exchange program, which will be discussed in chapter 3, members of the city's police and fire departments also carry naloxone.

Biehl said paying for naloxone has been a challenge. The police department has largely relied on state and local funds as well as asset forfeiture funds to pay for naloxone, but Biehl said this is not enough. "At the current rate, we don't think we'll have enough funding to keep paying for naloxone. We need someone to step up and help us pay for it," he said.

### *Conversations for Change outcomes*

Approximately 285 people have attended a Conversations for Change meeting since the program's inception in May 2014. Lepore-Jentleson of East End Community Services said that although they do not have data on the program's long-term outcomes, they do know that more people are signing up for treatment than before they began holding the meetings. She said this is an important step toward achieving the program's primary goals, which are to make people aware of treatment options and to help connect them directly to treatment.

Lepore-Jentleson also said that the use of naloxone by members of the community to reverse the effects of overdoses also tends to increase after Conversations for Change meetings, though they do not have data to pinpoint the exact numbers.

Biehl said that Dayton police officers administered naloxone 240 times to 210 people with 198 overdose reversals during the program's first 18 months. This number does not include naloxone administrations by fire department personnel. Biehl said that naloxone deployment contributed to a slight decline in fatal overdoses from 264 in 2014 to 259 in 2015 and that the number of overdose deaths would have increased had naloxone not been administered by Dayton police officers.

### *Overcoming challenges*

Both Biehl and Lepore-Jentleson said the primary challenge they face is the city's lack of drug treatment capacity and integrated treatment services. They said it has been difficult to keep up with the demand for treatment, especially given the limited number of bed spaces in treatment facilities and the lack of funding for treatment programs. "Unfortunately, right now we don't have the ability to expedite people into treatment, even if they are committed to going down that path. We just lack the capacity for treatment upon demand," Biehl said.

The lack of treatment capacity is particularly concerning given the results of a survey of Conversations for Change participants conducted by Wright State University. The survey showed that people chose to attend Conversations for Change events primarily to gain access to treatment and recovery services and not just to acquire naloxone.

Recognizing that Conversations for Change has fulfilled a much-needed role in the community—acting as a "front door" for people to gain initial exposure and access to treatment and services—the program's organizers are now developing a proposal for an expanded front-door treatment program. The proposal involves 14 community partners including the police department, the sheriff's department, service providers, and researchers from Wright State University.

"We've been spending a lot of time trying to understand the barriers to getting treatment, and what we've found is that there is no full-fledged treatment system in place here. We only have four publicly funded detox beds in the entire county. Police have been saving people with naloxone and then begging treatment programs to take them, but there is no room. Until there is a system that provides treatment on demand, the police will be spinning their wheels."
– Jan Lepore-Jentleson, Executive Director, East End Community Services

"Conversations for Change was supposed to be a stopgap measure until the rest of the community could respond to the opioid crisis," Lepore-Jentleson said. "The city needs a robust on-demand treatment system with an accessible front door to obtain timely services. If we had that, we wouldn't even need this program. So this is the next big step," she said.

### The Deflection Model for Substance Abusers—Montgomery County, Maryland

The Deflection Model for Substance Abusers, which is currently being implemented by the Montgomery County (Maryland) Police Department, is another example of a program aimed at diverting people toward assistance and away from the criminal justice system.

Under this model, officers have the discretion to offer people arrested for low-level crimes the option of making an appointment with a licensed clinical social worker rather than being charged with the crime. People are given a defined period of time to make and attend the appointment. If they do not comply, the officer has the option to charge them.

The program involves a partnership between the police department and the Montgomery County Department of Health and Human Services, which is where the social workers are employed. Although the program is still in the implementation phase, it represents another important step toward building public safety-public health partnerships to get people the help they need.

# 2. Law Enforcement Use of Naloxone

Law enforcement officers, who are often the first responders on the scene of an opioid overdose, can play a critical role in preventing overdose fatalities through the deployment of naloxone. Naloxone, often referred to by the brand name Narcan, is a medication that can reverse the effects of an opioid overdose while it is occurring. Naloxone may be administered through an injection or a nasal spray.

Naloxone has long been carried by paramedics and other first responders, and the opioid crisis has led to many law enforcement agencies equipping their patrol officers with naloxone as well. According to the Bureau of Justice Assistance, as of October 2015 law enforcement agencies in at least 29 states had implemented naloxone programs.[13] The North Carolina Harm Reduction Coalition (NCHRC), which provides naloxone training to law enforcement agencies and monitors national trends regarding the law enforcement use of naloxone, listed 971 U.S. law enforcement agencies as having naloxone programs as of April 26, 2016.[14]

Many naloxone programs are joint efforts between law enforcement agencies and public health organizations. For example, in 2014 the Maryland Department of Health and Mental Hygiene (DHMH) established the Overdose Response Program to train people on the use of naloxone. People who participate in the training—which can include family members or friends of opioid users—receive a prescription for naloxone and are certified in its use. Michael Baier, the Overdose Prevention Director for DHMH, said that almost all law enforcement officers in Maryland who are trained in using naloxone have been through this program.

> "I think that law enforcement using naloxone has been an incredibly important step. Not only has it had a positive impact on how police officers interact with people with addiction but it is also a great way for public health and law enforcement to collaborate. These programs will help get public health and law enforcement involved with each other in ways they may not have in the past, and the benefits of that are significant."
> – Michael Baier, Overdose Prevention Director, Maryland Department of Health and Mental Hygiene

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[13] National Training and Technical Assistance Center, "Naloxone Background," Bureau of Justice Assistance, accessed August 23, 2016, https://www.bjatraining.org/tools/naloxone/Naloxone-Background.

[14] "Law Enforcement," North Carolina Harm Reduction Coalition, last modified April 26, 2016, http://www.nchrc.org/law-enforcement/us-law-enforcement-who-carry-naloxone/.

Another example of how naloxone programs have brought public health and law enforcement together is the Deaths Avoided With Naloxone (DAWN) program in Ohio. The DAWN program, housed under the Ohio Department of Health, provides naloxone training and assistance to law enforcement agencies, first responders, and other stakeholders throughout the state. Lisa Roberts is a registered nurse with the Portsmouth (Ohio) City Health Department and helped to develop the DAWN program. "The program is really a product of a statewide coalition that included both public health experts and law enforcement agencies," she said. "One of our main goals is to promote naloxone deployment among law enforcement agencies, and so we do trainings and help agencies get their programs off the ground. It has been a great partnership between public safety and public health."

### Fayetteville (North Carolina) Police Department

- Program began: May 2015
- Overdose reversals as of August 2016: 31
- Program development and partners: According to Captain Lars Paul, who helped develop the program, the idea for the program came from Fayetteville Police Chief Harold Medlock as a direct response to the opioid epidemic. The police department partners with the North Carolina Harm Reduction Coalition (NCHRC).
- Program training: The NCHRC conducted a train-the-trainer program for police supervisors, who then trained the officers. Training topics included North Carolina's 911 good Samaritan/naloxone law, recognizing overdose symptoms, administering naloxone, working with people who are coming out of an overdose, following up with emergency medical services (EMS), and agency protocol.
- Program funding: The first batch of naloxone was donated by a private pharmaceutical company called Kaleo through a partnership with the NCHRC. After that batch expired, the NCHRC and Fayetteville Police Department used a combination of their funding to purchase nasal naloxone, which cost $37.50 per dose.
- Program administration: Every uniformed officer (approximately 275 patrol officers and direct support personnel) carries a naloxone auto injector (Evzio by Kaleo) or a nasal auto injector (Narcan by Adapt). Captain Paul coordinates naloxone acquisition and maintenance. After a naloxone kit is used, the officer turns it in and obtains a new one. Captain Paul said maintaining the supplies and monitoring expiration dates can be challenging, but the program runs fairly seamlessly.
- Building program support: According to Robert Childs, Executive Director of the NCHRC, officials had little difficulty building support for the program among officers. "The Fayetteville Police Department has been incredible to work with. We haven't encountered any pushback. We're working with the department now to develop a LEAD program, and we have had great support from everyone involved."

## Benefits of naloxone programs

### *Reducing overdose deaths*

Many law enforcement leaders have credited naloxone with helping to drastically reduce overdose fatalities in their jurisdictions. For example, the Camden County (New Jersey) Police Department, whose officers began carrying naloxone in May 2014, had more than 200 overdose reversals or "saves" during the first two years of the program.

"The idea of not doing everything possible to save someone's life is completely antithetical to the work of law enforcement and public health. So when people ask whether police should be carrying naloxone, I think the answer is 'yes, of course!' Carrying naloxone fits exactly into law enforcement's mission—to save lives."
– Chauncey Parker, Executive Assistant District Attorney and Special Policy Advisor, New York County District Attorney's Office and Director, New York-New Jersey High Intensity Drug Trafficking Area

Because police officers are often the first to be called or the first to arrive at the scene of an overdose, they may be in a better position to administer naloxone than other first responders, underscoring the importance of law enforcement agencies having access to this life-saving measure. This is particularly true in rural areas, where ambulance response times are often much longer than in larger cities. For example, the Lummi Nation Police Department, which serves the Lummi Nation, a self-governing nation of approximately 5,000 members living in rural Washington State, implemented a naloxone program in part because of ambulance response time that stretched up to 20 minutes. Lummi Nation officers had 12 overdose reversals during the first six months. "At first, our department didn't know what to think of this—the idea of using naloxone was a complete unknown for us. But once we received training and began using it, we began to see great outcomes," said Lummi Nation Police Department Chief Ralph Long.

Captain Lars Paul of the Fayetteville (North Carolina) Police Department described another situation in which police officers might be in the best position to administer naloxone. "We often respond to overdose scenes where it might be too dangerous for EMS to enter until we've cleared the scene. Now that we're carrying naloxone, EMS doesn't have to rush in. They can wait for the scene to be cleared while the police administer the naloxone," Paul said.

**Lummi Nation Police Department, Washington**

- Program began: 2014
- Overdose reversals as of April 2016: 21
- Program development and partners: As a response to an increase in opioid overdoses and long ambulance response times, the police department partnered with clinical staff serving the Lummi Nation to develop its naloxone program.
- Program training: A doctor from the Lummi Nation trained police personnel. Training includes a video on how to prepare and administer naloxone. Lummi Nation casino and housing security staff, as well as community members, can also receive training on how to administer naloxone.
- Program funding: The Lummi Nation clinical staff provides naloxone to the police department at no cost. Funding is through the Lummi Nation treatment center.
- Program administration: All officers are equipped with nasal spray that is prescribed by the partner treatment doctor.
- Building program support: According to Police Chief Ralph Long, "At first officers were reluctant, because any change can be difficult. But once they were trained and understood that here were no liability concerns, they were accepting. In terms of the community, there was really no pushback. Although a very small number of people had concerns that naloxone may enable people with addictions, for the most part we've had only positive feedback because of the lives we've saved."

### *Connecting people with treatment*

Some police agencies partner with service providers to follow up with and offer assistance to people whose lives have been saved with naloxone. These agencies use naloxone as an opening to talk to people about treatment options and connect them with services, extending the benefits of naloxone beyond just the initial save.

For example, the New York City Police Department's (NYPD) naloxone program in Staten Island includes a feature in which officers revisit the people whose overdoses were reversed with naloxone. "After we use naloxone, we're going back to people and their families to find out if they are getting services. If not, we're working with them to try to get them the help they need. In this sense, naloxone has opened the door to other opportunities. It is really opening up a dialogue with people we may not have been encountering before," said NYPD Assistant Chief Edward Delatorre, the borough commander for Staten Island.

The Camden County Police Department's naloxone program also has a follow-up component. As part of the department's Operation Save a Life (SAL) program, people who have been saved by naloxone are offered the immediate chance to go into a 30-day drug treatment program.

> "Naloxone isn't a cure. It's saving your life until you want to live. Our job is to first make sure you don't die, and then to make sure you get the help you need."
> – Paul Kifer, Captain, Hagerstown (Maryland) Police Department

Many public health experts believe that following up on overdose reversals plays a key role in addressing the opioid crisis. For example, one focus of the Harm Reduction Coalition,[15] a national advocacy organization that promotes policies and programs to assist communities and people impacted by drug use, is to ensure that there is adequate follow-up with people who have had overdoses reversed with naloxone.

"We know that someone who experiences an overdose is at a higher risk of subsequent overdoses. Ideally, people in this situation should be guided into assessment and treatment referral as quickly as possible after a naloxone save," said the Harm Reduction Coalition's policy director, Daniel Raymond.

However, a lack of treatment capacity can pose a challenge to taking this approach. "We can reverse the overdoses, but then what happens to the people? There are wait lists for treatment. Until that changes, we will continue to see problems," said Long of the Lummi Nation.

Captain Paul Liquorie of the Montgomery County (Maryland) Police Department agreed. "The frustrating thing is that if there is no intervention after a save, then we will keep seeing the same people over and over. How do we break that cycle? We need help from public health practitioners, and we need better options for intervention," he said.

[15] "Harm Reduction Coalition," Harm Reduction Coalition, accessed August 25, 2016, http://harmreduction.org/; not to be confused with the North Carolina Harm Reduction Coalition (see note 14).

**Virginia Beach (Virginia) Police Department**

- Program began: 2016
- Overdose reversals as of August 2016: 31 (averaging around one save per week)
- Program development and partners: The program was created in response to a significant increase in opioid use, overdoses, and fatalities. The police department modeled the program on existing naloxone programs in the northeast. After obtaining legislative authorization to acquire and administer naloxone, the police department partnered with the Virginia Beach Department of Human Services (DHS) and EMS to launch the program.
- Program training: DHS provided comprehensive training to officers. Topics included information about opioids and addiction, the prevalence of addiction in the community, and how naloxone works and how to deploy it. Training also included hands-on, practical exercises to teach officers how to prepare and administer naloxone.
- Program administration: Officers carry a nasal spray kit. The police department also has access to injection kits through the city's rescue squad. The city also provides training in the delivery of naloxone directly to members of the community through the local DHS. According to Deputy Police Chief William Dean, the high demand nationally for naloxone has made it difficult to maintain the supply, and there are waiting lists to get additional naloxone.

### *Strengthening community outreach and awareness*

Some law enforcement officials have said that another benefit of naloxone programs is that they can facilitate community outreach and awareness of drug abuse issues. Naloxone deployment can serve as an opening for providing information on addiction and treatment, as Paul found in Fayetteville. "Our naloxone program has helped raised awareness within the community about opioid abuse. Many people didn't understand how bad the problem is, or that it could hit so close to home," Paul said.

In many places, police agencies are also finding that naloxone programs have helped improve relationships between the community and police. "The fact that we are out there doing something to try to address this opioid epidemic has given us a lot of credibility with the community in Staten Island. We go out to community meetings, and when we start talking about naloxone and other initiatives, people are so encouraged. It has made a huge difference in how they view us," said the NYPD's Delatorre.

"Our naloxone program has shown the community that we are not just there to enforce the law, but to also be a resource to the community. We work hard to be that resource, because we feel we have a responsibility to help people. That mentality helps you build relationships with the community and with public health partners. In addition to saving lives, that's why naloxone programs are so important."
– William Dean, Deputy Chief, Virginia Beach (Virginia) Police Department

### New York City Police Department—Staten Island

- Program began: January 2014
- Overdose reversals as of April 2016: 53
- Program development and partners: The Staten Island program served as the pilot program for the New York City Police Department's (NYPD) naloxone deployment. Staten Island was the first borough in New York City to equip NYPD officers with naloxone. Police in Staten Island work in collaboration with the Richmond County, New York, District Attorney's Office on this and other opioid-related initiatives.
- Program funding: Naloxone for the pilot program was provided through the District Attorney's Office. The program is now funded by New York City Department of Health and Mental Hygiene.
- Program administration: At the beginning of the pilot program, officers could volunteer to carry naloxone. Now every officer carries it. The NYPD also does "revisits" on each save, which means that personnel follow up to ensure that drug users and their families are receiving assistance.
- Building program support: According to Assistant Police Chief Edward Delatorre, officers have embraced the program and are excited to be involved in saving lives. The NYPD has also received support from the community and recently spoke at a community forum on naloxone. At the forum, nurses from the New York City Department of Health and Mental Hygiene trained members of the community on how to administer naloxone, and more than 500 naloxone kits were provided to participants through funding from local elected officials. NYPD officials also shared information on the department's naloxone program and other opioid-related initiatives including prescription drug drop-off sites. "If anyone questions why police are involved in these kinds of efforts, I just point them to the New York City charter. It says that the city's police officers are responsible for public safety and public health. So this absolutely is our responsibility," Delatorre said.

## Challenges of naloxone programs

While naloxone programs can offer many benefits, there can also be challenges in implementing these programs. At the PERF/COPS Office/ONDCP forum in April 2016, participants shared several promising strategies for addressing these issues.

### *Addressing liability concerns*

Police executives may be hesitant to implement a naloxone program because of concerns about whether officers could be held liable for their efforts to administer naloxone at a scene. Liability concerns are also common among officers themselves.

However, the Bureau of Justice Assistance (BJA), which maintains an online toolkit featuring resources and information on naloxone, says that there is little risk of liability for law enforcement officers who administer naloxone "in good faith and within the scope of their training and standard operating procedures."[16]

One reason that the risk of liability is so low is that most states have enacted laws that protect law enforcement officers and their employers from lawsuits resulting from naloxone administration. Almost half of the states in the United States go even further and protect any person, not just first responders or law enforcement personnel, from civil or criminal liability if they administer naloxone.[17] In states that do not have laws protecting officers against liability, it can take longer to get naloxone programs off the ground.

> "The risk of liability for a law enforcement officer or their employer resulting from naloxone administration is low. From a legal standpoint, it would be extremely difficult to win a lawsuit against an officer who administers naloxone in good faith and in the course of employment. Overdose response activity is no different from any other good faith effort to provide assistance in an emergency."
> – Bureau of Justice Assistance, Law Enforcement Naloxone Toolkit (see note 16)

[16] National Training and Technical Assistance Center, "Law Enforcement Naloxone Toolkit: Liability and Risk," accessed August 23, 2016, https://www.bjatraining.org/tools/naloxone/Liability-and-Risk.

[17] Ibid.

Many police executives said understanding the low risk of liability has made officers more supportive of adopting naloxone programs. “At first, some of our officers were reluctant to use naloxone. But once they were trained and realized there were no real liability concerns, they were very accepting of the idea,” said Long of the Lummi Nation.

**Robert Childs**
North Carolina Harm Reduction Coalition

As part of its national law enforcement training efforts, the NCHRC focuses on educating law enforcement agencies about the benefits of carrying naloxone and the liability of its use. The NCHRC also tracks law enforcement implementation of naloxone programs throughout the United States. Robert Childs, the group’s executive director, said, “I’ve never seen a law enforcement officer or agency sued for administering naloxone in the United States. But it remains a big concern for a lot of agencies, so in our training we try to mitigate those concerns by talking about the reality—that as long as officers are acting in good faith, there is no liability risk.” The NCHRC has worked with advocates and law enforcement agencies in many states to make sure that the legal language in new naloxone legislation clarifies that officers and members of the public are immune from civil and criminal liability when administering naloxone.

Captain Paul Kifer of the Hagerstown (Maryland) Police Department said any concerns his agency had about liability were outweighed by the benefits of having a naloxone program. “We need to be out there saving lives,” he said. “That’s more important than worrying about being sued.”

### Camden County (New Jersey) Police Department

- Program began: June 2014
- Overdose reversals as of April 2016: 200+
- Program notes: The program is part of Operation Save a Life (SAL), which was named after Sal DiRenzo, a New Jersey man who died of a drug overdose in 2010. Sal’s mother, Patty DiRenzo, helped police create a program that offers those who have been saved by naloxone the immediate chance to go into a 30-day drug treatment program.

## *Building officer support for naloxone programs*

Some law enforcement personnel have expressed concerns that naloxone perpetuates the cycle of addiction or unease about performing a medical procedure. Others believe that police agencies should focus on enforcing drug laws, not providing assistance to people with addictions.

At the April 2016 forum, several law enforcement officials and public health experts shared strategies for addressing these concerns and for building support for naloxone programs within their agencies. For example, when the Vermont State Police implemented its naloxone program, some troopers expressed concerns about whether they were equipped to perform this type of medical procedure. Colonel Matthew Birmingham addressed these concerns by reminding the troopers that this approach was nothing new. "We were able to strengthen support for the program by equating naloxone use to other medical procedures that our troopers were already doing, like CPR or using defibrillators. Naloxone is not that different. It is a life-saving measure, and no harm can really come from it. If something is on fire, the police are going to jump in to put the fire out and save people. It's the same concept with naloxone," Birmingham said.

Many police executives also said that officers became more supportive of naloxone deployment once they saw how effectively this tool can be used. "I call each officer who is involved in a naloxone save to talk to them about the experience. They all say that they feel like they're part of a miracle. They can't believe what they've done," the NYPD's Delatorre said.

> "We hold an awards banquet that recognizes every officer who uses naloxone to reverse an overdose. One officer has 18 'saves,' and he was late showing up to the awards event because he had stopped on the way and saved two more lives using naloxone. This officer has said how rewarding it is that he has saved many lives and hasn't had to take any as a police officer. This type of work instills a sense of pride and really shapes an officer's identity."
> – Scott Thomson, Chief of Police, Camden County (New Jersey) Police Department

"A lot of police officers used to say that they would arrive at the scene of an overdose and feel helpless. Naloxone has given them a tool that they can use to help people, and that has helped secure support for these programs," said Raymond of the Harm Reduction Coalition.

> "It is so inspiring to hear the excitement and compassion in officers' voices as they talk about what it felt like to save someone's life."
> – Edward Delatorre, Assistant Chief of Police, New York City Police Department

To address concerns about whether naloxone perpetuates the cycle of addiction, Thomson of Camden, New Jersey, said that education is key. "People in the community, or even some officers, may think that naloxone is going to cause people to be more cavalier and to push the envelope—the idea that, 'Oh, it doesn't matter if I do drugs, because they can just give me naloxone if I go too far.' But that way of thinking represents a complete misunderstanding of the disease of addiction. Education and raising awareness can help with that," Thomson said.

**Montgomery County (Maryland) Police Department**

- Program began: Late 2014
- Overdose reversals as of August 2016: 5
- Program training: Officers who carry naloxone receive a two-hour training.
- Program funding: Naloxone is purchased through the county's Department of Health and Human Services, using grant funds from the State of Maryland as well as county funds.
- Program administration: The police department's naloxone program is voluntary, and approximately 75 officers are trained and carry naloxone. Local EMS personnel also carry naloxone, and members of the community can also be trained and provided with naloxone. The program is administered by a case manager who is employed by the Maryland Treatment Centers, which receives funding from the Department of Health and Human Services.

### *Acquiring, funding, and storing naloxone*

Law enforcement agencies must first obtain authorization for personnel to possess and administer naloxone, which is a prescription drug. According to the BJA's Law Enforcement Naloxone Toolkit, many police agencies partner with state and local departments of health, hospitals, EMS, or other public health organizations to obtain authorization for naloxone through a standing order issued to the entire police agency.[18] Larger agencies may also have a medical director or other licensed staff member who can issue naloxone prescriptions.

Some states, such as New York, have taken actions to streamline the naloxone authorization process for law enforcement agencies. Delatorre said that when the NYPD first piloted its naloxone program on Staten Island, an NYPD medical doctor had to write a separate personal prescription for every officer

[18] National Training and Technical Assistance Center, "Law Enforcement Naloxone Toolkit: Acquiring Naloxone," accessed August 23, 2016, https://www.bjatraining.org/tools/naloxone/Acquiring-Naloxone.

participating in the program. The state's Board of Pharmacy streamlined that process so law enforcement agencies now can purchase naloxone directly from wholesalers rather than at a retail pharmacy via a prescription.

The BJA toolkit provides guidance on the various methods of obtaining authorization for naloxone. It also provides information on the costs of naloxone programs, which can be significant. According to the BJA toolkit, the cost of a single naloxone nasal spray kit can range from $22.00 to $60.00, and the injection kits can be even more expensive.[19] There may also be costs associated with training officers on naloxone deployment, though many public health and community organizations provide this training for free.

One model for acquiring and funding naloxone is the approach taken in North Carolina, where the NCHRC successfully advocated for the state funding of community and law enforcement naloxone programs. Furthermore, the NCHRC has acquired grants and donations to directly purchase naloxone for law enforcement agencies and the community at competitive pricing. "The law enforcement agencies can also operate under NCHRC's medical standing order, which streamlines the process. In North Carolina, we have state and private funding that pays for many of the 109 programs in the state," said, the group's executive director.

Childs said that acquiring naloxone can be much more difficult for law enforcement agencies in states that do not have adequate resources dedicated to these programs. When providing training and assistance to law enforcement agencies in these states, Childs emphasizes the need to be creative. "We train law enforcement agencies on how to access potential free naloxone programs, how to partner with health departments and community-based agencies, and how to apply for grants for these programs. There are ways to find money and partners to pay for these programs, and we can help find them," Childs said.

"As police officers, our duty is to protect and to serve. So if there is even a 0.0001 percent chance that we can save one person's life with naloxone, we have to try, no matter what it costs. You just can't put a value on that one human life you might save. Every dollar you spend, every ounce of energy you put into saving that person—it is all worth it."
– Russ Hamill, Assistant Chief of Police, Montgomery County (Maryland) Police Department

[19] Ibid.

One additional challenge that many law enforcement agencies face is the relatively short shelf life of naloxone, which is typically between 18 and 24 months. "A lot of the police officials I meet with raise concerns that the shelf life is short, at least if you go by the labeled expiration date. Research was published in 2006 involving FDA scientists indicating that the real shelf life of many medications is much longer than the labels suggest, at least six years,[20] and it would be really helpful if the expiration date could be officially extended based on that," said Caleb Banta-Green, Senior Research Scientist at the University of Washington Alcohol and Drug Abuse Institute.

In addition, the requirement that naloxone be stored at a fairly low temperature can become an issue in places with hot climates.

### Hagerstown (Maryland) Police Department

- Program began: 2015
- Overdose reversals as of April 2016: 10
- Program training: Officers receive a one-hour training from the local health department on how to prepare and administer naloxone.
- Program funding: The program is funded by the local health department.
- Program administration: All 60+ patrol officers carry naloxone nasal spray kits, as do personnel from the local fire department and sheriff's office.
- Building program support: According to Captain Paul Kifer, there was little opposition from police personnel or from the community. Kifer said that education is key to helping people understand the importance of naloxone deployment.

[20] Robbe C. Lyon et al., "Stability Profiles of Drug Products Extended beyond Labeled Expiration Dates," *Journal of Pharmaceutical Sciences* 95, no. 7 (July 2006), 1549–1560. doi: 10.1002/jps.20636.

# 3. Mitigating the Consequences of Injection Drug Use

One consequence of the opioid epidemic is the rise of HIV, hepatitis B and C, and other infectious diseases that can be transmitted through the sharing of contaminated needles and syringes. According to the Centers for Disease Control and Prevention (CDC), approximately 30,000 new cases of hepatitis C occurred in the United States in 2013, representing a national increase of more than 150 percent since 2010.[21] It is also estimated that there were 20,000 new cases of hepatitis B in 2013, the first increase in acute cases of the disease since 1990.[22] The CDC cautioned that these viruses are one of the top health threats facing people who misuse opioids and that they have "reached epidemic proportions" in most states.[23]

As a response, some jurisdictions have begun implementing programs aimed at reducing these additional harmful effects of opioid use. Many of these harm reduction efforts include syringe services programs, which often involve providing people with clean needles and syringes, syringe exchanges, medical testing, treatment referrals, and information on available services. Although there had long been a ban on federal funding for needle exchange programs, in response to the opioid epidemic the U.S. Congress effectively lifted this ban in late 2015.[24]

Syringe services programs often involve partnerships between public health and public safety agencies, but the role of local police is typically fairly limited. The programs are primarily coordinated and administered by local public health organizations and service providers, and the local police support the program by agreeing to not arrest participants or to patrol needle exchanges for the purpose of enforcement.

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[21] "Viral Hepatitis," Centers for Disease Control and Prevention, last modified March 30, 2016, http://www.cdc.gov/hepatitis/featuredtopics/youngpwid.htm.

[22] Ibid.

[23] Ibid.

[24] The legislation also allows for federal funding of these programs with the exception of costs spent on syringes (which is a minor cost compared to other program expenses). Pub.L. 114–113, https://www.congress.gov/bill/114th-congress/house-bill/2029/text.

> "From the standpoint of the police, we want to reduce harm. So a syringe services program makes sense. It not only helps reduce disease, but it is also a way to engage the community and get people into treatment. It is a pragmatic solution."
> – Richard Biehl, Chief of Police, Dayton (Ohio) Police Department

In some places, however, local law enforcement agencies have taken a more active role in supporting syringe services programs. This is the case in Huntington, West Virginia, whose harm reduction program is highlighted later in this chapter. In Huntington, local police officers are on hand during syringe exchanges to provide security and assistance.

At the April 2016 forum, participants discussed the benefits of syringe services programs including mitigating the spread of infectious diseases and reducing associated health care costs. Some participants said syringe services programs can also provide an opportunity to engage with people who need help and connect them with additional treatment and services.

Roberts, the registered nurse with the Portsmouth (Ohio) City Health Department, said her county has seen a 40 percent reduction in new cases of hepatitis C since implementing a syringe services program and other harm reduction services. "We have about 74,000 people in Scioto County, and we exchanged more than 85,000 syringes last year. The more clean syringes we exchanged, the more our hepatitis C rates declined," Roberts said.

### Concerns about syringe services programs

Despite these benefits, syringe services programs have traditionally been somewhat controversial because of the concerns they raise among members of the community. For example, participants at the April 2016 forum said that some people may be concerned that providing access to clean needles and syringes will enable intravenous drug use and send a signal that it is accepted. People may also fear that syringe services programs will lead to crime and disorder especially at or near the physical location where the syringe exchanges take place.

These concerns may also cause some law enforcement personnel to hesitate in supporting syringe services programs. In addition, because criminal law typically prohibits possessing drug paraphernalia—including needles and syringes—some law enforcement officers may believe that supporting syringe exchanges violates their duty to enforce the law.

**Alejandro Lares Vallardes**
Tijuana (Mexico) Police Department

"It is hard for us, as police officers, to understand how to treat people who have syringes on them. The law says to arrest and prosecute them, but is that really the right way to go? It can be hard for police officers to change how they respond in these situations," said Alejandro Lares Valladares, the former police chief of the Tijuana (Mexico) Police Department. Lares has been working with Beletsky of the Northeastern School of Law and Bouvé College of Health Sciences on an initiative that includes training police officers in how to respond when they encounter someone carrying syringes.

"In the past, you've sometimes seen police and the community work at cross-purposes when it comes to syringe services programs," Beletsky said. "You sometimes hear that police use the needle exchanges as indicators of illegal activity and then hang around outside to look for warrant violations. So one thing we're trying to do is work with police to align law enforcement actions with the goals of syringe services programs."

Corey Davis, deputy director with the Network for Public Health Law, agrees that sometimes it can be difficult to obtain law enforcement support for syringe services programs. "Public health experts know, without question, that if addicted individuals can carry clean syringes, their risk for disease goes down. These exchanges have other positive effects too, such as providing access to a counselor and the potential to get people into treatment. But criminal law typically says that possession of drug paraphernalia is illegal, and police often don't know the evidence supporting syringe access programs. This can cause tension between the public health and public safety communities. Fortunately, we are seeing some slow changes whereby criminal law is becoming more aligned with public health goals," Davis said.

## Building support for syringe services programs

At the April 2016 forum, participants shared several strategies for building support for syringe services programs among community members and law enforcement partners. They said that one key strategy is to dispel the myths that surround these programs and demonstrate the benefits they can bring.

"When we talk about these programs, some people have this image in their heads of a fast food drive-thru for syringes. They imagine that you just give someone a syringe and then send them on their way," said Raymond of the Harm Reduction Coalition. His organization provides technical assistance to agencies looking to implement syringe services programs, including advice on how to educate people about syringe exchanges. "When you do messaging for these programs, it is helpful to show people that they are about more than just giving people syringes. They also involve connecting people with longer-term assistance and services," he said.

Childs, Executive Director of the NCHRC, said "Law enforcement personnel often tell us that they want people to have access to drug treatment. Well, we know that syringe exchange participants are five times more likely to enter drug treatment than nonparticipants, so these programs are among the best gateways to treatment that we have. That's one of the many reasons why we're seeing more support for syringe services programs among law enforcement agencies and within the community."

> "Syringe services programs involve so much more than just exchanging needles. They also involve building relationships with people who may be mistrustful and feel stigmatized. Through these relationships, you can help get them into counseling and services. You're moving people towards a place of health and recovery. And there just isn't much research to show that these programs encourage drug use or increase crime. These are the points we need to emphasize to people who have concerns about syringe services programs."
> – Daniel Raymond, Policy Director, Harm Reduction Coalition

Another way to build support for syringe services programs, particularly among law enforcement agencies, is to demonstrate the nexus between these programs and officer safety. "People who think they'll get arrested for possessing drug paraphernalia may be hesitant to disclose that they are carrying syringes. This can make officers more vulnerable to needle-stick injuries while conducting searches or patting someone down," Raymond said.

Davis of the Network for Public Health Law said that syringe services programs can help reduce these injuries to officers by giving people a safe place to dispose of their needles. In addition, he said that laws like Have Syringes, Tell an Officer, which the NCHRC worked with legislators and law enforcement associations to pass in North Carolina in 2013—which states that if a person is stopped by a law enforcement officer and informs the officer of having a syringe, the person cannot be charged for syringe possession—can also help prevent needle-stick injuries.

"When we emphasize to officers that implementing these programs and policies can reduce the chances that they'll get stuck with a dirty needle, it is an argument that really resonates," Davis said. "The North Carolina law passed with the support of the state's sheriffs' association. That's an example of public health influencing criminal law in a way that benefits everyone."

Law enforcement officials and public health experts agreed that taking a gradual approach to implementing syringe services programs can also help strengthen support among community and law enforcement partners. For example, the Dayton Police Department and its partners, Dayton Montgomery County Public Health & Life Enrichment Center, developed a syringe exchange program as part of its comprehensive response to opioids. Dayton Police Chief Biehl credits taking a gradual, low-key approach for the limited pushback they have received. "When we opened the syringe services center, we did what we called a 'soft opening.' We didn't make it a big media event. Instead, we sent

advocates and outreach people into the community to inform people about the center. They went under bridges, into vacant homes, wherever people might be who needed help. We still had some pushback from some abstinence-only organizations, and we understand those concerns," Biehl said.

Childs of the NCHRC also said taking a gradual approach is important. "If you're getting pushback for implementing a syringe exchange program, I'd recommend increasing education on the topic and look at moving forward with syringe access and biohazard initiatives by doing it piece by piece. Introduce the concept and let people become familiar with the issues," Childs said.

As noted earlier, in 2013, the NCHRC worked with legislators and the law enforcement associations to pass the bill Have Syringes, Tell an Officer, which decriminalized syringes if the subject declared them to officers prior to a search. In 2015, the NCHRC successfully advocated for, and saw the passage of, a bill that decriminalized residue found in syringes that are declared to officers prior to a search. This legislation also legalized community-based biohazard collection in four pilot counties. Most recently, in 2016 the NCHRC successfully advocated legislation legalizing community-based syringe exchange programs.

Childs explained that the mitigating factors behind these pieces of legislation were to decrease the chance of officers getting stuck with syringes that potentially carry HIV and viral hepatitis and to decrease the overall prevalence of needle stick injuries. According to the Foundation for AIDS Research, one in three law enforcement officers will experience a needle stick injury during the officer's career, and 28 percent will experience multiple needle stick injuries. Furthermore, a study examining the impact of increased legal access to needles revealed that when syringes are decriminalized or syringe exchange programs are legalized, law enforcement needle stick injuries decrease by 60 percent.

Childs' organization followed this approach when it began a program that involves doing sweeps of neighborhoods to locate, pick up, and dispose of syringes in Wilmington, North Carolina. "We decided to do a syringe cleanup rather than an exchange before it was legal, because it is a stepping stone," Childs said. "People are very comfortable with programs that involve going out and cleaning up syringes, and once they see the benefits of that, they are more likely to embrace enhanced public health and public safety programs like syringe exchange programs."

The remainder of this chapter highlights a harm reduction initiative in Huntington, West Virginia, that features a syringe services program. This program, which involves extensive collaboration between local policymakers, public health organizations, service providers, and law enforcement agencies, demonstrates the benefits of syringe services programs and illustrates how to build support for these programs.

### The Cabell-Huntington Harm Reduction Program, Huntington, West Virginia

In 2015, Huntington, West Virginia, was in the throes of an opioid epidemic. In the first six months of that year, Huntington, a city of around 50,000 people, saw 474 overdoses (including 34 fatal overdoses). "I don't think there is a single family in Huntington that is unaffected by this crisis. Our youngest overdose victim was 12 years old, and our oldest was 78. It is touching everyone," said Scott Lemley, a criminal intelligence analyst with the Huntington Police Department.

The Mayor's Office of Drug Control Policy (MODCP), directed by former Huntington Police Chief Jim Johnson, began exploring how to address the problem. "We spent six months looking at how to tackle this issue and developing our response," Johnson said. "At first, we didn't know what to do. So we went out and talked to people in the field, public health experts and service providers. And we decided that whatever we did, it had to include efforts to tackle the demand side of the equation."

"We started looking at the data on overdoses and on disease, and it became so clear that we had a massive public health crisis, and we were spending millions of dollars on programs that weren't fixing the problem. To tell you the truth, at first I didn't know if a syringe exchange program was a good idea. I couldn't imagine people supporting it. But as we looked at best practices and programs from around the country, we saw that these programs worked. We had a moral obligation to the community to do this."
– Jim Johnson, Director, Huntington, West Virginia, Mayor's Office of Drug Control Policy

During this process, Johnson and other members of the MODCP—including Scott Lemley of the Police Department, Deputy Director Kenneth Burner of the Appalachia High Intensity Drug Trafficking Area (HIDTA), and Jan Rader, a registered nurse and deputy chief with the Huntington Fire Department—discovered another troubling consequence of the opioid crisis in Huntington. "We learned that, per capita, we had more new cases of hepatitis B than anywhere else in the country," Johnson said. "We were seeing an increase in HIV and hepatitis C, too. The magnitude of this problem was bigger than we ever expected."

After researching the benefits of harm reduction programs in other states, and with assistance from the Harm Reduction Coalition and the CDC, the MODCP began developing the Cabell-Huntington Harm Reduction Program.

### *How the Cabell-Huntington Harm Reduction Program works*

The program, which is a collaborative effort between local elected officials, law enforcement agencies, first responders, treatment providers, universities, and community groups, involves both a syringe exchange and naloxone deployment component.

- **Syringe exchange.** The syringe exchange takes place each Wednesday from 9:00 a.m. to 4:00 p.m. and is held at the local health department. New clients fill out intake forms and are assigned a unique identifier, which can be used to track demographic information (though clients do not have to provide their names).

  In the waiting room, there are recovery coaches from three different treatment programs, each representing a different type of treatment option (faith-based, medically assisted, and clinical-based treatment). Clients are called in to meet one on one with a nurse, who offers to test for infectious diseases and other medical issues; offers birth control if appropriate; and provides information and counseling on addiction, the consequences of drug use, treatment options, and overdose and disease prevention.

  The nurse also works with the client to exchange syringes. Clients are limited to receiving 40 syringes per week. Though clients are strongly encouraged to return old syringes in exchange for the clean ones, it is not a strict requirement.

  Michael Kilkenny, the physician-director of the Cabell-Huntington Health Department, said the syringe exchange component is viewed as one avenue to a greater harm reduction effort. “Our program is really focused on education, health testing, and treatment referrals,” Kilkenny said. “It is a comprehensive harm reduction approach. Syringe exchange may lead the person there, but we do much more than that.”

- **Naloxone deployment.** Naloxone deployment is coordinated through the local health department, and training for members of the public occurs on the same day as the syringe exchange. There are also naloxone kits and trained providers in the local schools. EMS personnel carry naloxone, and all police and fire department personnel are undergoing training and will eventually be equipped as well.

### *The role of law enforcement in the program*

Kilkenny said that the Huntington Police Department is very supportive of the harm reduction program and was instrumental in its development. “We work very closely with the police department. The police have been critical in helping those of us on the public health side understand things from the law enforcement side, like the role of enforcement efforts and how the criminal laws intersect with what we’re doing,” Kilkenny said.

A police officer is also on hand during the weekly syringe exchange days to provide security for clients and staff. The officer is not there to make arrests or to monitor the people who come in for help. “When we first started the program, we didn’t think it was a good idea to have police officers there. We knew that people would be scared of being arrested, and that they didn’t always trust the police. We were afraid it would scare people off,” Johnson said.

The program organizers agreed that clients became more comfortable as they saw that the officers were there to assist them, not to arrest them. “We made an effort to educate people about why the police officers were there. We reassured them that the officers were there to make sure they received services without any problem, and to make sure that they were safe,” Kilkenny said.

“People are fine with the officers being there now,” Johnson said. “You see the officers sitting and talking to clients, and no one is concerned.”

### *Program partnerships and funding*

The Cabell-Huntington Harm Reduction Program represents a truly collaborative effort. Approximately 40 to 50 partner organizations participate in the program, including the MODCP, the local police and fire departments, the Cabell-Huntington Health Department, the Marshall University School of Pharmacy and School of Medicine, treatment facilities, faith-based groups, neighborhood organizations, treatment facilities, medical and service providers, political organizations, local business groups, labor unions, the local judiciary, and other community and public health stakeholders. “We have a unique cooperative culture in Huntington. When we see a threat to the community, everyone bands together. We’ve had no obstacles to securing partnerships,” said Kilkenny.

“We’ve learned so much from interacting with the people who come into the program. They don’t want to have hepatitis or HIV. They don’t want to die. They don’t want to be drug users. But it’s tough to beat, and the demand for treatment exceeds the supply. Until we can get people treated and off of drugs for good, then we have to keep doing what we’re doing when it comes to harm reduction.”
– Michael Kilkenny, Physician-Director, Cabell-Huntington Health Department

The program received a modest grant from a private foundation for operational funding as well as a small amount of funding from the state. It also received small grants from local agencies to purchase syringes. “Funding is always an issue. We are always looking for money, but the state isn’t in the best financial shape,” Johnson said. “And the demand is so great that we can’t keep up.”

“We thought the money we got for syringes would be enough for a year’s worth. But the demand was so great that it only lasted for five months,” said Kilkenny.

### *Building community support for the program*

Johnson said he was initially unsure of how the program would be received in Huntington. “I was scared that if we came out and said we were doing a syringe exchange program, we’d be dead in the water,” he said. “People weren’t used to this kind of thing, and no one knew what it would look like. And we did get some bad publicity at first, but we eventually got people on board, and actually received very little pushback.”

The approach Huntington took to build support for the program can serve as a model for other places that have seen a rise in infectious diseases related to opioid use and are seeking to implement syringe services programs, particularly when it is anticipated that there will be concerns about these programs among people in the community

- **Raising awareness.** The program organizers first put together a strategic plan and PowerPoint presentation, which they used to present the program to local officials, potential partners, and members of the community. Their presentation focused on the moral obligation they had to reduce infectious diseases and overdoses in the community, as well as the cost-effectiveness of implementing a harm reduction program.

  “We included data that showed the horrifying rates of infectious diseases in Huntington, and how much it costs to treat those diseases. We talked about how we had a 10 times higher rate of babies born with neonatal abstinence syndrome [NAS] than in Detroit. We estimated that we were spending between $50 million and $100 million in Huntington just on the health care costs associated with this epidemic—not even including law enforcement or treatment costs,” Lemley of the police department said. The group also provided data from the syringe exchange program in Portsmouth, Ohio, to demonstrate the potential cost savings of implementing a similar program.

  The group also sought to inform people that the program went beyond syringe exchange and was instead a full harm reduction effort. “If I thought the program was just us sitting there with a trunk full of needles that we passed out and then sent people on their way, I wouldn’t support it,” Johnson said. “We had to show people that it isn’t about the syringes; it is about the services and long-term assistance we’re providing.”

"In the beginning, I had to be convinced that this program was the right thing for us to do. But I went and saw the syringe exchange in Portsmouth [Ohio], and I saw all the services they were providing people. I realized that it's about so much more than syringes. It's like when faith-based groups organize food ministries. Does giving someone food save a person's soul? No, but it gets them in the door so that you can have a conversation with them, and give them something they may need. That's how a harm reduction program works."
– Scott Lemley, Criminal Intelligence Analyst, Huntington (West Virginia) Police Department

- **Building a coalition.** As the group began presenting the program to the community, it focused on building a coalition of supporters one person or group at a time. "We talked to people about this in very small groups, sometimes even on a one-on-one basis," Johnson said. "We brought in a group of faith leaders, then a group of politicians, then the news media. We did our presentation, talked to people, and listened to their concerns. I think that was one of the keys to why the community accepted this program."

  "I presented the program to law enforcement groups, and I didn't receive any pushback," said Kenneth Burner of the Appalachia HIDTA. "They all seemed to understand the importance of this, and they were fully on board. It was so important that we had support from them, and from the other groups in the community. If we hadn't built that coalition, we wouldn't have been able to do the program."

- **Having strong leadership.** Johnson and Kilkenny emphasized the importance of having strong leadership and support from the top, starting with the mayor. "Although this was in some ways a grass roots effort, it really helped us that the mayor recognized there was a problem, established this task force, and supported our efforts," Kilkenny said. "That demonstrated ownership of the problem from the top down. From ownership, you develop solutions."

  "We had strong leaders at every level," Johnson said. "The mayor, the police chief, the governor, and ONDCP Director Botticelli, who had a big impact on this program. Without this leadership, we never would have gotten support from the rest of the community."

  Kilkenny also credits the efforts and leadership of the MODCP in building support for the program. "The MODCP did an outstanding job in Huntington of educating the public on this. Jim Johnson and his crew, they went out and beat the bushes, they got anyone who would listen to watch their slideshow. They were able to show the connection between opioid use, and disease, and property crime, and all of the other consequences that were impacting our community. They were really the key to this."

### *Program evaluation and outcomes*

The syringe exchange component of the Huntington program began in September 2015, and by April 2016 it had already served more than 1,000 people. The program serves between 130 and 150 people at each weekly syringe exchange. “We’ve seen more people in the first six months than some larger cities have seen in 10 years,” Burner said. By April 2016, the program had issued more than 77,000 clean needles and collected more than 50,000 used needles.

“The Harm Reduction Coalition advised Huntington as the program got started. It has been amazing to see the results. It has already reached more than 1,000 people. There is strong support from law enforcement, from elected officials, and from the community. I’ve been very impressed with the focused, pragmatic approach that everyone involved has taken. They saw a problem, and they worked within the community to address it.”
– Daniel Raymond, Policy Director, Harm Reduction Coalition

Kilkenny said during the first quarter of 2016, overdose fatalities were down by 40 percent from the first quarter of 2015. He attributes this in part to naloxone deployment, which only began in February 2016, but also to an increased awareness and willingness to seek help among people who have addictions.

The program’s impact on infectious disease rates is being measured; because the program is so new, results are not yet available. Kilkenny said that obtaining resources to more effectively capture and manage this data is one of his priorities. He would also like to see a more formal data sharing process between the police department and public health department to help analyze and operationalize the data they capture. “We still have a long way to go when it comes to getting the most useful data. But from what we’ve seen so far, this program is producing some really promising results,” Kilkenny said.

# 4. Improving Access to Data and Intelligence

At the April 2016 forum, participants discussed the importance of robust data sharing between law enforcement agencies and public health organizations in developing a response to the opioid epidemic. Integrating public safety data and public health data can improve how officials track opioid use and overdoses, identify current trends, and direct their resources and interventions.

To this end, it is critical that law enforcement agencies and public health organizations develop strong data collection and sharing protocols. By collecting and sharing data regarding opioid-related events such as overdoses, arrests, hospitalizations, and emergency room visits, officials can better collaborate to address the problems in their communities.

> "The first thing we have to do is to agree on our primary goal. If it is to reduce drug overdoses—to save lives, then everything we do should be focused on accomplishing that goal. It starts with collecting and analyzing key data from labs, medical examiners, emergency departments, police departments and prosecutors' offices—from anyone who has information or resources that can help us accomplish our goal. We are taking steps in the right direction, but we aren't quite there yet. But if we all agree on the same goal and if we all agree to urgently work together to accomplish that goal, I have no doubt we will be successful."
> – Chauncey Parker, Executive Assistant District Attorney and Special Policy Advisor, New York County District Attorney's Office and Director, New York-New Jersey High Intensity Drug Trafficking Area

### Overcoming barriers to data access and sharing

The forum participants stressed that while there has been some progress toward integration of public health data and public safety data, there are still many obstacles that must be overcome before data can be used to improve policies and programs.

### *Access to timely mortality data*

For example, public health and law enforcement officials agree that it is often difficult to get access to timely mortality data from medical examiners' offices. "In New York, we have a great record of reporting mortality data, but there is still an incredible lag," said Denise Paone, Director of Research and Surveillance at the New York City Department of Health and Mental Hygiene's Bureau of Alcohol and Drug Use Prevention, Care, and Treatment.

"Mortality data is important, but it usually just isn't timely enough. Similar to driving, we need real-time information so that we can make quick informed decisions. But mortality data is like driving while looking in the rearview mirror. Part of the time lag is because most medical examiners' offices are severely understaffed around the country," said Captain Juan Colon, Bureau Chief of the New Jersey State Police Information and Intelligence Support Bureau.

### *Access to medical and pharmacy records*

Many law enforcement officials said that patient confidentiality safeguards can make it difficult or impossible for them to gain access to medical and pharmacy records. They said that although patient privacy should be paramount, there should be a more streamlined process for law enforcement to access these records in certain cases.

"A lot of times we're collaborating with treatment providers and the health department, but we can't get access to the same information they have," said Kifer of the Hagerstown (Maryland) Police Department. "We've had addiction specialists say that they wish they could share more information with us. Sometimes we can't discuss whether people are following up with their treatment plans. It would be better if we could share those things."

Some jurisdictions have overcome this barrier by asking patients to allow information sharing, so that program partners can all have access to relevant patient records. This is the approach taken by the LEAD program in Seattle. "When it comes to information sharing, we found it very helpful to have patients sign a release form that allows case managers to share information on a need-to-know basis with police officials and prosecutors," said Daugaard of the PDA's Racial Disparity Project. "And people generally agree to sign these releases because they know the information will be used to help them, not hurt them."

Many state and local law enforcement officials said that when they lack access to information, it makes it difficult for them to participate in their states' prescription drug monitoring programs. For example, Captain David Kelly of the Michigan Department of State Police said his state's monitoring program has a database that is run by the Department of Licensing and Regulatory Affairs, and law enforcement has

limited access to it. “It would be helpful if we could better work with the public health people to comb through that data proactively to identify the outliers, both in the prescribers and the pharmacies, and to generate leads that we can work,” Kelly said. “Right now, we have limited access. We have to pretty much already have a suspect’s name and a case built before we can use the databases.”

> “Patient information is sensitive, and we are very careful with how it is used. In our program, this information is used to increase the humanity of the exchange between the patient and police, prosecutors, and case managers. It is never used against them. This is an information sharing modality that has evolved, and it has broken down what many people assumed was a necessary barrier.”
> – Lisa Daugaard, Policy Director, Public Defender Association’s Racial Disparity Project

### *Access to law enforcement data*

Many public health officials said they would like to have better access to certain law enforcement data, such as information that police departments keep on overdose incidents.

“In some jurisdictions, law enforcement agencies collect very detailed information about overdoses, especially nonfatal ones. This information becomes a timely and rich data source about what is happening in the community at that time,” said Baier at the Maryland Department of Health and Mental Hygiene. “Public health officials and treatment providers don’t generally have access to that kind of comprehensive data, but it would incredibly useful for identifying who to follow up with, to offer treatment, support, naloxone training, et cetera. Sharing this data could be used beneficially in a public health capacity.”

Public health officials said it would also be useful to have better access to the results of forensic tests conducted on drugs that are seized by police or sheriffs’ departments, especially given the rise of fentanyl and other synthetic opioids. “Sharing lab data when there is a drug seizure, or even at the individual case level, would really help us understand what drugs are out there, and that could inform public health responses,” said Paone of the New York City Department of Health and Mental Hygiene.

“It might be helpful for crime labs that test drug samples for law enforcement to expand the scope of what they test, beyond just what might go to trial,” Baier said. “They could test broader samples to see if there are other substances mixed in, or if there are certain mixtures that are causing deaths in a particular area. This information could be used in public health outreach and harm reduction efforts. If we had this data, we could have a quicker response when we start to see something new out there, like fentanyl. It could really go a long way towards reducing deaths.”

Some public health officials also said that getting data on the locations of arrests and drug enforcement activities would help them develop more targeted interventions. “When I was the chair of the county board of health, I would have loved to know more about where the police department was targeting its drug arrests and activities. That would have helped us know where to deploy our public health assets, and it would have made collaboration much easier,” said Davis with the Network for Public Health Law.

### *Building trust between public health and public safety*

Many participants at the April 2016 forum said that public health and law enforcement officials must learn how to trust one another to strengthen data sharing between the two professions. This includes working to understand each other’s perspectives and find common goals.

“Law enforcement agencies and public health groups have to learn how to speak the same language,” said Childs, Executive Director of the NCHRC. “Sometimes they have different goals and capabilities, and they may not always understand where the other is coming from. For example, a police department may want real-time data from a public health organization, but that just might not be possible.” In order to facilitate better partnerships between law enforcement and public health, Childs’ organization works to bridge the communication gap between the two in order to build working relationships that benefit the community as a whole.

“The broader question is, how do we get everyone on the same page and make sure we are working towards the same goals?” Davis said. “Historically, public health and public safety have worked at cross-purposes. How do we overcome those trust barriers? It will involve a shift in priorities, incentive, and culture.”

One example of law enforcement agencies and public health professionals coming together to share information is in Washington, D.C., where the mayor coordinated a working group that meets twice per month to develop strategies for addressing the opioid epidemic. The group includes representatives from the local health department, EMS, the D.C. Metropolitan Police Department (MPD), the medical examiner’s office, and other stakeholders from the public health and public safety sectors. Commander Robin Hoey of the MPD said that these meetings are a valuable resource for information sharing and collaboration.

“Everyone contributes information that could be critical to our opioid response. For example, the health department and EMS personnel report on locations where they encounter overdoses, the medical examiner’s office provides information on toxicology reports and overdose and drug use trends, and we hear from probation and parole officials about drug content that is coming up when their clients get tested. This level of coordination has been a huge help,” Hoey said.

The remainder of this chapter highlights four programs that focus on improving the collection, access, sharing, and analysis of data to develop better responses to the opioid epidemic. These programs illustrate the benefits of robust data sharing between public health and public safety partners, the challenges to building these data systems, and how these successful programs can be implemented in other communities.

## RxStat, New York City, New York

RxStat, which was established in 2012 and is funded by the BJA and the ONDCP, has quickly become a model for how public health and law enforcement organizations can operationalize shared data in order to reduce opioid-related deaths.

The initiative emerged from the New York City Task Force on Prescription Painkiller Abuse to address the growing opioid problem in the city.[25] The task force, led by the New York City Department of Health and Mental Hygiene, brought together people from a wide range of disciplines across the public health and public safety fields. After realizing the important role that data could play in addressing the opioid problem, the group developed the system of data collection and sharing known as RxStat.

### *How RxStat works*

RxStat focuses on using public health and public safety data to reduce overdoses and deaths. According to the RxStat Technical Assistance Manual,

> RxStat is a model for advancing a shared understanding of the patterns and characteristics of problem drug use—including prescription opioid misuse - in a local jurisdiction. In New York City, RxStat was initially developed with the goal of preventing overdose mortality. RxStat uses existing datasets to generate information which can be used to tailor targeted interventions and policy responses to reduce deaths and illnesses involving prescription opioid and other drug misuse.[26]

Chauncey Parker, a prosecutor with the New York County District Attorney's Office and the director of the New York-New Jersey HIDTA, described RxStat as being similar to CompStat, the performance management tool used in many police agencies to reduce crime. "RxStat is like CompStat for fatal overdoses," Parker said. "Like CompStat, RxStat uses timely and accurate data to drive our strategies. The key lesson that we have learned from CompStat is 'what get measured gets done.' If the goal is to reduce crime, crime goes down. So if the goal is to reduce overdoses, then overdoses will go down as well."

RxStat is led by the New York City Department of Health and Mental Hygiene together with their public safety partners. It involves partnerships among a wide range of organizations representing a variety of disciplines. Partners include the local health department; federal, state, and local law enforcement

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[25] Daliah Heller et al., *RxStat: A Public Health and Public Safety Collaboration for Responding to Problem Drug Use at the Municipal/County Level*, Technical Assistance Manual (New York: Department of Health and Mental Hygiene, 2014), http://www.pdmpassist.org/pdf/RxStat.pdf.

[26] Ibid.

(including the NYPD); prosecutors; hospital systems; substance use disorder treatment programs; social services; the New York-New Jersey HIDTA; probation and parole authorities; correctional health services; and Medicaid fraud investigators.

RxStat consists of two general phases: collecting timely and accurate data and using the data to develop targeted interventions aimed at reducing overdose deaths.

**Phase I: Collecting timely and accurate data.** Phase I focuses on collecting public health data across a wide variety of metrics, including overdose deaths, hospitalizations, emergency room visits, and prescription drug monitoring data. "The goal is for us to get timely and actionable data so that we can understand emerging trends and develop multiprong approaches," said Paone of the New York City Department of Health and Mental Hygiene.

Paone said that public health officials have faced several challenges when it comes to collecting timely and accurate data. "The public health community isn't always geared towards recording data in a timely way," she said. "And there are some limits to our access to prescription drug monitoring data, which most people think of as a law enforcement tool."

Paone said that with RxStat, the data stream has typically flown from public health to public safety and rarely the other way around. To address that issue, RxStat officials are working on a data sharing initiative under which the NYPD will share drug seizure data both at the individual case level and beyond. Paone said this will help public health organizations better understand what types of drugs are on the streets, which is particularly important with respect to the rise of fentanyl.

The RxStat Technical Assistance Manual recommends implementing a data use agreement to resolve potential concerns about confidentiality and to outline the parameters regarding what types of data will be shared, who owns the data, and what the penalties will be for violating the agreement.

**Phase II: Developing targeted strategies to reduce overdose deaths.** Phase II focuses on applying the data collected during phase I to develop policies, interventions, and other strategies for reducing overdose deaths. Law enforcement officials and other stakeholders who are responsible for developing policies and programs are critical to this phase. "Police can use the data we collect to identify the neighborhoods that have the highest numbers of overdose deaths and go there to deploy naloxone. Or we can identify whether prescribing practices are an issue, and then come up with interventions to address that." Parker said.

"Looking at the data in this way really helps expand the conversation about possible intervention options. We can see where the problems are and what the problems are and then collaborate to come up with creative solutions."
– Denise Paone, Director of Research and Surveillance, New York City Department of Health and Mental Hygiene's Bureau of Alcohol and Drug Use Prevention, Care, and Treatment

### *RxStat in action—Staten Island*

The experiences in Staten Island, one of New York City's five boroughs, illustrate how RxStat can help improve a city's response to the opioid epidemic.

After reviewing overdose data, Paone and her team discovered that Staten Island's rates of prescription painkiller overdoses were 3.5 times higher than those in the rest of New York City. Their review of prescription drug monitoring data also found that in Staten Island, prescriptions for opioids were being filled at higher doses and for longer durations than in most other places.

Based on the data, the team put together a multipronged strategy that targeted Staten Island. One element of this strategy was to strengthen awareness and accountability for prescribers of opioid painkillers, which Paone said was done throughout New York City. "We issued prescribing guidelines to all prescribers in New York City. We also had the health commissioner participate in two town hall meetings with prescribers, and did a public health campaign in which we visited 1,000 doctors who were prescribing opioids. We talked to them about our key messages on prescribing opioid painkillers, urging them to prescribe them at lower doses and for shorter durations."

"Staten Island was the perfect place to pilot some of these programs. Not only did we have a very serious opioid problem, but we have a population that is demographically comparable to many places in the country. We have local elected officials who are very committed to addressing opioid misuse, and a harm reduction community that is very active and willing to help. Even our local newspaper is highly focused on the issue. In short, we were ready to take this on."
– Michael McMahon, District Attorney, Richmond County, New York

Another element of the multipronged strategy involved establishing a naloxone deployment pilot program for NYPD officers in Staten Island. (The NYPD's naloxone program is detailed in chapter 2 of this publication.) Staten Island was the first borough to equip NYPD officers with naloxone, and it was selected as the pilot site based on data showing that it had the highest rates of opioid overdoses in the city.

Officials in Staten Island also implemented protocols geared toward gathering intelligence from overdoses with the goal of using the information to prevent future incidents from occurring. Under these new protocols, NYPD detectives and prosecutors from the Richmond County, New York, District Attorney's Office work with overdose victims' family members and friends to gather information and evidence that might help them better understand where the drugs came from.

"We rely on the cooperation of the families and friends. We reassure them that we aren't there to target them, and we send counselors out to talk with them and make them feel comfortable," said Richmond County District Attorney McMahon. "Our goal is to use this information to hopefully predict where the next incident will occur, so that maybe we can stop it."

Police officials in Staten Island, in collaboration with elected officials and community organizations, also developed the Youth FIRST (Family Intervention Resource Support Team) Initiative, which identifies and assists youth who are using illegal drugs. "We realized that the only time we really paid attention to the kids using drugs is when we arrested them for some other crime. But we decided that we needed to intervene before it got to that point," said the NYPD's Delatorre, the borough commander for Staten Island.

Under the initiative, police work with local schools to identify youth who are under the influence of drugs. EMS responds and confirms that the youth is using drugs. The youth is taken to the emergency room, and the youth's parents as well as partner treatment providers are called in. Delatorre said that the youth's identity is always safeguarded and that the treatment providers are initially introduced to the parents rather than to the youth. "We are getting to these kids early, before they get in too deep with drugs or crime," Delatorre said. "And because of that, we're seeing some success."

Paone said that Staten Island has seen a 29 percent decrease in prescription opioid deaths since officials first began implementing the data-driven strategies. "We used the data to help us define our approach, and we never lost sight of the ultimate goal—reducing overdose deaths," Paone said. "So far, we have been very encouraged to see that it is working."

## Drug Monitoring Initiative, New Jersey

The Drug Monitoring Initiative (DMI) was started under the New Jersey Regional Operational Intelligence Center (ROIC), a fusion center and the state's primary contact point for collecting, analyzing, and disseminating criminal and terrorist intelligence data. DMI has become a national model for how to implement multistate, multiagency data sharing programs to better understand and respond to the opioid epidemic.

The DMI involves an information sharing process that allows the New Jersey ROIC to access the results of forensic tests conducted on drugs seized by law enforcement within 24 hours of the drugs being received by the lab. These data are analyzed and correlated with information on overdoses, naloxone deployments, hospitalizations, and other public safety and public health data. The results provide a more comprehensive picture of how drugs are being distributed and seized throughout the region as well as their impact on public health outcomes.

### *Developing the Drug Monitoring Initiative*

Many federal, state, and local law enforcement agencies participate in the DMI as do several county, municipal, and nongovernmental partners from within the state.

In 2008, as the New Jersey ROIC began fielding more and more information about a rise in heroin overdoses, Colon, the Bureau Chief of the New Jersey State Police's Information and Intelligence Support Bureau, decided to start systematically collecting information about heroin throughout the state. Colon began by reaching out to law enforcement and health partners and asking what they needed in order to better respond to the emerging opioid crisis. "We asked people questions like, 'What drug information will help you fulfill your responsibilities? What will make you more effective? What kind of information do you need, and how quickly do you need it?' The answers to those questions identified customers' information needs and the program's intelligence requirements," Colon said.

Colon's team used the information to identify essential data sets that included both public safety metrics (e.g., drug seizures, shootings, gun recoveries, drug arrests) and public health metrics (e.g., naloxone administrations, treatment admissions, toxicology reports). As they worked to identify who held these data, they focused on building relationships with the handful of forensic labs that analyze drugs seized by law enforcement agencies throughout the state.

"I had a meeting with all of the lab directors, and we discussed the intelligence value that can be derived from analyzing drug seizure data," Colon said. "I asked them to supply me with the results of their drug examinations within 24 hours. And in return, I promised to send them reports outlining the patterns, trends, and anomalies we found for all drugs, not just heroin."

The New Jersey ROIC entered into data sharing agreements with the labs, and ultimately an automated information sharing process was put into place. "Now, we don't have to rely on a person to send us the information. It is all done automatically behind the scenes," said Colon.

"To develop a robust data sharing initiative, you need to first establish a process. Identify the data you want. Identify where you can get the data. And then build strong relationships with the people who have the data so that you can better collaborate and share the information you have."
– Juan Colon, Captain, New Jersey State Police and Bureau Chief, Information and Intelligence Support Bureau

### *Collecting, analyzing, and operationalizing the data*

The forensic labs provide the New Jersey ROIC with drug analysis data within 24 hours of receiving the seized drugs. Colon said that the labs test the samples for all types of drugs, and in 2014 they also began testing for synthetic drugs such as fentanyl and "bath salts." The 24-hour turnaround time represents a significant improvement over the eight to ten weeks it previously took for drug examination data to be disseminated. Colon said the fast turnaround is critical to the initiative in providing real-time information to law enforcement and public health during emergent situations.

Colon's team also gathers data from law enforcement and public health partners on measures such as toxicology examinations, drug-related hospitalizations, arrests, prescription drug monitoring, naloxone deployments, firearm shootings, and gun recoveries. The team analyzes all of these data sets separately and then conducts cross-data correlation analysis to develop an enhanced understanding the presence and prevalence of specific drugs in specific areas.

"These efforts provide a live and realistic picture of the drug environment based on empirical data, not just anecdotes," Colon said. "We can tell what drugs are being seized, the composition of those drugs, where the drug hot spots are, where prescription pills are being dispensed. And we can parse it down not just to a particular city, but to a particular block."

The New Jersey ROIC then pushes this information out to its law enforcement and public health partners, who use it to inform their policies, programs, tactics, and resource deployment. For example, public health partners can use the information to understand the types of drugs on the illicit market—and what new drugs may be emerging—which can help them tailor drug prevention and intervention efforts to target these drugs. Similarly, EMS personnel can use the data to tactically deploy resources to locations where there has been a rash of overdoses. This enhances their readiness posture and response with naloxone.

> "The DMI is a multi-disciplinary approach. We try to avoid having the law enforcement side develop a policy without considering the impact of that policy on the public health side and vice-versa. We want this to be an initiative that benefits everyone."
> – Juan Colon, Captain, New Jersey State Police and Bureau Chief, Information and Intelligence Support Bureau

On the law enforcement side, the information disseminated by the New Jersey ROIC can help police agencies develop more targeted supply-side enforcement actions such as surveillance and undercover drug buys. Police can also use the data to connect overdoses and other drug-related incidents.

"Before the DMI, there could be thousands of drug arrests and overdoses, and none of them were ever connected. Now, agencies can use empirical forensic data to connect arrests and overdoses. DMI connects these incidents by comparing the specific drugs identified within the package, the packaging type and color, the stamp or marking on the packages and color, regional proximity, temporal analysis, Colon said.

Law enforcement agencies and public health groups are not the only ones that benefit from the data shared through the DMI. "The community benefits too," said Colon. "We can use our findings to educate the public on a particular trend or danger. For example, each year on Halloween, we issue a notice for parents to be on the alert for candy that may have been laced with marijuana. We know that this is a real threat."

### *DMI training and funding*

The New Jersey ROIC conducts a basic drug training course for law enforcement personnel, firefighters, EMS personnel, and health care professionals. The purpose of the course is to help participants understand the DMI, emerging drug trends, how to identify drugs, and what to do when they encounter drugs and drug paraphernalia. Colon said that the ROIC is training 2,500 people throughout the state as part of this program.

The DMI does not have any dedicated funding sources; instead, it relies on leveraging existing resources and partners to collect and disseminate information. Colon said that as the program became nationally recognized, he has received some additional staffing resources as well as a Drug Enforcement Administration (DEA) analyst to provide assistance.

### *The future of the DMI*

As of April 2016, 13 other states across the country have implemented programs modeled on the DMI. The ONDCP has cited DMI as a best practice, and the U.S. Office of the Director of National Intelligence held a summit to establish a nationwide plan to collect, analyze, and share drug data based on the DMI model.

According to Colon, the National Governors Association has adopted the DMI as model for its Learning Lab on State Strategies for Reducing Overdose and Deaths from Heroin and Illicit Fentanyl: Improving Information Sharing and Data Analysis Between Law Enforcement and Public Health.

In New Jersey, Colon is exploring ways to use DMI data to help identify people who need help and connect them to treatment before they are arrested or they overdose. He also wants to start a network among medical examiners throughout the country to improve how mortality data are collected and shared. He also seeks to have the fusion center provide 24-hour investigative support to law enforcement. He sees the need for law enforcement and EMS to report naloxone administration into the same biosurveillance system. Finally, he seeks to implement a drug harm index to help measure the impact of efforts by both law enforcement and healthcare partners.

## Project VISION, Rutland, Vermont

In 2012, Rutland, Vermont, which has a population of 16,495, was reeling from the effects of the rising opioid epidemic. James Baker, who was then chief of the Rutland Police Department, said that the situation had reached a near-breaking point. “People were extremely frustrated, both inside the police department and throughout the community. Everyone was turning to the police department to do something,” Baker said.

Then, a young local woman was killed after being struck by a car driven by someone who was high on drugs. “That incident was the final straw,” said Commander Scott Tucker of the Rutland Police Department, who serves as the Executive Director of Project VISION (Viable Initiatives and Solutions Involving Neighborhoods). “That was the moment when everyone decided that we needed to stop talking about the problem and instead actually do something about it.”

Baker began reaching out to key community partners, and together they explored ways to address the crisis in their community. Together, along with a local researcher, they developed Project VISION, which focuses on building partnerships, sharing information, and leveraging resources in order to reduce crime, address substance abuse, and strengthen neighborhoods.

Project VISION is a collaborative, community-wide effort that involves partners from across a variety of fields. Partners include the Rutland Police Department (now led by Chief Brian Kilcullen), elected officials, representatives from the medical field, social service providers, local businesses, criminal justice agencies, schools, nonprofit organizations, mental health providers, faith-based groups, federal and state law enforcement agencies, and other stakeholders. “We brought in nearly everyone you can think of. It was an all-hands-on-deck effort, and everyone rallied around this project,” Baker said.

> “Project VISION started before I came to Rutland, and I had no idea what to expect. When I attended my first meeting, I was so impressed by the passion and energy that I saw. There were probably 100 people there, from all across the community, and you could see how dedicated everyone was to this. It is this excitement and sense of community that has made this project work.”
> – Brian Kilcullen, Chief of Police, Rutland (Vermont) Police Department

### *How Project VISION works*

Project VISION takes a multidisciplinary approach to the opioid crisis. It uses data to inform policies and tactics and combines a public health response (e.g., treatment and service delivery) with a traditional law enforcement response (e.g., supply-side enforcement actions) and includes committees of volunteers focused on outcomes. Project VISION members meet at least once each month. The program involves many components, which are detailed in this section.

- **Data collection and analysis.** The police department collects data regarding measures such as calls for service, neighborhood disorder complaints, opioid-related hospitalizations and overdoses, school truancies, and census information. The police department first contracted with a private analyst to strategically analyze the data and hired its own crime analyst to focus on tactical responses. The results are used to determine the connections between opioid use and other community-wide problems such as poverty, truancy, and neighborhood disorder and to develop targeted interventions and enforcement tactics with a focus on drugs and violence.

- **RutStat meetings.** RutStat, which is modeled on CompStat, involves meetings every other week in which partners discuss the data and how to use it. According to Tucker, approximately 30 people attend most RutStat meetings, and about two-thirds of the participants are non–law enforcement partners. Crime mapping is available on a public platform, so neighbors can see calls for service.

  During the meetings, representatives from the police department present specific addresses within the community that have been the subject of three or more police visits during the previous two-week period. Project VISION members can then determine whether they are familiar with the addresses through their own work—for example, a social worker who is at the meeting may have a client at the address.

  "Based on what is learned at the RutStat meetings, Project VISION partners can devise a plan to provide the person identified with the appropriate services," Kilcullen said. "We're looking to flood that person with services that address the underlying problems that they're facing. Each person may have a different piece of the puzzle, and RutStat meetings are a way to put those pieces together."

  In addition to identifying where services are needed, Baker said that RutStat meetings help to promote police accountability. "If the same address kept coming up at every meeting, the shift commander in charge of that section of the city would have to report why there were still problems and what they were doing to address them," he said.

"The data piece is critical to the success of Project VISION. We are committed to the idea of open data and sharing our information with partner organizations, researchers, and members of the public. We find that we are able to share most types of information, and so we make every effort to put that information out there."
– Scott Tucker, Commander, Rutland (Vermont) Police Department and Executive Director of Project VISION

- **Vision Center.** The Vision Center is a facility located within the Rutland Police Department. It is staffed with practitioners from a variety of disciplines, including mental health crisis professionals, licensed social workers, domestic violence coordinators, and probation and parole personnel. Some work full time out of the Vision Center, while others are part-time. "The goal of the Vision Center is to improve collaboration and communication between the various Project VISION partners," Tucker said. "Bringing everyone together in a central location helps us better coordinate our efforts."

- **Targeted enforcement.** The police department also implemented an initiative that applies Operation Ceasefire principles to disrupt drug markets. In Rutland, the police department used this approach to make sure that drug dealers are held accountable.

  "We created a list of the dealers who were causing the most harm to the community," Baker said. "Then we used the 'pulling levers' approach. We offered services and support to help them, but we also put them on notice that if they continued dealing, we would hold them accountable. We worked with probation and parole; we assigned special prosecutors to their cases, et cetera. We used whatever 'levers' we had available to change the environment in the areas where those drug markets were located."

- **Methadone clinic.** Project VISION's comprehensive opioid response included providing strong support for the opening of a methadone clinic in the fall of 2013. The clinic is run by the hospital and now serves more than 900 clients.

- **Committees.** Project VISION boasts 400 members on its listserv. There are three committees that offer opportunities for agencies, nonprofits, citizens, and others to work collaboratively to deliver outcomes that make Rutland a healthy and safe place to live.

### *Building community support for Project VISION*

Baker received little pushback from the community regarding Project VISION aside from some initial skepticism. "For a long time, people in the community felt that they weren't being taken seriously when it came to drug-related issues. They felt like they were continuously going to the police and asking for help but that we weren't doing anything about it. They didn't really trust us to keep our word," Baker said.

Baker began spreading the message that the police department was making a serious commitment to address the opioid problem. He also focused on changing the narrative of how the department responded to drug issues. "We made sure people understood that this wasn't just about enforcement. This was about getting people help. I think that helped improve trust as well," he said.

> "We knew we had to earn the people's trust and that we had to show them we were serious about solving this problem. So we attended community meetings to talk to people about the drug problem and Project VISION. I announced my cell phone number to the crowd and told people to call it if they didn't get an adequate response from the police. We walked door to door to talk to people about the problems in their neighborhoods. We held block parties in front of drug markets; we introduced ourselves to drug dealers and told them that they have options. As we put the pieces of Project VISION into place, people began trusting that we were committed to this cause."
> – James Baker, Director of the Advocacy Team, International Association of Chiefs of Police and former Chief of Police, Rutland (Vermont) Police Department

Tucker said that strong leadership by Baker, Rutland Mayor Christopher Louras, and community partners helped garner support for the program. "My advice for people looking to implement programs like this is to reach out to the leaders in your community. Find people who are passionate and charismatic, and get them on board so they will bring others to the table," he said.

"After a while, people started calling in to the police to report drug activity in their neighborhoods," Baker said. "That is actually where a lot of our data came from. I think this demonstrates how the community has begun to trust in their police department again."

### *Project VISION funding*

Most of the funding for Project VISION comes from leveraging community resources, from existing agency budgets, and from donations of services. For example, the Vision Center, the crime analyst, the community response sergeant, and the executive director are all paid through city funds. The practitioners embedded within the project, such as social workers and mental health crisis counselors, are largely funded through grants from their respective organizations and services donated pro bono to the project. The only additional money came from a $50,000 grant from the Vermont Department of Corrections, which went toward startup and infrastructure costs. "It isn't always easy, but everyone who is involved has just found a way to do it. The flexibility and generosity of our partners is what makes this thing work. We do it because we believe in doing it together," Tucker said.

### *Project VISION outcomes*

Project VISION's leaders are currently working to evaluate the program. Baker and Tucker agree it is already clear that the program is having an overall positive impact. They said the use of researchers and evidence-based models are an important facet of Project VISION.

According to Tucker, many of the crimes associated with drug use have decreased since the program started. Burglaries have decreased by 60 percent in the past two years and shoplifting is down 36 percent while larcenies overall are down 40 percent in the same time period.

Tucker said that one of the most important benefits of the program is that it has helped bring the community together in a grassroots effort to address common problems. "People are engaged in a way that they weren't before. They are building relationships and learning from each other and recognizing that change is a continual and community-wide process," he said.

## Local Overdose Fatality Review program, Maryland

In response to the opioid epidemic, in 2014 the Maryland legislature passed a law establishing local overdose fatality review teams in each county in the state. According to Baier, Overdose Prevention Director at the Maryland Department of Health and Mental Hygiene (DHMH), the purpose of the teams is to conduct an in-depth review of overdose fatalities in order to gather information about how each death might have been prevented. This information is then submitted to state leaders, who use it to inform changes to laws, policies, and practices to prevent future deaths.

"One important aspect of the Overdose Fatality Review program is that it gets input from all the different counties in Maryland," said Kifer of the Hagerstown (Maryland) Police Department, which participates in the program. "What works in one place may not work in another, so it is important to gather everyone's ideas in order to see the big picture. We're providing information on what is being done locally, what we need help with, and what works and what doesn't. It is a really important initiative."

### *How the Local Overdose Fatality Review program works*

The Local Overdose Fatality Review program is supported by the BJA and coordinated at the state level through the DHMH. The review teams are developed and implemented at the county and local level. The program involves the following general process:

- **Creating the overdose fatality review team.** Each jurisdiction creates its own overdose fatality review team. The teams are composed of members from a variety of disciplines and include representatives from the local health department, local police and sheriff's departments, hospitals, EMS personnel, treatment providers, social services agencies, the Office of the State's Attorney, local detention centers, parole and probation personnel, and other community service providers. "The goal is to establish a team that includes a wide range of people who would have contact with individuals affected by overdoses," said Baier.

- **Conducting an overdose fatality review.** Baier said the teams conduct in-depth collaborative reviews of each overdose fatality case. "This is really a mortality review, like you usually see in the field of medicine or public health. It is taking a public health approach to reviewing overdose cases," Baier said.

  For each overdose incident, the DHMH provides the local review team with information from the state medical examiner's office including raw information about the death and any substances found during the medical examination. The DHMH also provides the local review team with any other information it can gather such as the deceased's drug treatment records. Team members must sign a confidentiality agreement to obtain access to protected health information.

The local review teams examine these data and all other information they receive about each case. Based on this review, the team develops a set of findings about what potentially could have been done to prevent the death including any missed opportunities for prevention, gaps in the system, and areas for increased collaboration among agencies and stakeholders at the local level. The team also develops recommendations for how these deficiencies could be addressed through changes in laws, policies, and protocols.

- **Data sharing.** The review team's findings and recommendations are shared with officials at the state level, who use the information to inform policies and programs aimed at preventing future overdose deaths. For example, Baier said information gathered from the local review teams has been used to drive the adoption of naloxone by many law enforcement agencies in Maryland.

> "The act of meeting regularly, of sitting down to discuss and strategize, really strengthens relationships among the people on the teams. Each partner gains a better understanding of what the others can bring to the table, which allows them to work collaboratively from a prevention standpoint. And the benefits of these partnerships go beyond this program. By building these relationships, people can work together to address a variety of community-wide problems."
> – Michael Baier, Overdose Prevention Director, Maryland Department of Health and Mental Hygiene

### *The Local Overdose Fatality Review team in Hagerstown, Maryland*

In Hagerstown, Maryland, the local overdose fatality review team is managed by the local health department and includes partners from the Hagerstown Police Department, addiction specialists, pain management facilitators, treatment providers, counselors, staff members from the local hospital, mental health providers, staff members from the local Department of Social Services, and representatives from the Washington County (Maryland) Sheriff's Office. "When the program first started, we spent some time getting a feel for what everyone was doing in their own fields as it related to opioid abuse and prevention," Kifer said. "Once we did that, we realized there were things that we could to do support each other, and that became the focus of our efforts."

The team reviews two to three overdose fatalities per month. It receives data from the health department, and team members also contribute information from their own agencies about the case. The team compiles and reviews the data to identify where any breakdowns in the system occurred in each case and then puts its findings into a report that is sent to the Department of Health and Mental Hygiene.

> "Participating in this program has helped me understand how much more we could be doing as a police department to address some of these problems. It gave me the opportunity to go out and say, 'This is a public health crisis, not just a public safety crisis.' These reviews aren't about being critical or blaming each other. They are about looking at the situation with our eyes wide open and being willing to admit when you can do more to help."
> – Paul Kifer, Captain, Hagerstown (Maryland) Police Department

"We ask questions such as, what kinds of services were offered? Did the person not get the information he or she may have needed? Did the family not know how to get help? Did law enforcement have an opportunity to engage? The exercise isn't meant to place blame, but to understand where the breakdowns were and develop solutions from that," Kifer said.

The Hagerstown Police Department's role illustrates how local law enforcement agencies can contribute to these types of initiatives. For example, as a result of the program, the police department began working with mental health care providers to understand how they could work together to improve the response to people with mental health crises. The police department also began looking at its own data to determine how it could better address opioid-related issues and started using the data to perform research and share it with the group.

The police department is also working with the local health department to implement an initiative similar to the ANGEL Program in Gloucester, Massachusetts. As part of this program, people can turn their drugs and drug paraphernalia in to the police without fear of arrest, and a counselor is on hand to provide assistance with treatment and services. "These efforts have really helped us as a police department to broaden our response to the opioid crisis," Kifer said. "It is also helping us demonstrate to the public that we are here to help, not to arrest our way out of this problem."

### *Local Overdose Fatality Review program outcomes*

Baier said the program has yielded a great deal of information from the local review teams, which has helped them better understand the circumstances surrounding fatal overdoses. "Information is very specific to each case, so it's difficult to generalize the data we're collecting. But we're learning about the factors that are present, or are not present, in these overdose cases. We're learning where the service gaps are, whether law enforcement or EMS has responded to people, what kinds of assistance people are getting or not getting," he said.

Baier and Kifer agreed that improved collaboration and data sharing are key benefits of the program. "Team members get access to information that they wouldn't normally have without this partnership," Baier said. "And we're seeing people considering ideas that they wouldn't have even thought of before, like police and prosecutors supporting public health approaches to addiction."

Kifer said the lessons he has learned by participating on the team have been invaluable. “It has been eye-opening for me. I’ve been exposed to so many new ideas that have changed my perspective on things like addiction and treatment. I’m learning about the barriers to treatment and how we can work together to reduce those barriers. Just sitting down with people from other agencies and organizations is itself one way to reduce the barriers,” Kifer said.

### *The future of the Local Overdose Fatality Review program*

Baier would like to strengthen data collection and sharing by developing a better database for teams so that teams can access more detailed information about cases. He also wants to work with the highest-performing local teams—those with the best representation and that are the highest functioning—and support them in taking a more direct role in outreach. As part of this effort, teams would engage with healthcare providers who have had contact with decedents, especially if the provider prescribed the substances responsible for the person’s death. The goal of this outreach is to learn whether providers are screening for potential substance use issues and how they address high-risk patients. Baier would also like to increase the ability of teams to coordinate services for the decedents’ family members.

In Hagerstown, the police department is looking to develop an expanded education component to its program. “We’re trying to reach kids starting at the elementary school level and up through the high schools, with the goal of raising awareness about opioid abuse and the dangers of going down that road,” Kifer said.

### The Douglas Interagency Narcotics Team (DINT) Opiate Task Force, Douglas County, Oregon

The Douglas Interagency Narcotics Team (DINT) is a multiagency task force that includes personnel from the Roseburg (Oregon) Police Department, the Douglas County Sheriff's Office, the Oregon State Police, the state Department of the Interior, and the Douglas County District Attorney's Office. Though DINT's primary responsibility is drug investigation and enforcement, this component also works closely with partners on the treatment and demand reduction side.

For example, one DINT initiative is the Opiate Task Force, which was established in 2012 and represents a partnership between law enforcement agencies, medical providers, pharmacists, treatment providers, and social service professionals. The group meets monthly to share information, understand trend data, and develop strategies for disseminating data to other stakeholders in the area. They also hold awareness events in rural areas, coordinate prescription drug take-back programs, and work to expand the number of naloxone providers.

"Over a 30-month period, our rural area experienced 33 overdose deaths, with two-thirds of these caused by prescription medications and nearly three-quarters by opiates or opioids," said Commander Patrick Moore of the Roseburg Police Department. "Partnerships like the ones we've forged through the Opiate Task Force are one way we are trying to address this crisis. The biggest benefit to these kinds of programs is that they give you access to more information and resources than you would have if you tried to go it alone."

#### The Role of Federal Partnerships in Tackling the Opioid Epidemic

At the April 2016 forum, participants discussed the important role that federal partners play in the response to the opioid epidemic. Many federal agencies provide training, technical assistance, and funding to support state and local efforts both on the public health and public safety sides. In addition, several promising initiatives have been launched that take an integrated public health-public safety response and that involve key partnerships between federal, state, and local stakeholders.

For example, the Heroin Response Strategy, an initiative launched in 2015 and funded through a grant from the Office of National Drug Control Policy (ONDCP), involves a coalition of public health and public safety partners across 17 states and seven High Intensity Drug Trafficking Areas (HIDTA). The initiative created an information sharing network between the partners to improve access to and use of data regarding interstate drug trafficking and overdoses. Through this initiative, each state has an assigned drug intelligence officer, also known as a "point of light," to track local felony opiate arrests of people from out of state and then share this information

with the arrestee's home state. The initiative also placed a public health analyst in each state's health department to track overdose deaths and coordinate this information between law enforcement officials, public health organizations, federal justice officials, the Centers for Disease Control and Prevention (CDC), and other stakeholders.

**M.J. Menendez**
U.S. Department of Justice
Organized Crime Drug Enforcement Task Force

M.J. Menendez, the Heroin/Opioid Initiative Coordinator for the U.S. Department of Justice's Organized Crime Drug Enforcement Task Forces (OCDETF), said that the goal of this initiative goes beyond drug enforcement. "OCDETF is thrilled to be a partner in this HIDTA-led initiative. People are longing for real-time data, and that's what we're trying to provide here. We want to get hard data that law enforcement and public health can share, put it in a centralized database, and then send it out to points of contact in each region. This effort is important because law enforcement is traditionally enforcement-focused, and this is a whole new way of looking at things," Menendez said.

Another example of a program that leverages partnerships between federal, state, and local stakeholders to improve information-sharing is the Minnesota Model, launched in 2012 by Special Agent in Charge Dan Moren of the Drug Enforcement Administration (DEA) and Andrew Luger, U.S. Attorney for the District of Minnesota. This model involves collaborating with medical examiners' offices on identifying emerging fatal overdose trends on a more real-time basis; implementing a statewide or regional intelligence collection plan among federal, state, local, and tribal law enforcement partners; conducting integrated enforcement operations; and launching an aggressive public awareness campaign.

"The opioid problem is not just a county or local problem. It's a regional problem, and the best way to tackle it is to connect the dots though the sharing of actionable intelligence information," Moren said. "We collected and analyzed opioid-related information from the region, linked drug-related offenses and overdose deaths to criminal organizations, shared information with our law enforcement partners, and developed a collaborative plan to dismantle organizations peddling these deadly drugs."

***The Role of Federal Partnerships in Tackling the Opioid Epidemic (cont'd)***

The campaign to disseminate information about opioids and connect people to treatment and other services was a critical component of the Minnesota Model. The organizers hosted town halls and public forums with health care and mental health professionals, treatment providers, law enforcement representatives, prosecutors, people in recovery, and family members of victims whose lives were lost to addiction. Organizers distributed information about drug treatment and naloxone, and guest speakers shared their own experiences.

**Dan Moren**
Drug Enforcement Agency

"No matter where the events occurred, the venues were filled to capacity," Moren said. "This included churches, high school gymnasiums, and civic auditoriums. It was incredibly touching to have parents meet with us afterwards and express their gratitude for doing something about the heroin problem. The forums opened everyone's eyes to the magnitude of the opioid crisis, efforts made by law enforcement and the medical communities to combat the epidemic, strategies moving forward, and the struggles faced by people with addiction. There wasn't a dry eye in the place."

Moren said that the basic concept of this model is building relationships and sharing information. "If you're not regionally connecting the dots on the issues that are most negatively impacting our communities, you're missing the mark," he said. "Does this model work? In the greater Twin Cities area of Minnesota, there were fewer opioid overdose deaths in 2014 and 2015 as compared to prior years. While we are cautiously optimistic of the results seen thus far, the law enforcement, medical, and drug treatment communities know that we must redouble our efforts in this endeavor if we are to continue saving lives."

# Conclusion

There is no doubt that the opioid epidemic has caused widespread suffering throughout the country. The statistics are astounding: More people died from all types of drug overdoses in 2014 than in any year on record, and more than 60 percent of those deaths involved an opioid.[27] Since 1999, the number of overdose deaths involving opioids has nearly quadrupled, and currently 78 Americans die every day from opioid overdoses.

As communities face the devastating consequences of the opioid epidemic, they are urgently calling upon their leaders to take action. Law enforcement and public health officials have heard that call, and as the programs highlighted in this publication demonstrate, these leaders are exhibiting a passion and commitment to working together to reduce the harm, prevent future cases of addiction, and provide treatment to those who are addicted now.

For decades, the United States has implemented national drug strategies based on the concept of a "balanced approach," which includes drug abuse prevention, education, treatment, and enforcement initiatives. Law enforcement agencies generally saw their role as providing the enforcement components, while social service agencies and educators handled prevention, education, and treatment programs.

The opioid epidemic has brought a shift in thinking by many law enforcement agencies. Today, forward-thinking law enforcement executives are realizing that they must expand their role. It is no longer enough for police chiefs to provide moral support to the principles of drug treatment, education, and prevention; law enforcement agencies are becoming actively involved in those "demand-side" initiatives.

In many ways, police and sheriffs' departments are well-positioned to be involved in drug treatment and prevention efforts. Law enforcement agencies operate 24 hours a day, 365 days a year, and officers are constantly out on the streets, where they encounter persons who are struggling with addictions. Police officers and sheriffs' deputies naturally have opportunities to connect with persons who need help.

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[27] The most recent CDC data are from 2014. "Injury Prevention & Control: Opioid Overdose;" "Opioid Data Analysis;" "Prescription Opioid Overdose Data;" "Heroin Overdose Data" (see note 1).

So in many places, today's law enforcement agencies are spearheading efforts to develop innovative programs aimed at reducing fatalities and other harms caused by opioids. These programs—which focus on connecting people to treatment and services, deploying naloxone to reverse overdoses, mitigating the dangers of intravenous drug use, and using data to inform policies and practices—reflect an important shift in how police agencies are responding to addiction and drug use.

"Focusing on getting people into treatment rather than on simply arresting them is an unprecedented idea for law enforcement. Police never saw themselves in this role, but given the opioid epidemic, it is one that is critical for us to take on," said Biehl of the Dayton (Ohio) Police Department.

> "At some point, as you look at the lives lost and the harm to the communities that opioids have caused, you have to weigh whether arresting and incarcerating someone outweighs trying to get people who are addicted into treatment."
> – Leonard Campanello, Chief of Police, Gloucester (Massachusetts) Police Department

Of course, law enforcement agencies cannot do this alone. They need the expertise and experience of their public health partners such as the treatment providers, mental and physical health professionals, addiction specialists, researchers, and others in the field who work each day to help people in need. These partnerships are the cornerstone of the new approach to the opioid epidemic—an integrated approach that has its roots in the public health model, reflects principles of community policing, incorporates research and data into decision making, and emphasizes community-based solutions.

There is still much to be done. At the April 2016 forum, law enforcement executives and public health experts agreed that fully addressing the opioid epidemic will require expanded treatment capacity, additional resources for social services, and more research to determine which policies, programs, and strategies are effective.

However, in places where people from the public safety and public health sectors have come together to collaborate, share information, and learn from one another, real progress is being made. People are going into treatment instead of the criminal justice system. They are being connected to mental health care, housing, employment, and other support services. Lives are being saved with naloxone and through syringe services programs, and the public is gaining a better understanding about addiction and treatment.

The programs featured in this publication represent promising strategies for achieving these and other positive outcomes, and they can serve as models for other jurisdictions that are looking to implement similar strategies. By working together to develop and implement these types of programs, police and public health officials can strengthen their communities and curtail the harms caused by the opioid epidemic.

"The programs we've been seeing implemented recently, like naloxone programs, really go to the heart of what it means to respect the sanctity of human life, which should be central to what we do as police officers."
– Scott Thomson, Chief of Police, Camden County (New Jersey) Police Department.

# Appendix. Participants at the April 27, 2016, Forum

**Peter Arno**
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Maine Drug Enforcement Agency

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Lieutenant
New York City Police Department

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Overdose Prevention Director
Maryland Department of Health and Mental Hygiene

**James Baker**
Director of the Advocacy Team
International Association of Chiefs of Police

**Alexis Bakos**
Acting Director, Division of Policy and Data
U.S. Department of Health and Human Services
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**Tamas Balaton**
Sergeant
New York City Police Department

**Caleb Banta-Green**
Senior Research Scientist
University of Washington Alcohol and Drug Abuse Institute

**Leo Beletsky**
Associate Professor
Northeastern School of Law and Bouvé College of Health Sciences

**Richard Biehl**
Chief of Police
Dayton (OH) Police Department

**Matthew Birmingham**
Colonel
Vermont State Police

**Michael Botticelli**
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New Jersey State Police

**Laura Cooper**
Director of Government Affairs
Major Counties Sheriffs Association

**Dwayne Crawford**
Executive Director
National Organization of Black Law Enforcement Executives

**Gary Cunningham**
Acting Deputy Associate Director
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Division of Drug Enforcement

**Lisa Daugaard**
Policy Director
Public Defender Association Racial Disparity Project

**Ronald L. Davis**
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**William Dean**
Deputy Chief of Police
Virginia Beach (VA) Police Department

**Edward Delatorre**
Assistant Chief of Police
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**Mike Duggan**
Founder and Certified Interventionist
Wicked Sober

**Sean Fearns**
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**Ralph Long**
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# About PERF

The **Police Executive Research Forum (PERF)** is an independent research organization that focuses on critical issues in policing. Since its founding in 1976, PERF has identified best practices on fundamental issues such as reducing police use of force, developing community policing and problem-oriented policing, using technologies to deliver police services to the community, and developing and assessing crime reduction strategies.

PERF strives to advance professionalism in policing and to improve the delivery of police services through the exercise of strong national leadership, public debate of police and criminal justice issues, and research and policy development.

The nature of PERF's work can be seen in the titles of a sample of PERF's reports over the last decade. Most PERF reports are available without charge online at www.policeforum.org/ free-online-documents.

- Guiding Principles on Use of Force (2016)
- Identifying and Preventing Gender Bias in Law Enforcement Response to Sexual Assault and Domestic Violence (2016)
- Advice from Police Chiefs and Community Leaders on Building Trust (2016)
- Gun Violence: Regional Problems, Partnerships, and Solutions (2015)
- Implementing a Comprehensive Performance Management Approach in Community Policing Organizations: An Executive Guidebook (2015)
- Labor and Management Roundtable Discussions: Collaborating to Address Key Challenges in Policing (2015)
- Constitutional Policing as a Cornerstone of Community Policing (2015)
- Re-Engineering Training on Police Use of Force (2015)
- Overcoming the Challenges and Creating a Regional Approach to Policing in St. Louis City and County (2015)
- Police Accountability – Findings and National Implications of an Assessment of the San Diego Police Department (2015)
- Defining Moments for Police Chiefs (2015)
- Implementing a Body-Worn Camera Program: Recommendations and Lessons Learned (2014)

- Local Police Perspectives on State Immigration Policies (2014)
- New Challenges for Police: A Heroin Epidemic and Changing Attitudes Toward Marijuana (2014)
- The Role of Local Law Enforcement Agencies in Preventing and Investigating Cybercrime (2014)
- The Police Response to Active Shooter Incidents (2014)
- Future Trends in Policing (2014)
- Legitimacy and Procedural Justice: A New Element of Police Leadership (2014)
- Social Media and Tactical Considerations for Law Enforcement (2013)
- Compstat: Its Origins, Evolution, and Future in Law Enforcement Agencies (2013)
- Civil Rights Investigations of Local Police: Lessons Learned (2013)
- A National Survey of Eyewitness Identification Procedures in Law Enforcement Agencies (2013)
- An Integrated Approach to De-Escalation and Minimizing Use of Force (2012)
- Improving the Police Response to Sexual Assault (2012)
- How Are Innovations in Technology Transforming Policing? (2012)
- Voices from Across the Country: Local Law Enforcement Officials Discuss the Challenges of Immigration Enforcement (2012)
- 2011 Electronic Control Weapon Guidelines (2011)
- Managing Major Events: Best Practices from the Field (2011)
- It's More Complex than You Think: A Chief's Guide to DNA (2010)
- Gang Violence: The Police Role in Developing Community-Wide Solutions (2010)
- Violent Crime in America: What We Know About Hot Spots Enforcement (2008)
- "Good to Great" Policing: Application of Business Management Principles in the Public Sector (2007)
- Police Management of Mass Demonstrations: Identifying Issues and Successful Approaches (2006)
- Managing a Multi-Jurisdiction Case: Identifying Lessons Learned from the Sniper Investigation (2004)

In addition to conducting research and publishing reports on our findings, PERF conducts management studies of individual law enforcement agencies; educates hundreds of police officials each year in the Senior Management Institute for Police, a three-week executive development program; and provides executive search services to governments that wish to conduct national searches for their next police chief.

All of PERF's work benefits from PERF's status as a membership organization of police officials, who share information and open their agencies to research and study. PERF members also include academics, Federal Government leaders, and others with an interest in policing and criminal justice.

All PERF members must have a four-year college degree and must subscribe to a set of founding principles emphasizing the importance of research and public debate in policing, adherence to the Constitution and the highest standards of ethics and integrity, and accountability to the communities that police agencies serve.

PERF is governed by a member-elected President and Board of Directors and a Board-appointed Executive Director.

# About the COPS Office

The **Office of Community Oriented Policing Services (COPS Office)** is the component of the U.S. Department of Justice responsible for advancing the practice of community policing by the nation's state, local, territorial, and tribal law enforcement agencies through information and grant resources.

Community policing begins with a commitment to building trust and mutual respect between police and communities. It supports public safety by encouraging all stakeholders to work together to address our nation's crime challenges. When police and communities collaborate, they more effectively address underlying issues, change negative behavioral patterns, and allocate resources.

Rather than simply responding to crime, community policing focuses on preventing it through strategic problem solving approaches based on collaboration. The COPS Office awards grants to hire community police and support the development and testing of innovative policing strategies. COPS Office funding also provides training and technical assistance to community members and local government leaders, as well as all levels of law enforcement.

Another source of COPS Office assistance is the Collaborative Reform Initiative for Technical Assistance (CRI-TA). Developed to advance community policing and ensure constitutional practices, CRI-TA is an independent, objective process for organizational transformation. It provides recommendations based on expert analysis of policies, practices, training, tactics, and accountability methods related to issues of concern.

Since 1994, the COPS Office has invested more than $14 billion to add community policing officers to the nation's streets, enhance crime fighting technology, support crime prevention initiatives, and provide training and technical assistance to help advance community policing.

- To date, the COPS Office has funded the hiring of approximately 127,000 additional officers by more than 13,000 of the nation's 18,000 law enforcement agencies in both small and large jurisdictions.
- Nearly 700,000 law enforcement personnel, community members, and government leaders have been trained through COPS Office-funded training organizations.
- To date, the COPS Office has distributed more than eight million topic-specific publications, training curricula, white papers, and resource CDs.
- The COPS Office also sponsors conferences, roundtables, and other forums focused on issues critical to law enforcement.

The COPS Office information resources, covering a wide range of community policing topics—from school and campus safety to gang violence—can be downloaded at www.cops.usdoj.gov. This website is also the grant application portal, providing access to online application forms.

As the incidence of opioid and heroin addiction grows, American law enforcement has developed new approaches to combating it. Based on collaborative partnerships with public health and other professionals, these new strategies stress prevention and treatment as well as enforcement. To identify the most effective of these approaches, the COPS Office hosted the Law Enforcement and Public Health: Successful Partnerships in Addressing Opioid Use Forum in partnership with the Office of National Drug Control Policy and the Police Executive Research Forum.

Participants—who included representatives from public health agencies, law enforcement executives, and other stakeholders—discussed the establishment of treatment and prevention partnerships, the use of naloxone deployment programs, and best practices to mitigate drug use. They also discussed methods for sharing access to data and intelligence. This report not only documents the discussions but also describes innovative programs based on collaboration between the public health and public safety sectors.

COPS
Community Oriented Policing Services
U.S. Department of Justice

POLICE EXECUTIVE RESEARCH FORUM

U.S. Department of Justice
Office of Community Oriented Policing Services
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To obtain details about COPS Office programs, call the COPS Office Response Center at 800-421-6770.

Visit the COPS Office online at www.cops.usdoj.gov.

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