The New York State

Chief's Chronicle

Serving New York's Police Executives Since 1901

September 2018

IN THIS EDITION:

Opening Conference Ceremony

— OPENING CONFERENCE CEREMONY, continued on back cover

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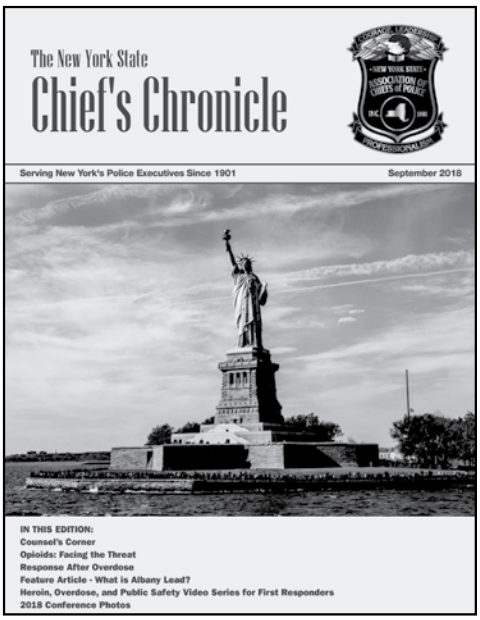
Do you have an interesting law enforcement story or an article you would like to submit, photographs of member activities or field scenes?
Contact the editor: Larry Eggert at leggert@nychiefs.org

On the Cover:

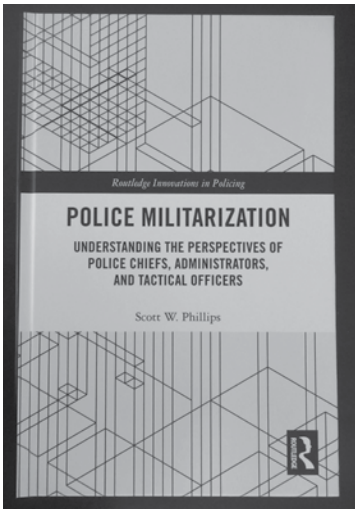
The picture of the Statue of Liberty on the cover was taken during the dinner cruise, which was part of our annual Training Conference in Long Island this past July. To many, the Statue of Liberty is more than a monument. She is a beloved friend, a living symbol of freedom to millions around the world. Sculptor Frederic Auguste Bartholdi was commissioned to design a sculpture with 1876 in mind for completion, to commemorate the centennial of the American Declaration of Independence. The Statue was named "Liberty Enlightening the World" and was a joint effort between America and France. The story of the Statue of Liberty and her island has been one of change. Lady Liberty's significance grew as an inspiration to immigrants who sailed past her on their way to America. Today the Statue stands as an enduring reminder of the strength and freedom of our country. The torch is a symbol of enlightenment that lights the way to freedom showing us the path to Liberty. A chain disappears beneath the draperies of the statue, only to reappear in front of her left foot, its ends link the broken chains at the feet of the Statue of Liberty symbolize freedom and democracy. For police officers, the Statue is a fitting example of all that we stand for, protect, and guarantee for our citizens and community.



Book Review: Police Militarization

The increased militarization of the police in the United States has been a topic of controversy for decades, brought to the public eye in notable events such as the Los Angeles Police Department's use of battering rams in the 1980s and the siege of the Weaver family at Ruby Ridge, Idaho, in the 1990s, among others. The issue of police militarism has been back at the forefront of criminal justice policy discussions in the wake of the militaristic police response to the protests that took place after the fatal shooting of Michael Brown by a police officer in Ferguson, Missouri, in 2014. This book examines the issue of militarization in a post-Ferguson environment from the perspective of those inside policing.

Drawing from a variety of data—this work provides a nuanced look at police militarization that will inform future conceptual discussions and empirical research into the phenomenon. Considerations identified for police policy-makers include politics, media, leadership, and marketing. These themes are explored in detail, suggesting multiple dimensions, both theoretical and empirical, to better understand policing and policy, making this book an excellent resource for students, scholars, and professionals in law enforcement, political science, and public administration.



From the Editor: I recently completed reading this book and found it to provide useful information for a Chief of Police. If Police Militarization has become an issue in your community, this book will give you some of the necessary information to lead an informed discussion on this sometimes sensitive and misunderstood subject.

Counsel's Corner

Fantasy Versus Reality: Learning from Leeroy Jenkins

BY CHIEF (RET.) MICHAEL RANALLI, ESQ.

In 2004, Blizzard Entertainment released the multiplayer online role-playing game World of Warcraft (WoW). Players in the game have named characters and play individually or in teams while communicating with each other. Players must move from area to area and level to level to battle various threats and collect needed items. A video released by a group of players in 2005 became an internet sensation and has millions of views[1]. The video starts with a group of players in a dungeon planning out a strategy. They must enter a particularly dangerous area and obtain a piece of armor for a character named Leeroy Jenkins. A detailed plan is developed while the players are huddled around in a group, with assignments doled out to various members. Unfortunately, Leeroy is quietly sitting off to the side and not saying anything, ostensibly because the person controlling Leeroy is off fixing himself a plate of chicken.

As the plan is finalized, one character advises the rest that the plan will provide them with the admirable survival rate of 32.33%, which is apparently better than they are used to. Leeroy suddenly jumps to his feet and yells, "All right chums, let's do this! LEEEEROY JEEENKINS!" and runs into the next chamber, oblivious to the plan. The other players follow Leeroy and attempt to stick to their plan, but his actions doom them all to multiplayer death at the hands of the dragons Leeroy unleashes. As the players of the now deceased characters tell Leeroy at the end of the video what they think of him and his actions, Leeroy states, "At least I have chicken."

> If the risk can be isolated–that is, the only person at risk is the one causing the risk–then you may have discretionary time to discuss and plan a proper response.

The video is hilarious to watch and, as was long suspected and later confirmed by the creators, was created to be an internet meme. Showing the video in a room full of experienced police officers and administrators not only leads to laughter, but also paves the way for a discussion of actual incidents in which officers rush into situations without communicating with other officers or considering the available facts. While these real-life incidents may not unleash dragons, their outcomes are sometimes equally catastrophic.

LEARNING FROM LEEROY

While designed for comic relief, the video depicts important concepts relating to police response to incidents—using available discretionary time to communicate with each other and develop a plan based upon the information you have available. This plan needs to consider Priority of Life, which requires an assessment of risk—who is at risk and who is causing the risk—and whether action is warranted or justified (we would usually want a better survival rate than 32.33*%!*). If the risk can be isolated—that is, the only person at risk is the one causing the risk—then you may have discretionary time to discuss and plan a proper response. If not, as in the case of an active shooter, you must take appropriate action.

Effective communication among multiple officers may allow for consideration of all available options, leading to a more effective plan. Acting individually without using available discretionary time increases the chances of a less-than-optimal result. In my years as an attorney and a police instructor, I have reviewed the facts and results of countless cases. I have also been asked to review numerous fact patterns by officers and administrators. A significant number of incidents that do not end well have common denominators: a failure to use discretionary time and a failure to effectively communicate actions before they were taken. Communication, in the context of this discussion, has two facets: communication with other involved officers and an attempt to communicate with the person involved in the incident.

Two cases serve as examples of how failure to assess risk, plan and use discretionary time can contribute to a tragic result.

GLENN V. WASHINGTON COUNTY[2]

Eighteen-year-old Lukas Glenn came home from a high-school football game intoxicated and agitated. He became angry when his parents would not let him take his motorcycle out. Lukas argued with his parents and then started damaging household property. Lukas had no history of violence and his parents had never seen him intoxicated. The parents called a couple of his friends to come over and help to calm him down, which they could not do.

Lukas then held a pocketknife to his neck and threatened to kill himself. His mother called 911, advising the dispatcher Lukas was holding the knife to his neck and threatening to kill himself if the cops came. A staging area was established nearby, but the first two deputies bypassed it, responding directly to the scene. The first deputy positioned himself about 8–12 feet from Lukas with his weapon drawn and pointed at Lukas. While Lukas stood with the knife to his neck, the deputy screamed at him to drop the knife or he would kill him. The second deputy arrived a minute later. He started behaving the same way as the first deputy. Family members tried to calm the deputies down, but the deputies ordered them to ▶

get back into their house.

A sergeant radioed to the officers to use their tactical breathing and to control the situation. An officer from a local agency arrived with a beanbag shotgun and the first deputy ordered him to "beanbag him." Lukas was struck by multiple beanbag rounds and attempted to retreat toward the house. The deputies had already determined that if Lukas went *toward the house—where the deputies had told the family to remain—they would shoot him. The*y fired 11 rounds at Lukas and he died on his grandmother's porch.

> The court had difficulty finding it would be reasonable for the solution–deadly force–to be better than the problem–a person threatening to kill himself.

The entire incident took less than four minutes. The 9th Circuit Court of Appeals denied summary judgment to the officers, finding the reasonableness of their actions was questionable. The court had difficulty finding it would be reasonable for the solution—deadly force—to be better than the problem—a person threatening to kill himself.

WEINMANN V. MCCLONE[3]

Jerome Weinmann drank half a bottle of vodka after an argument with his wife. His wife called 911 and told them Jerome was in the garage, threatening to kill himself, and had access to a shotgun. This information was passed on to the responding deputy. The deputy knocked on door of garage but got no response. He peeked in two windows but could not see Jerome. The deputy did not try to speak with Jerome through the door, but he heard sounds in the garage like "pattering on cupboard doors." Within three minutes of arrival, fearing that Jerome may be attempting suicide, the deputy decided he would force entry into garage.

Jerome was sitting in a lawn chair with the shotgun when the deputy kicked in the door. While the facts of what happened next are disputed, the deputy recalled that while Jerome never pointed gun at him, it was pointed in his direction. The deputy shot Jerome four times. Jerome survived with permanent injuries and filed a §42. U.S.C. 1983 case, claiming excessive force.

The issue was whether the deputy was entitled to qualified immunity. Both the district court and the Court of Appeals for the 7th Circuit found he was not entitled and denied summary judgment. The 7th Circuit reasoned "…a person has a right not to be seized through the use of deadly force unless he puts another person (including a police officer) in imminent danger or he is actively resisting arrest and the circumstances warrant that degree of force." The deputy argued he was in a "fatal funnel" coming in through the only door, so he was in imminent danger. The court rejected that argument, reasoning it would allow officers to shoot suicidal people any time they entered through a single door.

RISK ASSESSMENT, PLANNING AND COMMUNICATION

Before analyzing these cases, or any other police incident, it is important to understand the need to balance the risk of hindsight bias and the importance of objectivity. It can be difficult for officers to quickly assess a situation, and what is clear after the incident may not be as clear at the time. In analyzing these situations, the intent is not, nor cannot be, to unfairly criticize law enforcement officers acting in good faith in difficult situations. Instead, the intent is to try to learn from past tragedies to prevent future ones.

Critical in both cases is that the only person currently at risk was the person causing the risk. Neither of the persons involved threatened anyone but themselves.

In the *Glenn* case, the deputies bypassed the staging area where a plan could have been formulated. Seeing Lukas had a knife to his neck, the deputies moved quickly to get the family away from him. This isolated the risk, but the officers' actions created several objective issues. First, they remained within 12 feet of a person with a knife. As a result, Lukas could have charged the officers faster than they would have been able to react. The officers were certainly justified in having their weapons at the ready because of the presence of the knife, but they limited their own defensive capability by remaining in proximity.

The second issue was both officers screaming commands at Lukas. This is contrary to proper contact-and-cover training since it can create confusion. One officer should do the talking—which leads to another issue. Lukas was in crisis and de-escalation was appropriate. Understanding his purpose—wanting to kill himself—may have led to more effective communication.

Jerome Weinmann was alone in his garage, so the risk was already isolated to the person causing it even before the deputy arrived. The deputy defended his actions by stating he was at risk since he was in a "fatal funnel" in the doorway. While correct, this is also the exact reason why he should not have entered as he did. Entry unnecessarily placed the deputy at risk.

In both cases, the priority of the officers should have been containment while keeping themselves as safe as possible. Using the discretionary time created by containment, officers can conduct the proper planning and communication. It is important that all officers are on the same page. This should then lead to proper communication with, and possible de-escalation of, the person at risk.

> Years of researching and evaluating fact patterns and cases, especially over the last few years, leads me to a rather simple conclusion: All officers are potentially one decision away from a changed life.

While these are extreme cases, the problem of moving too fast can occur in other settings where the risk does not justify the action. A classic example occurs at the end of a vehicle pursuit. Reality police TV shows and YouTube are full of examples where officers run up on the suspect vehicle, guns drawn, screaming at the occupants, all while fully exposed and vulnerable to the occupants and friendly crossfire. This is contrary to the training officers should have received in performing high-risk stops.

But it is also predictable that officers may react in such a manner under extreme emotional arousal and stress. Should they? No. We are all human, however, and can be susceptible to such vulnerabilities, especially in the absence of ongoing refresher training of perishable skills. I know I was, especially as a young officer. Training our officers to think, plan and communicate with each other, when possible, is important. We frequently train officers in physical skills, but equally if not more important is training in the mental processing of an incident and decision-making. Learning from our own mistakes and those of others is critical. ▶

Also critical is helping each other by intervening when another officer is not responding properly. The behavior of the first-arriving deputy in the *Glenn* case was mimicked by the second deputy, rather than corrected. The police culture may resist the thought of one officer correcting or challenging another officer mid-incident. But that must change. If you were flying in an airplane or undergoing a medical operation, and the pilot or doctor in charge was acting in a dangerous manner, I would guess you'd want another member of the crew to act.

Years of researching and evaluating fact patterns and cases, especially over the last few years, leads me to a rather simple conclusion: All officers are potentially one decision away from a changed life. This has happened to many officers over the last few years. No one is perfect, and we all have the potential to make bad decisions. If you are willing to think, slow down, and help and listen to each other, you may be able to avoid a tragedy. Leave Leeroy Jenkins in the dungeon where he belongs.

Authors Note: I would like to thank Sgt. Michael Musengo of the Syracuse Police Department for introducing me to Leeroy during an excellent presentation he gave on decision making during a Law Enforcement Training Directors of NYS conference.

(Endnotes)

[1]Here is a link to one version of the video: https://www.youtube.com/watch?v=mLyOj_QD4a4&t=92s *last accessed on 07/25/18.*

[2]673 F.3d 864 (9th Circ. 2011)

[3]787 F.3d 444 (7th Circ. 2015)

Opioids: Facing the Threat

BY JAMES P. KENNEDY, JR., UNITED STATES ATTORNEY
WESTERN DISTRICT OF NEW YORK

The numbers are staggering. Drug overdoses are now the leading cause of death for Americans under the age of 50. In 2016, there were 64,000 overdose deaths, the clear majority of which resulted from opioids. Here in America, we have 5% of the world's population, yet we consume 80% of the world's opioids. Simply stated, opioids are a threat.

When confronted with a threat, we as humans generally employ one of two protection mechanisms that seem to be hard-wired into our species. Think back to September 11, 2001. How did you feel that day? Well, if you are anything like me, then your feelings likely alternated between desiring vengeance, i.e., wanting to hold those responsible for the attacks accountable for their actions, and empathy, i.e., wanting to reach out to the thousands of victims. Indeed, these alternating responses seem to reflect the two predominant protection systems that we as humans have developed to deal with threats.

> **Here in America, we have 5% of the world's population, yet we consume 80% of the world's opioids.**

Accountability—the desire to hold others responsible for the consequences of their actions—promotes personal responsibility and helps us to protect ourselves by providing a means to enforce the social cooperation of others. In the civilized world, this innate desire to hold people accountable for what they do is what underlies our criminal laws and our entire criminal justice system.

Empathy—our ability to connect with and look out for one another—derives from the experiences of our ancestors on the savannah over 10,000 years ago. Back then, predators abounded, and to survive, our ancestors had to develop relationships with and depend upon one another. By sharing stories, ideas, and experiences, we learn from one another, and by helping each other survive, we all benefit.

Each of these protection mechanisms—accountability and empathy—seem to be hard-wired into our DNA. Perhaps it is unsurprising then that both mechanisms have been incorporated into the 3-pronged strategy which has been developed to combat the opiate threat here in the Western District of New York (WDNY). *Broadly, that strategy is to fight the opioid threat using prosecution, prevention, and treatment.*

To those of us working in law enforcement, our specialty is holding people responsible for their actions. It is what we do when we enforce the law. While I am tremendously proud of my outstanding partners in federal law enforcement, I also understand and appreciate the fact that 85% of the law enforcement officers in this country serve at the state and local levels. You are the ones in the trenches every day fighting the battle on the streets gathering the street-level intelligence that can lead to national and even international cases and interfacing with those whose lives are being destroyed by their drug use. As such, you represent the front line in our battle to combat the threat.

Yet, we on the federal side do bring some firepower to the fight. Among the weapons we have at our disposal federally are the so-called "death or serious bodily injury results" provisions of 21 U.S.C. §841(a)(1). That statute provides that any individual who distributes a controlled substance, which results in death or serious bodily injury, shall face a statutory mandatory minimum sentence of a term of imprisonment of 20 years and a maximum of life. ▶

> **We on the federal side do bring some firepower to the fight.**

— *OPIOIDS: FACING THE THREAT, continued from page 5*

(1) The statute provides a heavy hammer. Notably, unlike state homicide statutes, the statute contains no mens rea requirement beyond that for the distribution itself. All that is required is simple "but-for" causation. In other words, the government need only

U.S. Attorney Kennedy takes part in a PBS program in opiates that aired statewide.

prove that but-for the use of the controlled substance provided by the defendant, the individual would not have died or suffered a serious bodily injury. We have aggressively used the statute. In fact, since I became U.S. Attorney in late-October of 2016 we have, to date, used the statute to charge drug dealers and doctors in connection with over 20 overdose deaths. While most of those cases remain pending, several defendants have already been convicted under the law.

In addition, our Office has also not shied away from charging the healthcare professionals who prescribe these potentially lethal drugs outside the usual course of medical practice and not for a legitimate medical purpose. Without question, irresponsible

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prescribing practices helped to create the threat in the first place. In taking on those healthcare professionals who helped to create the huge demand for these drugs, my Office has used all resources we have at our disposal—including bringing criminal prosecutions for drug trafficking and healthcare fraud, as well as bringing civil healthcare fraud, and affirmative civil enforcement actions—to combat improper and illegal prescribing practices.

Beyond prosecuting everyone from doctors to low-level distributors who provide drugs that kill, my Office has further adopted a zero-tolerance policy when it comes to cases involving fentanyl and its analogues. The reason for our zero-tolerance policy is because the lethality of fentanyl is virtually unmatched—it is 30-50 times more potent than heroin, and carfentanil is 100 times more potent than fentanyl. These highly dangerous illicit fentanyl and fentanyl analogues are typically produced in China and shipped, primarily through common carriers or international mail, directly into the United States.

With its low dosage range and high potency, 1 kilogram of fentanyl purchased in China for $3,000 - $5,000 can generate upwards of $1.5 million in revenue on the illicit market – and is enough to kill as many as 500,000 people by overdose. (2)

That unmatched lethality is not currently reflected in the federal drug statute, the Controlled Substances Act (CSA), which punishes dealers of fentanyl less severely than sellers of less lethal drugs, such as crack. Although opioid tolerance may develop in users, as little as 2 milligrams of pure fentanyl is a lethal dose in most people. The amount required for a lethal dose of fentanyl analogues, such as carfentanil, is even less.

I am a member of Attorney General Sessions' Advisory Committee Subcommittee on Controlled Substances. Several months ago, we sent a member of our Subcommittee to testify before Congress urging them to increase punishments for smaller amounts of fentanyl and to reduce the amount of fentanyl and its analogues required to trigger mandatory minimum sentencing.

In addition, my Office and our federal partners have worked with state and local law enforcement and first responders in WDNY to develop protocols for treating overdose scene as a crime scene in order that we may secure sufficient evidence to bring the "death or serious bodily injury results" prosecutions described above.

U.S. Attorney Kennedy joins with members of the Niagara County Opiate Task Force to discuss their efforts and the DEA National Drug Takeback Day.

Beyond these efforts in the WDNY, the Administration and the entire DOJ have been very proactive in their efforts to confront this threat at the national and international levels. On February 6, 2018, on the heels of the White House directive declaring the opioid crisis as a national public health emergency, the DEA used its authority

— *OPIOIDS: FACING THE THREAT, continued on page 7*

under Section 201 of the CSA to place all non-scheduled fentanyl-related substances into Schedule I temporarily, on an emergency basis, for two years.

In January 2018, Attorney General Sessions ordered the creation of the Joint Criminal Opioid Darknet Enforcement (J-CODE) team. J-CODE is an FBI initiative, aimed at targeting drug trafficking, especially fentanyl and other opioids, on the internet and Darknet.

The Opioid Fraud and Abuse Detection Unit, created in August 2017, uses sophisticated data analysis to identify and prosecute individuals who are contributing to the opioid epidemic, including pill-mill schemes and pharmacies that unlawfully divert or dispense prescription opioids for illegitimate purposes.

Also working internationally, both Deputy Attorney General Rosenstein and Attorney General Sessions have met extensively with Chinese Governmental Ministers, both in Beijing and in DC, to discuss the issue of Chinese fentanyl. Those efforts resulted in positive actions by the Government of China over the last year. Between March and July of 2017, China's National Narcotics Control Commission announced scheduling controls against five different fentanyl-class substances, including carfentanil, furanyl fentanyl, valeryl fentanyl, acryl fentanyl, and U-47700, each of which are powerful synthetic opioids that have been trafficked and abused in the United States. In December 2017, China announced it was scheduling controls on two fentanyl precursor chemicals, NPP and 4ANPP.

Each of these law enforcement efforts have been largely directed toward reducing the supply and availability of these deadly opiates.

Beyond the foregoing aggressive law enforcement efforts directed toward reducing the supply of these killer drugs, demand reduction, through prevention and treatment efforts, also plays an important role in the overall opioid strategy within the WDNY. While such initiatives—largely rooted in the empathetic response—are not those traditionally considered to be within the purview of those of us working in law enforcement, partnerships between law enforcement, NGOs, public health and healthcare professionals, educators, faith-based organizations, treatment providers, and others, help to provide these necessary components of the overall strategy. Moreover, some of law enforcements' tools can help to aid in these prevention and treatment efforts. In Cheektowaga, NY, for example, a pilot program has been initiated and public health officials are using police data-mapping software to locate high-risk drug users. These treatment providers get detailed police reports about overdose victims who have been revived with Naloxone, and then after a day or two, a peer counselor reaches out and offers to help the drug users get into treatment right away.

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I am pleased to report that our multi-faceted strategy—emphasizing both accountability and empathy— seems to be working. Bucking the national trend—which showed that the drug overdose death toll continued to rise in 2017, albeit at a much slower pace from preceding years—I am pleased to report that in Erie County during 2017, we experienced an overall 11% drop in drug overdose deaths from the prior year! Such a reduction was virtually unheard of anywhere else in the country in 2017. We are an outlier, and that is a good thing. We are making progress.

That said, as I hope I have demonstrated, what is needed is a coordinated response across all levels of law enforcement and other disciplines. Know that those of us working across the four U.S. Attorney's Offices across New York State are here to support each of you, our partners in state and local law enforcement. Each of our Offices have a designated opioid coordinator, and I would strongly urge state and local law enforcement officials across the state to reach out to the opioid coordinators working out of the relevant US Attorney's Office covering their jurisdiction and to ask how the USAO can assist you in addressing the opioid threat in your community. As I hope I have also suggested in this article, we have many tools at our disposal on the federal side. In closing, I will echo a sentiment often expressed by Attorney General Sessions whenever he meets with members of state and local law enforcement—"please know that you have our thanks, and we have your backs." I am confident that working together—as federal, state, and local law enforcement officials—we have what it takes to defeat the opioid threat.

United States Attorney James P. Kennedy, Jr. who has been with the United States Attorney's Office since 1992, formerly served as First Assistant, Criminal Chief, Appellate Chief, White Collar/General Crimes Chief, as well as both an OCDETF and civil AUSA. He became Acting U. S. Attorney in October of 2016, and in 2017, Attorney General Jeff Sessions named him United States Attorney for the Western District of New York. Previously, Mr. Kennedy clerked for both the Honorable Michael F. Dillon and M. Dolores Denman, Presiding Justices of the New York State Supreme Court, Appellate Division, Fourth Department. He graduated Phi Beta Kappa and magna cum laude from Hamilton College and earned his J.D. cum laude from the State University of New York at Buffalo Law School, where he was Editor of the Buffalo Law Review.

Footnotes:

[1]Relevant case law has held that a Narcan save itself is sufficient to establish "serious bodily injury."

[2] The allure of these substantial profit margins has also proved irresistible to traditional transnational criminal organizations—groups which historically trafficked in cocaine and marijuana—and as a result, they have now also begun to distribute opioids in the United States.

Response After Overdose

ARTICLE WRITTEN BY LT. BRIAN J. GOULD, CHEEKTOWAGA POLICE DEPARTMENT

Like most communities across New York State, the Town of Cheektowaga in Erie County has been seriously affected by the opiate epidemic. In 2014, the Cheektowaga Police Department began training their officers in the use of Naloxone (Narcan) and began issuing this lifesaving drug to their patrol officers. The training class was less than an hour long and officers learned that there were no circumstances were the use of Naloxone could cause harm to those the officers were trying to assist. The Naloxone kits were provided to the department free of charge by the Erie County Health Department. By January of 2015, almost all officers were trained and carrying Naloxone.

The timing of the implementation of the Naloxone program proved very valuable. The calls for help regarding people overdosing in the town increased drastically. Officers responded to 127 overdoses in 2015. Unfortunately, 12 of the subjects who overdosed were not able to be revived. Those numbers continued to increase in 2016 when the department responded to 167 overdoses (a 24% increase) and investigated 16 overdose deaths (a 24% increase). The department fostered a culture where the officers were expected to respond to the overdoses, provide emergency care and direct the person who overdosed to treatment providers who could help. Officers were willing to provide this life saving service to the residents, however many were getting frustrated after responding to the same addresses and seeing the same people overdosing numerous times. Those who overdosed were being directed towards help and funds were being directed to making the help more available, yet the overdoses continued. The administration of the department realized the need to find a better response, not only to stop the overdoses from continuing to increase, but also to address the concerns of the officers on the streets.

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Over the summer of 2017, representatives from the Washington/ Baltimore High Intensity Drug Trafficking Areas (HIDTA) were in the Buffalo area demonstrating the ODMAP system and urging departments to begin using the system to track overdose cases. The system is a web-based mapping system that allows officers on the scene of an overdose to input the location of the overdose on a map, document the time an overdose occurred, and the outcome of the call for service. Use of the ODMAP system is free and takes very little training. Entries take less than a minute to complete. One of the major supporters of bringing the use of ODMAP to Western New York was the Erie County Health Department. The health department was granted access to the back end of the system which allowed them to monitor overdoses in real time and issue alerts if they saw a spike in activity. For the Cheektowaga Police Department, OPMAP represented a catalyst that would build a close relationship between the police department and the health department. Once we began using ODMAP, the police department reached out to the health department and asked for help in addressing the concerns of the police officers regarding people who overdose not getting help.

> There appeared to be a much better chance of engaging the person who overdosed if help was offered as soon as the day following the overdose.

The Cheektowaga Police Department's policy dictates that anyone who overdoses and received Naloxone, must be transported to the hospital for treatment. However, the local emergency rooms were overwhelmed and many times the patients were discharged shortly after arrival. Officers were leaving an information pamphlet that identified our local substance abuse providers and the contact information for our area hospitals that were offering services. Unfortunately, very few people who needed the help were voluntarily searching out the help they needed. It was obvious we needed to do more to connect the addicts to treatment. We realized that ODMAP was allowing representatives from the health department to be notified of when and where every overdose took place. Additionally,

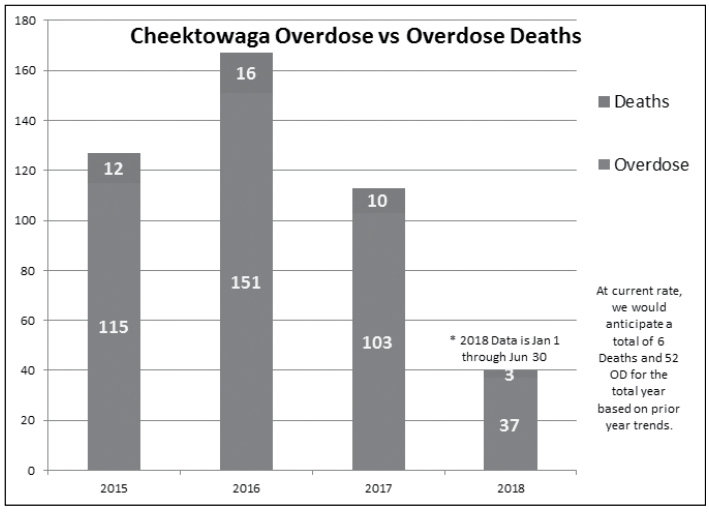


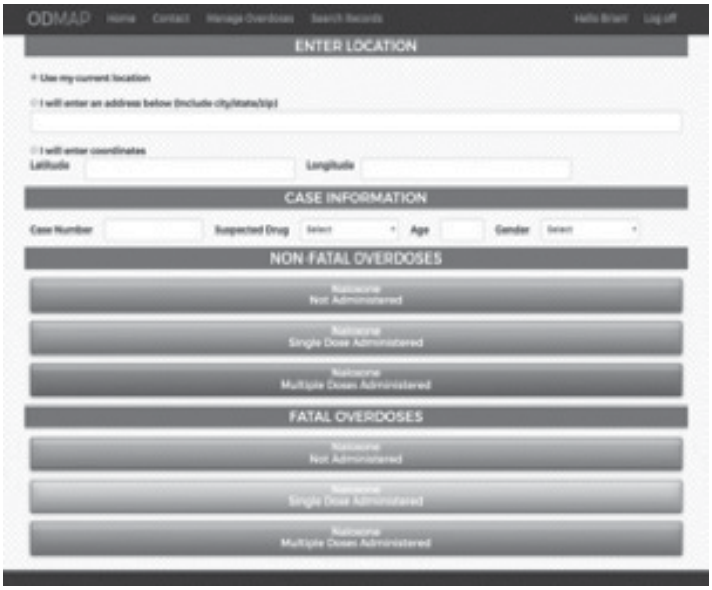
Chart showing Cheektowaga Police Overdose Responses.

research showed that the best time to link people who overdose with treatment was the day after an overdose. Offering help at the time of the overdose was unsuccessful as most people didn't even remember

— RESPONSE AFTER OVERDOSE, continued on page 9

— *RESPONSE AFTER OVERDOSE, continued from page 8*

the events that took place during the overdose. If the help was offered days later, it was too late, the person who overdosed was most likely back to using and not interested in our help. There appeared to be a much better chance of engaging the person who overdosed if help was offered as soon as the day following the overdose.



Screen shot showing the ODMAP interface that officers use to document overdoses on the mobile data terminals.

Armed with this knowledge and realizing more needed to be done, the Cheektowaga Police Department requested that the health department attempt a more rapid offer of assistance to those who overdosed by contacting them as soon as the next day after their overdose. The health department was always willing to reach out and follow-up. However, due to health privacy laws, hospitals could not provide the health department with information on those who came in for treatment after an overdose. The police department created a process where the health department would use a Freedom of Information (FOIL) request to obtain a copy of the police report of each overdose when it (the overdose) was entered in the ODMAP program. In turn, the health department assigned a specially trained peer navigator to the case. That peer navigator then had the responsibility to follow up on each overdose by contacting the person the day following the overdose.

This pilot project began in September of 2017. Over the first nine months, 39 individuals were identified by using ODMAP. As the program progressed, our Officers realized that they were aware of other Town residents who could use the help of our peer specialists. Consequently, the program was amended to include direct officer referrals as well. Fourteen (14) individuals were identified through direct officer referrals in the first nine months. We monitored the 53 individuals that were referred to the program. Of those 53 people, 30 were engaged in treatment 60 days after referral. One is currently incarcerated and 6 refused assistance. The other 6 are in touch with the peer specialist but not yet engaged in treatment. These statistics reveal that 57% of those identified through this pilot project have engaged and remained engaged in treatment. To those in the substance abuse treatment field, that percentage reflects success. That success has translated to fewer overdoses responses by the police department. In 2017, the Cheektowaga Police Department response to 113 overdoses - a 33% reduction from 2016 figures and investigated 10 overdose related deaths - a 38% reduction from 2016 figures. For the current year (2018), the department has responded to just 41 overdoses in the first six months of the year, which if extrapolated out for the year, would represent an almost 50% reduction in overdoses from our 2016 figures! The success we have earned through this program are amplified even further when considering that the overdose problem nationwide continues to display a steady and continuing increase from 2016 to present.

The "Response After Overdose" pilot project represents a very successful collaboration between the police department and the county health department. The police department has no monetary costs related to the program and the time commitment is minimal. Fostering this successful partnership has allowed the leadership of the Cheektowaga Police Department to be an active partner in the fight against the opiate epidemic, to significantly reduce the deaths and overdoses in their community, and to respond to the concerns of the officers who are on the front line of the fight.

Special thanks to Cheryl Moore, a medical care administrator for the Erie County Health Department and Antonio Estrada, the health department's peer navigator, for their dedication to making this project a success.

Lt. Brian J. Gould is second line supervisor of the afternoon patrol division. He has 18 years of law enforcement experience with the Cheektowaga Police Department. Lt. Gould holds Master of Science degree in Criminal Justice Administration and is a graduate of the FBI National Academy.

See Related newspaper article at:
http://buffalonews.com/2018/05/07/health-officials and-cops-get-overdose-survivors-into-treatment-by-waiting/?utm_campaign=puma&utm_medium=social&utm_source=Facebook#link_time=1525705097

ODMAP for New York State

BY NEW YORK-NEW JERSEY HIDTA DIO DAN RINALDO AND DIO JIM HAWLEY – NEW YORK STATE ODMAP COORDINATORS

In 2017, recognizing the worsening problem of opiate abuse and the difficulty of tracking and responding to these incidents, the Washington/Baltimore HIDTA (High Intensity Drug Trafficking Area) introduced a program called ODMAP, Overdose Detection Mapping Application Program. This is a valuable and unique tool to assist law enforcement and other public service entities to better identify and track opiate abuse. The problem of opiate abuse is well known to law enforcement in New York State and across the country. Nationally, over 63,000 overdose deaths were reported in 2017, with all but nine states reporting an increase from 2016. Preliminary data from 2017 shows a significant increase in overdose deaths to date, and each state is investigating tools to deal with this emerging crisis. Unfortunately, we lack a consistent methodology to track overdoses, both fatal and non-fatal, in real time and across jurisdictions, which is necessary to mobilize a public health response capable of addressing these issues within our communities.

> By utilizing a consistent and complimentary system to track overdoses, both fatal and non-fatal, jurisdictions can plan and prepare for real-time overdose spikes.

ODMAP addresses this lack of consist reporting by providing real-time overdose surveillance data across jurisdictions to support public safety and health efforts to mobilize an immediate response to an overdose spike. It links first responders on scene to a mapping tool to track overdoses and stimulate real-time response and strategic analysis across jurisdictions. It is a mobile tool, capable of being used in the field on any mobile device or data terminal connected to an agency CAD system. ODMAP greatly increases the efficiency for public health, law enforcement and other select agencies to track overdose data and therefore identify and respond to sudden increases or spikes in overdose events. Participating agencies must sign a teaming agreement and have the capability to upload data and view the map in real time. Suspected overdose incident information is submitted to a central database and mapped to an approximate location. First Responders enter data into the systems central database identifying if the incident is fatal or non-fatal and if Naloxone was administered in a simple one-click system that takes seconds. The system then maps the incident to an approximate location, including details about the time and date of the incident. No personal identifying information is collected on the victim or location.

LEVELS OF ACCESS TO ODMAP

There are different levels of users identified in the system with differing rights for the information contained in the system. **Level I** users are primarily defined as law enforcement or EMS providers who provide on-scene reports of real-time overdoses. They do not collect any personal identifying information on the victim, nor is the data stored in the central database. **Level II** users, defined as public health or safety staff, are issued a login credential to enter the secure server to view the map. There are several filtering tools for analytical purposes and Level II users can elect to receive email notification when an overdose spike, defined specifically for each county, occurs within a 24-hour period. The spike notification system is designed to help public health and safety entities mobilize a response to affected areas including treatment and prevention strategies. Level II users are most often leadership from public health and safety, or data analysts. Level II access requires special permission for login credentials to access the central database and map which captures the approximate locations of the overdoses as reported by the Level I user. The general public does not have access to this system.

HIPAA CONCERNS

A major area of concern with regards to harvesting data is HIPAA. In an overdose setting, HIPAA rules can become a great concern when attempting to compile data on overdose victims. However as currently constituted, ODMAP, its Users, and the data shared within the Electronic Map, does not violate HIPAA. Certain users are covered entities under HIPAA, and the information contained within ODMAP is Protected Health Information (PHI) under HIPAA. However, HIPAA does not pose an issue to ODMAP's operation because there are exceptions to the HIPAA Privacy Rule that support the policies and procedures of ODMAP. It's important to note that ODMAP is a police report, not a medical record.

WHY USE ODMAP

By utilizing a consistent and complimentary system to track overdoses, both fatal and non-fatal, jurisdictions can plan and prepare for real-time overdose spikes. While localized information can be helpful, regional and national data collection enable a broad reaching mechanism for identifying and tracking overdose trends. This information can alter and empower neighboring

— ODMAP FOR NEW YORK STATE, continued on page 15

WHAT IS ALBANY LEAD?

In April 2016, the City of Albany implemented a groundbreaking, innovative public safety and public health intervention that aimed to reorient the City's approach to substance use, mental health, and poverty-driven contact with law enforcement. This initiative, called Law Enforcement Assisted Diversion (LEAD®) is built on an approach that understands that these issues are complex and difficult to easily improve, recognizes that behavior change is often a messy and lengthy process, and acknowledges that individual and systemic barriers often require a true "meeting of a person where they're at." This underlying philosophy, called "harm reduction" leads to service delivery that is non-judgmental, non-coercive, and person-centered.

How does it work?

In LEAD, individuals who would typically be arrested and jailed for low-level offenses often driven by psychosocial challenges are instead diverted to harm reduction-based case management and outreach services. One key feature of the project is the continuous communication loop that occurs post-diversion between case management staff, service providers, LEAD stakeholders, and the Albany Police Department. This allows all parties in this communication loop to understand the individual needs of the participant and the importance of meeting the participant where they are at in a non-judgemental, non-coercive manner. Unlike many other models, services delivered to LEAD participants are extremely active and focused on engagement.

What Does Albany LEAD Seek to Accomplish?

LEAD aligns its goals with the following principles:

- **Reorient** government's response to safety, disorder, and health-related problems.
- **Improve** public safety and public health through research based, health oriented and harm reduction intervention
- **Reduce** the number of people entering the criminal justice system for low level offenses related to drug use, mental health, sex work, and extreme poverty
- **Address** racial disparities in the front end of the criminal justice system
- **Sustain** funding for public health responses to behavioral health issues by capturing and reinvesting justice system savings
- **Strengthen** the relationship between law enforcement and the community

Who is Involved with Albany LEAD?

The key stakeholders are: The Albany Office of the Mayor, Albany Police Department, Albany County Executive (which includes multiple agencies like Department of Mental Health and the Public Defenders), Albany County District Attorney, Albany County Sheriff, Central District Management Association (business improvement district), Catholic Charities Care Coordination Services, the Center for Law and Justice, and the Katal Center for Health, Equity, and Justice. Multiple service provider agencies and other entities play key roles in ensuring quality of services for LEAD participants.

How is the Community Involved in Albany LEAD?

Albany LEAD was developed as the result of community demands to develop new approaches to achieve public safety and health. In 2016, a Community Leadership Team (CLT) was formed as a vehicle for community members who were not otherwise connected to the LEAD process to provide input, ask questions, and help hold the program accountable to community demands for reform. The CLT provides the community with an additional avenue for input into the program. In Albany, the CLT is coordinated through the Center for Law and Justice. The group has also mounted an educational campaign which engages area businesses about LEAD.

For more information, please contact Keith Brown, MPH, Director of Health and Harm Reduction, Katal Center for Health, Equity, and Justice.
keith@katalcenter.org | **518.527.6263**

ALBANY LEAD STAKEHOLDERS & ROLES

LEAD ALBANY

Albany LEAD MOU Partners and Roles	
City of Albany, Office of the Mayor	Committed to providing staff towards implementation, execution, and sustainability of LEAD. Appointed qualified senior staff member to PCG. Directed police department to make LEAD a priority and is committed to addressing racial and ethnic disparities.
Albany Police Department	Committed to participate in LEAD on operational and policy level. Trained all sworn officers on the LEAD initiative and the principles of harm reduction. Have dedicated staff to the PCG and OPW.
Albany County Executive's Office	Committed to participate in the LEAD initiative and has dedicated senior staff to the PCG and OPW. Executive level staff from the County Departments of Health, Mental Health, the Office of the Public Defender, and the Probation Department play key roles at the PCG and OPW. The Departments of Health and Mental Health provide support at the PCG and OPW and consultation and technical assistance in connecting LEAD clients to appropriate services. The Public Defender's Office provides support at the PCG and OPW to ensure that LEAD clients receive legal services. The Probation Department provides support at the OPW for any LEAD client that is on supervision.
Albany County District Attorney's Office	Committed to participate in the LEAD initiative and assign an Assistant District Attorney, or other prosecuting attorney, to the PCG and OPW.
Albany County Sheriff's Department	Committed to participate in the LEAD initiative and assign senior level staff to the OPW and PCG. ACSD will eventually become an active agency diverting arrests and making referrals.
Central District Management Association	Assigns staff who attend and actively engage in policy and outreach meetings representing the business and property owners in the BID area. Acts in an advisory and advocacy capacity for the LEAD partners.
The Center for Law and Justice	Committed to supervising the LEAD Community Outreach Coordinator and assisting with community organizing and outreach efforts. Assists in communicating the LEAD process in other jurisdictions.
The Katal Center for Health, Equity, and Justice	Participates in an advisory capacity and assists the PCG with advocacy, fundraising, document drafting, stakeholder consultation, troubleshooting, and technical assistance. Will provide support for the Project Manager. **The original entity serving as project manager was the Drug Policy Alliance. In 2016, Katal took over as project manager, via its role as a LEAD technical service provider.*

MOU Addendum for Service Providers	
Catholic Charities Care Coordination Services	Will assist in the development and implementation of LEAD. Will provide technical assistance as an expert in direct case management/case coordination and harm reduction services. **Since MOU was signed and executed CCS is now the case management provider for LEAD through a contract with Albany Medical Center.*
St. Catherine's Center for Children	Will assist in the development and implementation of LEAD. Will provide technical assistance as an expert in direct case management/case coordination and harm reduction services.
The Addictions Care Center of Albany	Will assist in the development and implementation of LEAD. Will serve as an expert technical advisor in Substance Use Disorder prevention and community education.

Other Attendees	
Finn Institute	Contracted to conduct process evaluation through NYS DCJS.
Catholic Charities Drug User Health Hub	Provide 24-hour outreach, engagement, and harm reduction services to LEAD referrals and non-LEAD clients. This increases the capacity for services and builds a foundation for social contact referrals.
Governor's Office of Public Safety	Interest in replication statewide and potential for state resources for Albany LEAD.
NYS CORe Initiative	Interest in cross system design and connection with CORe initiative in Albany and Newburgh.
New Horizons Christian Church	Community input and outreach. Part of the Community Leadership Team.
ROOTS	Community input and outreach. Part of the Community Leadership Team.

For more information, please contact Keith Brown, MPH, Director of Health and Harm Reduction, Katal Center for Health, Equity, and Justice.
keith@katalcenter.org | 518.527.6263

ALBANY LEAD PARTICIPANT ELIGIBILITY CRITERIA

FROM THE OPERATIONAL PROTOCOL, CURRENT VERSION I.2.20

Summary

There are a range of criminal offenses eligible for diversion, but it might be most helpful to consider what offenses are *ineligible*. Exclusions focus on individuals with convictions for certain violent crimes as well as for certain types of warrants. The outline below provide a diversion criteria; for more details about the diversion process, please refer to the Operational Protocol, available from any LEAD Operational Work Group member.

Note about consent: Any individual diverted into LEAD must provide consent to diversion after being informed about the project and its requirements by the responding officer. In cases where there is a complainant (victim), they, too, must consent to diversion.

Diversion Criteria

Adults who have a known history of alcohol, drug, poverty, homelessness, or mental health related needs, will be eligible for diversion to the LEAD program, and should be diverted to LEAD in the pre-arrest phases, when probable cause exists that the individual committed any of the following offense(s):

a. Criminal Possession of a Controlled Substance in the Fifth Degree;

b. Non-Violent Penal Law Misdemeanor(s);

c. Non-Violent Penal Law Violation(s); or

d. Non-Violent General City Ordinance Violation(s); and

- **i.** The complainant is willing to decline prosecution, if applicable, in order to allow the offender to proceed with diversion processes; and
- **ii.** The individual committed the offense(s) in relation to an alcohol, drug, poverty, homelessness, or mental health related need.

Exclusion Criteria

Adults shall be considered *temporarily* ineligible for diversion to LEAD if, at the time of initial police contact, the individual meets any of the following criteria:

1. The individual does not appear amenable to diversion.
2. The individual exploits minors or others.
3. There is probable cause to believe the individual committed a violent offense.
4. There is probable cause to believe the individual committed a felony, any type, except Criminal Possession of a Controlled Substance in the Fifth Degree.
5. There is probable cause to believe the individual committed promoting prostitution in the fourth degree or prostitution in a school zone offense.
6. There is probable cause to believe the individual violated an order of protection.
7. There is probable cause to believe the individual committed a domestic violence offense.
8. The individual is currently under the supervision of Parole.
9. The individual is a registered sex offender.
10. The individual is in need of acute emergency care and is taken into custody under the NYS Mental Hygiene Law Section 9.41.
11. The individual is under the age of sixteen (16) years old.
12. The individual is permanently disqualified from the LEAD program if they have ever been convicted of any of the following offenses (including attempts):
    - **a.** Murder 1st or 2nd
    - **b.** Arson 1st or 2nd
    - **c.** Robbery 1st
    - **d.** Assault 1st
13. The individual is temporarily disqualified from the LEAD program if they have ever been convicted of any of the following offenses within the past ten (10) years (including attempts)
    - **a.** Robbery 2nd
    - **b.** Assault 2nd
    - **c.** Burglary 1st or 2nd
    - **d.** Criminal Possession of a Weapon 3rd

The diversion and exclusion criteria is reviewed regularly in the Albany LEAD Operational Work Group.

For more information, please contact Keith Brown, MPH, Director of Health and Harm Reduction, Katal Center for Health, Equity, and Justice.
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RECOMMENDED COMPONENTS AND CONDITIONS FOR DEVELOPING A SUCCESSFUL ARREST DIVERSION PROGRAM

LEAD ALBANY

As jurisdictions across New York State and the Northeast explore and develop community-based pre-arrest diversion models like Law Enforcement Assisted Diversion (LEAD), it is crucial to understand the components and conditions necessary for successful projects. While not exhaustive, this document outlines several key elements based on the Albany LEAD experience.

Community anchor (organization): Community members must be engaged in the process of creating the program—they need to be involved to shape it and hold it accountable. Thus, the process must be anchored by a community organization to be effective. This group must have legitimacy on the ground and with communities directly impacted by mass incarceration. The community based organization may wish to adopt or support a Community Leadership Team to expand the reach of community engagement in the process. The community group must be resourced to anchor this process.

Police buy-in: While it is important to organize the police to practice diversion, the program won't work if the police are not also at the table to help design it. Training and buy-in around harm reduction is essential. The police should dedicate a supervisor to be the point person for operations.

Project manager: No one group or agency "owns" LEAD. It is a collaborative engagement; it only works through multiple partners coming together and agreeing to work together to transform practices and achieve better outcomes. Because no one group "owns" LEAD, it works best when there is a project manager who facilitates and convenes the body of stakeholders in the process of developing, implementing, and running the program. The project manager should be housed at a community organization or service provider, not at a law enforcement agency.

Case managers: It is essential to have case managers who manage the day-to-day needs of the clients through street based case management. Case managers should be placed at a local harm reduction agency or another agency that: 1.) demonstrates a history of effective case management and 2.) has a demonstrated history of implementing harm reduction practices and approaches. This is something that can possibly be funded through Medicaid in expansion states (as in Albany, NY). Each case manager should not exceed 25-30 active clients due to the complex needs of program participants.

Outreach workers: The program needs a handful of peer outreach workers who can be on the street and in the community to assist with locating and engaging participants.

Service providers: Partnering service providers are essential to the process—this is different from case managers. Non-displacement is important here, so service providers may have to expand or adapt to accommodate more people. Those in the diversion program shouldn't get to the "front of the service line" ahead of others who are receiving services, otherwise it incentivizes net-widening. There can be initial resistance by service providers because of this and of perceived service duplication.

District Attorney engagement: It is important to have involvement of the DA's office once the program really starts to grow. This is because many participants are likely to have open cases or warrants. DA office involvement and cooperation will be instrumental to ensuring diversion actually happens.

Public defender engagement: Every participant with an open case needs a public defender who works as an advocate for participants to protect their legal rights.

Data collection, reporting, and evaluations—process and outcome: Data collection, reporting, and evaluations are absolutely essential. If funding can be allocated for a research partner to manage and report on data from the program, that's ideal. Sometimes local universities can be engaged to serve as the research partner. Independent process and outcome evaluations are also needed. Again, it can be difficult to find funding for these, so finding an academic institution to play this role can be a viable option. Finally, setting up a data workgroup, which meets regularly and involves community members, can serve as a step toward transparency.

Travel and training for key stakeholders: The team of local stakeholders building a program—including community members, service providers, police and prosecutors—will benefit from a trip to an existing diversion site to see how it works—like Albany, Baltimore, or Seattle.

For more information, please contact Keith Brown, MPH, Director of Health and Harm Reduction, Katal Center for Health, Equity, and Justice.
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— ODMAP FOR NEW YORK STATE, continued from page 10

communities to mobilize swift public health responses capable of reducing and preventing overdose deaths.

HOW DOES ODMAP WORK?

ODMAP evaluates counties and jurisdictions with the goal to isolate and establish a baseline for overdose spikes within a 24-hour period. ODMAP is designed to alert Level II users when an overdose spike occurs in real time. Level II users can receive a spike alert within their jurisdiction or surrounding jurisdictions enabling the public safety and public health community to mobilize a rapid response strategy.

ODMAP ACCESS

To access ODMAP as a Level I or II user, your agency or organization must sign a teaming agreement. To register for ODMAP cut and paste the following link into your browser: http://odmap.hidta.org. Once on the site, follow the directions to register.

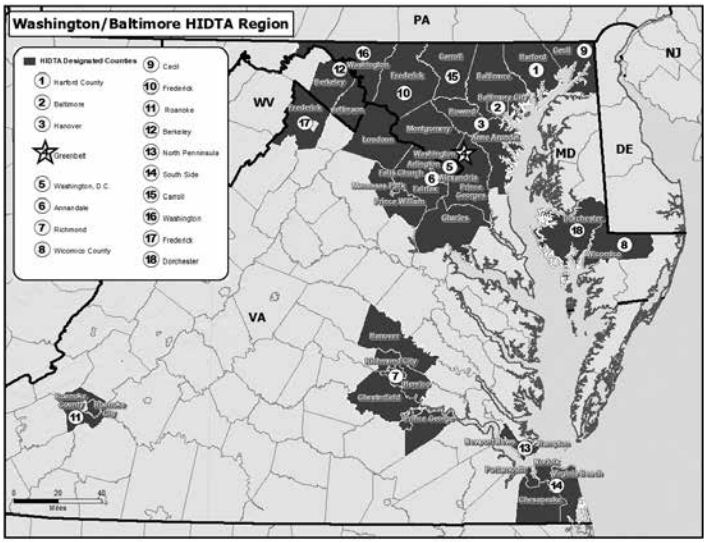
ENTERING DATA INTO ODMAP

Entering data into the ODMAP is simple and consists of a series of drop down boxes that are color coded. As you work through the screens, you will be prompted to enter your location or the location of the overdose if the person entering the data is not physically at the location of the overdose. There are prompts for use/no use of Naloxone and listing if the overdose was fatal/non-fatal. It is a quick and easy procedure to enter data. Keep in mind that data may be entered using several devices including a cell phone. An API is also available to allow data to be automatically pushed from a native record management system to ODMAP.

LEVEL II ACCESS

After a teaming agreement is signed, an agency's ODMAP administrator can assign Level II access to individuals at their agency.

If you have any questions regarding rules for access to the ODMAP program or for any general inquiries, please contact Washington/Baltimore HIDTA Deputy Director Jeff Beeson at 301-489-1744 or DIO's Dan Rinaldo at drinaldo@nynjhidta.org or Jim Hawley at jhawley@nynjhidta.org.



Heroin, Overdose, and Public Safety Video Series for First Responders

SUBMITTED BY: CHIEF (RET.) MARK A. SPAWN

The heroin epidemic has touched every corner of our nation. Not only are lives lost each day from opioid overdose, but also from other drugs including cocaine, synthetic drugs, and prescription medications. First responders carrying naloxone overdose rescue kits have reversed opioid overdoses countless times and have saved many lives. For New York State law enforcement officers, various laws have changed in recent years surrounding naloxone rescue kits, syringe exchange programs, expanded syringe access, the possession of trace amounts of controlled substances in or on certain syringes, and exemptions from prosecution for certain Good Samaritan actions. Former Police Chief Mark Spawn said, "For veteran police officers, some of the things we learned in the police academy may no longer be valid."

As law and regulations have changed to embrace the philosophy of *harm reduction* (measures to reduce the negative impacts and risks of a particular behavior or activity), there is a continuing need to provide information to our law enforcement officers and other first responders about changes to legislation and regulations. It is equally important to discuss the merits of improving drug user health, which ultimately impacts our entire society. We also need to inform our society about the drug epidemic, overdose prevention, and the common misconceptions about persons who use drugs.

Three videos have just been released to underscore important issues in public health concerning illicit drug use.

Overcoming Drug User Stigma challenges the traditional stereotype of an injecting drug user. While many people may envision persons with addiction as being unemployed, homeless, and with criminal records, the faces of addiction include ALL demographics. In this video, former Police Chief Mark Spawn

— HEROIN, OVERDOSE, AND PUBLIC SAFETY, continued from page 15

discusses the true faces of addiction – persons of all ages, races, and social standing. Spawn examines the implications of someone being labeled a "drug addict." He added, "When a person with addiction wants help, they may not feel able to ask for it due to shame and embarrassment from friends, family, and employers. It is counterproductive and insensitive to brand persons with addiction." He continued, "We also have to understand that when a drug user wants to quit, they probably won't be able to do it the first time. When a drug user has access to sterile hypodermic syringes, the risk of spreading infectious diseases through contaminated needles and sharing is reduced. As first responders, there is always a heightened concern about getting stuck with a needle – the police officer conducting a pat-down search, the EMT treating an unresponsive person, or the booking officer at a jail searching personal effects and clothing. The ramifications of needle sticks reach far beyond the drug user. There are serious, legitimate reasons why our society should be concerned about keeping drug users healthy."

> As first responders, there is always a heightened concern about getting stuck with a needle – the police officer conducting a pat-down search, the EMT treating an unresponsive person, or the booking officer at a jail searching personal effects and clothing. The ramifications of needle sticks reach far beyond the drug user. There are serious, legitimate reasons why our society should be concerned about keeping drug users healthy."
>
> *– Police Chief/Retired Mark Spawn*

Chief Spawn noted, "There are many things that we, as a society need to know about helping persons with addiction. This is about providing assistance to drug users – to empower them to stay healthy while they are using drugs, and to support them as they are trying to quit. By focusing on the health of persons who use drugs, we can better ensure their well-being, and the health and safety of their family, partners, and for first responders who encounter them."

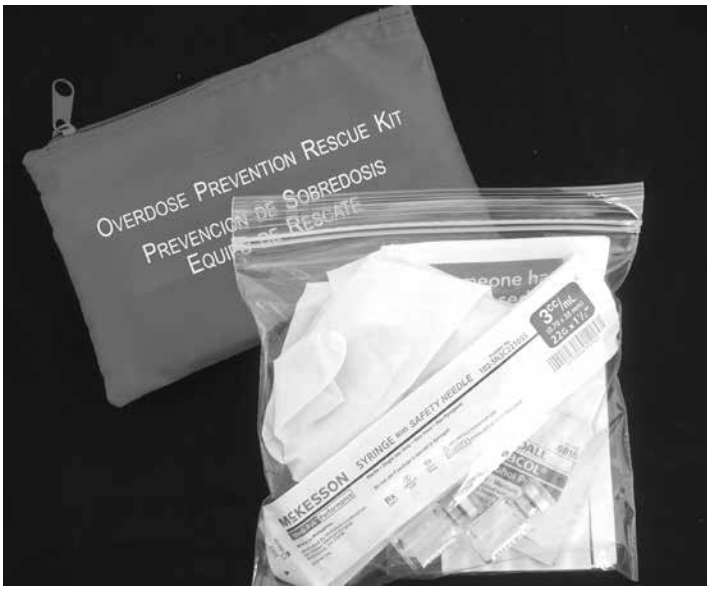
CONFISCATION OF OPIOID OVERDOSE KITS

In response to the heroin epidemic, New York State law authorized several initiatives to reduce the harm associated with drug use. Among them is the Opioid Overdose Prevention Program. Established in 2006, this program has provided overdose prevention training and kits of naloxone to first responders and citizens. Many law enforcement officers have been trained and routinely reverse overdoses on people who otherwise would have died. The same law allows citizens to possess and administer naloxone. However, there have been recent accounts of naloxone overdose kits being seized from citizens by law enforcement. The kits include naloxone, also known as Narcan, with either syringes for injection, or a nasal atomizer for delivery through the victim's ose. The law does not require trained responders, whether they are law enforcement, EMS or private citizens, to possess any proof, receipt or prescription for naloxone, syringes or atomizers. Some of the kits are distributed in labeled pouches, and some are simply in clear plastic bags. The reasons for confiscation of overdose kits are not clear, but it is important for police and others to know that the issuance and possession of these kits are lawful under Section 3309 of the New York State Public Health Law. In this production, former Police Chief Mark Spawn discusses the Opioid Overdose Prevention Program. "This is another area of law that has changed over the years. It can be confusing, but it is important to know that trained responders under this program can lawfully possess naloxone, syringes and atomizers, whether as a first responder or as a citizen." Spawn explained that police officers often look for documentation to verify ownership, training, or certification in other aspects of their job. He said, "But under Section 3309 of the New York State Public Health Law and regulations, the issuance, possession and use of naloxone is authorized. The law does not require a prescription, certificate, receipt, or other proof. The absence of that type of documentation does not give us cause to confiscate the legally-issued kits."

If officers and agencies have questions about the law, please consult with your municipal counsel or district attorney.

FIRST RESPONDER BURNOUT IN OVERDOSE REVERSALS

The Opioid Overdose Prevention Program has put lifesaving naloxone in the hands of firefighters, police officers, and EMS providers. While there have been several accounts of lives saved because of the prompt administration of Naloxone, there have also been stories of some first responders who have become frustrated with repeatedly reversing overdoses, sometimes on the same people. In this video production, former Police Chief Mark Spawn talks about the importance of being non judgmental and committed to the duty of providing first aid to persons in distress. He said, "We have to realize that behind the layers of addiction is a person - a person who wants to quit - a person who is struggling." Perhaps there is no better example than the story of a man who was addicted to heroin and has since turned his life around. Roberto Gonzalez of Utica, New York shares his inspiring story of how he suffered an overdose and was saved by paramedics.



KEY TO LEADERSHIP: LOOK IN THE MIRROR

Former Navy Captain Michael Abrashoff took command of the worst-performing ship in the U.S. Navy's Pacific Fleet and, in 1 year, with the same crew, turned it into the best in the entire Navy. He wrote, "[M]ost obstacles that limit people's potential are set in motion by the leader and are rooted in his or her own fears, ego needs, and unproductive habits."

Those who agree would say that leaders must address these areas. Those challenges represent probably the hardest work for these individuals. Sadly, while quick to see the faults in others, most leaders are slow to recognize their own shortcomings, which limit their ability to influence those they lead. As a result, our organizations suffer.

> **Most obstacles that limit people's potential are set in motion by the leader and are rooted in his or her own fears, ego needs, and unproductive habits.**

One leadership trainer has expressed confusion about how managers sometimes invite him to lecture about concepts they themselves do not practice. He determined that many leaders fall into this trap because they confuse beliefs and feelings with skills and action. He stated, "We judge ourselves by our motives, but others by their actions."

Leaders need examine themselves in the mirror. As Superbowl-winning coach Tony Dungy stated, "The ability to take an honest look at yourself and examine who you are—what makes you tick, what makes you do the things you do—is a mark of maturity for a mentor leader."

Retired Colonel Lee Ellis learned much about leadership while spending 5½ years as a POW in North Vietnam, including time in the infamous prison known as the Hanoi Hilton. To survive physically and mentally, the POWs had to become a team and develop a set of values they bought into and reinforced among themselves. Is this not the culture we expect leaders to establish in our organizations? As Ellis stated, "Authentic leadership flows from the inside out. You will be most successful and fulfilled when you clarify who you uniquely are in terms of purpose, passion, and personality and then lead authentically from that core."

So, what does this look in the mirror involve? It starts with the commitment to be honest with yourself, even when it hurts. You also must be aware of your feelings and behaviors, as well as others' perceptions of you, and allow that knowledge to influence your actions in a way that works to your benefit. We all can discover actions we should not take that do not align with what we purport to stand for, thus limiting our influence.

A look in the mirror also must result in openness to feedback. We need to allow those we supervise to express their thoughts about us and how our leadership affects them. Secure leaders should not fear the conversation that includes, "Hey boss, when you do this (whatever action), it makes us feel like you don't trust us." If you never have that conversation, you probably are surrounded by either silent critics or "yes" people. "Pity the leader caught between unloving critics and uncritical lovers."

An honest look in the mirror even may enlighten you to the reality that you are a better leader than you thought, but not as effective as you could be. Whatever the result, a look in the mirror can allow you, as Abrashoff states, to begin "understanding yourself first, then using that to create a superb organization."

Josh Phillips, an instructor/developer with the North Carolina Justice Academy, Law Enforcement Leadership Center, prepared this Leadership article. He can be reached at mjphillips@ncdoj.gov. Reprinted with permission of the FBI Law Enforcement Bulletin from December 2017 issue.

— HEROIN, OVERDOSE, AND PUBLIC SAFETY, continued from page 16

He has been completely clean and sober for more than five years. Today, Roberto is the Assistant Coordinator for ACR Health's Syringe Exchange Program in Utica, helping others who suffer from addiction. Spawn said, "As a first responder, if you find yourself frustrated and questioning the value of first aid for persons suffering an overdose, you need to talk about it. Speak with your supervisor, employee assistance program, or critical incident debriefing team. We need to provide first aid to overdose victims just like we would stop bleeding for a crash victim or give CPR to someone who is in cardiac arrest."

If officers and agencies have questions about the law, please consult with your municipal counsel or district attorney.

The video series, *What's Happening in Harm Reduction*, was funded by a grant from the New York State Department of Health and produced by The Spawn Group. Videos available for free on YouTube and in the iTunes Store – Search "What's Happening in Harm Reduction"

A Task Force Approach to Stemming the Tide

Like many communities around the country, by 2016 Niagara County was facing the grim reality of the opioid crisis ravaging our country.With overdose rates on the rise and law enforcement agencies stretched to their limits, local elected officials/community members responded quickly to address the problem and the Overdose/Addiction Strategy Implementation Standing Committee (OASIS) was born.

The task force was formed with the immediate goal of assessing the County's current situation and provide help to those already in the grip of substance abuse. It was obvious we needed to stem the tide at its source, but how? As we are now well-aware, the opioid crisis is a complex problem with numerous contributing factors requiring a multifaceted response to elicit long-term change. As such, a sub-committee style program was developed with each sub-committee staffed by a carefully selected panel of experienced members with both professional and personal experience in this crisis.

The first committee formed was the Public Awareness/Involvement Sub-committee. Their mission was to expand discussion about the epidemic, with the goal of reducing the stigma for those caught in the disease of addiction and reducing the barriers faced by those in recovery. Within six months of its creation, short-term goals of public education and involvement were well under way through involvement at local forums, community events, parent/teacher/staff trainings through local school district involvement (i.e. presentations at school sports orientation programs) and public relations initiatives on television. Radio ads, bus bench banners, pizza box flyers and educational handouts are all being used to promote the Niagara County Crisis Services help line, which offers a 24/7 resource for support and treatment. "There is Help. There is Hope. Recovery is Possible." has become a commonly used phrase in our literature. This phrase communicates our understanding of the harsh reality of the disease of addiction, but also promote the positive focus of our mission.

More commonly known by its brand name Narcan, naloxone is an opioid antagonist used for the emergent reversal of an opioid overdose. Controversy has certainly surrounded the use and distribution of the life-saving drug, with opponents questioning the use of tax payer dollars to supply the lifesaving drug to addicts "with a choice" in their addiction. Some also argue that the easy access to naloxone can cause a false sense of security and greater risk-taking by opioid users. However, while statistics show that overdose fatalities for our county were slightly higher in 2017 in comparison with 2016, there is a belief that increased use of naloxone by our first responders, as well as expanded training and access for members of our community, has played a role in preventing overdose deaths and keeping those statistics lower than they certainly could be. Through funding and training programs offered in conjunction with NYS OASAS (Office of Alcohol and Substance Abuse Services), the Public Awareness/Involvement Subcommittee has already partnered with local hosts to train over 500 community members and supply them each with a free overdose kit. Our efforts will now turn to a "train the trainer" effort to ensure ongoing access to Opiate Overdose Response training in our community.

Because no community is immune to the devastating effects of the current epidemic, it is important to understand and recognize the differences between city, suburban & rural communities within a diverse county, such as ours. Statistical tracking for "hot spots" of drug use, types of drugs used, locations of overdoses & methods of reducing those occurrences was a key component in the development of our second working group, the Law Enforcement/First Responders Sub-committee. Led by current and former law enforcement officials, the goal of this group has been to standardize tracking, reporting & follow-up procedures for overdose events throughout the county, while ensuring the front-line people who fight this problem firsthand have the resources and training needed to safely and effectively handle the situations they encounter daily. Through strong support of the District Attorney's Office, Sheriff's Department, City and Town Police Departments and our first responder agencies, there is a daily coordinated effort to stem the tide – to get the drugs off the streets, prosecute the drug dealers who prey upon our citizens and offer help to those in need. New programs and initiatives for standardizing fatal overdose investigations, diversion tactics to help individuals resolve their life struggles, and outreach to instill trust in the community are ongoing.

In our earliest meetings and efforts, there was clearly an emergency phase of response to cleaning up a mess in which we were already entwined and "throwing things at the wall to see what would stick". While certain initiatives were not thought to be largescale solutions, if one life could be saved, it was worth the effort. Our research has taught us what programs have worked in other areas, and recognize the gaps in our own efforts, we can now approach our work with a much more proactive, calculated and preventative approach.

One obvious shortcoming to our approach was the lack of treatment options for county jail inmates. Through enthusiastic cooperation between the Niagara County Sheriff's Department, the Niagara County Department of Mental Health and Substance Abuse, and funding from a federal grant, the Niagara County Jail was recently able to launch a pilot program offering help to inmates battling opioid, alcohol and other addictions. Through group and one-on-one therapy, education, medication and links to outside providers after release, inmates are given a chance to work on their sobriety in a safe environment, away from the everyday stressors and instigators in their outside lives.

In other efforts countywide, tracking and reporting of overdose statistics have vastly improved and are now coordinated using their ODMAP system. Long-term efforts to expand treatment options for those seeking help have expanded using peer programs, recovery coaching, residential and inpatient treatment services and medication-assisted treatments. Secure drug drop-off boxes are now placed throughout the county for safe disposal of unwanted prescription drugs. The Niagara Falls Police Department has started a pilot program in which a police officer will pick up unwanted prescription drugs directly from people at their homes. However, much more needs to be done.

As our work and efforts evolve, it is time to start our next subcommittee, which will focus on the medical community. Several eager physicians and health care workers have already agreed to give their time and expertise to discuss issues of alternative treatments for pain management, ensuring access to treatment through insurance company requirements, continuing improvements to prescription practices and monitoring, and ensuring pharmaceutical company accountability.

As our OASIS initiative grows, our task force model will be able to better focus our efforts on the constant challenges and changes that will occur as the opiate crisis evolves. By involving all public and private stakeholders, planning and commitment to a broad range of strategies, and simply working together, we have generated a positive energy and support throughout our community that will ensure that we will turn the tide and overcome this scourge of opiate addiction!

By: Rebecca Wydysh, Niagara County Legislator and Laura Kelemen, Director of Mental Health.

2018 Conference Banquet

2018 Conference Banquet MTA pipes and drums.

2018 Conference Banquet Nassau County Honor Guard.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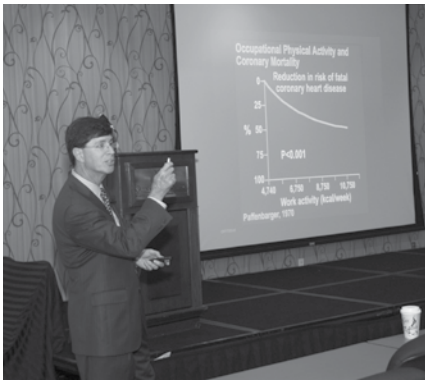

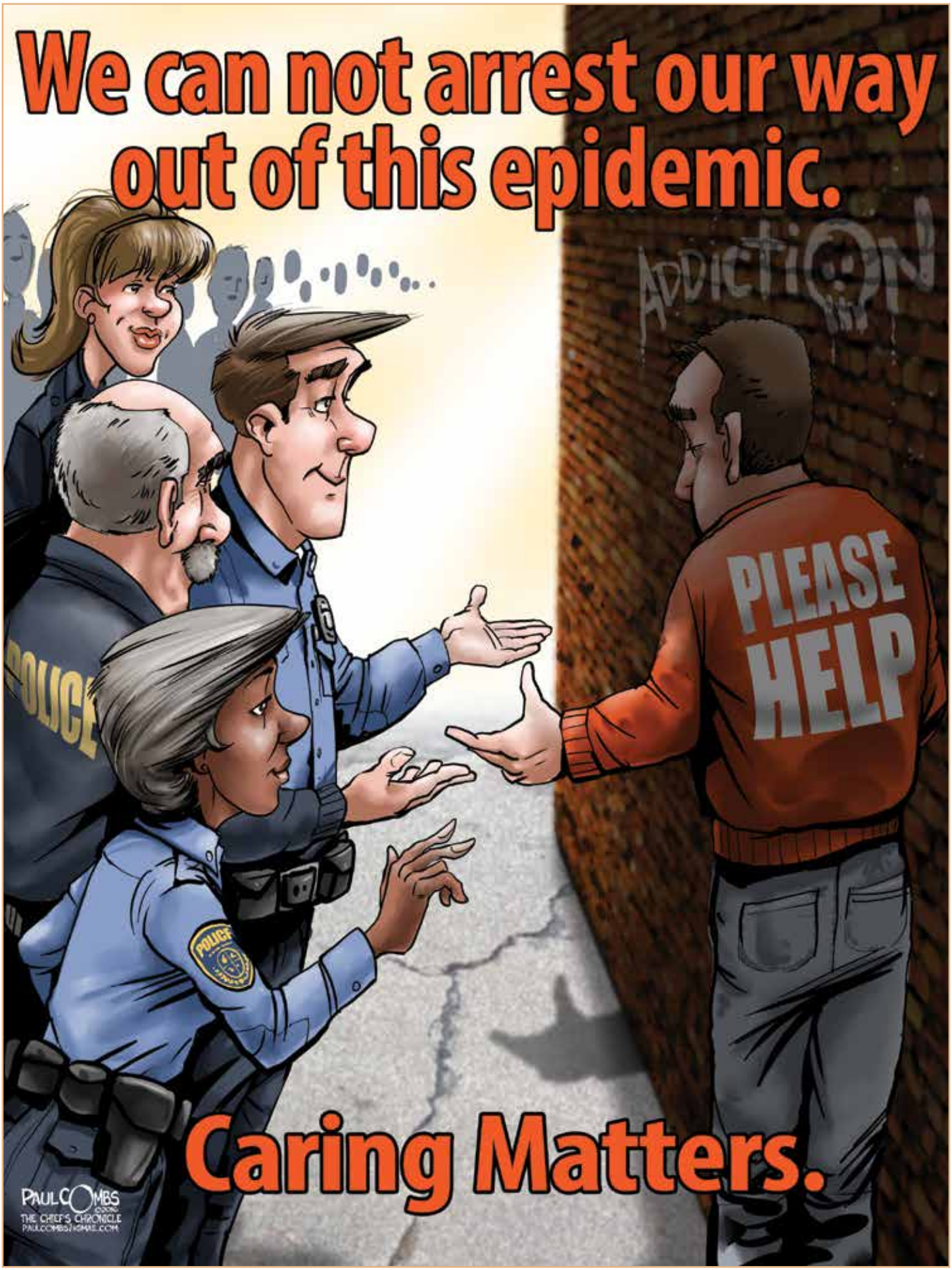
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— OPENING CONFERENCE CEREMONY, continued from inside front cover