NCJTC- Fox Valley | Effective Collaborations 10 Steps To Address The Opioid Crisis

Welcome everyone to the National Criminal Justice Training Center webinar. Our topic today, Effective Collaborations, 10 Steps to Address the Opioid Crisis. Presenting today's webinar is Cindy Cipriani and Bob Bishop. My name is Justine Souto, and I will be your moderator for today.

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And with that, let's try our first poll question. This is a simple question to find out who's joining us today. The question is which of the following best describes your role? The choices are law enforcement or first responder, a tribal stakeholder, a prosecutor or attorney, children's advocacy center, social worker, victim services provider, or mental health provider, or other.

It looks like we have the majority being other. And if you all wouldn't mind from the other category, if you just type what your position is in the comments section of the GoToWebinar dialog box. The second majority of you are from the law enforcement realm followed by social workers, mental health providers, and so forth. Thank you all for joining us today.

With that, I'd like to welcome you again to our webinar. And I'll introduce our presenters for the day. Assistant US Attorney Cindy Cipriani develops partnerships and programs that further the US Department of Justice's mission to prevent crime and enforce federal laws. She co-chairs San Diego's Multidisciplinary Opioid Coalition, which works across sectors to raise public awareness and end the vicious cycle of addiction and overdose deaths.

Mrs. Cipriani body also leads the Juvenile Smuggling Prevention Team, a collaboration that Attorney General William Barr selected as 2019's outstanding contribution to community partnerships for public safety. In addition, she has organized numerous events and efforts to address targeted violence and hate incidents earning the Anti-Defamation Leagues Sherwood Prize for Community Engagement Working Combating Hate.

Bob Bishop is the director of public safety for the San Pasqual Band of Mission Indians. His 33-year career includes assignments in detentions, parole, narcotics, traffic, rural law enforcement, prisoner transportation, general crimes investigations, and gang investigations. In 2006, Bob was promoted to Sergeant and reassigned to the Valley Center area in northern San Diego County. That station

provides law enforcement services to three rural communities and five Indian reservations.

In 2013 after retiring from the San Diego Sheriff's department, Bob was hired by the San Pasqual Band of Mission Indians in Valley Center to establish a police department on the reservation. Welcome to both of our presenters for today. And with that, Cindy, I'll turn the time over to you.

Thank you. It's a pleasure to be here today speaking with you about 10 ways that you can work together with your community to address the opioid crisis. And I think for many of us, we're familiar with where this all began. But I'm just going to give you a quick overview, because I think it does illuminate how the problem started and how we can best climb our way out of it.

And as many of you know, we in America do consume more opioids than any other country. And this really started with prescription opiates back in the 90s with a number of pharmaceutical companies really pressuring doctors saying that pain was a vital sign and needed to be medicated. These drugs are safe. And so doctors started writing scripts upon scripts for Vicodin and other pain relievers. And we found that a number of people became dependent and addicted. And it started a wave of substance use disorder in our country.

So it starts out with essentially fraudulent marketing that the pills are safe, overprescribing, which increases substance use disorder. And unfortunately, eventually the individuals with substance use disorder are turning to stronger opioids. They're using up their script in a very short period of time. And they're turning to street drugs, black market, dark web. And we're seeing a huge spike in opioid overdoses. That's actually changing our mortality rates in this country.

So it helps to understand the problem. When you understand the problem, you can craft a plan that hopefully will provide some solutions. And the way we've approached this in San Diego is through a multidisciplinary coalition. So not every area has a coalition, but I believe these coalitions are popping up all over the country, because they're being funded by a number of states and also federal government grants.

And basically, the idea behind these coalitions is that you're going to bring together people from multiple disciplines, bring health care providers together with public health officials and also law enforcement, addiction specialists, and individual's family members, people who can tell the stories that will basically send important messages out to the community.

So we're very fortunate in San Diego to have such a coalition that really started back when Oxy first started becoming a major problem in the 90s. They started this coalition. And it was basically one

agent at DEA who basically said we have a crazy number of overdoses. We have to do something about this. And started going after the rogue doctors who were overprescribing and working to get people into treatment. And the coalition just grew and grew from there.

And it does include, in San Diego, members of the Indian Health Service. It includes a member of the medical profession who's been on the leading edge of problem solving. And you're going to be hearing from her virtually through some of the plans that she did create that helped us better address the problem in San Diego.

So it's important to have a game plan. And my kids are huge history buffs. And they've read The Art of War several times. And one of his favorite quotes for me is "Strategy without tactics is the slowest route to victory. But tactics without strategy is the noise before defeat." And so it helps to bring everyone together and to get in basically alignment. We actually have strategic planning sessions and our coalition. And we break down into public health, messaging, law enforcement.

We basically pick our top five goals, and we come together at the end of that and share them as a group, and agree on a strategic plan every year. And we do this for both opioids and Meth because we're actually seeing now as many overdoses, if not more overdoses, from Meth in our county as we are from opioids. So poll. Does your tribe/community have a multidisciplinary coalition that focuses on opioid solutions?

Choices are yes, no, or unsure. Over half of the people voted and the majority say that they're not sure. And yes and no's are relatively close, as you can see, together. And why do you think that there is a challenge, Cindy, in knowing whether or not they've got these community multidisciplinary coalitions?

I have to say when I first began working in this arena, I was not aware that there was a prescription drug abuse task force in our area. And I made a number of calls and eventually stumbled upon the medical doctor that I was referring to. And once I met with her, I realized that there was this group of people that had been brought together that met quarterly. And I know now that there are a number of organizations that are forming these coalitions across the country.

So we have a group in California that is working to fund coalitions and expand their work. And that group is now starting a national overdose prevention network that essentially will be forming these coalitions. So if you're not sure if there is a coalition, I would encourage you to reach out to your law enforcement coordinator at your local US attorney's office, reach out to your public health department. Chances are there are groups of people who are working on these issues. And I could

also, if you want to contact me, connect you with the Overdose Prevention Network because that is an organization that is now taking off nationally and really working to establish these coalitions and bring people together nationally.

So as I mentioned, in San Diego, we do engage in strategic planning. And this is an example of our logic model that basically sets forth what our goals were for addressing the prescription opioid epidemic. These goals change over time as the problems changes. And I'm going to go through with you some of the information you need to assess what the current problem looks like and to always be reacting to basically the current data so that your approach is data-driven.

But basically what we were seeing was a lot of misuse and abuse and addiction with regard to prescription drugs in San Diego County. And we came up with three objectives. We wanted to increase knowledge and awareness of the issue. Because so many people thought these are drugs. My doctors giving them to me. They must be safe.

We wanted to make sure we reduced access to prescriptions for purposes other than those prescribed. Because we saw a lot of teens who were raiding their parents or their grandparents medicine cabinets. Basically these drugs were not locked up appropriately. And there were a lot of issues with regard to safe disposal and access to the drugs.

And we also wanted to increase the perception of harm related to prescription misuse and abuse. Particularly we saw with teens, they would have a sports injury and end up on these drugs. And we saw studies showing that after three to four days, they could actually become dependent in a very short period of time. They were just unprepared for the kind of euphoria that these drugs produce. And these are kids who didn't have drug issues, weren't doing recreational drugs.

So we saw a huge need to educate students, their families, doctors to ensure that doctors who were prescribing the drugs understood the risk of abuse and dependence. And also, there are certain drugs that, in combination with other drugs, really significantly amplify the problem. And we wanted to ensure that doctors knew about that.

So we came up with the list of short term objectives. And basically we wanted to ensure that we were increasing knowledge of misuse among parents. We were reducing ways to get the drugs illegally, for example theft robberies at pharmacies, the known docs that were overprescribing, the bad docs in other words that were essentially operating like pill mills.

We want to do ensure that people had more supervision and accountability for the pain meds. And

that they had alternative methods of dealing with pain. And we also wanted to make sure that we were increasing the knowledge about the very real harms and increasing peer disapproval of prescription drug use and misuse and parent communication.

And once we came up with those objectives, we created action steps to achieve change. And this is where it's really helpful to have a multidisciplinary approach, so that you're all connected together. Because I've learned so much from the individuals in our coalition who are in public health, or in the medical profession, who are family members of individuals who've either overdosed and passed away or are living with significant ongoing lifelong effects of an overdose.

And in fact, we have one individual whose son became addicted when he was in high school. He was a football player with a sports injury, started getting the drugs on the black market, and ultimately took too many, overdosed, was brought back to life, and is essentially he's paraplegic living life in a vegetative state. Can't feed himself, take care of himself. His parents provide 24 hour care for him. And they go out into the schools. And it's very telling for students to see death is just the tip of the iceberg. Some people are living with addiction and with the effects of an overdose.

And so bringing those folks together with law enforcement with public health, you can tell the story from multiple perspectives. And oftentimes law enforcement is not the most powerful messenger. We can be an important part of the solution, but oftentimes it's peers that are the most important and powerful messenger. So we wanted to ensure we had peer to peer intervention, media messaging, pharmacy messaging, education enforcement, and prosecution policy changes, which I'll be talking about a little bit later.

So step one in San Diego was let's get the prescribing under control. And our doctor, who actually is an emergency room physician, she was seeing all night people coming in trying to get pain meds at the ER. She was becoming really frustrated, and she realized that we need standards.

Because ER doctors, they want to get people out of pain, right? And they don't know how to recognize is this a real problem that I should be medicating, or is there an issue with addiction? Should I be referring someone to treatment? How do I do that? That's not my area. We saw that dentists were basically providing what could be 30 days of pain pills for a wisdom tooth surgery that really maybe required a day. And then the person would be fine on Tylenol.

So she came up with the strategy working with both pharmacies and with prescribers. And the idea is everyone should have, ideally, one provider, so they're not doctor shopping, and one pharmacist. If someone's going to a number of doctors and a number of pharmacists, that should be monitored.

And we should be making sure that folks are aware of that, that the who is doing that is spoken to and that the pharmacy is spoken to, as well as the doctor knows that this person is doctor shopping.

And the way you do that is through the prescription drug monitoring program, which virtually I think, 49 of 50 states have. In California, it's called Cures, and it gives you access to that information. And then also that there will be mainly one doctor, or the primary doctor, or pain control specialist, only one doctor prescribing opioids.

And there will be an agreement by the patient and the doctor as to how that was going to work, and that you would never be combining opioids and benzodiazepines. So some of you may know benzodiazepines. Those are drugs like Xanax and Valium, anti anxiety drugs. And what we're seeing now is a shadow epidemic where the number of prescription opioids is going down and the number of benzodiazepines is skyrocketing.

And those drugs are just as addictive and create a lot of issues with safe driving, ultimately with mental health cognition, dementia. So it's really important to get a handle on that as well. And that you would have emergency department guidelines that every single emergency department would know about and would train their doctors to honor.

So these are the safe medicine prescribing guidelines that were developed for our emergency department. Ultimately, these were adopted by the state of California, and they are now a statewide standard. And this all started really with one doctor who was alarmed at what she saw, and who basically was willing to get out there and engage in training and education, and ensure that her colleagues and her peers understood the best way to handle this.

The idea is if you can stop the overprescribing, you can cut down on the number of people with substance use disorder. Those individuals usually will turn to street drugs and even more powerful opioids than prescribed prescription opioids. So if you can cut it off basically at the start, then you're going to eliminate a lot of pain for families and individuals and communities down the road.

So this was an incredibly successful program that did result in, as we're seeing in California now, the number of prescription opioids going down. Far fewer prescriptions now than there were when we started this program. So another poll. Have your Indian Health Services and centers, or your community through your ERs, have they implemented this kind of safe prescribing protocol to get a handle on the number of prescription opioids that are being dispensed?

The majority answered that there are-- 69% say they're unsure if their community health centers

implementing these safe prescribing protocols.

As for individuals who are within law enforcement or within public health and in a position to be involved in a dialogue about this, I think that this has become a national priority now. And so I think the message it is getting out there. So my guess is there are efforts to train physicians and that more and more, we're seeing these in place.

And I think the challenge now is to ensure that they cover benzodiazepines and muscle relaxers as well as opioids. That combination is a really dangerous combination. So if you do have access to engage in that kind of a dialogue in your community, it's definitely worth exploring whether those prescribing protocols are in place for not just opioids but benzodiazepines as well.

So step two. Our goal was to stop diversion, which means drugs that are supposed to go to patients getting diverted from legally permissible prescriptions off to the street, or individuals they were intended for, rogue doctors who are writing lots of scripts, getting numerous people addicted which happened in some areas more than others. West Virginia and Florida were known for having just huge numbers of scripts written that when you looked at the population could not be explained by looking at the population. And also going after pharmacies for violations.

So basically we did that by looking at the data, by getting a sense of who are the doctors that are prescribing beyond a median that would be the norm. We looked at the number of what they call MMEs, morphine equivalents, that they were prescribing. And you can really see kind of a bell curve and then these outliers. And when you see the outliers who are overprescribing far beyond what the median is, you know you have an issue that you need to look at.

And sometimes that would involve law enforcement. Sometimes that would involve a visit from a coaching medical professional to basically school that doctor or school that pharmacy in terms of what's appropriate and-- for example, the pharmacy may be filling scripts-- when they need to notify law enforcement that they're seeing a crazy number of scripts from a doctor, from a single doctor that it doesn't make sense.

So another step that we've taken is to raise awareness about addiction. And I think this is so important because I know coming from a law enforcement culture, you see people who are used to thinking of addicts sometimes as these are people who are out on the street. They're dealing with drug addiction every day. They're dealing with homeless individuals who have oftentimes dual diagnosis and addiction. And it's easy to become jaded, right? It's easy to make a lot of assumptions.

Anyone who has addiction in their family who have suffered through that, we're all aware that it takes a toll. There's a fatigue, a compassion fatigue that comes with being the family member of someone who has substance use disorder. And I'm sure, we have a number of probation officers in the audience, that it's very common for probation officers to experience that kind of fatigue and exasperation when somebody you know has a dirty drug test.

So basically what we've tried to do is to explain the way the brain works, the way addiction changes the brain. And you can see why someone's decision making changes, because that entire structure of the brain, the dopamine function of the brain changes to the point where the person is not necessarily is in control. It looks like a choice, but they're not as in control of their decision, because so much of their body chemistry is geared toward satisfying the addiction.

And I think it's important to do that because once you do educate people about the changes in the brain, and when you realize that anybody who is prescribed these drugs-- you could have somebody with a particular sensitivity or predisposition. You do understand much more that this is a medical rather than a character or a logical issue. And it just changes the entire way you look at the problem.

So at this point, I'm wondering, Bob, if you have thoughts. As a law enforcement professional, have you seen that culture and awareness about addiction and stigma? Have you seen that change in your agency?

Well, I was just thinking one of the major things we've done here in California is almost completely decriminalized possession of heroin, methamphetamine, cocaine, and opioids. I've been in law enforcement 41 years. And I frankly think this was one of the stupidest things that we could have ever done because it ties the hands of the courts. It ties the hands of custody, parole, probation. Effective tools that we used to have to deal with addiction, we don't have those anymore. There's no force of law behind the drug culture anymore.

Drug dealers are nothing if not opportunist. What we've been talking about this morning is the opioid, basically pharmaceutical abuse of the drug that has now transferred over. Like I said, drug dealers are nothing if not opportunists. If they see a market, they're going to provide a product.

We have very inexpensive and very powerful fentanyl being imported from China into Mexico. My tribe is located in northern San Diego County, and we're sitting right on the Mexican border. And what we are seeing are our high density drug trafficking teams are intercepting multiple pound quantities of pure fentanyl coming across the border, being walked across in backpacks, being smuggled by pedestrian crossers, vehicle crossers.

That fentanyl then finds its way into pill factories. The most popular thing we've been seeing in Southern California are counterfeit Oxy. We call them Oxy Blues. They're M30s. That's the markings that's on them. They're actually are counterfeit pill disguise as formally what was prescription Oxycodone. The illicit pill factories-- and this is our biggest problem-- are mixing fentanyl with oxycodone. And lab tests are coming back that those pills are up to 80% fentanyl, which is causing an epidemic proportion overdoses.

In northern San Diego County, the reservation that I'm the police chief for, we have former reservations within about 15 minutes drive time. We all talk. Families cross tribal lines. So we have good understanding of what's going on the different reservations. And we're seeing starting about three years ago, it really hit home early when one of our tribal chairman's grandson would just come out of treatment overdosed. And it was a fatal overdose.

A couple of months later, our then vice chair's brother overdosed. And it was a fatal. The first one was pure fentanyl. The second one was a heroin fentanyl combination. And about six months ago, one of our longtime tribal employees overdosed on M30. We were able to fight the battle of the tradition of not talking to law enforcement. And to be honest with you 41 years in law enforcement tells me that's not a reservation problem. There are communities that just don't talk to the cops.

We were able to actually push information out into the tribal community. We got one minor response through enforcement-- I'm sorry-- through investigative means. We were able to identify the dealer. We actually watched the dealer come into the local community and do a hand to hand buy. He had 500 pills, M30s on him at the time. We went back to his house with a search warrant, recovered heroin, cocaine, and another 500 pills.

Most recently starting about four weeks ago, our epidemic has gotten much worse. We've had 16 overdoses in the area, and that includes a couple of the other reservations involving tribal members, triballenials, the children of tribal members. We have a gaming Casino here on the reservation. Up to and including yesterday, we had an overdose in one of the bathrooms. A young man just out of treatment decided to use a white powder that we eventually tested and found that it was pure fentanyl. First time, we'd seen that. And it took three shots of Narcan to bring him back.

Of our 16 overdoses in the last three to four weeks, only four of them have been-- I'm sorry-- six of them have been permanently fatal in the area. Most of the others started out as fatal, and they were Narcan saves is what we call them. Narcan's a miracle drug. And I encourage anybody that has not sought the training to get the training to use it. It's only 30 minutes of training. It's more complicated

than applying Flonase.

My officers carrying it both for victim resuscitation and should they be exposed to it. Anybody working with probationers, parolees, people on the street, fentanyl exposure is absolutely going to happen. Gloves, goggles, all the safety measures need to be taken.

Bob, I have a comment from someone from Human Services saying that they completely agree with your comments. This has dire, and many times as deadly as you've just described, deadly consequences to children because there are no repercussions to the caregivers.

And we have another question related to that previous slide on the brain. And the question is for someone that is addicted, what is the possibility for repairing that temporal lobe? And can somebody adequately heal from that?

Well what we found is-- that kind of gets us right into the next area-- is that if you provide evidence based treatment, medication-assisted treatment, the one positive aspect to the opioid epidemic is that it is treatable. And Meth is much more difficult. It's very, very difficult to recover from Meth. There is no medication-assisted treatment. It's cognitive behavioral therapy. It can take a year or two to feel normal.

But what we found-- And we really had to, speaking of stigma, get over the stigma of treating opioid addiction with an opioid agonist. Basically what medication assisted treatment is a couple of different formulations. And basically it's feeding the part of the brain that is hungering for opioids in order to produce dopamine. Your brain because very dopamine deficient when you are suffering from addiction. And you need that opioid. And yet, you don't want to get people high, and you don't want to facilitate further addiction. But if you provide these medications, the individual will be able to function.

And we have found, because we did opt into an organized treatment delivery system and really increased our funding for that, that when we adopted this hub and spoke model-- meaning that there would be a hub for referrals, and then the individuals or the facilities on the spokes would all be able to provide medication assisted treatment. This is evidence based care that really does work.

So it is possible when you understand the way the disease works and the effect on the brain to provide medication assisted treatment. And basically what that will do is return the body to productive functioning, address the dopamine cravings. It can reduce drug use by 40% to 60%. They say it is about 60% effective, sometimes 80%, as high as 80%.

So if we go from essentially a problem that had no solution to being able to solve 60% of the cases, that's huge, right? And because it is so incredibly effective, they're finding that basically you can treat this the same way you treat diabetes, asthma, hypertension. And basically the strongest predictor of recovery is if someone stays in treatment. These are just a couple of the drugs, methadone, suboxone, which buprenorphine is the actual name of that, naltrexone. Those are all different forms of medication assisted treatment.

And we're finding now that more and more states and counties are putting this into the prison system, into the jail system, and into the reentry system. So that when somebody is an addict and they're recovering, when they get to-- if they have a relapse relapse-- 90% of people relapse. If they do relapse and they end up going to jail or prison, they should be provided this medication assisted treatment options.

Because if they are provided those, there's a much better chance when they come out, that is when you see massive numbers of overdoses occur. Somebody goes into jail or prison. They get clean. They come out, and they're especially susceptible to an overdose. And it really does aid their ability to function.

So what they found is if they do give medication assisted treatment, they see a reduction in drug related overdose deaths, a reduction in disease and violent crimes. Disease is like hepatitis. And violent crimes that involve home invasions to get money to feed the drug cravings, and improve treatment outcomes. And it's been so incredibly well produced and well received, that they've compared it to placebo, and they're seeing a huge difference when they've done the clinical trials in terms of the people who've been able to curb their opioid use as compared to placebo.

So with that in mind, those of you who are in probation, who are working with individuals who suffer from substance use disorder, the best thing you can possibly do is to refer that person into a medication assisted treatment program. And all public health departments should be in a position to refer you to where those prescriptions are being written.

There is a certain amount of training. They are trying to dramatically increase the number of doctors who are able to prescribe medication assisted treatment, but it is a treatment that works. And it's the best chance and hope of recovery for individuals. I think that experience and access to that is growing and becoming much more acceptable.

In fact, on the law enforcement front what we're seeing is that individuals who are going into prison,

if they're finding they can't get it when they're in custody, they're filing suit and they're winning. All of the cases come down on the side of providing that both in custody and upon reentry, providing that treatment.

Cindy, we are getting a lot of questions related to the effects of this treatment on women who are pregnant, about what are the after effects of being on this medically assisted treatment. Like does their brain get completely restored? And what are the effects on juveniles? So in the interest of time, I'm wondering if you have a resource that you can refer these people, these questions to.

Yes, I would definitely invite anyone to go ahead and email me. And I will try to put you in touch with individuals who have answers to those specific questions. I'm not that familiar with pregnancy aspect of this, how they are handling individuals who are pregnant. I mean to me, at the idea of providing something like this as opposed to continued use of an actual opiate would be it would be preferable to that. But I don't know what the guidelines, the medical guidelines are for people who are pregnant.

And for juveniles, I mean, I would think for juveniles that they would treat with lower doses. But it would be very similar to if they had an addictive juvenile basically that they could catch it early and give that person a chance at treatment. And the individual I was telling you about who is a paraplegic now, I mean, his mom who does a lot of outreach for us, she put him through two or three unsuccessful rehabs when he was a teen. And they didn't work. She said, I just wish I would have known about medication assisted treatment. He might not be in a wheelchair for life. Now if I'd known about that, he wouldn't have overdosed.

So I do believe they are providing it to juveniles, but I'm not sure about pregnancy. But I would invite anyone who has questions to email me and I will try to put you in touch with resources in your area, hopefully who can give you specific answers to that.

Thank you for that. And another participant said that SAMHSA, the Substance Abuse and Mental Health Services Administration, have a lot of information on this medical assisted treatment on their website. Thank you all for those questions.

Yes, that's a great resource. SAMHSA has wonderful-- Actually the head of SAMHSA is someone who speaks on this frequently. And she's very compelling. So you can probably find YouTube videos of her as well speaking about this.

OK so step seven is to monitor the critical data. And this is really interesting because we've seen that the problem is changing. And you heard Bob talk about this. It's a totally different problem now than

it was just a few years ago. So you need to be in touch with data, so you know what's currently causing harm.

And the data, the real time data is so much more accessible now. The first time I sponsored a statewide opioid summit in California with all four US attorneys, they were saying they had no idea. One US attorney said I had no idea that most of the overdoses in California are occurring in my district. How do I get that data?

Well, now our department of public health has county by county, zip code by zip code information on the number of scripts written, the number of overdoses, information on your data for 2018, 2019, what the fentanyl death numbers were, what the overdose numbers were for other kinds of drugs. And what we've seen is the final fentanyl-related overdose deaths have gone up 72%, 72% since 2017. And meanwhile, we've decreased on the opioid prescriptions that are dispensed almost 10%.

So when you see those overdoses go up and you see the scripts going down, you know something else is going on here. And we've taken a close look at the data, so that we can respond to the current problem, which is we've taken these steps to get the scripts under control. What are we going to do about the fentanyl?

So the response has to address the problem as it exists in today's world. And what we've seen is nationally from CDC, heroin down, cocaine down, and methadone basically stable, and fentanyl and other synthetic opioids skyrocketing. And that trend continued in 2019.

So we've seen in San Diego, we had 12 fentanyl deaths in 2010. And then in 2018, 92. And we're on track-- that was for 2018-- for 2019 to have far more than that. I think it looks more like 134, 135 for 2019. And we're already at that for 2020. We're not even halfway through the year. So here's another poll question. Has your tribe community experienced an increase in fentanyl overdoses in the past three years?

The choices are yes, no, or unsure. And quite a few weighing in that they are quite certain that they have seen an increase. 32% said yes. And the majority of the other 2/3 were just not sure.

It is helpful to know what the problem is that you're dealing with because to the extent you're able to engage in raising awareness about the fentanyl problem, what we've seen is that people are taking these counterfeit pills that are laced with fentanyl, and they have no idea they're taking fentanyl. And some of them may know, but many of them don't. And they think it's just like the same M30 that a doctor might've prescribe them when they have a sports injury. And they have absolutely no idea. So

it is important to be engaged in awareness and prevention. I'll talk a little bit about that and offer some resources for that.

And what we're seeing is that this huge increase in fentanyl ODs mirrors the nationwide fentanyl seizures. So you've seen from 2015 where we had 70 pounds seized to 2019 2000 pounds seized. And that was only halfway through FY2019. We're still waiting on final numbers. We have just shocking numbers. And most of it is coming through the California border. We hear from you know from Bob and his experience being in San Diego County just north of the border.

We're the gateway in California. We're getting a lot of it this is what we're seizing, but what are we not seizing? And it's hard sometimes to get the M30 pills because they bring those over and small-- It's not as if they bring a whole truckload of those over. They're having a lot of pedestrians cross with those and bury them on their bodies. So we're seizing a lot, but what we're not seizing is causing a problem.

And the reason why that drug makers are turning to this, this is a huge, huge moneymaker for the cartels. With heroin, they had to grow the plants and the poppies. They had to cultivate, harvest. So basically for a $5,000 or $7,000 investment, they'd maybe get $80,000. Here for a $3,000 investment, they can make almost $2 million.

They basically make these huge super labs down in Mexico. And they get the precursor chemicals oftentimes from China. And we're trying to find ways to cut back on that. And we've had a couple precursor chemical cases, but basically it's pretty easy. You get some chemists and you get a laboratory going. You don't have to grow plants. You don't have to harvest. You get the precursors, and you're looking at a really, really sizable profit.

And the dangerous thing about fentanyl is that it's 30 to 50 times stronger than heroin. And the pills that are made with fentanyl might look like they're ordinary pills, but a teeny little bit that's wrongly mixed in that pill, as little as two milligrams of fentanyl you can see compared to a penny, can kill you.

And what happens with the tableting is that you might get a tablet. You see all those tablets on the bottom, the active substance being purple. They're blending this. And we're not talking FDA quality controlled blending here, right? These are people in a lab in Mexico who don't really care that one pill over on the right has a deadly amount of fentanyl and one pill might not have hardly any.

So when you're taking one of those, it's Russian roulette every time. And that's why you just heard

from Bob that we're seeing this huge, huge number of overdoses from these pills. So for those that have seen the increase in fentanyl overdose-- another poll-- have you seen it fentanyl mixed with heroin, laced with counterfeit pills, both, or unsure?

The majority are unsure again, but quite a few are saying fentanyl mixed with heroin and both, the fentanyl mix with heroin and laced counterfeit pills.

So initially when we first started seeing fentanyl come across the border, it was bulk fentanyl. The pills came later. And we were seeing a lot of areas. Wisconsin was one area, some areas along the east coast, that it was mostly fentanyl mixed with heroin. Now what we're seeing is fentanyl laced counterfeit pills. And it's not just M30s that look like Oxy. We're also seeing it in xanax and even adderall. So people really need to be aware that anytime they're getting a pill from other than a doctor, it is definitely Russian roulette.

And what we're seeing is that people are buying this on the dark web. They no longer have to go find a dealer. They go to these dark websites. And basically the post office postal guy is bringing them their pills in something that looks like a gift, or a present, or a puzzle, or electronics. This has become the new frontier for law enforcement trying to find dark web purveyors who are selling these deadly drugs, everything from ketamine to fentanyl to counterfeit laced pills. And they're basically using a number of different disguises for this.

So this is a dark web shipment. This is actually what looks like a dragonfly. It's actually a sticker that you can lick that had fentanyl in it. So it's incredibly creative. We also had a domestic to San Diego fentanyl shipment. These are a little gel tabs. And this guy was actually-- We did end up prosecuting him. He was super proud that he had five out of five for customer reviews for his gel tabs. And he took pride that they were all mixed, he thought very evenly. And he didn't have this quality control problem. But essentially, these are gel tabs with a deadly amount of fentanyl in them, especially if you take more than one of those.

Often these are in mylar. The plastic that you see them wrapped in, that's usually a sign of dark web activity. The blue 30s, those are mixed in with puzzle pieces. And that is what the blue 30s look like.

Cindy, we have a question. Are you aware if the postal services know what to look for when there are things like this mailed?

Yeah. They do have a huge number of postal inspection service staff who are devoted to this problem. Their numbers for interdiction are staggering when you see the amount of fentanyl that they've

interdicted from postal packages. So they have dogs now that are trained to smell fentanyl. They do have ways of looking at the packages. They are collaborating with law enforcement, DHS, Federal Express as well collaborating with law enforcement. And the postal inspection service has its own, obviously, law enforcement arm

They are trying to get it. They can't possibly get it all, but they are trying to get it. And when you see how it's packaged, you can see what the challenge is for getting things that are packaged in a very, very convincing manner. And especially the smaller it is, the less likely it is potentially to be detected. And so it's hard to stay one step ahead of these folks, but their interdiction numbers are skyrocketing. So they're making a dent in the problem.

But community education has to be a big part of this. And also law enforcement education so that when they show up at a scene, they understand what the signs are of dark web activity and know what to look for. And the best thing law enforcement can do is when they walk into a scene, and maybe they're executing a search warrant, they want that computer when it's open and not locked. They want to be able to see the dark web activity. It can be really hard to unlock the computer and define the sites. And so it's a constant challenge for law enforcement, but there is a lot of law enforcement education going into this.

And so what we have in San Diego is a real time information exchange where we have law enforcement working with the medical examiners, working with prosecutors, paramedics calling. When they see deadly drugs, they call law enforcement and law enforcement tries to track down the source of those drugs.

And a huge effort has to also be focused on community education and messaging, so that the community knows. So for example, we had a number of cocaine laced with fentanyl overdoses. And these girls, they're young college girls, had no idea they were taking fentanyl. They thought they were doing a few lines of what they thought was recreational cocaine. And they overdose. They had to be revived over and over and over again. And they were shocked. They just couldn't believe that they had been exposed to fentanyl.

And basically based on that, our DA did a press conference. And our medical examiner DEA both issued warnings to the public. And all of those were picked up by the press. So it is important when you see that kind of thing and especially when it is an unusual trend, something unexpected, to notify the public right away and have that collaboration between public health, law enforcement, and the media.

Cindy, if I could jump in before you move to step nine. Step eight is so, so critically important. If you're not familiar with the fentanyl epidemic, pick up the phone, reach out, DEA, NTF, Sheriff's department, San Diego PD, probation. If you're a health worker and it's just not something you're exposed to, reach out, communicate. There is education available. There is training available.

For the law enforcement community that's on this call, if you're with an agency that you haven't had a lot of exposure to fentanyl-- I know in San Diego County, that's almost nobody. But you can call DEA, NTF, US attorney's office. Call Cindy. We'll get you in the loop because you may have information that we don't have. And that becomes critical to the entire cycle of enforcement. You may have information that needs to go into the real time information exchange that we're just not getting on a regular basis. So everybody is a participant in this issue.

Thanks for that, Bob. It is so, so incredibly important. And what you find is when you do start partnering on these issues, everyone is a willing partner. They really are interested in spreading the network and bringing in as many different aspects and disciplines as possible.

So Bob, you talked earlier about actually being able to file a homicide charge and did exactly what we're trying to do in all of these cases, which is we actually started a collaboration of our office and the district attorney working together with medical examiner. And what we're trying to do is trace these deadly overdoses back to the dealer. And that enables us to get the deadliest drugs off the street.

And as Bob was saying, the way we do this is you show up at a scene, you realize there's an overdose there. You basically get that person's phone and try to do a controlled buy so you're getting the same batch of drugs. And there's a whole protocol. We are treating every OD as a homicide scene. We asked the family, if there is a fatality, not to even talk about it on Facebook because we don't want the dealer to know about the fatality.

We're very careful about how we process the scenes. We try to get the phones and download everything from the phone, so that we can trace the phone to the GPS location and conduct a controlled buy. And we're actually working with the DEA. We have great collaborative relationships with our DEA to select the best prosecution forum.

And this does a couple of things. I mean, basically there are much more severe sentences. And it sends a message to the community that if you're selling these dangerous drugs, you're not going to just be treated as an everyday drug dealer. These are homicides. This is like poison. It's peddling poison when you have fentanyl laced pills that are killing this many people. And as Bob was saying,

that was 16 OD's, Bob, in what amount of time was that?

It started maybe three weeks ago, 3 and 1/2 weeks ago.

I mean, 16 ODs in three weeks in a small community. It's just unconscionable.

That's on my reservation, in the Valley Center community, Paula reservation, Palmer reservation. And it's not just customers at the Casino. We've had overdoses as young as 15 years old on Xanax sitting in the middle of the street with a pocketful of pills. So it's reaching a wide range in the community.

It's hard to find someone who hasn't been impacted by this. And it really does require a lot more enforcement and also you know community messaging. So these are just some of the headlines from the cases that we have been able to prosecute in our office where individuals died. And we're getting guilty pleas and very, very significant sentences by prosecuting these in federal court.

And we work with the DA to try to figure out what the best forum is, but it's very sad. I mean some of some of these people are relatively young people who are going to be spending a decade in jail or longer, 10 to 20 years for some of these crimes. But what it also does is it enables us to get the person with the deadliest drugs off the streets so that you're taking those drugs off the street.

So Bob mentioned naloxone and how easy it is to get trained. Everyone in this audience, I hope, get a prescription for naloxone. It's available without a prescription. If you have a prescription, insurance will pay for it. You never know when you would have an opportunity to save a life.

And our medical director believes like naloxone should be as commonplace as a defibrillator. So in every workplace, and every McDonald's, on every airplane, there should be people who are armed with naloxone. It is very easy to administer. And I think, Bob, you said that the training took about 30 minutes. Are all of your officers trained now, Bob, to administer naloxone?

Everybody on my agency have the training. And we, both San Pasqual Police Department and our reservation fire department, everybody has had the training. I also have two trainers. If anybody's interested, I can provide several sources that will do the training for free and supply the naloxone for free.

And Cindy's words are written in gold. Everybody ought to have access to this. It's a life saving drug. It essentially neutralizes the opioid at receptors in the brain. And people sit back, open their eyes, and they'd been dead and brought back to life. So yeah, it should be the same as having a defibrillator. It should be the same as having your employees trained to do CPR.

So has anyone else in the audience obtained and deployed naloxone?

Yes, no, or unsure? So the majority said no. Either the officers have not obtained it or have not deployed it. And 1/4 of the people said, yes, they've had to do that.

Well, I would encourage everyone to look into it. There are many free resources. Matter of fact, I'm going to contact Bob and get access to some of the free resources. We're trying to let-- especially if you know anyone who has gone through an OD, for individuals who are social workers or who deal with those with a drug problem, to encourage that person and their family members to have naloxone on hand. The best indicator of a future OD is a past OD. So when we do revive people with naloxone, we try to make sure they understand about the life saving benefits of naloxone and know where to get it.

So the other aspect that we're trying to pursue of this problem is to basically engage in contact tracing. So our medical director talks about contact tracing for COVID infections. We should do the same thing. Every time we see a fatal overdose, we should do the same kind of tracing and try to get back to the individual who has that overdose drug, and make sure that we get those drugs off the street.

So as an ER doctor, when she does see a number of deadly overdoses, she talks to those patients. She figures out where they got the drugs. She calls law enforcement because she has that relationship through the coalition. And she makes sure that law enforcement follows up.

And ideally, we'd love to see that approach happen in every community. So it's not just people in their silos, it's people communicating. So medical communicates with law enforcement, communicates with the families, finds the dealers, and gets the drugs off the street. Particularly when you have this kind of deadly poison out there, that's important.

And you can also accomplish through community awareness, harm reduction, messaging approaches. When fentanyl first started to appear, we had a press conference with the US attorney, the DA, the Chief of Police, the Sheriff, and the Chief of the Border to talk about the penalties seizures. It's really important to use the media as much as possible and engage in prevention education.

This is an example of what I do for students to let them know about the danger of fentanyl. And we've seen a number of kids die from taking these fentanyl laced drugs. We just had someone who was 14

who got it from somebody else at the school, a fatal dose essentially of fentanyl in a counterfeit pill.

So we play this game of can you spot the real thing? Can you spot the real Beyonce? I won't know which one you picked. I can never pick the right one. I always forget which one's the right. One I think they're both really convincing. OK, the one on the right is fake.

And then can you spot the real Nike's? The one on the left is fake. Can you spot the real percocet? The one on the right is fake. Can you spot the real xanax? They look identical, don't they? I mean, even when you know what to look for, they look identical. The one on the right is fake. Can you spot the real M30, oxycodone? The one in the left is fake.

It's really hard to spot the real thing. That's the moral of the story. And when kids see this, hopefully they'll understand they are playing Russian roulette. If you do you have a chance to provide any kind of community education, you're interested in these slides, I'd be happy to send them to you. We want to get word out far and wide that these counterfeit pills are extremely dangerous.

So that is it for my official part of the presentation. Bob, did you have anything that you wanted to add?

I am open to meeting with anybody that has any questions at any time. Like I say, it's important two things, communicate. And if you have not sought the training to apply what is essentially a lifesaving drug, it's 30 minutes of training. And it's no more complicated than applying Flonase. And you can save a life. You could save the life of your partner, coworker that gets an accidental exposure. We've seen that with on duty police officers dealing with people on the street. So the life you save may be somebody very important to you.

Thank you both for your time today. Bob, so many people are asking for links that you have to that training. So you'll be hearing from some people on your email. And we will try to get any information you have to relay back to the participants. And again, I just want to thank you, Cindy and Bob, for your time and all of the participants for your participation and submitting questions and comments. Thank you all for joining us today, and we hope you have a great day.