COMMONWEALTH Forum

Law Enforcement in the Twenty-First Century: Partnering to Combat the Opioid Overdose Epidemic

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COMMONWEALTH *Special Issue Editor Mark Nordenberg invited Pennsylvania's attorney general, Josh Shapiro, to discuss the steps that his office is taking to address the opioid crisis. As the state's chief law enforcement officer, Mr. Shapiro has taken a multipronged approach to the epidemic that includes partnering with other government agencies and nonprofits. The following article outlines the policies undertaken by the Office of the Attorney General to combat opioid abuse in 2017.*

The opioid epidemic is a national health and safety crisis, one that is hitting Pennsylvania particularly hard. In 2016, over 4,600 Pennsylvanians suffered fatal overdoses, a 37% increase from the year before. Pennsylvania ranked fourth out of all 50 states in overdoses per capita in 2016, the last year for which full data is available. Overdose is now the number one accidental killer in Pennsylvania, surpassing car accidents. This epidemic, which claims an average of 15 lives per day in our Commonwealth, is driven by prescription opioid pain medications, heroin, and dangerous synthetic drugs like fentanyl.

As I have traveled across Pennsylvania, I have heard so many stories from mothers, fathers, sisters, brothers, and even children about the loved ones they

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have lost to the scourge of heroin and opioids. My heart goes out to them, and I keep them in mind every day as I work to fight this epidemic affecting every type of community across our Commonwealth.

Law enforcement is on the front lines of responding to this crisis. As Pennsylvania's attorney general, the opioid crisis is my number one priority—not because I want it to be, but because it has to be. We need to go beyond the tough-on-crime approach of the past and use every tool in our toolkit to combat this epidemic. We need to try innovative approaches and see what works, but we are also compelled to act now, because the human toll of this epidemic is simply too much to bear.

Multidisciplinary, Preventative Approach

When this epidemic was still in its infancy and I was serving as chairman of the Montgomery County Commission, I had a conversation with a local police chief who told me that, while his officers were fighting this every day, police alone could not fix this growing problem. The people his officers were encountering needed treatment and other medical and behavioral health services, not jail.

Shortly after that conversation, I led the creation of a multidisciplinary task force that was charged with developing a strategy to combat the growing problem. One of the key recommendations of that strategy was to permit everyone—not just first responders—to have access to the overdose reversal drug naloxone. In 2015, our county medical director issued a standing order, allowing any person to obtain naloxone at any pharmacy in Montgomery County. Pennsylvania soon followed suit, with the physician general issuing a statewide standing order.

This task force also highlighted the connections between substance use disorder and crime. The fact that individuals in our prisons were not receiving adequate drug treatment only increased their likelihood of recidivism. In response, we increased spending on treatment within our county prison. While these steps did not cure this epidemic, they saved lives and changed our thinking.

This multidisciplinary approach, which brings together law enforcement, medical professionals, treatment providers, government leaders, and social service providers in a collaborative, all-hands-on-deck manner, has shaped my thinking. Any one idea or strategy alone is not enough—we need to attack this scourge at every stage of the cycle of addiction and from every angle if we are going to be successful in addressing this crisis.

Reducing the Availability of Prescription Opioids

The root cause of this crisis is the wide availability and overprescription of powerful opioid medications. Eighty percent of people who are addicted to heroin started out by using prescription opioid painkillers. If there was ever truly a gateway drug, it is prescription opioids like OxyContin and Percocet. It is critical that we reduce the availability of these powerful medications that all too often are abused and lead to addiction.

Holding Opioid Manufacturers Accountable

Americans report the same levels of pain now as we did in 1999. Yet sales of prescription opioids *quadrupled* from 1999 to 2014. In 2015, U.S. doctors wrote over 300 million pain prescriptions. The wide availability of these powerful opioid medications is one of the leading drivers of this epidemic. Because of their unique civil enforcement and consumer protection authority, state attorneys general are taking the lead in holding drug manufacturers responsible for their role in this crisis.

Over the last few years, widespread allegations have arisen that drug manufacturers and distributors may have engaged in illegal sales and marketing practices, similar to the tobacco industry in the last century, that have inflated sales to the detriment of public health. To investigate these allegations and pursue any claims that may arise from this effort in the most effective way possible, the Office of Attorney General (OAG) is leading a bipartisan coalition of 41 state attorneys general in three separate multistate investigations. If this coalition finds that manufacturers deliberately oversold the use and effectiveness of these drugs, undersold the dangers, or otherwise misled the public to boost their profits, then they must be held accountable.

Even if no wrongdoing is found, this investigation sends a clear warning signal to the entire industry that boosting profits by creating unnecessary opioid sales will not be tolerated. We hope this signal will help reduce unnecessary prescriptions, discourage any future illegal behavior, and cause manufacturers to market their drugs even more carefully than they already do.

Addressing Overprescription Through Education and Behavioral Change

Our national obsession with opioids is without equal. Despite having less than 5% of the world's population, the United States consumes over 80% of the world's supply of oxycodone. The fact is, our doctors prescribe too many opioids too frequently to too many patients.

We need to stop the flood of pills at its source by educating doctors to change their behavior and curb their prescribing practices. Most doctors have not been overprescribing deliberately; many times, doctors prescribe medically unnecessary opioids because they truly want to help their patients feel better. People whom they care about come into their offices in serious pain, and the quickest way to alleviate that pain can be through powerful opioids. Many doctors, medical schools, and associations like the Pennsylvania Medical Society have recognized the need for more physician training, and OAG is partnering in that effort.

Additionally, doctors and hospitals are rated on pain management and patient satisfaction, which affects their ability to compete for patients with other doctors and hospitals. Under this rating scheme, doctors are overly incentivized to prescribe opioids. We need to realign doctors' incentives so that they look to alternative pain management therapies instead of opioids.

Leveraging Insurance Companies to Curb Overprescription, Promote Alternative Treatments, and Expand Access to Treatment

Insurers can and should be our next line of defense against overprescription. Most people will not fill prescriptions that are not covered by insurance, and many doctors will not write prescriptions that they know their patients won't fill. By denying claims for opioids that are not medically necessary or exceed the amount necessary to treat a patient's condition, insurers can significantly influence the behavior of both patients and doctors and check the proliferation of opioids.

OAG collaborated with medical professionals and insurance leaders to develop a 10-point plan to help insurers do their part to address this crisis. The plan calls for limiting coverage for first-instance opioid prescriptions beyond five days, requiring preauthorization for opioid prescriptions, and diligently reviewing claims to make sure opioid prescriptions are medically necessary.

Patients also need greater access to alternative, nonopioid pain treatments, which are often not covered by insurance. Opioid medications only mask pain, but alternative treatments like physical therapy can reduce short-term pain and also help correct the underlying conditions to reduce and eliminate long-term pain symptoms.

A number of leading Pennsylvania insurers, including Independence Blue Cross, have implemented some of these recommendations, but we need more insurers across the Commonwealth to step up and do their part.

Community-Based Prevention

The dangers of overprescription extend beyond the original patient to whom drugs are prescribed. Studies indicate that 60% of patients who are prescribed opioids end up with leftover pills when their treatment is over. These leftover pills often end up contributing to the addiction of others: over 70% of people who misuse prescription opioids get them from friends' or relatives' medicine cabinets. Reducing the number of prescriptions will help keep these drugs out of our medicine cabinets in the first place, but we also need solutions for those who already have them lying around before their long-forgotten prescriptions lead to another person's addiction.

Unused pills must be disposed of properly. Throwing them in the garbage or flushing them down the toilet are bad options, as doing so will cause the pills' chemicals to seep into our soil and water supplies, which in turn damages our crops, our livestock, and our health. Pills must be neutralized before they are thrown away. OAG has two programs to help people across Pennsylvania safely dispose of their unused medications—opioids or otherwise.

Prescription Drug Take-Back Boxes

The Prescription Drug Take-Back Box Program is a partnership between my office, the National Guard, the Pennsylvania Commission on Crime and Delinquency, and the Pennsylvania District Attorneys Association. Leveraging resources from all of these agencies, we have installed drug disposal boxes at locations throughout the Commonwealth. As of April 2018, there were 694 permanent take-back boxes across the Commonwealth's 67 counties, with each county having at least one. Anyone can simply drop their unused medications into the secure boxes, which are later emptied by professional staff who ensure that the drugs are disposed of properly and safely. In 2016, 26 tons of unused medications were disposed of in these drop boxes. In 2017, we collected over 43 tons.

Important steps that OAG plans to take as we continually improve our response to this epidemic are to increase the number and availability of take-back boxes and to increase the public's awareness not only of the existence of the boxes, but also of their responsibility to properly dispose of their unused medications.

Drug Disposal Pouches

Due to their limited availability, not every community has access to a take-back box. This is especially true in rural communities. People who do not live

near a take-back box still need options for safely disposing of their unused medications. In response, OAG launched a new Drug Disposal Pouch Initiative in 2017. The program is distributing 300,000 safe drug disposal pouches to pharmacies and palliative care facilities in 17 counties that are underserved by the Take-Back Box Program.

Under OAG's program, pouches can be obtained by anyone at no cost, even without a prescription, at participating pharmacies. They are also automatically given to anyone with an acute (30 days or less) prescription for Schedule II narcotics (a category that includes the most dangerous opioid medications). Additionally, hospice and homecare workers will distribute pouches to patients; this is an area of particular need, given that family members are left with unwanted medications after a loved one passes away.

The pouches are easy to use: all a person has to do is place up to 45 pills in a pouch, add some warm water, and shake. The pouch neutralizes the chemicals in the pills, making the pouch safe to throw in the trash. All told, these bags can take 1.35 million pills out of our communities.

To study the effectiveness of this program, OAG has partnered with the Pennsylvania Medical Society and researchers at the University of Pittsburgh Medical School. If it proves effective, OAG will seek to build on and expand the program.

The take-back box and drug pouch programs highlight the reality that law enforcement cannot root out the sources of addiction alone. It will take close collaboration with other government agencies, experts in the field, and public health organizations to develop and implement solutions that have a meaningful impact on our skyrocketing rates of addiction and overdose.

Enhancing Public Education Efforts

OAG's public outreach team is working to help every Pennsylvanian understand the dangers of opioid addiction. Our Office of Public Engagement has given dozens of presentations across the Commonwealth, connecting with thousands of people—from school-age children through seniors. The office is also partnering with public health and communications experts to update its educational materials and curriculum to make sure they are relevant to the current crisis and resonate with our target audiences.

Our office is also undertaking a major campus safety initiative that is seeking solutions specific to campus environments by hosting collaborative roundtable discussions on sexual assault, alcohol abuse, opioid addiction, and mental health treatment. Input and participation is being sought from campus administrators, local law enforcement, campus police, social service

providers, students, survivors, and other stakeholders. Our goal is to create a set of recommendations for colleges and their communities to implement to reduce the impact of all of these issues on students and their communities.

Policy Solutions

For the first time, OAG has staff dedicated to identifying new policies and strategizing implementation for the entire office. Our Office of Policy and Planning meets regularly with community groups and key stakeholders to learn about emerging policy ideas and to better understand how existing policies are impacting communities on the ground. They also connect with other government agencies at all levels to share ideas and find new opportunities for collaboration.

Expanding Access to Treatment

At the center of our multidisciplinary approach is the understanding that addiction is a disease, not a crime. But accessing treatment for this disease can be exceedingly challenging. The need for inpatient treatment far exceeds the availability of beds. The number of physicians licensed to dispense medication-assisted treatments (MATs) is highly regulated, and the number of patients they may treat is limited. For Pennsylvanians who are struggling with opioid addiction, getting access to treatment can be the difference between life and death. That's why OAG is working with insurers, members of Congress, and state attorneys general to expand access to treatment for those fighting addiction.

Expanding Insurance Coverage of Substance Use Disorder Treatment

In addition to steps to reduce overprescription, OAG's 10-point plan for insurers calls for increased coverage of addiction treatment, medication-assisted treatment (MATs), and mental health treatment. MATs are vital to this effort. Patients who receive MATs (such as Suboxone, methadone, and Vivitrol) are 75% less likely to die from overdose than those who do not. Unfortunately, MATs are not readily available. In Pennsylvania, 40% of people suffering from opioid addiction have no access to Suboxone treatment. Pennsylvania's Centers for Excellence, instituted by Governor Wolf, have significantly expanded outpatient treatment options for those insured through Medicaid. Expansion of coverage for these services by insurers would similarly expand access for Pennsylvanians relying on private insurance.

Lifting the Outdated Medicaid 16-Bed Limit on Inpatient Treatment

While private insurers cover large numbers of Americans, the single biggest payer in our system is Medicaid, which provides coverage for low-income Americans and individuals with disabilities. Unfortunately, Medicaid has a key, outdated provision that severely limits the number of inpatient beds available for substance use disorder treatment.

Part of Medicaid is the institutions for mental disease (IMD) exclusion, which prohibits Medicaid from paying for treatment at "institutions for mental disease" that had more than 16 beds for overnight or residential patients. It also places a cap on how long a patient can stay in a treatment facility. This exclusion was written into the original version of Medicaid in 1965 as a way to stop the proliferation of large, state-run mental health institutions. These institutions, colloquially known as asylums, were often overcrowded, inhumane, and ineffective. Their eventual closures were celebrated by mental health advocates, as mental health is most appropriately treated in community-based settings, rather than isolated inpatient settings.

An unfortunate side effect of the IMD exclusion is that substance use disorder treatment facilities ended up being classified as "institutions for mental disease." Unlike mental health, though, many substance use disorders *are* best treated in inpatient residential settings, thanks to their ability to restrict their patients from accessing drugs. Limiting substance use treatment facilities to such small sizes has greatly reduced the economic incentives to operate them; as a result, there are too few treatment options in our communities.

OAG has been a leader in advocating for the elimination of the IMD exclusion for substance use disorder treatment. We have partnered with Pennsylvania Congressman Brian Fitzpatrick to build support for legislation that would remove the size limitation on these facilities and the cap on length of stay, and I have enlisted support from my fellow state attorneys general in this cause. Thirty-eight state attorneys general have crossed state and party lines to support this commonsense policy change, and it is now official policy of the National Association of Attorneys General. If passed by Congress, this bill would greatly increase the amount and quality of treatment available for substance use disorder.

Addressing Prescription Drug Diversion

At some point during the course of addiction, the users make the switch from legally obtained opioids to illicit opioids. Of course, drug dealers on the streets aren't the only ones fueling the trade of illegal drugs. Sadly, there are doctors, nurses, pharmacists, and other medical professionals who abuse their access

to prescription narcotics by "diverting" them from legal to illegal uses. Diversion can take many forms, from writing fraudulent prescriptions to outright theft.

Diversion cases are a new area of focus for OAG and for law enforcement generally. This is due to the unique circumstances of the opioid epidemic. Eighty percent of people who are addicted to heroin started out by using prescription opioid painkillers. Past drug addiction crises had no such legal source to fuel them.

In response, OAG is amplifying our diversion efforts. We have created a new unit focused on diversion cases, with 28 dedicated agents. Our Medicaid Fraud and Insurance Fraud sections are also focusing on diversion when it is connected to their primary areas of enforcement. This new focus has already paid dividends. OAG increased the number of diversion arrests from 125 in 2016 to 216 in 2017, a 72% increase. OAG is also finding new ways to leverage Pennsylvania's Prescription Drug Monitoring Program (discussed further below) to identify and investigate individuals who may be engaging in diversion.

Leveraging the Prescription Drug Monitoring Program to Combat Diversion

In 2014, Pennsylvania enacted its prescription drug monitoring program (PDMP). This statewide system requires prescribers (usually doctors) and dispensers (usually pharmacists) to check a patient's history before writing or filling a prescription, as well as to upload new prescriptions for each patient. With the appropriate safeguards on privacy in place, Pennsylvania's PDMP has created a vital check on overprescription, and is now a key tool in law enforcement's effort to crack down on diversion.

Thanks to the PDMP, it is now more difficult for patients to "doctor shop" or illegally obtain more prescription drugs than they were prescribed. It also makes it nearly impossible to fill the same prescription at multiple pharmacies.

Data in the PDMP can be used for law enforcement purposes in limited circumstances. Pursuant to a valid court order, OAG can access the data to identify individuals who are illegally obtaining, prescribing, or dispensing opioid medication. OAG has used this access to forge new partnerships with federal, state, and local law enforcement partners with whom we share data in appropriate situations.

PDMPs are a national movement. Every state except Missouri operates its own PDMP. (The Missouri Governor issued an Executive Order instituting a PDMP on July 17, 2017, but it is not yet operational.) They have proven effective. One study showed that New York's system, which has been in effect

since 2012, has reduced opioid prescriptions and has caused prescription opioid overdose deaths to stop increasing. Between 2010 and 2015, prescriptions decreased 18% nationwide.

The next evolution is to make these systems interoperable across states. Until state PDMPs can talk to one another effectively, people will still be able to cross state lines to game the system. This problem is particularly acute for Pennsylvania, since our two largest cities are both close to the borders of two other states.

Targeted, Collaborative Criminal Enforcement

Most Pennsylvanians suffering from addiction ultimately turn to heroin and other street drugs because of their low cost. This is the point where law enforcement plays its most direct role.

OAG's approach to criminal enforcement relies on targeted enforcement in close collaboration with other law enforcement agencies at all levels of government, targeting the flow of illegal drugs into our communities and the diversion of legal medications into illicit markets. We are making a conscious break from the past by prioritizing our enforcement efforts on the criminals benefitting from this illicit trade, rather than those who are grappling with the illness of addiction, and by strategically deploying our limited resources.

Collaborative Criminal Enforcement

Cooperation with local law enforcement agencies is the bedrock of our collaborative efforts. These are truly partnerships of equals. Local law enforcement brings the aforementioned volume of resources and close understanding of their communities; in turn, OAG brings knowledge of statewide trends, sophisticated technical resources, and centralized coordination.

The primary form of these partnerships in drug law is OAG's state-local task forces. Agents embedded in each of our regions partner with county detectives, state troopers, and local police to target major drug operations within and across jurisdictions. OAG drug strike force attorneys collaborate with local district attorneys to prosecute these cases.

These partnerships regularly result in enormous successes. In 2016, these task forces combined to make 1,373 arrests. Many of these arrests come from major operations. In April of 2017, for example, OAG initiated a major drug bust in southwestern Pennsylvania that ended with 33 arrests. OAG collaborated with 18 different police forces from two different counties in the region. No one agency could have executed this alone. This serious source of heroin could only be stopped with strong collaboration.

OAG also convenes an investigative grand jury that has the power to issue subpoenas and recommend criminal charges. While some counties have their own investigating grand juries, many do not. In addition to having the ability to help dismantle statewide drug organizations, OAG's grand jury can be used as a resource for local law enforcement agencies that would not otherwise have access to one.

Drug trafficking is almost never confined to the borders of one state. However, gaps in enforcement can occur when criminal activity crosses state lines. OAG works closely with fellow state attorneys general to close these gaps and to stop interstate drug pipelines. For instance, OAG worked with New York Attorney General Eric Schneiderman's office to close a drug pipeline running from the Catskill Mountains in New York into Pike County in Pennsylvania. We have also worked with West Virginia Attorney General Patrick Morrisey's staff to address cross-border traffic into Pennsylvania counties like Greene, Fayette, and Washington. And we have even worked with Michigan Attorney General Bill Schuette's office to close off a pipeline that crosses Lake Erie from Michigan into our Commonwealth.

Federal law enforcement also plays a crucial role in stopping both interstate and international trafficking operations. To combat the inflows from overseas, OAG works closely with the FBI, DEA, DOJ, Homeland Security, USCIS, and other federal law enforcement agencies that have immense resources and experience working with these types of cases. OAG agents are embedded with the DEA, FBI, and Homeland Security on drug and other investigations. These embedded agents assist federal agencies by helping to target drug trafficking organizations that are most harmful to Pennsylvanians.

For example, in 2017, OAG and the FBI engaged in a seven-month investigation into fentanyl and carfentanil coming from China into Allegheny, Beaver, and Butler Counties. That effort resulted in the arrest of 18 people, including the ringleader of the operation. Additionally, over four kilograms of fentanyl, substantial amounts of carfentanil, six vehicles, four firearms, and over a million dollars in cash were seized.

Targeted Enforcement

To reduce the supply of heroin and illegal opioids, OAG is focusing its enforcement efforts on those who move high volumes of drug product. To do so, we are using intelligence gathering and data sharing to identify major supply corridors and to strategically deploy resources.

While these corridors often line up with major highways (such as Interstate 76 connecting Philadelphia, Harrisburg, and Pittsburgh), some routes are counter-intuitive at first glance. For example, Figure 1 shows that Philadelphia

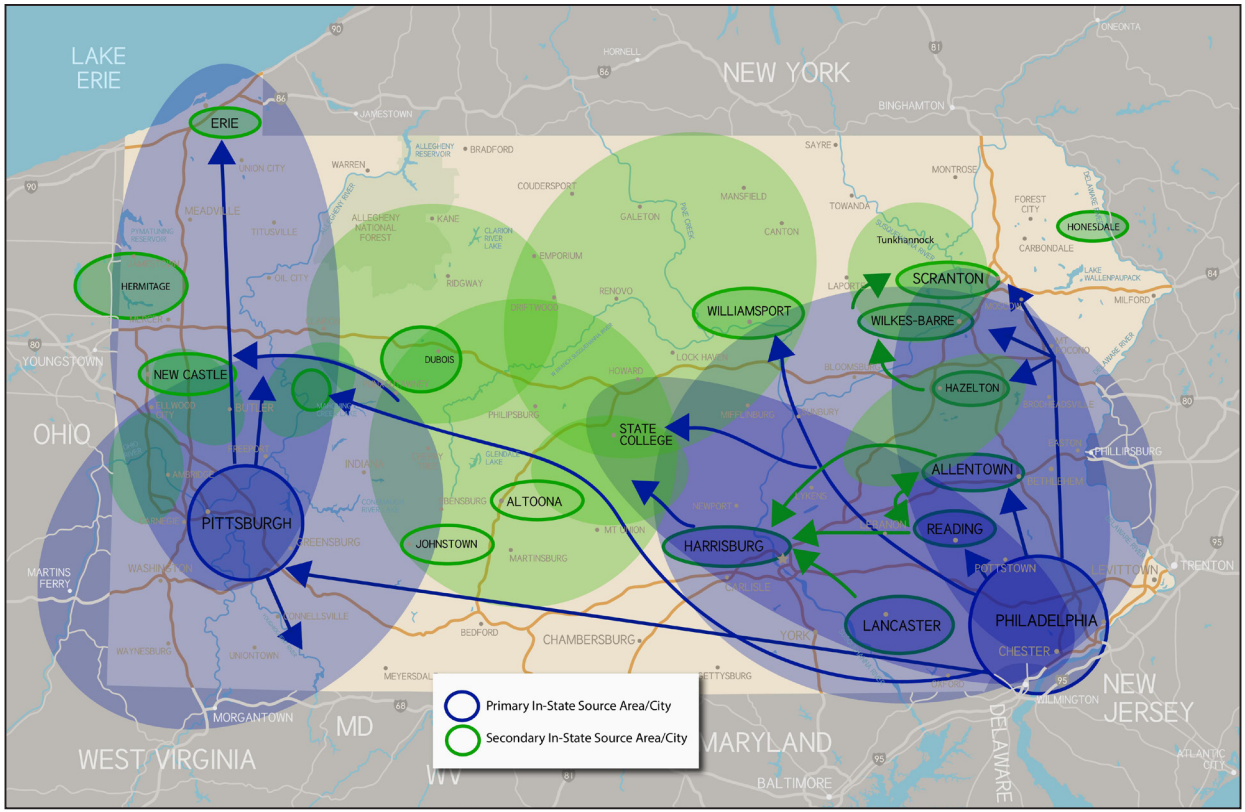

Figure 1. Major Corridors for Illegal Drug Trafficking within Pennsylvania. (*Compiled by Pennsylvania Office of Attorney General, Bureau of Narcotics Investigation.*)

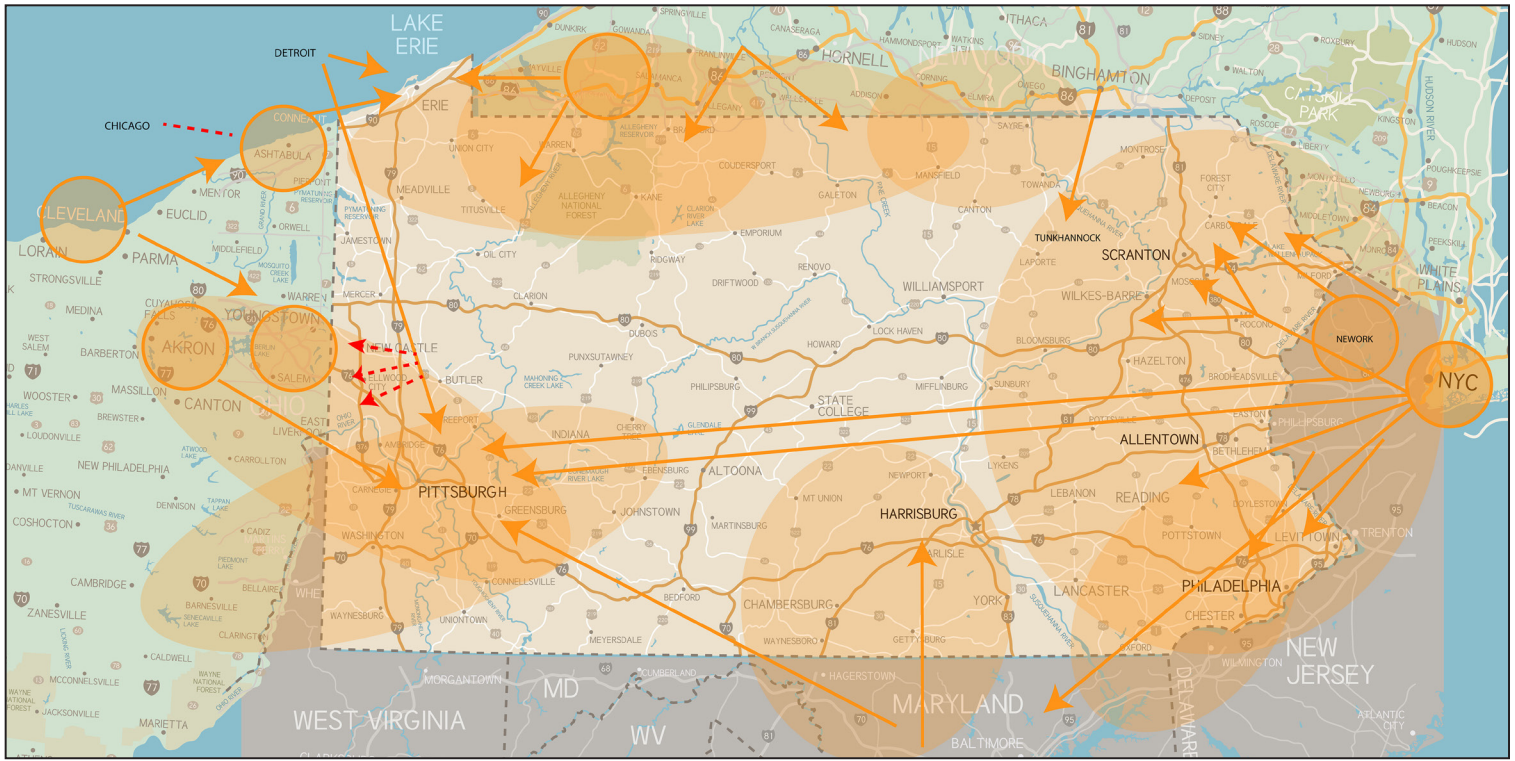

Figure 2. Major Corridors for Illegal Drug Trafficking Coming into Pennsylvania. (*Compiled by Pennsylvania Office of Attorney General, Bureau of Narcotics Investigation.*)

is the primary source for the Scranton/Wilkes-Barre area even though Allentown, which is also a significant source for much of the state, is far closer geographically.

Similarly, Figure 2 shows an unexpected out-of-state source. New York City naturally feeds the eastern half of Pennsylvania, but it also serves as a direct corridor to Pittsburgh and the western half of the state. Additionally, it is surprising that Baltimore serves as a major source for Pittsburgh but not for Philadelphia, which is much closer.

By better understanding these corridors and strategically attacking those who use them, law enforcement is better able to close off these routes and reduce the sheer volume of drugs in our communities.

Combatting Fentanyl Through Deterrence

Deterrence does play a role in our strategy, particularly when it comes to fentanyl. This drug is deadly: it can cause adverse symptoms just by contact with the skin, and accidental inhalation can cause overdose. It can be sold by itself or added to heroin and other drugs. But when users take fentanyl without knowing, the risk of overdose skyrockets. It is also a major risk to law enforcement and other first responders who may inadvertently come into contact with it.

Fentanyl and fentanyl-related substances (such as carfentanil, which is 5,000 times as strong as fentanyl) were relatively rare as recently as 2013. However, their prevalence has skyrocketed since then; according to DEA data, fentanyl was found in less than 1,000 drug seizures in 2013. In 2014, that number nearly quintupled to over 4,600 seizures. By 2015, it was found in over 14,000 seizures, and in 2016 it was found in well over 30,000 seizures.

To deter dealers from trafficking this exceptionally deadly drug, OAG has charged dealers with Drug Delivery Resulting in Death—a third-degree felony that can result in sentences of up to 40 years in prison—in select cases. Through the first half of 2017, OAG has employed this charge seven times, focusing on cases involving nonaddict dealers and prioritizing those who may be lacing their product with fentanyl or other dangerous additives.

Recovery-Oriented Methods

The science is clear that those suffering from substance use disorder do not use drugs because they want to, but because drugs have become a physical necessity like food and water. Society at large is beginning to understand the need to prioritize treatment, because arresting someone does not cure them

of their disease. The fact that we refer to today's drug crisis as an "epidemic," a distinctly medical term, is a subtle but important step toward treating those suffering from addiction as victims rather than criminals.

This fundamental shift in thinking informs OAG's approach to combatting the opioid epidemic. There is a growing body of evidence showing that treatment is an incredibly efficient and effective crime-prevention measure: every dollar spent on treatment saves three dollars on crime reduction. For every 100 patients receiving methadone treatment, there are 12 fewer robberies, 57 fewer break-and-enters, and 56 fewer auto thefts. A year of treatment costs an average of $4,000, compared to over $22,000 for a year of incarceration, making it a fiscally responsible strategy as well.

OAG implements a recovery-oriented approach in several ways. First, our agents and prosecutors prioritize arrests and prosecution of dealers and those involved in the illegal diversion of prescription drugs, not those who suffer from substance use disorder. We recognize that even low-level dealers who sell small quantities of drugs to make enough money to satisfy their own addictions are better served with treatment than incarceration.

We are also looking to test new ways to leverage our agents' presence in the community to connect more people with treatment. One program that has proven successful at the local level is the Police Assisted Addiction and Recovery Initiative (PAARI). This model started in Massachusetts and has been adopted by local law enforcement agencies across the country, including the police departments in Bensalem Township and Berwick here in Pennsylvania. Agencies that implement PAARI build networks of treatment providers; then, when they come across someone who needs treatment, they can immediately help to find them a bed in a treatment facility rather than arrest them. While this process is most easily executed by local law enforcement (thanks to their extensive connections with and presence in their local communities), OAG is exploring ways to implement some of PAARI's principles into our statewide efforts.

Law Enforcement's Frustrations

Even with all of these collaborations, law enforcement does not have nearly enough workforce to fight the opioid crisis, particularly when it must continue to fulfill its broader public safety mandate. Of course, that frustration is common to nearly every government agency; gaps in enforcement or services are well-known, but the revenue simply isn't there to address them.

The more pressing frustration is the lack of resources for the personnel that we do have. Opioid overdose is so common and so pervasive that every

single first responder, including police officers, must carry the overdose reversal drug naloxone. Naloxone is expensive, particularly the preferred brand-name Narcan, which allows for safe and easy delivery to an overdose victim via nasal spray. OAG has prioritized providing all of our agents with Narcan, but not all law enforcement agencies can afford to do so. This can mean that an overdose victim's chances of survival are left to a game of Russian roulette, with the winners responded to by officers carrying naloxone, and the losers responded to by officers not carrying naloxone.

It is important to remember that naloxone is not an addiction treatment; its only function is to reverse an overdose. It does nothing to address the underlying addiction. So even when an officer is able to stop an overdose with naloxone, treatment must be the next link in the chain to recovery. We have found that link too often missing. There are not enough treatment providers to handle the massive increase in demand for their services. Only 11% of people who need specialized addiction treatment have access to it. This is true both in urban areas (where large populations mean that small increases in addiction rates cause enormous increases in the number of people needing services) and in rural areas (where a historical lack of addiction problems has left many communities without reasonable access to treatment options).

A person who is revived with naloxone but has no treatment options will almost certainly resume using opioids. Often, they will overdose again. This can lead to repeated revivals of the same victim by the same law enforcement personnel. Officers and first responders have even revived the same individual multiple times in the same day. Understandably, these officers are getting frustrated, increasingly voicing their concerns. Officers' "revival fatigue" is a serious issue. They know that addiction is a disease, and that the people they revive are only using these drugs out of necessity. They know that each person's recovery path is unique, and that it may take multiple overdoses before they are ready, willing, and able to seek treatment. And they know that it may take many courses of treatment before recovery is achieved. But it is human nature to grow frustrated with repeated actions that do not *appear* to result in any meaningful change.

While law enforcement needs to resist sliding into revival fatigue, we also need better solutions for treatment and prevention. We need more treatment, but we may also need new tools to connect people to the treatment that is available, which may include changes to Pennsylvania's Good Samaritan Law, increased use of drug courts, mandatory meetings with social service providers following an overdose, or new civil procedures that allow family members to appeal to the courts to impose treatment on a loved one who needs it.

Conclusion

Part of OAG's role as the chief state law enforcement agency is to serve as leaders, both within law enforcement and in the community at large. We have the duty and ability to build strong collaborations, to implement innovative practices in every area in which we work, and to help other agencies implement successful practices. Nowhere is the need for OAG's leadership more apparent than with the opioid crisis.

Despite all of these efforts, law enforcement still faces many challenges in battling this epidemic. Our collaborations must go beyond traditional law enforcement. We can no longer be a "one-size-fits-all" operation. By working with agencies and industries in every field affected by addiction and overdose, we are best able to identify the resources and practices that will help us finally reach a turning point. We need an "all-hands-on-deck" approach from law enforcement and government agencies at all levels, the medical community, treatment providers, and every Pennsylvanian who comes into contact with opioid drugs. OAG will continue do everything we can to facilitate these collaborations and innovations.

Josh Shapiro is the attorney general for the Commonwealth of Pennsylvania. He previously served as chairman of the Montgomery County Board of Commissioners and as representative for the 153rd District in the Pennsylvania House of Representatives.