



Quick Response Teams (QRTs)

Announcer:

Welcome, and thank you for listening to this recording, part of the Comprehensive Opioid Abuse Program (or COAP) podcast series. COAP provides financial and technical assistance to states and units of local and Indian tribal governments to plan, develop, and implement comprehensive efforts to identify, respond to, treat, and support those impacted by the opioid epidemic. Since 2017, BJA has supported innovative work on these COAP sites across the nation.

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Amanda Auerbach:

Hello, and thank you for listening to the BJA Comprehensive Opioid Addiction Program podcast. My name is Amanda Auerbach—I'm a consulting administrator at TASC Center for Health and Justice and will be facilitating today's podcast.

As the national opioid crisis continues to grow, communities across the country are exploring innovative approaches to respond to this epidemic and save lives. Quick Response Teams, or QRTs, are one such approach. A QRT is an interdisciplinary collaborative and systemic community response to prevent opioids and respond to subsequent opioids by connecting individuals with critical substance use disorder services following an overdose.

I'm pleased to have Dan Meloy joining us today to talk about Quick Response Teams. Dan served Colerain Township, Ohio, for more than 28 years—starting as a police officer and then Chief of Police before becoming Director of Public Safety, overseeing both law enforcement and fire department in Colerain Township. Dan's last position in Colerain Township was serving as CEO administrator for the township until his retirement in 2018. Dan is a national presenter on the subject of community heroin and opioid response and was a leader in the development of an innovative police, fire, and addiction specialist partnership as a proactive effort to save lives—the Quick Response Team, or QRT model, for pre-arrest diversion.

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QRTs are now active in communities across Ohio, West Virginia, North Carolina, and Indiana—and continue to grow.
Dan, thank you so much for joining us today.

Dan Meloy: It's an honor. I'm happy to be with you.

Amanda: Great. Just to start off, I'll ask that you please describe for the listeners, what's the QRT model entail? And say a little about why Colerain Township decided to develop this program.

Dan: Absolutely. The Quick Response Team is actually—it was originated after the 2013 International Association of Chiefs of Police Conference in Philadelphia. More specifically, it was created with the idea that a partnership of law enforcement and fire and EMS would be a better response to the critical incidents, such as active shooters. Specific in that conference were presentations on the Aurora, Colorado, shooting and the Wisconsin shootings. My wife's actually the one that looked at me and said, "Okay, the world is changing. How are you going to deal with this, Chief?"

Shortly after returning home, I was promoted to the position of Director of Public Safety, and having that fire response and learning how the two can work together, that's really how the basis of the Quick Response Team was created. Proactive life safety response, critical incidents, first emergency first response, community paramedicine, Alzheimer's, special needs engagement, crisis intervention, and the heroin and opioid overdose follow-up. Those were all parts of the logic model that was created when we started with the Quick Response Team in 2014.

It kind of started out of a law enforcement-driven, "How do we respond to critical incidents?" And it looked at the community as a whole and all the things that we needed to be more proactive with and how could we partner the two? The third piece was reaching out to the smart people, as I like to call them, the addiction professionals, to provide us with the people on the ground and on the street and go to the homes and meet people basically wherever they are, to help bridge them from the incident—the overdose, the substance abuse disorder—to treatment and a road to recovery.

Amanda: Could you describe, please, when someone overdoses, how QRT is activated and what happens from that point?

Dan: Absolutely. As I stated, the partnership is law enforcement, EMS from the fire service, and the addiction professionals. Whether it be social workers or peer recovery coaches, all that, they're actually a four-person team. Upon learning of the incident, the team will then engage the family, engage the individual, help them understand the steps, we'll conduct on-

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site triage, we'll assess what's the best course of treatment for them and then start making that contact and building the bridge towards treatment.

It's just not that simple, but the reality is, what we learned very, very early on is the answer to the questions, "Why do you care? Why does law enforcement care? Why is EMS here? Why do you care about? I'm a problem child, so to speak. I'm a problem citizen." They appreciate the fact that you've come to them and you sought them out, and the families are as important as the victims in this piece. The families are lost, often. The families are in need of assistance and counseling.

It's a wide spectrum of resources that come into play, whether it's specific to the person with the substance use disorder or the families that are in need of understanding and how to work with them. Many of the times, they're at their wits' end and they've lost confidence in their family member. They want to know that they're not alone and help understand what's happening and how the road looks like ahead of them. Having these professionals and working more within this community and understanding that, again, it's going to be oftentimes six or seven more overdose incidents.

When the person is wanting to get to recovery, they're engaged in treatment and it's just not an easy thing to turn on and turn off. Helping educate all those involved has been a huge piece in understanding how we better serve this issue.

Amanda:

With that, what was the greatest challenge? You mentioned education. What was the greatest challenge your community encountered in instituting this program, and how did you work together to overcome that?

Dan:

Internal culture, internal and externals, was the issue. Internally, you had to build the culture and help our police officers and our firefighters and our EMS service providers, as well as general workers—our parks workers, our road department workers—understand that we have a responsibility to serve and that is our job. Whether the needle's found in the park, what to do with it. Quit looking at people as threats to society and understanding that it is a problem. It's not something that changes overnight, but it's a process of education.

Again, I used to get emails criticizing me and phone calls telling me to just let them die. There's a big community education piece in understanding that there is a proactive side to this and our responsibility is to problem-solve. Problem-solving brings a lot of people together.

That was probably the biggest piece, was bringing all the partners together—bringing the folks from public health, the school district, the business community, the human resource professionals, the faith-based

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community, the media, our politicians, our police, our fire—all sitting at the table and talking this through and understanding they're moving forward and that we move forward together. Not just one department and one agency deciding they were going to do something—everything was at the table and we just moved forward as a group, as a collaborative. We called it the Colerain Community Health Collaborative. We learned that together we can make a difference and together we can move forward. Obviously, this is a police- and fire-driven outreach, but the reality is that it's a community response.

Again, even as I retired in '18, people would tell me that I was wrong and why was I wasting resources and things of that nature, but they're not understanding the responsibility that goes along with public safety and public service. We can't just cast people aside. That is not what we do. We're there to solve problems and work with our community to make it safer and better for everybody.

Amanda:

Kind of along that same vein, we talk about culture and stakeholder engagement. One aspect of QRT is that there is a mechanism to share this data—a way to notify partners when someone overdoses. Data sharing is such a hot topic. It's something that creates a huge barrier for a lot of communities, and I'm wondering how you all were able to—whether it was through MOUs—how you all were able to establish a system by which all partners that needed to were able to engage in that and felt comfortable doing so.

Dan:

You know, that's still a work in progress, four years into this effort. I'll be very honest with you, in the beginning, I didn't care about anybody else. My responsibility was a 46-square-mile community with 60,000 people—the 240-plus first responders that we had working for us—those were my drives. I wasn't worried about what another community did, because no one else was really doing anything. As we move forward, and as you stated in your introduction, the fact that Quick Response Teams are working across many different states, the need to understand simple definitions like, what does “refer to treatment” mean? We found that as we moved through this and started talking to other communities, that in its simplistic presentation, “refer to treatment” meant a lot of different things.

For Colerain and the Quick Response Team, it meant that you got to the door of the treatment facility, they opened the door, and you walked in. That was treatment. That was “refer to treatment.” We also learned that in some other communities, “refer to treatment” was the Quick Response Team showing up after the overdose and scheduling a date for an assessment. That was called “refer to treatment.”

We learned, really in the last year, that it's very important for us to establish—what we call down here now—a common model of data, or a

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central model. We all start working along the same page with the same definitions, so that if a community out of West Virginia, or northern Ohio, or North Carolina, or Indiana, Kentucky, or Ohio—when they say, “We have this many people that are ‘refer to treatment,’” we know that “refer to treatment” means that they got some treatment, not that they got an assessment or something else. We’re learning as we move along, and we’re helping to educate and people to understand that this is important. As we gather information, we know we can learn more about what success looks like.

People used to ask me, “What was success?” Well, success really is, at the street level, it’s every individual. When that family member, that individual comes back and tells you that they’re eight months clean, a year and a half clean, they have a job, they’ve got a family, they’re doing things—or it could be the guy that required two SWAT callouts that knew you were working and showed up at your office when the QRT was operational because he knew he needed help, and he was tired of being a burden.

All of those things are about people, and I think that’s the biggest thing that makes this successful. This is a people-driven engagement model. This about people and it’s not specific. While the heroin and opioid crisis is today, there is alcohol—we deal with people with alcohol abuse and addiction problems. We deal with anyone under that substance use disorder headline. It fits because it’s about people. The processes and the engagement and the information and the education is all relative.

That data is huge because we want to learn as we move forward what works. I’ll give you a little example: We learned that when our team engaged you within three to five days of the overdose, face-to-face, more than 80 percent of the time, we were getting you into treatment. Well, if we’re looking about understanding what this data tells us—and what I would really like to know, as we move forward, is it better three days or is it better five days? Is it 90 percent in three days and 14 percent in five days? Where did that 80 percent come from? But the ability to collect useful data and understand the individuals and know that a person who became addicted from a surgery at age 23 and is prescribed Percocet is a different kind of client and needs different kinds of service and support than a person who is a 25-year heroin user and they got a batch of fentanyl and overdosed and they’re ready to move forward.

There’s a different kind of mind-set—and I’m learning that as I work with the professionals in the treatment side—to understand that it helps us learn how to better serve this population, so we can give them the things that they need to be successful.

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Amanda: Thank you. We're actually nearing the end of our time. Before we go, final question I'd like to ask you: What advice would you give to communities that are considering implementing a QRT program?

Dan: Don't be afraid to fail. I think that oftentimes—and sadly you hear of the, “Why are you wasting resources? Why are you doing this?” This is a population, our client base, it isn't worth the time and the trouble of first responders. The reality is that these folks live within our community, these families are in our communities. Our communities and our neighborhoods are all effected and good people are being taken in and lost in this disease, and people in the community look to leaders.

Leaders sometimes have to think differently and be open to, “You know what? I never expected 25 years into my career to have to be looking at something and say, How do we respond to an opioid crisis?” As the Chief of Police, I thought I was doing everything within street-level drug work, task force-level drug work, proactive traffic stops, engaging all these things. We were arresting people left and right, but our neighborhoods were still suffering. Crime was still occurring and property crimes were still going up. Where were we missing out? We were missing out because we were not problem-solving. We were not working to solve a problem that was expected from our communities for us to do something about.

Sometimes things work. This was a model that, again, the heroin response was just one fifth of it, but it's taken on a whole element of its own and to learn that it's being modeled across the country is humbling, but it's very sad because it means we're just continuing to struggle on how to respond to a nationwide epidemic.

Don't be afraid to care. Don't be afraid to realize that they're looking at us and everyone and hoping that the people that they believe—public safety is at the forefront of that—that we're working and we can be trusted and we care. We have an ability through who we are to create some powerful relationships and powerful partnerships, and that's exactly what happened.

Sitting at the table with the CEO of the Cincinnati Addictions Services Council and saying, “This is my idea. This is what I'd love to do. What do you think about it?” Nan Franks is the CEO—and she looked at me, and she just smiled and said, “Dan, I've been doing street-level social work for 30-plus years—I'm going to tell you right now that this is going to work. We are going to save lives.” I said, “How do you know that?” She said, “I'll tell you. We're eliminating a lot of the barriers. We're eliminating cell phone minutes, we're eliminating bus tokens, we're eliminating the process of traveling on a bus for 35 or 40 minutes or an hour to get from point A to point B—which is our place down here in Clifton Area, Cincinnati. All the things that keep people from moving closer to help we're eliminating because we're going out and finding them. That is the

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piece that we move forward with—is not just following up from the overdose, but actively outreach with people.” We understand who’s working and who’s living in our community and not waiting for the tragedy to occur and the Narcan to be distributed and a life to be saved. We’re actively engaging because we know them.

We have people that are stopping our police cars in the street, we have people showing up to the police department, we have people showing up, as I stated, during their shift to say, “I hear you’re out here and I need help. Can I bring a friend?” All these different examples. I know we’re short on time, but just in the recent weeks, an ER doctor from the University of Cincinnati Medical Center—UC Hospital—Dr. Rick Ryan, stated that, “QRT is the gold standard.” Here’s why he believes in that: because it’s about relationships. He said, “We have a facility that we can move people from the overdose or the known, the need, and it’s like 500 feet to get them to treatment, and we have a seven-percent success rate.” I realized that because I learned that the QRT is built on relationships and engaging. I put myself to the test and I said, “I am going to work harder on the relationship piece and work harder on the people side of this.” Since I’ve been doing it, I want to tell you that I’m 100 percent successful moving people from the need to the treatment.

I absolutely believe that proactively engaging people—along with their families and their support groups—while it shouldn’t be unique, it is something that makes a difference. That’s what we said all along—devoted to engage people, the ability to work with them and let them know that you’re here for them, and the people they expect the least to be showing up at your front door and knocking and saying, “You know what? I’m here to help you. I brought this really, really great partner to help you. Let’s work together because we care about you and we want to save your life.” To see the look on their faces—the first guy that I put into it said, “Nine out of ten times when we said that, it was either crying or hugging that was happening next.” This guy worked dope for me—and he loved doing that—but he said when he retired, the most impact he ever had was working with the QRT, and he’s so thankful that he had the chance to do that.

It’s crazy, but the reality is, treating people like human beings is not unique, but it does work. It’s not expected, but it’s appreciated, and I think we’ve shown success that way.

Amanda:

That’s great. Thank you so much for your time, Dan. This is amazing—the program sounds wonderful, and I hope that all of you listening have found something useful from this. Again, thank you, and that is all we have for today.

Dan:

Thank you, it was an honor—appreciate the time.

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