



How Police and other First Responders can Create Recovery Pathways for People with Substance Use Disorders

Pamela Baston, MPA, MCAP, CPP, JBS International
Karen Maline, International Association of Chiefs of Police
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TASC's Center for Health and Justice

COSSAP TTA Provider for First Responder Led Diversion Initiatives



Website: <http://www.centerforhealthandjustice.org/>



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- The International Association of Chiefs of Police is the largest and most influential professional association for law enforcement in the world. With more than 30,000 members in 150 countries, the IACP is a recognized leader in global policing, committed to advancing safe communities through thoughtful, progressive police leadership.
- Since 1893, the association has been serving communities worldwide by speaking out on behalf of law enforcement and advancing leadership and professionalism in policing worldwide.

HOW POLICE AND OTHER FIRST RESPONDERS CAN CREATE RECOVERY PATHWAYS FOR PEOPLE WITH SUBSTANCE USE DISORDERS

July 22, 2021

Pamela Baston, MPA, MCAP, CPP



Learning Objectives

1. Review common factors that contribute to the development and maintenance of substance use disorder (SUD) in individuals;
2. Increase understanding of opioid use disorder (OUD) and other SUD-related disruption in the brain's neurocircuitry that affects one's ability to prioritize beneficial behaviors over destructive ones; and
3. Identify strategies to effectively interact with individuals with SUD and connect them to harm reduction, treatment, and recovery support services.

Common factors that contribute to the development of a SUD



Source this quote...

“Today feels like a great day to develop an addiction to drugs so bad that I will risk my health, my family, my job, my dignity, my future, my freedom and possibly even my life.”
Source?



Answer?

No One!

The pathways to substance use disorders (SUDs) are varied and complex. Strap on your seatbelt; we have a lot to cover!



We often see this rather than their pathway.





Meet Beth

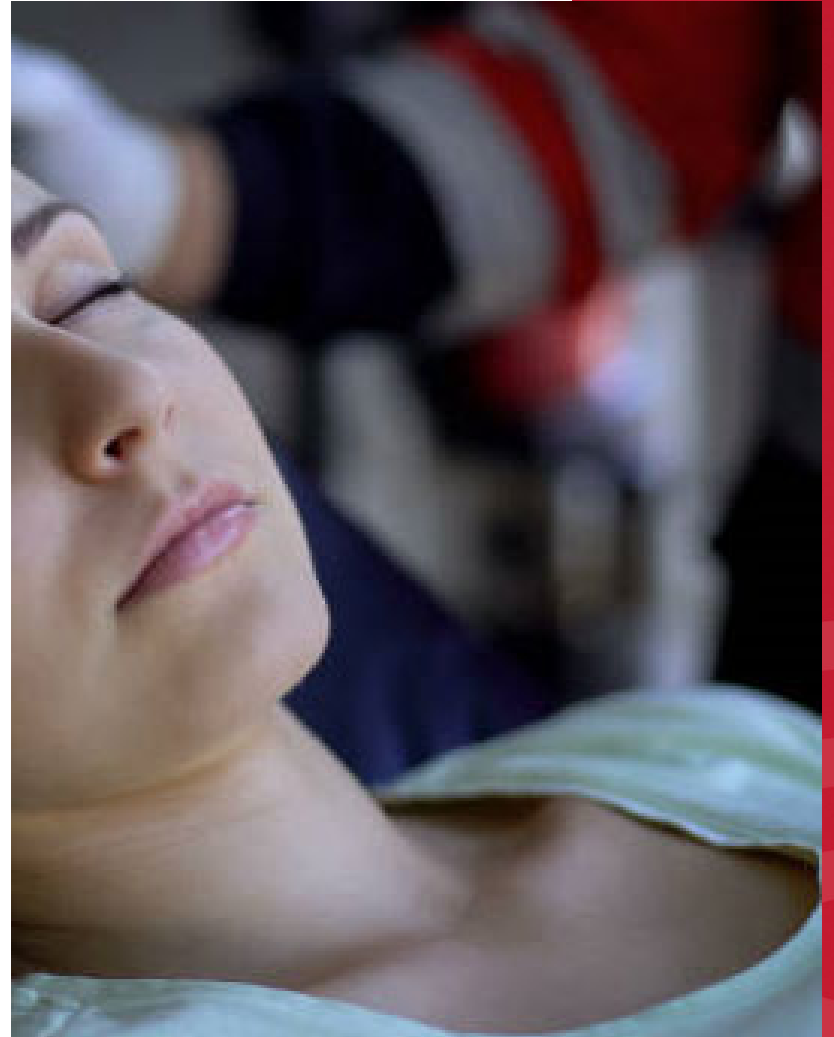
“Beth”, 26, grew up in a very violent household. From age 7, Beth was physically and sexually abused by her mother’s many boyfriends and was in and out of foster care. At 17, Beth escaped by running off with her then 27-year-old boyfriend. Fearful of losing her place to live, Beth reluctantly succumbed to her boyfriend’s constant pressure to “party” with him which involved taking various pain pills.

Beth's Story (cont.)

Within six months, Beth became addicted and no longer needed to be pressured to use, she was a willing volunteer. The relaxed warmth and heightened sense of wellbeing Beth experienced from the pills was a welcome relief from the dark thoughts, anxiety, and feelings of doom she otherwise experienced. The pain relief provided by the pills was a bonus given the lingering pain Beth experienced from the many broken bones and internal injuries she had received as a child. The pills also stopped the agonizing dope sickness that crept in between use periods. Beth began helping her boyfriend steal pills and eventually both began stealing anything they could to support their growing opioid habits.

Beth's Story (cont.)

Over the next eight years, several arrests followed, as did various stints at local detox programs, addiction education programs, and short-term treatment programs. After an exceptionally successful burglary of a nearby house, Beth and her boyfriend used more excessively. Beth overdosed but survived. After two more overdoses weeks apart, the first responder team wondered what they could possibly do to help Beth.





Meet Tony

“Tony”, 45, was born to a single mother. His father was never a part of his life. Some of Tony’s early memories include having to help his mother “clean up” in very personal ways after her sexual encounters with various men which also involved excessive alcohol use.

Tony's Story (cont.)

Tony also remembers his mother using a wire grill brush as part of his bathing process in an effort to “scrub the black off him” particularly around his knees and places where his black skin was naturally darker. Not surprisingly, Michael struggled in school and in relationships. After dropping out of high school, he got a job mowing lawns and began dating “Brittany” who he later found out had a methamphetamine addiction. He tried to leave Brittany, but she was pregnant with his child. When Brittany gave birth, the baby was identified as “substance exposed.” Brittany went on the run and her parents were awarded temporary custody of the baby and Tony moved in with them to help.

Tony's Story (cont.)

At first, Tony tried to balance his new caregiving duties and doctor's appointments with his full-time job but after too many absences, he lost most of his business and was unable to support himself and his baby. Tony began sinking into a deep depression as each day grew harder to manage and more exhausting than the day before. One day Brittany showed back up and it wasn't long before Tony found himself on the other end of a meth pipe. Many petty thefts and drug arrests ensued. Tony became very familiar to the local police who wondered if Tony would ever get his life straightened out.

Contributing Factors for Beth and Tony

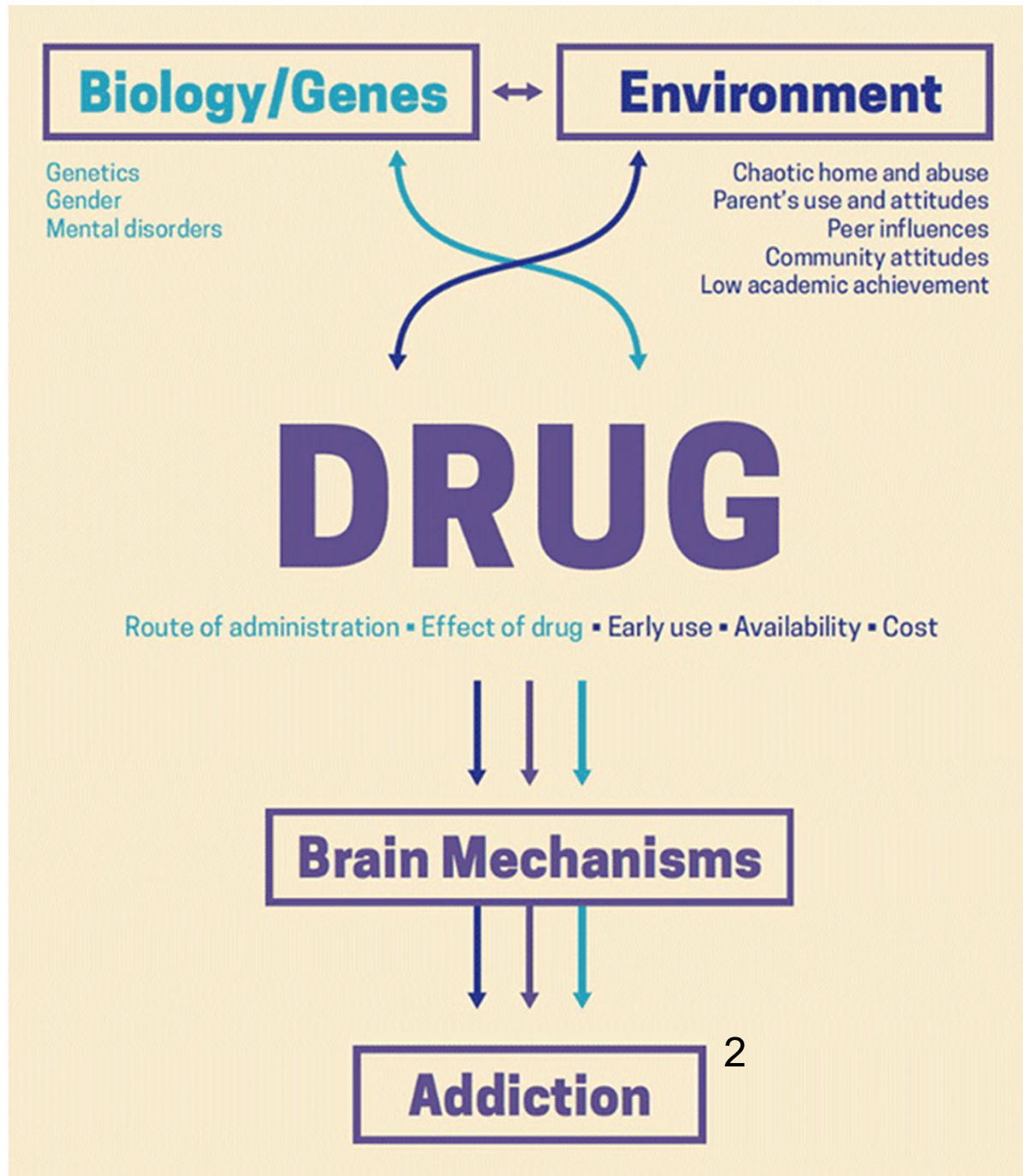
- Violent household
- Physical abuse (including lingering physical pain from past injuries)
- Sexual abuse
- Housing insecurity (potential homelessness)
- Coercion
- Inappropriate/misaligned/poor treatment
- Traumatic childhood (ACEs)
- Self loathing/discrimination
- Significant family challenges
- Poverty
- Justice involvement
- Employment and self sufficiency challenges

SUD-related disruption in the brain's neurocircuitry

Addiction Factors¹

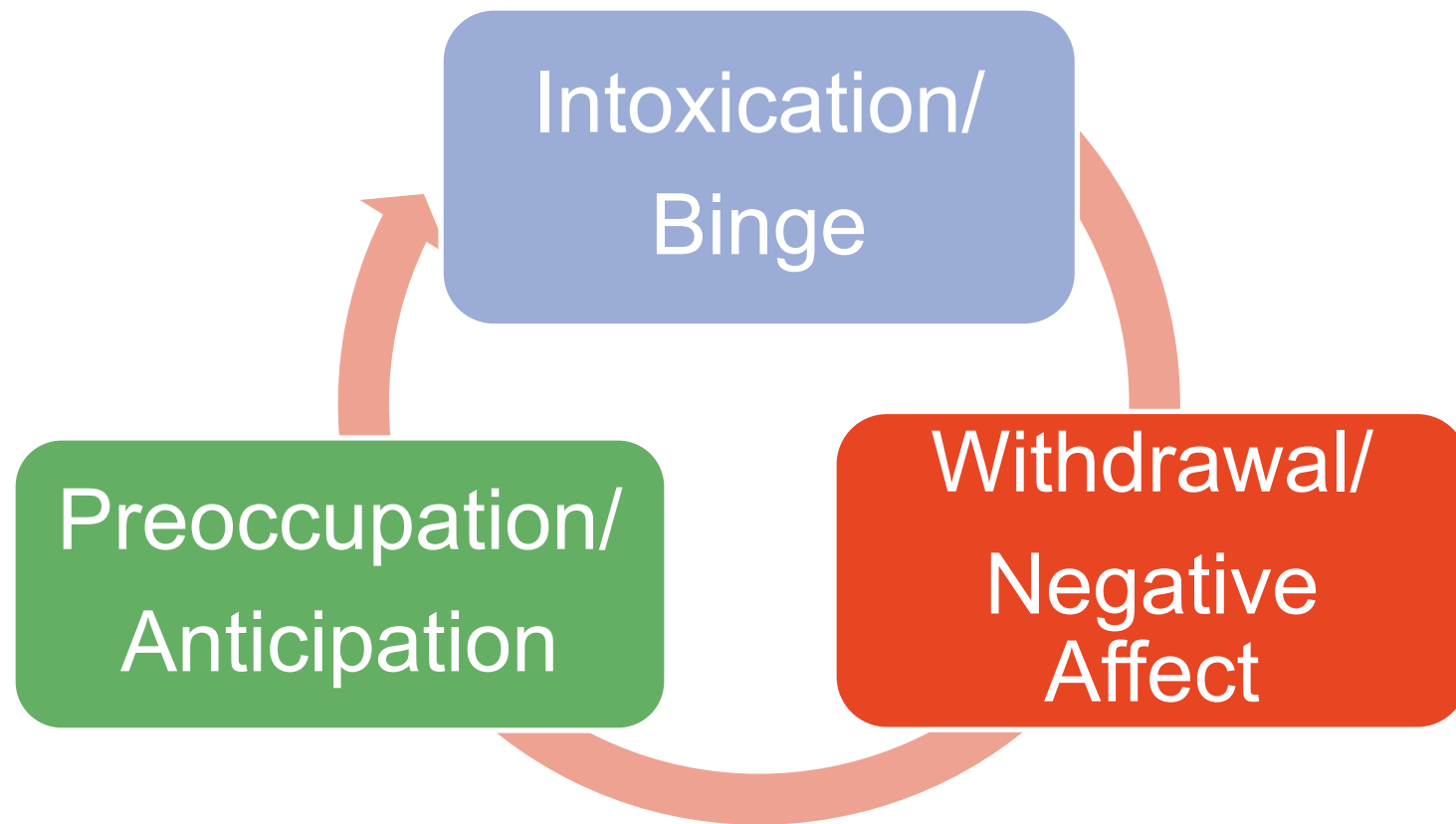
- Like diabetes, cancer and heart disease, addiction is caused by a combination of behavioral, psychological, environmental and biological factors.
- Genetic risk factors account for about half of the likelihood that an individual will develop addiction.

1. Source: <https://drugfree.org/article/is-addiction-a-disease/>



2. Source: <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>

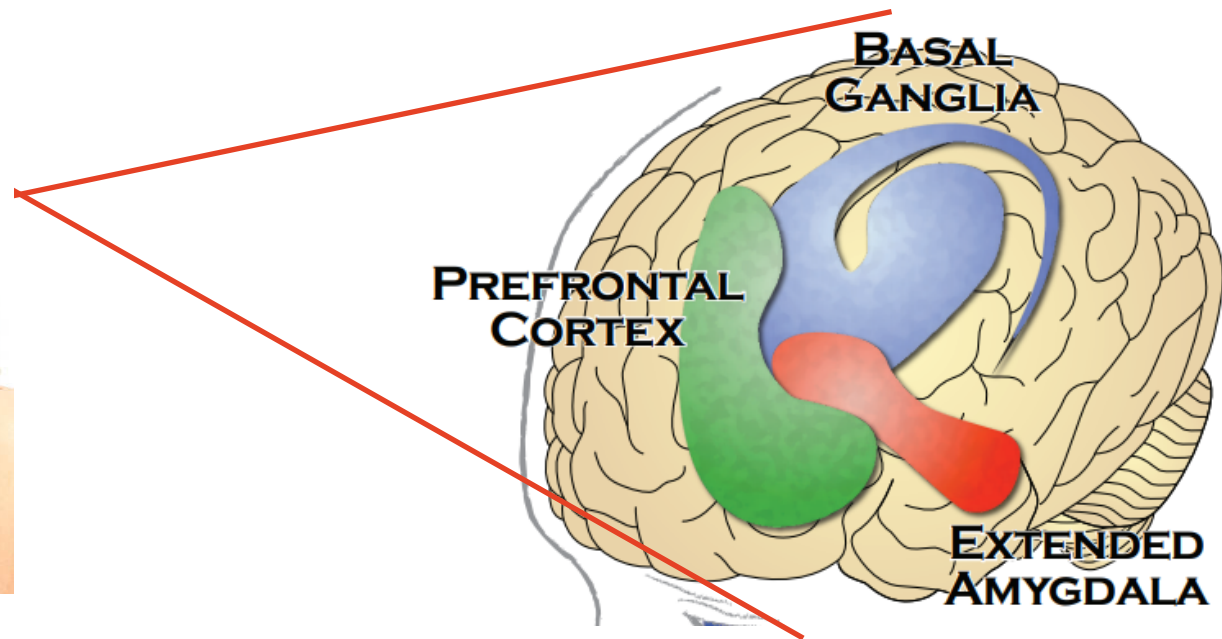
Addiction Process³



3. Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. Melinda Campopiano, MD presentation 5.26.21 (SAMHSA AIAN ATTC)

Addiction Process (cont.)

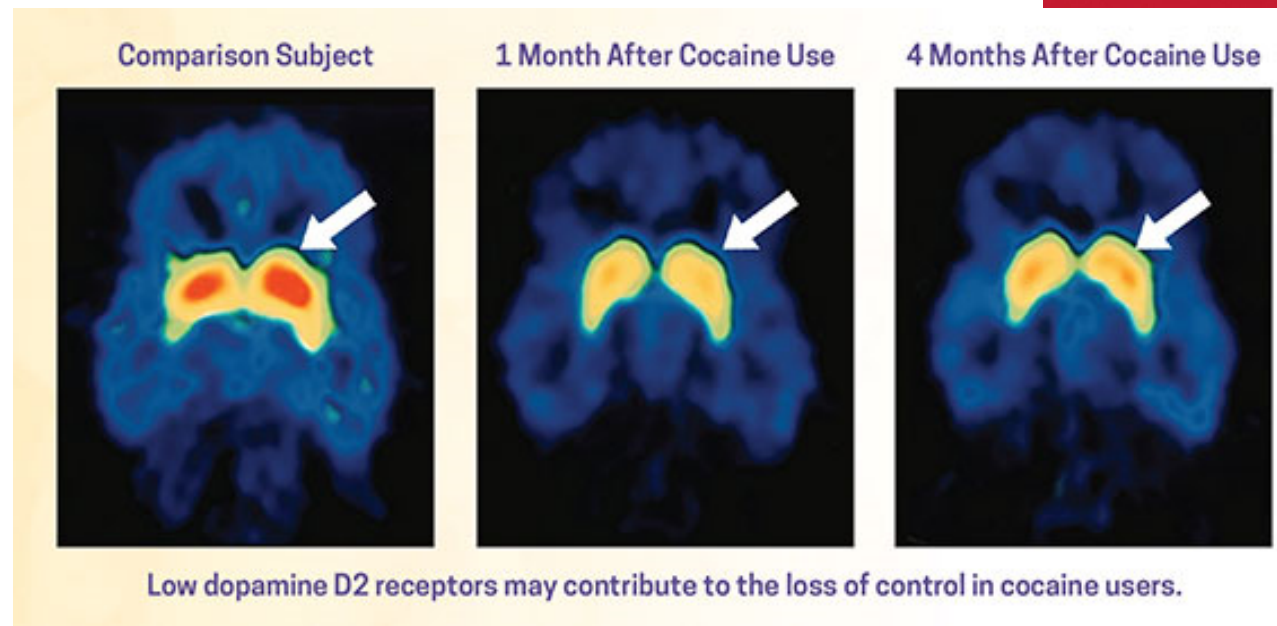
Addiction happens in the same three parts of the brain, no matter what drug is used. These parts are responsible for reward, motivation, learning, decision making, judgment, and memory and are impacted by substances and trauma in similar ways.⁴



4. Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

Addiction Process (cont.)

Brain imaging studies of people with addiction show physical changes in areas of the brain that are critical to judgment, decision-making, learning and memory, and behavior control.⁵



5. Source: <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>

Addiction Process (cont.)⁶

- When some drugs are taken, they can cause surges of chemicals that produce pleasure in much greater amounts than the smaller bursts naturally produced in association with healthy rewards like eating, hearing or playing music, creative pursuits, or social interaction.
- The intense euphoria reinforces the connection between taking the drug and the resulting pleasure and signals the brain to repeat the activity again and again **without thinking about it, leading to the formation of habits.**

6. Source: <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain>



Addiction Process (cont.)

This disruption in an individual's neurocircuitry affects their ability to prioritize beneficial behaviors over destructive ones and their ability to exert control over these behaviors even when associated with catastrophic consequences.⁷

Addiction Process (cont.)

- The changes in the brain can remain for a long time, even after the person stops using substances. These changes may leave those with addiction vulnerable to physical and environmental cues that they associate with substance use, also known as triggers, which can increase their risk of relapse.⁸
- This reason, combined with the many factors that contributed to the SUD in the first place, render detox as a stand-alone treatment ineffective.

8. Source: <https://drugfree.org/article/is-addiction-a-disease/>



Addiction Process (cont.)

While the initial decision to use substances is often voluntary,* the brain changes that occur over time challenge a person's self control and ability to resist intense impulses urging them to continue using substances.⁹

* Coercion is often a factor

Choice?

- Individuals do not **choose** how their brain and body respond to substances, which is why some people with addiction cannot control their use while others can. People with addiction can still stop using substances — it's just much harder than it is for someone who has not become addicted.

Good news...

- With abstinence and proper care, addiction-induced brain impairments rapidly reverse themselves.
- Millions of individuals have achieved complete long-term recovery from addiction and have gone on to experience healthy, meaningful, and productive lives.
- For those not ready or able to achieve abstinence, harm reduction (e.g., Narcan, fentanyl test strips, syringe services programs, peer support) can be an effective strategy to keep them alive.

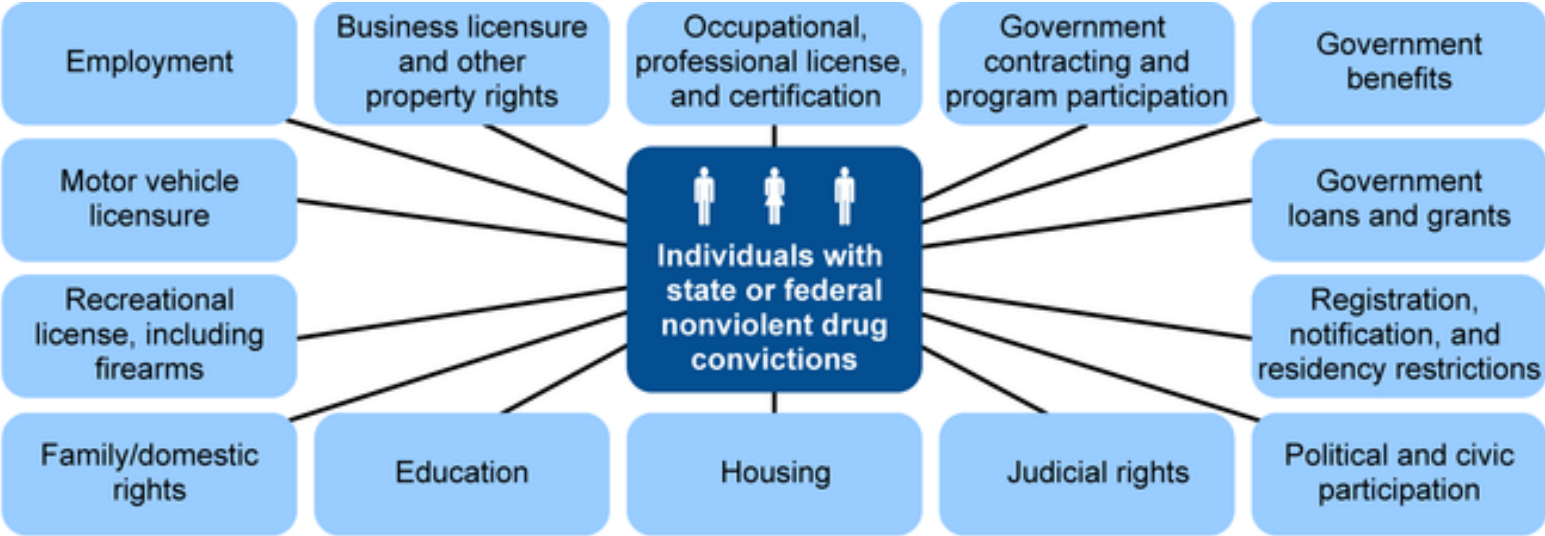
**Strategies to effectively
interact with individuals
with SUD and connect
them to harm reduction,
recovery, and support
services**



Individual Barriers

Individual barriers make it harder for individuals to attain positive outcomes.

So many barriers...¹⁰



Source: GAO analysis of the American Bar Association's National Inventory of the Collateral Consequences of Conviction (NICCC). | GAO-17-691

10. Source: U. S. Government Accountability Office 2017



Systems Barriers

Misaligned policies (lack of timely connection to services, punitive vs. therapeutic, punishment vs. accountability, unrealistic, timelines, unreasonable efforts) and workforce challenges abound.

Managing Expectations

- Effectively treating people with histories of abuse, abandonment, loss, and associated trauma requires a time-involved process of testing and engagement. (These behaviors should be **expected** as confirmation of their disorder, yet they can nonetheless be challenging for programs).
- Accountability is when we have clear expectations and offer support to meet those expectations. Punishment is a penalty for an offense.

Engagement Challenges

Individuals with a SUD often have significant and complex histories of physical and sexual abuse, abandonment, loss, and associated trauma (for Native populations and communities of color, historical trauma) adversely affecting their ability to engage in/comply with services.



Law Enforcement/First Responder Substance-Related Encounter

If your lived-experience was like Beth or Tony's and you encountered a law enforcement officer on one of the worst days of your life, what would you want the interaction to be like? (Feel free to respond in the chat box).





DESTINATION RECOVERY

DEAD END

DEAD END

CAUTION
SHORT DURATION

CAUTION
INEFFECTIVE

CAUTION
EXCLUSIONARY CRITERIA

CAUTION
INFRASTRUCTURE BARRIERS

DEAD END

CAUTION
WAITING LISTS

DEAD END

TOLL ROAD ↑

CAUTION
LOW INTENSITY

TOLL ROAD ↑

CAUTION
FINANCIAL BARRIERS

CAUTION
MISALIGNED POLICIES

DEAD END



POOR

HOMELESS

CJ HISTORY

DV SURVIVOR

TRAUMA VICTIM

**SINGLE PARENT/
PREGNANT**

LOW JOB SKILLS

4 X DAY OPIOID USER

NO TRANSPORTATION

**3RD GENERATION
SUBSTANCE USER**



JBS INTERNATIONAL
A CELERIAN GROUP COMPANY



Don't worry!
We can squeeze you
in every Wednesday
from 3:00-4:00
starting in 2 weeks

Systems Barriers

- OUD and other SUD treatment is offered to and accepted by too few—only about 10% a year of people in need of it and only a lifetime engagement rate of 25%.
- Treatment engagement begins too late—with years and, in some cases, decades of dependence preceding first treatment admission.

Systems Barriers (cont.)

- SUD treatment retains too few (less than 50% national treatment completion rate) and some kicked out for confirming their diagnosis (for no other major health problem is one thrown out for becoming symptomatic in the service setting);
- Expelling a client from addiction treatment for substance use—often involves thrusting the client back into drug-saturated social environments without provision for alternate care. What have we accomplished?

Systems Barriers (cont.)

SUD treatment often:

- Ends too quickly, e.g., before the 90 days across levels of care recommended by the National Institute on Drug Abuse (NIDA)
- Offers too few evidence-based choices (especially MAT which is not often offered);
- Is too disconnected from recovery community resources.

Systems Barriers (cont.)

- Fails to alter treatment methods in response to patient non-responsiveness, (e.g., blaming substance use disorder recurrence on the patient rather than the treatment methods); and
- Offers minimal continuing care--far short of the five-year point of recovery durability.

System Failure

“We are routinely placing individuals with high problem severity, complexity, and chronicity in treatment modalities whose low intensity and short duration offer little realistic hope for successful post-treatment recovery maintenance. For those with the most severe problems and the least recovery capital, this expectation is not a chance, but a set-up for failure—a systems failure masked as personal failure.” (Bill White, 2013)

Good News for Persons with OUD

- For persons with an OUD, it is likely that, in addition to treatment services, they will need one of the FDA-treatment medications, methadone, naltrexone, or buprenorphine (Suboxone) to minimize “dope sickness” and block the cravings that can last for a very long time and interfere with successful treatment.
- Opioid treatment medications (pharmacotherapy/MAT) suppresses withdrawal symptoms, crime, infectious disease transmission while promoting metabolic stabilization, recovery initiation/maintenance, and enhanced quality of personal/family life. (White, 2011)

For Best Long-Term Recovery Outcomes

- Recovery-oriented practices linked to elevated long-term recovery outcomes include:
 - 1) rapid access to treatment.
 - 2) client involvement in clinical decision-making.
 - 3) opioid meds with (no arbitrary dose ceilings) capable of suppressing withdrawal distress, reducing craving, and inducing a “blockade effect” to other opioids.

For Best Long-Term Recovery Outcomes (cont.)

- 4) therapeutic responses to any continued drug use.
- 5) a chronic care perspective that placed no arbitrary limits on duration of MAT participation.
- 6) emphasis on creating a strong therapeutic alliance with each client.

For Best Long-Term Recovery Outcomes (cont.)

- 7) use of recovering staff as role models.
- 8) development of programs for populations with special needs.
- 9) the broader mobilization of community resources to respond to addiction, including long-term recovery support needs.

Stigma (Discrimination) Affects Outcomes

- People who experience stigma are less likely to seek out treatment services and access those services.
- When they do, people who experience stigma are more likely to drop out of care earlier.
- Both factors compound and lead to worse outcomes overall.



Stigma (Discrimination) Affects Outcomes

- Despite the brain science, OUD and other SUDs are among the most stigmatized conditions in the world due to two main factors:
 - ❖ Perception that the person has control over the condition; and
 - ❖ Perception that it is the person's fault for acquiring the condition.

Sample Conversation Starters

Is it possible to let the individual know that...

- You care about their well-being?
- You know they don't want to be in the situation they are in?
- You know the path that led them to this place is complicated and that you aren't judging them?
- You have encountered others in similar situations who were able to get help and turn things around?
- You can connect them to resources that may help them begin their journey to recovery?
- You have hope for a successful outcome even if they are finding hope hard to come by?

Relevant Strategies

- Do you know the local SUD treatment providers in your area? Have you ever been to their facilities for a tour or to meet the staff?
- Do you know which programs handle assessment and intake (the first step into treatment)?
- Do you know which programs take individuals regardless of their ability to pay (and Medicaid clients)?
- Do you know the programs that are effective (not all are)?
- Do you have business cards, pamphlets, or other information to leave with an individual you encounter who may need it?

Relevant Strategies (cont.)

- Are there recovery support staff with SUD lived-experience who are available in our community to help people with SUD navigate your local system and reduce access barriers?
- Do you know about the various mutual aid groups are in your community (AA, NA, and others including the virtual ones)?
- Do your local programs have Narcan available and access to fentanyl test strips to help these folks stay alive until they are ready to come in for treatment?
- Since SUD is rarely the only problem affected individuals have, do you have information about other commonly needed services (e.g., safe housing, domestic violence, economic assistance)?

Help bend the trajectory towards recovery

- The good news is that, with your help and the right interventions, the crooked roads to addiction can give way to productive and hopeful paths to recovery.
- However, just as the roads to addiction are crooked, the recovery pathways are nonlinear and complex, with detours, potholes, and dead-ends along the way.

Hope is Essential (and Free)

- *Pain is rarely a motivator for recovery in the absence of hope. Hope is the key catalytic ingredient in recovery initiation. Pain (physical and emotional) in the absence of hope within the context of addiction drives only sustained drug use and further self-destruction. (White, 2012)*

CITATIONS

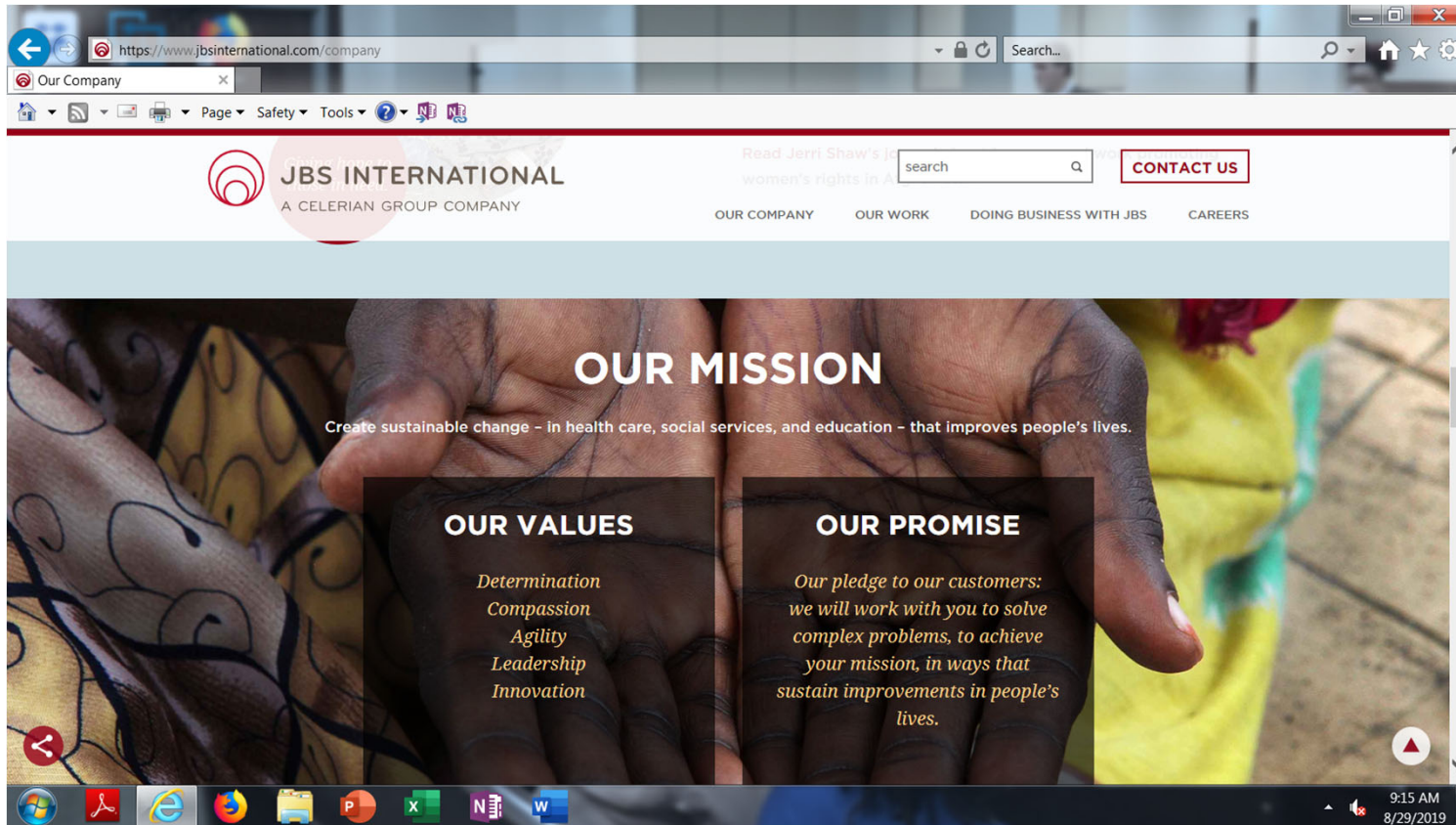
1. <https://drugfree.org/article/is-addiction-a-disease/>
2. <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>
3. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. Melinda Campopiano, MD presentation 5.26.21 (SAMHSA AIAN ATTC)
4. Ibid

CITATIONS CONT.

5. <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain>
6. Ibid
7. <https://ajp.psychiatryonline.org/doi/pdfplus/10.1176/appi.ajp.2018.17101174>
8. <https://drugfree.org/article/is-addiction-a-disease/>
9. <http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction>; and <https://www.ncbi.nlm.nih.gov/books/NBK424849/>
10. U. S. Government Accountability Office 2017

Video Resource (SUD and the brain)

- <https://www.drugabuse.gov/videos/reward-circuit-how-brain-responds-to-natural-rewards-drugs>



Questions/Information about this presentation:
Pam Baston 828.817.0385



Questions?

For more information on this webinar

Pam Baston, Technical Expert Lead, JBS International
pbaston@jbsinternational.com

Karen Maline, Project Manager, IACP
maline@theiacp.org

For information about Training and Technical Assistance

Ben Ekelund
Director of Consulting and Training
Center for Health and Justice
(312) 573-8337
bekelund@tasc.org

<https://cossapresources.org/Program/TTA>



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TRAINING AND TECHNICAL ASSISTANCE

The COSSAP training and technical assistance program offers a variety of learning opportunities and assistance to support BJA COSSAP grantees and other local, tribal, and state stakeholders to build and sustain multidisciplinary criminal justice responses to illicit substance use and misuse.

Training and technical assistance is provided in a variety of formats, including virtual and in-person training events, workshop and meeting presentations, and online resources.

[REQUEST TTA](#)

The COSSAP TTA Program supports communities by:

- Facilitating peer-to-peer learning opportunities in which communities can learn from experienced programs through virtual consultations and on-site visits.
- Providing speakers for conferences and workshops or skilled subject-matter experts for training events to educate stakeholders and build capacity.
- Facilitating strategic and cross-system planning to identify community resources, establish priorities, and develop a road map to achieving goals.
- Identifying materials such as policies and procedures, guidelines, and data sharing agreements that support program activities.
- Supporting PDMPs by increasing PDMP efficiencies and facilitating coordination between PDMPs and state and national stakeholders.