BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Key Recommendations for Enhancing Public Safety and Public Health Partnerships to Address Stimulants

August 16, 2022

This project was supported by Grant No. 2019-AR-BX-K061 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Opening Remarks

- Danielle Fenimore, *Police Executive Research Forum*
- Presenting today:
  - Ali Burrell, *Washington/Baltimore HIDTA*
    - ODMaps – data tracking and analysis
  - Dr. Brandon del Pozo, *The Warren Alpert Medical School of Brown University*

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

ODMAP Overview

The Severity of the Problem

- Between **December 2020** and **December 2021**, it is estimated that **107,149** persons died of a drug related death (**105,891** confirmed deaths)
  - A 13.7% increase from the previous 12-month time period (December 2019 - December 2020)
- This is only the number of deaths and does not capture the number of persons who overdosed or the number of persons who are currently using drugs
- This is not a new epidemic, it adapts over time

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Public Health and Safety Collaboration through ODMAP

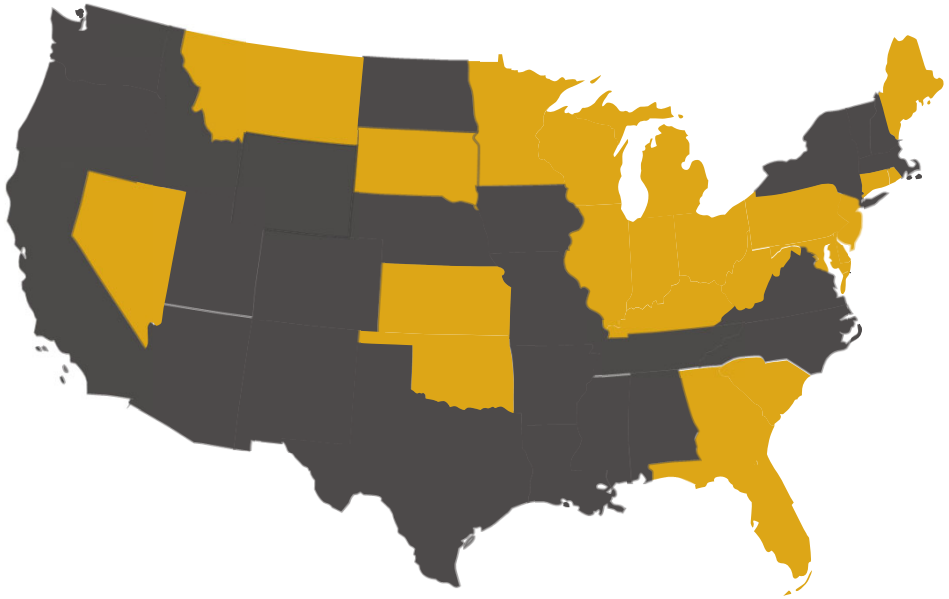
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

What is ODMAP?

ODMAP is a **free**, web-based tool that provides near **real-time surveillance** of suspected overdose events to **support public safety and public health** efforts to mobilize an **immediate response** to overdose events

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

ODMAP National Engagement



Number of participating states: 50, DC, and Puerto Rico

Number of participating agencies: over 3,900

Number of ODMAP users: ≈ 26,000

Number of states with statewide implementation: ≈ 25

Number of suspected overdoses entered: ≈ 1.26 million

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

ODMAP 101

How to engage with and use ODMAP

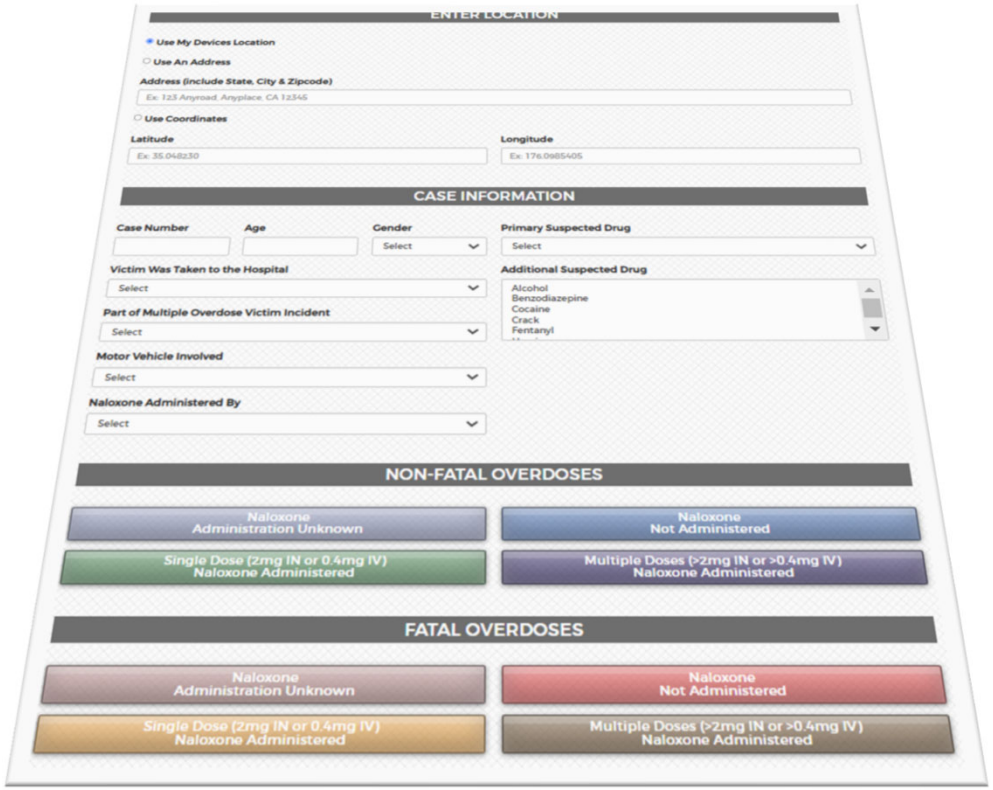
ODMAP Agency Eligibility

- Federal, State, Local, and Tribal
  - Law Enforcement/Criminal Justice Personnel (including medical examiners/coroners)
  - Public Health Personnel
- Licensed First Responders (Fire/EMS)
- Hospitals with Emergency Departments

  Excludes associated researched units commonly seen with universities
- All agencies **must sign** a Participation Agreement prior to gaining access, it outlines the ODMAP Policies and Procedures

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Overdose Event Data Entry Methods



Suspected overdose cases can be entered into the ODMAP system in **three** ways:

- Manual entry through the secure website (ODMAP is mobile friendly)
- ODFORM (for select law enforcement agencies)
- Application Programming Interface (API)

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Overdose Event Data Points Collected by ODMAP

- Each case entry **must** include:
  - Date and Time
  - Location
  - Outcome (fatal/non-fatal)
  - Naloxone Administration
- Agencies can add additional information, including:
  - Suspected drug
  - Demographics (age and gender)
  - Transported to hospital

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Real-time Data Collection through APIs

- An API allows for the **direct**, **automated integration** of the two software systems
- ODMAP utilizes a REST (Representational State Transfer) API, combined with a JSON payload to transfer data between both systems
- This is a combination of modern technology that is **developer friendly** and **compatible** with **nearly all** programming languages
- The API requires some set up at the beginning but does not require any changes to an agencies current data entry protocol

ODMAP and HIPAA

- ODMAP is not considered a “system of record” – it collects location, date/time, fatality status, and naloxone administration
- The information captured by ODMAP is not considered PHI - the location is translated into a geo-located point where an overdose occurred without any other information about a person
- W/B HIDTA and ODMAP do not retain any address information within the platform or on the server (they are deleted)
- ODMAP Zoom function is restricted to a zoom Level ID: 15 (scale of 1:18055.95)

ODMAP Tools

The National Map and Spike Alerts

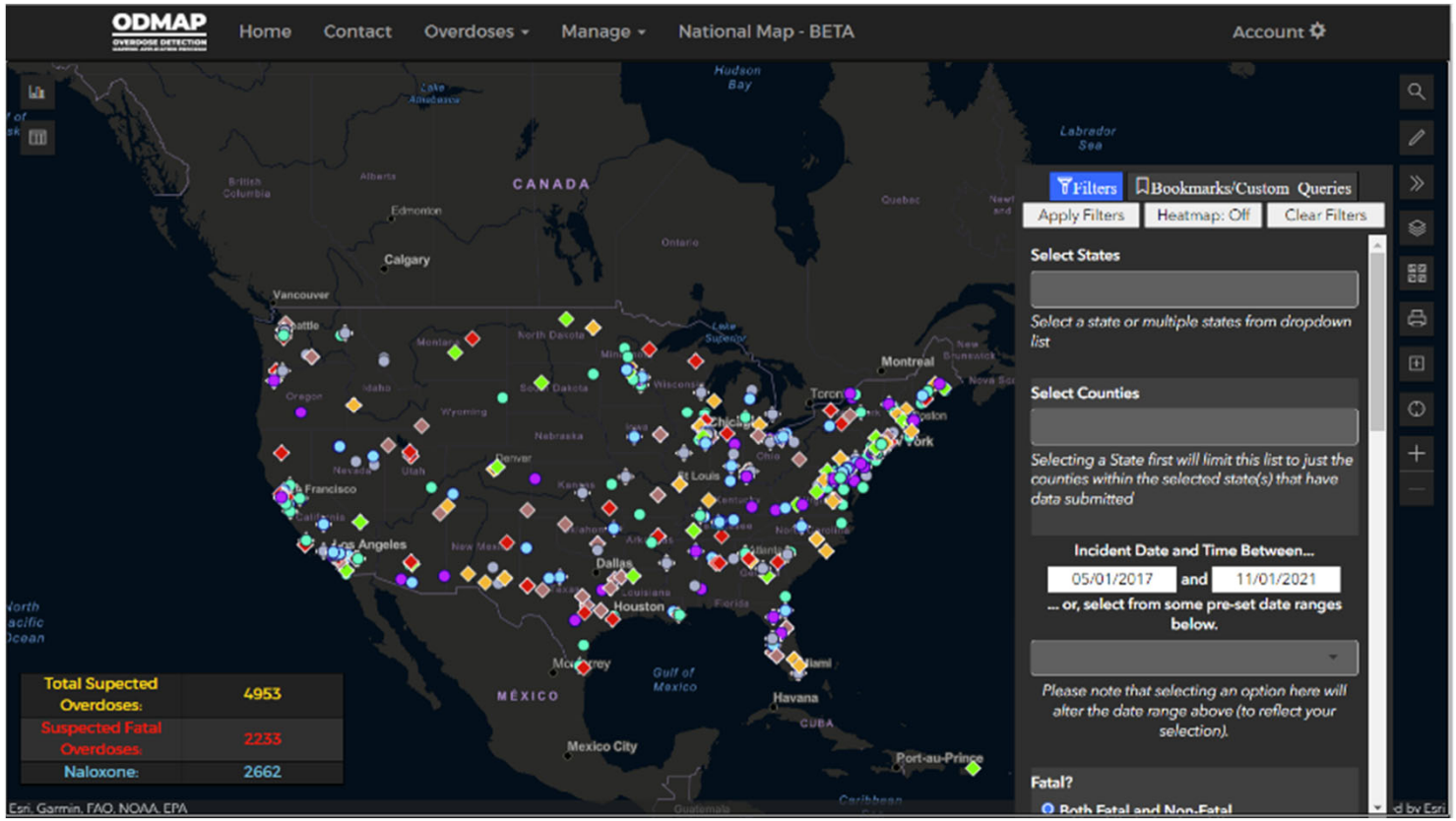
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

ODMAP Features

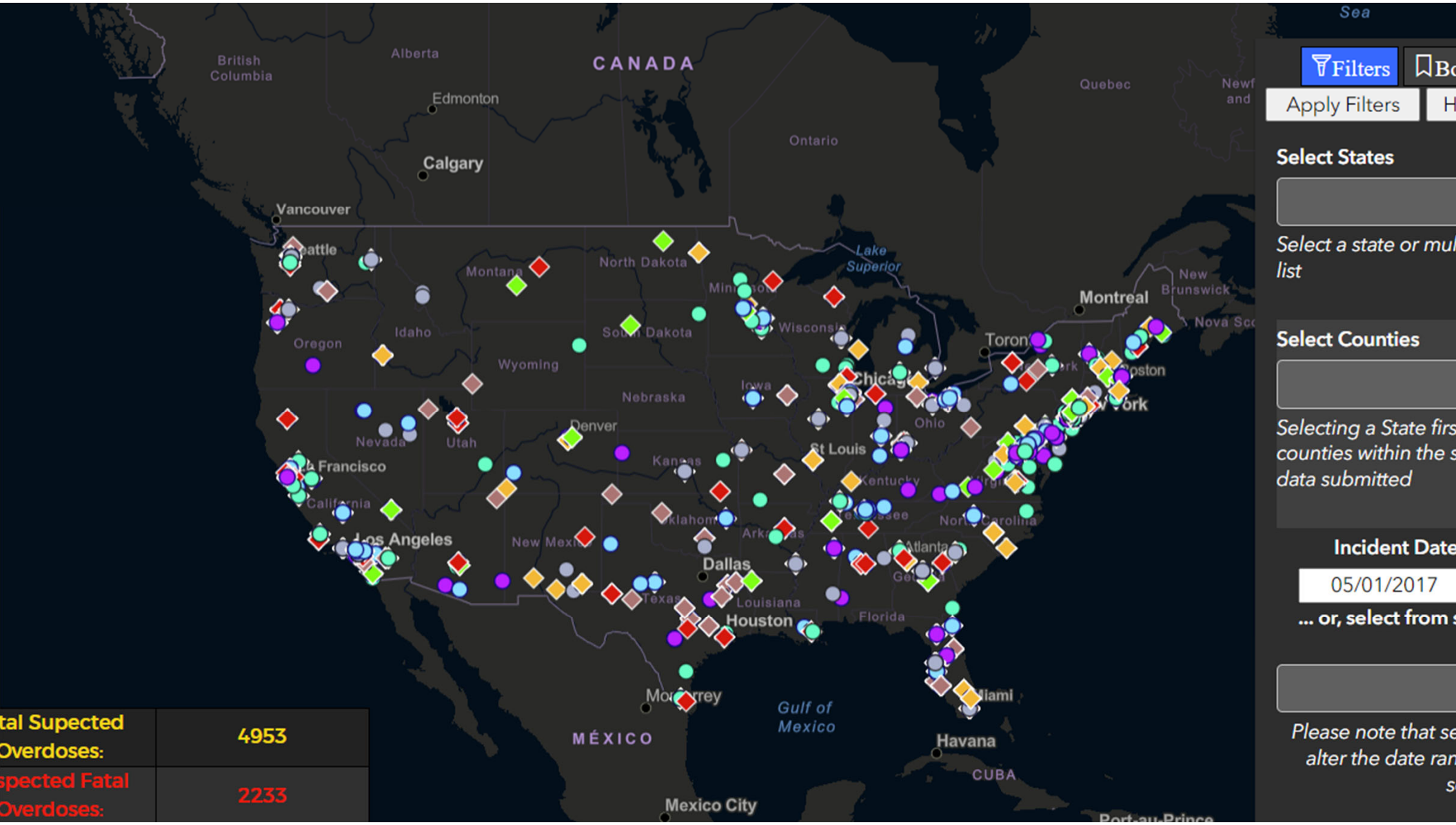
- ODMAP National Map
  - Cross jurisdiction suspected event information
  - Filters
  - Heat maps
  - Charts
- Spike, Overdose, and Statewide Alerts
- Adding personal data and Esri web layers
- **Multiple agencies** providing data for areas, capturing more suspected events

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

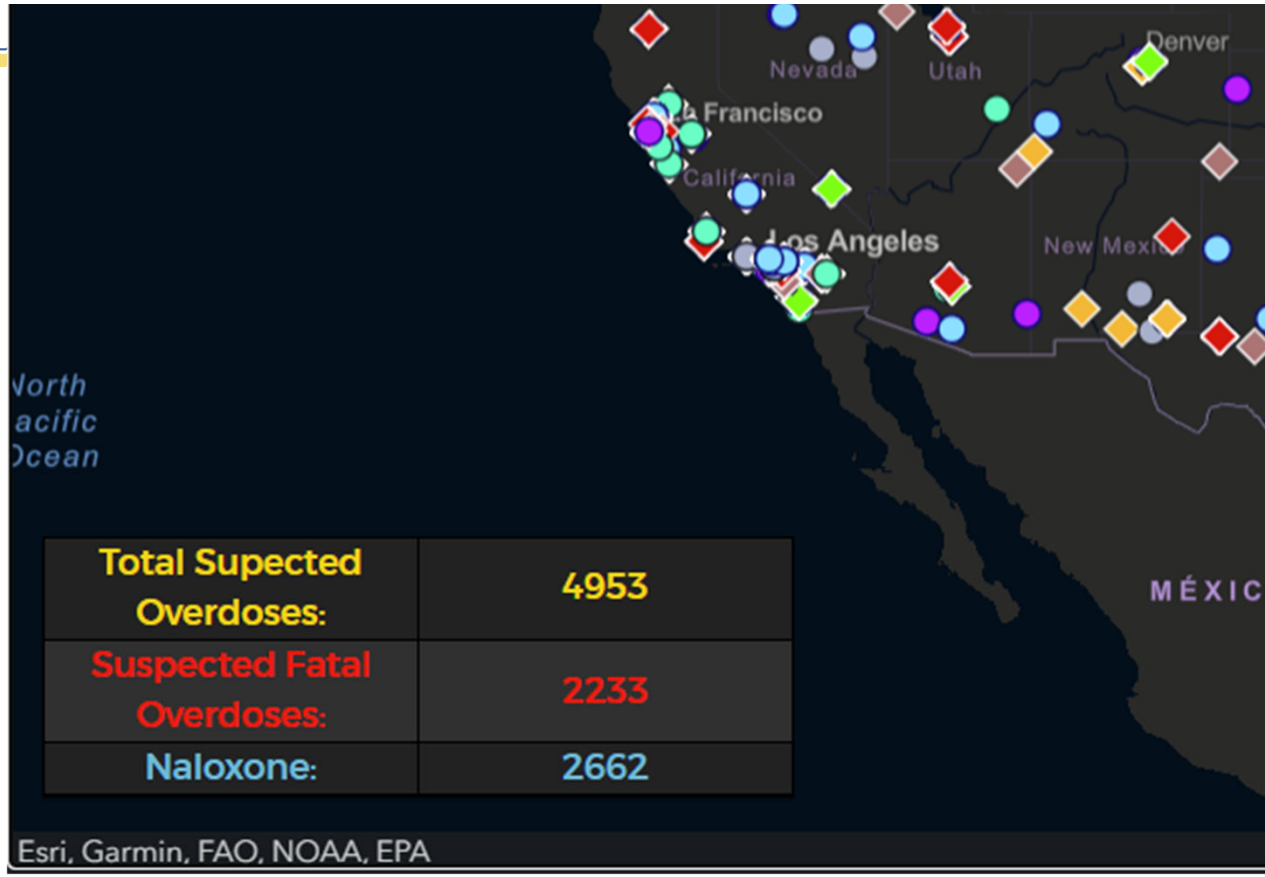
National Map and It's Features



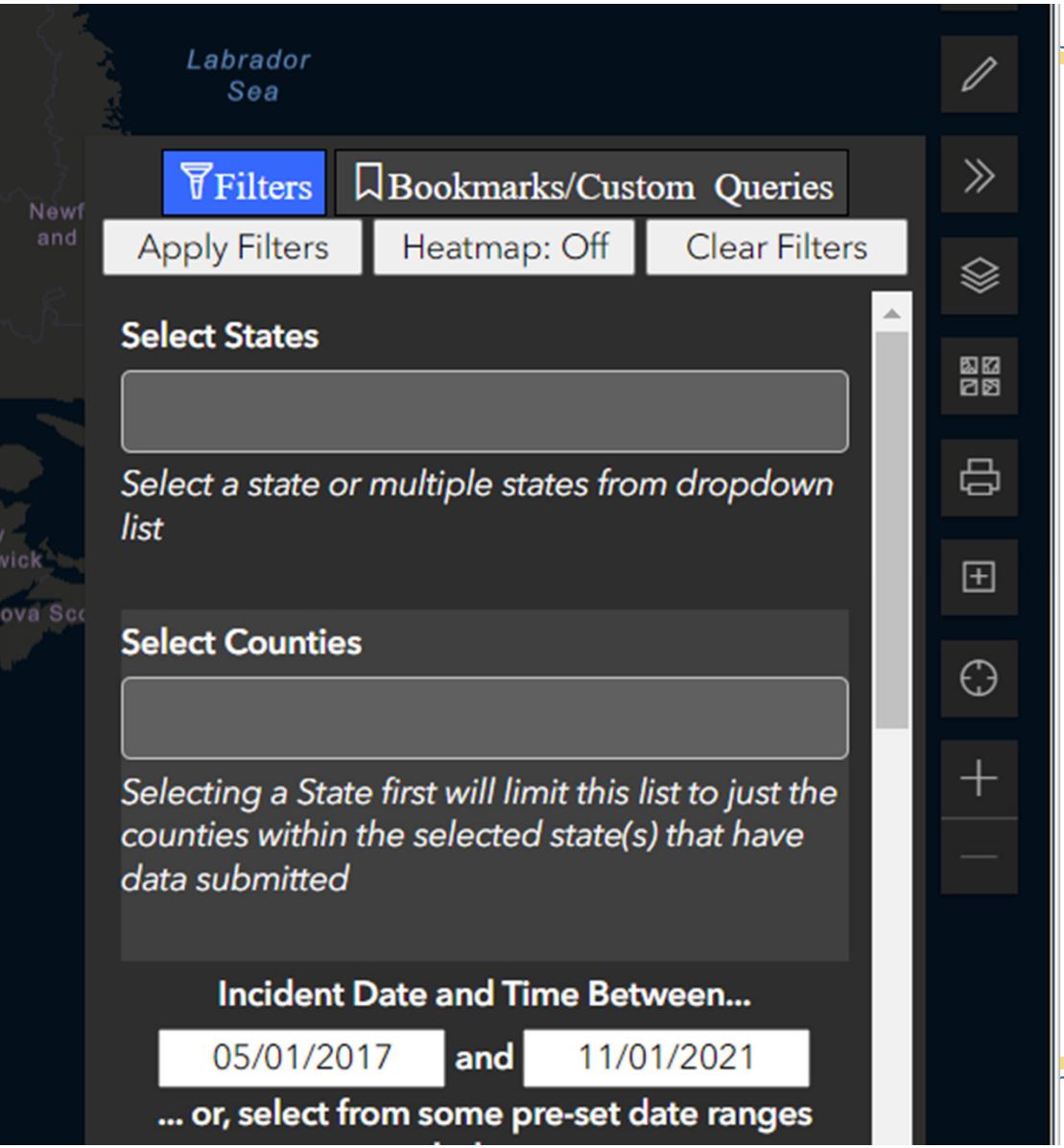
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program


Sea
Filters
Apply Filters
Select States
Select a state or mul
list
Select Counties
Selecting a State firs
counties within the s
data submitted
Incident Date
05/01/2017
... or, select from
Please note that se
alter the date ran
s
CANADA
British Columbia
Alberta
Edmonton
Calgary
Vancouver
Ontario
Quebec
Montreal
Toron
Lake Superior
Montana
North Dakota
Minnesota
Wisconsin
Idaho
Oregon
South Dakota
Wyoming
Nebraska
Iowa
Chicago
Ohio
Denver
Nevada
Utah
St Louis
Kansas
Kentucky
Francisco
California
Los Angeles
New Mexico
Dallas
Texas
Louisiana
Houston
Florida
Atlanta
Gulf of Mexico
MÉXICO
Havana
CUBA
Mexico City
tal Supected Overdoses:
4953
spected Fatal Overdoses:
2233

Default 24-hour Summary Statistics



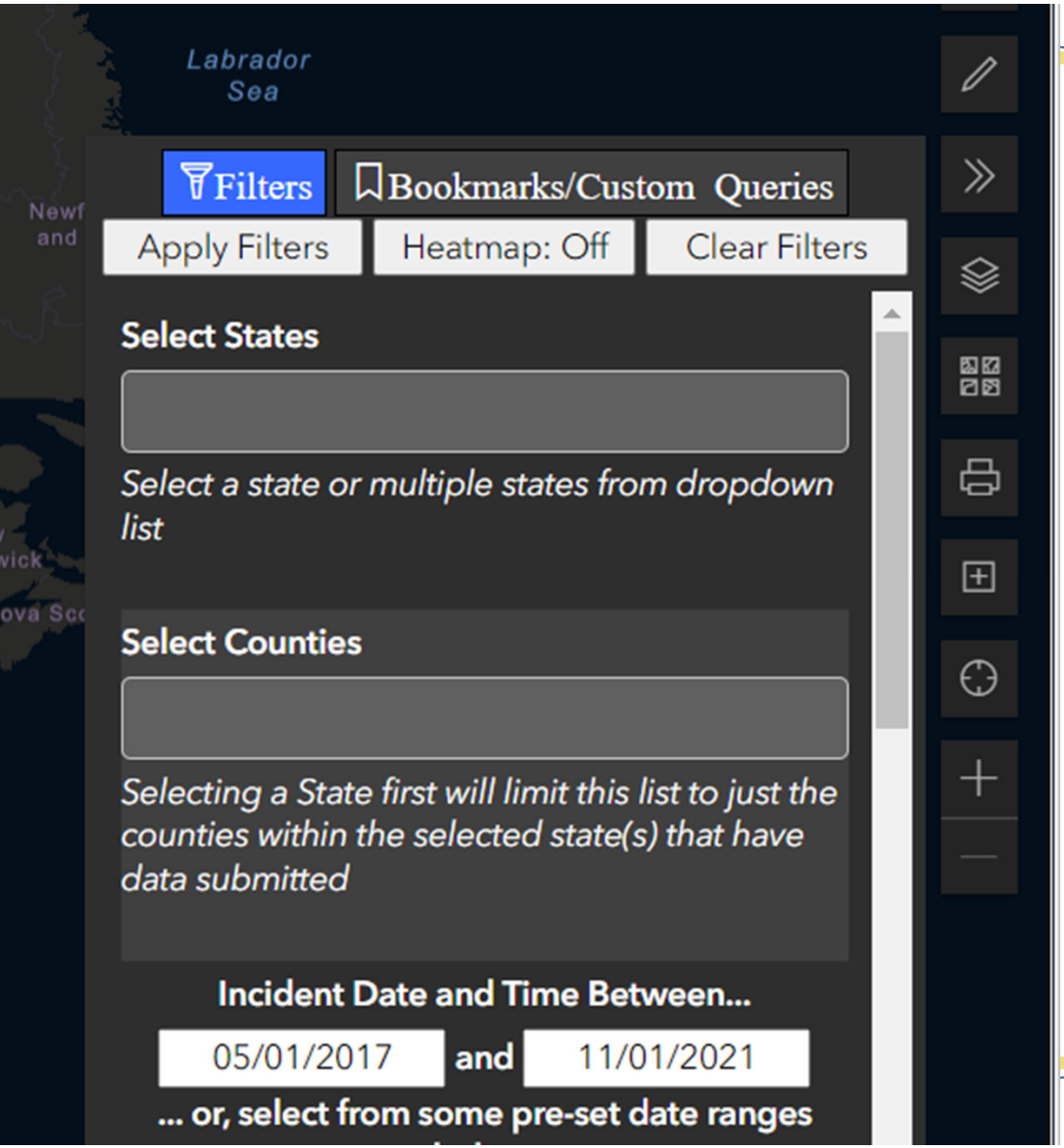
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program



Built-in filters to do deep dives into ODMAP data, including:

- Dates
- Location
- Type of Drug

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program



Stimulants included in ODMAP*:

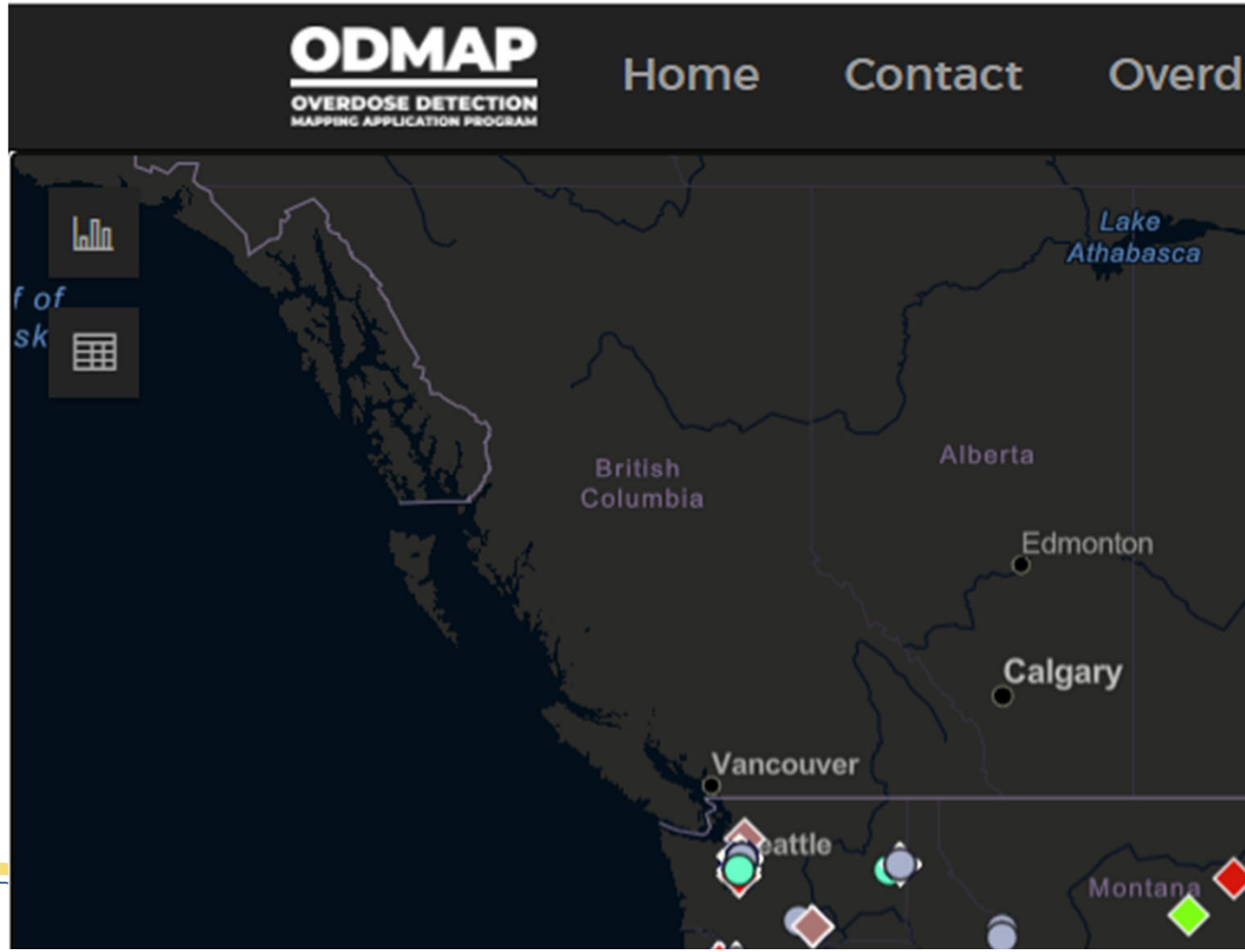
- Cocaine
- Crack Cocaine
- MDMA
- Methamphetamine
- "Other"

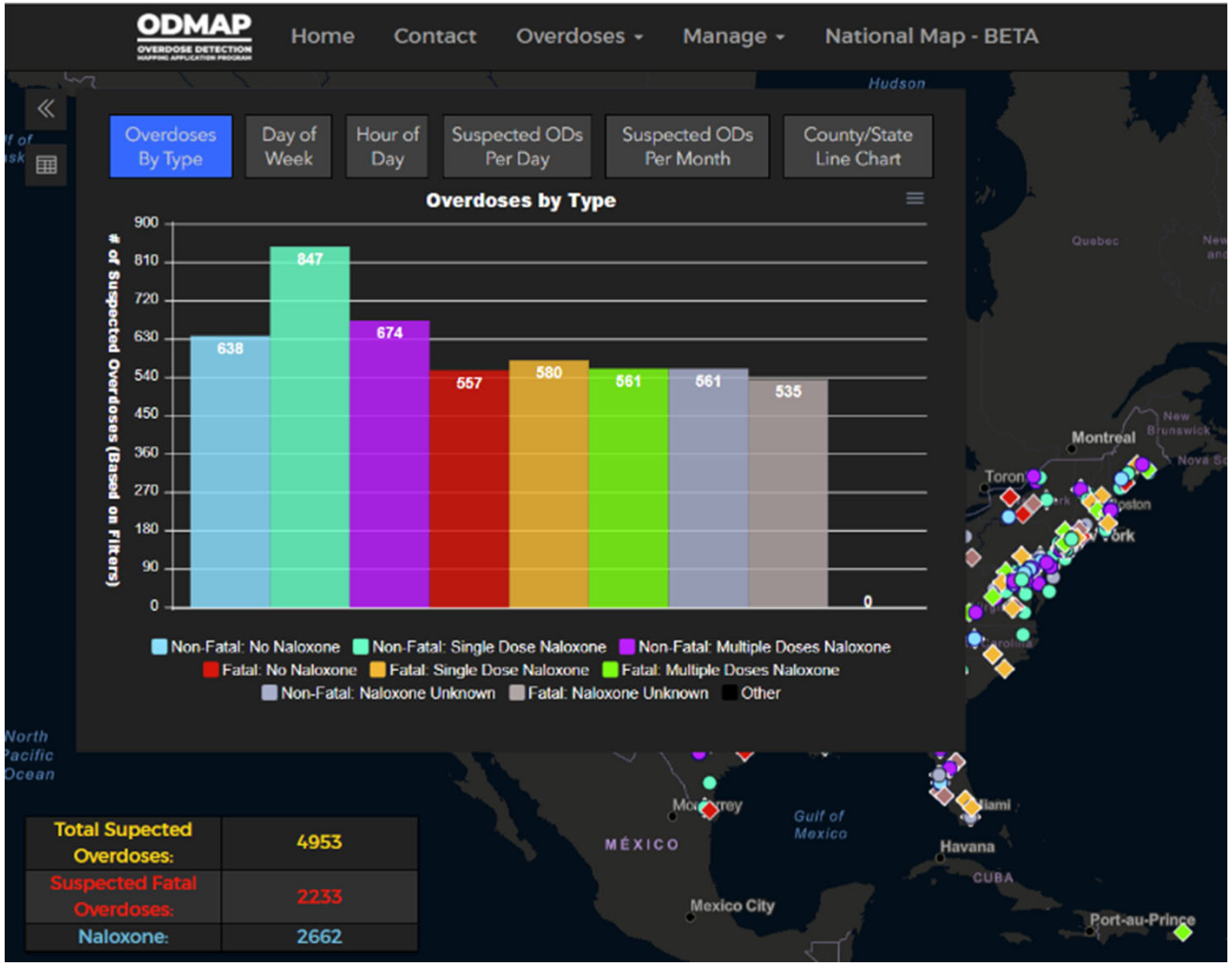
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Built-in charts, including:

- Outcome
- By Day/Month
- County/Line Comparison Chart

These are filtered based on your chosen parameters

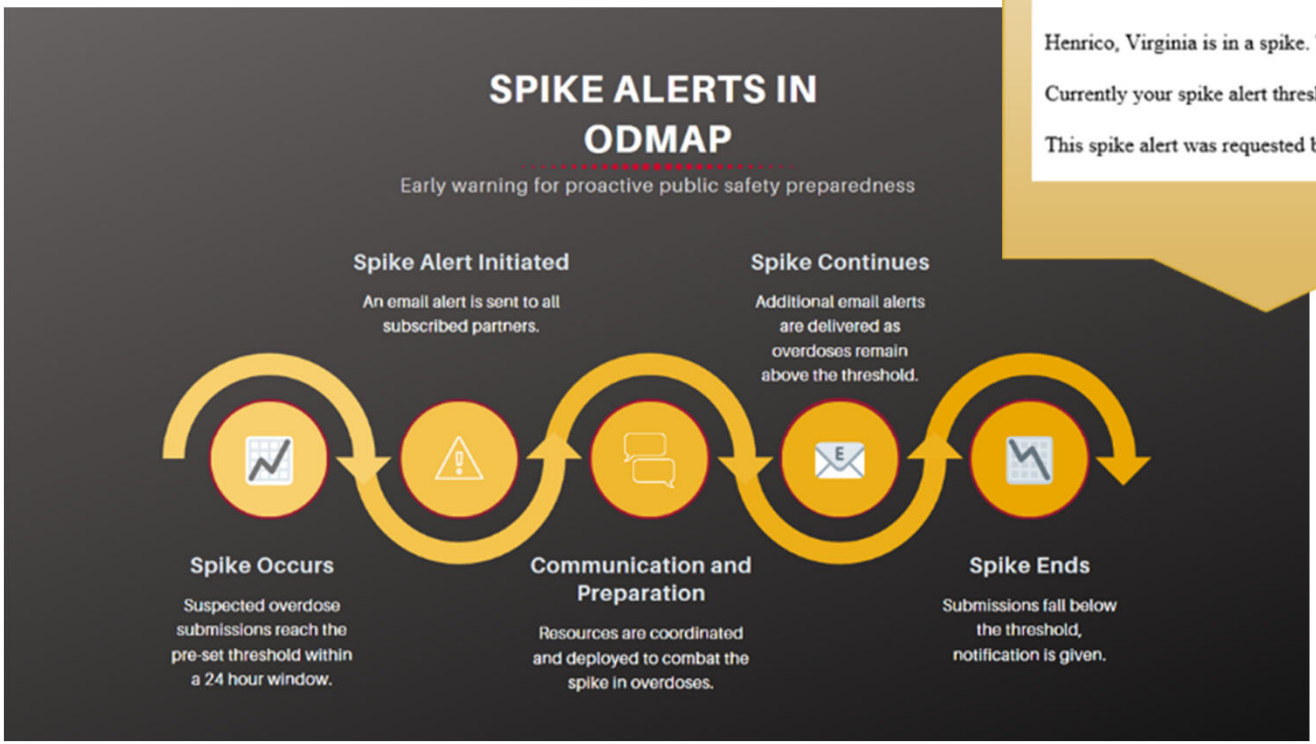




BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Spike Alerts

Spike Alerts



odmap@wb.hidta.org | Kehoet@chesterfield.gov; laubachr@chesterfield.gov

Henrico, Virginia Spike Alert

Henrico, Virginia is in a spike. There have been 4 total overdose incidents in the last 24 hours.

Currently your spike alert threshold is 3 overdose incidents in 24 hours.

This spike alert was requested by the Chesterfield County Police Department.

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Spike Alert in Action: Florida

Alachua County

Spike Started: 03/11 at 13:00

Sumter County

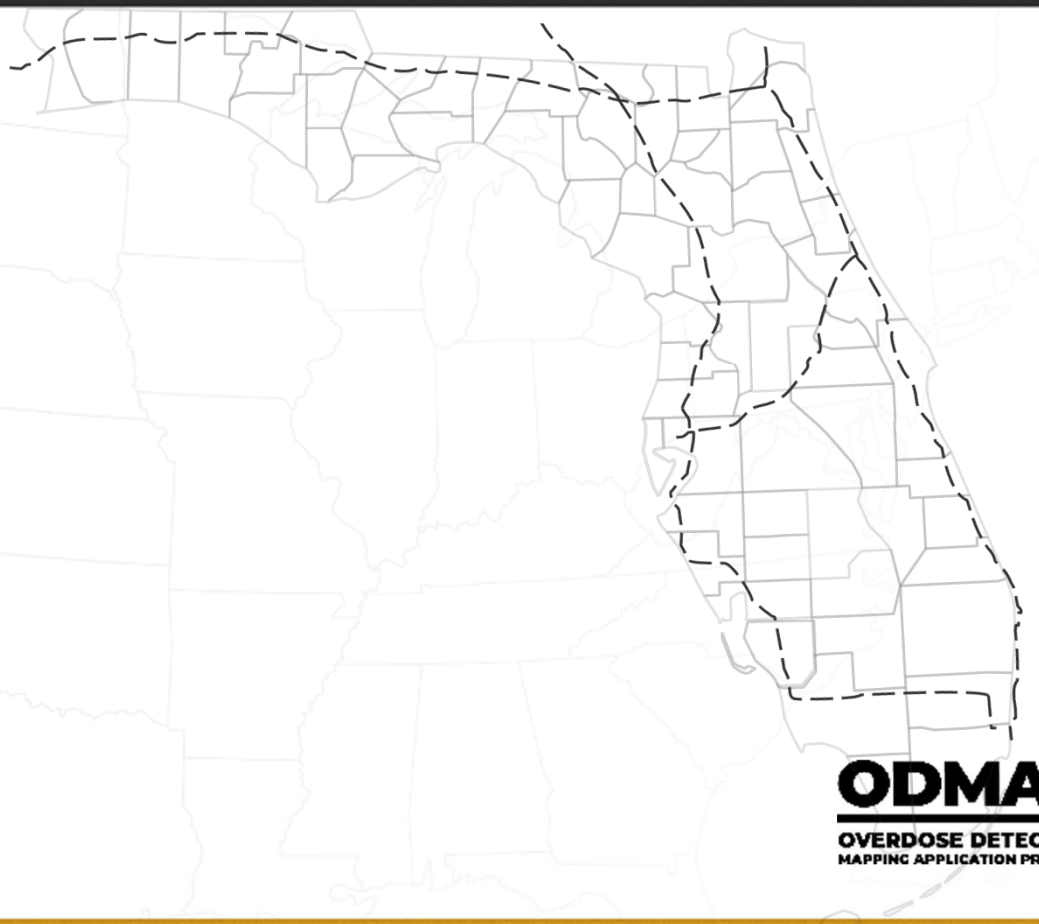
Spike Started: 03/12 at 15:00

Lake County

Spike Started: 03/12 at 19:00

Pinellas County

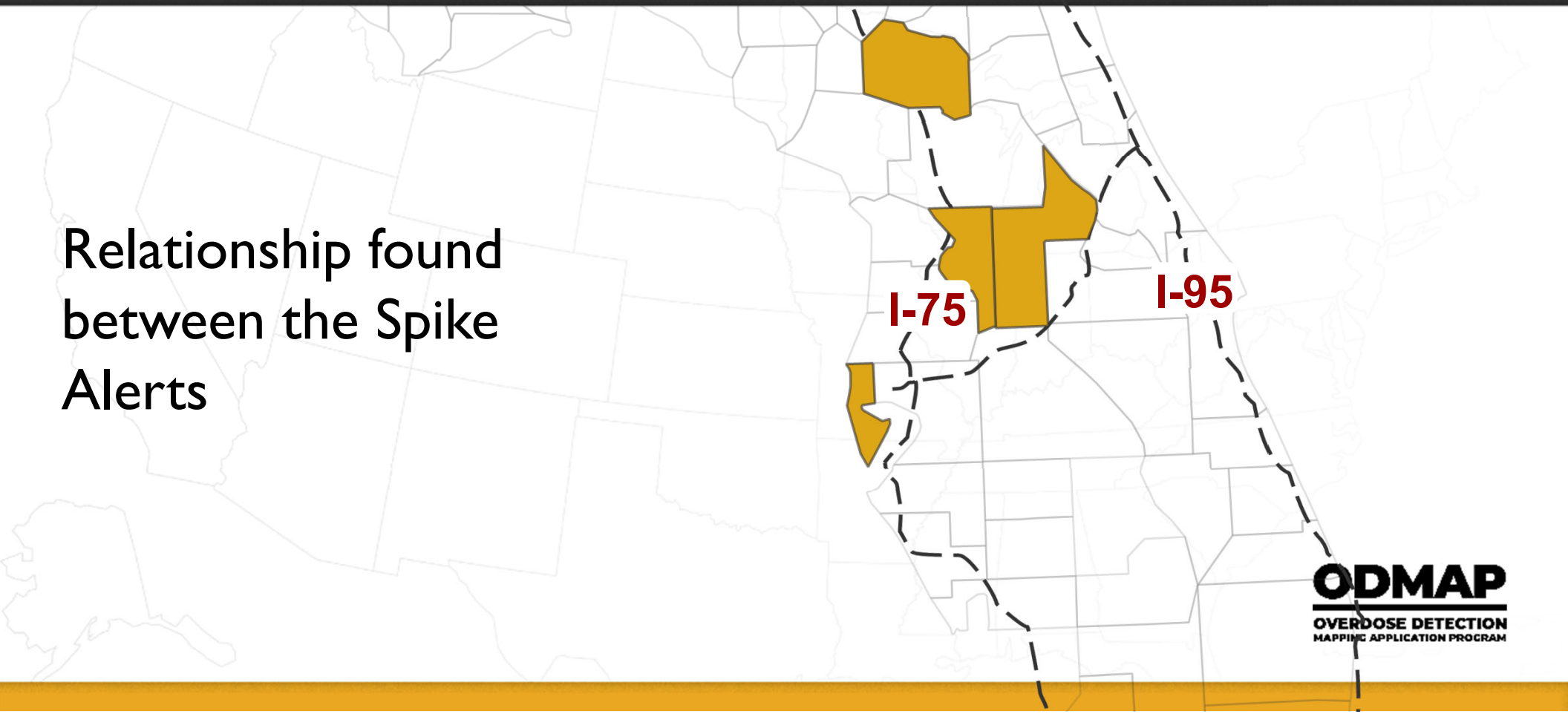
Spike Started: 03/12 at 23:00



ODMAP
OVERDOSE DETECTION
MAPPING APPLICATION PROGRAM

Spike Alert in Action: Florida

Relationship found between the Spike Alerts



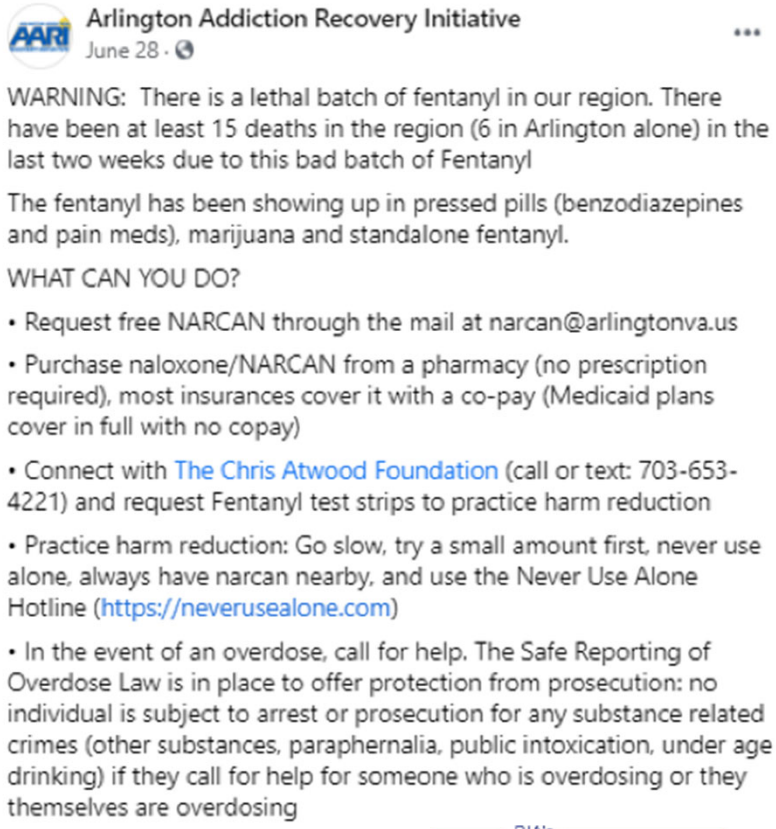
ODMAP in the Field

How do Agencies Use the Data in ODMAP to Drive Decisions

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Spike Alerts in the Field: Arlington County, VA

- On June 28, 2021, a spike alert was triggered for Arlington County, Virginia
- Public safety and health officials reached out to neighboring counties to identify scope of the spike
- Two other Northern Virginia counties reported higher than normal overdoses over the past weekend
- Arlington County stakeholders drafted a community alert and posted information on their coalition Facebook page, it included:
  - Information on the presence of Fentanyl
  - Local resources
  - Information on the local Safe Reporting of an Overdose Law



Arlington Addiction Recovery Initiative
June 28 ·

WARNING: There is a lethal batch of fentanyl in our region. There have been at least 15 deaths in the region (6 in Arlington alone) in the last two weeks due to this bad batch of Fentanyl

The fentanyl has been showing up in pressed pills (benzodiazepines and pain meds), marijuana and standalone fentanyl.

WHAT CAN YOU DO?

• Request free NARCAN through the mail at narcan@arlingtonva.us

• Purchase naloxone/NARCAN from a pharmacy (no prescription required), most insurances cover it with a co-pay (Medicaid plans cover in full with no copay)

• Connect with The Chris Atwood Foundation (call or text: 703-653-4221) and request Fentanyl test strips to practice harm reduction

• Practice harm reduction: Go slow, try a small amount first, never use alone, always have narcan nearby, and use the Never Use Alone Hotline (https://neverusealone.com)

• In the event of an overdose, call for help. The Safe Reporting of Overdose Law is in place to offer protection from prosecution: no individual is subject to arrest or prosecution for any substance related crimes (other substances, paraphernalia, public intoxication, under age drinking) if they call for help for someone who is overdosing or they themselves are overdosing

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Spike Alert Response Teams/Protocols

- Agencies create a tailored spike response program to ensure there is a quick response to increases or spikes in overdoses
- Should include public health, law enforcement, EMS, hospitals, and adjacent agencies (i.e. medical examiners/coroners and hospitals)
- Can set up spikes for any threshold on ODMAP, so agencies can be alerted based on their agency's prevention/response program

Outreach Teams

- Agencies can use ODMAP to identify cases in their specified jurisdiction
- Once an overdose is identified, they will connect with the reporting agency and implement their follow-up protocol
- Specific case information comes from the agency itself, not ODMAP

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

How You Can Get Started with ODMAP

- If you are part of an eligible agency, you can request agency access to ODMAP at odmap.org and complete the form
- Once approved, you can login and begin using ODMAP and all its features, like the National Map
- If you are part of an ODMAP agency, you can work with your admin to be added as a user using their agency code

Questions?

Thank you for attending the ODMAP presentation

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Ali Burrell
ODMAP Program Manager
aburrell@wb.hidta.org
Phone: 410-662-2355

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

THE WARREN ALPERT Medical School
BROWN UNIVERSITY

Rhode Island Hospital
A Lifespan Partner

Role of Funding Sources

Dr. del Pozo was supported by the National Institute on Drug Abuse (grant T32DA013911) and the National Institute of General Medical Science (grant P20GM125507). The institutes had no role in the preparation of this material, and the opinions expressed are the author's alone.

Conflicts of Interest

None to declare

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

THE WARREN ALPERT Medical School
BROWN UNIVERSITY

Rhode Island Hospital
A Lifespan Partner

Brandon del Pozo, PhD, MPA, MA

POLICE DEPARTMENT CITY OF NEW YORK

BURLINGTON POLICE VERMONT

VE RI TAS

JOHN JAY COLLEGE OF CRIMINAL JUSTICE

THE GRADUATE CENTER
CITY UNIVERSITY OF NEW YORK

Comprehensive Opioid, Stimulant, and Substance Abuse Program

1997-2015

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

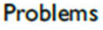
Chief of Police, 2015-2019

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Article

Contemporary Drug Problems
2022, Vol. 49(1) 3-19

DOI: 10.1177/00914509211052107
journals.sagepub.com/home/cdx



CommunityStat: A Public Health Intervention to Reduce Opioid Overdose Deaths in Burlington, Vermont, 2017–2020

Brandon del Pozo[1]

Abstract

From 2017 to early 2020, the US city of Burlington, Vermont led a county-wide effort to reduce opioid overdose deaths by concentrating on the widespread, low-barrier distribution of medications for opioid use disorder. As a small city without a public health staff, the initiative was led out of the police department—with an understanding that it would not be enforcement-oriented—and centered on a local adaptation of CompStat, a management and accountability program developed by the New York City Police Department that has been cited as both yielding improvements in public safety and overemphasizing counterproductive police performance metrics if not carefully directed.

BURLINGTON / DRUGS

Opioid Deaths Rise in Vermont but Plummet in Chittenden County

POSTED BY KATIE JICKLING ON THU, FEB 14, 2019 AT 5:59 PM

Howard Center CEO Bob Bick | KATIE JICKLING

Fatal opioid overdoses in Chittenden County decreased in 2018 to the lowest level in at least six years, local and state officials announced Thursday. The number of deaths fell by 50 percent, from 35 in 2017 to 17 last year.

From a randomized survey of 279 US chiefs of police

30. My police officers know how to effectively respond to **opioid** overdoses.

Strongly disagree 1 2 3 4 5 6 7 Strongly Agree

31. My police officers know how to effectively respond to **methamphetamine** overdoses.

Strongly disagree 1 2 3 4 5 6 7 Strongly Agree

Meth	5.19
Opioids	5.73

Meth 95% CI	4.99 - 5.40
Opioids 95% CI	5.53 - 5.93

Preliminary data; please do not cite or circulate

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

From a randomized survey of 279 US chiefs of police

30. My police officers know how to effectively respond to **opioid** overdoses.

Strongly disagree 1 2 3 4 5 6 7 Strongly Agree

31. My police officers know how to effectively respond to **methamphetamine** overdoses.

Strongly disagree 1 2 3 4 5 6 7 Strongly Agree

	Opioids	Meth	Diff.
Northeast	6.05	4.80	(1.25)
South	5.39	5.05	(0.34)
Midwest	5.69	5.31	(0.39)
West	6.07	5.93	(0.13)

Preliminary data; please do not cite or circulate

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

SUBSTANCE USE & MISUSE
2018, VOL. 53, NO. 2, 330–333
https://doi.org/10.1080/10826084.2017.1363238

Taylor & Francis
Taylor & Francis Group

COMMENTARY

Barriers to Medications for Addiction Treatment: How Stigma Kills

Sarah E. Wakeman[a,b,c] and Josiah D. Rich[c,d]

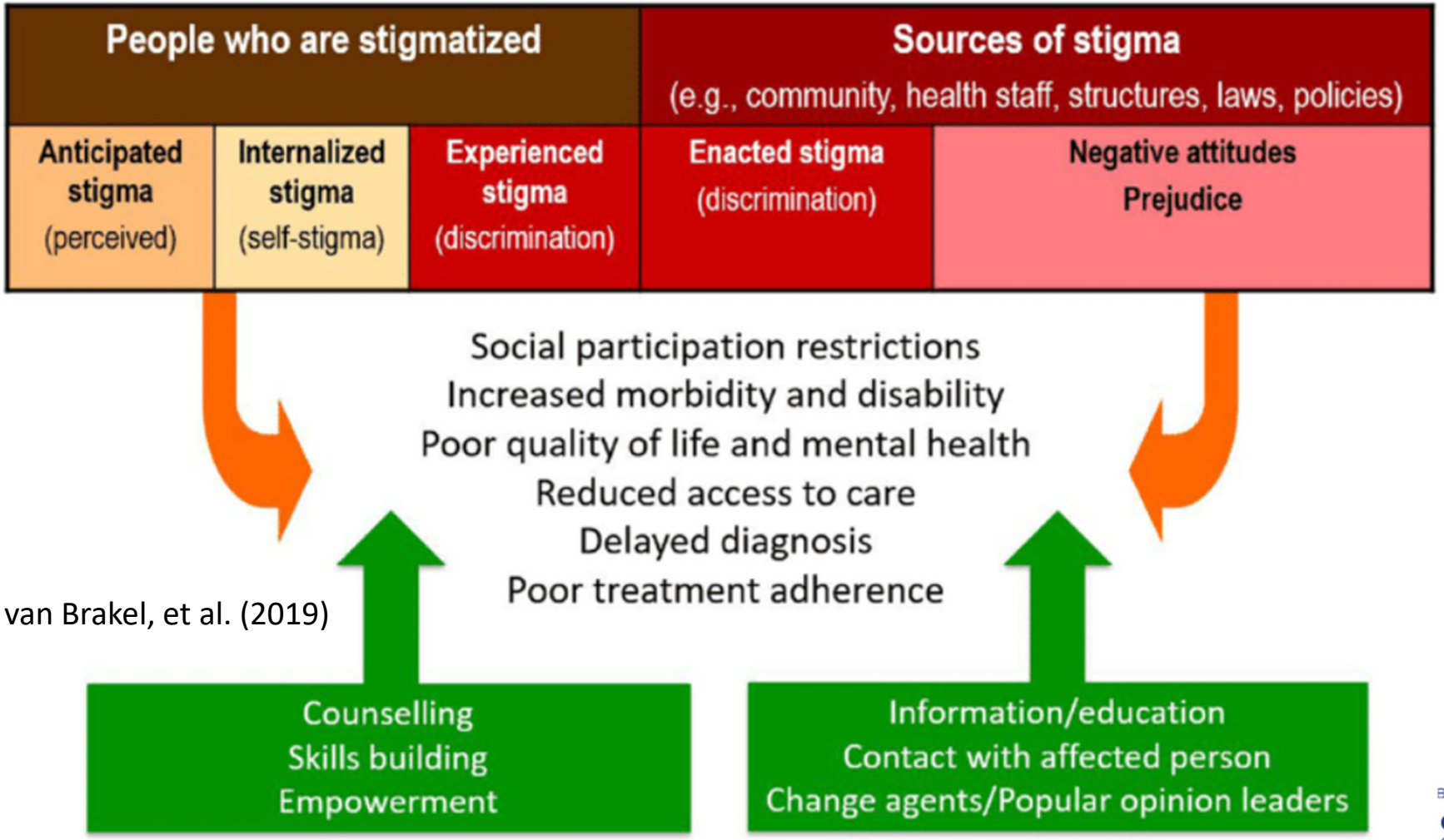
[a]Massachusetts General Hospital, Department of Medicine, Boston, Massachusetts, USA; [b]Harvard Medical School, Department of Medicine, Boston, Massachusetts, USA; [c]Center for Prisoner Health and Human Rights, Providence, Rhode Island, USA; [d]Warren Alpert Medical School of Brown University, Department of Medicine, Providence, Rhode Island, USA

Background on Stigma

- At least 20 million Americans struggle with substance misuse and substance use disorder
- People who use drugs (PWUD) are highly stigmatized, resulting in poorer health outcomes
- People continue to be blamed for their disorders, based on false beliefs about willpower
- PWUD may lie, steal, or behave aggressively, contributing to and reinforcing stigma
- Stigma affects PWUD decisions to seek help/engage with others; harms psychological well-being
- PWUD who internalize stigma are more likely to continue taking drugs, exacerbating the problem
- The study of stigma is an emerging field in its earliest stages; more research is critical

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Volkow, 2020



van Brakel, et al. (2019)

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

International Journal of
Police Science
& Management

Original Article

Police officers, stigma, and the opioid epidemic

International Journal of
Police Science & Management
1–14

DOI: 10.1177/1461355720962524
journals.sagepub.com/home/psm
SAGE

Nathan E Kruis, Jaeyong Choi, Richard H Donohue

Ab

Researchers have suggested that provider-based stigma of substance use disorders is one barrier to fighting the opioid epidemic. Yet, to date, virtually no study has examined provider-based stigma among law enforcement officers who are on the front line of the opioid crisis. This study attempts to fill this gap in the literature by assessing provider-based stigma toward opioid-using persons among a sample of 208 police officers working for departments located in the Northeastern Region of the United States. Results show that officers hold relatively high levels of stigma toward this vulnerable population, as measured by perceptions of dangerousness, blame, and social distance; however, comparatively, officers hold less fatalistic views toward this group of persons. Additionally, our multivariable analyses indicated that officer rank, support for the disease model of addiction, and beliefs about the demographic characteristics of a substance-using person are significantly associated with provider-based stigma among officers. Potential policy implications are discussed within.

Prior Research on Police Stigma

- In a survey of police, researchers found officers were susceptible to high levels of stigma against people with OUD, similar to the population at large
- In a survey of officers, 65% agreed “People who become addicted to opioids are to blame for their own condition.”
- Officers with biological perspectives on PWUD drugs favor effective treatment
- Officers with moralistic perspectives favor punitive practices over treatment

Del Pozo, 2021; Kruis et al., 2008; Murphy & Russel, 2021; Watson et al., 2005

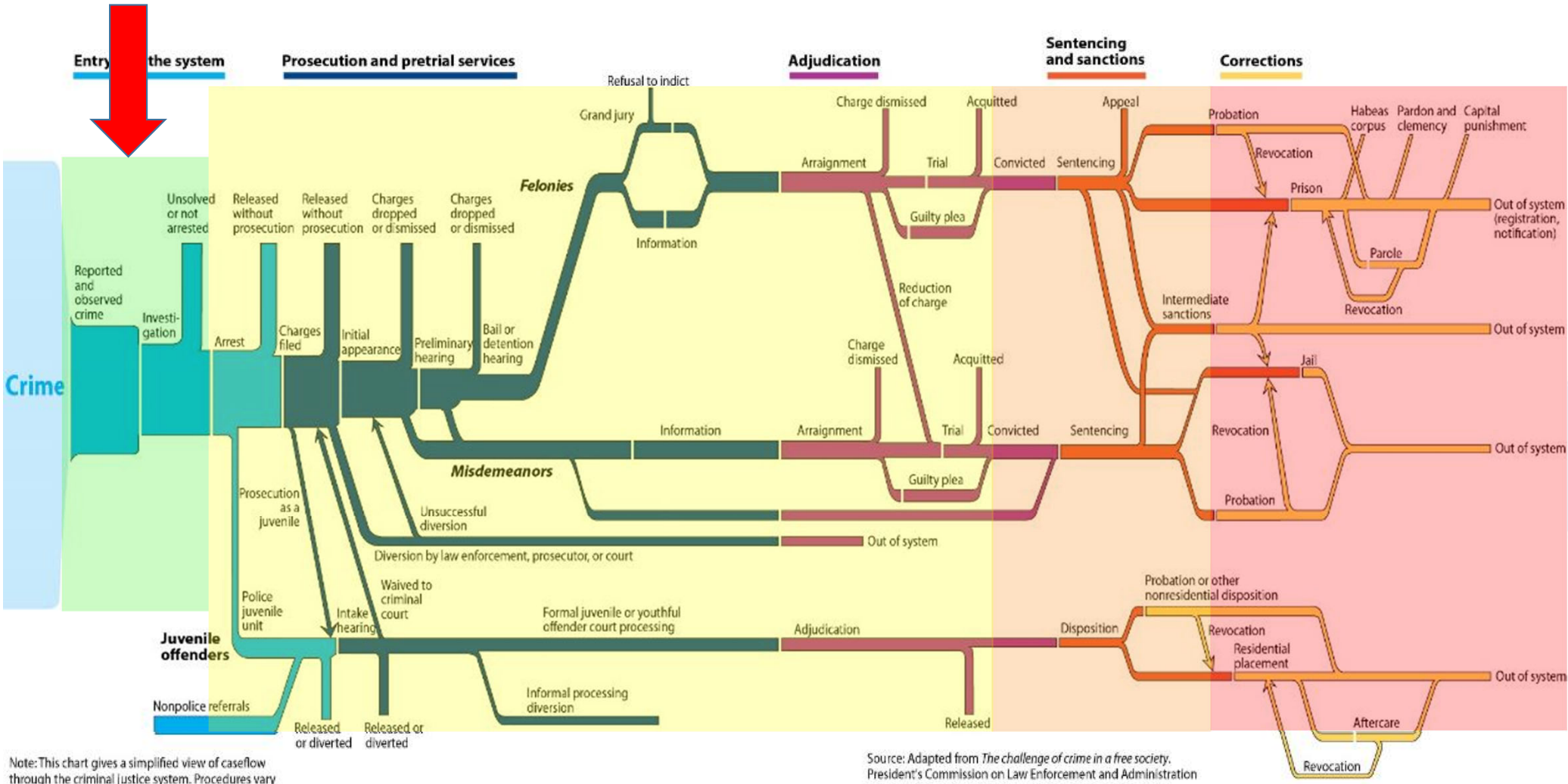
BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Police and Stigma

- Police officers encounter PWUD, frequently and under a range of circumstances
- Police have varying knowledge, beliefs, and attitudes toward PWUD, treatment, harm reduction; there is little consistency
- PWUD are often subject to criminalization, incarceration, and police mistrust, which creates a cycle of stigma
- Chauvin defense case in death of George Floyd showed stigma again PWUD, particularly people of color, can be used to justify use of force (e.g., “excited delirium”).

Baker et al., 2019; Galea & Vlahov, 2002; Mann, 2021

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program



Note: This chart gives a simplified view of caseflow through the criminal justice system. Procedures vary among jurisdictions. The weights of the lines are not intended to show actual size of caseloads.

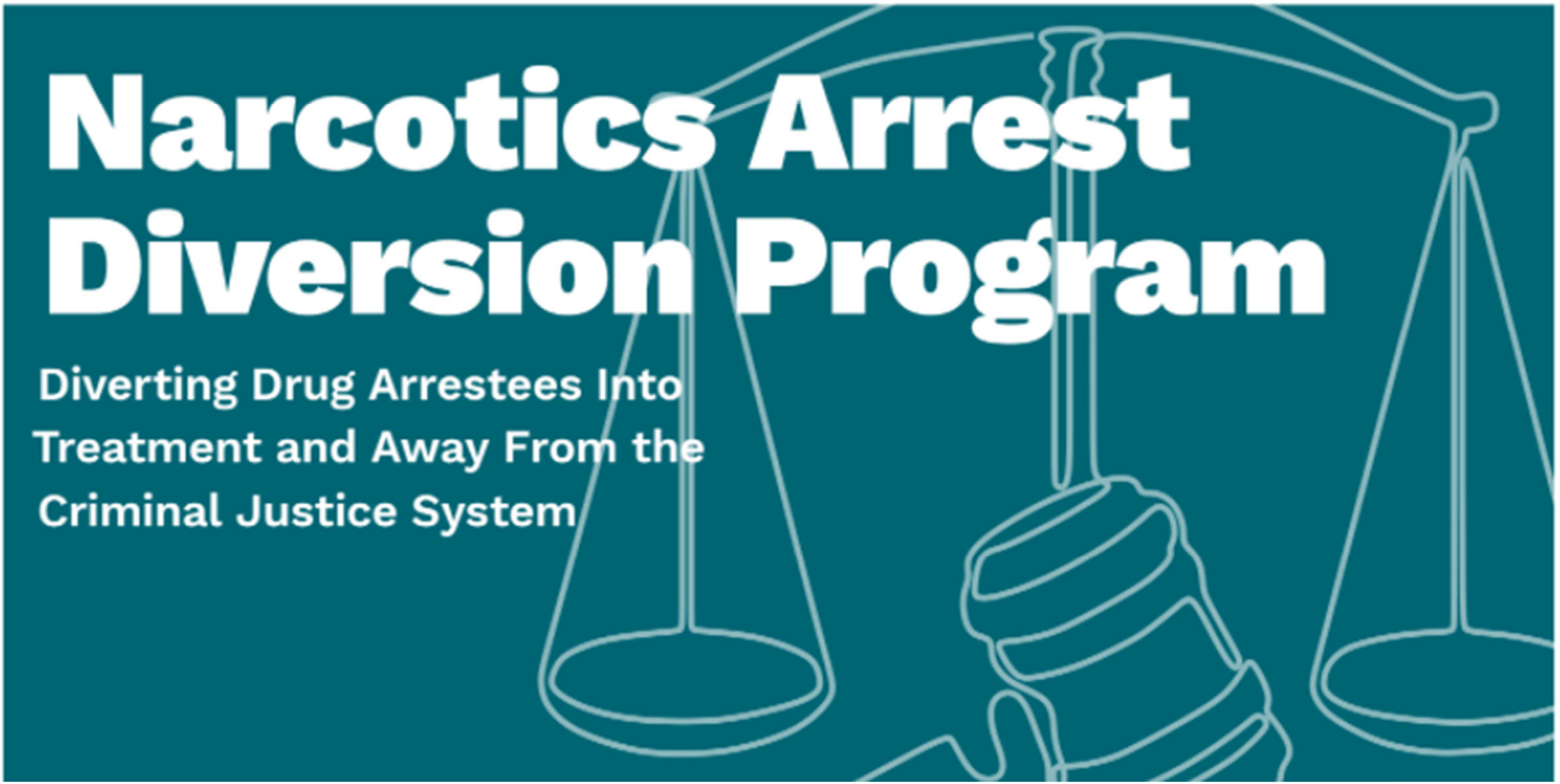
Source: Adapted from *The challenge of crime in a free society*. President's Commission on Law Enforcement and Administration of Justice, 1967. This revision, a result of the Symposium on the 30th Anniversary of the President's Commission, was prepared by the Bureau of Justice Statistics in 1997.

RESEARCH BRIEF: ADVANCING JUSTICE
November 2021

UCHICAGO URBANLABS CRIME LAB

Narcotics Arrest Diversion Program

Diverting Drug Arrestees Into Treatment and Away From the Criminal Justice System



TEMPLE UNIVERSITY

Steven Belenko, Ph.D.
Professor

In a 1999 article in the *Albany Law Review* entitled "The Challenges of Integrating Drug Treatment into the Criminal Justice Process," I remarked that pre-arrest diversion "offers the earliest intervention opportunity and thus the greatest potential for minimizing unnecessary costs to the criminal justice system, and helps the offender avoid the stigma associated with arrest and prosecution." The challenge, I observed, lies in "relying on a law enforcement officer to make a quick judgment about a suspect's suitability for treatment, and the potential for discriminatory behavior or abuse of authority stemming from broad police discretion."

Twenty-two years later, we are facing the worst opioid overdose crisis ever recorded, and the number of communities practicing or considering pre-arrest diversion is expanding. Yet, after two decades, we have made little scientific progress in understanding how police knowledge, attitudes and beliefs shape the discretionary decisions officers make to connect people to treatment rather than arrest. These are decisions that directly affect the health of this vulnerable population, as well as the efficiency and fairness of the criminal justice system. I am therefore very pleased to see that

Harm Reduction Journal

Research | Open Access | Published: 16 December 2021

Police discretion in encounters with people who use drugs: operationalizing the theory of planned behavior

Brandon del Pozo, Emily Sightes, Jeremiah Goulka, Brad Ray, Claire A. Wood, Saad Siddiqui & Leo A. Beletsky

Across the sites, 259 respondents perceived control over their decision to arrest for misdemeanors (69%) and confiscate items such as syringes (56%). Beliefs about others' approval of referrals to treatment, its ability to reduce future arrests, and to increase trust in police were associated with stated practices of nonarrest for drug and possession and making referrals ($p \leq .001$), and nonarrest for syringe possession ($p \leq .05$). Stigma a towards PWUD was negatively associated with stated practices of nonarrest ($p \leq .05$). Respondents identified supervisors as having the most influence over use of discretion, seriousness of the offense as the most influential value, and attitude of the suspect as the most important situational factor. The 17 Likert scale items analyzed had a Cronbach's alpha of 0.81.

Police discretion in encounters with people who use drugs

Table 1. Officers' perceived control over decisions to arrest and confiscate in drug-related encounters (1-6 Likert scale) (N=259)

Enforcement type	Mean (SD)	No control (1)	Lack of control (1-3)	Some control (4-6)	Total Control (6)
Control over arrest	4.42 (1.56)	16 (6%)	79 (30%)	179 (69%)	90 (35%)
Control over confiscation	3.96 (1.79)	38 (13%)	114 (44%)	145 (56%)	79 (31%)

Reported discretionary behaviors concerning drug-related arrests and confiscation (1-6 Likert scale) (N=173)

Discretionary behavior	Mean (SD)	Always (1)	Inclined toward (1-3)	Inclined against (4-6)	Never (6)
Confiscate naloxone	5.50 (1.22)	6 (3%)	16 (9%)	157 (91%)	140 (81%)
Confiscate syringes	2.35 (1.72)	81 (47%)	139 (80%)	34 (20%)	22 (13%)
Not arrest for syringe poss.	3.20 (1.75)	44 25%)	108 62%)	65 (38%)	27 (16%)
Not arrest for drug poss.	3.87 (1.68)	21 (12%)	78 (45%)	95 (55%)	40 (23%)
Refer to treatment/nalox.	2.94 (1.76)	44 (25%)	123 (71%)	50 (29%)	29 (17%)

Table 3. Approval of treatment as an alternative to arrest and beliefs about addiction and treatment (1-6 Likert scale) (N=173)

	Mean (SD)	Very likely (1)	Likely (1-3)	Unlikely (4-6)	Not at all likely (6)
Supervisors would approve of referrals	2.64 (1.65)	60 (35%)	130 (75%)	43 (25%)	18 (10%)
Coworkers would approve of referrals	2.67 (1.58)	50 (29%)	131 (76%)	42 (24%)	17 (10%)
Friends/neighbors would approve	2.67 (1.53)	49 (28%)	128 (74%)	45 (26%)	12 (7%)
Referrals reduce future arrests	2.83 (1.30)	29 (17%)	134 (77%)	39 (23%)	10 (6%)
Referrals increase trust in police	2.69 (1.32)	36 (21%)	139 (80%)	34 (20%)	8 (5%)

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Subjective norms influencing discretionary drug enforcement (1-6 Likert scale) (N=259)

a. Normative values at work in making a discretionary arrest

Rank	Factor	Mean position (SD)	95% Confidence interval
1	Seriousness of the offense	1.38 (0.70)	1.30-1.47
2	If effective alternatives exist	2.65 (0.97)	2.53-2.77
3	The need for there to be consequences	2.97 (0.82)	2.87-3.07
4	Arrests should be made when laws are broken	3.00 (1.08)	2.86-3.13

b. Influence of the expectations of others in making a discretionary arrest

Rank	Factor	Mean position (SD)	95% Confidence interval
1	Expectations of supervisor(s)	1.90 (0.82)	1.80-2.00
2	Expectations of colleagues/peers	2.61 (0.95)	2.50-2.73
3	Expectations of friends/family	2.69 (0.98)	2.54-2.84
4	Expectations of community	2.80 (1.18)	2.65-2.94

c. Influence of situational factors in making a discretionary arrest

Rank	Factor	Mean Position (SD)	95% Confidence Interval
1	Attitude of the suspect	1.63 (0.71)	1.54-1.72
2	Personal sense of right and wrong	2.04 (1.02)	1.91-2.16
3	Suspect hasn't learned their lesson yet	2.72 (0.84)	2.62-2.82
4	Personal factors (overtime/work schedule)	3.69 (0.69)	3.53-3.70

	Mean (SD)	Strongly agree (1)	Agree (1-3)	Disagree (4-6)	Strongly disagree (6)
People addicted to opioids are to blame for their own condition	3.22 (1.30)	15 (9%)	112 (65%)	61 (35%)	12 (7%)
People addicted to opioids won't hesitate to lie when it benefits their addiction.	2.35 (1.53)	66 (38%)	138 (80%)	35 (20%)	11 (6%)
I would worry about a person in recovery for opioid addiction taking care of my family' s children for a few hours	2.66 (1.67)	65 (38%)	126 (73%)	47 (27%)	17 (10%)
People become addicted to opioids because they lack the willpower to stop before it's too late.	3.76 (1.55)	16 (9%)	81 (47%)	92 (53%)	29 (17%)
Opioid/heroin users will use more opioids/heroin if they know they have access to naloxone	3.44 (1.57)	22 (13%)	96 (55%)	77 (45%)	25 (14%)
Harm reduction services that distribute items such as syringes and naloxone condone a person's addiction	3.83 (1.63)	18 (10%)	76 (44%)	97 (56%)	39 (23%)
There should be a limit on the number of times one person receives naloxone to reverse an overdose	4.39 (1.75)	16 (9%)	56 (32%)	117 (68%)	76 (44%)
Everyone at risk of experiencing or witnessing an overdose should be given a supply of naloxone	2.56 (1.54)	57 (33%)	135 (78%)	38 (22%)	12 (7%)
People can successfully overcome an opioid addiction	2.14 (1.23	65 (38%)	155 (90%)	17 (10%)	6 (3%)
An officer who completed treatment for addiction to prescription opioid pills could be trusted to return to duty	2.90 (1.22)	22 (13%)	127 (73%)	46 (27%)	4 (2%)

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Study Design

Online survey administered using Qualtrix; police chiefs were contacted and opted in

Sample size: **248**

Asked officers about:

- Views of PWUD, those with OUD
- Police officer decision making regarding arrest, confiscation, and referrals to treatment
- Police resources in response to addiction and overdose
- Knowledge of science of substance use disorder, OUD, SUD, MOUD
- Harm reduction measures and techniques

Sample Characteristics (*N* = 24

Years in policing	Stage	Percent of sample
0-3 Years	Rookie	10%
4-7 Years	Early career	13%
8-15 Years	Mid career	21%
16-25 Years	Veteran	40%
>25 Years	Retirement eligible	16%

Race
Black
White
Other/Multiple

Education
HS/some college
Associate's
Bachelor's +

Rank	Percent
Officer	50%
Detective	19%
Sergeant or Lieutenant	21%
Captain/Executive	7%

Gender: male 84%, female 13%

Dept. Size	Percent
Small	19%
Medium	40%

Urban/Rural
Urban
Rural

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Do Illinois police perceive having discretion?

Whether or not I arrest a suspect for a nonviolent misdemeanor is:

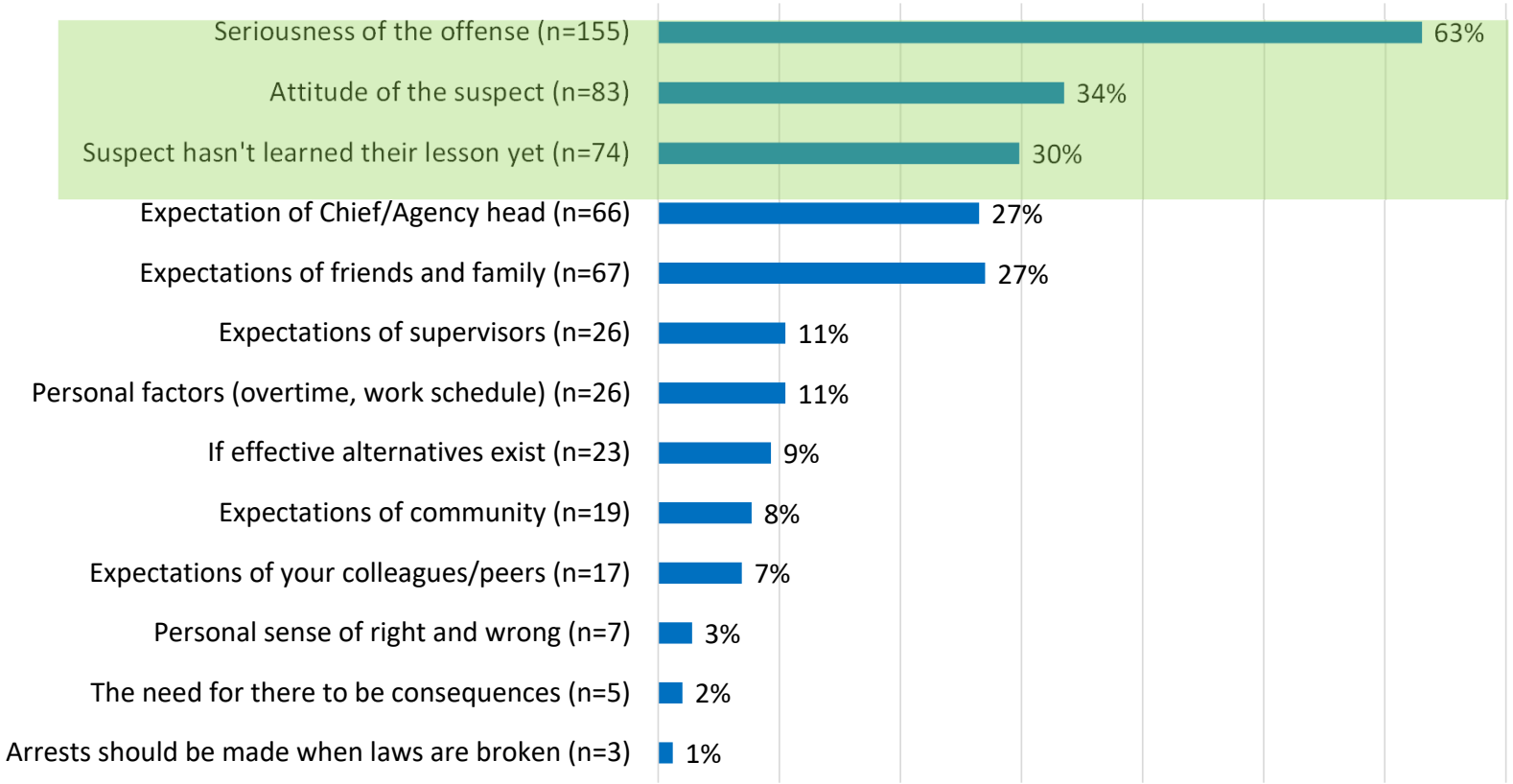
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Entirely under my control	18	7.3	7.3	7.3
	Under my control	63	25.4	25.4	32.7
	Somewhat under my control	98	39.5	39.5	72.2

Whether or not I confiscate items such as syringes or unprescribed addiction medication is:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Entirely up to me	15	6.0	6.0	6.0
	Up to me	46	18.5	18.5	24.6
	Somewhat up to me	64	25.8	25.8	50.4

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

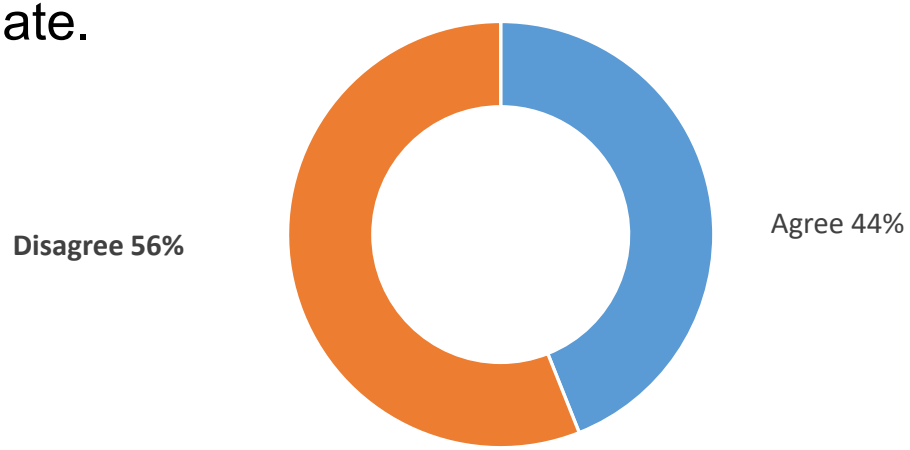
What influences police discretion?
Rank ordered, top factors



BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Officer views on PWUD (n = 213)

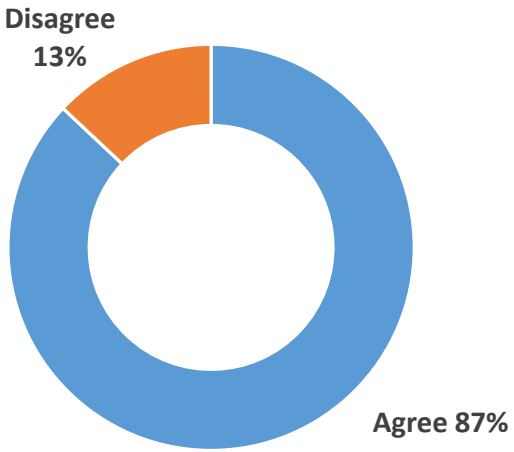
People get addicted to opioids because they
lack the willpower to stop
before it's too late.



BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Officer Views on PWUD (n = 213)

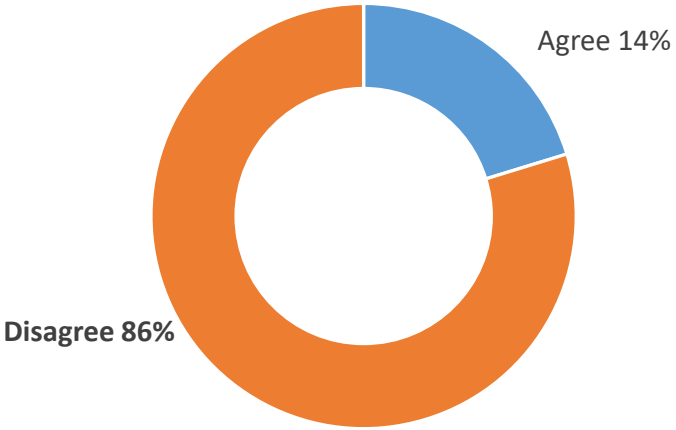
People who are addicted to opioids
won't hesitate to lie
when it benefits their addiction.



BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Officer Views on PWUD (n = 213)

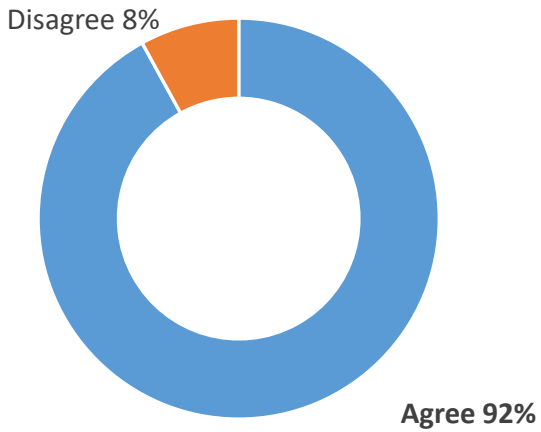
People who become addicted
can't really be blamed
for their own condition.



BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

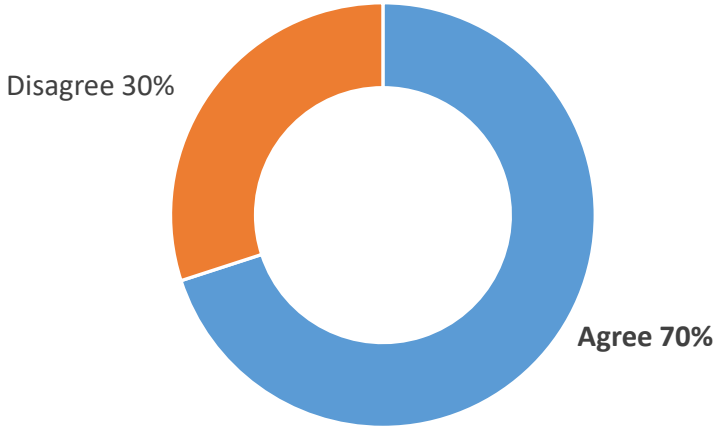
Officer views on PWUD (n = 213)

I would worry about a person in recovery
taking care of my family's children
for a few hours.



Officer Views on PWUD (n = 213)

A police officer who completed treatment for addiction could be trusted to return to duty as an officer.



BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Officer Views on PWUD (n = 213)

When a person with an opioid addiction is in your life, you need to be on guard for what they might do:

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	48	19.4	19.4	19.4
	Agree	91	36.7	36.7	56.0
	Somewhat agree	58	23.4	23.4	79.4

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Officer Characteristics and Stigma Item Responses

		Agree	Disagree	
	Education	%	%	Chi-square tests
PWUD addicted because they lack willpower to stop	Less than bachelor's	**56.7%**	43.3%	X^2 (1, N = 213) = 5.323, ***p* = 0.021**
	Bachelor's or higher	39.2%	60.8%	
	Education			
PWUD won't hesitate to lie	Less than bachelor's	**95.0%**	5.0%	X^2 (1, N = 213) = 4.854, ***p* =0.028**
	Bachelor's or higher	83.7%	16.3%	
	Race			
PWUD are the ones to blame for their own condition	White	**15.8%**	84.2%	X^2 (1, N = 213) = 4.326, ***p* = *0.038***
	Non-White	2.8%	97.2%	
	Rurality			
Officers who completed treatment can be trusted to return to duty	Urban	**73.9%**	26.1%	X^2 (2, N = 213) =6.998, ***p* = *0.030***
	Rural	46.2%	53.8%	

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Discussion

Of statistically significant associations

A higher proportion of officers…

- With less formal education (not a college degree or higher) agreed PWUD have a lack of willpower, lying
- Who were white (rather than non-white) agreed PWUD are to blame for their own condition
- From urban departments (not rural) agreed that after treatment officers can return to duty

Implications: How do we mitigate stigma?

With the public:

- Use non-stigmatizing language
- Educational leaflets inform, reduce stigma
- Use messaging that “treatment works”
- Emphasize situational, environmental factors over behavioral to explain substance use

For PWUD:

- Acceptance and Commitment Therapy (ACT) decreases self-stigma
- Peer educator programs connect PWUD to harm reduction services

For officers:

- Training, support for own behavioral health issues
- Facilitate social contact with persons in recovery, lived experience
- CIT and other training

Bahora et al., 2007; Csete & Wolfe, 2017 ; Latkin et al., 2019; Livingston et al., 2012; Luomo et al., 2009; Luty et al., 2018; McGinty et al., 2014; McGinty & Barry, 2020; PTTC, 2020

From a randomized survey of 279 US chiefs of police

32.If there was a way to de-escalate people high on **methamphetamines** and get them to medical treatment, I'd implement it.

Strongly disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Strongly Agree | Don't know

	Opioids
Northeast	5.81
South	5.68
Midwest	5.99
West	6.14

Preliminary data; please do not cite or circulate

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

2021 Public Safety and Public Health Partnerships Workshop: *Findings & Recommendations*

Meeting Summary

- Discussion of impacts of stimulants in communities across the country
- Stimulants represent the fourth wave of the overdose epidemic [1]
- Response to front line workers → need to extend focus beyond opioids
- Highlight innovative and collaborative programs/practices to respond, and intersections of public safety and public health
- Representatives from law enforcement, researchers and public health officials, and service providers

1. Ciccarone, 2021

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Panel Discussion Highlights

- Arrest and incarceration are not viable solutions to substance use disorders
- Law enforcement buy-in
- Limitations in data *collaboration*
- Specific discussions about juveniles
  - Deflection programs and need the right partners
- Need to consider the effects of structural issues
- Provide recovery and treatment options before leaving the hospital – doctors need training too
- Unintended consequences of mass seizures
  - Significant spikes in overdoses, need outreach before major drug bust

Key Recommendations

1. Pre-Arrest Deflection Programs

2. Better Data Collection

3. Increase Community Awareness

4. Access to Harm Reduction Programming

5. Research on MAT for stimulants

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

2. Better Data Collection

- Data should be collected in a standardized, central location that is accessible by relevant stakeholders or easily shared.
- Timeliness
- Policies for promoting data sharing
- Measuring the effects of illicit supply networks

3. Increase Community Awareness

- Create academy and in-service training on SUD and include the causes and risk factors for SUD.
- Develop outreach programs in areas where misuse and abuse of substances is most common.
- Training and awareness for stigma reduction for the public and for practitioners

5. Research on MAT for stimulants

- Create academy and in-service training on SUD and include the causes and risk factors for SUD.
- Develop outreach programs in areas where misuse and abuse of substances is most common.
- Training and awareness for stigma reduction for the public and for practitioners

https://cossapresources.org/Program/TTA

If you are interested in requesting training and technical assistance, please complete the form at https://www.cossapresources.org/Program/TTA

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

COSSAP Resources

Tailored Assistance—The COSSAP training and technical assistance (TTA) program offers a variety of learning opportunities and assistance to support local, tribal, and state organizations, stakeholders, and projects in building and sustaining multidisciplinary responses to the nation's substance abuse crisis. ***You do not need to be a COSSAP grantee to request support***. TTAs are provided in a variety of formats, including virtual and in-person training events, workshop and meeting presentations, and online resources. Request TTA to support your activities at https://cossapresources.org/Program/TTA/Request.

Funding Opportunities—Current COSSAP and complementary funding opportunities are shared at https://www.cossapresources.org/Program/Applying.

Join the COSSAP community! Send a note to COSSAP@iir.com with the subject line "Add Me" and include your contact information. We'll be happy to ensure you receive the latest-and-greatest COSSAP opportunities, resources, and updates.

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program


BJA's
Comprehensive
Opioid, Stimulant,
and Substance Abuse
Program