Law Enforcement & Corrections Track

Takeaways from the HIDTA/CDC Heroin Response Strategy and an Assessment of 911 Good Samaritan Laws

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Disclosures

- Chauncey Parker, JD; Rita Noonan, PhD; Jennifer J. Carroll, PhD, MPH; and Jessica Wolff, MPH, have disclosed no relevant, real, or apparent personal or professional financial relationships with proprietary entities that produce healthcare goods and services.
Disclosures

- All planners/managers hereby state that they or their spouse/life partner do not have any financial relationships or relationships to products or devices with any commercial interest related to the content of this activity of any amount during the past 12 months.

- The following planners/managers have the following to disclose:
  - Kelly J. Clark, MD, MBA, FASAM, DFAPA – Consulting fees: Braeburn, Indivior
Learning Objectives

 Explain the HIDTA Heroin Response Strategy.
 Outline two examples of the HIDTA Heroin Response Strategy Cornerstone Projects (process, findings, actions).
 Evaluate the possibility of implementing a Cornerstone Project in your region.
 Identify regional and environmental (i.e. urban/rural) patterns in law enforcement knowledge, attitudes and behaviors related to 911 Good Samaritan Laws.
 Describe patterns and variations in the implementation of law enforcement policies and procedures related to 911 Good Samaritan Laws.
 Identify patterns in the effect of 911 Good Samaritan Laws on patterns of opioid overdose and overdose related 911 calls.
An Overview of The Heroin Response Strategy

Investing in partnerships to build safe and healthy communities
A Shared Goal

**Vision:** The Heroin Response Strategy (HRS) is committed to creating overdose-free communities

**Mission:** The mission of the HRS is to reduce fatal and non-fatal opioid overdoses by developing and sharing information about heroin and other opioids across agencies and by offering evidence-based intervention strategies.
What is the Heroin Response Strategy?

- **Local Innovation**
  - COOCLI Grants
  - Pilot Projects

- **State Teams**
  - Drug Intelligence Officer
  - Public Health Analyst

- **Cornerstone Projects**
  - Fentanyl report (2016)
  - 911 Good Samaritan Laws (2017)
HRS Strategic Directions

- Law Enforcement
- Response
- Treatment & Recovery
- Prevention
Encouraging Local Innovation

- Medication-Assisted Treatment (MAT) in Jails and Prisons
- Diversion and Court Programs
- Peer Recovery Coaches
- MAT Referral in Emergency Departments
- Local Public Health and Public Safety Partnerships
State Teams: Building Capacity

- Intelligence Sharing
- Overdose Data Analysis

Data Sharing

- Overdose Spike Protocols
- Post Overdose Follow-Up

Strategic Responses

- Coalition Building
- Engaging Stakeholders

Engaging Local Communities

- Local Resources
- Community Education

Opioid Misuse Prevention
HRS Cornerstone Projects

Coordination and collaboration in research for opioid overdose prevention
Purpose of Cornerstone Projects

- Enhanced and purposeful PHA/DIO collaboration
- Mobilize the entire HRS to explore evidence-based responses to overdoses
- First Cornerstone was the Fentanyl Project
- Topics selected by HIDTA Directors and CDC
- Produce deliverables highlighting HRS work
What are 911 Good Samaritan Laws (GSLs)?

- Policies that provide legal protections for individuals who call for emergency assistance in the event of a drug overdose
- Vary by state
  - Arrest, Charge, Prosecution, Paraphernalia, Parole Violations, Etc.
- Designed to encourage people to summon emergency assistance if they experience or witness an overdose
- All HRS states have a GSL in place except Maine
Methodology

- Interviews with law enforcement leaders
  - PHA/DIO teams asked to conduct semi-structured interviews with chiefs, sheriffs, etc., in their state.
  - Target: 10 interviews per state
  - Approx. 120 interviews conducted

- Police survey
  - Intended for patrol officers who respond to service calls
  - Designed to capture Knowledge/Attitude/Behavior
  - Circulated among departments with permission of leadership
  - Collected anonymously
  - Over 3,000 respondents
# Survey Demographics

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>38.5</td>
</tr>
<tr>
<td>County</td>
<td>22.4</td>
</tr>
<tr>
<td>State</td>
<td>19.1</td>
</tr>
<tr>
<td>Town</td>
<td>18.6</td>
</tr>
<tr>
<td>Village</td>
<td>1.4</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Number of officers in agency</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>9 or less</td>
<td>1.5</td>
</tr>
<tr>
<td>10-19</td>
<td>4.3</td>
</tr>
<tr>
<td>1/ ,38</td>
<td>19.9</td>
</tr>
<tr>
<td>4/ ,88</td>
<td>11.8</td>
</tr>
<tr>
<td>0/ / ,388</td>
<td>22.0</td>
</tr>
<tr>
<td>500 or more</td>
<td>40.6</td>
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</table>

<table>
<thead>
<tr>
<th>Years in public safety</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or less</td>
<td>38.2</td>
</tr>
<tr>
<td>00,1/</td>
<td>37.2</td>
</tr>
<tr>
<td>10,2/</td>
<td>20.5</td>
</tr>
<tr>
<td>20,3/</td>
<td>4.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or less</td>
<td>6.1</td>
</tr>
<tr>
<td>15,23</td>
<td>28.5</td>
</tr>
<tr>
<td>24,33</td>
<td>32.3</td>
</tr>
<tr>
<td>34,44</td>
<td>26.8</td>
</tr>
<tr>
<td>55 or more</td>
<td>4.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>84.8</td>
</tr>
<tr>
<td>Female</td>
<td>9.4</td>
</tr>
</tbody>
</table>
Descriptive Statistics: Naloxone Training/Use

Received OD response training?
- City, Town, Village = 90%
- County = 80%
- State = 50%

Officers carry naloxone?
- Town = 90%
- City, County = 80%
- Village = 70%
- State = 31%

How does carrying naloxone affect your ability to protect and serve the public?
- Improves: 48%
- No Diff: 42%
- Worsens: 10%

What are your fellow officers’ opinions about carrying naloxone?
- Positive: 29%
- Mixed: 49%
- Negative: 22%
Data from Interviews: Naloxone Training/Use

- Law enforcement leaders overwhelmingly supportive of naloxone carry and administration across the HRS
- The majority reported no liability concerns related to naloxone carry.
- A few liability concerns voiced. Rare, not concentrated in any one region
  - Are officers liable if they don’t use naloxone correctly?
  - What if an officer uses naloxone and the individual still dies?
  - Is naloxone safe to carry if an officer has kids in the house?
- A minority believe that carrying naloxone encourages risk taking among people who use drugs. (It doesn’t).
### Descriptive Statistics: Naloxone Training/Use

<table>
<thead>
<tr>
<th></th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Town</th>
<th>Village</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am worried about the liability of police officers who carry and/or administer naloxone.</td>
<td>54.0</td>
<td>56.4</td>
<td>64.6</td>
<td>39.0</td>
<td>35.0</td>
</tr>
<tr>
<td>Programs that train and distribute naloxone to lay community members to treat overdose save lives.</td>
<td>72.6</td>
<td>77.0</td>
<td>82.3</td>
<td>84.0</td>
<td>82.5</td>
</tr>
<tr>
<td>Programs that train and distribute naloxone to lay community members may encourage opioid use by sending the message that drug use is OK.</td>
<td>71.3</td>
<td>66.3</td>
<td>33.7</td>
<td>55.3</td>
<td>55.0</td>
</tr>
</tbody>
</table>
Descriptive Statistics: 9-1-1 Good Samaritan Laws

- Does your state have a GSL?
  - 90% correct
  - Most scored >95%

- Does your GSL protect against arrest?
  - 54% correct
  - Highest: N. Jersey, Maryland = 87-88%

- Does your GSL protect against charges?
  - 56% correct
  - Highest: N. Hampshire, Pennsylvania, >90%
Data from Interviews: 9-1-1 Good Samaritan Laws

- Law enforcement leadership is split on whether the law hinders policing or helps police by providing new tools and alternatives

- Favorable view of GSLs:
  - Increases 9-1-1 calls
  - Enhances community trust and linkage to treatment
  - Little change in policing, followed “spirit” of the law prior to its enactment

- Less favorable view of GSLs:
  - No effect on overdoses or 9-1-1 calls
  - Removes all coercive tools (threat of arrest, compulsory treatment) leaving police unable to do anything
# Number of Overdose Calls in Past 6mo

<table>
<thead>
<tr>
<th></th>
<th>City N = 1087</th>
<th>County N = 633</th>
<th>State N = 540</th>
<th>Town N = 524</th>
<th>Village N = 40</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8.3%</td>
<td>22.9%</td>
<td>84.0%</td>
<td>22.5%</td>
<td>17.1%</td>
<td>29.3%</td>
</tr>
<tr>
<td>1-5</td>
<td>36.1%</td>
<td>33.6%</td>
<td>8.5%</td>
<td>53.4%</td>
<td>60.0%</td>
<td>33.7%</td>
</tr>
<tr>
<td>6-10</td>
<td>19.1%</td>
<td>17.5%</td>
<td>4.6%</td>
<td>15.7%</td>
<td>17.1%</td>
<td>15.2%</td>
</tr>
<tr>
<td>11-25</td>
<td>23.4%</td>
<td>16.6%</td>
<td>2.0%</td>
<td>6.6%</td>
<td>5.7%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>
Data from Interviews: Overdose Response

- Significant variation in officers’ discretion to arrest at the scene
- Treating fatal OD as homicides is now the norm
- Knowledge of GSL provisions is mixed
  - Some underestimate the law’s protections
  - Some overestimate the law’s protections
- Law enforcement leadership is overwhelmingly supportive of police involvement in post-OD outreach, but, per the survey, patrol officers are not
### Descriptive Statistics: Overdose Response

<table>
<thead>
<tr>
<th></th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Town</th>
<th>Village</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrest can play an important role in helping drug users change their behavior.</td>
<td>77.2</td>
<td>74.9</td>
<td>77.0</td>
<td>72.5</td>
<td>80.0</td>
</tr>
<tr>
<td>Opioid misuse is a disease that should be dealt with through treatment and support services.</td>
<td>52.3</td>
<td>60.7</td>
<td>69.7</td>
<td>67.2</td>
<td>59.0</td>
</tr>
</tbody>
</table>
Ideal Pathway of Care Post-Overdose (as imagined by most...)

GSL

Overdose → 9-1-1 → First Responders → Hospital? → Peer/Follow-up → Care for SUD
Data from interviews: Post-OD Follow-up

- Law-enforcement leadership overwhelmingly agrees that law enforcement *should* be involved in post-overdose follow up
- Some feel that law enforcement shouldn’t be involved in outreach, but they are in the minority
- Some are aware of problems with treatment capacity, concerned that there may be nowhere to direct victims toward
- A small number report hosting AA and NA meetings in their departments
LEO Perceptions of who should be involved in post-OD follow-up
Who has “boots on the ground”?
Interview Data: Most common frustrations, per leadership

- Individuals overdosing multiple times
  - “[We keep] bringing people back who are ruining their own lives”
- Overdose victims released from hospital (or leaving AMA) without linkage to care
- No consequences for overdose victims
  - “Addicts need to be held accountable”
  - People are “taking advantage of the [GSL] law”
- Financial burdens of naloxone carry and overdose response
Ideal Pathway of Care Post-Overdose (as imagined by most...)

1. Overdose
2. 9-1-1
3. First Responders
4. Hospital?
5. Peer/Follow-up
6. Care for SUD

GSL

Police Assisted Addiction Recovery Initiative (PAARI)
Making New Silos

- **Clinic-based models:** ED-based buprenorphine induction; Peer recovery coaches in the ED
- **Police-assisted models:** Pre-arrest diversion; PAARI/post-overdose outreach
- **Criminal justice models:** Drug courts; Involuntary commitment/compulsory treatment
- **Community-based models:** Safe stations; Ongoing peer recovery outreach
Most communities lack an efficient, coordinated pathway to treatment
Building better response systems

- What does the opioid epidemic look like in my community?
- Is the treatment capacity needed actually there?
- Are all stakeholders serving the community (police, EMS, hospitals, treatment, harm reduction, recovery, outreach) unified behind common goals?
- What gaps exist in the pathway to care? Who can fill them? How can we pay for it?
- Are people who use drugs included in these conversations?
No one is interested in jumping lanes, but everyone needs to stretch their roles
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THANK YOU