Public health and police: Building ethical and equitable opioid responses

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The opioid overdose epidemic remains a profound public health crisis in the United States, killing more than 500,000 people between 1999 and 2020 (1, 2). The dominant narrative explaining policy responses to the epidemic concludes that because opioids are disproportionately a problem of white populations, governments have opted for public health solutions rather than the criminal justice responses to previous drug epidemics, such as crack cocaine in the 1980s. We assert that this understanding is too simplistic. Opioid overdose mortality rates among American Indian and Alaska Native communities have long paralleled those of whites, and Black and Latinx people have seen precipitous increases in opioid overdose death in recent years (3, 4).

Additionally, we argue that, despite this apparent sea change, policy responses to the opioid overdose epidemic have not been primarily those of public health, defined as responses that prioritize nonpunitive and noncoercive treatment and prevention over interdiction and criminal enforcement. Rather, we believe policy responses entail a counterproductive integration of public health and law enforcement—namely, local health authorities and local police departments—thus creating new forms of surveillance and criminalization. We contend that this integration undermines the effectiveness of public health practice and threatens racial health equity.

Policy responses to the opioid epidemic thus far have entailed a counterproductive integration of public health and law enforcement. This approach has undermined the effectiveness of public health practice and threatens racial health equity. Image credit: Shutterstock/Kimberly Boyles.

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Published November 3, 2021.

Collaboration as an Opioid Response

Public health and police collaborations integrate public health and law enforcement agencies and policy agendas. Implemented in jurisdictions nationwide, these collaborations take shape through cross-sector data sharing, policy, and programming (5). Despite the priority given to collaborations by policymakers, these initiatives remain understudied, with limited appraisal of their functions, benefits, and unintended consequences.

We must assess these collaborations within the broad legal context of drugs. Unlike other public health issues for which public health engages with civil enforcement (e.g., disease outbreaks, occupational health, and food service), drugs represent a unique conundrum in US policy: Drug possession and sales are criminal offenses addressed by the criminal justice system, but substance use disorder is a medical condition addressed by the healthcare system. The primary tools of police—interdiction and criminal enforcement—work against the interests of public health. Aggressive policing and the collateral consequences of arrest, such as incarceration, are social determinants of health and risk factors for a range of poor outcomes (6, 7). Likewise, public health's primary tools—harm reduction, education, and noncoercive treatment—are ineffectual or permissive of illegal behavior by law enforcement standards.

This leaves both fields lacking easy answers as to whether and how to work together. Whereas others have argued for deepened cross-sector collaboration (5), we assert that the consequences of integrating public health and police outweigh the benefits of conjoined approaches. Building effective and equitable opioid responses requires public health practitioners to critically appraise our role in perpetuating and aiding drug policies that incur harm. We need to parse what a collaborative approach to opioid policy might look like when the tools of law enforcement are at odds with population health promotion.

We argue that drug enforcement's vast scope has limited public health practitioners' abilities to translate collaborative rhetoric into structural drug policy changes. Structural change would entail direct reductions to enforcement through divestment (i.e., cutting police budgets), decarceration (i.e., limiting the number of people arrested and detained), and reallocation of funds toward health care and social services to, in effect, cede power and resources from police to public health. Such an approach, however, has not been widely implemented.

Rather, we assert that public health and police collaborations allow enforcement actors to maintain control of drug policy behind compassionate rhetoric. Collaborations have thus resulted in training police in public health methods (e.g., equipping officers with the opioid overdose antidote naloxone) and joint program development (e.g., criminal justice diversion to treatment programs) without direct cuts to enforcement and interdiction. Although such changes are laudable, albeit incremental, steps toward reform, it is crucial that public health practitioners recognize the limits and risks of collaborations.

Data-sharing grounds public health and police collaboration. In practice, however, data hold different value for the two sectors. Population-level health data are useful for police to identify trends in harm, conduct geospatial analyses, and target enforcement resources. Case-level enforcement data, in contrast, hold little utility for public health. Details about a single drug seller or even networks of drug sellers may help target overdose prevention resources to a given community but are unable to guide public health interventions to scale. Population-level arrest data illuminate trends in who police target, not population-level drug trends, hence limiting the meaningfulness of cross-sector reciprocity. We highlight here the unintended consequences of cross-sector data sharing with respect to two interventions: drug-induced homicide prosecutions and postoverdose follow-up programs.

An Important Distinction

Drug-induced homicide statutes, which emerged in the 1980s but remained little used by prosecutors until the mid- to late-2000s, categorize overdose deaths as homicides (for which the decedent is the victim and the drug seller or sharer is the perpetrator) rather than as accidents. As police have begun to use public health surveillance and overdose reporting data, some police departments have operationalized the transition of overdose death from accident to potential homicide in response protocols [see NYPD Patrol Guide Procedure 216-23 (8)]. This operational distinction formalizes the investigation of overdose scenes in the manner of homicide for fatal overdose and attempted homicide for nonfatal overdose. Although such police practices have received little to no scrutiny from legal scholars, they raise civil liberties implications for people who use drugs, as well as their social networks, now subject to investigation as homicide suspects and witnesses. It is crucial that healthcare providers and public health practitioners are aware of these practices should they encounter police seeking electronic health records or administrative data as part of drug-induced homicide investigations.

Furthermore, given the difficulty in concluding that a specific drug transaction resulted in a specific death, these cases rely on the compliance of health actors operating under dual public health and law enforcement capacities, such as medical examiners or coroners, as well as access to data typically housed in public health agencies, such as prescription drug monitoring programs or emergency service use records. Limited data exist on the extent of drug-induced homicide prosecutions and the impacts of this strategy on drug-related outcomes such as overdose. Emerging research indicates that these prosecutions perpetuate racial bias in the criminal justice system, with Black and Latinx drug sellers disproportionately receiving homicide charges compared with white drug sellers, and Black and Latinx defendants receiving longer median sentences than white

defendants (9, 10). Although a majority of drug-induced homicide prosecutions occur in a minority of states (Pennsylvania, Ohio, Wisconsin, and Illinois), these prosecutions have occurred in all 50 states and are increasing in frequency (9).

Public health policymakers must oppose drug-induced homicide prosecutions and the investigative practices that facilitate them. Because data sharing is essential to this strategy, public health authorities could establish stricter guidelines governing the use of health data by law enforcement. At the federal level, the US Department of Health and Human Services could eliminate HIPAA exemptions for law enforcement investigations. At the local level, municipal and county executives could restrain police investigative practices, foreclosing the possibility for departments to conflate accidents with crimes.

Indeed, one recent study found that in a national sample of police officers who respond to overdose, more than one-third (36%) reported making an arrest at an overdose scene (11), suggesting that enforcement does occur during overdose response. The potential for arrest at overdose scenes and subsequent drug-induced homicide prosecutions remains an important consideration for health officials as reliance on police as overdose first responders becomes standard in many jurisdictions through police equipment with naloxone. Coupled with changes in investigative practices, this has the potential to introduce a chilling effect on overdose reporting and undermine Good Samaritan laws (12), which provide immunity from arrest or prosecution for individuals who report overdoses.

Additionally, we recommend that positions under dual health and enforcement loyalties, such as medical examiners or coroners, become independent scientific bodies and end embedded relationships with law enforcement. Research indicates that, despite their medical training and licensure, medical examiners routinely demonstrate bias toward police in determinations (13). Further, surveys of medical examiners found that more than one-fifth had experienced political pressure to alter findings of an investigation (14). As such, it is likely that such pressure could occur as part of drug-induced homicide investigations. For drug-induced homicide prosecutions, a medical examiner's determination of a given death's intent as homicide versus accident can influence whether prosecutors bring homicide charges (15), positioning these medical professionals to stymie this practice.

Follow-Up Interventions

Postoverdose follow-up interventions (sometimes called "door-knocking" programs) are a strategy through which police officers conduct home visits to individuals after nonfatal overdose to offer naloxone and treatment referrals. Like drug-induced homicide prosecutions, these interventions rely on cross-sector data sharing, using emergency service or hospitalization records to identify individuals who have experienced nonfatal overdose. Programs are conducted by police departments independently or collaboratively with public health agencies.

Although participation in such interventions remains voluntary, using police to conduct home visits has the potential to produce coercive treatment engagement—associated with increased risk of relapse and overdose death (16, 17)—should individuals feel unable to decline services offered by police. These programs also raise the possibility of arrest, because drug possession remains a crime in all but one state. Likewise, such programs necessarily cultivate lists of people who use drugs in the possession of law enforcement agencies for use in future investigations, including drug-induced homicide prosecutions. Door-knocking programs have not been rigorously evaluated; it is critical that researchers assess these programs to detail their ethical and public health implications and ensure that people of color are not being targeted.

Research indicates that people who use drugs desire health care engagement after nonfatal overdoses, but the potential for law enforcement response is a deterrent to seeking care (18). As alternatives to door-knocking, public health agencies could expand noncoercive, emergency department (ED)-based responses to nonfatal overdose. EDs represent a key point of contact for individuals who have experienced an overdose, and the period immediately after an overdose is an opportune moment for providers to engage individuals in care.

Several models exist for provider-delivered naloxone distribution, connections to harm reduction and treatment services, and ED-based buprenorphine induction after overdose. Notably, patient induction in buprenorphine—a highly effective treatment for opioid use disorder—in the ED immediately after overdose has been shown to increase treatment retention (19). Alternate models that use peers with lived experience of substance use to deliver postoverdose services to patients and their social networks have the potential to increase engagement in care (20). Funding these models at scale, however, requires the political will to reallocate funds from police to public health.

Innovations in Psychiatric Services

Innovations in mental health crisis response may be instructive for drug policymakers. Like overdose response, psychiatric emergency response often has functioned collaboratively between public health and police, with co-response models proliferating over the last two decades. To reduce the unintended consequences of encounters between police and individuals with mental illness, including the disproportionate risk of death faced by Black individuals with mental illness (21), policymakers recently have prioritized nonpolice psychiatric crisis responses.

The country's leading public health-centered psychiatric crisis intervention, Crisis Assistance Helping Out on the Streets (CAHOOTS), began in Eugene, OR, in 1989 but has gained traction in the last decade as a replicable model for jurisdictions nationwide. Through the CAHOOTS model, 911 dispatchers divert qualifying calls away from police to a team of mental health professionals trained in crisis management and de-escalation, operational 24 hours per

day (22). The program is associated with an estimated annual savings of $8.5 million to public safety spending, as well as no risk of arrest or police killing for individuals in crisis (23). This model has been successfully replicated in Denver, CO, with upstart replications in New York City, San Francisco, and Phoenix. It soon will expand nationwide; the Biden Administration's 2021 American Rescue Plan includes a dedicated funding mechanism to support public health-led psychiatric crisis response, an estimated $1.1 billion cost to Medicaid over the next decade.

We see the CAHOOTS model as replicable for overdose response, and we implore policymakers to follow the lead of psychiatric emergency services. The tools of ED-based overdose responses are readily translatable to community-based models to supplement and bolster existing ED interventions. Public health policymakers can harness the current political momentum for structural mental health reform to build transformative overdose responses.

The above examples underscore the ways in which criminal justice reforms—here, orienting police toward public health—are rhetorically and politically expedient but either have not resulted in appreciable policy changes or have increased enforcement, as others have identified with respect to prison reform (24). Instead, a commitment to structural public health solutions is needed if policymakers are serious about ending the opioid overdose epidemic. Institutional public health shares these values; in 2020, the American Public Health Association adopted decarceration and divestment from the criminal justice system as official policy positions (25). The legacy of US drug enforcement leaves little room for trust in police-led reforms, and public health practitioners and researchers must demand that policymakers reallocate funds from police to public health and social services, make police data and protocols transparent and public, and implement changes structurally across institutions. If we ground drug policy in an ethic of antiracism and antiviolence, we can end the opioid overdose epidemic. But we must ensure that our actions are more than hollow rhetoric or half-steps toward unintended harm.

Acknowledgments

This work was supported in part by the Rudin Fellowship in Medical Ethics and Humanities at the New York University Grossman School of Medicine to B.A.

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