

The Opioid Crisis: The Impact and Implications on Law Enforcement

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Abstract

The United States has seen immense growth in opioid abuse and deaths in recent years. This paper explores the relationship between the opioid crisis, how it affects law enforcement, and what law enforcement can do to help aid in the solution to this epidemic. We aim to make this connection by understanding what an opioid is, the impact it has on the brain and body and how the crisis started. In discerning where and why the crisis began, this paper will also delve into the role pharmaceutical companies, and doctors played in causing the crisis and what is being done to help prevent it and the impact this epidemic has had on law enforcement officers. Finally, this paper will probe into how law enforcement can begin to aid in the opioid prevention endeavors of today's politicians by offering the perspectives of four officers serving in three different geographical areas in the United States.

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Our goal in this study is to emphasize the need for alternative options rather than incarceration of those addicted to opiates. Community awareness must be a component as without proper education the urgent need for broader awareness is lost. We must emphasize the importance of cooperation and collaboration between law enforcement, healthcare providers and the judicial system working together to combat misuse before it occurs. Through educational resources and community engagement, we will focus on responsibilities associated with prescription opioids, as well as raising awareness about the importance of community education.

We are told growing up that history repeats itself, the opioid crisis is a perfect example of this happening. The history has not only repeated itself but gotten exponentially worse. In 2016, there were sixty-four thousand (64,000) deaths due to opioid abuse; forty-two thousand (42,000) of these deaths were directly tied to the abuse of opioids (Center for Disease Control and Prevention, 2017). While this statistic may not seem striking, let us put it into perspective. In 2016, 40 thousand deaths were attributed to car accidents, and thirty-eight thousand (38,000) deaths were due to firearms, twenty-five thousand (25,000) being suicide (Center for Disease Control and Prevention, 2017). Additionally, opioids in the past year have killed more than six times the amount of men and women we have lost in the fight against terrorism in the Middle East, post-September 11 (Felter, 2017). What is attributing to this high death rate attached to opioids? Prescription pills are high up on that list. Not only are they overprescribed, as seen by the statistic stating, “last year 9 billion Vicodin was prescribed in the U.S., where half of those are thought to be unused and lying around (Westlake, n.d. PowerPoint slide 5). This directly correlates to the fact that over half of the population that uses prescription pain medication is said to get these pills from friends and relatives, thus meaning they are not prescribed to them

(Westlake, n.d.). As law enforcement officers, not only does this affect our job on a daily basis, in terms of arrests, but it also opens up the idea of how we can help alleviate this issue.

This paper will discuss what an opioid is and how it affects the brain and body, how the opioid crisis began, and why it is here to stay. We will explore the role of pharmaceutical companies and how they benefit from the crisis and how doctors and hospitals are responding to the crisis. Finally, how law enforcement and emergency responders are impacted, as well as what they can do to help bring down those startling statistics.

Historical Context

What starts a crisis that is so deeply entrenched in the United States? In truth, opium made its debut in around 3400 B.C., as was taken directly from poppy plants. It is used in this form until the 1500s, when laudanum, a medicine derived from opium, citrus, and gold, was used to treat pain (Public Broadcasting Service, 1998). Opium continued to be used as a painkiller from then on. In 1821, the first documented addiction case came by a form of autobiography. This book is called “Confessions of an English Opium Eater (Public Broadcasting Service, 1998).” While this was the first documented case portraying the addictive qualities of opium, it indeed would not be the last.

From the 1820’s on, the world saw an onslaught of opium-inspired medications. In 1827, George Merck began to produce morphine. By the 1850s, morphine was not only produced, but a system for injecting morphine came into play by Dr. Alexander Wood. Wood’s injectable morphine made its impact due to its “instantaneous effects” and strength (Public Broadcasting Service, 1998). Instantaneous pleasure? Patients of Wood were not the only ones excited by this idea. During the Civil War, injured soldiers were treated with morphine; no matter what type of

pain they were feeling, causing many soldiers to deal with addiction post-war (Public Broadcasting Service, 1998).

As we entered the 1900s, we begin to see a strong push against opioids. In 1914, the Harrison Narcotics Act was intended to stop the recreational use of opioids and strictly make it a prescription-only drug. Not only did this act push opium-based products as a prescription, but also designated that these prescriptions should be given in acute pain situations (A Brief History of Opioids, n.d.). This trend of not prescribing opioids as painkillers, if not acute pain, continued until the 70s because people were fearful of addiction. Still, the Food and Drug Administration approved the creation and prescribing of Percocet and Vicodin in 1976, despite the fear of opioids addictive tendencies (A Brief History of Opioids, n.d.). By the 80s, the World Health Organization began to recommend opioids for cancer pain, if non-addictive treatments were not working (Public Broadcasting Service, 1998). This small push towards using opioids when necessary is what officially got the movement of opioids going again. By the mid to late 1990s, doctors began to be pushed to treat acute and chronic pain with opioids. Not only did they treat pain this way, but they did so aggressively, often overprescribing so that patients did not need to come back. This push towards relieving pain, no matter whether it was acute or chronic, undid the work of doctors in the 1920s to 1950s on using opioids sparingly (Felter, 2017). Once doctors began prescribing pills more regularly, pharmaceutical companies began to take advantage.

Many think pharmaceutical companies are to blame for the push to opioids and rightfully so. The 1990s were led by a huge pharmaceutical campaign that not only promoted opioid use but downplayed the negative effects of using opioids (Felter, 2017). Pharmaceutical companies and those manufacturing their drugs did not appropriately inform doctors and patients about the

risks of opioid use. Haffaje and Mello (2017) go as far as to say that drug manufacturers purposely misled the public about the negative impact of these drugs and marketed the drugs as safer than the alternative pain treatment and therapy options, which later was found not to be true.

Purdue Pharmaceutical, especially, has seen negative publicity for its role in the opioid crisis. Purdue, according to Andrew (2018) has named itself “a pioneer in developing medications for reducing pain, a principal cause of human suffering.” It is with this claim; they began to market OxyContin, a popular opioid pain reliever. In 1998, Purdue spent over 200 million dollars in marketing OxyContin as a low chance of addiction opioid pain reliever (Andrew, 2018). Purdue claimed that OxyContin lasted 12 hours, although its clinical trials negated this claim before the drug was even on the market (Ryan, 2016). While not having clinical trials that lived up to the marketing, Purdue used incentives to not only sell OxyContin but to prescribe it (Andrews, 2018). Van Zee (2009) shares this startling statistic “from 1997 to 2002, the use of OxyContin in non-cancer related pain increased from 670 thousand to 6.2 million.” So what did Purdue earn from lying to its consumer about its ability to last longer than it is not addictive counterparts? OxyContin sold for around one hundred dollars per bottle, so with 6.2 million bottles sold in 2002, the company made roughly 620 million dollars (Ryan, 2016).

Eventually, the huge revenue and incentives were not enough to keep Purdue or other companies from inaccurately marketing addictive painkillers as non-addictive out of the limelight. As the number of people addicted to opioids began to increase, so did the deaths resulting from this addiction. The Department of Justice finally began the process of holding the company accountable for its misrepresentation in 2007 (Andrews, 2018). While the settlement does not begin to cover the damage, loss of condition of life, and pain and suffering that many

faced due to false advertising, it began to show all companies that they will be accountable for their actions.

As said above, pharmaceutical companies offered an incentive to its salespersons, which inadvertently trickled down to incentives to doctors. With pharmaceutical companies, along with teams of doctors, pushed that pain should be “the fifth vital sign” and that as such, those prescribing the medicine should do so liberally (Andrew, 2018). With this understanding of the importance of treating pain, many doctors began to push for more aggressive pain treatments, which was known as a good medical practice (Dupont, 2015). So not only were doctors pressured into promoting opioids, but patients caused an added stress, as opioids were typically less expensive than non-addictive pain therapies, especially in rural areas where more specific treatments were not readily accessible for those who needed them (Felter, 2017). However, as pharmaceutical companies began to be held more accountable, so were doctors. Now, doctors need to look at each pain case a little bit more specifically. They need to analyze the pain and try to find a treatment plan that is best for the patient, especially in terms of addictive tendencies (Westlake, 2018). Some hospitals are even turning opioid-free. With the heroin epidemic knocking on the door of middle-class white America, hospitals are beginning to find ways to treat patients, especially those that have struggled with addiction in the past.

Operationalizing Opioids

What does heroin have in common with regular doctor prescribed oxycodone? Both are opioids. If opioids are the problem, it is essential that we understand what an opioid is. The National Institute on Drug Abuse statistics that “opioids are a class of drugs that include prescription pain relievers, heroin, fentanyl.”(<https://drugabuse.gov/drugs-abuse/opioids> paragraph one). Opioids are known for relieving pain and creating pleasure through chemically

creating endorphins that directly hit the nerve cells within the nervous system (National Institute on Drug Abuse, 2017). Opioids can be natural, coming directly from the poppy plant, or made with some help from the man leading to partially or fully synthetic versions (National Institute on Drug Abuse, n.d). In one form or another, opioids are used to combat chronic pain, which according to the National Institute of Drug Abuse, accounts for over 100 million United States Residents. While many addictions start with prescription pills, as it seems to be the gateway opioid, patients often switch to stronger forms as their dependence grows.

Chemical Dependency

But what is creating this addiction? The chemical interaction that opioids have with the brain and nervous system creates a unique set of issues. While opioids are known for their connection to fighting pain and producing pleasure, the very interaction that opioid has on the nerve cells via an opioid receptor lends the body to have a lower pain tolerance (National Institute on Drug Abuse, 2017). With a lower tolerance, created through use of opioids, patients often take more than prescribed or take their prescription in a different form (i.e. crushing, snorting, or shooting), as it will deliver the message to the nervous system to ebb the pain, thus creating a chemical dependence (National Institute on Drug Abuse, 2017).

This chemical dependence is not so easy to fight off. As patients come off these pills, many are up against strong withdrawal symptoms. If not properly treated, when coming off opioids, patients are at risk of turning back to the very drug that put them in that position (National Institute on Drug Abuse, n.d.). It is this very instance that accounts for many deaths by opioids. When patients begin to withdraw but chose to go back to the amount of opioid they were taking before withdrawal, often the body cannot tolerate the quantity of drugs, causing overdose (National Institute on Drug Abuse, 2017). But this is not the only risk to the patient. The Center

for Disease Control and Prevention (2017) lists risk factors attributed to those with opioid dependency. One risk to opioid users is that as tolerance goes up, patients need more. In order to obtain the quantities necessary for pain to stop and pleasure to begin, patients collect multiple prescriptions from multiple doctors. Additionally, when mixing opioids with other drugs, such as benzodiazepine, to control depression, the body goes into overdrive since the body is looking for those pleasurable experiences that the opioid creates (Center for Disease Control and Prevention, 2017).

Genetics also play a significant role in opioid addiction. When mentally unstable or genetically predisposition to addictive behaviors, abuse of opioids becomes substantially more likely (Center for Disease Control and Prevention, 2017). However, addictive traits and those with depression are not the only people at risk. The Center for Disease Control and Prevention (2017) explain in their research that people in rural communities, specifically low-income areas, are more prone to develop an opioid addiction. Part of this is due to Medicaid. Since doctors do not receive as much money per patient, they often give out or over-prescribe pills more freely so that they have the ability for in-and-out appointments (Center for Disease Control and Prevention, 2017). For pregnant women taken opioids, their chemical dependence can directly affect their fetus, creating them also to have a dependence, which upon birth, causes the infant to go into withdrawal (National Institute for Drug Abuse, 2017). Finally, those who built up a high tolerance and moved to stronger forms of opioids often do so by injecting the drug into their body. With dirty and shared needles, other diseases such as HIV and AIDS become prominent within the opioid-addicted community (National Institute for Drug Abuse, n.d.).

Role of Law Enforcement in the Opioid Crisis

While all of the material above has helped look into the issue of how and why the opioid epidemic is still going strong, one group that opioids affect, although it is not often spoken about is law enforcement and other emergency responders. In fact, the impact of opioids as it concerns the jobs of law enforcement individuals was rarely discussed until these individuals had the power to stop overdoses with a drug called Naloxone (National Institute on Drug Abuse, 2018). Essentially, law enforcement and its connection to opioids are not researched in depth. Nevertheless, the available prominent literature in this area is published in the Police Executive Forum (2017). Upon examining the research made available, we can see the substantive role law enforcement may have, and its limitations. For example, although 63% of officers are trained to give Naloxone, it remains unclear the number of times one person be given a dose of Naloxone (Narcan). Repeat offenders are using the resources regarding Naloxone (Narcan), but they are not recovering from their addiction. The Health Department in Baltimore, Maryland is now required to ask doctors for every opioid prescription given, to also give the patient a prescription of Naloxone, as this is what they will need if they abuse their prescription and overdose (Police Executive Forum, 2017). However, is this the best option?

The Police Chief of Plymouth, Massachusetts does not believe in this process. In the Police Executive Forum (2017), Chief Botieri discusses the fact that the first twelve to twenty-four hours after an overdose is critical. He and his team go to victim's homes to provide follow-up visits for all overdose victims. Sometimes, this means letting family members know that they have an addict whom they need to help. Other times it is to provide resources to help the victims. This, along with other programs, is taking the lead in getting addicts to find law enforcement when they are ready to seek help (Police Executive Forum, 2017). This forum even goes as far

as to address the better use of jails. When those convicted of using drugs are put in jail, can that platform be used to provide treatment for both addiction and treatment as the inmate withdraws from their drug of choice? In Essex County, Massachusetts, the Sheriff's department works to help choose inmates to be part of a selective detox program designed towards low-level offenders, mainly those who committed crimes to help drive their addiction (Police Executive Forum, 2017). Opinions differ regarding using jails as treatment centers. However, we believe to combat the existing problem of opioid abuse must begin in the jail. We are not advocating full in-patient treatment in jails, instead baseline evaluations for chemical dependency. Other programs such as Alcoholics Anonymous, Narcotics Anonymous, mentoring, and sponsorship programs can also be introduced into a jail setting.

Officers are making a significant push to get laboratory results completed as quickly as possible. Because of this, law enforcement can link cases of 'bad batches' of drugs directly to specific locations, and ultimately certain dealers. They also can inform the public of this, if they so choose, based on the population they are dealing with (Police Executive Forum, 2017). Even if law enforcement does not want to inform the public of all issues, it is facing, sharing information with each other, hospitals, and other emergency medical responders are essential.

Law enforcement and police officers have also begun to notice the populations who can best be served to help prevent more people from becoming addicted to opioids, the children, specifically at-risk youth. Departments in New Jersey have targeted young children who have faced traumatic events, as they are most likely to use opioids when dealing with anxiety, depression, and other repercussions from the events. By creating police to school connection, both the school and the law enforcement can ensure students safety, but trauma is dealt with in a healthier way. Police officers also provide these students with someone to look out for them from

a 'safety' standpoint (Police Executive Forum, 2017). In the same scope, children of addicts often show the same tendencies, as they model the behaviors which they see. By watching these children and discussing the implications of drugs with them, officers hope to see a reduced number of addiction cases (Police Executive Forum, 2017). However, at risk do not have to be the only children educated on drugs and how they affect the body.

Police officers, through programs like Drug Awareness Resistance Education (D.A.R.E.), have a huge platform for educating all youth on the issues they may face when it comes to peer pressure, drugs, and how to handle specific situations and where to go if help is needed (Police Executive Forum, 2017). Based on the theory that educating young children about the dangers and consequences of substance use will have a lasting effect on a child's attitudes toward drugs and alcohol, D.A.R.E. was founded in 1983 by the Los Angeles Police Department and the Los Angeles Unified School District (www.dare.com, 2005). The program is a prevention curriculum that universally targets students in promoting the development of skills to aid them in resisting substance use and engaging in violence. Specifically, the program assists youth in developing a skill set that will enable them to resist peer pressure to use drugs, alcohol, tobacco, and violence (www.dare.com, 2005).

Recently the North Dakota State legislature passed legislation referred to as Justice Reinvestment. Senate Bill 2015 was designed to decrease the number of convicted individuals sent to prison. Incarcerations and its negative effects are costly and detrimental to society. Many of the offenders who are currently incarcerated are not best served by the prison and jail systems.

For Justice Reinvestment to be successful, these offenders must be effectively treated and managed within the community. These offenders are more likely to re-offend, are more difficult

to treat and manage, and are more likely to have probation revoked if on probation. How do we keep the community safe now, while ensuring that the community is safer in the future?

Treatment designed to be responsive to the offender's needs begins to lower the offender's likelihood of reoffending almost immediately. The likelihood continues to decrease as treatment continues. According to the *Risk-Need-Responsivity* (RNR), Simulation Tool, (https://www.gmuace.org/research_rnr.html) offenders have dynamic needs which, if met correctly, reduce an offender's likelihood to re-offend. These needs include:

Antisocial attitudes, values, and beliefs

- Antisocial peers
- Substance Abuse
- Environmental factors (e.g., anger, employment, income, etcetera)
- Family conflict

An individual's risk to re-offend is managed by targeting these needs. In addition, barriers that may impede an attempt to target these needs should be reduced. Reducing barriers can be achieved by:

- Assessment of characteristic obstacles to treatment
- Access to mental health assessment and treatment
- Access to Transportation
- Motivation and support

The past failures of community-based rehabilitation systems (and the resulting public outcry to “lock them up”) are attributed to lack of treatment programs, but this is only partially true. More programs alone are not the answer. The challenge is to deliver effective treatment. The existing system in North Dakota is a disjointed patchwork of state, county, city, and private agencies,

each receiving funding from a number of different sources, each with a different mandate, and priorities. Some of the programs are not amenable to coordination with other service or agencies, despite the fact that many need prompt treatment services. These are some of the challenges we face. No single branch of government or agency can do this alone. We must collaborate with our many public and private entities to create a safe, responsive, and effective system. (Justice Reinvestment: Foundations Requirements for Effective Community-Centered Offender Rehabilitation, 2018).

We understand this program is a huge undertaking and currently in its infant stages in Cass County, North Dakota. As leaders, we have a responsibility to support new and innovative programs not because we are mandated to do so, instead because we believe they are beneficial for everyone. Demands of modern policing require officers who are not only technically competent, they must continually strive to be virtuous and thus contribute to the best of their ability to family, those around them, career and the community (*Becoming MAGNUS-Success is Equal Opportunity*) <https://lawenforcementtoday.com/becoming-magnus-success-is-equal-opportunity> (para. 3). A leader with authentic leadership qualities will approach this project with understanding and leadership of purpose which will help align others to create a positive impact.

Other programs such as Vivitrol programs are expanding throughout the country. We believe they should begin within the correctional facility itself by identifying at-risk inmates. Vivitrol is a non-addictive, non-narcotic medication that these traits make it appealing for prisons and jails. The drug is a monthly injection which is a long-acting version of Naltrexone (Vivitrol), which works by shutting down the opioid receptors in the brain. A person on Vivitrol is not able to get high and has fewer cravings.

Conclusion

The United States opioids crisis is killing thousands of people. Agencies are gearing up their response to the crisis by working with public health agencies, hospitals, drug treatment facilities and other strategies for saving lives and helping addicted persons get into treatment. As police officers, we believe departments should consider the use of Naloxone (Narcan) for patrol and correctional officers as it is a lifesaving drug when administered to someone dying from an opioid overdose. Inmates who are identified through a screening process as opioid abusers can benefit from Vivitrol injections. The inmate must be free of opioids for seven to ten days and must be willing to cooperate with outside rehabilitative services. This education can include day treatment, counseling and Narcotics Anonymous and other programs. With these systems and programs, officers can obtain data from the programs for future strategic law enforcement practices.

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