Master's Thesis

The Health Consequences of Policing for People Who Use Drugs

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I. Abstract

Although drug prohibition was a direct result of racism and xenophobia, the United States maintains the view that punishment and criminalization are the solution to substance use and substance use disorders (SUDs). As a result, communities of color are hyper-policed and experience disproportionate brutality, particularly for individuals who use drugs. Policing is not only associated with worse health outcomes, but actively hinders people who use drugs from accessing overdose prevention resources and other harm reduction services. Crisis intervention teams aim to improve interactions between people experiencing crises and the police, but there are mixed results regarding their efficacy. Furthermore, they do not fundamentally address the root causes of substance use, nor do they acknowledge the negative effects of policing on the health of this group. Ultimately, involving the police in crisis intervention reinforces the punitive system that is maintained through brutality and incarceration, neither of which come from a health-oriented framework. To maximize the health, safety, and dignity of people who use drugs, it is necessary to re-evaluate the need for police to serve as the default first responders for behavioral health and substance use crises. This narrative review explores the relationship between the war on drugs, policing, and the health of the policed, and recommends the expansion of crisis intervention models that do not involve the police.

II. Introduction

Decades of punitive "war on drugs" policies in the United States have resulted in an environment where substance use disorders (SUDs) are viewed as a criminal-legal issue rather than a public health issue (Cooper et al., 2004; Daly, 2020; Moore & Elkavich, 2008; Strathdee, Beletsky, & Kerr, 2015). People who use drugs (PWUD) are therefore highly stigmatized, both by the general public and by the police (Osborne, 2019). Because drug criminalization laws have historically been motivated by racial bias and xenophobia, the criminal-legal system disproportionately targets Black and Latine individuals, further exacerbating existing health disparities among these populations (Drug Policy Alliance, 2021; Dumont et al., 2013; Wildeman & Wang, 2017). The criminalization of PWUD does not address why people use drugs or develop SUDs, nor does it provide appropriate support or treatment for those who seek it. This leads to downstream consequences such as an increased risk for rearrest, unsafe drug use, and overdose (Håkansson & Berglund, 2012; Joudrey et al., 2019). For these reasons, a public health approach to substance use, SUDs, and substance-related crises is long overdue.

Policing and police violence have a deleterious effect on the physical and mental health of those who are policed, particularly PWUD (Del Toro et al., 2019; DeVylder et al., 2018; Fuller, Lamb, Biasotti, & Snook, 2015; Geller, Fagan, Tyler, & Link, 2014; Hirschtick et al., 2020; Sewell & Jefferson, 2016; Sewell, Jefferson, & Lee, 2016; Zweig, Boquero, Meropol, & Vasan, 2017). Mental health issues frequently co-occur with substance use issues (National Institute on Drug Abuse, 2020). Therefore, the effects of policing on these issues are inextricably linked. The above issues disproportionately harm the health and well-being of people of color, particularly Black and Latine individuals, due to systemic racism and higher rates of policing and police violence in their communities (Geronimus, Hicken, Keene, & Bound, 2006; Zweig et al., 2017).

While it is clear that policing, criminalization, and bias can be harmful to the health of hyperpoliced communities, there are two gaps in the literature on this subject. First, there is limited information about the mechanisms by which policing specifically harms the health of PWUD. Second, there are limited existing models for crisis intervention, particularly those which fundamentally address the role of policing in exacerbating crises or other substance-related harms. Therefore, this thesis synthesizes evidence of an association between policing and health issues and identifies barriers to success in existing crisis intervention programs. In order to

maximize the health and safety of PWUD, it is necessary to identify knowledge gaps in these topics and best practices for responding to substance-related crises. This paper reviews how the war on drugs and mass incarceration contribute to the current state of drug criminalization, then assesses whether there is strong enough evidence to infer a causal link between policing practices and negative impacts on the health and safety of PWUD. In this process, there is an emphasis on the intersection of racial minority status and substance use, both of which increase an individual's risk for harmful experiences with police. This review also critically assesses the effectiveness of current interventions for public safety that involve police officers. Next, this review describes existing interventions that serve PWUD who experience behavioral health crises. From this, this review extracts and describes a set of best practices that seek to maximize the health and safety of this population that has for too long been unjustly criminalized and persecuted. Finally, this review discusses recommendations for policy change specifically in New York City, which has its own unique history of racialized policing practices; any changes could therefore serve as a model for other large cities.

III. Methods

The literature review focuses mainly on the U.S. because of the unique history, laws, and policies that have shaped policing practices. However, international studies that discuss the impacts of policing on the health of PWUD have not been excluded. This review includes literature related to the history of the war on drugs and its current manifestations, studies linking drug criminalization and policing practices to health and mental health outcomes (in general and for PWUD), and the effectiveness of existing crisis interventions both by police and by non-law enforcement entities. The review is being conducted to examine the effects of war on drugs policies and policing practices specifically on the health of PWUD, as well as to identify key strategies to improve the health and safety of PWUD through challenging and removing the association between substance use and criminality. Gray literature reports (news articles, fact sheets, etc.) which are relevant to the topic are also included. All references are managed using Zotero.

Inclusion and Exclusion Criteria

This review follows PRISMA guidelines to the extent they are applicable to narrative reviews. It includes academic articles, focusing on more recent publications (2015-present) because of increased mainstream media attention towards these topics and public conversations

about decriminalization and harm reduction. The chosen articles assess the effects of the war on drugs on health, the effects of policing on health (in general and for PWUD), and the efficacy of crisis intervention models. Search terms include combinations of the following topics and "health" or "mental health:" war on drugs, policing, law enforcement, police violence, police brutality, people who use drugs/PWUD, people who inject drugs/PWID, substance use disorders, addiction, crisis intervention teams, crisis response, behavioral health crisis, overdose response, Good Samaritan Laws, and drug criminalization. Studies about the health of police officers or other people who work in crisis response (i.e., 911 call center operators) will be excluded from analysis, as this review is aimed at understanding the health effects of policing specifically for PWUD.

IV. Results

This narrative review includes literature from peer-reviewed sources, as well as those containing news articles and gray literature, such as fact sheets and other public-facing information that is not peer-reviewed. The initial search included 130 articles, 24 of which were excluded as they were not considered to be as relevant to the topic or appropriate for the purposes of the present review. The final search yielded 78 peer-reviewed articles, 8 news/media articles, 1 book chapter, and 19 pieces of gray literature. The dates of publication ranged from 2002 to 2021 and 74% of the publications were written since 2015.

V. The War on Drugs

The history of the war on drugs provides fundamental context for understanding the current state of drug criminalization. Drug laws in America have always been influenced by race and class, mainly due to the contrived association between drug use and Black and poor people (Dollar, 2019). Such laws go hand in hand with the societal belief that drug use is a moral failing, which is often tied strongly to race and class. This is illustrated well by the "medicalized" and empathetic response to the most recent opioid epidemic, which is more strongly associated with and has affected a greater proportion of middle and upper class whites (Dollar, 2019).

The war on drugs is a set of policies initially motivated by racism and a desire to quash political dissent during the 1960s (Drug Policy Alliance, 2021). Most drugs have been used for millennia for medical and spiritual purposes and were generally not outlawed until the mid-late 20th century. Despite their association with criminal behavior, the legal prohibition of drugs does not stem from any scientific assessment of risk, but rather a desire to target specific groups and

associate them with criminality so as to prevent them from gaining political and institutional power. In 1971, President Richard Nixon declared a "war on drugs" as a response to "youthful rebellion, social upheaval, and political dissent" (Drug Policy Alliance, 2021). He increased both the size and presence of federal drug control agencies and increased sentencing. One of Nixon's top aides admitted that the war on drugs was a response to the Nixon administration's two biggest enemies: "the antiwar left and Black people." Therefore, the war on drugs was not conceived out of a genuine desire to improve people's health or even to deter drug use. Because they could not outlaw being Black or having left-wing beliefs, the Nixon administration designated substance use as "public enemy number one" in order to disrupt those communities by vilifying and incarcerating them (Lacroix, 2016).

While these policies began with President Nixon, they have been embraced by all presidents since, regardless of political party. States such as New York also passed their own legislation increasing punishments for low-level drug offenses (e.g., Rockefeller Drug Laws) (Drucker, 2002). This system has not actually reduced the rate of drug use, as it is purported to do. This system has created extreme hardships for many people, especially people of color living in urban areas (Moore & Elkavich, 2008).

The policies enacted by President Nixon were further accelerated by President Ronald Reagan and his administration, which greatly expanded the drug war by using drug trafficking concerns as justification for anti-Mexican xenophobia and enhanced policing of the U.S.-Mexico border (Lacroix, 2016). Around this time, First Lady Nancy Reagan introduced the 'just say no' campaign, which came to fruition alongside new zero tolerance policies in the 1980s and draconian penalties that rapidly increased the prison population. President George W. Bush's administration amplified the war on drugs through the militarization of domestic law enforcement (Drug Policy Alliance, 2021). Throughout the 1990s, both politicians and those involved in the criminal-legal system expanded the prison system (Schoenfeld, 2012). While it was not the only factor that contributed to the current state of mass incarceration, the drug war created the conditions that gave rise to the passage of hundreds of crime bills, the lengthening of sentences, and harsher convictions for less serious crimes (Schoenfeld, 2012). Because the drug war was never intended to improve the health of PWUD and was founded on a racist and classist framework, it is imperative to dismantle the association between substance use and criminality in order to improve the health and well-being of PWUD.

VI. Impact of the War on Drugs

Racial Inequity

The war on drugs significantly contributes to racialized inequities seen in the United States today due to increased arrest and incarceration rates of racial minority groups (particularly Black and Latine individuals) for nonviolent drug-related offenses. Drug laws have never been enforced equally; poor people of color are disproportionately punished for drug offenses. A 2002 analysis of incarceration rates after the implementation of the now-repealed New York Rockefeller Drug Laws (RDLs) found that the ratio of incarceration of Black and white males aged 21-44 was 40:1. For Latine and white men, this ratio was 30:1 (Drucker, 2002). Further, Black & Latine people represented 30% of the New York State population but over 94% of those incarcerated specifically due to RDLs. More recently, the 2015 National Survey on Drug Use and Health estimated that approximately 5% of U.S. civilians who use illicit drugs are African American, yet African Americans represent 29% of arrests and 33% of those incarcerated for drug-related offenses (NAACP, n.d.).

While white individuals and African Americans use drugs at similar rates, the incarceration rate for drug charges for African American individuals is nearly six times the rate of white individuals (NAACP, n.d.). Among those historically hit hardest by the war on drugs are people who use crack-cocaine, particularly in Black communities. Despite crack and powder cocaine being pharmacologically identical, there has been a massive sentencing disparity (100-to-1 until 2010, currently 18-to-1) between the two formulations (Drug Policy Alliance, n.d.). Black people are statistically more likely to be convicted of offenses related to crack-cocaine, despite the fact that most people who use crack-cocaine are white. Conversely, white people are more likely to be convicted of offenses related to powder cocaine, and because the punishments for crack are much harsher, this results in the conviction and incarceration of a disproportionate number of Black individuals (Drug Policy Alliance, n.d.). Because Black and Latine communities are overpoliced relative to white communities, this leads to higher rates of stops, arrests, and incarceration simply due to increased vigilance and surveillance, not because of higher rates of actual crime. According to the Stanford Open Policing Project, Black and Latine individuals are less likely to have contraband during police stops but more likely to be arrested, charged, and spend more time in prison (Pierson et al., 2020).

Another example of racial disparities in policing is known in New York City as ‘stop and frisk’ and more broadly known as a ‘terry stop.’ These policies allowed police to detain and question an individual if they were suspected to have contraband (such as illicit drugs). It has been demonstrated that even after controlling for precinct variability and race-specific estimates of crime, people of African and Hispanic descent were still stopped and frisked at a higher rate than white people (Gelman, Fagan, & Kiss, 2007). Stop and frisk encounters often involve use of excessive force towards Black and Latine individuals, which leads to increased distrust of police and ironically, no actual reduction in drug-related crimes (Ross, 2016).

Incarceration is strongly associated with worse physical and mental health (Wildeman & Wang, 2017). States with higher incarceration rates have a lower average life expectancy as well as higher incidence of HIV infection and infant mortality. The stress and stigma associated with incarceration can also negatively impact the health of an incarcerated person’s family and community (Wildeman & Wang, 2017). This can happen in several ways. The stigma associated with incarceration results in discrimination towards formerly incarcerated individuals in the housing and job markets, which limits the family’s ability to generate wealth and creates added stress. Formerly incarcerated people often have few resources available to them, limited social support, few opportunities for rehabilitation, and extremely constrained employment prospects, all of which can increase one’s risk for reincarceration (Moore & Elkavich, 2008). Additionally, children who have an incarcerated parent have a higher incidence of physical and mental health problems, such as depression, anxiety, asthma, and obesity. On the community level, high incarceration rates in a given neighborhood are associated with a host of negative health conditions, including asthma, sexually transmitted infections, and psychiatric disorders (Wildeman & Wang, 2017). For all of these reasons, because the prison population disproportionately consists of Black and Latine people, mass incarceration contributes to long-term racial health disparities through the disruption of individual lives, families, and entire communities. Therefore, addressing the racial bias present in the carceral system would keep more families and communities together, improve the prospects of the formerly incarcerated, and provide more opportunities for socioeconomic growth.

In addition to its negative health effects, incarceration specifically harms PWUD in a few key ways. First, being forced to quit a substance suddenly (due to incarceration) can be dangerous to one’s health (Abadie et al., 2018). Furthermore, there is a heightened risk of

overdose post-incarceration due to lowered tolerance (Joudrey et al., 2019). These health risks impact racial groups differently due to unequal treatment and criminalization of substance use.

Other Impacts of the War on Drugs

The war on drugs and its related punishment and abstinence-oriented policies have created barriers for many individuals to improve and maintain their health. Moreover, there are many social factors that contribute to one's health that are similarly impacted by these policies. For instance, formerly incarcerated individuals frequently experience systemic barriers such as precarious housing and employment, which threatens recovery and increases risk for relapse and reincarceration (Chavira & Jason, 2017). There is a high degree of discrimination against formerly incarcerated individuals in the process of obtaining employment, although this varies greatly by racial group (Holzer, 2007; Western & Sirois, 2019). It has been estimated that resumes with prison records are roughly 50% less likely to get a response from an employer compared to a resume that is otherwise equivalent but does not have a record (Looney & Turner, 2018). These systemic forms of discrimination towards individuals with criminal-legal system involvement cause immense stress and limit their opportunities to secure stable housing and gainful employment.

Drug-Induced Homicide Laws

The war on drugs has also led to the passage of drug-induced homicide laws, which implicate drug distributors in overdose deaths. While the aim of these laws is to deter the sale and use of drugs, they ultimately exemplify the ways in which the U.S. relies on the criminal-legal system to address SUDs instead of using a health-based approach. This punitive approach makes individuals who witness an overdose less likely to call emergency medical services due to fears of being potentially charged with a homicide (Beletsky, 2018). Furthermore, there are racial disparities in both sentencing and the general enforcement of these laws, as well as misclassification of people as 'dealers.' Ultimately, these policies are counterproductive to public health goals because they are not evenly enforced and can reduce the likelihood for emergencies such as overdoses to be reported.

Treatment and Harm Reduction

Another significant impact of the war on drugs is the stigmatization of drug use and implementation of punitive policies instead of prevention or treatment methods for substance use disorders. The war on drugs has largely diverted resources *away* from community-based

treatment. This can be viewed as an extension of the "Penrose Effect," which was first described in 1939 by Lionel Penrose and refers to the inverse relationship between mental or behavioral health treatment infrastructure and the prison population in industrialized nations (Grecco & Chambers, 2019). When a country's behavioral health infrastructure is insufficient, people with mental illness and SUDs become "absorbed" into the criminal-legal system. It is no coincidence that the war on drugs co-occurred with the rise of mass incarceration in the United States. The Penrose Effect is driven by societal perceptions that substance use disorders are immoral and criminal behavior rather than health conditions to be treated, despite many recent advances in neuroscientific research that support the use of a medical model to treat SUDs and co-occurring mental health conditions (Grecco & Chambers, 2019). As a result, the United States has both a low capacity and very little political incentive to treat substance use disorders without involving the carceral system.

One of the most notable and harmful consequences of the war on drugs is public stigma against a harm-reduction model of treatment. Harm reduction is a set of practices with the goal of reducing the negative consequences of drug use, rather than an abstinence-only model (harmreduction.org). This means that the goal of SUD treatment is not necessarily abstinence, but focuses more on reducing other types of harm, such as infectious disease transmission or overdose. Harm reduction is also a social justice movement that believes in respect and dignity for the lives and health of PWUD and people with SUDs. The harm reduction model focuses on maintaining a non-judgmental view towards PWUD and recognizing the social factors, such as poverty, class, racism, trauma, and other vulnerabilities that contribute to SUDs. While an abstinence-only model works well for some people with SUDs, harm reduction has been associated with positive outcomes due to the promise to 'meet people where they are at' and view people with SUDs in an unconditionally compassionate manner, which is free of blame or moral judgment. Harm reduction practices also include the use of medication-assisted treatment (MAT), which includes medications for opioid use disorder (MOUD). These include methadone, a synthetic opioid, and buprenorphine, a partial opioid agonist (Harm Reduction Coalition, 2020). The goal of these medications is to reduce the symptoms associated with opioid use disorder and prevent other harms related to drug use, such as overdose and infectious disease transmission, without the need to fully abstain from putting opioids into the body. Despite their effectiveness at reducing morbidity and mortality related to opioid use, there are many barriers to

obtaining treatment with MOUD, largely due to stigmatizing beliefs. These include the notion that addiction is a willful choice, stigmatizing language around addiction, and a lack of medical integration into the criminal legal system (Wakeman & Rich, 2018). There is also a prevalent belief that MOUD is simply replacing one addictive substance with another, despite empirical evidence that individuals who take these medications consistently can successfully reduce their risk for overdose and other drug-related harms (Mancher & Leshner, 2019; Wakeman et al., 2020). The effects of the war on drugs, such as a punitive and judgmental view of PWUD, present a massive barrier to effective implementation of harm reduction services on a state or federal level.

Was the War on Drugs Effective?

While there have been advancements in recent years towards a public health approach to substance use issues, drug policy funding largely has not shifted to a health-based (or evidence-based) approach. The war on drugs continues to disproportionately harm communities of color due to uneven enforcement of drug-related laws. Additionally, these policies harm PWUD by creating stigma and diverting people away from treatment and into the criminal-legal system, which does little to address the root of substance use problems or help people who seek SUD treatment.

The war on drugs has resulted in prohibition and stigma, both of which encourage unsafe drug use and avoidance of health care due to anticipated discriminatory experiences (Godlee & Hurley, 2016). For example, heavier policing has been associated with less access to harm reduction supplies and health care, higher rates of injection drug initiation, and higher rates of overdose (Baker et al., 2019). This will be covered in greater depth in later sections. Conversely, it has been shown that drug-related illness and death can be reduced through decriminalization. For example, Portugal decriminalized the possession and personal use of all drugs in 2001, which led to a decrease in HIV infections and drug-related deaths and no increase in actual use (Murkin, 2014). These decriminalization efforts, which were coupled with a health-centered approach to drugs and more progressive social policy changes, provide critical evidence that removing harsh punitive measures do not result in more drug use or more drug-related health issues.

Despite evidence that the war on drugs was wholly unsuccessful in reducing drug use or drug-related harms, the health of PWUD, particularly those who are Black and/or Latine,

continues to suffer due to an unnecessarily punishment-oriented and racially biased system. It is crucial to assess how the war on drugs has influenced all elements of the criminal-legal system, which directly impacts the health of PWUD. This includes but is not limited to arrest and incarceration rates, police (mis)conduct, and police response to crises.

VII. Policing and Health

Police Brutality and Killings

Racial bias is a key driver of police brutality and police killings. In general, research has demonstrated that Black and white U.S. civilians have fundamentally different interactions with police. Black civilians are much more likely to experience violence or lethal force by the police; an analysis by Kramer and Remster (2018) found that between 2007 and 2014, truly racially equitable policing would have resulted in 61,000 fewer stops of Black civilians including police use of force, and 1,000 fewer stops including potentially lethal force.

Police killings are highly unequal by race and directly associated with the level of structural racism in a given location (DeGue et al., 2016; Mesic et al., 2018). A study examining police killings between 2009 and 2012 in seventeen U.S. states found that in absolute numbers, victims were majority white (52%) but disproportionately Black (32%), with a fatality rate among Black individuals being 2.8 times higher than white individuals (DeGue et al., 2016). Additionally, Black victims were more likely to be unarmed, which corroborates the claim that structural racism is embedded within policing itself because officers are less likely to exert lethal force on white individuals despite a higher likelihood of being armed (DeGue et al., 2016).

The Physical Effects of Stress

Policing is a source of psychological stress for those who are subjected to it. Police contact has been found to cause high levels of anxiety (Geller, Fagan, & Tyler, 2017; Sewell et al., 2016). This contributes to one's allostatic load, a term used to describe cumulative 'wear and tear' on the body over time (Geronimus et al., 2006). Psychological stress has also been linked to telomere shortening (i.e., accelerated aging process) and a weaker immune system (Chae et al., 2020, Epel et al., 2004, Segerstrom & Miller, 2004). In the U.S., people of color tend to experience more stress (both acute and chronic) due to the effects of racism and hyperpolicing, which translates into a 'climate of fear' and ultimately a higher allostatic load (Herd, 2020). Police contact is associated with extreme stress, which can cause earlier aging and a lowered resistance to disease (Sewell et al., 2016). Furthermore, any exposure to the U.S. criminal-legal

system has been found to be associated with worse well-being in five major domains - physical, mental, social, spiritual, and overall life evaluation (Sundaresh et al., 2020).

Policing itself is an understudied determinant of health (Feldman, 2015). A number of factors contribute to the effects of policing on health, including fatal and nonfatal injuries, psychological stress, economic strain (which makes it more difficult to access health services), and systematic disempowerment, particularly in Black and Latine communities (Alang et al., 2017; Nichols, LeBrón, & Pedraza, 2018). Any involvement with the criminal-legal system, which includes being stopped, searched, questioned, or abused by the police, incarcerated, or placed under community supervision is associated with a host of negative outcomes. This includes poor self-rated physical and mental health, activity limitation, hypertension, and binge drinking compared to people who had no involvement (Zweig et al., 2017). Because poor Black and Latine communities are hyperpoliced, they consequently experience worse overall health as a result.

Mental Health

Policing practices have been found to be strongly associated with worse mental health outcomes. The negative impacts of policing on mental health have been studied in urban communities, as well as among men, people of color, gay people, and transgender people (DeVylder et al., 2018; Geller et al., 2017; Hirschtick et al., 2020). This effect has been studied the most extensively among racial minorities specifically (Del Toro et al., 2019; Geller et al., 2014). Furthermore, the effects of police killings have been found to have a spillover effect onto the overall mental health of Black Americans (Bor, Venkataramani, Williams, & Tsai, 2018). This is unsurprising considering the well-established relationship between traumatic experiences and both mental health and substance use problems (Breslau, Davis, & Schultz, 2003).

In addition to worsening the mental health of the policed, police also tend to exert more force on people with mental illness (Fuller et al., 2015). Substance use issues and mental health issues are highly co-occurring (National Institute on Drug Abuse, 2020). Therefore, it is critical to assess the extent of police violence on those with mental illnesses as well as individuals who use drugs. There exists a bidirectional relationship between policing and mental health issues, evidenced by the fact that people with mental health problems are disproportionately killed by police, who often resort to violence instead of peaceful de-escalation tactics (Baker & Pillinger, 2020; Dempsey, Quanbeck, Brush, & Krueger, 2020; Hollander et al., 2012, Fuller et al., 2015).

In fact, people with mental illnesses are 16 times more likely to die in a police encounter than those without mental illnesses (Fuller et al., 2015). There is a dose-response relationship between the number of psychotic episodes a person experiences and police encounters, with more psychotic episodes predicting more police encounters (DeVylder et al., 2017). Additionally, it should be noted that police tend to hold extremely negative and stigmatizing views of people with mental illness (Stuart, 2017). This likely creates a compounded effect wherein police who respond to 911 calls about a person of color having a mental health crisis are primed both by the individual's race as well as their mental health status. There is a combined effect of race and mental illness that leads to heightened perceptions of dangerousness, leading to an extremely high rate of escalation, violence, and fatal encounters with police (Fuller et al., 2015).

Other Indirect Effects

Aggressive policing in communities of color produces many other negative effects that often co-occur with substance use disorders. These are generally related to social determinants of health, such as education, housing, employment, and having a criminal record. For example, higher levels of policing have been found to negatively impact educational attainment for minority youth, which is associated with worse physical health outcomes (Legewie & Fagan, 2019).

Police surveillance also leads to 'system avoidance,' which refers to institutions ('systems') that keep formal records, such as the medical system, labor market, and educational institutions (Brayne, 2014). People who have had more contact with the criminal-legal system (e.g., police stops, arrests, convictions, incarceration) are more likely than those without to avoid these institutions as a way to avoid being targets of further surveillance. For PWUD, system avoidance may act as a mechanism by which criminal-legal involvement causes further social stratification. This occurs by cutting off an already marginalized group (which disproportionately consists of racial minority individuals) from services that could be utilized to improve their socioeconomic position as well as their overall health, such as education, job support, and medical care.

VIII. Policing the Lives of PWUD

Does Policing Actually Deter Drug Use?

It is commonly accepted that substance use and its related harms can and should be handled by police. However, from a public health perspective, this can lead to many negative

consequences. Since the 1980s, the main response to increasing rates of injection drug use has been to increase police presence in affected communities, with the goal of reducing the supply and use of drugs (Kerr, Small, & Wood, 2005). Yet, there is little evidence of the effectiveness of this method; in truth, increased police presence causes more disruption to the provision of health care to people who inject drugs (PWID) and has *not* been found to reduce the initiation of injection drug use (Melo et al., 2018).

Increased policing has been associated with unsafe behaviors related to drug use. For example, a street-level police program, which was designed to disperse and deter drug sales, resulted in officers harassing syringe exchange programs (SEP) participants. There were even instances of police arresting such individuals for possession of syringes they legally obtained at SEPs (Davis et al., 2005). Concerns about arrest and search were found to lead to riskier behaviors, such as being less likely to procure sterile syringes, more rapid and less hygienic injection, and deterrence of uptake of health care and preventative services. In this study, open drug sales were reduced but so was SEP use, especially among Black and male participants (Davis et al., 2005). Another study found that in Puerto Rico, repressive policing practices did not decrease drug distribution and have resulted in disproportionate incarceration in poor and rural areas (Abadie et al., 2018).

Policing has been strongly associated with decreasing PWUD's ability to practice harm reduction and obtain relevant resources, making it difficult for PWUD to take steps to protect their health (Baker et al., 2019; Collins et al., 2019; Davis et al., 2005). A systematic review found that out of 27 studies, policing practices were independently associated with the avoidance of harm reduction services for PWID in more than half (Baker et al., 2019). Routine policing near overdose prevention sites, which (like SEPs) are key to obtaining safe supplies for many PWUD, has been found to deter participants from accessing needed services (Collins et al., 2019).

Relatedly, policies based solely in law enforcement and not public health or human rights particularly increase the risk of acquiring HIV or hepatitis for PWID (Burris et al., 2004; Strathdee et al., 2015). Access to syringe exchange programs and overdose prevention sites can drastically reduce one's risk for contracting HIV or hepatitis. However, a review of policing practices found that in 22% of 27 studies, HIV infection among PWID was associated with factors related to policing, such as syringe confiscation, reluctance to buy or carry syringes for

fear of police, rushed injection due to police presence, fear of arrest, being arrested for planted drugs, and physical abuse (Baker et al., 2019). Additionally, policing has been associated with disruptions in general health care for PWID, which is also associated with transmission of infectious diseases (Kerr et al., 2005).

Overdose

The U.S. has a higher fatal overdose rate than any other country in the world (overdoseday.org). Police in the U.S. typically serve as "first responders" for drug-related medical emergencies such as overdoses. Therefore, it is crucial to examine the effects of policing and the criminalization of drug use on the health and safety of PWUD who may be at risk for overdose. The frequent extrajudicial murders of mostly Black individuals by the police validate the fear of police interactions felt by many in the U.S., particularly those who often experience police violence in their daily lives. Considering the deleterious effects of police interactions on one's health (as described above), it is understandable that many individuals, especially those who are viewed as less than human due to decades of tough-on-crime policies related to substance use, will avoid these interactions at any cost.

It is worth investigating whether people would be more willing to report an overdose if police were not involved in the response. In fact, studies that center the perspectives of PWUD confirm that one of the most common reasons for delaying or foregoing a 911 call when witnessing an overdose is fear of arrest or police contact (Jakubowski, Kunins, Huxley-Reicher, & Siegler, 2018; Koester et al., 2017; Latimore & Bergstein, 2017; Tobin, Davey, & Latkin, 2005; van der Meulen, Chu, & Butler-McPhee, 2021). It has been found that the mere presence of police in an area increases risk behavior associated with overdose, such as rushed injection or the foregoing of sterile supplies (Kerr et al., 2005). Additionally, the fear of arrest or police engagement can make people feel like they have to respond to overdoses on their own, rather than contacting emergency services (Collins et al., 2019).

One response to this issue has been to enact Good Samaritan Laws, which provide some legal amnesty when calling 911 to report an overdose (New York State Department of Health, 2019). Some studies have noted success in increasing the rate of 911 calls for overdoses since the implementation of Good Samaritan laws, although the results have been extremely mixed and levels of awareness about the law remain low (Moallef & Hayashi, 2020, Nguyen & Parker, 2018). Additionally, these laws are both confusing and limited in who they protect, which creates

an additional barrier to calling 911. For example, the law does not apply to those who are in possession of more than eight ounces of a controlled substance, who sell or have 'intent to sell' controlled substances, who have warrants open for their arrest, or who are currently on probation or parole (New York State Department of Health, 2019). These rules are difficult to memorize and in some cases difficult to interpret (e.g. proving/disproving 'intent to sell'). Many PWUD wonder why the police must respond to overdose events, as they are medical emergencies and experiencing a medical emergency is not a crime (van der Meulen et al., 2021). Additionally, PWUD frequently report a discrepancy between the law as it is 'on paper' and the actual actions of police officers (Butler-McPhee, Chu, & van der Meulen, 2020). For instance, one individual reported being charged and handcuffed in their hospital bed while recovering from an overdose.

Considering the high risk of experiencing police violence and unjust criminal penalties, many individuals will avoid interacting with police, even when witnessing an overdose. Therefore, disentangling police from overdose response may decrease the fatal overdose rate in the U.S. by increasing comfort with calling for emergency services.

IX. Crisis Intervention

The literature on crisis response tactics for substance use is limited and generally refers to mental health or encompasses both mental health and substance use crises (sometimes referred to as 'behavioral health' more broadly). This is an issue in itself, as there have been very few studies specifically examining the effectiveness of the police as default responders to substance use-related crisis calls. Behavioral health crises are generally addressed by crisis intervention teams (CITs), which are typically a partnership between police and medical or mental health professionals (Compton et al., 2011). The CIT is also sometimes referred to as the 'Memphis Model' and was originally conceived in 1988 in Memphis after the fatal police shooting of a Black man who was suffering from a mental health crisis (University of Memphis CIT Center, n.d.; Watson & Fulambarker, 2012). The goal of these teams is to de-escalate crises, reduce the use of force against people with mental illnesses, and increase the safety of all parties involved. Another goal of CITs is to foster pre-booking diversion from the criminal-legal system and to help people get into treatment (Kubiak et al., 2017).

CIT training programs often include multiple components, such as mental illness education, de-escalation training, and partnerships with relevant health professionals. While many studies which evaluate these programs in various cities have reported effectiveness, it is

important to consider how ‘effectiveness’ and ‘success’ are measured and whether this translates into actual benefits for those served by crisis intervention programs. For instance, a systematic review of police-based mental health interventions found CIT to be more effective than other interventions, such as street triage, embedded staff in contact control rooms, or liaison and diversion (Kane, Evans, & Shokraneh, 2018). However, success was measured by the number of people with mental illness directed to mental health services, which is heavily dependent on the nature of the services available in that location. An evaluation of a crisis intervention team pilot program in Baltimore determined that the program was successful because officers felt more confident handling behavioral health crisis calls after completing training (Booty, Williams, & Crifasi, 2020). This measure of success, while beneficial, may not directly translate into more peaceful interactions with people who experience crises. A study assessing the implementation of CITs across Oakland County, Michigan found that completing the training program led to more officer drop-offs of individuals to mental health crisis centers (Kubiak et al., 2017). However, this county had a 24-hour crisis drop off-center, which is not common in the U.S. and therefore calls into question the generalizability or relevance of these results to other contexts, particularly large cities. Another study, which examined the effectiveness of a CIT training with police officers in Miami-Dade County, Florida, found that officers’ knowledge about mental illness improved, perception scores (regarding people with mental illness) improved, and attitudes towards this population were generally more favorable (Ellis, 2014). However, it has not been shown that this improvement in knowledge and attitudes translates into action or decreases rates of violence encounters with people who have mental health or substance use problems.

CITs are often regarded as a ‘best practice’ in law enforcement (Watson & Fulambarker, 2012). While some CIT programs are reported to be effective, it is still important to question why police officers must be involved in this process considering the massive risk of police violence against people with mental health problems or substance use disorders, particularly those who are Black or Latine. As mentioned, people with mental illness are 16 times more likely to be killed by the police than other civilians (Fuller et al., 2015). When it comes to substance use crises, particularly overdose, it has been found that police officers experience a high degree of burnout and compassion fatigue from working in this context. Receiving overdose calls on a regular basis diminishes officers’ likelihood to endorse overdose response efforts

(Carroll et al., 2020). Furthermore, there have been instances of police directly refusing to use naloxone, the lifesaving opioid overdose reversing drug (Newberry, 2020; Wootson Jr., 2017). Moreover, officer burnout has been associated with increased aggression and reduced efficacy (Queirós et al., 2013). Finally, empirical evidence showing that CITs actually decrease rates of arrest has not been found. A systematic review and meta-analysis of CIT programs found that despite being a widely adopted program, there was a null effect of CITs on arrests of people with behavioral health problems (Taheri, 2016).

Another major flaw of the CIT paradigm is the inherent assumption that all mental health and substance use-related crises require a police response, which reinforces the perception that substance use is a criminal act. While it is true that many drugs still remain illegal, the experience of a crisis is not in itself a crime. Additionally, because of the power imbalance between law enforcement officials and people who experience crises, there is a large risk for coercion into treatment programs. Even when a person is deemed to be in need of treatment, a central tenet of harm reduction is that the person in need should be empowered to make these types of decisions on their own and not be coerced (Recovery Research Institute, n.d.).

There are a few other issues with existing CIT programs that call their effectiveness into question. First, regardless of training, police still tend to hold negative biases against people with mental illness or substance use problems (Boyd et al., 2015). While one solution might be to direct more resources into programs such as implicit bias training for officers, a large meta-analysis of implicit bias interventions found an overall null effect (Forscher et al., 2019).

Another key flaw is that CIT programs are generally voluntary and therefore self-selecting for people who already hold more positive or empathetic views towards people with mental health and substance use problems, which influences their decision to join CITs (Kane et al., 2018; Kubiak et al., 2017). Therefore, the police officers who stand to benefit the most from this type of training are likely not the ones who choose to undergo it. What is most troubling about this is that CIT training programs may appear to produce more compassionate officers who are less likely to exert force on people experiencing crises, which leads to the conclusion that the program is successful. However, this may simply reflect the fact that people who choose to join CITs may already embody these qualities. Therefore, it is difficult to conclude whether the CIT program itself has provided any benefit, particularly to the officers who hold the most negative views and likely are not part of CITs. Additionally, many cities that implement increased training

for police officers are able to do so due to extremely high budgets for law enforcement, which come directly at the expense of critical social services, such as health care and education (Smith, 2020). It is also crucial to acknowledge that people who undergo mental health and substance use crises do not want to work or interact with the police due to actual or anticipated negative (and often traumatic) experiences (Rogoza, Dolatshahi, Harocopos, & Paone, 2020; van der Meulen et al., 2021).

Perhaps the most overlooked aspect of CIT programs is that even with additional training, police continue to murder civilians experiencing behavioral health crises. This is especially prevalent when the victim is Black or Latine. This behavior is exemplified by cases like the murder of Daniel Prude, a Black man who was fatally shot by police in Rochester, New York in 2020 while experiencing a mental health crisis that was exacerbated by substance use (Gold, 2020; Westervelt, 2020). Rochester was one of the first cities in the United States to implement CITs, but this was not enough to prevent police bias, misreading of situations, and murder of unarmed individuals experiencing crises.

Police are generally not trained as first responders for crises related to mental health and substance use. Assigning them by default to this role is therefore harmful and ineffective for reasons such as police brutality, cost to taxpayers, and the desire expressed by those who experience crises to not interact with police (Baker & Pillnger, 2020; El-Sabawi & Carroll, 2020). In order to achieve an equitable and public health-oriented framework for crisis response, it is necessary to center the needs and perspectives of those most affected. The population of PWUD tends not to trust the police and to avoid interacting with them at any cost (Collins et al., 2019; El-Sabawi & Carroll, 2020, van der Meulen et al., 2021). Therefore, an interrogation of (and subsequently, a change to) the currently accepted status quo is of utmost importance.

Other Options?

Despite being seen as the default option for crisis response, police officer-involved crisis teams are not the only option available. Crisis Assistance Helping Out on the Streets (CAHOOTS) is an Oregon-based program in which 911 operators have the option to dispatch a medic and behavioral health crisis counselor in lieu of a police response (El-Sabawi & Carroll, 2020). This unarmed team is trained extensively in crisis intervention and de-escalation tactics. CAHOOTS has been shown to be both effective in de-escalating crises without the need for police, as well as being extremely cost-effective in saving police hours, reducing the need for

ambulance rides, and reducing emergency department costs. In 2019, CAHOOTS handled over 24,000 calls, which is about 20% of the total call volume of the city of Eugene (CAHOOTS Media Guide, 2020). Of those calls, less than 1% required police backup. Additionally, CAHOOTS saved approximately $14 million in EMS costs (CAHOOTS Media Guide, 2020).

New York City's population is approximately 50 times that of Eugene and significantly more racially diverse, so it may not be possible to determine whether these results would be the same across cities. However, programs similar to CAHOOTS have been implemented in larger cities with higher levels of racial diversity, such as Support Team Assistance Response (STAR) in Denver (Hauck, 2021). Additionally, a coalition called Correct Crisis Intervention Today (CCIT-NYC) has developed and is currently advocating for a crisis intervention model in New York City that calls for a "health team response" to behavioral health crises (CCIT-NYC, n.d.).

New York has a unique history of police aggression towards unarmed civilians, particularly around drug-related offenses (Ross, 2016; Williams, 2021). Therefore, it stands to reason that removing police from these types of crisis calls would drastically lower rates of police violence towards populations who are at high-risk for both police interaction and behavioral health crises.

X. Discussion

Recommendations and Best Practices

The use of traditional CITs has revealed a core issue with the current emergency response system. Police are often relied upon to carry out the job of a social worker, a medic, and arbiters of justice, despite not being trained in any of these roles. Those who study CITs often recommend further research into non-police CIT partnerships that could ultimately improve the mental health system and its ability to provide crisis response, which would reduce society's reliance on police to address unmet needs in the community regarding mental health and substance use disorders and related crises (Watson & Compton, 2019). Many calls to 'defund the police' cite the blatant misuse of power that often occurs during these crises, particularly when the person experiencing the crisis is Black or Latine (El-Sabawi & Carroll, 2020). Calls to shift public funding to social services stem directly out of these violent and traumatic experiences. While criminal activity in itself does not justify extreme aggression by police, it should be noted that police aggression also frequently occurs in the absence of any crime. The unique history of the war on drugs in New York City ties directly into this through decades of targeted harassment,

trauma, arrest, and incarceration of these populations (Ross, 2016; Williams, 2021). This heavily fuels racial disparities in health through systematic deprivation of opportunities to improve one's socioeconomic position and take steps to preserve one's health. To truly address the root of health disparities and promote equal health for all New Yorkers, public funding must be shifted away from the police budget, which is significantly larger than all social services funding, to these resources that can be used to provide an adequate social safety net. It is important to turn to non-profit organizations such as the Ella Baker Center for Human Rights, which conduct grassroots advocacy work aiming to broaden the scope of how we as a society define public safety (Ella Baker Center, 2017). This involves prioritizing rehabilitation and community-based solutions over punishment and reliance on law enforcement. Examples include scaling up treatment for mental health and substance use disorders and developing accessible and affordable housing. Ultimately, these actions would not only reduce crime, but improve the population's overall health and safety.

Drug-related harms and mental illness are deeply linked, and any solution to one must address both. Currently, consideration is being given to new programs to dispatch non-police teams to mental health crises in New York City (NYC Office of the Mayor, 2020). It is crucial to ensure that these programs are not only enacted equitably so as not to continue reinforcing existing systems of oppression, but they must also include more provisions related to substance use crises, especially overdose. The removal of police from overdose response would not only allow for more resources to be directed towards ensuring that people who experience overdoses obtain proper medical care, but it would also likely increase the likelihood of a witness to actually call 911. While Good Samaritan Laws provide some level of amnesty for those who report overdoses, the fear of interaction with the police remains a significant barrier to mitigating the overdose epidemic. This barrier can be partially addressed through policy change that removes police from being the default option for response to these crises, as they are health emergencies, not criminal acts. This is particularly the case for instances where the individual is unresponsive and poses absolutely no threat, but also for any crisis in which the person requires care and treatment. Responding to these cases with lethal weapons and an often automatic assumption that these individuals are dangerous is counterproductive to public health goals. Additionally, expanding the Good Samaritan Law's protections would likely prompt more 911-calling behavior.

Behavioral health crises often overlap with other mental health issues, but for too long have been treated like criminal acts. This only serves to reinforce war-on-drugs conceptions of substance use disorders as a personal moral failing and a criminal offense, rather than a legitimate condition that is both caused by and alleviated by the social conditions under which we all exist.

Conclusions

Although public opinion has shifted towards a more sympathetic and treatment-oriented perspective, public policy is lagging behind. Police violence is a public health crisis and public health professionals have the responsibility to shed light on and address the upstream causes for health disparities. One such cause is policing itself, particularly for PWUD. Addressing substance use with law enforcement perpetuates the belief that substance use is an inherently criminal act. Therefore, in order to improve the health and safety of PWUD, it is crucial to acknowledge and remove this association. This review has highlighted the ways in which policing harms the health of PWUD and suggested evidence-based solutions to this public health issue, particularly with regard to crisis response. If policing is indeed a cause of health disparities, future research might address ways to improve the health of PWUD through interventions which do not involve the police, particularly those that are developed through a harm reduction lens. Ultimately, this would create a less punitive treatment environment, decrease stigma associated with substance use, and help more people receive treatment if they choose to seek it. In order to promote health equity and minimize issues related to substance use, such as the overdose epidemic, the inaccessibility of health services for PWUD, and racial bias in the criminal-legal system, there is a critical need to pursue alternatives to police involvement in crisis response.

XI. References

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