Whose Concerns? It's Time to Adjust the Lens of Research on Police-Involved Overdose Response

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See also White et al., p. 1326.

In their article "Leveraging Body-Worn Camera Footage to Better Understand Opioid Overdoses and the Impact of Police-Administered Naloxone," White et al. (p. 1326) creatively use body-worn camera footage—a previously unused data source—to support the following findings of previous research: (1) police can administer naloxone during an overdose, (2) combativeness toward first responders by overdose survivors is rare, (3) drug exposure is not a risk to police officers, and (4) arrests do occur at the scene of overdose emergencies as the result of police presence.[1,2]

Although we recognize this article's contribution to the growing literature on law enforcement involvement in overdose response, we would caution policymakers about using the findings of this study to bolster (or worse, solely rely on) the role of police in overdose response. The fact that police-administered naloxone is feasible and necessary does not mean that police response to overdose should be framed as a "potentially effective" response to opioid overdose. This is because police involvement in overdose response introduces new risks of harm, and the risks are potentially greater among Black and Indigenous people who may witness or experience an overdose.

NEW RISKS OF HARM

In keeping with the findings of other studies, White et al. demonstrate that police officers are able to administer naloxone to reverse opioid overdose and save lives; they therefore conclude that "the concerns over police-administered naloxone are overstated" (p. 1326). This is true only if the concerns of police are considered.

Research has consistently demonstrated that a concern about police involvement is the most significant barrier to people who use drugs (PWUD) seeking help during an overdose—often rendering a call to the emergency telephone number 911 an act of last resort.[3] These concerns are not misplaced. A recent study of more than 2800 US patrol officers found that officers who had responded to at least one overdose in the previous six months were just as likely to report making an arrest at the scene as they were to report administering naloxone during the study period.[4] That any person who overdoses or calls 911 for help with an overdose might be subject to arrest is cause for serious concern.

Arrest, harassment, or abuse at the scene of an overdose is a portion of the risks PWUD face when seeking help: drug-induced homicide charges following an overdose event are also reason to avoid calling 911.[5] Drug-induced homicide laws generally allow prosecutors to charge someone with homicide or murder for supplying a drug that is allegedly implicated in an overdose death. Police investigations of fatal overdoses as homicides are also becoming the norm. Importantly, drug-induced homicide arrests are not generally performed at the scene of the overdose but upon receipt of a finalized toxicology report furnished by a medical examiner, which can take many months to produce. When reporting arrests following overdose events, researchers must consider the length of time covered in their follow-up search to avoid excluding drug-induced homicide arrests from the findings.

White et al. document that arrest—of both overdose victims and other bystanders—does indeed occur. Thus, their conclusion that concerns about police-administered naloxone are "overstated" is dismissive of the most problematic and disruptive concern examined in the study. The concerns of overdose bystanders who summon help during overdose emergencies,

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often PWUD, warrant privileged consideration. Research on police involvement in overdose response must address the widely documented concerns for police involvement and preference for nonpolice overdose response.

PWUD are responsible for the vast majority of overdose reversals. Even in cases when police beat emergency medical services to the scene, the person who called 911 is already on the scene. So why not focus policy efforts on ensuring that PWUD and friends and family members of PWUD have access to naloxone? Recent research suggests that all 50 US states distribute naloxone at quantities well below that needed to ensure sufficient naloxone saturation.[6] Resources currently dedicated to scaling up police involvement in overdose response (especially state and federal resources dedicated to police-assisted recovery programs and police-involved postoverdose outreach) would be better spent ensuring that PWUD are sufficiently empowered to access and administer naloxone themselves.

DISPROPORTIONATE RISKS

Black and Indigenous people are disproportionately affected by overdose.[7] They are also disproportionately affected by police violence and more likely to die at the hands of law enforcement than are their White counterparts.[8] Black and Indigenous PWUD are at greater risk of excessive use of force by police, with one study finding that, compared with the general population, the risk of being injured by police was 40% higher among people with alcohol use disorder and 80% higher among people with another kind of substance use disorder.[9]

Although there are some legal protections afforded to persons who call 911, they often fall short of offering protection from arrest. For example, 911 Good Samaritan laws (also called 911 drug immunity laws) are state laws designed to increase the likelihood of calling 911 to ensure rapid access to naloxone during an overdose emergency. These laws provide limited immunity from arrest, charges, or prosecutions for possession of paraphernalia or controlled substances for the individual who calls 911 or is experiencing an overdose. The disproportionate risk of violence at the hands of police is a powerful deterrent to inviting law enforcement interaction (specifically by calling 911)—one that cannot be resolved by the limited protections provided by most 911 Good Samaritan laws.[10] Furthermore, drug-induced homicide investigations not only directly undermine the protective mechanisms of 911 Good Samaritan laws[5] but are also disproportionately used against non-White persons—and almost exclusively in response to the preventable overdose deaths of White persons.[11]

Disproportionate policing, police violence, and incarceration of Black and Indigenous persons affect these groups' access to overdose prevention interventions, broadly, and to naloxone, specifically, especially in cases when the nearest available naloxone rests in the hands of police. Black and Indigenous people have the highest fatal overdose rates and are least served by resource allocations that further support police involvement in overdose response. Until methodologically sound and Black and Indigenous PWUD–informed research indicates otherwise, policymakers and resource allocation decision-makers should consider any life-saving gains via police-involved overdose response to be disproportionately unavailable and inaccessible to Black and Indigenous people.

CONCLUSIONS

The acceptability, availability, and willingness among PWUD, particularly those who are Black and Indigenous people—as well as cis-women, trans people, and nonbinary people of all races—to utilize overdose prevention interventions delivered via public health–public safety partnerships warrant research. One effective way to achieve this is to engage in community-driven research with PWUD that places PWUD who are Black or Indigenous in meaningful and influential roles on research teams.

Policy and public health decision-makers should consider that promoting the role of police in overdose response consumes a considerable proportion of resources and may not necessarily indicate a best practice or policy. Any resource allocation to police-involved overdose response without ensuring naloxone saturation among PWUD and their social networks will not yield the full protective effects of naloxone distribution and will not bend the curve of overdose death in this country. AJPH

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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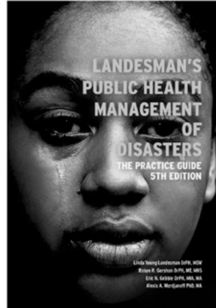

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