MARYLAND POLICE AND CORRECTIONAL TRAINING COMMISSIONS
LESSON PLAN

COURSE TITLE: 40 Hour Crisis Intervention Team

LESSON TITLE: Substance Use Disorder (SUD)

PREPARED BY: Elizabeth Wexler **DATE:** 12/30/20

TIME FRAME	**PARAMETERS**
Hours: 105 minutes Day/Time:	Audience: Experienced officers Number: maximum 25 Space: Training Academy
PERFORMANCE OBJECTIVES	**ASSESSMENT TECHNIQUE**
1) Through facilitated discussion, learners will be able to articulate the categories of reasons why someone with SUD continues to use, despite the negative consequences to the satisfaction of the facilitator.	1. Facilitated discussion
2) Given a case study and through facilitated discussion, learners will have a deeper understanding of Harm Reduction and Stages of Change models than presented in either the Academy, or In Service, including how they are connected to the satisfaction of the facilitator.	2. Case study and facilitated discussion
3) Given role-playing scenarios, learners will identify and apply successful interactions with those who are affected by substances on a call, as well as identify what intervention is needed on calls involving SUD (including, but not limited to: CRT, Medic, diversion such as BCRI) to the satisfaction of the facilitator.	3. Role playing scenario
4) Given a small group activity and facilitated discussion, learners will be able to identify the proper core principles of Crisis Response	4. Facilitated activity and small group discussions

to calls marked with SUD to the satisfaction of the facilitator.	

INSTRUCTOR MATERIALS

Chart Paper
Markers
Post-It Notes

EQUIPMENT/SUPPLIED NEEDED

1 Computer with internet access
1 Projector/Projector Screen

METHODS/TECHNIQUES

Lecture
Group exercises
Facilitated discussion
Interactive poll

REFERENCES

The following books and other materials are used as a basis for this lesson plan.
The facilitator should be familiar with the material in these reference documents to effectively teach this module.

1) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2528824/
2) https://harmreduction.org/about-us/principles-of-harm-reduction
3) Case Study – Military and SUD https://www.youtube.com/watch?v=8LzObDnNPAY
4) Case Study – SUD https://www.youtube.com/watch?v=PfwO4rrd5CM

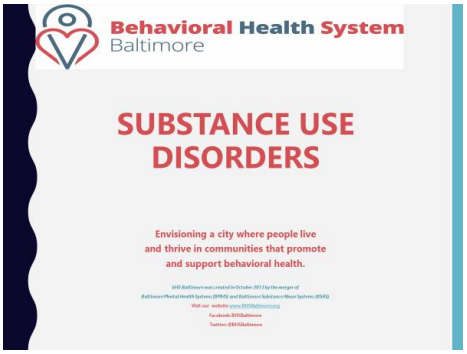
GENERAL COMMENTS

In preparing to teach this material, the facilitator should take into consideration the following comments or suggestions.

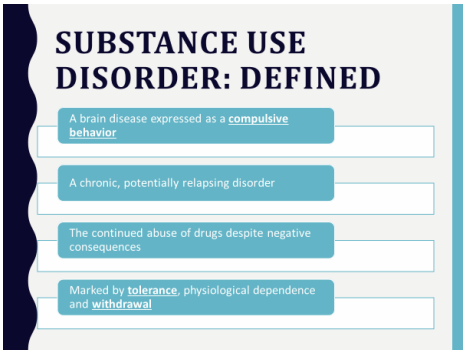
- *Have Post-It notes available for the polls where we want to offer anonymity for the responses.*
  *For the **SUD Poll in slide 17**, access the poll via the google doc using the link https://docs.google.com/forms/d/18BGmR6v3t7y8cUFQoR0Oc-u6Y-cx5TWa3yz-N--pX2o/edit?usp=sharing and have the poll up on a separate screen on the computer to show the polling results once completed*

LESSON PLAN

TITLE: Substance Abuse Overview

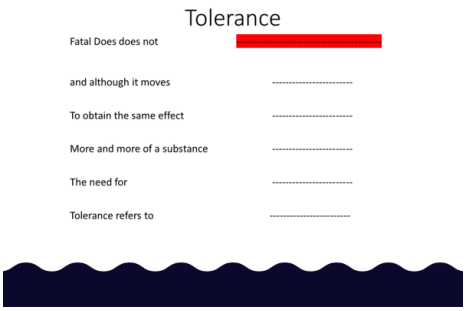
PRESENTATION GUIDE	TRAINER NOTES
ANTICIPATORY SET **Slide 1:** Introduction	**Time: 10 minutes** **Slide 1:**  *Take a minute to introduce yourself to students and share your area of expertise.*
Slide 2: Let's review the objectives we plan to accomplish with today's lesson. 1) Through facilitated discussion, learners will be able to articulate the categories of reasons why someone with SUD continues to use, despite the negative consequences to the satisfaction of the facilitator. 2) Given a case study and through facilitated discussion, learners will have a deeper understanding of Harm Reduction and Stages of Change models than presented in either the Academy, or In Service, including how they are connected to the satisfaction of the facilitator. 3) Given role-playing scenarios, learners will identify and apply successful interactions with those who are affected by substances on a call, as well as identify what intervention is needed on calls involving SUD (including, but not limited to: CRT, Medic, diversion such as BCRI) to the satisfaction of the facilitator.	**Slide 2:** 

4) Given a small group activity and facilitated discussion, learners will be able to identify the proper core principles of Crisis Response to calls marked with SUD to the satisfaction of the facilitator.	
INSTRUCTIONAL CONTENT **Slide 3:** **Opening Case Study: Military and SUD** You're now going to watch a case study about a military veteran who suffers from PTSD and substance use disorder. As you watch this case study, see what comes up for you, both about veterans and military service, and about SUD. Consider the following questions: What thoughts, feelings, biases, judgments; what does and does not surprise you. **Ask:** What is your response to the case study? **Review of SUD as an illness** We're going to review the basics of SUD as an illness, which you have likely had in your Academy training, or In Service. Let's review how we define a Substance Use Disorder. Who can give me a definition you've learned before, either in the Academy, In Service (or both?)	**Time: 75 minutes** **Slide 3:**  **Expected Responses:** *You should have an expectation of robust, possibly heated, discussion- in particular about people's gut responses, biases (ex: military/LE are not affected by SUD, and how that affects how LE views civilians with SUD)* **Desired Responses**: *a medical disorder * an illness *continued using despite negative consequences *impairment of ability to fulfill obligations, such as family or work *a brain disorder that results in compulsive behavior

Slide 4: From the medical perspective, it is an illness-just like mental illness, or cancer. BPD Policy defines Substance Use Disorder as "a problematic pattern of symptoms, including noticeable distress, resulting from the use of a substance that results in impairment." The BPD's definition aligns with the medical definition; BPD recognizes SUD as a medical disorder. Some people have a physical predisposition toward SUD. This brain disorder manifests as compulsive behavior, or the substance use. Some of its hallmarks are: continued use despite negative consequences, potential relapses (just like mental illness, cancer, or any medical illness), and a physiological tolerance. I'd like to introduce you to my co-facilitator today, Mr. Gregory Riddick. He is joining us today to discuss his lived-experience with substance use disorder. It's one thing to hear the clinical explanations of SUD, it's another thing entirely to meet someone and hear about their experience. Currently, Riddick is the Founder of the Trill Foundation here in Baltimore, and actively participates in the CPIC, which advises the BPD on its Behavioral health policies, programs, and training. Please give Riddick a warm welcome. My experience of substance use disorder is that it is both a medical condition and a spiritual deficiency for me. We all have an inherent desire to become relevant and express our gifts and talents. This was a driving force in my SUD-the feeling of not being relevant, of not expressing my gifts and talents to enhance the world. With regard to the pre-disposition to get an SUD, my desire to feel good-or more accurately, to feel less pain, overrode my physical ability to halt self-destructive behavior. So yes, this illness is expressed as compulsive behavior. For me, underneath it was also a spiritual deficiency.	**Slide 4:**  Co-facilitator introduces himself.

Slide 5:
Tolerance
You are no doubt very familiar with *Tolerance,*

Slide 5:



Ask: What is tolerance?

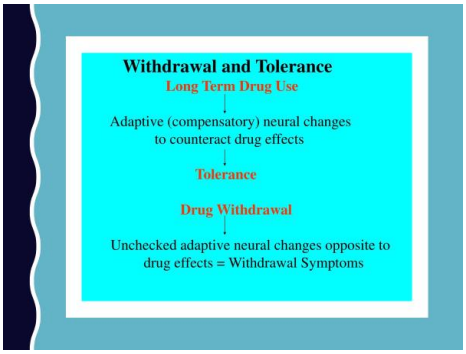
Expected Response:
When your body becomes used to a substance so much, that you need to increase the amount you use in order to obtain the same feelings.

Tolerance refers to the need to increase amounts of the substance in order to achieve intoxication or the desired effect. A sign of tolerance is a diminished effect with continued use of the same amount of substance.

It keeps going up, but a fatal dose does not. Many overdoses are accidental because of this, or mixing drugs, or not knowing what they are cut with. Especially when Fentanyl is involved, which is 100 times stronger than heroin.

Slide 6:
Withdrawal

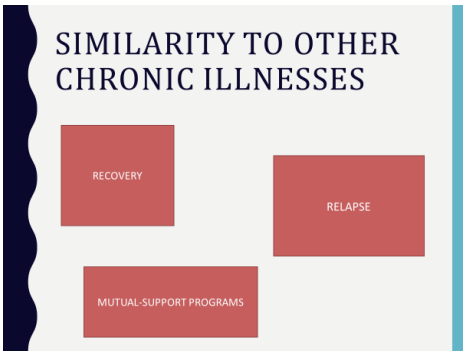
Slide 6:

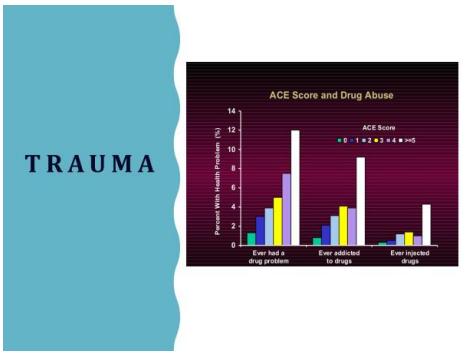


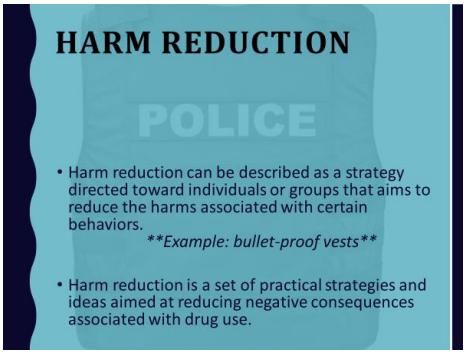
Ask: What is withdrawal?

Desired Response:
Something that happens when you suddenly give up decrease the amount of subtance you use.

As you all already know, *Withdrawal*, is the development of a substance-specific syndrome when

substance use is stopped or decreased. The type and length of withdrawal symptoms vary depending upon the substance. *reminder that ALCOHOL and BENZODIAZAPINE withdrawal can be fatal	
[co-facilitator] Physical withdrawal from a substance is real. However, in recovery we have a saying: "clean and crazy". This means someone is not using substances but acting and thinking the same way they did when they did use. When we are in this place, we continue to use people, places and things to, as stated earlier, because we have not made the changes we need to make in order to ease the pain without substance use. It appears selfish on the outside. I looked selfish when I was trying to do anything to ease my pain while not using substances.	Co-Facilitator material.
Slide 7: **SUD Similarities** Like Mental Illness, SUD is an illness. Both are illnesses just like cancer, heart disease, and other medical issues. There are deep stigmas about these illnesses; however, we need to start to look at them as illnesses. REMINDERS of how SUD is like other chronic illnesses: 1. Recovery from it--protracted abstinence and restored functioning--is often a long-term process requiring repeated treatments	**Slide 7:** 
Can someone give me an example of this in another chronic illness?	**Desired response**: any example, such as cancer, that requires repeated or ongoing treatment
2. Relapses to drug use can occur during or after successful treatment episodes	
Can someone provide an example of this from your own experience?	**Desired response**: any example, such as chronic illness like Lupus, where flare-ups occur periodically between times of medical stability
3. Participation in self-help support programs during	

and following treatment can be helpful in sustaining long-term recovery Who can share an example of this?	**Desired response**: support groups for people with illnesses are very common. Ex: Cancer, Parkinson's.
Slide 8: **TRAUMA** Remember when we talked about Trauma on Day 1? There is a high correlation between ACE scores and SUD. The higher the score, the more likely someone is to develop an SUD. The prevalence of SUD varies significantly by race/ethnicity, as well as gender. This is because ACEs-Adverse Childhood Experiences-predispose people to PTSD and longer-term trauma responses. Often substances are the first thing people find that gives them relief from these distressing symptoms; often, even before the trauma is detected. [co-facilitator] I was born with trauma embedded in my DNA. The experience of slavery carried through generations, whatever trauma my mother may have had, and the environment that African Americans face in this country, which is very pronounced in Baltimore. This, along with any genetic predisposition, made me very susceptible to self-absorbing and self-destructive behaviors, in response to living with trauma {reference back to Trauma-Informed Practice lesson at beginning} The purpose of those behaviors is to feel differently-and substances are often the preferred option for that. Understand that when you encounter someone who is using substances, that it may be due to very deep trauma, that the person may not even be aware of. Diversion is such a better option than criminal justice involvement. Diversion gets to the root of the issue, which requires treatment. Arrest just further traumatizes those of us that are using because we are in need of services which will allow us to challenge our current behaviors and give us the tools to productively work on avenues that lead to growth, day by day.	**Slide 8:**  Co-Facilitator Material

Ask: How does this matter here in Baltimore?	**Desired Response:** The demographics of Baltimore show disproportionately high POC and people living under the poverty line. People are likely to have higher ACE scores just from where they are born and raised.
Slide 9: **HARM REDUCTION** You learned a bit about Harm Reduction in In Service, and perhaps in your Academy training. Here is a quick overview.	**Slide 9:** 
Slide 10: We are going to take a deeper look at this lens through which we can view SUD, as it can have quite an impact on how we interact with folks suffering with SUD.	**Slide 10** 
Slide 11: Here are Eight principles of Harm Reduction that you are expected to apply in your work with people with SUD: 1. Accepting that substance use exists, and choose to work to minimize its harmful effects, rather than ignore	**Slide 11:**

or condemn them.

2. understanding that substance use is complex, is on a continuum from abstinence to recreational use to total dependence, and we acknowledge that some ways of using are safer than others.

3. accepting that quality of life is the main criteria for successful policies, not simply elimination of substance use. This means that quality of life is prioritized over the stopping of substance use. Though the ultimate goal is abstinence, Harm Reduction recognizes that this is a long process, where quality of life IS a fundamental part of recovery.

Slide 12:

4. This approach calls for the non-judgmental and non-coercive provision of services and resources to substances users, and their communities, in order to reduce the harm associated with use.

5. Ensuring that individuals who use substances, or have a history of using substances, have a legitimate say in how policies and programs intended to serve them are created.
Why is this important?

6. Acknowledges that persons who use substances are the primary agents of reducing the harm of the use and seek to empower them to share their input into Harm Reductions strategies.

Slide 12:

Desired response: the people suffering are those who know best what works and what does not work

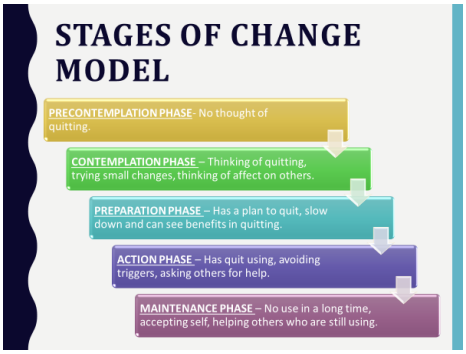
Slide 13:

7. Recognizes that the following realities affect people's vulnerability to/capacity for dealing with drug-related harm: poverty, class, racism, social isolation, past trauma, sex discrimination, and other social inequities

8. Does not ignore or minimize the real harm and danger that can be associated with substance use. This harm and danger, as you know as officers, is not

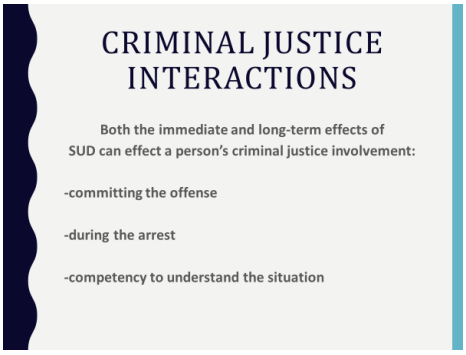
Slide 13:

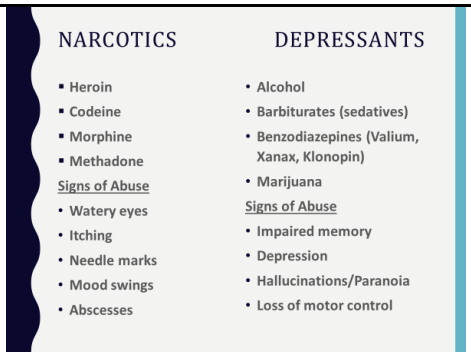
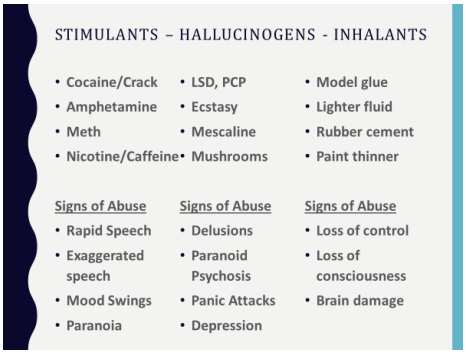
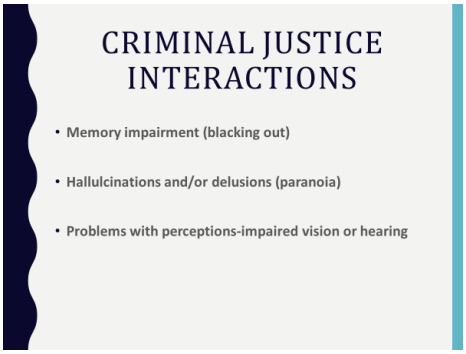
limited to the person with SUD. It affects their loved ones, and the whole community.	
Slide 14: Here is a brief video with people giving their personal statements, in some cases their personal experiences, with SUD and how Harm Reduction works. Will anyone share how this video struck you? What new aspect or insight about this model may have come from watching these testimonials?	**Slide 14:**  **[Video Link here: https://youtu.be/x9f5rz75swE]** **Desired response**: that harm reduction is not enabling, that it is a fundamental piece of recovery, that it can save lives
Slide 15: **Small Group Exercise:** We're going to break out into 4 groups. Each group will have two of the principles we just reviewed to discuss. The discussions should focus on two things: 1. Your thoughts about the principles 2. How they relate to your work as a police officer officers Particularly, are there any principles that cause you some conflict (e.g., SUD may involve breaking the law—these principles are soft on crime) How often do you encounter people with SUD and what are your feelings about them? Does incarceration solve an individual's SUD problems?	**Slide 15:**  *Separate class into 4 groups, and assign each group 2 principles*
We'll have 4 minutes in small groups, then come back for a class discussion. Please have someone designated to share what your group came up with.	*Allow 5 minutes for the small group discussion.*

(*after small groups return*) I'm going to call on each group, please have a designated person report out what you discussed. **Slide 16:** **Stages of Change** You should recall the exercise from IST about Stages of Change. Remember, these can be applied to any change but are very useful when dealing with SUD. **Ask:** Can I get one participant to read each stage? Thank you. We are going to explore how Stages of Change and the Harm Reduction Model go together.	*Facilitate each group reporting back and allow appropriate time for large group discussion.* **Anticipated areas of responses**: *that they encounter people with SUD often. *that it can be frustrating to see people use over and over. *that the LE interactions they have with people using substances often involve subject trying to get away, or not being truthful. *that they can have empathy for them in the abstract; it's hard to know how to use that empathy on a call that they are unsure how to put these principles into action. *that BPD's policies and core principles for crisis response apply during these interactions: we will try to de-escalate, divert, and above all, will respect an individual's civil rights in every encounter. Our mission isn't to further criminalize SUD but, where possible, help individuals find the help they need. **Slide 16:**  *Call on a volunteer to read the stages.*

More specifically, how we can use these models TOGETHER to improve outcomes in our community, especially on CIT calls. **Ask:** What are the possible connections you see in these two models?	**Desired Response:** *harm reduction may help people move through stages of change much more easily *people with SUD being involved in how policies and services are developed may help them move through the stages of change more easily *as people move through the stages of change, they are likely to be more willing and able to be a part of developing policies and resources that will benefit all people with SUD
Slide 17: Using the link provided on the PPT, open this poll up in your web browser on your departmental or personal phone and answer the following questions by choosing one answer for each statement (agree or disagree): 1) Having an SUD is 100% a choice 2) Having an SUD is 0% a choice 3) Having an SUD somewhere in between? Keep in mind, the way in which you choose to answer each statement is anonymous. (*discussion of this is based on results of poll*) Now, if you're comfortable discussing this, I'd like to engage in an open-discussion forum. **Ask:** Would anyone would like to share why they chose the response they chose.	**Slide 17:**  ***Facilitator Note**: It should be voluntary; only call on those who volunteer to engage in the discussion.* ***Important Note:** This is a time when the discussion can get heated. Folks have very strong feelings about SUD, and many have*

	personal experiences, such as with family members. This discussion should be in-depth and encouraged, in order to help officers a. identify their implicit biases, and b. move toward a Harm Reduction and Stages of Change approach to SUD. ** It is important to keep reinforcing that from a MEDICAL perspective, we see, and BPD treats, SUD as an illness; obviously individuals have their own opinions about it, but as public servants there is a responsibility to have all of the information available, so that your decisions on patrol can be based on the medical model rather than personal and societal bias.*
How we view SUD directly informs how we interact with folks who suffer from it. As law enforcement, you are constantly interacting with citizens and it is inevitable that your biases will come into play.	
Ask: How do you think a bias (not necessarily yours, but just a bias) could affect how you interact with someone using substances when you are on patrol? Does anyone want to share their response?	**Desired Response**: We may make assumptions without fully understanding the person or their diorder. We may be concerned that someone who is using may respond to officers in erratic, impulsive, or dangerous ways.
What is the reason, underneath all the reasons? It is similar to, "why do people attempt suicide?"	
Ask: Does anyone remember the answer?	**Desired repsonse:** to cover some kind of pain
This is also true for people who have Substance Use Disorder (SUD):	
To cover the pain, whether it is from a previous or current traumatic event, be it physical, mental, systemic,	

vicarious, environmental, or medicinal. ENCOUNTERING SUD ON CIT CALLS You know from experience that what you bring to a call, to an interaction with a citizen, can greatly affect how a call plays out. **Ask:** When someone is intoxicated, how do your beliefs, thoughts, and behavior impact the interaction?	**Desired Response:** If the SUD is seen as a choice, LE are not going to be likely to want to offer resources for harm reduction or treatment. If the SUD is seen as an illness, LE will be far more likely to offer resources for harm reduction or treatment. This can affect every part of an interaction. Whether we are
Slide 18: As I know you are very familiar with, there are several aspects of criminal justice interactions that can be affected by substance use. We're going to talk about a few of them, and ways tactics that can help you get the optimum outcome, in accordance with the five core principles (which we are going to look at shortly). *committing the offense *during the arrest *ability to understand what is happening	**Slide 18:** 
Slide 19: Let's do a quick overview of signs of misuse for different substances. Can someone tell me what signs of abuse are for narcotics?	**Slide 19:** **Note:** this slide has animations; the sections come in one at a time

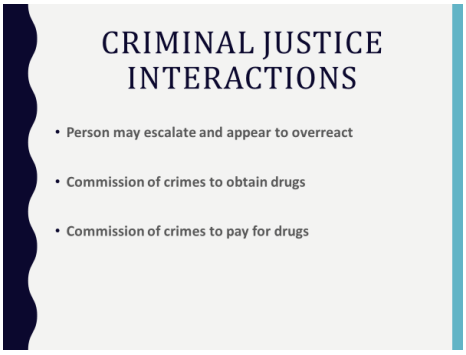
And signs of abuse for depressants?	 **Desired response: As seen above**
Slide 20: Now can someone identify signs of abuse for *Stimulants *Hallucinogens *inhalants	**Slide 20:**  **Desired response:** as seen on slide
Okay-let's talk about how all that we've talked about effects your interactions with people with SUD, in particular on a behavioral health crisis call.	
Slide 21: In a CJ interaction with someone who has substances on board—and this varies by the substance, of course—the person may escalate much more easily than they would if they were sober.	**Slide 21:** 

Slide 22:
They may be committing crimes in order to obtain illicit drugs, or to pay for drugs.
recall that this is what the LEAD program is based on: people who are committing low-level offenses to obtain or pay for drugs (rather than distribute them) are not going to stop doing that because of doing jail time, if they have an SUD.

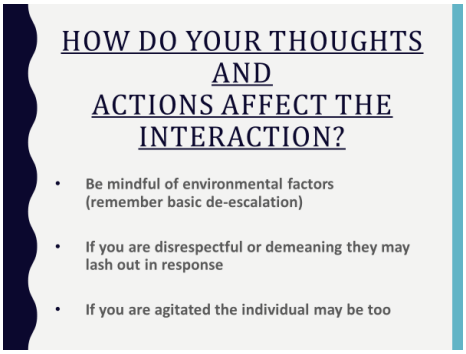
When we treat SUD as a health problem rather than a criminal justice problem, we get better outcomes. SUD is an individual—and a community—health problem. If affects the sufferer, and the effects can ripple out to the family, and larger community.

Slide 23:
Ask: What training and tactics do you already have that can make these interactions easier for you to handle, and give them a chance for a better outcome?

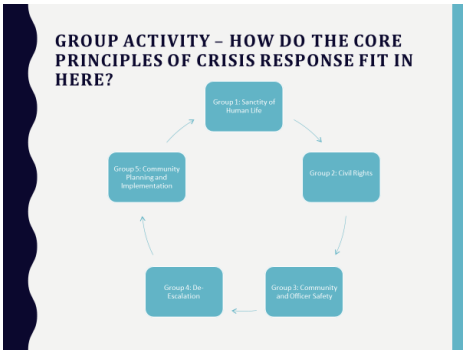
Slide 22:



Slide 23:



Desired Responses:
*always keep ICAT and BH de-escalation in mind
distance + cover = time
taking your time
staying calm; they may be very agitated, and reactive to what you say or do
Ex: if you are demeaning, or disrespectful, or raise your voice, they may become aggressive in response

Slide 24: Now I'd like to know what your experiences are. **Ask:** When you encounter someone in the field who has substances on board, what signs and symptoms do you encounter or observe? **Ask:** How does it impact your sense of safety? **Ask:** How does it impact how you act, the tactics you use, and your decision-making?	**Slide 24:**  **Desired Response:** *Allow volunteers to share their responses to the questions*
III. EVALUATION/CLOSURE **CORE PRINCIPLES** **Slide 25:** How do the Core Principles of Crisis Response fit in here? We will break into 5 small groups, and each one will answer this question for their assigned Core Principle. Each group will have about 5 minutes to work together. Group 1: Sanctity of Human Life Group 2: Civil Rights Group 3: Community and Officer Safety Group 4: De-Escalation Group 5: Community Planning and Implementation	**Time:** 30 minutes **Slide 25:**  *Facilitator will break class up into 5 even groups and assign each group a Core Principle.* **Desired Responses are below:** ***Group 1:*** Nothing is more important than human life; law enforcement need to prioritize saving people from overdoses and treating SUD as an illness *harm reduction *stages of change *Naloxone

	Group 2: Civil Rights under the ADA state that people with disabilities be treated with dignity and given appropriate accommodations. This applies to how you interact with them, as well as offering them resources. ***Group 3:*** Different tactics may be called for when interacting with someone who is intoxicated, both for the safety of the citizen and the officer. Harm Reduction and connecting folks to resources can keep both the community and LE more safe, if the person is less likely to commit crimes to support SUD, drive while intoxicated, be aggressive with LE. [Examples:] ***Group 4:*** De-escalation techniques that may otherwise be effective may not be when someone is intoxicated; different techniques may be called for. [Techniques that may help:] ***Group 5:*** Officers should be familiar with community resources that serve people with SUD, as well as skilled in connecting citizens suffering from SUD with those resources. In addition, keeping the Stages of Change in mind can reduce officer frustration when offering resources before a person is ready to act (which is still an important part of the process)

Ask: Are there any questions about any of this material? Thoughts?	
Slide 26: **Closing Case Study** We are going to end with a case study, and briefly process it afterward.	**Slide 26:** 
Ask: What did you take away from this case study?	**Desired/Anticipated Responses:** 1. She was a CO-law enforcement. No one is immune from SUD. 2. Worried about what people would think, and "faked it" 3. Was not aware of the harm her SUD did on her loved ones-but could sometimes see it in herself 4. She uses her experience to help others now. Peer support is an integral part of SUD recovery, both on the individual level, and the community level.
[co-facilitator] For me, peer support was the key to getting clean. I felt like I could trust another person with a previous SUD, especially someone that had gotten clean and created a new life and wanted to help me do the same. I'm going to explain a few points about Peer Support and how indispensable it is towards one's recovery: As Peer Support Specialists, whether state certified or not, we are Allies who appeal to the spirit within an addict, bringing self-awareness, wisdom and hope to a soul that needs the nourishment of light, guidance, support, without judgment, blaming or shaming. As each one teaches one, we build trust and community growth where once we were destructive and self-absorbed.	Co-Faciliator Discussion on Peer Support

As Peer Recovery Coaches we are proactive. We plan to discover and practice solutions to the problem(s) that needs solving in our lives and communities. We are always ready to initiate change regardless of the presence of fear and/or bad news. We take the necessary risks and expect fear from those who feel threatened by new ways of thinking, relating and living. We cannot afford to be biased, we are open to new life styles, norms and values. in short, we are interdependent and know that our collective survival is dependent upon our surviving. We seek to share how our lives are enriched by our recovery, our healing and wellness. We commit ourselves to appreciating the diversity of cultures, individuals and groups, and are willing to experience the conflict and uncertainty that this appreciation may create. Why? Because we understand the freedom our sobriety provides, so we support each other by providing encouragement, reminders, safety, and strength to continue our process of change in our lives, our family lives and our community at large. Thank you for your time, attention, and participation in a topic that is very complicated for all of us, and especially for LE. I hope you will integrate this into your CIT toolkit, and look at new ways of relating to folks with SUD. **Ask:** Any questions, or final thoughts? **Slide 30:** The Here to Help Hotline is available 24 hours a day seven days a week, including live linkage to behavioral health services 8:30-4:30 daily. The Here 2 Help number is the central place to call for all behavioral health referrals.	*Allow learners to express thoughts and ask questions;answer questions as able.* **Slide 30:**