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A police-led addiction treatment referral program in Gloucester, MA: Implementation and participants' experiences

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ABSTRACT

Background: The increasing rates of opioid use disorder and resulting overdose deaths are a public health emergency, yet only a fraction of individuals in need receive treatment.
Objective: To describe the implementation of and participants' experiences with a novel police-led addiction treatment referral program.
Methods: Follow-up telephone calls to participants in the Gloucester Police Department's Angel Program from June 2015–May 2016. Open-ended survey questionnaires assessed experiences of program participants and their close contacts, confirmed police-reported placement, and queried self-reported substance use and treatment outcomes.
Results: Surveys were completed by 198 of 367 individuals (54% response rate) who participated 214 times. Reasons for participation included: the program was a highly-visible entry point to the treatment system, belief that placement would be obtained, poor prior treatment system experiences, and external pressure to seek treatment. Most participants reported positive experiences citing the welcoming, non-judgmental services. In 75% (160/214) of the encounters, entry into referral placement was confirmed. Participants expressed frustration when they did not meet program entry requirements and had difficulty finding sustained treatment following initial program placement. At a mean follow-up time of 6.7 months, 37% of participants reported abstinence since participation, with no differences between participants who entered referral placement versus those who did not.
Conclusions: A police-led referral program was feasible to implement and acceptable to participants. The program was effective in finding initial access to treatment, primarily through short-term detoxification services. However, the program was not able to overcome a fragmented treatment system focused on acute episodic care which remains a barrier to long-term recovery.

1. Introduction

In 2015, 3.8 million people in the US reported using prescription opioids for non-medical purposes, 2 million had a diagnosis of opioid use disorder (OUD) involving prescription opioids, and over 590,000 had an OUD involving heroin (Center for Behavioral Health Statistics and Quality, 2016). Rising opioid overdose deaths have prompted local, state and federal efforts to promote prevention and treatment efforts (Compton, Jones, & Baldwin, 2016; Han, Compton, Jones, & Cai, 2015; Jones, Mack, & Paulozzi, 2013; Martins et al., 2017; Volkow, Frieden, Hyde, & Cha, 2014). Despite evidence-based and effective treatments, only one-fifth of people with OUD received any treatment from 2009 to 2013 (Saloner & Karthikeyan, 2015); in 2013, 23% received detoxification alone, 8% received opioid agonist treatment, and the remaining received counseling-based interventions (Substance Abuse and Mental Health Services Administration, & Center for Behavioral Health Statistics and Quality, 2015b). Barriers identified to treatment include stigma, cost, insurance, geography, and a difficult to access treatment system (Appel & Oldak, 2007; Drainoni et al., 2014; Mattick, Breen, Kimber, & Davoli, 2014; Olsen & Sharfstein, 2014; Volkow et al., 2014).

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Abbreviations

OUD	opioid use disorder
GPD	Gloucester Police Department
AP	Angel Program
PAARI	Police Assisted Addiction Recovery Initiative
DCF	Department of Children and Families

The criminal justice system is the second largest source of referrals for substance use treatment nationally behind self-referral (Substance Abuse and Mental Health Services Administration, & Center for Behavioral Health Statistics and Quality, 2015a). Specialized programs within the criminal justice system including diversion, drug courts, community-based treatment, and integrated case management (Chandler, Fletcher, & Volkow, 2009; Collins, Lonczak, & Clifasefi, 2015; Warner & Kramer, 2009) attempt to link individuals to substance use treatment following an arrest. New, voluntary, police-led programs have focused on using the criminal justice system as an access point to addiction treatment *prior* to arrest. Since 2015, >200 police departments in 29 states have affiliated with the Police Assisted Addiction Recovery Initiative (PAARI), an organization that supports the development of voluntary police-led addiction referral programs (Gang, 2017; Knopf, 2017).

This paper describes the first year of one of the earliest of such programs, the Gloucester Police Department's (GPD) Angel Program (AP). First, we describe the initial program design, its rapid adaptation, and implementation. Second, we discuss why participants chose to come to the AP, their experiences, and facilitators and barriers to treatment access and retention. Finally, we report placement results and participants' self-reported substance use treatment outcomes following program participation.

2. Program development

Gloucester is a small city north of Boston where substance related hospital discharges are approximately 1.5 times the state average (Massachusetts Community Health Information Profile: Health Status Indicators Report for Gloucester, 2013). In June 2015, the GPD launched the AP to provide a no-arrest, voluntary screening and referral service to individuals seeking help for OUD at the police department. The program was developed by then Police Chief Leonard Campanello in response to increasing opioid-related overdose deaths in Gloucester. It aimed to improve access to the treatment system for people with OUD. The program was advertised in community meetings and on social media with the claim that if an individual came to the GPD seeking help they would not be arrested, charged with a crime, or jailed (Gloucester Police Department, 2015).

Based on initial experiences, the program structure evolved rapidly. On arrival to the GPD, police staff confirmed individuals met the program's inclusion criteria: no active arrest warrants or acute medical or safety concerns. If active arrest warrants were found, participants were instructed to go to court (located in same building) where the AP facilitated in clearing warrants if possible. If successful, participants could return to the AP for placement; if unsuccessful, the participant would have to fulfill warrant requirement. Initially, a partnership was developed with a local hospital where eligible participants were transported to the emergency department to be evaluated and placed by state-supported staff trained to screen and find treatment for OUDs. The program was modified almost immediately when hospital leadership expressed concern that participants would overwhelm the emergency department. In response, eligible participants would stay at the police department and trained staff came to them to complete assessments for those seeking treatment. The GPD officers observed the screening process, modeled off the emergency department referral process, which involved a brief set of questions assessing for any acute medical or psychiatric needs, asking about current drug use and time of last use, followed by calls to treatment programs. (Supplementary Table 2) After observing the screening process for several weeks, the GPD officers felt it would be more efficient to screen and place participants themselves.

In the final iteration, officers screened participants and called treatment centers directly. The time involved ranged from minutes to hours. If an officer judged that the process would take several hours, individuals were assigned an "Angel," a volunteer willing to provide company and support for the participant while awaiting transfer to services. Once a referral was accepted, the police department ensured immediate transport to the treatment center from a relative, friend, or a contracted ambulance service. On rare occasion, philanthropic funds paid for transport to a distant treatment program.

As program popularity grew, participants occasionally called the AP for help. Whenever possible, officers would attempt to screen and place individuals over the phone. The GPD operated the program with on duty existing personnel supported by both voluntary and paid overtime.

3. Materials and methods

We performed a formative evaluation of the AP during its initial 12 months (June 2015 through May 2016) through follow-up calls to all participants. Trained research assistants working for PAARI made the follow-up calls. Eight call attempts were made per participant during both daytime and evening hours (four to the participant and four to a listed contact if the participant could not be reached directly). Callers took detailed notes while completing a 10–30 min semi-structured questionnaire that was created de-novo for the evaluation.

Respondents were first asked a series of open-ended questions, outlined in Table 1, to assess how the participant was currently doing and elicit program experience. For individuals who participated in the AP more than once, each encounter was assessed separately to confirm program placement. Next, participant's continued substance use, and

Table 1
Survey questions used in semi-structured interview.

Opening question	• How are you doing now?
Program placement	• Where were you placed from the Gloucester Angel Program? (If uncertain as to placement, asked if placement from Police Department records was correct) • How long did you stay at this program? • Did you complete this program? • How helpful was the initial treatment/detox program where the GPD placed you? • At the program Gloucester placed you at, did they talk about follow up treatment? • Did you go to follow up treatment? • Where did you go?
Substance use and treatment outcomes	• Since going to the Gloucester Police Department, have you started using again? • What substances have you used? • Are you getting any treatment now? • If yes, what type of treatment are you receiving? (Options included: inpatient, short term residential/CSS/TSS (<30 days), long term residential (>30 days) intensive outpatient counseling, sober house/sober shelter, outpatient substance counseling, 12 step/AA/NA or other peer support group, buprenorphine, methadone, naltrexone, other)
Participation experience	• What was the reason you sought help from the GPD as opposed to a hospital or treatment center? • Can you tell me about your experience with the GPD? • Do you have any advice or suggestions of how to improve the GPI or treatment and recovery services for people like you?