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The Police Assisted Addiction and
Recovery Initiative

Doing a Lot with a Little: How to Start a Police Department-Based Opiate Outreach Program

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Today in the United States, drug overdoses are the leading cause of accidental death for people aged 25 to 64. Opiate overdoses are driving this epidemic, quadrupling in number since 2011. As the epidemic moves from disenfranchised neighborhoods to the suburbs, policy makers and politicians are taking notice. Seeking solutions and strategies, they are turning to programs embedded in police departments. These programs originated from necessity, as first responders witnessed the ravages of this epidemic firsthand. Before there was interest in policies, and predating the media attention, municipal police departments were responding to the growing crisis. In this article, I document how one police department-based program in Arlington, Massachusetts, did just this, how we achieved positive outcomes with slim resources, and what we learned along the way.

The Story of the Arlington Model

I am a mental health clinician embedded in the police department of the town of Arlington, a suburb outside Boston. Typically, my job involves assisting the police when they intervene with individuals experiencing psychiatric symptoms. As any officer will tell you, this is a daily occurrence, and the addition of a mental health clinician not only helps officers work more efficiently, but also increases the department's ability to serve and protect a vulnerable population. In this capacity, I am often involved with other behavioral health concerns, including substance abuse.

The Arlington Police Department began tracking overdoses in the community in 2013. That year, there were eight overdoses and two were fatal. In 2015, there were thirty-four overdoses, six of which were fatal. The death of a young and beloved local woman drove us to take action. Three times in one week she overdosed from heroin, and twice, first responders saved her life using nasal Naloxone (a temporary opiate blocker). She did not survive her third overdose that week. As we reviewed the first responder interventions prior to her death, and compared them to other opiate-related deaths in Arlington, her story became instructive in two ways: (1) some of these deaths might have been preventable; and (2) prevention approaches need to precede the moment of crisis. We saw in our data that people who overdosed on opiates often overdosed again. We needed to find a way to reach individuals at risk, their families and friends, with lifesaving technology and training before the next overdose.

Here is what we did:

Step One: Educating the Public and Widening Access to Naloxone

In the spring of 2014, the Arlington Health and Human Services and police departments held our first opiate overdose prevention community event, called Naloxone Night. We invited the community through social media, our town website, local newspapers, local cable television and flyers around town. The event featured three speakers:

- 1) A court clinician explained how to commit someone for substance abuse treatment through the courts. (In Massachusetts, that's a Section 35.)
- 2) A certified interventionist talked about his own addiction. He also offered to connect people to treatment, and he committed to providing free private interventions. (This gentleman, Mike Duggan, founder of Wicked Sober, became a key member of our team, volunteering his time to facilitate entry to treatment.)
- 3) Staff from the local needle exchange program discussed the physical signs of overdose, demonstrated administration of Naloxone, instructed individuals in administering it, and provided free double-dose Naloxone kits to those who wanted them.

We achieved three goals with Naloxone Night that would later mark our comprehensive approach: 1) education for families and those struggling with addiction; 2) distribution of Naloxone; and 3) access to services for those seeking help.

I asked Mike Duggan to co-facilitate twice-monthly community meetings. We called this component of our program, Arlington ACTS (Addiction, Community, Training and Support). Arlington ACTS meetings offer a place for community members to get information and connect to resources. The meetings begin with an outside speaker, followed by offers of access to treatment, and ending with distribution of, and training in, Naloxone use.

Step Two: Removing Surplus Prescribed Opiates from the Community. In an effort to remove potentially addictive drugs from the town, Arlington was already hosting drug take-back days. The police department also installed a permanent kiosk in the police station lobby for 24/7 drop-off. Arlington then went a step further by organizing proactive drug take-back at its public housing buildings, thereby eliminating the obstacle of transportation. Over the past three years, these efforts have resulted in the destruction of more than 61,000 prescription drugs.

Step Three: Targeting Those Most at Risk. The individuals who actively use heroin are the least likely to attend our Arlington ACTS meetings. The more chronic the use, the more likely the person is afraid of contact with the police. While Naloxone is available in pharmacies without a prescription, these individuals are often reluctant to go to pharmacies to get it, due to stigma, misinformation or the foresight required to make such an effort. If we really wanted to decrease opiate deaths, we needed to reach the people abusing opiates, and we needed to show them they could freely ask for help.

Naloxone is clearly not a cure-all for the crisis of opiate deaths. Like CPR, it is an effective lifesaving technique, but does little to prevent life-threatening behaviors or illnesses. However, as we distributed this medication at the ACTS meetings, I began to realize that the way it is dispensed has its own preventative benefits. I saw that Naloxone could be a way to reintroduce police officers to people who use substances; that it might shift the dynamic between the two in a positive way. If police department personnel distributed Naloxone to individuals most in need, the medication became a kind of handshake, a symbol that the police were there to help users, not simply to arrest them.

As the police department clinical responder, I have access to police reports. So I began reaching out to everyone who had recently overdosed. In addition, police officers – always very aware of what is going on in the neighborhoods they patrol – started to share with me their concerns about residents, and I would reach out to offer help. After an overdose, or after I receive information from an officer about someone of concern, I call the person and anyone else listed on the report, to offer Naloxone and treatment options. If I can't reach people by phone, I go to their home. If they refuse to see me, I make sure they understand they can contact me when and if they decide they want help.

Step Four: Access to Treatment: Inspired by the Gloucester Program, a police department-based model in which police officers help individuals access treatment, we wanted to create our own means for achieving this goal. Finding detox beds or treatment facilities can be challenging and time-consuming because of high demand and limited numbers of beds. If you are addicted to substances and are ready to commit to treatment, calling many facilities and being rejected can be discouraging and overwhelming. Now a local interventionist who volunteers his time, and I, assist people with bed searches.

Reviewing what we had accomplished, we identified one more element that would complete our comprehensive model: We wanted to find a way to stem the hemorrhage of use. We were far from naïve – we knew the road to recovery is a marathon, not a sprint – but our goals were modest.

Step Five: Relapse Prevention: At an Arlington ACTS meeting, a gentleman in recovery stated that one of the most difficult times for someone struggling with addiction is often the first day home from treatment. Once home from the restrictive environment of a treatment center, a person is often left to their own devices with little to do and no support structure. We wanted to find a way to welcome them back and ensure they had support. Our solution was to inform the community about our Coming Home Day program. We encourage anyone about to be discharged from treatment to call us. We arrange for a community volunteer to meet with them on the day of discharge and bring them to an AA meeting or help link them to other services. Coming Home Day is a kind of social or community relapse prevention technique, bridging the precarious gap between inpatient care and community living.

Don't reinvent the wheel

Across the country, police departments are rapidly and creatively using limited resources to address the opiate misuse epidemic, from creating positions called Harm Reduction Clinician to designing small assignments for civilian staff. Police departments can do a lot with a little to offer an effective first response to the epidemic.

The conversation has changed; stigma must be set aside if we want to save lives. Our model is an example: We provide a program that is comprehensive and effective, yet no staff in our town are dedicated full-time to this problem. Instead, we use a team approach designed strategically and tactically to assist the neediest people. As a result, we are able to provide a quick, compassionate and effective response to this crisis.