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RESEARCH ARTICLE

Perspectives of Treatment Consumers, Treatment Providers, and Law Enforcement on Drug Treatment and Prevention

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ABSTRACT

Background: While much of the literature has focused on examining barriers to substance use disorders (SUD) treatment with individuals with SUD, there is a dearth of research from the perspective of treatment providers and law enforcement, 2 groups who witness the challenges for addressing SUD.

Methods: Using content analysis, this qualitative study explored the perspectives of individuals with SUD, treatment providers, and law enforcement on recommendations about SUD treatment and prevention. Data from 12 focus groups with individuals with SUD were analyzed and triangulated with interviews from treatment providers and law enforcement. Cross case analysis was utilized to identify common categories.

Results: The categories identified included education, judicial system, psychosocial barriers, resources, stigma, stages of change, and treatment. Results indicated all groups had similar ideas on how to address SUD. Participants provided recommendations in each category for addressing SUD.

Conclusion: Individuals with SUD, treatment providers, and law enforcement officers are affected by complex issues of SUD on micro, mezzo, and macro levels. Public health professionals can help to facilitate changes by advocating for prevention and intervention methods to be implemented to address SUD.

Keywords: Substance use disorders; Law enforcement; Treatment providers; Focus groups

INTRODUCTION

In 2017, an estimated 21.2 million Americans needed substance use disorders (SUD) treatment, yet only an estimated 3.7 million received treatment.[1] For individuals, families, and communities, SUD are associated with adverse outcomes such as medical and mental health conditions, lost wages, and criminal activity.[2] Community and governmental responses to SUDs have addressed them as public health and criminal justice matters.[3,4] While street-level enforcement strategies such as arrests have been the standard response toward illicit drug use,[5] public health responses addressing prevention, treatment, and harm reduction have been popular in recent decades. These include screening, brief intervention and referral to treatment,[6] medication treatment,[7] and harm reduction approaches such as support programs, resources on safer ways to use substances, take-home naloxone kits, supervised consumption services,[8,9] and syringe exchange programs.[10]

Ohio State and Regional Trends

From 2007 to 2018, drug overdose was the leading cause of death from planned and unplanned injuries in Ohio.[11] Ohio has the fifth-highest overdose death rate in the nation,[12] with an age-adjusted

overdose death rate of 35.9, as compared to a national average of 20.7.[13] The Cincinnati region, as identified by the Ohio Substance Abuse Monitoring Network (OSAM), encompasses 13 counties in Southwest Ohio.[14] Death rates by unintentional drug overdoses range from 23.6 to 53.3 per 100 000 people in these counties.[15]

Study Background

Research on barriers to SUD treatment has predominantly been conducted with individuals with SUD. Limited research has been explored with the counselors and therapists providing SUD treatment or with the law enforcement officials enforcing substance use laws and policies.[3,16] Counselors provide an essential perspective to the discussion, as they are privy to the challenges of SUD treatment delivery and maintain connections to those receiving treatment.[16] Research with law enforcement populations can offer insights, as they have wide discretion in how they enforce the law.[17] Furthermore, the criminal justice system has served as a primary service delivery system for adults facing the challenges of SUD.[17] This study contributes to the underdeveloped literature investigating law enforcement officers' attitudes toward drug use and treatment.[4]

Study Purpose

Established in 1999, the OSAM Network is a prospective, longitudinal study of illicit and prescription drug abuse in Ohio.[18] Regional epidemiologists conduct focus groups with persons receiving SUD treatment (treatment consumers). These focus group findings are cross-referenced with findings from individual interviews and focus groups conducted with community professionals who provide SUD prevention/treatment services (ie, social workers and counselors/therapists), as well as with those whose work is directly impacted by substance use disorders (ie, law enforcement, probation officers, and coroners). Once integrated, these data provide Ohio's behavioral health authority, Ohio Mental Health and Addiction Services (OhioMHAS), real-time, epidemiologic descriptions that policymakers need to plan prevention and intervention strategies. This study was a smaller examination of a larger study that OSAM conducts twice a year to monitor drug trends in specific regions. Our study examined a focus group question that was not analyzed in the larger study.

The research question analyzed for this study was: "Imagine you could speak to the governor and other state officials right now. What recommendations regarding drug abuse prevention and treatment, specific to this region, would you make?"

METHODS

This expedited study was approved by the institutional review board. Participants included individuals who were using illicit drugs or had stopped using illicit drugs within 6 months prior to study enrollment, treatment providers who provided SUD treatment, and law enforcement officers. Focus groups and interviews occurred August 2018 through May 2019.

Setting and Design

Recruitment occurred by the first author calling SUD facilities and law enforcement in the region and requesting their participation. Agencies then received an email with a flyer to distribute with information about the study, location, date and time of group, and incentive payment.

Focus groups (n=12) were implemented at SUD residential, intensive outpatient, and outpatient treatment centers. Eligible participants were individuals receiving treatment for SUD aged 18 years or older who spoke English and had less than 6 months in recovery from SUD. Participants were provided a $20 gift card to a local store.

Providers and law enforcement were interviewed individually or in focus groups at their location or at a location such as a library. Treatment providers and law enforcement were eligible if they were working at a SUD treatment facility or in law enforcement and had knowledge on drug abuse in Ohio within the past 6 months. Due to ethical considerations, treatment providers and law enforcement did not receive monetary compensation. Three focus groups and 1 interview occurred with treatment providers. Three interviews and 1 focus group took place with law enforcement officers.

Participants

Eighty-nine treatment consumers, 18 treatment providers, and 8 individuals in law enforcement were interviewed regarding drug abuse prevention and treatment. The interviews and focus groups were conducted in 5 counties in Ohio: Butler, Clermont, Clinton, Hamilton and Warren. Focus groups ranged from 4 to 12 participants per group of treatment consumers. Table 1 describes the demographics of the treatment consumers. Missing data included 2 participants not answering questions on income and poverty status and 1 participant not answering questions on ethnicity and graduation rate. Demographic information of providers and law enforcement were unavailable.

Procedures

Focus groups for treatment consumers were conducted in a room at the SUD treatment center between or after SUD treatment groups. Before the start of the focus group, participants were screened for eligibility, informed the interview would be recorded, assured of anonymity, and assured treatment would not be impacted if they declined or decided to participate. Confidentiality among focus group participants was also stressed. Participation consent was then obtained. Participants completed a demographic survey prior to the start of the focus group. The focus groups were facilitated by the first author with a coauthor present to observe and take notes. A debriefing session was held by the researchers after each focus group to discuss observations and record field notes.

Interviews with treatment providers and law enforcement occurred with the first author. Similar to procedures with treatment

consumer participants, screening for eligibility, consent, request to record the interview, and assurance of anonymity of responses occurred. The first author documented field notes after each interview.

Data Analysis

The audio recordings of the interviews and focus groups were transcribed verbatim by the second author. Participants were de-identified. The transcriptions were read by the first author to check for consistency. Qualitative content analysis process was used to analyze the data.[19] Through an iterative process, the research team constructed a qualitative coding scheme, which was applied to the interview transcripts.[20] As themes emerged from the data, they were added to the scheme, which allowed for inductive analysis.[21]

Transcripts from the treatment consumers were reviewed by the first 3 authors independently to identify common codes though an iterative process. Next, preliminary codes were identified. The first 3 authors then met and developed a codebook. These authors recoded the transcripts with the codebook and discussed any discrepancies. After reaching saturation with the treatment consumers disorders transcripts, the authors triangulated the data[22] by utilizing cross case analysis[23] with the treatment providers and law enforcement transcripts. Peer debriefing[24] also occurred.

Table 1. Demographics

Characteristic	N	%
Gender		
Male	50	56%
Female	39	
Race		
White	68	76%
African American	20	
Ethnicity		
Latinx	4	4%
Age in years		
< 20	1	1%
20–29	12	13%
30-39	36	40%
40-49	12	13%
50-59	23	26%
≥ 60	5	6%
Education		
Less than high school graduate	22	25%
High school graduate	32	36%
Some college or associate degree	29	33%
Bachelor's degree or higher	5	6%
Household income		
< $12 000	37	42%
$12 000 to $20 999	17	19%
$21 000 to $28 999	12	13%
$29 000 to $37 999	8	9%
≥ $38 000	11	12%
Drug of choice		
Alcohol	31	35%
Cocaine, crack	17	19%
Cocaine, powdered	16	18%
Ecstacy/Molly	6	7%
Heroin/Fetanyl	31	35%
Marijuana	32	36%
Methamphetamine	23	26%
Prescription opioids	26	29%
Prescription stimulants	9	10%
Sedative-hypnotics	18	20%
Suboxone®/Subutex®	25	28%
Other drugs*	4	4%

Sample Description (n=89)
Not all participants filled out forms completely; therefore, numbers may not equal total participants.
Some respondents reported multiple drugs of use during the past 6 months.
*lysergic acid diethylamide (LSD) and dextromethorphan cough syrup (DXM)

RESULTS

Codes were identified in each focus group that overlapped with all groups conducted. Table 2 provides information on codes and categories, whereby the specific codes were identified by participant group and specific transcript (C=clients, P=providers, L=law enforcement). Overall, recommendations regarding drug abuse prevention and treatment in Ohio overlapped for treatment consumers, treatment providers, and law enforcement. Eight categories were identified.

Access to Care

Treatment consumers reported the biggest barrier to SUD treatment was access to care: "*More availability ... there needs to be more bed space.*" They discussed how they could not get the help they needed in a timely manner. Treatment providers also reported this issue and discussed how they had to provide a lower level of treatment until the treatment consumers could be admitted. "*We have patients that come into our program and we are just not providing them the services they need.*" Law enforcement also saw a great need for treatment. "*We need easier access to providers.*" Insurance, or lack thereof, was discussed. This included private and Medicaid, as Ohio has state-run Medicaid insurance. Many treatment consumers lose their jobs, rendering them without insurance. A treatment consumer summarized the problem succinctly: "*A lot of rehabs only accept private insurance, and a lot of the people that are doing drugs won't have insurance*." Treatment providers talked about the time it took to get a client to get Medicaid, their frustration with the system, as well as their concern that clients would not be able to stay alive long enough to get treatment: "*Our clients are struggling to stay alive [while] waiting for Medicaid to go through.*" Even those who did have benefits did not always have access to care: "[*I'm*] *here [in treatment at a community agency] because the VA is too busy right now.*" Recommendations focused on bringing more SUD treatment providers to rural areas, changing the process to more quickly get Medicaid coverage for individuals who need SUD treatment services, and providing more and longer-term treatment at different care levels so that treatment accessed is appropriate to the individual's severity of SUD regardless of their insurance provider or ability to pay.

Table 2. Categories and Codes

Categories	Definition	Codes collapsed into categories	Found in focus groups or interviews with		
			Treatment consumers	Treatment providers	Law enforcement
Access to care	Ability to get treatment that is needed	Access, Insurance	1C, 2C, 4C, 5C, 6C, 7C, 8C, 9C, 10C, 11C	1P, 2P, 3P	1L, 3L
Education	Lack of preparation and knowledge regarding SUD, drugs and alcohol, and addiction provided to individuals in the school system, family members/ friends of those with SUD	Prevention, Lack of education	1C, 2C, 5C, 6C, 7C, 8C, 9C, 10C, 11C, 12C	2P, 4P	1L, 2L, 3L, 4L
Judicial system	Refers to laws, jail, or anything related to legal system	Jails, Decriminalization	3C, 5C, 6C, 7C, 8C, 9C, 10C, 11C, 12C	3P	1L, 2L, 3L
Environmental barriers	Environmental factors that impede recovery	Unemployment, Housing, Homelessness, Transportation	2C, 4C, 5C, 6C, 7C, 9C, 11C	1P, 3P, 4P	2L, 3L
Resources	Providing outside support through services and material goods	Finances, Material goods, Allocation of money, Case management, Community engagement, Advocacy, Outreach, Insurance	2C, 3C, 4C, 5C, 6C, 7C, 8C, 9C, 10C, 11C, 12C	1P, 2P, 3P, 4P	1L, 2L, 3L, 4L
Stigma	Negative perception of those treatment consumers	Stigma, Isolation	1C, 2C, 6C, 8C, 10C, 9C, 12C	2P, 3P, 4P	1L, 2L, 3L
Stages of change	How ready is the individual to receive treatment	Readiness to change	1C, 2C, 3C, 4C, 5C, 6C, 7C, 8C, 10C, 9C, 11C, 12C	3P	2L, 3L
Treatment	The type of services a client receives to aid in addressing SUD	Medication-assisted treatment, Therapies, Integrated health, Sober living	1C, 2C, 3C, 4C, 5C, 6C, 7C, 8C, 9C, 10C, 11C, 12C	1P, 2P, 3P, 4P	1L, 2L, 3L, 4L

Note: Transcripts analyzed for categories and codes are indicated by number and group. C=clients, P=providers, L=law enforcement

Education

Treatment consumers, treatment providers, and law enforcement saw a need to educate the public. All groups agreed that: "*Prevention has to start at a young age"* (law enforcement). It was suggested that education take place in schools. Treatment consumers who were in recovery thought they should be a part of this process: "*Maybe start having some recovering addicts go and speak to kids."* Educating parents on how to talk about SUD with their children was recommended. Using media and venues such as community centers and churches were discussed. Furthermore, medical professionals need to provide education regarding the safe use of prescribed medications that are potentially addictive. For example, a treatment consumer reported: *"And I also think that when a doctor prescribes these opiates, that doctor also need to explain that they are very addicting. When they gave me all my prescriptions, not one doctor came up to me and said, 'Oh, this is very addictive.'"* Treatment consumers and treatment providers suggested education on medication treatment for those needing help. "*Educating people to what's available out there, as far as, like, medications and treatment*" (treatment consumer).

Judicial System

The challenges to recovery within the judicial system were discussed. For one, it was difficult for individuals to stay drug free while incarcerated. "*Jail's not going to do you any good, 'cause you can get high in jail… probably easier than you can on the street, at this point"* (treatment consumer). Therefore, controlling the influx of illegal substances in prison was recommended. All groups discussed the impact of having a drug charge for individuals trying to make a positive change in their life. "*And if you're giving them this drug record and they get out of jail and they can't get a job, so then what are they supposed to do?"* (law enforcement). Treatment consumers, treatment providers, and law enforcement discussed decriminalization as a possible way to help: "*So decriminalize … Emphasize that it's a medical issue"* (treatment providers). Concern about the overall cost for incarceration was discussed as well as the effectiveness of prison: "*How much is it to arrest them and take them to jail and leave them sit there?"* (law enforcement). All groups reported additional outside pressure, such as those from the judicial system, was sometimes necessary. A treatment consumer reported: "*…but though I think you need a little more encouragement, such as: you are, you must do this. You must go in treatment. You must, or you, you know, you're never going to get off probation or whatever. Just, something to kick your butt.*"

Treatment consumers and providers discussed drug court and the treatment in jail that helped treatment consumers to become stable in recovery. "*I attribute my sobriety, majority of it, now to, the TC* [therapeutic community] *program that I went through that is now offered within the prison system"* (treatment consumer). Overall, all groups felt there needed to be programs in place for those who were in and/or interested in recovery and involved in the judicial system: *"… people need opportunities for second chances"* (treatment provider).

Environmental Barriers

Environmental barriers were discussed, including housing, employment, and transportation needs. Unfortunately, many of the treatment centers were not located along transportation routes that were accessible to treatment consumers, especially those in rural areas: "*I've been payin' Uber and Lyft rides every day to get here and back… seventy or eighty [dollars] for the ride every day and fifteen for the juice [Methadone] when I get here. That's for me to stay clean, and you know, I'm lucky that I can do that. A lot of people can't afford that kind of thing"* (treatment consumer).

In addition to the recommendations to bring more SUD treatment facilities to rural areas, which was mentioned by multiple participants, one treatment consumer had a recommendation to provide mobile treatment clinics similar to those provided for mammograms: *"… it's already bad enough you don't want to have to come here. Then it was like, having to come here three times a week, three hours at a time, gas back and forth. You know, how they got those … mobile breast cancer vans? Maybe do like one of them for the outlying communities. So people don't have to travel as far."*

As mentioned in the previous section, many participants discussed that felony drug convictions can severely limit employment and housing options, which led to recommendations of making it easier to have felony convictions expunged.

Resources

All groups had suggestions on resources that could help treatment consumers. These included case management, outreach, access to Narcan, advocacy, and funds. "*Case management is so important, because you need someone to help you and guide you, let you know where those resources are*" (treatment provider). Treatment consumers who experienced outreach talked about how it helped them to seek treatment, and more was needed. The need to access Narcan was important to all groups. All groups realized that funding for resources was needed, and thought that the public was onboard, but not necessarily the government. *"Honestly, I think that if it was put on the ballot for an increase in funding, I think that it would pass in this area, because of how bad things are"* (treatment provider). Treatment providers talked about advocating for the individuals they treated but saw little impact: *"But is limited to our population because of the resources, the lack of resources, we need to move forward and address those and everybody comes to those meetings* [meetings with legislators] *and shakes their heads and says, 'Oh I didn't understand' but then nothing gets changed"* (treatment provider). One law enforcement personnel suggested a way to access the money and resources needed: *"So, it'd be nice if the state of Ohio somehow could, whether it was OMAS, or whether it was the governor, state legislator, someone could declare a health emergency. And have the resources on the street, to not only save lives but shift addiction."*

Stigma

Health-related stigma is a social process whereby social groups are devalued, rejected, blamed, and excluded on the basis of a socially discredited health condition or health-related problem.[25] Treatment consumers reported the stigmatization they received as a group: *"We've got a bad stigma on us and I don't think that, you know, we get a fair fighting chance because we've got so many people against us."* Treatment providers and law enforcement agreed. A treatment provider summed up why treatment consumers face stigma: *"I think a big problem in our state is that it is still seen as a moral issue … Rather than a medical issue."* Treatment consumers discussed how isolating it felt: *"That's just, like, me personally like, for a minute, I just felt like I was in a black hole. I couldn't talk to anybody about this so I didn't talk to anybody about it. But it just made my addiction worse."* Treatment providers and law enforcement saw this as impeding recovery, as they would go back to their previous lifestyle. *"So they go right back to the people that they know, who will actually spend time with them. What are they doing? Probably drugs. They feel hopeless, so what do they want to do? Probably more drugs. We set the system up to just completely not support you in recovery, if you do get stuck in it"* (law enforcement).

All groups discussed the need to support more drug-free activities to decrease the feelings of isolation. Additionally, recommendations were made to offer opportunities to prepare those in the community to support those with SUD: *"I think there should be, like, class or meetings for people who are dealing with people who have addictions, more like empathy, compassion. Because a lot of these people, they don't feel like they have anyone they can turn to or talk to"* (treatment consumer).

Stages of Change

The stages of change, applied to treatment consumers, is drawn from the transtheoretical model, conceptualizes behavior change as a process that unfolds over time, and involves a series of 5 stages: precontemplation, contemplation, preparation, action, and maintenance.[26,27] All groups discussed the realized importance of the individual with SUD wanting to change: *"He can throw me in jail a hundred times. If I'm not ready, I'm not gonna quit"* (treatment consumer). They also discussed the challenges of continuing to maintain that substance-free lifestyle: *"But it's, from what we see and it's almost… Like a revolving door"* (law enforcement). The solution often suggested was making treatment available for longer periods of time: *"But if I would have been at treatment for a full ninety days, I would have had more drive to continue my recovery"* (treatment consumer).

Treatment

All groups had suggestions about treatment. Sober living opportunities for individuals in recovery were discussed in all groups: *"Sober living that are MAT* (medication-assisted treatment)*-friendly"* (treatment provider). *"You had a transitional living type o' sober living facility where they go in there and they stay there for six months"* (law enforcement). Integrated care was discussed as a need: *"Part of treatment is getting physically healthy … So, getting people back in and seeing a doctor regularly"* (treatment consumer). Treatment providers and consumers discussed how some programs only provided medication treatment but not counseling, so individuals do not get needed help. As a treatment consumer shared: *"'Cause the other place I was goin' in, you just pay 'em and got your medicine and then you left. I think there needs to be counseling, not just hand out the medication."* Providers talked about their concern that there was a growth in different types of medication treatment but not one that has a history of success: *"We, we got all these suboxone programs… Poppin' up everywhere for profit. But yet methadone is still the gold standard, for treating opioid addiction, but yet we still have the same regulations that have been in place for probably the last thirty years."* Treatment consumers also discussed this challenge with methadone, leading to less methadone clinics: *"Remove the tight, unyielding restrictions they've had on it since the sixties."* Overall, all groups agreed treatment was essential to addressing drug abuse: *"Treatment is the most powerful tool that can change lives"* (treatment provider).

DISCUSSION

Substance use disorder is a common and under-treated problem that has a major impact on individuals, their families, and the community. While most research has focused on understanding the barriers to SUD treatment, qualitative studies have sought out suggestions and recommendations about SUD treatment and prevention among treatment consumers, treatment providers, and law enforcement,[3,28-30] but none have explored the perspectives of all 3 of these groups simultaneously.

Participants interviewed from all 3 groups shared recommendations within the same categories (education, judicial system, psychosocial barriers, resources, stigma, stages of change, and treatment) when asked what they would propose to the governor and other state officials regarding drug abuse and prevention. Similar to a recent study by Bunting and colleagues,[29] the participants identified individual, interpersonal, institutional, organizational, and system-level barriers, yet were still able to provide system-level recommendations appropriate for public policy interventions.

Recommendations addressing access to care included helping individuals receive appropriate levels of treatment regardless of where they live, their insurance provider, or status. Suggestions regarding the judicial system included advocating for treatment over incarceration and using the judicial system for leverage when needed. Decriminalization and revoking drug felony convictions were frequent suggestions especially because of the limiting impacts felony convictions have for employment and housing. A possible solution to help treatment consumers in the judicial system is to connect them to a caseworker prior to being released. In Massachusetts, the Hampden County jail developed a program whereby health care teams worked within the correctional facility and the

community to provide care for individuals during their release.[31] By providing individuals with support to access resources, they may be more likely to become connected to services.

Recommendations for overcoming psychosocial barriers included decreasing transportation challenges through mobile treatment vans and providing treatment in rural areas. Efforts to address stigma included recommendations to offer more drug-free activities and targeted education efforts for community members with stigmatizing beliefs.

The importance of recognizing the readiness for individuals to seek treatment was a frequently mentioned concept in all groups, with recommendations to ensure that treatment is available when people are ready. For many individuals, readiness fluctuates over time, rather than being a linear experience, which underlies the importance of having treatment available on demand, as readiness may wane if too much time is allowed to pass before access to treatment is available.[30]

Finally, recommendations for treatment were suggested by all groups. This included increasing all levels of treatment; ie, medication treatment, sober living, and integrated health care. This echoes sentiment found by Browne and colleagues, whose participants suggested partnerships between care providers to ensure the holistic needs of individuals who use substances are met while also providing flexible agency operating times as a way for treatment to be accessible beyond typical business hours.[28]

Limitations

There were some limitations in this study. Focus groups varied in the number of participants. Also, participants self-selected to participate in the study. Social desirability may have impacted data provided by participants. Furthermore, generalizability of findings is limited due to convenience sample within a specific geographical location as well as the nature of qualitative research exploring more in-depth topics. Finally, demographic information on treatment providers and law enforcement officers was not collected.

PUBLIC HEALTH IMPLICATIONS

Public health can address SUD on micro, mezzo, and macro levels. Counselors who provide treatment can link clients to case management services or provide outreach to individuals who are actively using substances or have recently overdosed. For example, in Cincinnati's Colerain Township, the community paramedicine model is utilized, whereby a team of police officers, firefighters/emergency medicine technicians (EMTs), and social workers make home visits within 1 week to an individual who overdosed and EMTs were called to the scene.[32] School personnel such as counselors and health educators could help to design programs on SUD for parents and pupils, such as working with individuals in recovery to share their stories and providing parents with talking points to discuss SUD with their children. These interviews show that in addressing SUD, law enforcement, treatment providers, and treatment consumers are often in agreement over the importance of treatment options. Public health professionals could build coalitions with community groups and representatives from treatment providers and law enforcement to agree on options when addressing SUD. Furthermore, public health professionals can lobby legislators for funding to support treatment options, advocate for laws to reduce sentencing for drug use, and replace prohibitive regulations associated with methadone treatment to increase accessibility. Future public health researchers can design studies on the effectiveness of prevention and treatment options to determine impact.

Conclusion

Treatment consumers, treatment providers, and law enforcement officers are affected by complex issues of SUD on micro, mezzo, and macro levels. Yet these 3 groups identified possible solutions to address SUD. Public health professionals can help facilitate changes by advocating for prevention and intervention methods to be implemented to address SUD.

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