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Examining the implementation of police-assisted referral programs for substance use disorder services in Massachusetts

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Abstract

Background: In response to the dramatic increase in opioid overdose deaths in recent years, police departments and community partners across the United States have begun to implement programs focused on connecting individuals to substance use disorder services. We examined the implementation of police-assisted referral programs from the perspectives of different team members to understand the key components of these programs and strategies used to implement them.

Methods: Qualitative research methods were used to examine the implementation of police-assisted referral programs in five Massachusetts communities between June 2019 and March 2020. Focus groups and interviews were conducted with 33 individuals, including 5 police chiefs, 12 police officers, 6 outreach workers, 4 community-based organization (CBO) directors, 2 interns, 1 clinician, 1 program manager, 1 religious representative, and 1 prevention specialist.

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Ethics approval: This study was determined to be exempt by the Boston University Medical Campus Institutional Review Board (IRB#H-38656).

Availability of data and materials: The dataset analyzed for this study is available upon reasonable request to the corresponding author.

Results: Five key themes emerged regarding the implementation of police-assisted referral programs across the communities: 1) program development was an ongoing process; 2) partnerships between police departments and community stakeholders were essential for starting and sustaining a program; 3) high-level leadership influenced program priorities and facilitated implementation; 4) program success was defined in multiple ways; and 5) programs contributed to shifts in beliefs about substance use and addiction among police officers.

Conclusions: Police-assisted referral programs in Massachusetts have adopted a variety of models of service delivery, evolving from post-overdose outreach and walk-in models to more complex hybrid forms. Implementation was facilitated by the support of departmental leadership, particularly the police chief, and the development of key partnerships across institutional boundaries. Communities continue to develop their programs to incorporate additional components, such as new mechanisms of outreach, harm reduction services, and long-term engagement activities. Further evaluation of these programs is needed to understand how each of these unique components may influence a program's impact on future overdoses, entry to treatment, and long-term recovery.

Keywords

Law enforcement; police; substance use; addiction; outreach; qualitative research

Background

Opioid overdose mortality in the United States has increased dramatically in recent years, with over 46,000 deaths in 2018, more than twice the number ten years prior (National Institute on Drug Abuse, 2020). In response, some police departments began shifting their focus from arresting individuals who use opioids to trying to prevent overdose deaths by connecting individuals to services (Bagley et al., 2019; Schiff et al., 2016, 2017). Across Massachusetts, police departments began implementing police-assisted referral programs focused on increasing access to substance use disorder (SUD) services. The nonprofit Police Assisted Addiction and Recovery Initiative (PAARI) formed in Massachusetts in 2015 to support these early adopters and has since expanded nationwide. As of July 2020, 112 police departments across the state have partnered with PAARI to implement these programs with adaptations designed for their communities (PAARI, 2020).

Early adopter police departments primarily began with two types of program models. Outreach models involved interdisciplinary teams conducting follow-up home visits, usually in response to reported overdoses, to help connect individuals to SUD services (Bagley et al., 2019; Formica et al., 2018). Walk-in models encouraged individuals to enter police departments or other designated locations and request assistance without fear of consequences for having or using drugs (Reichert et al., 2017; Schiff et al., 2016, 2017). Since their inception, there have been rapidly emerging adaptations and variations in program models, often resulting in hybrid forms that combine walk-in and outreach approaches with novel components. The programs have also continued to spread across the country.

Police-assisted referral programs represent unique innovations developed by and for communities that alter how law enforcement responds to substance use, and they indicate that partnerships between community organizations can be developed to respond to crises that occur 24-7 (Scott, 2016). These emerging partnerships between public safety and public health stakeholders should be examined from a variety of perspectives. Understanding the key components of police-assisted referral programs and strategies used to implement them can support further research on their design, implementation, and effectiveness – particularly how these programs may affect health outcomes including future overdoses, entry to treatment, and long-term recovery.

More research is needed on the experiences of those charged with implementing police-assisted referral programs to understand how they are currently operating. To address this need, we examined implementation of five programs in Massachusetts from the perspectives of different team members.

Methods

Study design

We used qualitative research methods to examine the implementation of police-assisted referral programs in five Massachusetts communities between June 2019 and March 2020. The study team partnered with PAARI to identify and recruit police departments implementing these programs. Originally departments in six communities were targeted to participate; one withdrew early in data collection due to personnel changes.

Study context

The five communities selected provided diversity in location, size, and demographics. The first community represented an urban setting with high population density within a small land mass. Approximately two-thirds of the population identified as Latinx, one fifth as non-Hispanic White, and between 5-10% as Black. Community two was a small coastal setting with a predominately non-Hispanic White population. Community three was rural and predominately non-Hispanic White. The fourth community was a culturally diverse urban setting with high population density and an active seaport. Approximately two-thirds of the population identified as non-Hispanic White, one fifth as Latinx, and between 5-10% as Black. The fifth community was a moderately-sized suburb adjacent to a larger city where a majority of residents identified as non-Hispanic White. These communities also varied in rates of poverty, United States citizenship, and health insurance coverage.

Participants

The study team worked with each department's police chief and PAARI to identify appropriate individuals to participate in data collection. Our sample included 33 individuals, with a mean of 6.4 (range 4-9) per community. Participants included 5 police chiefs, 12 police officers, 6 outreach workers, 4 community-based organization (CBO) directors, 2 interns, 1 clinician, 1 program manager, 1 religious representative, and 1 prevention specialist.

Data collection

Our study was guided by the Promoting Action on Research Implementation in Health Services (PARiHS) framework, which conceptualizes implementation success as a function of relationships among three related constructs: evidence, context, and facilitation (Rycroft-Malone, 2004). The PARiHS framework suggests that successful program implementation depends on participants' perceptions of evidence, receptiveness to change within the implementation context, and the appropriateness of facilitation strategies used (Rycroft-Malone, 2004).

The PARiHS framework was used to develop focus group and interview guides. We investigated the role of evidence by asking questions that explored views regarding substance use and addiction, as well as the acceptability and perceived impact of these programs. Context questions related to how the programs began, how they were operating currently, and how they were perceived within the police department and wider community. Finally, we investigated the role of facilitation with questions that explored implementation strategies, resources, and program adaptations.

We conducted six focus groups, which were between 3-7 participants each and composed of participants from the same community. Two groups were smaller in size (3 participants), but all sessions were conducted using focus group principles. We adapted our data collection techniques to the communities as needed, since programs in some communities had only a few implementers, a hierarchical structure, or a small number of individuals available to participate in data collection. Four individual interviews were also conducted to gather additional data. Study team members trained in qualitative data collection facilitated focus groups and conducted supplemental interviews, and all sessions were audio recorded. This study was determined to be exempt by the Boston University Medical Campus Institutional Review Board (IRB#H-38656).

Data analysis

Audio-recordings were professionally transcribed verbatim and de-identified. The study team began by developing an initial codebook with *a priori* codes based on the PARiHS framework and content of the interview guides. We then conducted a pilot coding round in which two coders reviewed the same set of transcripts and updated the codebook to incorporate inductive codes derived from the data. Example codes included: acceptability of the program, beliefs about substance use, departmental culture, resources, implementation strategies, and adaptations.

Once the codebook was finalized, all transcripts were double-coded. NVivo software (Version 12) was used to manage the data and facilitate the coding process. In any case of coding inconsistency, the two coders reached consensus through discussion and co-review of each transcript. The study team reviewed the content of each code and used an inductive content analysis approach to develop a set of key themes related to program implementation across the five communities.

Results

Police-assisted referral programs across the five communities differed in their design, though all shared a focus on increasing access to SUD services for community members. Programs initially began to take shape when police leadership reached out to community stakeholders, forming interdisciplinary teams across organizations. Their activities generally fell into the categories of outreach, harm reduction, long-term engagement, and self-referral (Box 1). Outreach activities were triggered by variety of mechanisms, including overdose events, and involved building relationships, providing education, distributing harm reduction supplies, and/or offering referrals to services. Long-term engagement activities included wraparound services, such as case management, and diversion programs. Self-referrals were facilitated via walk-in services in police departments or other local organizations. Four of the programs operated in a single community while one was multi-jurisdictional, with different police departments sharing overdose data to trigger outreach visits. Communities also utilized different strategies to facilitate program activities; for example, one had a formal transportation assistance program to provide access to detoxification, SUD treatment appointments, and aftercare services, while others provided referrals for food and shelter assistance.

Despite variation in program design, five overarching themes regarding implementation emerged across communities: 1) program development was an ongoing process; 2) partnerships between police departments and community stakeholders were essential for starting and sustaining a program; 3) high-level leadership influenced program priorities and facilitated implementation; 4) program success was defined in multiple ways; and 5) programs contributed to shifts in beliefs about substance use and addiction among police officers. These themes are linked to the PARiHS constructs of evidence, context, and facilitation; they also serve to conceptualize implementation success from the perspective of program team members. First, the ongoing nature of program development via adaptation was a key factor in facilitating implementation. Second, partnerships and supportive leadership were elements of the outer and inner context, respectively, that both facilitated implementation and were characterized by receptiveness to change. Finally, program team members' perceptions of evidence in terms of successful outcomes and beliefs about substance use changed over the course of implementation in a manner that increased program acceptability, particularly among police officers. These themes represent overarching elements of successful implementation shared across the five communities.

Program development was an ongoing process

We found police-assisted referral programs had evolved from primary models, such as post-overdose outreach or walk-in services, to more complex hybrid models. Interviewees across sites described an ongoing process of incorporating new program components and adapting existing ones to address barriers to implementation and meet community needs. Though the programs evolved, they continued to share two common goals: reducing overdose mortality and shifting policing behavior toward connecting individuals to SUD services. To accomplish these goals, programs underwent shifts toward new methods of outreach, harm reduction services, and long-term engagement activities.

Post-overdose outreach, in which interdisciplinary teams conduct home visits, continued to be a core program component. However, interviewees across the communities recalled their early difficulties in connecting with individuals following overdoses. This was also true for self-referral strategies; while some programs still welcomed walk-ins to designated locations, difficulties in successfully connecting with community members led to the first major programmatic shift toward new mechanisms of outreach. Each program had significant involvement from outreach workers who were either employed by the police department, contracted through local organizations, or were volunteers. Most often these were recovery coaches who had lived experience with addiction and were trained in coaching-based models of peer recovery support. The first example of a new outreach mechanism was to have outreach workers seek out individuals who may or may not have had a recent overdose in community settings to build relationships and offer referrals to SUD services. This included outreach on the street or at local CBOs.

> "We navigate. We are moving around the city. And as we have background in substance abuse, we can see the body language, we see signs. Every person is different, so we have a different way to approach. We can start with a conversation. Once we have made that relationship … it's easy just to approach and remind them that we provide different services and also services for addiction. And they open up." [Outreach worker #1]

A second example of a new outreach mechanism was the adoption of risk-driven community collaborative models, in which police departments and other public safety and public health stakeholders engaged in regular meetings and information sharing to inform outreach visits. While all programs had begun conducting risk-driven collaborative processes, interviewees at most sites described their adoption of a specific “Hub” model that included weekly stakeholder meetings, structured decision-making to categorize individuals with “acutely elevated risk,” and outreach visits to those meeting criteria (Nilson, 2016; Sanders & Langan, 2019). “Acutely elevated risk” is defined by the model’s developers as “a quick and noticeable elevation of risk that involves high probability of intense harm that crosses multiple human service sectors” (Nilson, 2014). Notably, most programs had adapted the “Hub” model protocol for use in their community. Interviewees emphasized how these new risk-driven collaborative processes improved cooperation across institutional boundaries and represented a new pathway for outreach.

> "Now what [the hospital] does is that they have some social workers and nurses that will speak to the patients when they're there, and they'll say, 'If you want to get some assistance… can I call so and so?' Some of them even offer and will say, ‘Oh, I'm working with the [outreach workers].’ So they'll call and they'll say, ‘We have so and so,’ or they'll present at the Hub and then we're able to say, ‘Yep, we're working with them, we'll continue to work with them.’ Or, ‘They fell off the radar for a little bit and we'll continue to work with them.’ And that's big.” [CBO director #1]

The second major development was a shift toward harm reduction services. Interviewees noted that for individuals with whom they did connect following an overdose, only a small percentage chose to accept a referral.

> "I would say … on average between like 15 and 20 percent of the people we outreach to actually accept some level of interaction with us. Not to say that all of that then goes on to be a complete and utter success. In my world, any positive step that we can take in anybody's life, who is willing to accept our assistance, that's a win in my column. Even if it's just a win for today, I'll take the win for today, and then we can try to get a win for tomorrow." [Clinical provider #1]

In these cases, programs would provide harm reduction education and supplies, such as naloxone and fentanyl test strips, along with connection to an outreach worker. Another example of services offered in situations where an individual chose not to accept a referral included connecting family members to support groups.

The third major shift was toward long-term engagement. Interviewees recognized that individuals who accepted referrals often required additional assistance and continued follow-up to be successful. Many reported realizing they could improve their ability to meet program goals by engaging with individuals over time and providing ongoing assistance navigating different SUD and social services.

> "When we started to have success, we started to get people to detoxes, but there wasn't any support for them when they got out. That's when the city decided that they were going to create a second contract, which is the wraparound services or support services, and that's through [CBO]." [Program manager #1]

This led programs to engage in wraparound services, including helping with access to housing, food, transportation, and health insurance. To achieve this service expansion and longer-term engagement, one police department partnered with a CBO that provided formal case management, while others provided these services through grant-funded staff.

> "Just doing crisis intervention and postvention was still not enough. We needed … a full gamut of services, almost more on the lines of care coordination and case management … Because what we were seeing was folks getting into recovery but then having financial struggles, struggles getting employment, family and domestic issues." [Clinical provider #1]

While not all programs had evolved to this degree, each engaged in a process of iterative and ongoing program development. Interviewees described removing program components found to be ineffective based on prior experience, as well as adapting existing components to meet community needs.

Partnerships were essential for starting and sustaining a program

Programmatic changes were facilitated by the development of essential organizational partnerships. Interviewees at each site described partnerships amongst police departments and community stakeholders – such as other public safety and local government agencies, hospital-based behavioral health services, outpatient treatment and aftercare programs, health and social service agencies, and CBOs – as key to the development of their programs. They emphasized the importance of moving from "siloed" positions to working together. Interviewees reported that as they began to learn more about individuals' complex needs,

they recognized their lack of relationships with other community stakeholders and individuals who could help.

> “We have every avenue that's possible here, but we didn't know anybody. We didn't have numbers of any [SUD service providers]. We didn't have any connections with any of these individuals. We were just doing the policing. Handcuff, incarcerate, [protective custody], send to the hospital, forget about… When we saw what was going on and we thought, let's develop some sort of a strategy, try to put us in a better position.” [Police chief #1]

Interviewees described how programs were born out of the recognition that departments and other community stakeholders were repeatedly engaging with the same individuals, but they needed to collaborate in order to save lives. New partnerships among police departments and public health stakeholders were created, and these were key to implementation.

> “The realization came that we can't help everybody. We can't save the world … We needed resources. We needed help, and thank god [for]… PAARI and [recovery coach] … So, if there were so many things that we couldn't do, we had somebody to send them to. It wasn't, 'No, go away.' It was, 'You know what? [Recovery coach] can help. And if [recovery coach] can't help, he knows somebody that can help'. So, no one ever got sent away without being helped to some degree.” [Police officer #1]

Partnerships among community stakeholders were also key facilitators to successfully completing referrals, particularly for securing access to SUD services. As programs began to engage in a wider array of services, partnerships were a valuable source of institutional knowledge along with human and financial resources.

> “I think the very first thing you need to do, whatever community is looking to start this, you have to identify who your partners would be. You have to identify resources. Because this is labor-intensive. It's not just going to be the police department doing this. They need partners.” [Police officer #2]

High-level leadership influenced program priorities and facilitated implementation

Key partnerships were often developed based on departmental leadership, particularly the police chief, facilitating the process. Lack of leadership support was seen as a barrier, while having police chiefs who championed the program facilitated successful implementation by building team cohesion and influencing departmental culture.

> "You've got to get the buy-in from the top … I've talked with different places where it hasn't worked … They didn't have the buy-in start at the chiefs and work its way down. If you send the message in your department that, as the chief, you would want to support this … that really sends the message." [Police chief #2]

Police chiefs were also influential in determining program design, and changes in leadership contributed to the evolution of the programs.

> “When [the new chief] took over … He's the one that added [other community's] model to it … The program started moving smoothly. We created some policies

around how watch commanders are to assist people asking for help." [Police officer #3]

Interviewees reported that a program's momentum and sustainability suffered when police leadership was not receptive to feedback. They also noted the importance of having additional departmental leadership beyond the chief and individual community partners as champions of the program.

"One of the first things you've got to do is identify your champions. The people that will herald the program and stay to maintain … those legacy folks. When you're starting it, you don't have legacy folks. You've got people that have been a part of it siloed. It's bringing them together." [Religious representative #1]

Program success was defined in multiple ways

Programs developed a variety of definitions of success as their models evolved. Reducing overdose mortality and referring individuals to SUD services remained distal outcomes for all five programs, but some had begun to emphasize different proximal outcomes based on their priorities. For programs moving toward an emphasis on new mechanisms of outreach, harm reduction, and long-term engagement, team members usually shared definitions of success despite being in different roles. These definitions were generally driven by the specific needs of each program participant.

"We keep track of where we're going. Sometimes it's recovery support services because they're already engaged in treatment, sometimes it's family support … For those that are still caught up in active addiction, it's follow-up visits … Our goal is to meet people wherever they're at. So, it might be a harm reduction call. It might be, do you want inpatient treatment, is it appropriate? I think out of habit, we say beds. But it might be medically assisted treatment. We're open to any and all modalities of treatment. That's a part of our goal." [CBO director #2]

A common emphasis was the need to "meet people where they are" based on an individual's willingness to accept help in the moment. Interviewees described each engagement as an opportunity to provide someone with options.

"The interaction that we have – some people who, they're not ready to get sober yet, but they will still call us, or still have an interaction with us, and talk to us. And the hope is that at some point, maybe they will change." [Police officer #4]

In situations where an individual was ready to accept assistance, success was usually defined as completing the appropriate referral, helping them access wraparound services, and ultimately, long-term recovery. In the many cases where individuals were not ready for intervention, interviewees reported engaging in a variety of activities that could not always be formally tracked, with the ultimate goals being to prevent overdoses and move individuals toward eventually accepting a referral.

"A lot of our reputation of the team is that we are here to help. It's not to be punitive, not to be judgmental. We just want to get people the services that are available … We drive an unmarked cruiser car, a very old one. We've had people actually wave down the car. 'Are you the outreach team? We want to talk to you' …

> We've been working on that trust in the community and we have the results for it. There is a lot of positive feedback." [Police officer #2]

However, not all programs had shared definitions of success across team members in different roles. For example, some police officers defined success as assisting with a post-overdose outreach visit and linking the individual to an outreach worker. The distal goal of referral was seen as the responsibility of the outreach worker.

> "We're the more tip of the sword kind of guys. We're just trying to get you through that night when we show up and put some Narcan in you to try to block the receptors, just trying to get you to live through that day … Once you get to the hospital, then we hope that through our overdose services, we can get you services down the road where normally maybe you would not. But for the most part … That's where it's going to come to … the outreach services guys that try to get you into the beds … Where you can actually do some good, some long-term good." [Police officer #5]

This was a more unique viewpoint, as most teams had developed shared proximal definitions of success based in the mentality of "meeting people where they are." Other definitions of success beyond individual level – such as gaining the community's trust, building positive relationships between officers and community members, and shifting the attitudes and beliefs of officers regarding substance use – were also noted.

Programs contributed to shifts in beliefs among police officers

Many interviewees agreed that seeing changes in policing over time and shifting officers' attitudes and beliefs regarding substance use and addiction were key impacts of these programs.

> "I think what this program is trying to create is a culture change within a whole department … I think it goes beyond the ride-along, goes beyond that particular day. And we have developed that relationship with some of the – most of the officers, I would say – that attend a lot of the trainings we provide. It's really about how do you move the department mentality and change it … We have had officers that actually bring people out on the street to our office. They literally transport them and say, 'There you go. They can help you.' I think that is probably one of the most important things that has happened." [CBO director #2]

Interviewees at most sites emphasized the importance of changes in the culture of police departments. They mentioned examples of officers who had opposed the programs at the start becoming involved and referring individuals to services. However, these changes were not immediate, rather they developed over time. Interviewees reported a driving force for change came from officers starting to see results of the programs.

> I think that a lot of times, once [officers] start seeing it work and people doing better or making better choices, then they kind of … buy-in a little bit more." [Police officer #4]

The initial buy-in established through seeing the practical benefits of the program contributed to increased program acceptability amongst officers. This was followed by more

substantial changes in beliefs about substance use and addiction, particularly in terms of viewing addiction from a disease perspective and considering the ways law enforcement could shift their responses to better serve their communities.

> "Some of the best officers we have that do these outreach rides are the ones that I had the most concerns about going in. Because it does mellow you, and you see this is a disease that we're facing. This is not a crime we're dealing with. We're dealing with people that do have an earnest problem. And it's affecting not just them, personally, but it's affecting their families." [Police officer #7]

> "Society's changing. The whole world realizes that. Incarceration isn't the answer to addiction, it's not the answer … But we're changing as society's changing, because we do mirror our society." [Police chief #3]

Discussion

We used qualitative methods to examine the implementation of five police-assisted referral programs for SUD services in Massachusetts from the perspectives of different team members. Results indicated the programs had evolved over time toward hybrid models that incorporated post-overdose outreach and walk-in components along with new mechanisms of outreach, harm reduction services, and a focus on long-term engagement. These changes were facilitated by development of essential organizational partnerships across police departments and other community stakeholders, a process primarily driven by the presence of engaged and supportive police chiefs along with departmental and community champions.

Based on the variety of program components within these new hybrid models, their success had come to be defined in multiple ways, with definitions shifting over time to include both shorter-term outcomes of connecting with individuals and the more distal goals of SUD treatment engagement and reduced overdose mortality. The focus on "meeting people where they are" was also found in the shifting beliefs regarding substance use and addiction amongst police officers. Many officers had come to view connecting individuals to SUD services as the most appropriate response to substance use. This change in the culture of police departments was seen by interviewees as the major, if not most important, impact of these programs.

The development of police-assisted referral programs represents an example of communities coming together to implement innovative solutions to complex problems (Bagley et al., 2019). Programs initially emerged when departmental leadership began to recognize they were not well-equipped to address issues related to substance use and addiction through criminalization and arrest during a period of rising overdose mortality (Schiff et al., 2016, 2017). Instead, they recognized individuals were often better served through referral to SUD services. Since their inception, the ongoing development of these programs appeared to occur quickly, with changes implemented to overcome observed difficulties and meet immediate community needs.

Over time, police-assisted referral programs have begun to play a greater role in connecting individuals to SUD and other social services. In some cases, police departments have

directly taken on the role of community outreach and long-term navigation through departmental staff, partnerships, and/or joint funding arrangements. These developments stemmed from an increased understanding of the complex SUD service landscape, and the recognition that additional support was necessary to help individuals maintain their recovery. Moreover, while these programs may have begun in response to the opioid crisis, they have pivoted to assist individuals experiencing any type of SUD. For example, connecting to services for alcohol use disorder was increasingly common.

Police departments and other public safety stakeholders are called upon to respond to a wide array of situations involving substance use and addiction, often when individuals are most in need (Scott, 2016). This is due in part to the fact that crises occur 24-7, rather than exclusively during business hours when SUD services might be available. In addition, individuals often face insurmountable barriers to seeking help on their own, including availability of treatment beds and transportation (Madras et al., 2020). In response, communities have developed their own local innovations to address these barriers, in which a 9-1-1 call can generate a holistic response from an interdisciplinary team of responders. To do so, stakeholders built organizational partnerships, and in many cases personal relationships, across traditional institutional boundaries.

Future work should consider how these programs have evolved to target individuals in different stages of change (Glasgow & Emmons, 2007; Prochaska & DiClemente, 1983). For example, in response to difficulties making connections with community members through self-referral or following an overdose, programs expanded to utilize new mechanisms of outreach. Most notably this included having outreach workers approach individuals in community settings or using risk-driven collaborative models wherein stakeholders share information regarding individuals with “acutely elevated risk” to trigger outreach visits. These program components represent unique interventions, each with their own potential risks, benefits, and target population, and should be evaluated as such (Bhayani & Thompson, 2016; Sanders & Langan, 2019; Scott, 2016). This will also help to clarify key program components and define specific metrics in evaluating the impact of police-assisted referral programs.

Evaluators should consider how they might incorporate a variety of proximal and distal outcome measures for each program component and the stage of readiness of its target population. They should also consider the variety in definitions of success from the perspective of implementers, such as changes in departmental culture or relationship building amongst police officers and community members. This will align with implementers’ emphasis on “meeting people where they are” and building positive relationships that can be in place when individuals decide to seek help. Overall, implementation and effectiveness studies that utilize theory to specify the mechanisms of action for each unique program component can help inform future adaptation of these increasingly popular programs in different settings (Bauer et al., 2015; Moore et al., 2015, 2019).

Limitations

Our study had some limitations. Like all qualitative studies, our results may not be generalizable. Programs contacted by the study team were all affiliated with PAARI, and it is possible differences may exist for those not affiliated. Differences may also exist for those that did not respond to the invitation to participate (2 departments) or dropped out of the study (1 department). Perceived workload required and personnel changes during the study period were the most common reasons provided in choosing not to participate. In addition, this study did not focus on gathering outcome data or ask implementers about data collection relative to the definitions of success outlined above. However, despite these limitations, our qualitative approach allowed us to gain in-depth insight into the evolving nature of police-assisted referral programs and may be transferrable to other communities.

Conclusions

By examining the implementation of a subset of police-assisted referral programs in Massachusetts, we found a variety of models of service delivery, evolving from the original outreach and walk-in models to more complex hybrid forms, as well as some overarching elements of implementation that contributed to success from the perspective of program team members. This study can assist other communities interested in developing similar programs. It may also help in planning quality improvement and sustainability efforts for communities already implementing these programs.

Our results indicate that for communities hoping to implement similar approaches, leadership support is key and initial efforts can be focused on building partnerships across institutional boundaries and identifying program components that meet community needs. Further research is required on the implementation of police-assisted referral programs as they continue to develop and expand, along with rigorous evaluation of their impacts. Communities interested in developing their own programs should incorporate systematic evaluation into plans for implementation.

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List of Abbreviations

CBO	Community-Based Organization
PAARI	Police Assisted Addiction and Recovery Initiative
PARiHS	Promoting Action on Research Implementation in Health Services
SUD	Substance Use Disorder

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Box 1.

Glossary of common police-assisted referral program activities

Outreach

- *Community-based navigation:* Implementers seek out individuals in community settings to build relationships, provide education, distribute harm reduction supplies, and/or offer referrals to services.
- *Post-overdose follow-up:* Implementers conduct home visits following reported overdose incidents.
- *Risk-driven collaboration:* Implementers engage in regular meetings and information sharing amongst multisectoral stakeholders to identify and intervene with individuals in the community.

Harm reduction

- Implementers engage in activities designed to lessen the potential negative consequences associated with substance use, e.g. naloxone distribution.

Long-term engagement

- *Diversion:* Implementers reroute individuals with low-level drug-related offenses either pre- or post-arrest to social and legal services instead of prosecution and incarceration; usually includes intervention following any relevant diversion event, e.g. aftercare.
- *Wraparound services:* Implementers track individuals after an initial engagement with a focus on providing “wraparound” care; characterized by ongoing check-ins and assistance with accessing different SUD and social services, sometimes in the form of care coordination or case management.

Self-referral

- *Walk-in:* Individuals can enter the police department or another designated location and request referral to services.