Law Enforcement Assisted Diversion: Qualitative evaluation of barriers and facilitators of program implementation

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Running title: Implementation of Law Enforcement Assisted Diversion

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Highlights

- We examined LEAD implementation barriers and facilitators.
- Barriers included procedural complexity and a belief in a punitive police role.
- Facilitators include addiction as a chronic disease and treatment entry incentives.

ABSTRACT

Background: Despite widespread interest in adoption, there has been limited systematic examination of Law Enforcement Assisted Diversion (LEAD) implementation, a model for police-led arrest diversion for those with substance use disorders (SUD). In the fall of 2017, the City of New Haven started a LEAD program. During the first 9 months of the pilot, only 2 clients were successfully diverted from arrest. Therefore, we examined the and barriers and facilitators of LEAD implementation.

Methods: We conducted semi-structured interviews and field observations of LEAD police officers and health care providers between August 2018 and June 2019. Interviews and field observations were analyzed using directed content analysis and guided by the Integrated Promoting Action on Research Implementation in Health Services framework.

Results: Lead professionals participated in 19 semi-structured interviews and three field observations. Barriers to arrest diversion implementation included procedural complexity of arrest diversion, concerns about reduced penalties for substance use among officers, stigma of SUDs, and a belief in a punitive role for policing. Facilitators included a positive longitudinal relationship with potential clients and an understanding of SUD as a chronic disease.

Conclusion: We identified several barriers to LEAD implementation. Our results suggest promotion of SUD as a chronic disease, ongoing training of officers, and positive incentives for entering substance use treatment should be utilized to facilitate implementation.

Key words: Police diversion; Implementation science; Substance use disorders; Criminal justice; Harm reduction

1. INTRODUCTION

A half-million of the 2.2 million people incarcerated within the United States are incarcerated for drug-related crimes (Wagner & Sawyer, 2019), and substance use disorders (SUD) are more prevalent among criminal justice populations than the general population (Fazel et al., 2006). People with SUD are at markedly increased risk of overdose death following contact with the criminal justice system due to intersecting factors such as poverty, social isolation, interruption in medical care, and stigma (Binswanger et al., 2007; Joudrey et al., 2019). For this reason, programs aiming to divert people with SUD to treatment have been created spanning the continuum of criminal justice exposure: law enforcement interactions, courts, jail or prison, re-entry, and probation and parole (Brinkley-Rubinstein et al., 2018). In 2011, following a lawsuit related to racial disparities in drug arrests, Seattle, Washington started the first Law Enforcement Assisted Diversion (LEAD) program, which aimed to connect people to substance use treatment services as an arrest alternative. Specifically, police officers made referrals to LEAD engagement specialists who connected clients to services based on medical and social needs, which did not require abstinence from substance use prior to program entry or connection to services. Further, the arrest was removed (not processed or entered into the legal record) for participants who completed an initial assessment within 30 days regardless of the reason for arrest. Police officers could also offer the program to individuals with SUD outside of arrest events, called a social contact referral. Social contact referrals were offered to individuals with previous police contact who were likely to benefit from LEAD program services (Beckett, 2014).

Evaluation of the Seattle LEAD program suggested participant and community benefits. Participants had lower odds of subsequent arrest and felony charges relative to a propensity matched group receiving traditional arrest processing (Collins et al., 2017). Further, reduced odds of subsequent arrest among participants were preceded by improvements in housing, employment, and financial security (Clifasefi et al., 2017). Participants perceived the program as client-centered and reported improved quality of life and relationships with police officers (Seema L. Clifasefi, 2016). Relative to a similar criminal justice population, LEAD participants used the criminal justice system less, resulting in reduced costs (Collins et al., 2015). The Seattle LEAD program created new collaborations and partnerships between law enforcement, state prosecutors and defense organizations, the state department of corrections, health care agencies, social service agencies, and the community to achieve these benefits (Beckett, 2014).

In response to this evidence, the LEAD National Support Bureau was created to provide strategic guidance and support to local jurisdictions implementing the LEAD model. There are now over 36 United States municipalities operating a LEAD program and over 70 more municipalities pursuing implementation (*LEAD National Support Bureau*, n.d.), and the Bureau of Justice Assistance is providing technical assistance grants to support implementation (*LEAD National Support Bureau*, n.d.). Despite widespread national interest, there has been limited systematic examination of the factors impacting successful LEAD program implementation. Implementation research is needed to ensure model fidelity and maximize adoption in new settings.

In the fall of 2017, the New Haven Community Services Administration, in partnership with the Connecticut Department Mental Health and Addiction Services, the New Haven Police Department (NHPD), the local federally qualified health center and opioid treatment program, and State's Attorney launched a LEAD program within two city districts with frequent substance use related arrests. During the first 9 months of the pilot, only 2 arrest diversions and 15 social contact referrals were successfully completed. Due to the slow rate of participant entry into the program, the New Haven LEAD policy group requested the research team examine program adoption. Therefore, we examined the barriers and facilitators of LEAD implementation in New Haven, Connecticut.

2. MATERIALS AND METHODS

2.1 Study setting

The City of New Haven is a medium sized city in the Northeastern, United States. Unlike the Seattle program, Connecticut reduced substance use related penalties for drug possession from a felony to a misdemeanor several years prior. Like the Seattle program, the New Haven program was governed by a policy group consisting of the aforementioned stakeholders. An operations group consisting of service providers and officers facilitated weekly meetings on client engagement and services. After the first 12 months of the program, a community leadership team (i.e. people living in the pilot neighborhoods, local non-government organizations, and business owners) was created to provide community input and feedback to the LEAD policy group. Before the start of LEAD, 32 NHPD officers from the implementation districts received an 8-hour training on SUDs and LEAD procedures. The officer training was provided by addiction treatment providers from the

local federally qualified health center in the form of passive lectures on topics including the science of addiction and harm reduction. Three service providers from the federally qualified health center were selected and trained as engagement specialists to connect clients to services based on medical and social needs.

2.2 Study sample

To conduct our qualitative evaluation of the New Haven LEAD program, we purposively sampled LEAD-trained NHPD officers, NHPD leadership, and engagement specialists between August 2018 and June 2019. We grounded our work in the implementation science framework Integrated Promoting Action on Research Implementation in Health Services (iPARIHS) to systematically examine perceptions of the innovation (the LEAD model), recipients of innovation (LEAD professionals and clients), and the context of the innovation (**Table 1**) (Harvey & Kitson, 2016; Kitson et al., 1998). We adhered to the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007). The Yale University Institutional Review Board approved this study and participants received no compensation.

Table 1: The domains of the Integrated Promoting Action on Research Implementation in Health Services (iPARIHS) framework

Domain	Description
Innovation	The nature and strength of the evidence supporting the potential for program implementation, which includes research, practitioner experience and intended population.
Recipients	The impact of individuals and teams have in supporting or resisting an innovation.
Context	The environment or setting in which the proposed change is to be implemented.

2.3 Data collection

Our team consisted of general internists with implementation science experience (Joudrey et al., 2020), a community psychologist and program evaluator, a member of the New Haven community with qualitative research experience, and one member with lived substance use experience. All team members and the New Haven LEAD policy group participated in the development of the interview guide (**Appendix A**) with questions organized by the iPARIHS domains. The first (male) or second (female) author conducted semi-structured interviews and field observations of LEAD professionals until thematic saturation (i.e., no new ideas emerged across the entire sample). Participants were initially contacted by email. Interviews were conducted at the participants' preferred location (i.e. NHPD station or office) and were audio recorded and professionally transcribed. Participants were told the information being collected may be used to inform the implementation of LEAD within New Haven and other cities. Interview participants completed a brief survey assessing age, race and ethnicity, gender, years in current profession, and position within profession. Of the 20 individuals contacted, a total of 19 participated in a semi-structured interview and completed a survey (**Table 2**). One department leader declined to participate, and 18 LEAD professionals changed jobs prior to being contacted about the study and were not interviewed. One engagement specialist and one member of NHPD leadership changed jobs. All other turnover (n = 16) was among patrol officers. Among two pilot city districts, there were four officers in leadership roles (i.e. assistant chief, lieutenant, or sergeant). Interviews lasted a median of 34 minutes. We completed field observations with two NHPD officers and one engagement specialist, with at least one observation occurring within each city LEAD district. NHPD leadership selected

the patrol officers for field observation participation. For field observations, the first or second author joined NHPD officers or engagement specialists for four hours while on patrol within one of the two city LEAD districts. All research team members agreed notes taken during field observations would be limited to LEAD related tasks and attitudes organized by iPARIHs domains with an emphasis on the steps required to complete an arrest diversion or social contact referral. Notes were taken contemporaneously and immediately after completion of the field observations.

Table 2: Interview participant characteristics

Characteristic	**Participants (n = 19)**
Age, median (IQR*)	35 (29, 44)
Race/ethnicity, n (%)	
Hispanic	7 (37)
Non-Hispanic Black	4 (21)
Non-Hispanic White	8 (42)
Female gender, n (%)	4 (21)
Years in current profession, median (IQR)	6 (4, 12)
Profession, n (%)	
Patrol officer	15 (79)
Sergeant	1 (5)
Assistant Chief	1 (5)
Engagement Specialist	2 (11)

* Interquartile range

2.4 Data analysis

Our team held over eight meetings, one to two hours duration, during data collection and analysis to discuss interview content, the interview guide, and new observations. We analyzed transcripts using directed content analysis grounded by iPARIHS (Hsieh & Shannon, 2005). Team members reviewed two transcripts applying iPARIHS constructs to segments while noting additional ideas and relationships to create a preliminary code list. At subsequent meetings, we refined the code list and named additional sub-codes. We

repeated this process over a three-month period until we reached consensus on a final code book. The first author then coded all transcripts and the second author reviewed the coding to ensure agreement. After organization of segment text by code, we used an iterative inductive approach to develop emerging themes. Team members reviewed coded segment text and developed preliminary themes. At subsequent meetings we refined the themes until we reached consensus. Following our analysis, we shared preliminary results with LEAD stakeholders, including LEAD policy group members, NHPD leadership, and members of the New Haven community to elicit feedback. To organize and facilitate our analysis, we used Dedoose (2018 version, SocioCultural Research Consultants, Los Angeles, CA) software.

3. RESULTS

3.1 LEAD implementation barriers and facilitators

We identified barriers and facilitators to LEAD implementation among key stakeholders (**Table 3**). Barriers and facilitators were organized into three categories: 1) client factors, 2) LEAD professional factors, and 3) community and contextual factors. Client and LEAD professional factors represent results from the innovation and recipient domains of the iPARIHS framework. The community and contextual factors represent results from the contextual domain of the iPARIHS framework. We present representative quotes for each category.

Table 3: Summary of barriers and facilitators of LEAD implementation by category

Category	Barrier	Facilitator
Perceived client factors	Negative healthcare experiences Social needs	Positive longitudinal relationship with potential clients
LEAD professional factors	Arrest diversion complexity Insufficient training Stigma of people with SUDs Belief in a punitive role for policing in SUD*	Understanding SUD as a chronic disease Knowledge of the Seattle Program Integration of LEAD procedures into regular police functions
Community and contextual factors	Reduced substance use penalties Polarized views of LEAD	-

* Substance use disorder

3.2 Barriers

We identified eight barriers to successful LEAD implementation. Key barriers included negative healthcare experiences among potential clients, complexity of arrest diversion procedures, insufficient training, stigma of SUD, belief in a punitive role for policing, reduced substance use penalties, and polarized community views of LEAD.

3.3 Perceived client barriers

3.3.1 Negative healthcare experiences

Police officers reported that potential LEAD clients had previous negative experiences with the healthcare system, which created a barrier to program entry. Officers expressed difficulty describing how the LEAD program would be different than these past negative experiences reported by clients.

> *I said, I'd really love for you to go to this program. He said the answer was no, I'd been to all the programs. I've been through the [program name], I've been to [program name]. "Every single program," he goes, "they don't work." (Officer)*

3.3.2 Social needs

The social needs of potential LEAD clients created barriers by complicating program entry or by disrupting engagement with LEAD services. Applicable services were at times unavailable to address specific needs of the client.

> *Since the suspect did not have an ID and his name did not match any records, the officer said this situation now required an actual arrest: the suspect would have to go down to the station and do fingerprinting/booking in order to be identified. (NHPD ride along field notes)*

> *Right now, the need for housing is out of control. There are rules about who we can offer housing to. It's like a catch-22. Go get cleaned up but then we can't offer you anything else until you get your own income to get your housing. (Engagement specialist)*

3.4 LEAD professional barriers

3.4.1 Arrest diversion complexity

The perceived complexity of arrest diversion procedures, as compared to usual arrest, reduced officer attempts at arrest diversion. This perspective was widespread among patrol officers. During an arrest diversion, officers reported completing the same arrest related paperwork but also having to enter additional LEAD documentation into a separate electronic form. Additional tasks created by LEAD arrest diversion included contacting the engagement specialists or other service provider or arranging transportation for the client. Officer awareness of these additional tasks reduced motivation to offer the program.

From what I'm hearing from other officers who have done it, [arrest diversion] is certainly not a streamlined process. (Officer)

Officer early experience of unsuccessful arrest diversion also reduced confidence in LEAD. While initially excited about the program, officers were less likely to offer the program after experiencing unsuccessful arrest diversion attempts.

I haven't been successful with the LEAD Program at all. At first, I was very excited about the program. Every single person that we came across was like, yes, we're going to get one in there. Everyone rejected us. (Officer)

Officers reported workload and other demands competed with LEAD tasks. This perspective was widespread among patrol officers. These perceived demands included a high volume of calls involving public safety but also included concerns about work extending beyond the shift, such as paperwork.

Sometimes you are running two cars in a district. We don't have the time to go out and start seeking social diversion contact. Tell you the truth, not a lot of guys are going out there doing proactive work because we just don't have enough time. (Officer)

3.4.2 Insufficient Training

Officers reported insufficient follow up training on offering prospective clients arrest diversion or social contact referral, reducing outreach among officers. In the absence of follow up training and the experience of unsuccessful arrest diversions, officers stopped making attempts to engage with potential LEAD clients.

I think that there needs to be an updated training, so that people remember what to do, the steps that - that need to be - any new changes that had been made needs to be conveyed because lot of the guys don't even remember the steps to the program. (Officer)

3.4.3 Stigma of people with SUD

Some officers saw potential clients as undeserving of LEAD services, consistent with stigma, or unfavorable attitudes, beliefs, and policies directed toward people with SUD (Kulesza et al., 2013; Room, 2005). Officers believed SUD resulted from individual choices. Because potential LEAD clients were perceived as choosing to use drugs, officers believed they should not receive community assistance.

There is a reason why the majority of people are in the situations they are in because of life choices, personal responsibly, the goals they do or don't have in life. These are the consequences of those life decisions. (Officer)

I don't see what [LEAD] offers to someone who is already receiving Section 8 housing, Social Security Disability because their entire life is taken care of by the state. They chose to–"I want to do drugs." They had many opportunities. (Officer)

3.4.4 Belief in a punitive role for policing around SUD

Officers saw criminal justice penalties as necessary to force treatment entry among people with SUD. Officers believed greater penalties within the courts would result in greater LEAD program entry.

It is going to work better in the courts than on the street because courts already got them. It's like listen you don't want to go through with this program we are going to proceed with this charge. (Officer)

Some officers believed it was inappropriate to extend officers beyond the role of enforcing community laws. These officers believed arrest diversion or social contact referral were not a part of policing and another agency should be responsible for these services.

Now, we are asking police officers to be social workers and outreach counselors. That's not what we are. I know people want us to be that but we're not. It's not fair. I don't ask counselors to come out and enforce laws and practical application of criminal codes and investigate crimes. (Officer)

3.5 Community and contextual barriers

3.5.1 Reduced substance use penalties

Officers frequently saw the reduced penalties for substance use and other misdemeanors as a barrier to arrest diversion and this undermined confidence in the LEAD model. Officers believed more severe penalties were needed to compel acceptance of arrest diversion.

The mission behind the program is the diverting people from being arrested, but if people aren't afraid of getting arrested because they're not getting any jail time, that sort of goes against the whole program. (Officer)

3.5.2 Polarized views of LEAD

Officer awareness of polarized community views of LEAD added to doubts about the fit of the LEAD model. Officers felt caught between community members calling for greater criminal justice intervention in misdemeanors to promote public order and other community members calling for a medical and public health response to people with SUD.

> *You get some people some help and you clean up the area, the problem is, the people that are living here want these people arrested because nothing does happen. So, you have a community saying, "I want these people in jail because they're making my life…" - And we're sitting there wanting to extend help. So LEAD says these people are [people who use drugs], we're going to give them help or offer them programs. But that's where the lines are blurred. We're offering help and they're not accepting the help. Someone has to take care of your quality of life issues. (NHPD Leadership)*

3.6 Facilitators

We identified four unique facilitators of LEAD program implementation. Key facilitators include positive longitudinal relationships with potential clients, understanding SUD as a chronic disease, knowledge of the Seattle program, and the integration of LEAD procedures into regular police functions. We did not identify any community level facilitators.

3.7 Client facilitators

3.7.1 Positive longitudinal relationship with potential clients

LEAD professionals viewed a longitudinal relationship with potential clients as important for program success. Such a relationship helped officers identity potential clients likely to enter and benefit from the LEAD program.

> *The officer then exited his file and entered a new name into the system. She pulled up a 23 year old white woman and said that she would really like to get this woman involved in the program. The officer thinks she is a good fit because she has not been on the streets for very long, only a few years, and that she commits low-level thefts in order to support her drug habit. (NHPD ride along field notes)*

LEAD professionals believed using positive incentives that address social needs, including housing, transportation, and food access, would encourage client engagement with the LEAD program.

> *If we have maybe a bus pass. Like a little gift card to Dunkin Donuts. Yeah or probably for a coffee or you know something to eat for the day. You know give it to them and then once you do that they want to talk to you. (Engagement specialist)*

> *Specifically, she likes that the [city name] LEAD program makes care packages for people in the community and offers those as incentive for joining LEAD. She thinks that NHPD could offer incentives to people. (NHPD ride along field notes)*

3.8 LEAD professional facilitators

3.8.1 Understanding SUD as a chronic disease

A portion of officers acknowledged SUD not as a moral failing but as a chronic disease, shaped by social needs and benefiting from non-punitive action. These officers were more confident in the LEAD model and expressed greater interest in adopting its procedures.

> *We're all human beings, we don't want to punish people for things that they don't have any control over because they're in a bad spot. That's why as police, we also have discretion, so there are times where we say, "We're going to give you a break on this. Try to get yourself doing something healthier." (Officer)*

In this context, officers acknowledged the importance of expanding their role of policing beyond enforcing the law to include actions which promote individual and community health.

> *When he is working with new officers he always asks them why did they become a police officer and they frequently say to "help other people." But now when they say this the officer asks, "how are you going to do that?" Many officers struggle to answer this second question. The officer feels that the LEAD program gives officers a chance to meet that goal. (NHPD ride along field notes)*

3.8.2 Knowledge of the Seattle program

LEAD professionals frequently reported a positive view of LEAD overall and accepted the Seattle program as successful. Officers with knowledge of the Seattle program expressed a desire to adopt LEAD procedures.

Yes, overall, I think it's a great program. I like what it stands for. I read up on Seattle because they started it. Just learning about how they took it seriously, that there was a discrepancy with minorities being put in prison for drug offenses versus whites. (Engagement specialist)

3.8.3 Integration of LEAD procedures into regular police functions

Officers believed the integration of LEAD procedures into regular department functions and identifying department champions would improve adoption. Officers believed the integration of LEAD procedures would signal the LEAD program was a department priority.

You can't just introduce it. You've got to constantly remind cops; this is part of our vision. All of a sudden, you go to a [crime statistics] meeting and people are reporting on it automatically, like it's just what we do. We did this many diversions this week, automatically, it becomes part of our practice. (NHPD leadership)

You've got to get champions. You've got to identify champions that are going to help you move this forward. (NHPD leadership)

LEAD professionals believed pairing engagement specialists with officers on patrol would help arrest diversion and social contact referrals. LEAD professionals believed pairing would improve communication between engagement specialists and officers and would allow initial client engagement to include a LEAD team member outside of a criminal justice role.

I think a social worker could walk with us for the first hour or last hour of our shift and just have a social engagement with the people they see. (Officer)

4. DISCUSSION

In this qualitative evaluation of LEAD implementation within a medium sized Northeastern United States city, we identified multiple barriers to LEAD adoption. Barriers at the client, provider, and community levels included prior negative healthcare experiences among potential clients, complexity of arrest diversion procedures, insufficient training, stigma of SUD, belief in the punitive role of policing, reduced substance use penalties in court, and polarized community views of LEAD. Implementation facilitators included positive longitudinal relationships with potential clients, understanding SUD as a chronic disease, knowledge of the Seattle LEAD program, and the integration of LEAD procedures into regular police functions. These implementation barriers and facilitators present potential targets for future interventions to enhance LEAD fidelity and adoption within other municipalities, particularly municipalities with reduced penalties for substance use.

Our findings are consistent with prior research of other police diversion programs. Early rates of arrest diversion were also low in other LEAD cities (Worden & McLean, 2018), and this should inform early expectations for implementation. Negative healthcare experiences and socials needs were also identified as a barrier to police diversion by people with SUD (Barberi & Taxman, 2019; Schiff et al., 2017), suggesting community access to patient-centered substance use treatment and partnerships with organizations which attend to client's social needs may impact LEAD implementation. The complexity of arrest diversion procedures in the setting of a high officer workload was also a barrier to arrest diversion within other municipalities (Barberi & Taxman, 2019; Tallon et al., 2017), demonstrating the importance of clear and simple arrest diversion procedures. Also consistent with

previous evaluations of police diversion programs (Bailey et al., 2018; Barberi & Taxman, 2019; Worden & McLean, 2018), we identified stigma of SUD and a preference for a punitive role for policing as key barriers to officer adoption of LEAD. Finally, polarized community views of arrest diversion were also identified as a barrier to adoption of police diversion in other community settings (Barberi & Taxman, 2019; Worden & McLean, 2018).

Our results identify several implementation strategies for future investigation. There is now widespread interest in LEAD within the United States. As states and municipalities reduce criminal justice involvement among people with SUD, the LEAD model may increasingly be implemented in settings with reduced substance use penalties. In our study, reduced substance use penalties decreased officers' confidence in the LEAD model and their adoption of LEAD procedures. In the setting of reduced substance use penalties, implementation interventions should emphasize positive incentives for program entry (i.e. care packages, bus pass, or harm reduction supplies) among potential clients and leverage longitudinal relationships. Research is needed to determine if the LEAD program will remain effective (improve health and reduce criminal justice involvement) in jurisdictions with lower substance use penalties. Our results suggest police department leadership support for approaching SUD as a chronic disease and the early identification of police champions should be incorporated into future implementation interventions. Deepening community engagement prior to implementation may also be critical for success in such settings. The lack of community facilitators within our results may reflect the delayed creation of a community leadership team in New Haven. Future research should examine the degree to which early community outreach facilitates implementation.

This evaluation has several limitations. First, while this study captures the perspective of LEAD professionals, it does not include the perspective of potential LEAD clients, which should be the focus of future research. Second, the barriers and facilitators of LEAD implementation within this medium sized Northeastern United States city may not generalize to larger cities or rural communities. Third, only three field observations were completed and perspectives among patrol officers who were not selected by NHPD leadership to participate may differ from those observed. Fourth, we were not able to interview LEAD professionals who changed jobs and the high turnover among LEAD professionals may have been an additional barrier to adoption.

5. CONCLUSIONS

This qualitative evaluation of LEAD implementation identified multiple barriers and facilitators of adoption. Future implementation interventions should examine the impact on LEAD adoption of positive longitudinal relationships with potential clients, promoting an understanding SUD as a chronic disease, and the integration of LEAD procedures into regular police functions, particularly within municipalities with reduced penalties for substance use.

DECLARATION OF COMPETING INTERESTS

None

AUTHOR CONTRIBUTORS

Paul J. Joudrey: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Original draft, Review & editing
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ABBREVIATIONS

LEAD Law Enforcement Assisted Diversion

SUD substance use disorder

NHPD New Haven Police Department

iPARIHS Integrated Promoting Action on Research Implementation in Health Services

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